

Centers for Disease Control

Center for Global Health

Cooperative Agreement on Immunization with the World Health Organization (WHO)
CDC-RFA-GH18-1803
Application Due Date: 05/09/2018

Signature _____ Date _____

Cooperative Agreement on Immunization with the World Health Organization (WHO)
CDC-RFA-GH18-1803
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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-GH18-1803. 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 (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:

Cooperative Agreement on Immunization with the World Health Organization (WHO)

C. Announcement Type: New - Type 1

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-GH18-1803

E. Catalog of Federal Domestic Assistance (CFDA) Number:

93.099

F. Dates:

1. Due Date for Letter of Intent (LOI):	**N/A**
2. Due Date for Applications:	**05/09/2018**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Date for Informational Conference Call:

N/A

G. Executive Summary:

1. Summary Paragraph:

This agreement provides resources to the WHO to support polio eradication, measles mortality reduction and regional measles and rubella elimination, and other VPD surveillance; global laboratory networks for polio and measles/rubella; planning and implementation of supplemental immunization campaigns; and strengthening of immunization delivery systems and capacities in high priority countries. These functions are critical to achieving globally and regionally agreed goals for VPD elimination and reduction. This agreement also may be used to support activities to address other global health priorities in line with CDC goals.

Results and measurable outcomes must align with Government Performance Results Act (GPRA): Long Term Objective 10.B.1: Help domestic and international partners achieve WHO's goal of global polio eradication; or Long Term Objective 10.B.2: Work with global partners to reduce the cumulative global measles-related mortality by 90% compared with 2000

estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles and rubella transmission in the Americas.

This announcement is for non-research activities. If research is proposed, the application will not be reviewed. For the definition of research, please see the website: http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf.

a. Eligible Applicants: Single
b. NOFO Type: Cooperative Agreement
c. Approximate Number of Awards: 1

d. Total Period of Performance Funding: $0
There is no project period ceiling; however, estimated funding is $400M

e. Average One Year Award Amount: $80,000,000

f. Total Period of Performance Length: 5
g. Estimated Award Date: 07/01/2018
h. Cost Sharing and / or Matching Requirements: N
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Part II. Full Text

A. Funding Opportunity Description

Part II. Full Text

1. Background

a. Overview

The World Health Organization (WHO) and the U.S. Centers for Disease Control and Prevention (CDC) have a long-standing collaboration to support and implement global health priorities. The U.S. Government supported resolutions to include the creation of the Global Polio Eradication Initiative (WHA 41.28), the adoption of ambitious measles mortality reduction goals (WHA 56.20), the adoption of the Global Vaccine Action Plan (GVAP) (WHA 65.17). As the lead scientific public health agency for the United States, CDC works with WHO and other global partners on these efforts.

CDC's efforts as part of the Global Polio Eradication Initiative (GPEI) helped reduce polio cases to a record low of 12 in 2017, down from ~350,000 in 1988. Yet, to achieve and maintain worldwide polio eradication, CDC must minimize the risk of poliovirus reintroduction to areas declared polio-free. Only three countries have never interrupted wild polio circulation. However, four out of six WHO regions, covering 80% of the world's population, have already achieved certification of being free of wild poliovirus. CDC will collaborate with partners to address the country-specific challenges to achieve global polio eradication. CDC will also continue polio transition planning devised to ensure that functions essential for maintaining a

polio-free world remain in place.

Measles elimination, mortality reduction, rubella/congenital rubella syndrome (CRS) elimination are also of vital importance to the U.S. Nearly all measles cases in the U.S. are caused by international importation of the measles virus as measles has been eliminated from the US since 2000. Progress has been made toward both measles and rubella elimination since 2001 with measles-related deaths down 84 percent from 2000 (as of data available in 2016), preventing 20.4 million measles-related deaths, and rubella/CRS having been eliminated from the Americas. Despite these advances, neither measles nor rubella elimination targets in the GVAP are on track worldwide, putting Americans at risk for these diseases. Improving case-based, fever/rash surveillance enabling early outbreak detection and response, on-time delivery of the first and second doses of measles/rubella combined vaccine, and reducing missed opportunities for vaccination is required to ensure that gains in measles and rubella control can be sustained.

Vaccines are cost effective and lifesaving public health interventions. While the U.S. has reduced the domestic vaccine preventable disease (VPD) burden, the nation remains at risk from importation of other VPDs. CDC's global immunization activities focus on people in developing countries who are at the highest risk for illness and death from VPDs to stop these diseases before they reach our borders, which saves lives of Americans. CDC’s global immunization program is essential in identifying where VPDs emerge and teaches other nations the basic skills needed to control disease outbreaks at the source.

b. Statutory Authorities

Sections 301 (c), 307, and 317 of the Public Health Service Act (42 U.S.C. sections 241 (c), 242l, and 247b); and section 104 of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b)

c. Healthy People 2020

This program addresses the “Healthy People 2020” focus area(s) of Immunization and Infectious Disease (https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases), and Maternal, Infant and Child Health (https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health)

d. Other National Public Health Priorities and Strategies

This NOFO will support the US Government endorsed Global Polio Eradication Initiative (GPEI) and the Global Vaccine Action Plan (GVAP). In addition, this NOFO will support CDC’s Global Health Strategy, which focuses on: 1) improving the health and well-being of people around the world; 2) improving capabilities to prepare for and respond to infectious diseases, other emerging health threats and public health emergencies; and, 3) maximizing the potential of CDC’s global programs to achieve public health impact. By working closely with WHO to support this Global Health Strategy, CDC enhances the technical capabilities of WHO and ensures that the interests of Americans are well represented.

e. Relevant Work

Agency Funding Opportunity Number: CDC-RFA-GH13-1301, *Cooperative Agreement on Immunization with the World Health Organization (WHO)*, is the previous NOFO between

CDC and WHO. This NOFO builds on the activities and goals of GH13-1301 by continuing the progress in polio eradication, measles elimination and enhancing other life-saving VPD activities.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-GH18-1803

Logic Model: Cooperative Agreement on Immunization with the World Health Organization (WHO)

Strategies/Activities	Short-Term Outcomes (1-2 years)	Intermediate Outcomes (3-4 years)	Long-Term Outcomes (5+ years)
• Provide logistical, vaccine, technical and material support to countries to achieve and sustain Global, Regional and National goals for polio eradication and transition; measles, rubella/CRS, maternal and neonatal tetanus (MNT) elimination; control of other VPDs; immunization coverage and equity; and new vaccine introduction. • Lead development of guidelines, norms and standards for routine and supplementary immunization activities, VPD surveillance, outbreak response and laboratory networks which support testing for VPDs. • Generate evidence to inform decision making for immunization programs, including the design and delivery of routine and supplementary activities, VPD surveillance and outbreak response.	• Increased synergy between efforts to eradicate polio, eliminate measles and rubella, achieve targets for control of other VPD and strengthen routine immunization systems • Policies, guidelines, norms, standards and tools reflect best available evidence and meet needs of countries and global immunization community • Improved performance of immunization systems • Broader understanding of barriers to vaccination and effect of strategies to address these. • Countries are able to identify the need for and prioritize the introduction of new vaccines relevant to their country context • More countries meet global, regional and national surveillance targets for polio, measles/rubella and tetanus compared to 2017 • Improvement in detection and response to VPD outbreaks • No reported cases of wild polio virus • Polio transition strategies implemented as planned in the GPEI Transition Planning Framework. • Improved workforce development strategies implemented and evaluated • Sufficiently skilled human and material resources are available at regional and national levels to conduct VPD surveillance, generate, interpret and use VPD laboratory data and respond to disease outbreaks • Increased availability and use of relevant immunization related economic and financial data by countries for planning and decision-making	• High access and utilization of routine immunization services and SIAs at national and/or sub-national level • Improved national and district-level coverage for vaccines in the national immunization schedule. • Increased country ownership and financing of national immunization programs • Reduced reliance on SIAs and increased reliance on a strong routine immunization system • Global interruption of wild poliovirus • Countries fully implement post-interruption, certification, and post certification activities for polio • Improved quality, real-time availability, and use of vaccination and VPD surveillance data • Demonstrated improvements in performance of national surveillance systems for polio, measles/rubella, CRS and MNT. • Improved availability of vaccines to special risk groups including humanitarian emergencies • Reduced number and/or frequency of outbreaks of VPDs • All countries have introduced MCV2 and established CRS surveillance • Demonstrated progress in reaching elimination targets for measles, rubella/CRS and MNT • Demonstrated progress toward reaching hepatitis B control goals • Demonstrated progress in improving technical and management capacity, performance and accountability of the immunization workforce	• Reduced mortality and morbidity from VPDs in children under 5 years of age, compared to 2017 estimates • All countries have adequate human, material and financial resources available to maintain effective national immunization systems and disease surveillance programs • Certified eradication of wild poliovirus globally • Certified interruption of vaccine derived poliovirus globally • Polio assets and resources fully transitioned to other priority health initiatives • Measles and MNT eliminated globally • All WHO regions reach rubella/CRS elimination goals • All WHO regions reach their hepatitis B control goals

i. Purpose

The NOFO is to sustain support for the US Government-endorsed Global Polio Eradication Initiative (GPEI), Measles and Rubella Initiative (M&RI), Global Vaccine Action Plan (GVAP) and the CDC's Global Immunization Strategic Framework, 2015-2020. This agreement provides resources to strengthen immunization systems, enhance global laboratory networks for polio and measles/rubella, and conduct supplemental immunization campaigns in priority countries. All are critical to achieving globally agreed goals for disease elimination and

reduction.

ii. Outcomes

The recipient is expected to achieve the short, intermediate, and long-term outcomes below and also bolded in the logic model.

Short Term Outcomes

- Increased synergy between efforts to eradicate polio, eliminate measles and rubella, achieve targets for control of other VPD and strengthen immunization systems
- Policies, guidelines, norms, standards and tools reflect best available evidence and meet needs of countries and global immunization community
- Improved performance of immunization systems
- Broader understanding of barriers to vaccination and effect of strategies to address these
- Countries are able to identify the need for and prioritize the introduction of new vaccines relevant to their country context
- More countries meet global, regional and national surveillance targets for polio, measles/rubella and tetanus compared to 2017
- Improvement in detection and response to VPD outbreaks
- Polio transition strategies implemented as planned in the GPEI Transition Planning Framework
- Improved workforce development strategies implemented and evaluated
- Increased availability and use of relevant immunization related economic and financial data by countries for planning and decision-making

Intermediate Term Outcomes

- Improved national and district-level coverage for vaccines in the national immunization schedule
- Increased country ownership and financing of national immunization programs
- Reduced reliance on SIAs and increased reliance on a strong routine immunization system
- Countries fully implement post-interruption, certification, and post certification activities for polio
- Improved quality, real-time availability, and use of vaccination and VPD surveillance data
- Demonstrated improvements in performance of national surveillance systems for polio, measles/rubella, CRS and MNT
- All countries have introduced MCV2 and established CRS surveillance
- Demonstrated progress in reaching elimination targets for measles, rubella/CRS and MNT
- Demonstrated progress toward reaching hepatitis B control goals
- Demonstrated progress in improving technical and management capacity, performance and accountability of the immunization workforce

Long Term Outcomes

- Reduced mortality and morbidity from VPDs in children under 5 years of age, compared to 2017 estimates

iii. Strategies and Activities

1. Provide logistical, vaccine, technical and material support to countries to achieve and sustain Global, Regional and National goals for polio eradication and transition; measles, rubella/CRS, maternal and neonatal tetanus (MNT) elimination; control of other VPDs; immunization coverage and equity; and new vaccine introduction.

I. Strengthening of immunization systems

i. Support countries to adapt and implement immunization guidelines and multi-year plans for immunization program strengthening.

ii. Foster timely, effective and safe delivery of vaccines through supporting implementation and evaluation of strategies to improve immunization program delivery, such as

a. Integration of immunization with other health interventions

b. Identification of RI-SIA synergies

c. Reducing missed opportunities for vaccination

d. Safe immunization practices and reducing barriers to safe delivery of vaccines

e. Responding to AEFI clusters and mitigating effects of real or suspected AEFIs on public confidence in immunization programs

f. Improving timeliness and validity of doses (reminder systems)

g. Addressing challenges associated with co-administration of multiple injectable vaccines

h. Identifying, evaluating and promoting best practices for supply chain and vaccine management systems

i. Promoting in-country adoption and scale-up of innovative delivery technologies and strategies that improve vaccine supply chain efficiency (e.g., compact-pre-filled auto- disable injection devices for TT in difficult settings)

j. Identifying hard-to-reach groups and special populations (e.g., refugees) and tailoring delivery of routine immunization services to reach them

k. Identifying and addressing individual, community and health-sector barriers to equitable access and optimal utilization of immunization systems

l. Increasing demand for vaccines and addressing barriers which reduce demand

m. Identifying characteristics of unvaccinated persons

n. Regular evaluation of the skill level of trained healthcare workers and implementation and evaluation of strategies to enhance knowledge, skills and retention of staff involved in management and delivery of immunization programs

And any other elements as programmatically relevant.

iii. Support countries to develop/maintain national immunization information systems which are sustainable and link appropriately with broader health information systems.

a. Support countries to routinely monitor the quality (accuracy, timeliness,completeness) of administrative vaccination data and data on adverse events following immunization (AEFI) at national and sub-national levels.

b. Support countries to routinely analyze and use administrative vaccination data and data on AEFI at national and sub-national levels.

iv. Support countries to routinely monitor performance of immunization program and conduct periodic evaluations of identified strategies and sub-national risk-assessments, as needed. Foster sharing of results from these.

v. Support workforce development strategies, e.g., training to implement Global Routine Immunization Strategies and Practices (GRISP) strategies in targeted countries and disseminate lessons learned.

vi. Support countries to evaluate their needs and preferences for new and emerging vaccines, formulations, presentations, dosing and scheduling and support countries to introduce and evaluate these.

a. Support countries to implement and evaluate introduction of new opportunities for vaccination throughout the life course (e.g., second year of life, primary school-age children, adolescence, women of childbearing age, adults, elderly).

vii. Provide technical assistance to countries transitioning from Gavi Alliance support to plan for, and establish sustainable immunization financing

II. Optimizing planning and performance of supplemental immunization activities (SIA)

i. Support countries to plan, implement and evaluate SIAs and immunization campaigns

ii. Improve SIA quality, especially in polio-endemic and high risk countries

iii. Identify, implement and evaluate strategies to reach underserved and hard to reach populations

iv. Implement and evaluate approaches to delivery of SIAs and immunization campaigns in security-compromised areas

v. Implement and evaluate strategies to improve cross border collaboration in planning and implementation of SIAs and campaigns

vi. Integrate delivery of tetanus vaccine in polio and MR SIAs especially in challenging settings

III. Strengthening surveillance of VPDs and vaccine safety

i. Assist countries to develop and/or update country-level guidelines and standard operating procedures for VPD surveillance.

ii. Assist countries to establish and/or maintain relevant and high performing systems for VPD surveillance across all relevant levels of the health systems.

iii. Establish and/or strengthen and evaluate surveillance for VPDs

iv. Assist countries to conduct serosurveys to document prevalence of VPDs in the population, impact of vaccination, and verify achievement of global/regional eradication, elimination and/or control goals.

v. Support countries to establish and/or maintain high-performing acute flaccid paralysis and environmental surveillance for poliovirus.

vi. Establish and/or strengthen, and evaluate surveillance for AEFI.

vii. Support development or maintenance of high-performing laboratory networks to support polio, measles/rubella and other VPD surveillance and outbreak preparedness and response

viii. Facilitate linkage between national laboratories and VPD surveillance systems

ix. Support the development of innovative technologies for the rapid detection of VPDs (including polio, measles and rubella) from specimens and the environment

x. Support and strengthen surveillance data quality, management, analysis, visualization, dissemination and use

xi. Support countries to develop/maintain national surveillance information systems which are sustainable and link appropriately with broader health information systems

xii. Identify, implement and evaluate strategies to enhance the knowledge, skills and retention of staff managing and implementing VPD surveillance and staff from Global Polio Laboratory Network and VPD-supporting laboratories

xiii. Support the integration of VPD surveillance training into the curricula of institutions that train peripheral level healthcare workers

IV. Strengthen VPD outbreak response and evaluation

i. Support countries to implement poliovirus containment activities outlined in Global Action Plan for Poliovirus Containment (GAPIII), including deployment of consultants to provide technical assistance.

ii. Support development and updating of national plans for VPD outbreak preparedness and response.

iii. Strengthen countries' human and material resource capacity to detect and respond to any possible event/outbreak independently, promptly and adequately

iv. Support rapid deployment of logistics and personnel to support the response to outbreaks of polio, other VPDs and emergencies where vaccination is an appropriate response strategy.

v. Assist countries to conduct thorough analyses of the risk factors and underlying causes of recent VPD outbreaks or ongoing endemic transmission of polio, measles and rubella and use results to define corrective measures.

vi. Strengthen countries' human and material resource capacity to plan, implement and monitor vaccination campaigns as part of a targeted response to VPD outbreaks.

V. Support polio transition and certification of VPD eradication and/or elimination

i. Support countries to develop written plans for polio transition, to include inventory of country specific polio program assets, infrastructure and economic and financial data.

ii. Develop guidelines and recommendations and provide technical assistance to countries in to support the transition of polio program assets and infrastructure

iii. Support planning for, coordination and evaluation of the eventual withdrawal of type 1 and type 3 oral polio vaccines (OPV)

iv. Support countries to collect evidence required for certification of eradication/elimination of VPDs.

v. Support countries to plan for and gather evidence to support certification of the elimination of measles and rubella

vi. Support countries to prepare and submit complete documentation for certification of polio eradication and/or measles/rubella elimination to the Regional Certification Commissions and the Global Certification Commission (RCC and GCC).

vii. Support the establishment and functioning of regional verification committees to track progress of countries in achieving regional and global targets for control of other VPDs including hepatitis B and neonatal tetanus

VI. Strengthen financial management and evaluation

i. Enhance national planning and financial management in order increase efficient use of existing financial resources

a. Provide technical support for tracking domestic expenditures for national immunization programs to facilitate accurate reporting of indicators on sustainable immunization financing.

2. Lead development of guidelines, norms and standards for routine and supplementary immunization activities, VPD surveillance, outbreak response and laboratory networks which support testing for VPDs.

I. Support partner coordination mechanisms to foster exchange of technical information and data between partners in global immunization and country governments.

i. through regional and national structures, support the exchange of technical information and data between partners and country governments at regional, national, district and local levels

ii. provide programmatic advice to donors to help inform introduction of new vaccines

II. Support the SAGE secretariat, SAGE working groups and other regional and/or technical working groups.

III. Develop or update WHO policy and/or position papers for identified priority technical areas which may evolve over time. Currently these may include, but are not limited to:

i. measles, rubella and tetanus

ii. neonatal and non-neonatal tetanus surveillance indicators including serosurveillance

iii. delivery of fractional doses

iv. catch-up vaccination for IPV

v. appropriate surveillance performance indicators for measles/rubella, congenital rubella syndrome, and non-neonatal tetanus

vi. vaccine safety including AEFI

IV. Develop and/or update guidance documents for identified priority technical areas, which may evolve over time. Currently these may include, but are not limited to:

i. national introduction of human papillomavirus vaccine including target populations

ii. harmonized vaccination recommendations/schedules

iii. coverage survey methods

iv. budgeting and financial management

v. missed opportunities for vaccination

vi. vaccine safety and AEFI (including response to AEFI clusters)

vii. delivery of immunization in outbreak or humanitarian emergency settings

viii. norms and standards for collection and use of VPD surveillance and immunization data

ix. planning, implementation and evaluation of SIAs

x. response strategies to measles and rubella that are specific to the endemic and post-elimination settings

xi. global policy for infection prevention and control

xii. reviews: national EPI, vaccine introduction, joint external evaluations (JEE)

V. Strengthen approaches to policy development at global, regional and national levels

i. create enabling environments for evidence-based decision making

ii. support NITAG development

iii. encourage inter-ministerial coordination and collaboration to develop and implement policy

VI. Develop, evaluate and/or support workforce development initiatives that are timely, appropriately delivered and meet the performance needs of the workforce.

i. Define, test and disseminate standards and best practices for immunization competencies,

ii. Analyze worker performance needs and strategies using organization objectives and factors influencing performance outcomes

iii. Incorporate performance improvement and support strategies including training based on analysis

iv. Support emerging technologies and strategies, e.g., distance learning, to enhance learning and performance

v. Evaluate workforce development interventions

vi. Provide and use evidence of planning and implementation quality, outcomes and apply lessons to ensure continuous quality improvement.

VII. Develop/refine strategies/communication materials to reduce vaccination hesitancy & increase demand for vaccines (e.g., global version of EURO TIP guide).

3. Generate evidence to inform decision making for immunization programs, including the

design and delivery of routine and supplementary activities, VPD surveillance and outbreak response.

I. Support planning, implementation and use of findings from reviews of national immunization and VPD surveillance programs. Promote integration and synergy of these reviews.

i. Collect, analyze, interpret/visualize and disseminate immunization and VPD surveillance data to monitor progress toward global, regional and national vaccination coverage targets and disease elimination, eradication and control goals.

ii. Continue to review and refine approaches to this.

II. Monitor and/or evaluate strategies to strengthen immunization service delivery across the lifespan and in special populations and identify the un-vaccinated. This could include:

i. Public/private partnerships

ii. introduction of immunization at new ages (at birth, in the 2nd year of life)

iii. Catch-up vaccination

iv. School-based delivery of vaccines

v. Screening of vaccination status at school/childcare entry

vi. Delivery of immunization services in peri/post humanitarian emergencies and in highly mobile and/or underserved populations

vii. Defaulter tracking systems (e.g., SMS)

viii. Electronic immunization registers and strategies to improve quality of administrative vaccination data

ix. Supply chain and vaccine management systems

x. Best practices for safe delivery of vaccines and response to AEFIs

III. Monitor and/or evaluate the introduction of new vaccines, presentations, formulations, dosing, scheduling and delivery technologies, and facilitate use of these findings. This could include, but is not limited to;

i. dosing (e.g., fractional dose)

ii. vial size (e.g., 5 vs 10 dose vials)

iii. need for, and frequency of, vaccine booster doses

iv. post-vaccine introduction evaluations

v. financial and economic evaluations prior to and after changes to immunization programs

vi. analysis of bottlenecks inhibiting the introduction of new vaccines

vii. emerging devices and delivery technologies (e.g., vaccine patch, controlled temperature chain)

IV. Generate evidence to inform the development and/or scale up of strategies to reduce vaccination hesitancy and increase demand.

This could include, but is not limited to:

i. measure and monitor demand for vaccination in the population and/or sub-groups

ii. identify strategies that effectively increase demand for vaccination among the general population and specific subgroups experiencing rates of vaccine uptake below national targets

iii. evaluation of responses to adverse events following immunization (AEFI) and other vaccine related events across a range of platforms including mass media, social media, community engagement and social mobilization

iv. optimising use of social media strategies

V. Monitor and/or evaluate policies, strategies to improve planning, and delivery of VPD surveillance and outbreak response.

i. conduct case studies of VPD surveillance systems at the national and regional levels.

VI. Generate economic and financial evidence to support sustainable immunization financing, program planning, budgeting and decision-making.

i. Assess the global cost of disease elimination/eradication and implementation of standard surveillance systems

ii. Increase availability of data on supply, demand, and vaccine pricing and procurement strategies.

iii. Develop and evaluate systems, strategies and policies to improve and strengthen financial accountability.

1. Collaborations

a. With other CDC programs and CDC-funded organizations:

Recipient is expected to collaborate with other immunization partners including CDC programs and CDC-funded organizations:

- CDC's Global Immunization Division (GID);
- National Center for Immunization and Respiratory Diseases (NCIRD);
- WHO regional and country teams;
- UNICEF country teams;
- CDC subject matter experts in other Centers and Offices (required when applicable);
- CDC staff in affected countries (required when applicable);
- CDC Incident Command leadership and staff (required when applicable)
- International Federation of Red Cross (IFRC)
- African Field Epidemiology Network (AFENET)
- Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET)
- Eastern Mediterranean Public Health Network (EMPHNET)
- National Stop Transmission of Polio Program (NSTOP)
- Field Epidemiology Training Program (FETP)

b. With organizations not funded by CDC:

Recipient may collaborate with other organizations external to CDC as deemed necessary to achieve project outcomes. Organizations include Bill and Melinda Gates Foundation, US Agency for International Development, GAVI Alliance, Rotary International, Ministries of Health, non-state actors and/or other organizations.

2. Target Populations

The target population will be children under the age of 5 years old but may include other populations that need vaccination (e.g., teenagers, women of childbearing age).

a. Health Disparities

The NOFO requires recipient to collaborate with WHO Country offices who will work with Ministries of Health and local health volunteers to conduct outreach to underserved communities in low-performing districts. The teams will develop and maintain registers of children in these communities to track their vaccination status and ensure they are adequately immunized against polio. The use of volunteers from within the underserved community will assure language does not impede inclusion.

Federal disability rights laws apply to foreign assistance programs. Funded programs consider including people with disabilities in all aspects of the program (e.g., advisory boards, planning committees, project staff, consultants), and ensure to best of their ability that persons with disabilities are not discriminated against in hiring processes, and that facilities and communications are accessible.

iv. Funding Strategy

N/A

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

The purpose of evaluation and performance measurement is to help CDC recipients: (1) Monitor the extent to which activities were successfully completed; (2) Demonstrate progress toward achieving program outcomes (e.g., Were outcomes of interest achieved?); and (3) Inform decisions about future programming that drive continuous program improvement for more efficient and effective program performance (e.g.,What and how could performance be improved?).

An Evaluation and Performance Measurement Plan (EPMP) is required as part of this NOFO to measure NOFO accomplishments. The primary objective of the EPMP implementation is to determine the progress of activities under this NOFO and indicate how they relate to the desired outcomes. The results will be used for program improvement, accountability and reporting, and for sharing with partners and other stakeholders. The EPMP framework describes the desired activities, outcomes and performance measures and how CDC will work with the recipient to support achievement of these.

Activity/strategy	Performance measure (process)	Potential data sources*
1. Provide logistical, vaccine, technical and material support to countries to achieve and sustain Global, Regional and National goals for polio eradication and transition; measles, rubella/CRS, maternal and neonatal tetanus (MNT) elimination; control of other VPDs; immunization coverage and equity; and new vaccine introduction	· Describe type and frequency of assistance provided to countries during the reporting period to achieve Global, Regional and National immunization goals including polio eradication. · Number of WHO-supported human resources providing support to member countries globally in the reporting period. · Minutes and reports from the SAGE and other technical working groups are disseminated to all partners in a timely manner	Reports WHO consultant and staff databases
2. Lead development of guidelines, norms and standards for routine and supplementary immunization activities, VPD surveillance, outbreak response and laboratory networks which support testing for VPDs.	· Topic/title and number of a) position statements, b) guidelines, c) tools and d) other norms, standards, communication materials either newly developed or updated in the reporting period. · Describe process used to ensure best available evidence is used as basis for development or revision of guidelines, norms and standards and provide examples.	
3. Generate evidence to inform decision making for immunization programs, including the design and delivery of routine and supplementary immunization activities, and VPD surveillance and outbreak response.	· Describe outputs from activities to generate evidence during the reporting period. · Describe most significant change that this evidence is meant to inform. · Describe type and importance of new economic and financial evidence generated during the reporting period. · Provide examples of use of this evidence.	
SHORT TERM OUTCOMES (outcome evaluation)		
Outcome	**Performance measure (outcome measure)**	**Potential data sources***

1. Increased synergy between efforts to eradicate polio, eliminate measles/rubella, achieve targets for control of other VPD and strengthen routine immunization systems	· Describe the nature and type of new partnerships created to facilitate activities under the GPEI, M&RI and control of other VPDs · Describe most significant change/s which have resulted from synergies between polio eradication, measles and rubella elimination and strengthening of routine immunization globally, in the reporting period	
2. Policies, guidelines, norms, standards and tools reflect best available evidence and meet needs of countries and global immunization community	· Determination of best available evidence of how existing policies, guidelines, standards and tools are being used by, and/or meet needs of countries · Gaps in policies, guidelines, standards and tools identified, and solutions developed to address the gaps · Number of countries aware of new position statements, guidelines, standards/norms or tools released in the reporting period. · Describe changes in global, regional or national level policy or practice resulting from WHO policies, guidelines, norms/standards or tools released during the reporting period. · Describe results from any monitoring and/or evaluation of position statements, guidelines, norms/standards or tools completed in the reporting period	Monitoring and/or evaluation of position statements, guidelines, policies, norms/standards or tools
3. Improved performance of immunization systems	· Number/% of countries reaching national coverage targets for DTP3 in reporting period · Change (n/%) in the number of unvaccinated children globally compared to 2017 WUENIC estimates · Number/% of SIA for polio that reach > 90% coverage · Number/% of SIAs for measles-containing vaccines which reach > 95% coverage	WUENIC estimates SIA reports

	· Describe improvements in response to, and monitoring of, AEFI globally and any changes that have directly resulted from these	
4. Broader understanding of barriers to vaccination and effect of strategies to address these at all levels	· Describe (including examples) of newly generated/updated evidence about barriers to vaccination and/or effect of strategies to address these. · Provide an example of how understanding barriers to immunization has been used to improve routine immunization systems, VPD surveillance and/or outbreak response during the reporting period. · Provide one or more examples effective strategies that are being implemented during the reporting period.	
5. Countries are able to identify the need for and prioritize the introduction of new vaccines relevant to their country context	· Number/% change in the number of countries which have introduced new or under-utilized vaccines compared to 2017 · Number/% of countries which have applied for/identified funding for introduction of new vaccines in the reporting period	JRF data
6. More countries meet global, regional and national surveillance targets for polio, measles/rubella and tetanus compared to 2017	· Number of countries who meet national surveillance targets for a) polio, b) measles/rubella during the reporting period. · Number of regions where neonatal and non-neonatal surveillance guidelines with established surveillance performance indicators are available · Most significant change in surveillance targets observed at global, regional and national level during the reporting period.	JRF data
7. Improvement in detection and response to VPD outbreaks.	· Number of VPD outbreaks in the reporting period & number/% of these detected within required timeframe/s · Describe change/s (including policy or practice) which resulted in improved detection and/or response to VPD	Outbreak investigation reports

	outbreaks in the reporting period.	
8. Polio transition strategies implemented as planned in the GPEI Transition Planning Framework.	· Number of transition strategies from the 16 high priority countries that have been implemented as planned during the reporting period	
9. Improved workforce development strategies implemented and evaluated	· Number/% of workforce improvement strategies implemented with worker performance needs, learning objectives and outcomes assessed and evaluation of process and outcome indicators. · Number/% of workforce improvement strategies developed based on analyzed performance and/or competency needs and cause analysis	Reports, Evaluation results
10. Increased availability and use of economic and financial data by countries for planning and decision-making	· Number of priority countries with completed assessment of economic and financial data needs to support sustainable immunization financing	
INTERMEDIATE OUTCOMES (outcome evaluation)		
Activity/strategy	**Performance measure**	**Potential data sources***
1. Improved national and district-level coverage for vaccines in the national immunization schedule	· Number/% of countries reaching each of the following targets: a) 90% national coverage for 3-doses of DTP-containing vaccines b) 80% coverage in 80% of districts or equivalent administrative area · For a-b above, number/% of countries which have improved, compared to 2017 WUENIC estimates	WUENIC data
2. Increased country ownership and financing of immunization programs	· Change (number/%) in number of countries that have a functioning NITAG. · Number of countries which increase % of total expenditure on vaccines financed by government, compared to 2017	JRF data
3. Reduced reliance on SIAs	· Change in the frequency of SIAs for	

and increased reliance on a strong routine immunization system	a) measles and b) polio, globally, compared to 2017 · Number of countries reaching 95% national coverage for two doses MCV · Describe factors contributing to successful reduction in SIA frequency, in one or more countries.	
4. Countries fully implement post-interruption, certification, and post-certification activities for polio	· Number of countries that have transitioned identified polio resources to support other VPD-related activities · Number of countries that provide at least one dose of IPV into their EPI schedule · Describe successful strategies to implement post-certification activities, from one or more countries. · Polio surveillance in countries is sufficiently robust to successfully document the absence of poliovirus to regional and global certification committees	
5. Improved quality, real-time availability, and use of vaccination and surveillance data	· Correlation between % districts with DTP3 coverage ≥ 80% compared to national coverage estimate for DTP3 · Describe factors affecting accuracy of numerator data globally, and any changes in these. · Number/% of low- and middle income countries with functioning real-time data (e.g., dashboard) for a) VPD surveillance and b) immunization coverage data.	JRF data
6. Demonstrated improvements in performance of national surveillance systems for polio, measles/rubella, CRS and MNT.	· Number/% of countries where case-based surveillance for neonatal tetanus is integrated with AFP and MR surveillance	
7. All countries have introduced MCV2 and established CRS surveillance	· Number of countries routinely delivering MCV2 in the EPI program · Number of countries with CRS	

	surveillance included in the national surveillance system	
8. Demonstrated progress in reaching elimination targets for measles, rubella/CRS and MNT	· Number of countries reaching surveillance targets for; a) measles/rubella, b) CRS · Number/% of countries which achieve high coverage (national coverage >80%) with tetanus toxoid containing vaccine among women of childbearing age · Describe most significant changes in the reporting period which directly effect the elimination of a) measles, b) rubella/CRS and c) MNT globally.	JRF data Coverage surveys
9. Demonstrated progress toward reaching hepatitis B control goals	· Number/% change of countries with universal hepatitis B vaccine birth dose in their immunization schedule · Number/% of countries that have reached the regional hepatitis B control goal · Describe most significant change in the reporting period that contributes to hepatitis B control globally.	JRF data Serological survey data
10. Demonstrated progress towards improved technical and management capacity, performance and accountability of the immunization workforce	· Number of strategies implemented with specific performance outcomes and learning objectives met · Number/percent of staff receiving intervention and performing adequately based on identified workforce performance priorities by demographics e.g., number of staff trained, local, sub-national, national level staff, etc.)	Monitoring and evaluation reports. Workforce analysis
LONG TERM OUTCOMES (outcome evaluation)		
Activity/strategy	**Performance measure**	**Potential data sources***
1. Reduced mortality and morbidity from vaccine preventable diseases in children under 5 years of age, compared	· Change in global under-five mortality rate (per 1000 live births) from vaccine preventable diseases, since 2017 · Change in global under-five	Global burden of disease data

to 2017 estimates	morbidity from vaccine preventable diseases, since 2017	
**Sources of data for performance measures may include existing data sources, such as administrative immunization coverage data provided through existing channels like the WHO/UNICEF Joint Reporting Form, or may include new data sources, such as quarterly update reports to CDC. Relevant data sources from the sub-national, national, regional or global level should be specified, as appropriate, in the Evaluation and Performance Measurement Plan (EPMP). As such, reporting frequency of measures will vary. Recipients should specify reporting frequency as quarterly or annually in the EPMP.*		

ii. Applicant Evaluation and Performance Measurement Plan
Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP), if applicable, for accuracy throughout the lifecycle of the project. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, within the first 6 months of award, as described in the Reporting Section of this NOFO.

Throughout the five-year NOFO period, CDC will work with the recipient to measure

performance. Note that:

- CDC will use results of performance measures to continuously determine whether NOFO activities and outcomes were achieved as planned.

- CDC will review the reported results and provide feedback, noting any necessary corrective and/or improvement actions and discuss these with the recipient

- Annually, CDC, in partnership with the recipient, will hold Implementation Reviews in order to review financial information, status of activities and key successes and challenges to achieve **outcomes.** This will include site monitoring in order to (1) demonstrate accountability of the NOFO investments, and (2) prioritize actions needed to achieve the desired outcomes as planned.

c. Organizational Capacity of Recipients to Implement the Approach

The eligible applicant must clearly describe their demonstrated experience and collaboration in the following areas:

- Collaboration in public health programs with priority country national governments;
- Collaboration with multiple polio eradication and measles/rubella elimination partners including BMGF, USAID, UNICEF, Rotary, Gavi and others;
- Demonstrated accomplishments in designing and implementing public health action and programs in complex settings;
- Demonstrated capacity to mobilize sufficient culturally competent personnel to achieve outcomes;
- Ability to manage financial reporting, budget management and administration, personnel, as well as management of grants and contracts.

d. Work Plan

Project Period Outcome: *[from Outcomes section and/or logic model]*		**Outcome Measure:** *[from Evaluation and Performance Measurement section]*	
Strategies and Activities	**Process Measure** *[from Evaluation and Performance Measurement section]*	**Responsible Position / Party**	**Completion Date**
1.			
2.			
3.			

4.			
5.			
6			

e. CDC Monitoring and Accountability Approach
Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient 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 deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

CDC Grant Monitoring Activities

Throughout the five-year NOFO period, CDC will engage in the following monitoring activities:

- Monthly calls to review program progress, determine needs for technical assistance, and review administrative actions
- Annual site visits to review programmatic progress and to plan for the following budget period; site visits will include a review of recipient program and financial reporting systems
- Technical review of annual workplans and budgets, with written feedback provided to the recipient
- Review of financial and programmatic reports submitted by the recipient

CDC Approaches for NOFO Evaluations:

Throughout the five-year NOFO period, CDC will partner with the recipient to conduct program

monitoring and evaluation of activities as needed. This includes:

- To conduct process and outcome evaluations of the funded activities.
    - Process Evaluation: Process evaluation will assess the extent to which the agreed NOFO activities have been implemented as planned. Limitations, barriers, and key success factors of the implementation will be explored. It is expected that this evaluation will be conducted during Years 2-3.
    - Outcome Evaluation: Outcome evaluation will be conducted to determine whether the funded activities are leading to the expected outcomes. It is expected that this evaluation will be conducted during Years 3-4.
- To finalize the evaluation protocols and plan for implementation at the designated timeframe, a system for collecting data over time to answer evaluation questions should be established during program implementation.
- To ensure that all evaluations are consistent with established frameworks and program specific requirements. Submission of Non-research Determination (NRD) CDC-ADS for ethical clearance is required. CDC will assist the submission process.
- To report the evaluation findings to relevant stakeholders and will make these publically available in order to enhance the utilization of the findings to improve program effectiveness, and continued program improvement upon completion of the award.

CDC Roles & Responsibilities:

CDC will provide technical assistance to the recipients to ensure that the following practices consistent with the established evaluation standards and are integrated with all evaluation activities:

- Engage stakeholders
- Clearly state evaluation questions, purpose, and objectives
- Use appropriate evaluation design, methods, and analytical techniques
- Address ethical considerations and assurances
- Identify resources and articulate budget
- Construct data collection and management plans
- Ensure appropriate evaluator qualifications and evaluation independence
- Monitor the planning and implementation of an evaluation
- Produce quality evaluation reports
- Disseminate results
- Use findings for program improvement and sustainability

f. CDC Program Support to Recipients (THIS SECTION APPLIES ONLY TO COOPERATIVE AGREEMENTS)

CDC Staff will be substantially involved in the program activities outlined in this NOFO to include

- Providing technical assistance to WHO in support of the activities implemented under

this agreement.

- Collaborating with WHO to provide programmatic support to national governments for planning, implementing, and evaluating polio eradication, measles mortality reduction, rubella control/elimination and other globally agreed VPD control activities.
- Assisting in providing technical training, support, and consultation to expert staff hired by WHO to assist in the polio eradication, measles mortality reduction, rubella control/elimination and GVAP strategies.
- Providing expertise for the maintenance and development of disease surveillance structures, including assessment, strategy design, evaluation and assistance in priority countries.
- Providing laboratory expertise to WHO for the strengthening and expansion of laboratory-based surveillance systems.
- Collaborating with and providing technical assistance to WHO to determine appropriate strategies to address other mutually agreed global health priorities that may be addressed through this CDC-WHO agreement, if and when required.

B. Award Information

1. Funding Instrument Type:	Cooperative Agreement CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.
2. Award Mechanism:	U2G
3. Fiscal Year:	2018
4. Approximate Total Fiscal Year Funding:	$80,000,000
5. Approximate Period of Performance Funding:	$0

This amount is subject to the availability of funds.

There is no project period ceiling; however, estimated funding is $400M

Estimated Total Funding:	$400,000,000
6. Approximate Period of Performance Length:	5 year(s)
7. Expected Number of Awards:	1
8. Approximate Average Award:	$80,000,000 Per Budget Period
9. Award Ceiling:	$0 Per Budget Period

This amount is subject to the availability of funds.

There is no ceiling for this award; however, estimated funding is $80M

10. Award Floor:	$0 Per Budget Period
11. Estimated Award Date:	07/01/2018

12. Budget Period Length: 12 month(s)

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. 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 period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance

Direct Assistance (DA) is not available through this FOA.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category: Others (see text field entitled "Additional Information on Eligibility" for clarification)

Additional Eligibility Category:

2. Additional Information on Eligibility

Single Eligibility - World Health Organization (WHO)

Eligibility is limited to the World Health Organization (WHO), 20 Avenue Appia, Geneva, Switzerland.

3. Justification for Less than Maximum Competition

WHO should be considered as the single source for this funding opportunity because:

1) WHO is the recognized global lead health agency with an unprecedented convening authority;

2) WHO has the sole responsibility among UN organization for implementing the World Health Assembly (WHA) resolutions calling for the global eradication of polio, a 95% reduction in measles deaths globally by 2020 compared to 2000 targets, and adoption of the Global Immunization Vision and Strategy (GIVS).

3) WHO is the only organization with a worldwide mandate, as supported by Member States, for the control and prevention of vaccine-preventable diseases (VPD).

4) WHO and the US Government signed an MOU on September 19, 2011 to help WHO Member States to strengthen their capabilities to support the International Health Regulations (IHR), an international agreement that requires Member States to prevent and respond to acute public health risks that have the potential to cross borders. The purpose of the MOU is to assist

WHO in implementing the IHR, including the development and implementation of coordinated plans and networks that enable national governments and regional authorities globally to better address infectious diseases. Specific activities are to improve infectious disease surveillance, prevention and control strategies; and strengthen public health infrastructure.

5) WHO has a robust global infrastructure, with presence in 193 countries, enabling it to work with multiple national Ministries of Health and other critical health agencies and institutions. Through its headquarters, regional and country offices, WHO provides the overall technical leadership and strategic planning for the management, coordination and evaluation of VPD eradication and control activities globally, as well as for other global health priorities.

6) WHO is a lead agency for the Global Polio Eradication Initiative, the Global Measles and Rubella Initiative, and the Global Vaccine Action Plan (GVAP) in partnership with CDC, UNICEF and others.

7) WHO has demonstrated success in this partnership, with a cooperative agreement history spanning 25 years. During this time, WHO has made outstanding progress towards strengthening worldwide field and laboratory surveillance systems for polio and measles/rubella, has developed a strong platform for strengthening surveillance for other VPDs, and has made substantial progress towards polio eradication and reduction of measles mortality. Since the World Health Assembly of WHO resolved to interrupt wild poliovirus transmission worldwide in 1988, the annual number of cases has decreased by greater than 99%. Global measles deaths decreased by 79% from 2000 to 2014, primarily attributed to measles supplemental immunization activities (SIAs) coordinated by WHO and designed to close immunity gaps. In addition, the number of children who did NOT receive a third dose of diphtheria-tetanus-pertussis vaccine reached an all-time low of 18.7 million in 2014. India has been polio-free since 2011. The South-East Asia Region was certified polio-free in 2014. WHO's unique qualifications made these achievements possible.

8) CDC values the strong collaborative relationship with WHO to provide programmatic support to national governments for planning, implementing and evaluating polio eradication, measles mortality reduction, rubella control/elimination and other globally agreed VPD control activities. No other global partner or agency has the technical expertise and access to implementation of immunization activities in countries.

Disapproval of WHO and its proven and mandated ability to work with priority country governments would significantly disrupt the harmonized and coordinated national VPD field activities such as disease surveillance, laboratory, and campaign planning; Disapproval would disrupt the coordinated and timely administration of life-saving vaccines for polio, measles and rubella and other vaccine-preventable diseases; putting at risk, millions of children under the age of 5 years; born and yet to be born. A coordinated approach to routine and supplementary immunization activities with measles vaccine is expected to avert 13.4 million deaths between 2011 and 2020. Further, disapproving WHO would delay the global eradication of polio by disrupting the global coordination of polio-specific surveillance, laboratory and immunization campaigns, leading to greater number of un-immunized children in the last three endemic countries; an increase in virus circulation and possibly exportation to neighboring countries. If polio is not eradicated as projected, we could see a global resurgence of the disease with as many as 200,000 new cases each year within a decade. Eradication is estimated at $800 million USD annually per year of delay.

As this is a new NOFO, no same or similar deviation has been previously requested for this project. However, the previous NOFO, CDC-RFA-GH13-1301 was approved as a single source NOFO. Also, a single source justification was approved June 2016 for an Expansion Supplement.

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement: No

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

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Application and Submission Information

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-recipients, those sub-recipients 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 a recipient. 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 instructions 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 https://fsd.gov/ fsd-gov/ home.do 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	Register early! Log into grants.gov and check AOR status until it shows you have been approved

			grants.gov)	

2. Request Application Package

Applicants may access the application package at www.grants.gov.

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this notice of funding opportunity at www.grants.gov. If Internet access is not available, or if the online forms cannot be accessed, applicants may call the CDC OGS staff at 770-488-2700 or e-mail OGS ogstims@cdc.gov for assistance. Persons with hearing loss may access CDC telecommunications at TTY 1-888-232-6348.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) 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 OGS.

a. Letter of Intent Deadline (must be emailed or postmarked by)

Due Date for Letter of Intent: **N/A**

b. Application Deadline

Due Date for Applications: **05/09/2018** , 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Information Conference Call

N/A

5. CDC Assurances and Certifications

All applicants are required to sign and submit "Assurances and Certifications" documents indicated at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa)) /Homepage.aspx.
Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications with each application submission, name the file "Assurances and Certifications" and upload it as a PDF file with at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http://wwwn.cdc.gov/ grantassurances/

(S(mj444mxct51lnrv1hljjjmaa))/ Homepage.aspx

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

Duplication of Efforts

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award. Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission

Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent

LOI is not requested or required as part of this NOFO.

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.
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.

9. Project Abstract Summary

(Maximum 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

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)
Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. 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 period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the public health problem as described in the CDC Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the logic model in the Approach section of the CDC Project Description. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (e.g., increase, decrease).

iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the period of performance outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the project period. See the Strategies and Activities section of the CDC Project Description.

1. Collaborations
Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities
Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see http://www.hhs.gov/ ocio/policy/collection/.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the

Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

Applicants must address the organizational capacity requirements as described in the CDC Project Description.

11. Work Plan

(Included in the Project Narrative's 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 recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

Applicants must submit an itemized budget narrative. When developing the budget narrative, applicants must 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
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs could include the cost of collecting, managing, sharing and preserving data.
Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.
If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies

include state, local, territorial governments (including 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), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.
Applicants must name this file "Budget Narrative" and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

13. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 2 CFR 200 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

14. Intergovernmental Review

Executive Order 12372 does not apply to this program.

15. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 Code of Federal Regulations (CFR) section 3.908 to the award and requires that recipients inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

16. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

17. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.

- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- 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 recipients.
- 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.
- In accordance with the United States Protecting Life in Global Health Assistance policy, all non-governmental organization (NGO) applicants acknowledge that foreign NGOs that receive funds provided through this award, either as a prime recipient or subrecipient, are strictly prohibited, regardless of the source of funds, from performing abortions as a method of family planning or engaging in any activity that promotes abortion as a method of family planning, or to provide financial support to any other foreign non-governmental organization that conducts such activities. See Additional Requirement (AR) 35 for applicability (https://www.cdc.gov/grants/additionalrequirements/ar-35.html).

Pre-award costs of up to 10% of the initial award will be allowed across all budget categories to support timely performance of work described in the project narrative, and specifically to facilitate timely 2018 STOP Team deployments.

18. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant's assurance of the quality of the public health data through the data's lifecycle and plans to deposit data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additionalrequirements/ar-25.html

19. Other Submission Requirements

a. Electronic Submission: Applications must be submitted electronically at www.grants.gov. The application package can be downloaded at www.grants.gov. Applicants can complete the

application package off-line and submit the application by uploading it at www.grants.gov. 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 OGS Technical Information Management Section (TIMS) staff.

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

If Internet access is not available or if the forms cannot be accessed online, applicants may contact the OGS TIMS staff at 770- 488-2700 or by e-mail at ogstims@cdc.gov, Monday through Friday, 7:30 a.m.–4:30 p.m., except federal holidays. Electronic applications will be considered successful if they are available to OGS TIMS staff for processing from www.grants.gov on the deadline date.

b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail 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 business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed 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 NOFO. 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 Grants.gov Online User Guide.
https:// www.grants.gov/help/html/help/index.htm? callingApp=custom#t=
Get_Started%2FGet_Started. htm

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.

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@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 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:

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/GMO 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, OGS 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. Review and Selection Process

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

a. Phase 1 Review
All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.
i. Approach
ii. Evaluation and Performance Measurement
iii. Applicant's Organizational Capacity to Implement the Approach
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.

i. Approach — Maximum Points:40

Evaluate the extent to which the applicant addresses the items below.

- How well does the applicant describe an overall strategy, activities and outcomes that

are consistent with the project period outcomes described in the CDC Project Description and logic model. (8 points)

- How well does the applicant describe strategies and activities that are achievable, appropriate and evidence-based to achieve the outcomes of the project? (8 points)
- To what extent does the applicant included plans to implement specific strategies to address noted challenges to achieving the long-term goals of this NOFO? (8 points)
- How well does the applicant show that the proposed use of funds is an efficient and effective way to implement the strategies and activities and attain the project period outcomes? (8 points)
- To what extent does the applicant present a work plan that is aligned with the strategies/activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by CDC? (8 points)

ii. Evaluation and Performance Measurement Maximum Points:30

Evaluate the extent to which the applicant addresses the items below.

- To what extent does the applicant demonstrate the ability to collect data on the process and outcome performance measures indicated by CDC in the project description, and provide timely and complete reporting? (10 points)
- To what extent does the applicant describe clear monitoring and evaluation procedures and how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities, as well as to address necessary adjustment of program activities based on monitoring information? (10 points)
- To what extent does the applicant describe how evaluation and performance measurement will contribute to developing an evidence base for immunization programs that lack a strong effectiveness evidence base? (5 points)
- To what extent does the applicant demonstrate a system able to generate financial and program reports to show timely disbursement of funds, and progress towards achieving the outcomes of the project? (5 points)

iii. Applicant's Organizational Capacity to Implement the Approach Maximum Points:30

Evaluate the extent to which the applicant addresses the items below.

- How well does the applicant demonstrate experience collaborating in public health programs with priority country national governments? (5 points)
- How well does the applicant demonstrate experience collaborating with multiple polio eradication and measles elimination partners including BMGF, USAID, UNICEF, Rotary, GAVI and others? (5 points)
- How well does the applicant demonstrate accomplishments in addressing and implementing public health program needs in complex settings, including demonstrated capacity to mobilize sufficiently culturally competent personnel to achieve outcomes? (5 points)
- To what extent are key staff involved in the project qualified to provide leadership, technical and management expertise required for effective and efficient program

implementation? (Reference Key Staff Curriculum Vitae) (5 points)

- To what extent does the applicant provide a staffing plan, organizational chart, and project management structure that will be sufficient to meet the goals of the proposed project and which clearly defines staff roles? (5 points)
- To what extent does the applicant demonstrate the ability to manage financial reporting, budget management and administration of personnel, as well as management of grants and contracts? (5 points)

Budget

The budget will not be scored but will be reviewed. CDC programs must assess whether the budget aligns with the proposed workplan. For additional guidance, check with the Center for Global Health extramural program office, GMO or GMS.

c. Phase III Review

Applicants must complete and submit the risk questionnaire with their application. The completed risk questionnaire and supporting document can be uploaded in the optional attachments section.

"Applicants must change this document to a PDF and upload under "other" and name this file "Risk Assessment" file in the www.grants.gov application.

Review of risk posed by applicants.

Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR

§75.207.
CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.
In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:
(1) Financial stability;
(2) Quality of management systems and ability to meet the management standards prescribed in this part;
(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;
(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and
(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.
CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

The Grants Management Officer will provide electronic communication to the successful recipient(s) in the form of a notice of award letter. Award date is expected to be 07/01/2018.

F. Award Administration Information

1. Award Notices

Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this Notice of Funding Opportunity 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 these results by e-mail with delivery receipt

or by U.S. mail.

2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.
Brief descriptions of relevant provisions are available at http://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-17.
The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

- AR-8: Public Health System Reporting Requirements
- AR-9: Paperwork Reduction Act Requirements
- AR-10: Smoke-Free Workplace Requirements
- AR-11: Healthy People 2020
- AR-12: Lobbying Restrictions (June 2012)
- AR-14: Accounting System Requirements
- AR-15: Proof of Non-profit Status
- AR-25: Data Management and Access

For more information on the CFR visit http://www. access.gpo.gov/ nara/cfr/cfr-table-search.html

3. Reporting

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

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the NOFO.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the "Agency Contacts" section of the NOFO copying the CDC Project Officer.

Report	When?	Required?
Recipient Evaluation and	6 months into award	Yes

Performance Measurement Plan, including Data Management Plan (DMP)		
Annual Performance Report (APR)	No later than 120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures	CDC program determines. Frequency will depend on specific measures agreed upon in performance measurement plan, but at least semi-annually.	Yes
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes
Final Performance and Financial Report	90 days after end of project period.	Yes
Payment Management System (PMS) Reporting	Quarterly reports due July 30, 2018; October 30, 2018; January 30, 2019; April 30, 2019; July 30, 2019.	Yes

a. Recipient Evaluation and Performance Measurement Plan (required)
With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. 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.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.

• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.
• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.

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.

b. Annual Performance Report (APR) (required)

The recipient must submit the APR via www.Grantsolutions.gov no later than120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.
This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.

    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

For year 2 and beyond of the award recipients may request that as much as 75% of their estimated unobligated funds be carried over into the next budget period.

The recipients must submit the Annual Performance Report via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period.

c. Performance Measure Reporting (optional)
CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for recipients at the beginning of the award period.

Performance Measure Reporting will be required semi-annually; specific measures for reporting will be determined in the agreed-upon Performance Measurement plan, to be finalized within 6 months of award.

d. Federal Financial Reporting (FFR) (required)
The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period. The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)
This report is due 90 days after the end of the period of performance. CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process

and outcome performance measures.

- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 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, http://www.USASpending.gov. 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:

- https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf,
- https://www. fsrs.gov/documents /ffata_legislation_ 110_252.pdf
- http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA.

5. Reporting of Foreign Taxes (International/Foreign projects only)

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 recipient 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 recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient 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. recipient 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 recipient must include this reporting requirement in all applicable subgrants and other subagreements.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

Julie Jenks , Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
1600 Clifton Road NE, Bldg 24, MS A-04

Atlanta, GA 30329-4027

Telephone: (404) 718-2794
Email: jdj2@cdc.gov

Grants Staff Contact

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

Rhonda Latimer , Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
2920 Brandywine Rd., MS K75
Atlanta, GA 30341

Telephone: (770) 488-1647
Email: ito1@cdc.gov

For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.
Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

For all other **submission** questions, contact:
Technical Information Management Section
Department of Health and Human Services
CDC Office of Financial Resources
Office of Grants Services
2920 Brandywine Road, MS E-14
Atlanta, GA 30341
Telephone: 770-488-2700
E-mail: ogstims@cdc.gov

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348

H. Other Information

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

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Report on Programmatic, Budgetary and Commitment Overlap

- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

- Resumes / CVs
- Organization Charts

I. Glossary

Activities: The actual events or actions that take place as a part of the program.
Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).
Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.
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 applicant.
Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 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 over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.
Catalog of Federal Domestic Assistance (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

CFDA Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency.
CDC Assurances and Certifications: Standard government-wide grant application forms.
Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established period of performance (i.e., extends the "life" of the award).
Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.
Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.
Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.
Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.
Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants /additionalrequirements /index.html.
DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at http://fedgov.dnb.com/ webform/displayHomePage.do.
Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.
Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.
Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.
Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition 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 a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.
Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.
Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.
Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.
Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.
Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.
Healthy People 2020: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.
Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.
Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.
Intergovernmental Review: Executive Order 12372 governs applications subject to

Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: http://www.whitehouse.gov/omb/ grants_spoc/.

Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating 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.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

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

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

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

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 persons responsible for making award decisions.

Outcome: The results of program operations or activitIes; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement 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.
Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.
Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period
Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.
Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).
Program Official: Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.
Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.
Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.
Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.
System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.
Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.
Work Plan: The summary of period of performance outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

NOFO-specific Glossary and Acronyms

ACRONYMS

AEFI	Adverse Events Following Immunization
AFENET	African Field Epidemiology Network
AFP	acute flaccid paralysis
ARC	American Red Cross
BMGF	Bill & Melinda Gates Foundation
CDC	U.S. Centers for Disease Control and Prevention
CRS	Congenital Rubellla Syndrome
cVDPV	circulating vaccine-derived poliovirus
DTP3	third dose of diphtheria–tetanus-pertussis vaccine
EMPHNET	Eastern Mediterranean Public Health Network
EPI	Expanded Programme on Immunization
EPMP	Evaluation and Performance Measurement Plan
FETP	Field Epidemiology Training Program
GAPIII	Global Action Plan for Poliovirus Containment
GAVI	Global Alliance for Vaccines and Immunization
GBS	Guillain-Barre syndrome
GIVS	Global Immunization Vision and Strategy
GPEI	Global Polio Eradication initiativehttp://polioeradication.org/who-we-are/governance/polio-oversight-board/.
GRISP	Global Routine Immunization Strategies and Practices
GVAP	Global Vaccine Action Plan
HAV	hepatitis A virus
HBc	hepatitis B core
HBV	hepatitis B virus
HBsAg	hepatitis B surface antigen
HepB3	third dose of hepatitis B vaccine

Hib3	third dose of *Haemophilus influenzae* type b vaccine
IDS	Integrated disease surveillance
IFRC	International Federation of Red Cross
IHR	International Health Regulations
IMB	Independent Monitoring Board
IDSR	Integrated Disease Surveillance and Response
IgA	immunoglobulin A
IgG	immunoglobulin G
IgM	immunoglobulin M
IMCI	Integrated Management of Childhood Illness
IPV	inactivated polio vaccine
IVB	Department of Immunization**,** Vaccines and Biologicals
IVD	Immunization and Vaccine Development
JRF	Joint Reporting Form
MCH	maternal and child health
MCV2	Measles-containing-vaccine-second-dose
MNT	maternal and neonatal tetanus
MoH	Ministry of Health
M&RI	Measles and Rubella Initiative
NCIRD	National Center for Immunization and Respiratory Diseases
NGO	Non-governmental organization
NIDs	National Immunization Days
NSTOP	National Stop Transmission of Polio
NT	neonatal tetanus
OPV	oral polio vaccine (live attenuated)
ORI	outbreak response immunization
OPV3	third dose of oral polio vaccine
PEI	Polio Eradication Initiative

RI	Routine immunization
RO	Regional Office
SIA	Supplementary Immunization Activity
SMS	Short Message Service
sNIDS	Sub-National Immunization Days
STOP	Stop Transmission of Polio
TEPHNET	Training Programs in Epidemiology and Public Health Interventions Network
TIP	Tailoring Immunization Programs
TT	tetanus toxoid
USAID	United States Agency for International Development
VAD(D)	Vitamin A Deficiency (Disorder)
UNICEF	United Nations Children's Fund
VAPP	vaccine-associated paralytic polio
VDPV	vaccine-derived poliovirus
VPD	Vaccine preventable disease
VVM	vaccine vial monitor
WHA	World Health Assembly
WHO	World Health Organization
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage
YF	Yellow fever vaccine

GLOSSARY

Acute Flaccid Paralysis (AFP): Any case with weakness or floppiness of the limbs of sudden onset, not due to trauma in a child less than 15 years of age.

Antibody: Protein molecules (immunoglobulin) produced by B lymphocytes to help eliminate an antigen.

Antigen: A live or inactivated substance (e.g., protein, polysaccharide) capable of producing an immune response.

Cold chain: A system whereby vaccines or drugs are transported from the manufacturers to the point of administration at a specified temperature. For example, most vaccines used in the EPI are stored between 4°C and 8°C. This is referred to as the vaccine cold chain.

Cold life: The interval of time between the coldest point in a load stored in cold chain equipment (i.e. specimens or vaccine) passing –3°C and the warmest point reaching +10°C at a specific ambient temperature. WHO usually tests cold chain equipment (refrigerators, freezers, cold boxes and vaccine and specimen carriers) at ambient temperatures of 32°C and 43°C.

Elimination: The situation in a large geographical area in which endemic transmission of a disease agent has stopped and sustained transmission does not occur following the occurrence of an imported case; continued intervention measures are required.

Epidemiology: The study of the transmission, control and prevention of disease in a community or a group of persons.

Epidemiologically confirmed: A case that meets the clinical case definition and is linked epidemiologically to a laboratory confirmed case.

Eradication: The interruption of transmission of a disease agent worldwide as a result of deliberate efforts; intervention methods may no longer be needed. Eradication represents the sum of successful elimination efforts in all countries.

Feedback: The process of routinely sending analyses and reports to the more peripheral levels of the surveillance system, particularly to the suppliers of data. Feedback may occur in the form of newsletters, bulletins, letters, memoranda, telephone calls, visits or any combination of these.

Immediately notifiable diseases: Those health events that should be reported "immediately" or within hours of detection. Usually these are public health emergencies and require immediate action (cholera, cerebrospinal meningitis, yellow fever, plague and hemorrhagic fevers).

Immunity: The ability of the human body to tolerate the presence of material indigenous to the body ("self"), and to eliminate foreign ("non-self") material. This discriminatory ability provides protection from infectious disease, since most microbes are identified as foreign by the immune system. Immunity to a microbe is usually indicted by the presence of antibody to that organism. Immunity is generally very specific to a single organism or group of closely related organisms. There are two basic mechanisms for acquiring immunity – active and passive.

- **Active immunity –** protection that is produced by the person's own immune system. This type of immunity usually lasts for many years, often for a lifetime.
- **Passive immunity –** protection by products produced by an animal or human, and transferred to another human, usually by injection. Passive immunity often provides effective protection, but this protection wanes (disappears) over time, usually a few weeks or months.

Incidence: The number of new cases of a specified disease diagnosed or reported during a defined period of time divided by the number of persons in a stated population in which the cases occurred.

Incubation: The time from the moment of inoculation (exposure) to the development of the clinical manifestations of a particular infectious disease.

Logistics (for surveillance): The management, obtaining and movement of human resources, diagnostic specimens and data supported through resource management, training and supervision.

Measles: An acute viral infection that is transmitted in the air, by respiratory droplets, or by direct contact with the nasal and throat secretions of infected persons.

Measles clinical case definition: Any person with fever and maculopapular rash and cough, coryza (runny nose) or conjunctivitis (red eyes), or any person in whom a clinician suspects measles.

Measles - clinically confirmed: A case that meets the clinical case definition and for which no adequate blood specimen was collected.

Measles control: reduction of measles morbidity and mortality in accordance with targets; continued intervention measures are required to maintain the reduction.

Measles – discarded: A suspect case that meets the case definition but laboratory results are IgM negative.

Measles – epidemiologically linked: those people with febrile rash illness who had direct or indirect exposure to a clinically –or laboratory-confirmed measles case during time when disease transmission was possible.

Measles – laboratory confirmed: A case that meets the clinical case definition and is laboratory confirmed by a positive IgM antibody test.

Monthly reporting: Those health events that should be reported on a monthly basis. These health events usually include selected diseases of public health importance.

Morbidity rate: An incidence rate used to include all persons in the population under consideration who become clinically ill during a stated period of time. The population

may be limited to a specific gender or age group or to people with certain other characteristics.

Mortality rate: A rate calculated in the same way as an incidence rate by dividing the number of deaths occurring in a given population during a stated period of time, usually a year, by the number of persons at risk of dying during the period. A total or crude mortality rate relates to deaths from all causes and is usually expressed as deaths per 1000 persons. A disease-specific mortality rate relates to deaths attributable to only one disease and is often expressed as deaths per 100 000 persons.

Notifiable disease: A disease that must be reported to the authorities by law or ministerial decree.

Outbreak: The number of cases observed is greater than the number normally expected in a given geographical area during the same period of time.

Performance indicators: The quality of surveillance should be demonstrated with data on standard surveillance performance indicators or measures of the function of surveillance. An example of a performance indicator for acute flaccid paralysis (AFP) surveillance is the reporting rate of non-polio AFP per 100 000 population aged less than 15 years.

Periodicity: The presence of a repeating pattern of excess cases. The repeater can be in years, months or weeks.

Poliomyelitis: An acute viral disease characterized clinically by fever, sore throat, headache and vomiting, often with stiffness of the neck and back. In the minor illness these may be the only symptoms. The major illness, which may or may not be preceded by the minor illness, is

characterized by involvement of the central nervous system, stiff neck, pleocytosis in the spinal fluid and perhaps paralysis. There may be subsequent atrophy of groups of muscles, ending in contraction and permanent deformity.

Prevalence: The total number of persons sick or exhibiting a certain condition in a stated population at a particular time (point prevalence) or during a stated period of time (period prevalence), regardless of when the illness or condition began, divided by the population at risk of having the disease or condition at the point in time or midway through the period in which it occurred.

Prodrome: An early or premonitory symptom of a disease.

Proportional morbidity: The relative amount of illness attributable to a given etiology (cause).

Reporting completeness: Proportion of all expected reports that were actually received (usually stated as "% completeness as of a certain date").

Reporting timeliness: Proportion of all expected reports that were received by a certain due date.

Reverse cold chain: In AFP surveillance the reverse cold chain involves transporting and storing stool specimens on ice from the moment of collection until arrival in a laboratory.

Sentinel site: A specific surveillance site, e.g. a hospital, clinic or health facility that collects surveillance data on a disease in order to provide an indication of the epidemiological trends of the disease in a wider area.

Specificity: The proportion of persons without disease who are currently identified by a screening test or case definition as not having disease.

Spot map: A map that indicates the location of each case of a disease by showing places that are potentially relevant to the health event being investigated, such as where the case lived, worked, or became ill.

Surveillance: The continuing systematic collection, consolidation and analysis of data and the dissemination of the information obtained to those who need to know in order that action may be taken.

- **Active surveillance -** when data are sought out by visiting or contacting a site and reviewing the medical records and registers of the site to identify cases.
- **Aggregate surveillance –** surveillance of a disease or health event by collecting summary data on groups of cases (e.g. in many general practice surveillance schemes clinicians are asked to report the number of cases of specified diseases seen over a period of time).
- **Case-based surveillance –** surveillance of a disease by collecting specific data on each case (e.g. reporting of details on each case of AFP).
- **Community-based, facility-based** and **laboratory-based surveillance –** surveillance involving detection and notification by communities, health facilities and laboratories respectively.
- **Comprehensive surveillance -** when data are collected from as many sites as possible throughout a country in order to achieve representativeness.
- **Facility-based surveillance** - surveillance where the starting point for a report is a

patient with a particular disease or syndrome who visits a health facility (hospital or health center).

- **Passive surveillance -** when data are routinely collected and forwarded to more central levels on a routine basis, i.e. the data do not have to be requested on each occasion.
- **Routine disease surveillance – the ongoing collection of information on health events and usually includes number of health events by district by month. It sometimes also includes health events by age group and/or immunization status.**
- **Sentinel surveillance –** the ongoing collection of information on health events from a limited number of reporting sites. Although these data are not representative of the entire country, they indicate trends and facilitate monitoring of severe diseases. More detailed data is often collected from sentinel surveillance sites than is possible from routine surveillance sites.

Timeliness: (1) The number of reports received on time compared to the number of health facilities designated to report. National authorities should define "on time" in accordance with local communication facilities. (2) The interval between the occurrence of an adverse health event and (i) the report of the event to the appropriate public health agency, (ii) the identification by that agency of trends or outbreaks, or (iii) the implementation of control measures. Effective disease surveillance provides information when it is due.

Thoroughness: The number of cases or outbreaks investigated compared to the number reported. Various time limits can be built in, e.g. the number of cases investigated within 48 hours after the receipt of reports.

Vaccine: a preparation containing weakened or dead microbes of the kind that cause a particular disease, administered to stimulate the immune system to produce antibodies against that disease. There are two basic types of vaccines: inactivated and live attenuated.

- **Inactivated vaccine –** composed of either whole viruses or bacteria, or fractions of either. These vaccines are not alive, cannot replicate, and cannot cause disease from infection, even in an immunodeficient person. Unlike live antigens, inactivated antigens are usually not affected by circulating antibody. Inactivated vaccines always require multiple doses. The immune response is mostly humoral; little or no cellular immunity results. Some inactivated vaccines may require periodic supplemental doses to increase, or "boost," antibody titers.
- **Live attenuated vaccine –** produced by modifying a disease-producing ("wild") virus or bacteria in a laboratory. In order to produce an immune response, live attenuated vaccines must replicate (grow) in the vaccinated person. Anything that either damages the live organism in the vial (e.g., heat, light), or interferes with replication of the organism in the body (circulating antibody) can cause the vaccine to be ineffective. The immune response to a live attenuated vaccine is virtually identical to that produced by a natural infection. These vaccines are generally effective with one dose, except those administered orally. Live attenuated vaccines may cause severe or fatal reactions as a result of uncontrolled replication of the vaccine virus.

Vaccine efficacy: A vaccine's ability to produce immunogenicity in the target population. Studies of efficacy often include the reduction in susceptibility and infectivity between those

who are vaccinated and not vaccinated. The vaccine efficacy in terms of transmission probabilities is defined as 1 minus the ratio of the transmission probability to a vaccinee and a nonvaccinee when both are exposed to a single infected person.

Vaccine potency: The amount of vaccine necessary to achieve the desired effect.

Vaccine vial monitor: A temperature-monitoring device or indicator applied to oral polio vaccine vials by major vaccine manufacturers in order to determine whether the cold chain has been maintained during vaccine transportation and storage.

Venipuncture: The collection of a blood sample from a vein, usually in the forearm, with a syringe and needle.

Weekly reporting: Those health events that should be reported on a weekly basis. Usually these require prompt action, but which are not as urgent as those on the immediately notifiable disease list.

Zero reporting: Reporting on a regular basis even if no cases are detected. The absence of surveillance reports in a given time period may indicate a failure of reporting or that no cases have been detected. Zero reporting removes this uncertainty.