

Centers for Disease Control and Prevention

NATIONAL CENTER FOR HIV, VIRAL HEPATITIS, STDS AND TB PREVENTION

Accelerating the Prevention and Control of HIV, Viral Hepatitis, STDs, and TB in the U.S. Affiliated Pacific Islands

CDC-RFA-PS23-2302

07/31/2022

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Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-PS23-2302. 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:

Accelerating the Prevention and Control of HIV, Viral Hepatitis, STDs, and TB in the U.S. Affiliated Pacific Islands

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)).

New

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-PS23-2302

E. Assistance Listings Number:

93.116

F. Dates:

1. Due Date for Letter of Intent (LOI):

N/A

2. Due Date for Applications:
07/31/2022
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:
An informational call will be held on June 28, 2022 at 7:00pm (EST)
Link to join call: https://www.zoomgov.com/webinar/register/WN_JV9XwkiuQ_ugCXh-iv5EOQ
Slides will be posted to the PS23-2302 website after the call
here: https://www.cdc.gov/nchhstp/funding/usapi/

G. Executive Summary:

1. Summary Paragraph
The six U.S.-Affiliated Pacific Island (USAPI) jurisdictions (Commonwealth of the Northern Mariana Islands [CNMI], American Samoa, Guam, Federated States of Micronesia [FSM], the Republic of the Marshall Islands [RMI] and Republic of Palau) experience challenges with prevention, care, and treatment of Human Immunodeficiency Virus (HIV), viral hepatitis (VH), sexual transmitted disease (STD), and tuberculosis (TB). The challenges presented by remote geographic location, dispersed populations, and lack of resources are exacerbated by insufficient and fragmented surveillance systems, laboratory testing and intervention capacity, and access to medications. People in these jurisdictions are disproportionately affected by TB and STDs and are potentially at increased risk for HIV infection. In addition, there is evidence suggesting high rates of VH.

The National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) has developed an integrated notice of funding opportunity (NOFO) to:

- Improve efficient use of resources through the integration and coordination of prevention, screening, and treatment programs for HIV, VH, STDs, and TB
- Reduce health disparities and adverse outcomes among persons in the USAPI jurisdictions
- Improve public health care infrastructure, delivery of public health care, laboratory capacity, and the public health workforce to prevent, diagnose, and treat HIV, VH, STDs, and TB
- Reduce incidence of morbidity and mortality from HIV, VH, STDs, and TB

a. Eligible Applicants:
Open Competition

b. Funding Instrument Type:
CA (Cooperative Agreement)

c. Approximate Number of Awards
6

d. Total Period of Performance Funding:
$19,500,000

e. Average One Year Award Amount:

$650,000

f. Total Period of Performance Length:

5

g. Estimated Award Date:

December 01, 2022

h. Cost Sharing and / or Matching Requirements:

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.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

USAPI jurisdictions experience challenges with prevention and control of HIV, VH, STDs, and TB. The combination of disproportionate or unknown disease burden, broadly dispersed populations, lack of infrastructure, and insufficient and fragmented surveillance, laboratory, and healthcare systems result in public health challenges including limited routine screening and testing for infectious diseases.

In 2019, the HIV rate in the U.S. was 13.2 per 100,000 persons, compared with 4.9 per 100,000 persons in the USAPI jurisdictions (excluding FSM, and RMI). Though HIV rates are lower in the USAPI jurisdictions, high rates of STDs are a cause of concern because they increase the risk for HIV infection.

There is no ongoing VH surveillance in the USAPIs, so prevalence of chronic hepatitis must be estimated. The World Health Organization (WHO) Western Pacific Region has the highest prevalence of Hepatitis B Virus (HBV) at 6.2%.[2]

In 2019 in the USAPIs, the total rate of reported cases of chlamydia was 534.4 per 100,000, gonorrhea was 121.6 per 100,000 and primary and secondary syphilis was 3.2 per 100,000, compared to the US total rate of 552.8, 188.4 and 11.9, respectively. Although lower than the reported case rates in the continental US, these infections continue to challenge the health and wellness of thousands of people in the USAPI jurisdictions.

During 2020, 341 TB cases were reported by the USAPI jurisdictions (74.2 cases per 100,000). The TB incidence rate of each USAPI jurisdiction exceeded the US national incidence rate of 2.2 per 100,000. Reported incidence rates per 100,000 persons were 6.3 for American Samoa, 33.8 for Guam, 75.2 for CNMI, 50.0 for the Republic of Palau, 73.7 for FSM, and 252.5 for RMI. The US state with the highest incidence reported 7.9 cases per 100,000; five of the USAPI jurisdictions reported higher incidence.

This NOFO supports the NCHHSTP strategy to increase program collaboration and service

integration (PCSI) through enhanced engagement, knowledge sharing, integration across prevention and treatment services, and consolidated administrative processes. This NOFO will contribute to advancing NCHHSTPs' Health Equity Implementation Plan including reducing health disparities within the USAPIs by developing a well-trained workforce and increasing access to diagnostic testing for populations disproportionately affected by HIV, VH, STD and TB. The NOFO will support recipients to:

- Implement PCSI to capitalize on opportunities to perform diagnostic testing, treat, and prevent infections in persons with similar risk factors
- Improve the collection, reporting, use, and sharing of surveillance data
- Develop public healthcare workforce through training and education.
- Strengthen laboratory quality management systems and improve capacity to conduct reliable, accurate, and timely testing
- Enhance prevention, care, and treatment for disease-specific activities

References

1. CDC. HIV Surveillance Report, 2019; vol.32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Accessed Dec 14, 2021.
2. WHO. Global hepatitis report 2017. www.who.int/hepatitis/publications/global-hepatitis-report2017 .Accessed Dec 14, 2021.
3. CDC. Sexually Transmitted Disease Surveillance 2019. Sexually Transmitted Disease Surveillance, 2019 (cdc.gov). Accessed Dec 14, 2021.
4. CDC. Reported Tuberculosis in the United States, 2020. https://www.cdc.gov/tb/statistics/reports/2020/default.htm. Accessed Dec 14, 2021.

b. Statutory Authorities

Human Immunodeficiency Virus, Viral Hepatitis, Sexually Transmitted Disease and Tuberculosis prevention programs are authorized under the following Sections of the Public Health Service Act: 317(k) (2); 317 E (a) and (b); and 318 (a), (b), and (c) (42 U.S.C. Sections 247b; 247b-6; 247c (a) (b) and (c)), as amended. Regulations governing the implementation of this legislation are covered under 42 CFR Part 51b, Subpart A.

c. Healthy People 2030

This NOFO addresses the Healthy People 2030 focus areas of HIV, Viral Hepatitis, STDs, and TB including:

- Reduce the number of new HIV infections (HIV-01)
- Increase knowledge of HIV status (HIV-02)
- Increase linkage to HIV medical care (HIV-04)
- Reduce the rate of acute hepatitis B (IID-11)
- Increase the proportion of sexually active female adolescents and young women who get screened for chlamydia (STI-01)
- Reduce the syphilis rate in females (STI-03)
- Reduce congenital syphilis (STI-04)
- Reduce the syphilis rate in men who have sex with men (STI-05)

- Reduce tuberculosis cases (IID-17)

For more details: https://health.gov/healthypeople/objectives-and-data

d. Other National Public Health Priorities and Strategies

National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Strategic Plan

National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Equity Initiative

National HIV/AIDS Strategy

National Strategic Plan: A Roadmap to End the Epidemic for the United States 2021-2025

Viral Hepatitis National Strategic Plan

Division of Viral Hepatitis 2025 Strategic Plan

U.S. Department of Health and Human Services. 2020. Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025

e. Relevant Work

This NOFO builds upon CDC-RFA-PS13-1301 and CDC-RFA-PS18-1801, "Accelerating the Prevention and Control of HIV, Viral Hepatitis, STDs, and TB in the U.S.-Affiliated Pacific Islands."

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy 1: Program Collaboration and Service Integration (PCSI): Implement integrated services in high priority settings.	**Increased receipt of testing and treatment for multiple diseases as clinically indicated among patients**	Increased awareness of HIV, VH, STD, & TB infection status among patients	Improved integration & coordination of resources for preventing and treating HIV, viral hepatitis, STDs, & TB Reduced health disparities and inequities among
Strategy 2: Surveillance, Data Management, and Reporting: Collect, manage, and implement quality assurance processes for data,	**Increased complete and timely data reporting for USAPIs**	**Improved prevention programs & service delivery for disproportionately affected populations**	

and use data to drive public health action	Increased knowledge and skills in data security and confidentiality across programs	Increased data sharing and use across programs	persons in the USAPIs Sustained capacity of healthcare delivery systems, public health, and health workforce to prevent, diagnose and treat HIV, VH, STDs, & TB Reduced new infections of and morbidity and mortality from HIV, VH, STDs, & TB
Strategy 3: Workforce Development: Build public health workforce capacity & develop policies and procedures to support PCSI	**Improved public healthcare workforce skills to deliver prevention, screening, and care services for HIV, hepatitis B, STDs, & TB**	Increased culturally appropriate diagnosis & treatment capacity	
Strategy 4: Laboratory Strengthening: Deliver reliable, accurate, and timely public health laboratory testing services and ensure strong laboratory quality management systems	**Improved availability of laboratory supplies within expiration date** **Improved availability of high-quality laboratory testing services** **Decreased turnaround times for HIV, hepatitis B, STDs & TB testing**	Increased laboratory efficiency from implementation of evidence-based policies/ procedures & enriched collaborations supporting laboratory quality management systems.	
Strategy 5: Disease-Specific Prevention and Care: Conduct or facilitate prevention, testing, linkage to care, partner services, contact investigation, treatment and case management	**Increased awareness of HIV, hepatitis B, and STD or TB infection** **Increased timely linkage to care for persons diagnosed with HIV, hepatitis B, STDs & TB or to**	**Improved care outcomes for patients with diagnosed infection**	

	prevention for persons testing negative Increased receipt of case management for diagnosed persons **Increased receipt of partner services and completion of contact investigations**		

i. Purpose

This NOFO will support the implementation of five core strategies to improve HIV, VH, STD, and TB prevention, testing, and treatment programs in the USAPI jurisdictions:

- Program Collaboration and Service Integration in high priority settings and for disproportionately affected populations
- Surveillance, Data Management, and Reporting
- Workforce Development through training and education
- Laboratory Strengthening for reliable, accurate, and timely delivery of public health laboratory services
- Disease-Specific Prevention and Care including testing, linkage to care, and partner services

ii. Outcomes

Strategy 1: Program Collaboration and Service Integration (PCSI)

- Increased receipt of testing and treatment for multiple diseases as clinically indicated among patients

Strategy 2: Surveillance, Data Management, and Reporting

- Increased complete and timely data reporting for USAPIs
- Improved prevention programs and service delivery among disproportionately affected populations

Strategy 3: Workforce Development

- Increased public healthcare workforce skills to deliver prevention, screening, and care services for HIV, VH, STDs, and TB

Strategy 4: Laboratory Strengthening

- Improved availability of laboratory supplies within expiration date
- Improved availability of high-quality testing services

- Decreased turnaround times for HIV, hepatitis B, STD, and TB testing

Strategy 5: Disease-Specific Prevention and Care

- Increased awareness of HIV, hepatitis B, and STD or TB infection
- Increased timely linkage to care for persons diagnosed with HIV, VH, STDs, and TB
- Increased receipt of partner services and completion of contact investigations
- Improved care outcomes for patients with diagnosed infection

iii. Strategies and Activities

Recipients are expected to implement the following strategies and activities during the 5-year period of performance. However, applicants may propose additional strategies and activities (beyond what is included in the logic model) to achieve the outcomes. CDC will only receive de-identified data.

Strategy 1: Program Collaboration and Service Integration (PCSI)

To ensure activities under Strategy 1 are implemented, funded jurisdictions should designate a public health professional (100% of time) to serve as the PCSI Lead. Roles and responsibilities include:

- Convene regular meetings (no less than quarterly) with the PCSI Steering Committee, which includes the PCSI Surveillance Coordinator, PCSI Laboratory Coordinator, financial official, and key staff from the laboratory, HIV, VH, STD, and TB programs.
- Coordinate the PCSI activities required in this NOFO and participate on routine calls with CDC staff.
- Identify and resolve barriers to implementing the PCSI strategies and activities required in this NOFO.

Activity 1.1: Implement integrated screening and testing in high priority settings

- Collaborate with Maternal Child Health (MCH)/Antenatal Care (ANC) departments to ensure pregnant persons receive recommended testing for HIV, hepatitis B virus (HBV), chlamydia, gonorrhea, and syphilis. Additional guidance can be found at: https://www.cdc.gov/nchhstp/pregnancy/screening/index.html and https://www.cdc.gov/std/treatment-guidelines/default.htm
    - Convene regular meetings to review screening data and address barriers (no less than quarterly).

- Ensure follow-up and case reviews of all perinatal deaths in an effort to identify linkage with mother-to-child transmission of syphilis, HBV, and perinatal transmission of HIV. Case reviews shall include staff from HIV, VH, STD, and MCH/ANC programs. The Fetal and Infant Mortality Review (FIMR)/HIV Prevention is a guide to assist with HIV perinatal case review. The Congenital Syphilis Case Investigation and Reporting Form is a guide to assist with mother-to-child transmission of syphilis case review. Additional guidance can be found at: https://www.cdc.gov/std/program/forms/Guidance-for-Case-Status Variable_clearance_cleared.pdf , https://www.cdc.gov/std/treatment-guidelines/clinical-reporting.htm and www.fimrhiv.org

- Collaborate with Family Planning Services to prevent STD-related pelvic inflammatory disease (PID), ectopic pregnancy, and infertility
- Ensure treatment of persons with STIs and their partners
- Promote screening, diagnosis, and treatment recommendations and guidelines among providers

Activity 1.2: Integrate screening and testing of persons at risk for multiple diseases

- Ensure recommended testing of pregnant persons for HIV, HBV, chlamydia, gonorrhea, and syphilis (during the same visit), once within their 1st trimester.
    - If testing capacity allows, also screen for hepatitis A virus (HAV) and hepatitis C virus (HCV (antibody)) in addition to HBV (hepatitis B surface antigen (HBsAg))
- Conduct HIV and diabetes testing on persons with TB disease and refer persons newly diagnosed with HIV and/or diabetes for services.
- Conduct HBV, chlamydia, gonorrhea, syphilis, and TB screening (during the same visit), on persons newly diagnosed with HIV, and annually during routine follow-up care for persons living with HIV.
- Ensure persons treated for chlamydia, gonorrhea, and/or syphilis are tested for HIV within 30 days.
- Ensure testing for all persons seeking STI evaluation who are not already known to have HIV infection
- Conduct targeted HIV, chlamydia, gonorrhea, and syphilis testing among populations disproportionately affected, such as men who have sex with men, persons who inject drugs (PWID), transgender women, and commercial sex workers and their clients.

Strategy 2: Surveillance, Data Management, and Reporting

To ensure activities under Strategy 2 are implemented, funded jurisdictions should designate a full-time PCSI Surveillance Coordinator. Roles and responsibilities include:

- Implement the current NCHHSTP Data Security and Confidentiality Guidelines.
- Coordinate the surveillance, data management, and reporting activities required in this NOFO.
- Ensure HIV testing, VH, STD, and TB surveillance data are entered on a weekly basis into local surveillance systems.
- Ensure HIV, VH, STD, and TB surveillance data are submitted to CDC by reporting deadlines.
- Identify and resolve barriers to sharing and using data across programs.
- Review surveillance data monthly to identify any potential outbreaks in any disease area, and ensure potential outbreaks are investigated immediately after identification.

Activity 2.1: Collect and manage surveillance and program data

- Report surveillance and program data to CDC in required format by required deadlines.

- HIV Surveillance: Within the first year of the award, if not already certified, the HIV Surveillance Programs must complete the HIV certification process to submit HIV Surveillance cases to the CDC, as authorized by the jurisdictions' public health reporting laws, and in compliance with the current Data Security and Confidentiality Guidelines.
    - Recipients should mail the HIV case report form to CDC within 1 month from the laboratory report date of the first HIV-positive test results, and from subsequent laboratory results or change in vital status.

- HIV Prevention: Follow the guidance in the Pacific Islands HIV Test Form Data Dictionary to be shared with recipients post award.
- VH: Follow the Viral Hepatitis Surveillance and Case Management: Guidance for State, Territorial, and Local Health Departments. Atlanta, GA 2021 available at https://www.cdc.gov/hepatitis/statistics/surveillanceguidance/index.htm.
    - Collect data on persons who test positive for hepatitis B surface antigen (HBsAg) to facilitate the notification, counseling and management of persons with chronic HBV infection.
    - A copy of the original laboratory report indicating the pregnant person's HBsAg status should be provided to the hospital or birthing facility where the delivery is planned and to the health provider who will care for the infant.

- STD: Follow the Program Operations and Guidelines for STD Prevention and Data Management, available at https://www.cdc.gov/std/program/Surveillance.pdf
    - Develop surveillance activities to review and investigate all reports on all perinatal deaths, and to identify and complete reports for possible links with maternal syphilis and perinatal HIV.

- TB: To accomplish the priority tasks of timely assessment and reporting of all confirmed TB cases; prompt detection and investigation of and response to possible TB outbreaks; and identification of surveillance infrastructure gaps and system needs, recipients are expected to:
    - Enhance identification, reporting, and follow-up of persons with confirmed or suspected TB by establishing collaborative relationships with appropriate reporting sources including:
        - Hospitals and clinics (e.g., TB and HIV/AIDS and STD clinics).
        - Laboratories performing testing for mycobacteria.
        - Healthcare providers (e.g., pulmonary and infectious disease subspecialists).
        - Correctional facilities.
        - Homeless shelters.
        - Community and migrant health centers.
        - Pharmacies.
        - Other public and private facilities providing care to populations at risk for TB.

    - Ensure complete, accurate, and timely reporting of persons with confirmed or suspected TB by:

        - Maintaining TB disease as a mandatory reportable condition to the extent as required by state and local laws.
        - Enhancing awareness among healthcare providers of the requirement to report TB cases.
        - Maintaining a passive surveillance data collection system that includes at least the data elements contained in the CDC Report of Verified Case of TB (RVCT).
        - Conducting active surveillance for TB when warranted because of a known or suspected TB outbreak, or when there is reason to believe that passive surveillance is insufficient to identify all cases of TB.
    - Notify CDC of TB cases in a complete, accurate, and timely manner by:
        - Maintaining an electronic data system for verified TB cases that is compatible with the National Electronic Disease Surveillance System (NEDSS) standards.
        - Reporting to CDC complete and accurate data on all TB cases (regardless of whether the cases are considered "countable" in official case counts) using the Report of Verified Case of Tuberculosis (RVCT). All RVCT data elements should be filled out completely according to CDC instructions for the RVCT.
        - Transmitting TB case notification messages via the National Notifiable Disease Surveillance System (NNDSS) or other CDC-approved system for all verified TB cases to CDC in a timely manner (within 1 week for newly verified cases and within 1 month for previously verified cases with updated information).
        - Ensuring that all RVCT data for a TB case, including treatment completion and outcome information, are submitted to CDC within 2 years of the initial case report.
    - Ensure prompt identification and investigation of TB genotype clusters by:
        - Submitting at least one isolate from persons with culture-positive TB to a CDC-designated laboratory for genotyping in a timely manner.
        - Linking genotyping results to surveillance data as soon as possible and within 8 weeks of genotype results becoming available, either through the TB Genotyping Information Management System (TB GIMS) or by entering the genotyping laboratory accession number in the appropriate field on the RVCT according to best practices for TB genotyping: www.cdc.gov/tb/publications/factsheets/statistics/Genotyping_BestPractices.pdf
        - Promptly reviewing (within 1 week of receiving notification) and collaborating with CDC to investigate TB genotype cluster alerts generated by TB GIMS to determine whether a TB outbreak is occurring.
    - Ensure appropriate response to large TB outbreaks (≥10 cases diagnosed in a 3-year period that are related by recent transmission) by:
        - Conducting timely and appropriate epidemiologic investigation of, and response to, TB outbreaks.

        - Reporting outbreak investigation and response activities to CDC at least monthly, including epidemiologic data and ongoing or planned interventions to control transmission (e.g., line lists of outbreak-related cases, epidemiologic links identified among patients, and results of contact investigations, including TB and latent TB infection (LTBI) treatment outcomes).

- LAB: Implement and maintain activities to support complete laboratory reporting of HIV, HBV, chlamydia, gonorrhea, syphilis, and TB cases. Additionally, monitor trends in antimicrobial susceptibility profiles for STD (particularly, Neisseria gonorrhea), and TB.
- Build and strengthen disaster recovery and business continuity plans for NCHHSTP data protections and maintenance.
    - Within the first year, recipients should submit their disaster recovery and business continuity plans to a disaster recovery subject matter expert (SME) for review of data protections and maintenance.
    - The disaster recovery SME should review the plans and provide support to recipients to eliminate and or reduce deficiencies for final plans as needed.
    - Where the disaster recovery SME identifies a need for improvements, recipients should work with the disaster recovery SME and NOFO SME to make improvements for a final optimal plan.

Activity 2.2: Evaluate program effectiveness

- Use surveillance and program data to assess effectiveness of screening, targeted testing, partner services/contact tracing, and treatment.

Activity 2.3: Implement quality assurance processes

- Conduct quality assurance of surveillance data monthly to ensure data completeness, timeliness, and accuracy.
- Additional information by program area:
    - HIV Surveillance
        - Conduct death ascertainment to identify deaths among all persons with HIV and identify persons with an HIV-related cause of death.
        - Conduct monthly intrastate de-duplication of HIV cases.
        - Complete routine interstate duplicate review (RIDR).
        - Conduct risk factor ascertainment for all cases of HIV infection, including prevalent cases annually in accordance with the Technical Guidance for HIV Surveillance.
    - TB
        - Develop or update annually a TB surveillance quality assurance plan as described in the CDC Quality Assurance for TB Surveillance Data Guide and Toolkit.
        - Use the National TB Surveillance System (NTSS) and National TB Indicators Project (NTIP) to conduct quality assurance of surveillance data

and to monitor performance towards meeting National TB Program Objectives and Performance Targets.

- STD
  - Collect, and manage and report, STD data.
  - Document the management information system tool used to collect STD data (e.g., Excel, NBS, etc.) using CDC recommended/approved data management information system report tools and program metrics.
  - Routinely evaluate ANC, MCH, and Family Planning data to ensure clients are linked to care, treatment, and partner services.
  - Routinely evaluate, and if needed, link perinatal deaths and serologic data to ascertain possible congenital syphilis cases.

Activity 2.4: Use and disseminate data to drive public health action

- Develop an annual publication of HIV, VH, STD, and TB activities and data that includes a summary per disease.
- Use the National Tuberculosis Indicators Project (NTIP) to submit the "Indicator Summary" report annually and describe barriers to meeting National Performance Targets.
- Disseminate programmatic findings to key stakeholders, including medical providers, government officials, and other collaborative partners.

Activity 2.5: Implement the current NCHHSTP Data Security and Confidentiality Guidelines

- Develop policies and procedures for security and confidentiality and ensure yearly reviews to keep them current.
- Provide yearly staff training on security and confidentiality and upon onboarding new staff.
- Ensure all staff complete the security and confidentiality agreement annually.
- Submit the Certification of Implementation of the NCHHSTP Data Security and Confidentiality Standards and Designation of Overall Responsible Party (ORP) statement annually and provide updated information as needed.
- Use the USAPI Integrated Site Visit Review Guide to prepare for a site visit. Template will be shared with recipients post award.

Strategy 3: Workforce Development

Activity 3.1: Designate a TB Education and Training Focal Point who will become a member (if not already) of the TB Education and Training Network (TB ETN). This focal point will be responsible for the following activities:

- Serve as primary contact in their respective TB program for CDC and TB Centers of Excellence (TB COEs) education and training activities, including needs assessments, capacity building, and resource development/sharing.

- Ensure development and implementation of annual training and Human Resource Development (HRD) activities specific to their TB program.
- Attend the biennial focal point meeting and the biennial TB ETN conference.
- Identify training and HRD needs.
- Coordinate competency-based in-service TB training and human resource development.
- Establish evaluation strategies to improve existing trainings and to identify ongoing training and HRD needs.
- Improve patient education and communications capacity within the program.
- Coordinate trainings related to TB control with training for other disease control programs, such as HIV, viral hepatitis, and STDs.
- Target TB trainings to other health care providers or organizations serving high-risk populations.
- Provide an update on HRD activities year-to-date and HRD plans for the upcoming budget period in the annual performance report.

Activity 3.2: Build public healthcare workforce capacity

- Develop or update individual training plans for programmatic, surveillance, and laboratory staff.
- Develop and deliver local in-service trainings related to programmatic, surveillance, and laboratory. The target audiences may include internal and external partners. Base content on existing training resources or develop in collaboration with partners (e.g., HIV Capacity Building Assistance Provider Network, National Network of STD Clinical Prevention Training Centers, and TB Centers of Excellence). The following describes the types of trainings to be developed or delivered including existing training resources where available.
    - HIV: Cover HIV testing algorithms, including use of rapid and point-of-care testing.
    - VH: Cover HBV testing algorithm, case definitions, data quality assurance, HBsAg data collection and reporting by using a CDC-approved data system.
    - STD: Cover Partner Services for program and medical staff, using the following resources:
        - DIS Fundamentals Training Plan (https://www.train.org/cdctrain/training_plan/4401)
        - Online continuing education resources for program and medical providers. https://www.cdc.gov/std/training/onlinetraining.htm and https://californiaptc.com/
        - Trainings and technical assistance for disease intervention specialists (DIS) and other partner services providers including medical providers and online training for continuing education.
    - TB: Incorporate materials from the following resources:
        - https://www.cdc.gov/tb/education/professional-resources.htm
        - https://www.cdc.gov/tb/education/professionaltools.htm
        - https://www.cdc.gov/tb/education/provider_edmaterials.htm

- LAB: Implement and document annual training and competency assessment for laboratory technicians, including safety training and shipping of infectious and diagnostic specimens per International Air Transportation Association (IATA) standards as well as basic and test-specific laboratory procedures.

Activity 3.3: Participate in CDC-sponsored conferences and meetings

- PS23-2302 PCSI NOFO Meetings
- National HIV Prevention Conference and National HIV Surveillance Conference
- National STD Prevention Conference
- National TB Conference (NTC)
- TB Education and Training Network/Program Evaluation Network (TB PEN/ETN) Conference
- Pacific Islands TB Controllers Association (PITCA) Conference
- ORP and PCSI Leadership (i.e., PCSI Lead, PCSI Surveillance Coordinator, and PCSI Laboratory Coordinator) should attend pandemic mitigation and control related trainings as available and needed

Activity 3.4: Develop and/or update policies and procedures to support program implementation across PCSI programs

- Develop and/or update policies and procedures to ensure PCSI staff are adequately trained to implement programmatic activities. Policies and procedures may include those needed to conduct service delivery, reporting of data, etc.
- Ensure policies and procedures are provided to PCSI staff.

Strategy 4: Laboratory Strengthening

To support the implementation of Strategy 4, recipients should identify a PCSI Laboratory Coordinator at a minimum of 25% of time. Roles and responsibilities include:

- Ensure the availability of high-quality public health laboratory services and sufficient supplies within expiration date to perform testing.
- Attend PCSI Steering Committee meetings.
- Provide quarterly updates on inventory of supplies and reagents and status of laboratory instruments (functionality and maintenance) to the PCSI Steering Committee, individual program leads, and CDC, on request.

Activity 4.1: Deliver reliable, accurate, and timely public health laboratory services and ensure strong laboratory quality management systems.

- Ensure strong inventory control system whereby test kits within expiration date are available as well as ordered with sufficient lead time with consideration of procurement timeframes.
- Develop standard operating procedures (SOPs) for proper specimen(s) collection, handling, transport, storage, processing, testing, and results reporting for HIV, VH, STD, and TB testing. SOPs should be reviewed at least annually and updated as needed.

- For STD testing, ensure quality of syphilis testing through resources such as: https://www.who.int/reproductivehealth/congenital-syphilis/spt-program/en/
- https://www.who.int/reproductivehealth/congenital-syphilis/spt-program-working/en/
    - Report results from molecular testing (e.g., GeneXpert *Chlamydia trachomatis* / *Neisseria gonorrhoeae*) within 48 hours of specimen receipt in the laboratory.
- For TB testing, use recommended acid-fast bacilli (AFB) staining methods for direct smear microscopy and report accurate and reliable results within 24 hours of specimen receipt in the laboratory. Use recommended nucleic acid amplification test (e.g., Xpert MTB/RIF) for direct detection of *Mycobacterium tuberculosis* and report results within 48 hours of specimen receipt in the laboratory.

- Follow procedures to ensure referred specimens are stored, packaged, and shipped in a timely manner to the associated reference laboratory per IATA standards. Report local results as applicable.
- Establish or maintain a laboratory quality assurance program including use of appropriate laboratory controls and participation in an external quality assurance program. Within the first year of funding, establish a baseline for the following:
    - Inventory of hospitals and clinics or other settings where HBV tests are provided
    - Inventory of type of tests for HBV, hepatitis C virus (HCV) and hepatitis A virus (HAV) (if available) ---point-of-care tests, type of point-of-care test (WHO PQ or any vendor)
    - Availability of facilities for VH testing—ELISA machines, qualified staff (identifying any training needs)
    - Inventory of laboratories where Hepatitis B serum is tested
- Develop procedures to report Laboratory Testing Metrics to include information about numbers of tests performed and results. Metrics should also include review of results for referred specimens shipped to reference laboratories.
- Participate on quarterly TB laboratory conference calls with the Pacific Island Health Officer's Association (PIHOA) Regional Laboratory Coordinator, regional TB reference laboratory, and CDC.

Activity 4.2: Evaluate laboratory data/practices and address needed improvements

- Develop and maintain an accurate and complete laboratory register (electronic or paper-based) that includes local and reference laboratory results.
- Develop procedures to report notifiable diseases to the appropriate local public health program.
- Develop procedures to collate and review quarterly laboratory statistics.
- Develop procedures to annually assess progress towards meeting CDC recommended and laboratory specific turnaround times.
- Develop procedures to maintain laboratory equipment to ensure accurate test results.

- Evaluate inventory control procedures to ensure system is efficient and effective in ensuring an adequate supply of all necessary test reagents. The system should monitor supplies and anticipate (forecast) the need to order recommended laboratory testing reagents and kits for HIV, HBV, STD, and TB

Strategy 5: Disease-Specific Prevention and Care

Activity 5.1: Conduct or facilitate high impact prevention including: prevention, screening, testing, linkage to care, treatment, and case management

HIV Prevention

- Implement and/or coordinate targeted HIV testing in non-healthcare settings to identify undiagnosed HIV infection using a point-of-care HIV test (i.e., results available within 30 minutes) on the following populations disproportionately affected by HIV: men who have sex with men (MSM), persons who inject drugs (PWID), transgender women, and commercial sex workers.
    - In non-healthcare settings, at least 70% of point-of-care tests should be used among disproportionately affected populations
- Use a second rapid HIV test (i.e., results available within 30 minutes) to confirm a preliminary positive HIV test result as promoted in the following: HIV Testing in Nonclinical Settings | HIV Testing | HIV/AIDS | CDC
- Distribute condoms for persons disproportionately affected by HIV and STDs, including persons with HIV (PWH).
- Provide linkage to medical care, treatment, and prevention services for PWH.
- Link persons with newly diagnosed HIV infection to medical care within 30 days of diagnosis.
- Support retention in medical care, treatment, and prevention services for PWH.
- Provide guidance on the importance of early HIV screening for all pregnant persons, according to current CDC recommendations.
    - Note: Other funding sources should be leveraged to implement HIV screening among pregnant persons. PS23-2302 funds should be used as payer of last resort to conduct HIV screening among pregnant persons. Additionally, given the low burden of disease among pregnant persons in this region in clinical settings, a cap of 10% of HIV funding can be used to test this population.
- Develop a plan to implement point-of-care testing in non-healthcare settings.
- Utilize the CDC/HRSA integration of prevention and care plan to facilitate prevention, treatment, case management, and linkage to care for newly diagnosed HIV positive individuals and PWH.
- Educate medical providers on the use of pre-exposure prophylaxis (PrEP) an HIV prevention strategy.

VH

- Work with partners (e.g., MCH/ANC, Immunization Programs, Community Health Center, private hospitals, DISs) to screen pregnant persons for VH.
- Ensure the HbsAg status for all pregnant persons is recorded and provided to the hospital or birthing facility where the delivery is planned and to the health provider who will care for the infant (prophylaxis (HepB vaccine and HBIG) within 12 hours of birth for all infants born to HbsAg-positive women).
- Provide HBV test kits to hospitals and other venues reaching populations disproportionately affected by HBV.
- Work with immunization programs to support an increase in HBV vaccination coverage for infants, children and adolescents, susceptible adults at risk for HBV (household contacts, sexual partners, IDU, MSM, occupational, others).
- Implement and/or promote HBV testing and screening among pregnant persons, and others included in the Target Populations section as resources allow, according to the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021-2025 and CDC Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (2018), including Screening All Pregnant Women for Hepatitis B Virus (HBV) Infection. As well as the Global Health Sector Strategy on Viral Hepatitis 2016-2021 (To be updated to the Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections 2022-2030), and WHO Interim Guidance for Country Validation of Viral Hepatitis Elimination.
- Conduct a needs assessment for viral hepatitis including
    - An inventory of hospitals, clinics or other settings where HBV testing can be conducted
    - An inventory of type of tests for HBV and HAV (if available) ---POC tests, type of POC test (WHO PQ or any vendor)
    - An estimate the number of tests needed/year
    - An assessment of the availability of facilities for VH testing—ELISA machines, qualified staff (need for training)
    - An inventory of laboratories where Hepatitis B serum tested
- Identify at least two high-volume clinics to expand hepatitis B testing

STD

- Promote and monitor the extent to which pregnant persons receive recommended prenatal screening for chlamydia, gonorrhea, and syphilis within the first trimester.
- Monitor the extent to which pregnant persons receive recommended treatment for chlamydia, gonorrhea, and syphilis.
- Conduct annual testing for sexually active females younger than age 25 years for chlamydia and gonorrhea using a CDC recommended testing technology.
- Identify internal and external partners and venues to increase chlamydia, gonorrhea, and syphilis screening rates among priority and vulnerable populations (see Target Populations section).

- Venues include family planning, women clinics, adolescent clinics, or other facilities providing reproductive healthcare, and schools/colleges.

- Develop/ enhance the data sharing system to ensure treatment of cases and their partners.
- Monitor extent to which clients with chlamydia, gonorrhea, and syphilis are appropriately managed according to CDC Sexually Transmitted Infections Treatment Guidelines, 2021: https://www.cdc.gov/std/treatment-guidelines/default.htm
- Manage, monitor, and document the number of women with a positive test for chlamydia, gonorrhea, and/or syphilis whose partners are treated.
- To eliminate congenital syphilis, manage, monitor, and document the number of pregnant persons with a positive syphilis test.

TB – Diagnosis and treatment of persons with suspected or confirmed TB disease

- Implement the TB case management approach to coordinate the necessary medical, nursing, outreach, and social services needed to ensure all persons with suspected or confirmed TB disease complete an appropriate and effective course of treatment.
    - Assign a specific worker (i.e., a case manager) who will be primarily responsible for each person with suspected or confirmed TB disease.
    - All reported persons with suspected or confirmed TB disease should be assigned to a case manager, regardless of whether medical care is provided by a health department/ministry of health TB clinic or a private provider.
    - The case manager will be responsible for ensuring that patients adhere to treatment, comply with medical visits, and complete treatment.
    - Case managers are also responsible for ensuring contacts are identified, evaluated, and complete treatment for LTBI, if appropriate.

- Ensure adherence to TB treatment by using in-person directly observed therapy (DOT), electronic directly observed therapy (eDOT), incentives, enablers, and/or outreach staff who are culturally competent.
- Assess adequacy and appropriateness of therapy for each patient by reviewing initial regimen, susceptibility results, adherence, and response to therapy. Therapy should be consistent with American Thoracic Society/ Infectious Disease Society of America/Centers for Disease Control and Prevention guidelines. Refer to the following web link for more information: http://www.cdc.gov/tb/topic/treatment/default.htm.
- Seek expert consultation for treatment of multidrug-resistant (MDR TB) and other complex cases from TB experts who are up to date on current evidence-based practices and guidelines, and who are readily available to provide timely documented advice and ongoing medical guidance. The TB COEs for Training, Education, and Medical Consultation services should be readily used as needed, and relationships should be fostered between any local TB experts who provides the program with clinical guidance and the funded jurisdictions' regional COE. Healthcare providers of record for patients with TB disease should be expected to be familiar with laboratory and chest imaging results as well as current medications and comorbidities when seeking additional medical consultation services.

- Seek expert consultation regarding laboratory results for molecular detection of drug resistance or interpretation of other laboratory results when needed. Refer to the following web links for more information: http://www.cdc.gov/tb/topic/laboratory/default.htm.
- Collaborate with partners at local jails, correctional facilities, homeless shelters, and substance abuse settings to ensure that all newly diagnosed TB cases are treated to completion.
- Partner with CDC Division of Global Migration and Quarantine (DGMQ) to support international TB quarantine efforts.
- Conduct monthly case conference meetings to systematically review the progress and treatment of persons with suspected or confirmed TB disease and develop plans to address any barriers to adherence.
    - These meetings should include staff who are involved in the care and management of TB patients including, case managers, DOT workers, contact investigation staff, nurses, and clinicians
    - The case manager presents information about the status of each TB patient under medical care and the progress of the contact investigation.
    - Each TB patient is presented once within 30 days of starting the intensive phase of treatment and again within 30 days of starting the continuation phase of treatment.

TB – Examination of Immigrants and Refugees with TB or LTBI (if applicable)

- Ensure that immigrants and refugees classified as A, B1, or B2 are located promptly and examined and treated appropriately: http://www.cdc.gov/immigrantrefugeehealth/
- Report examination results of domestic TB follow-up activities including treatment outcomes for TB and LTBI to the Electronic Disease Notification (EDN) system: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6207a1.htm

TB – Targeted Testing and Treatment of LTBI

- Within the first three months of the NOFO, identify a local population for targeted TB testing and treatment using epidemiological data. The selected local population must be at increased risk for LTBI or developing TB disease once infected with *M. tuberculosis* and may include, but are not limited to, persons with diabetes, end-stage renal disease, persons experiencing homelessness, have substance use disorders, or who are incarcerated.
- Within the first year of the NOFO, establish a baseline for seeking and evaluating persons from the target population and identify a goal and strategy for increasing targeted testing for LTBI.
- Within the first year of the NOFO, establish a baseline for initiating and completing treatment for persons diagnosed with LTBI who are recommended for treatment and identify a goal and strategy for increasing LTBI treatment initiation and completion rates.
- Establish or build on existing partnerships with non-communicable disease programs, primary care providers, community health centers, or other partners to expand LTBI testing and treatment.

- Report targeted testing and treatment data using the Aggregate Reports for Tuberculosis Program Evaluation (ARPE): Targeted Testing and Treatment of Patients with Latent TB Infection form.
- Refer to the following web links for more information:
    - https://www.cdc.gov/tb/publications/ltbi/ltbiresources.htm
    - https://theunion.org/technical-publications/management-of-diabetes-mellitus-tuberculosis-a-guide-to-the-essential-practice
    - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2945809/

Activity 5.2: Provide partner services and contact investigation

HIV

- Provide ongoing partner services for all persons with newly diagnosed infection, those with previously diagnosed infection, and their partners following the Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection, 2008. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm
- Collaborate and coordinate with STD surveillance programs to use data to maximize the number of persons identified as candidates for Partner Services.
- Partner with non-health department providers, including non-governmental organizations (NGOs) and private medical treatment providers, to identify more opportunities to provide Partner Services.

VH

- Follow up with household contacts and sex partners of persons with hepatitis B.
    - Asking about vaccination history and testing as needed.
    - If previously unvaccinated and susceptible, then provide hep B vaccines.

STD

- Provide partner services for sex contacts of persons diagnosed with syphilis, gonorrhea, and/or chlamydia within 14 days of diagnosis and link or provide treatment for those diagnosed.
- Use the following resources:
    - Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection, 2008. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm Program Operations Guidelines for STD Prevention-Partner Services link: https://www.cdc.gov/std/program/partners.pdf

Additional support services for sex contacts, including contraception for women HHS, Office of Population Affairs link: https://opa.hhs.gov/reproductive-health?pregnancyprevention/%20index.html

TB

- Ensure that contact investigation activities are initiated and completed promptly; including interviewing TB cases or utilizing location-based methods to identify contacts and ensuring that infected contacts begin and complete an appropriate diagnostic evaluation to exclude TB disease and a course of treatment for LTBI if recommended after TB disease has been excluded.
- Assess reasons for cases with fewer than 3 contacts elicited, for delays in interviewing cases or examining contacts, and for lower rates of completion of LTBI treatment, and devise strategies for improvement. Combine epidemiologic data with TB genotyping results, where appropriate, to confirm or identify previously unidentified transmission links between TB cases and use genotyping results to evaluate the completeness of contact investigation activities.
- Submit data from contact investigations in the Aggregate Reports for Tuberculosis Program Evaluation (ARPE): Follow-up and Treatment of Contacts to Tuberculosis Cases. Additionally, programs that have a more robust database for contact investigation should continue to make improvements to the data collection instrument and ensure data are used to inform progress on TB control and prevention.

1. Collaborations

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

Recipients are required to collaboratively partner with CDC, including other programs outside of those funded by this NOFO. Applicants should describe how each collaboration will assist in implementing activities and achieving the NOFO period of performance outcomes. Specific partners that recipients may collaborate with, if relevant, include the local jurisdiction programs funded by the 1) Division of Diabetes Translation, 2) Division of Global Migration and Quarantine, and 3) Immunization Services Division. Recipients may also collaborate with other CDC-funded recipients including the Association of Public Health Laboratories (APHL) National TB Controllers Association (NTCA); Pacific Community (SPC); Pacific Island Health Officers' Association (PIHOA); STD/HIV Prevention and Training Centers; TB Centers of Excellence (TB COEs); and the Viral Hepatitis Education and Training Centers. While not required, we encourage a memoranda of agreement/memoranda of understanding (MOA/MOU) to be established per collaboration to formalize the agreement.

These documents should describe the scope of work, intensity, duration, specific activities, and which parties are responsible for each specific activity. These documents should be labeled as *MOUwith(insert name)* and uploaded with the application at www.grants.gov.

b. With organizations not funded by CDC:

Recipients are also encouraged to collaborate with other programs focusing on the same population(s) in their jurisdiction. Collaborating partners may include, but are not limited to, the following organizations, agencies and groups within the geographic catchment area, if relevant: private and community medical providers; community leaders and providers serving the selected target population; medical and nursing schools and related teaching hospitals; public health schools and associations; TB advisory councils; U.S. panel physicians and civil surgeons (as guided by CDC); STD/HIV Prevention and Training Centers; Viral Hepatitis Education and Training Centers; Health Resources and Services Administration (HRSA) primary care centers, and maternal and child health programs; AIDS Education and Training Centers; Substance

Abuse and Mental Health Services Administration (SAMHSA); Addiction Technology Transfer Centers; National Alliance of State & Territorial AIDS Directors; National Coalition of STD Directors; and the World Health Organization.

Applicants should address whether they are already or plan to be enrolled in Health Resources and Services Administration's (HRSA) 340B Drug Pricing Program, which provides eligible organizations access to TB and STD medications at reduced prices. PS23-2302 funds may be used to purchase treatment as recommended in the STD treatment guidelines (https://www.cdc.gov/std/treatment-guidelines/default.htm), for women and their partners in an effort to prevent STD- related infertility. Funds may also be used to purchase drugs for the treatment of pregnant persons diagnosed with an STD. However, it is important to note that PS23-2302 funds should only be used as the payor of last resort for the treatment of STDs among the aforementioned populations. Funds may not be used to purchase TB medications. Please see the Funding Strategy section for additional details on the use of PS23-2302 funds to purchase STD medications and the Funding Restrictions section. An organization that enrolls in the 340B Program must comply with all 340B Program requirements and will be subject to audit at any time regarding 340B Program compliance. 340B Program requirements can be found: www.hrsa.gov/opa/.

Memoranda of Agreements (MOA), Memoranda of Understanding (MOU), letters of support/commitment, or service agreements are encouraged to formally document proposed and current collaborations. These documents should describe the scope of work, intensity, duration, specific activities, and which parties are responsible for each specific activity. If necessary, memoranda of agreements/memoranda of understandings (MOAs/MOUs), should be established. Each MOU should be labeled *MOUwith(insert partner's name)* and uploaded as a pdf at www.grants.gov.

2. Target Populations
Applicants should describe how HIV programs will reach the following priority groups:

- Gay, bisexual, and other men who have sex with men (collectively referred to as MSM),
- Transgender women,
- Persons who inject drugs (PWID),
- Commercial sex workers, and
- Pregnant persons.

Applicants should describe how VH programs will reach the following priority groups:

- Pregnant persons,
- Infants born to HBsAg-positive mothers,
- Household contacts and sex partners of HBV-infected persons,
- Persons who are the source of blood or body fluid exposures that might warrant post exposure prophylaxis (e.g., needle-stick injury to a healthcare worker or sexual assault)
- Persons living with HIV

- Men who have sex with men (MSM), and
- Persons who inject drugs (PWID).

Note: Routine HBsAg testing now is recommended for persons born in geographic regions in which HBsAg prevalence is >2%

Applicants should describe how STD programs will reach the following priority groups:

- Persons who are pregnant, and
- Adolescents, young adults, and sex partners.

Applicants should describe how TB programs will reach the following priority groups:

- All persons with TB disease
- Persons having recent contact to infectious TB, especially children younger than 5 years of age
- Non-U.S.–born persons from countries with elevated TB rates who reside in, or are traveling to, the USAPI jurisdictions
- Racial and ethnic minority populations
- Persons living with HIV and others who are immunosuppressed.
- Persons with diabetes with additional risks for TB.
- Persons working or residing in congregate settings (e.g., correctional facilities, homeless shelters)
- Persons with substance use disorders (i.e., excess alcohol use, injection-drug use, non-injection-drug use)
- Persons aged 65 or older
- Persons with multiple medical and social risk factors

Among the populations identified above, recipients should strive to be inclusive of people with limited health literacy, non-English speaking or limited English-speaking populations, or other vulnerable persons in the priority population who the program may miss. Recipients will also be expected to conduct data collection and analysis to assess progress on targeted testing and treatment efforts by population to describe the scope and successes of these efforts. TB fact sheets, language resources, culturally appropriate patient education materials, and other resources are available through TB Centers of Excellence and the following websites:

- TB Centers of Excellence https://www.cdc.gov/tb/education/tb_coe/default.htm
- Health Disparities in TB https://www.cdc.gov/tb/topic/populations/HealthDisparities/default.htm
- Find TB Resources https://findtbresources.cdc.gov/
- Racial and Ethnic Approaches to Community Health (REACH) https://www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/

a. Health Disparities

The program supports efforts to improve the health of populations disproportionately affected by HIV, Viral Hepatitis, sexually transmitted diseases (STDs) and TB by maximizing the health impact of public health services, reducing disease incidence, and advancing health equity.

A health disparity occurs when a health outcome is seen to a greater or lesser extent between populations. Health disparities in HIV, Viral Hepatitis, STDs, and TB are inextricably linked to a complex blend of social determinants that influence which populations are most disproportionately affected by these infections and diseases.

Social determinants are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes (https://www.cdc.gov/socialdeterminants/index.htm). These include conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and social exclusion. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic challenges. It requires:

- Continuous efforts focused on elimination of health disparities, including disparities in health and in the living and working conditions that influence health, and
- Continuous efforts to maintain a desired state of equity after health disparities are eliminated.

Recipients should use data, including social determinants data, to identify communities within their jurisdictions that are disproportionately affected by HIV, Viral Hepatitis, STDs and TB and related diseases and conditions, and plan activities to help eliminate health disparities. In collaboration with partners and appropriate sectors of the community, programs should consider social determinants of health in the development, implementation, and evaluation of program specific efforts and use culturally appropriate interventions and strategies that are tailored for the communities for which they are intended.

iv. Funding Strategy

Multiple funding streams support HIV, VH, STDs, and TB activities in each of the six USAPI jurisdictions. Throughout the period of performance, award amounts are subject to change based upon the availability of funds, evidence of satisfactory progress by the recipients (as documented in required reports), and the determination that continued funding is in the best interest of the Federal Government.

Recipients may utilize up to 5 percent of funds across activities to enhance Program Collaboration and Service Integration, strengthen collaborative work across disease areas, and integrate surveillance and/or services that are provided by related programs. Recipients will be expected to track expenditures by each funding stream.

Below are descriptions of how anticipated funding levels are determined.

1. HIV Surveillance

The USAPI jurisdictions are not included in the current funding formula for HIV surveillance due to the low number of identified cases within the six USAPI jurisdictions. HIV Surveillance expects to fund the USAPI jurisdictions with a total award of approximately $109,000, with a floor of $7,500 and a ceiling of $23,700.

2. HIV Prevention

As with HIV surveillance, the USAPI jurisdictions are not included in the funding formula for HIV prevention. HIV Prevention expects to fund the USAPI jurisdictions with a total award of approximately $1,375,514, with a floor of $140,600 and a ceiling of $355,000.

3. Viral Hepatitis
Anticipated funding for VH will be evenly distributed across recipients at approximately $10,000 for each jurisdiction.

4. Sexually Transmitted Diseases
Funding to improve STD Programs is to support priority activities for prevention and control. The Division of STD Prevention (DSTDP) funding allows a small proportion (at least 20 percent of the overall DSTDP award amount) to support provision of clinical preventive to screen for chlamydia and gonorrhea as well as purchase treatment as recommended in the STD treatment guidelines (https://www.cdc.gov/std/treatment-guidelines/default.htm), for women and their partners in an effort to prevent STD-related infertility. Funds may also be used to purchase drugs for the treatment of pregnant persons diagnosed with an STD. Funding has remained level for the past several years at approximately $540,000 for the six jurisdictions, with a floor of $34,800 and a ceiling of $137,000.

5. Tuberculosis Prevention & Control, Human Resources Development, and Laboratory
Funding amounts for Prevention & Control (P&C) and Human Resources Development (HRD) are based on cost per case (incident) and funding amounts for Laboratory (LAB) are based on legacy funding. CDC may implement a case-based and performance-based funding formula during the period of performance.

Currently, P&C funding includes a minimum floor of $50,000 and a ceiling of $550,000. HRD funding is awarded up to $20,000 for recipients who report between zero and 49 incident cases per year, and up to $30,000 for recipient who report 50 to 499 incident cases per year. LAB funding includes a floor of $10,000 and a ceiling of $85,000.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

The evaluation and performance measurement strategy will be used to assess the performance of the overall project and each jurisdiction individually. Program evaluation and performance measurement activities will include the collection and analysis of program implementation and performance data submitted by recipients and tracking of key performance outputs and outcome indicators. Additional information will be gathered through the review of performance reports, conference calls, and site visits. During the period of performance, CDC may partner with recipients on evaluation activities.

Data collected are used for program monitoring, evaluation, and improvement. Recipients will collect the required quantitative and qualitative data using CDC-approved applications (software) and submit to CDC, according to an established schedule and via CDC-approved systems. Data will be reviewed by CDC to identify challenges experienced by recipients, identify capacity building assistance needs and possible solutions needed to improve overall project performance.

CDC, with input from recipients, will produce reports on project accomplishments, project feedback reports, fact sheets, and other monitoring and evaluation reports. Findings may also be reported at national conferences, online, in peer-reviewed journals, and in other public forums.

Recipients will be expected to demonstrate measurable progress toward achieving the intended short and intermediate term outcomes as depicted in the logic model. For each of the NOFO's five program strategies, a list of outputs, outcomes, and performance measures (indicators) is presented below. CDC will work with recipients to finalize their detailed Evaluation and Performance Management Plan (EPMP), including a Data Management Plan (DMP), in accordance with CDC program guidance.

Strategy 1: Program Collaboration and Service Integration (PCSI)

Outputs:

- PCSI Lead assigned and devoted minimum of 100% of time
- Dates of PCSI Steering Committee meetings
- Sentinel event case reviews conducted

Outcomes: Increased receipt of testing and treatment for multiple diseases as clinically indicated among patients.

- **Indicator**: Percentage of pregnant persons tested for HIV, HBV, chlamydia, gonorrhea, and syphilis (during the same visit) within first 20 weeks of pregnancy (target: TBD)
- **Indicator**: Percentage (and number) of persons newly diagnosed with HIV who are screened for HBV, chlamydia, gonorrhea, syphilis, and TB (during the same visit) (target: TBD)
- **Indicator**: Percentage (and number) of patients diagnosed with TB disease who have a positive or negative HIV test result (target: 99%)
- **Indicator**: Percentage (and number) of persons with TB disease who are screened for diabetes (target: TBD)

Strategy 2: Surveillance, Data Management, and Reporting

Outputs:

- PCSI Surveillance Coordinator assigned and devoted 100% of time
- Annual integrated surveillance report developed and publicly disseminated to affected populations, communities, providers, and key stakeholders
- Number and percentage of all eligible staff with complete security and confidentiality training and agreements in personnel files (target: 100%)
- Number of NCHHSTP programs that have completed yearly Security and Confidentiality (S&C) policy reviews and updates in accordance with the NCHHSTP Data Security and Confidentiality Guidelines checklist (target: 4)

- Number of NCHHSTP programs that have a disaster recovery and business continuity plan with optimal data protections and maintenance in place

Outcomes:
2.1. Increased complete and timely data reporting for USAPIs

- **Indicator**: Percentage of data reporting deadlines met for HIV, VH (HBV), STD, and TB. See Reporting section for complete list of reporting deadlines (target: 90%)
    - For STD: See the De-Duplication Guidance for Gonorrhea and Chlamydia Laboratory Reports and the Program Operations and Guidelines for STD Prevention for Surveillance and Data Management: https://www.cdc.gov/std/program/Surveillance.pdf and https://www.cdc.gov/std/program/data-mgmt.htm
- **Indicator**: Percent completeness of core Report of Verified Case of Tuberculosis (RVCT) data item reported (target: 100%)
- **Indicator**: Percent completeness of core Aggregated Reports of Program Evaluation (ARPE): Follow-up and Treatment of Contacts to Tuberculosis Cases data item reported (target: 100%)
- **Indicator**: Percent completeness of core Electronic Disease Notification (EDN) system data item reported (target: 93%) – *if applicable*

2.2. Improved prevention programs and service delivery for disproportionately affected populations

- **Indicator**: Percentage (and number) of new HIV diagnoses identified in non-healthcare settings among MSM, PWID, transgender women, and commercial sex workers (target: TBD)
- **Indicator**: Percentage (and number) of new HIV diagnoses identified in healthcare settings (target: TBD)
- **Indicator**: Percentage (and number) of positive tests (for chlamydia, gonorrhea, and syphilis) identified among high-risk groups (target: TBD). See Target Populations section for complete list

Strategy 3: Workforce Development

Outputs:

- TB Education and Training Focal Point identified and is a member of TB ETN
- Percentage of HIV, VH, STD and TB program, surveillance, and laboratory staff with an individual training plan
- Percentage (and number) of trainings identified in individual training plans that were completed
- Number of trainings a year that ORP and PCSI leadership attend related to pandemic mitigation and control

Outcomes:
3.1. Improved public healthcare workforce skills to deliver prevention, screening, care services for HIV, VH, STDs, and TB

- **Indicator**: Percentage (and number) of HIV outreach workers trained on point-of-care HIV testing and other HIV testing technology

<u>Strategy 4: Strengthening Laboratory</u>

Outputs:

- PCSI Laboratory Coordinator identified and devoted minimum of 25% time
- Number of HIV, VH, STD, and TB tests that competent laboratory staff performed quarterly stratified by test type
- Number of new standard operating procedures developed for performing high-quality testing ensuring appropriate controls are used
- Number of standard operating procedures for performing high-quality testing that are reviewed and updated, as needed
- Laboratory standard operating procedures developed (or modified) to ensure effective and efficient monitoring for: 1) adequate stock of test kits and reagents including molecular tests; 2) expiration of test kits; 3) maintenance of laboratory equipment per manufacturer schedule; 4) reporting of notifiable diseases to local public health program; and 5) collection, transport, storage, packaging, and shipment of specimens to the associated reference laboratory per International Air Transportation Association (IATA) standards
- Quarterly laboratory statistics report (including HIV, VH, STDs, and TB): Annual TB testing metrics include:
    - Total number of individual patients for whom a sputum specimen was received for diagnosis
    - Total number of individual patients for whom a sputum specimen was received for treatment follow-up
    - Total number of AFB smears examined
    - Percentage of positive smears
    - Percentage of patients with positive AFB smears
    - Percentage of AFB smear microscopy results reported within 24 hours of specimen receipt
    - Number of molecular tests performed for rapid detection of *Mycobacterium tuberculosis* complex that might include rapid detection of mutations associated with drug resistance directly from a clinical specimen:
        - Of these, report the number of positive tests for Mycobacterium tuberculosis complex and the number of tests indicating potential resistance (e.g., rifampin resistance)
        - Percent of molecular test results performed for rapid detection of *Mycobacterium tuberculosis* complex reported within 48 hours of specimen receipt

- Number and percentage of laboratory equipment that received routine maintenance per manufacturer schedule

Outcomes:

4.1. Improved availability of laboratory supplies within expiration date

- **Indicator**: Number of days with stock outs of HIV, HBV, STD, or TB testing supplies
- **Indicator**: Percentage (and number) of laboratory equipment that received routine maintenance per manufacturer schedule
- **Indicator**: Percentage (and number) of AFB smear microscopy results for TB reported within 24 hours of specimen receipt
- **Indicator**: Percentage (and number) of molecular tests performed for rapid detection of *Mycobacterium tuberculosis* complex reported within 48 hours of specimen receipt
- **Indicator**: Passing score for external quality assessment/proficiency testing programs

4.2: Improved availability of high-quality laboratory testing services

- **Indicator**: Percentage (and number) of laboratory technicians trained and competent on the use of GeneXpert to conduct STD and TB testing

4.3: Decreased turnaround times for HIV, hepatitis B, STD, and TB testing

- **Indicator**: Percentage (and number) of results from molecular testing (e.g., GeneXpert MTB/RIF) reported within 48 hours of specimen receipt in the laboratory

Strategy 5: Disease-Specific Prevention and Care

Outputs:

- Number and positivity of all tests for: HIV, HBV, syphilis, chlamydia, and gonorrhea
- Number and positivity of CDC-supported tests for:
    - HIV conducted using a point-of-care HIV test
    - HBV testing events and persons
    - HBV among pregnant persons
    - Syphilis among pregnant persons during the first trimester.
    - Chlamydia and gonorrhea among pregnant persons at any time during pregnancy
    - Chlamydia and gonorrhea among sexually active women younger than age 25 years
- Percentage (and number) of preliminary HIV-positive tests confirmed using HIV rapid tests
- Percentage (and number) of HIV tests conducted among the priority population
    - See Target Population section
- Plan developed and/or updated/revised to implement point-of-care testing in non-healthcare settings
- Percentage (and number) of live and stillborn infants of syphilis seropositive pregnant persons who are appropriately managed

- Dates of monthly TB case conference meetings conducted

Outcomes:

5.1. Increased awareness of HIV, hepatitis B, STD, or TB infection

- Indicator: Number of new diagnoses of HIV, HBV, chlamydia, gonorrhea, syphilis, TB, and LTBI by gender and pregnancy status [pregnancy status needed only for HIV, chlamydia, gonorrhea, syphilis, and HBV]

5.2. Increased timely linkage to care for persons diagnosed with HIV, VH, STDs, and TB or to prevention for persons testing negative

- Indicator: Percentage (and number) of persons diagnosed with HIV infection who attended their first appointment within 30 days
- Indicator: Percentage (and number) of previously unvaccinated persons who received hepatitis B birth dose and hep B vaccine coverage

5.3. Increased receipt of partner services and completion of contact investigation

- Indicator: Percentage (and number) of partners of persons with diagnosed HIV who were 1) tested for HIV and 2) received test results
- Indicator: Percentage (and number) of partners of persons with a positive STD (syphilis, CT/ GC) test who are treated within 7 days (CT/GC) and 14 days (syphilis)
- Indicator: Percentage (and number) of contacts to sputum AFB smear-positive TB cases who have contacts 1) elicited (target: 100%) and 2) evaluated for infection and disease. (target: 94%)
- Indicator: Percentage (and number) of contacts to sputum AFB smear-positive TB cases with TB infection who 1) started LTBI treatment (target: 92%) and 2) completed LTBI treatment (target 93%)

5.4: Improved care outcomes for patients with diagnosed infection

- Indicator: Percentage (and number) of persons living with diagnosed HIV infection who are virally suppressed
- Indicator: Percentage (and number) of persons with a positive STD test (chlamydia, gonorrhea, and syphilis) who are treated within 7 days (chlamydia and gonorrhea) and 14 days (syphilis) [pregnancy status needed]
- Indicator: Number of days with stock outs of essential STI medications key commodities
    - Note: STD treatment medication includes: Benzathine penicillin G, azithromycin, ceftriaxone, doxycycline
- Indicator: Percentage (and number) of TB cases with newly diagnosed TB disease, for whom treatment for 12 months or less of treatment is indicated, who completed treatment within 12 months (366 days) (Target: 95%)
- Indicator: Percentage (and number) of TB cases with positive sputum culture results who have documented conversion to sputum culture-negative within 60 days of treatment initiation (Target: 83%)

- Indicator: Percentage (and number) of persons at high-risk for LTBI or TB disease who were 1) sought, enlisted, or registered (target: TBD) and 2) evaluated for infection and disease. (target: TBD)
- Indicator: Percentage (and number) of persons at high-risk for LTBI or TB disease with TB infection who 1) started LTBI treatment (target: TBD) and 2) completed LTBI treatment (target TBD)
- Indicator: Percentage (and number) of immigrants and refugees with abnormal chest radiographs (X-rays) read overseas as consistent with TB who 1) initiated a medical examination within 30 days of notification (target: 72%) and 2) complete a medical examination within 120 days of notification (target: 78%) – *if applicable*
- Indicator: Percentage (and number) of immigrants and refugees with abnormal chest X-rays read overseas as consistent with TB who are diagnosed with LTBI or have radiographic findings consistent with prior pulmonary TB (ATS/CDC Class 4) on the bases of U.S. examination, for whom treatment was recommended, who 1) started LTBI treatment (target: 87%) and 2) completed LTBI treatment (target 87%) – *if applicable*

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 the 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) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. 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/additional-requirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, the applicant 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, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

Applicants must provide an initial evaluation and performance measurement plan to show that they will be able to collect and report the outputs and outcome indicators described in the CDC Evaluation and Performance Measures section (maximum 5 pages). For each measure, specify:

1. Data source(s)
2. Who is responsible for collecting data and analysis

In addition, applicants should briefly describe how the outputs and outcome indicators will be used to determine and improve performance.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants must provide evidence of their capacity to successfully execute all proposed strategies and activities to meet program objectives. Applicants must describe workforce capacity and competence, expertise and experience related to all program focus areas, information and data systems, and electronic information and communication systems which will be used to implement the award. Applicants must have existing public health programs and ability to provide direct patient care. Applicants must have a history of collaborating with CDC/NCHHSTP and with international organizations such as the World Health Organization and other non-governmental organizations. Applicants must have the legal authority to collect and report surveillance data for the jurisdiction to CDC.

Applicants should describe their mission, organizational structure, overall organizational budget and funding sources, staff size and expertise, the nature and scope of their work and capabilities, long-term sustainability plan, and other information that would help CDC assess the organization's infrastructure and capacity to implement the proposed program. Applicants should address the physical infrastructure as it relates to equipment, electronic information and data systems, ensuring data security and confidentiality, and communication systems to implement the award.

Applicants must describe adequate program management/staffing plans, performance measurement, evaluation, financial reporting, management of travel requirements, and workforce development and training. Applicants should identify key staff to lead PCSI activities and represent HIV, VH, STD, and TB programs. A curriculum vitae (CV) or resume must be submitted for each existing key personnel who will be affiliated with this program. Applicant organizations are also required to provide an agency-wide organizational chart and an organizational chart for the proposed program. CVs or resumes should be labeled as *CV(insert staff last name)*, agency-wide organizational charts should be labeled *AgencyOrgChart*, and program organizational chart should be labeled as *ProgramOrgChart*. Attachments should be uploaded as pdf documents at www.grants.gov.

If applicant is other than a Department/Ministry of Health in the specified jurisdiction, the applicant must submit a memorandum of agreement/memorandum of understanding with the Department/Ministry of Health in the jurisdiction for which it is applying. The memorandum of

agreement/memorandum of understanding should indicate that the Department/Ministry of Health will provide the applicant access to surveillance data and will collaborate with the applicant on this NOFO to ensure complete data are submitted to CDC according to established guidelines and processes. Applicant should name the file *MOUwith(insert name of Department/Ministry of Health)* and upload as a pdf as part of their application at grants.gov.

d. Work Plan

Applicants are required to provide a work plan that provides both a high-level overview of the entire five (5)-year period of performance and a detailed description of the first year of the award. For the high-level overview, applicants should describe the intended outcomes for the entire five (5)-year period of performance. The work plan should incorporate all NOFO-related program strategies and activities. Applicants should propose specific, measurable, achievable, realistic, and time-based (SMART) process and/or outcome objectives for each activity aligned with the related NOFO performance objectives. No specific work plan format is required; however, a sample work plan format for the detailed description of the first year of the award is presented below.

SMART Objectives	**Activities**	**Process Measure**	**Responsible Position/ Party**	**Target Completion Date**	**Outcomes**
Strategy 1: Program Collaboration and Service Integration (PCSI)					
Strategy 2: Surveillance, Data Management, and Reporting					
Strategy 3: Workforce Development					
Strategy 4: Laboratory Strengthening					
Strategy 5: Disease-Specific Prevention and Care					

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.

Recipients are required to collaboratively partner with CDC. Specific partners that recipients are required to collaborate with include the 1) Division of HIV Prevention, 2) Division of Viral Hepatitis, 3) Division of STD Prevention, 4) Division of Tuberculosis Elimination, and 5) Program and Performance Improvement Office.

After review of each annual performance report, if the recipient is not conducting required recipient activities or not meeting process or outcome standards, CDC will provide or facilitate technical/capacity building assistance for program improvement. Recipients performing at a less than sufficient level to achieve program objectives within stated timeframes will be placed on a time-phased Programmatic Improvement Plan (PIP) developed by the CDC Project Officer/Project Consultant/Epidemiologist in collaboration with the recipient. The PIP is a comprehensive tool used to assist recipients to improve program performance through identifying factors contributing to less than sufficient performance and developing specific action steps to address areas in need of improvement. If placed on a PIP, the recipient will have an opportunity to document a plan of action to improve the performance of program activities. In subsequent budget periods, funding may be affected based on performance.

Additionally, performance monitoring data reported from recipients will be used to generate Rapid Feedback Reports (RFRs). RFRs will be produced routinely throughout the period of performance and shared with recipients to demonstrate overall progress towards NOFO outcomes and provide opportunities for improvement as needed.

f. CDC Program Support to Recipients

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring. CDC activities for this program are as follows:

1. Collaborate to ensure coordination and implementation of strategies to support the implementation of activities.
2. Work with recipients to identify and address capacity building assistance (CBA) and TA needs that are essential to the success of the project. Recipients must work with the assigned Project Officer/Project Consultant/Epidemiologist to establish a mechanism to request direct CDC TA and establish a CBA Request Information System (CRIS) user account to facilitate receipt of CBA.
3. Provide access to training and TA that will strengthen staff capacity relevant to all required strategies and activities of the program.
4. Provide guidance to recipients and set standards on data collection, use, and submission requirements.
5. Facilitate coordination, collaboration, and, where feasible, service integration among federal agencies, other CDC funded programs, other health departments, agencies and groups within the geographic catchment area, if relevant: private and community medical providers; community leaders and providers serving the selected target population; medical and nursing schools and related teaching hospitals; public health schools and associations; TB advisory councils; U.S. panel physicians and civil surgeons (as guided by CDC); STD/HIV Prevention and Training Centers; Viral Hepatitis Education and Training Centers; Health Resources and Services Administration (HRSA) primary care centers, and maternal and child health programs; AIDS Education and Training Centers; Substance Abuse and Mental Health Services Administration (SAMHSA); and Addiction Technology Transfer Centers; National Alliance Of State & Territorial Aids Directors; National Coalition of STD Directors; National TB Controllers Association; the Pacific Island Health Officers' Association; World Health Organization; and Pacific Community.
6. Provide guidance and coordination to funded organizations to improve the quality and effectiveness of work plans, evaluation strategies, products and services, and collaborative activities with other organizations.
7. Collaborate to compile and publish accomplishments, best practices, performance criteria, and lessons learned during the period of performance.
8. Collaborate in assessing progress toward meeting strategic and operational goals/objectives and in establishing measurement and accountability systems for documenting outcomes, such as increased performance improvements and best or promising practices.
9. Collaborate on strategies to ensure the provision of appropriate and effective HIV, VH, STD and TB prevention services to priority populations.
10. Provide requirements and expectations for standardized and other data reporting and support monitoring and evaluation activities.
11. Share information, best practices, lessons learned, and evaluation results between recipients (e.g., through conferences, guidance, material development, webinars, data sharing publications, other social media, participation in meetings, committees, conference calls, and working groups related to the cooperative agreement and its projects).
12. Support programs in using data, including social determinants data, to identify communities disproportionately affected by these infections and select appropriate interventions to reduce the health disparities.

B. Award Information

1. Funding Instrument Type:
CA (Cooperative Agreement)
CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.

2. Award Mechanism:
U52

3. Fiscal Year:
2023

4. Approximate Total Fiscal Year Funding:
$3,900,000

5. Total Period of Performance Funding:
$19,500,000
This amount is subject to the availability of funds.

Estimated Total Funding:
$19,500,000

6. Total Period of Performance Length:
5
year(s)

7. Expected Number of Awards:
6

8. Approximate Average Award:

$650,000
Per Budget Period

9. Award Ceiling:
$0
Per Budget Period

This amount is subject to the availability of funds.

10. Award Floor:
$0
Per Budget Period

11. Estimated Award Date:
December 01, 2022

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 available through this NOFO.

A recipient of an award under this notice of funding opportunity may request that CDC provide supplies, equipment, services, or detail a CDC employee to the recipient for the purpose carrying out the activities of the award. If the request is approved, CDC shall reduce the amount of the recipient's award by either - the fair market value of any supplies (including laboratory supplies and other preventive agents) equipment, or services; the amount of the pay, allowances, and travel expenses of any CDC employee when detailed to the recipient. Specifically, for this funding opportunity, you may request laboratory supplies to carry out the activities required of this award based on an identified need and pending the availability of funds.

To request laboratory supplies, provide the information requested below:

1. Names of supply items needed (i.e., test kit, reagent, etc.)
2. Brand name of item
3. Cost per each item requested
4. Number of each item requested
5. Purpose of each item requested
6. Stock number (if available)

Note: The request should be submitted as part of the application for Year 1 and the continuation application process for subsequent years. If a request for supplies is approved, the award will be reduced by the fair market value of such items.

Additionally, a request for supplies may also include medication from the TB Emergency Drug Stockpile (TEDS). Recipients will be notified by email when TEDS medications are available. Fair market value will be determined at the time of the request is to be fulfilled, which may result in the need for a reduction of the award in that amount.

To request TEDS, recipients should submit an amendment (amendment type = "Other") in Grant Solutions with a request that includes the following information:

TB Disease Burden Number of TB cases as reported through the National TB Surveillance System

- Jurisdictions requesting TB drugs must provide assurance that drugs will be used in treating TB patients and that it has sufficient patient volume for the drugs to be used by their expiration date.
- CDC will give priority to jurisdictions with the highest TB burdens.

2. **Program Performance** – Provide Completion of Treatment (COT) percentage as reported through the National TB Surveillance System.
    - Programs with at least 85% completion of therapy for patients with newly diagnosed TB disease for whom 12 months or less of treatment is indicated will be given priority for expiring TB drugs as Direct Assistance.
    - After meeting the prioritization requirement, programs will receive TEDs on a first come, first served basis.
3. **Information** to ensure secure receipt and storage of TB drugs.
    - Provide Point of Contact information (i.e., name, telephone number, and e-mail) and shipping address.
4. **Quantity Requested**
    - Request amounts in unit of issue stated above (i.e., PKGs or BTLs).

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:
00 (State governments)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

05 (Independent school districts)

06 (Public and State controlled institutions of higher education)

07 (Native American tribal governments (Federally recognized))

08 (Public housing authorities/Indian housing authorities)

11 (Native American tribal organizations (other than Federally recognized tribal governments))

12 (Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education)

13 (Nonprofits without 501(c)(3) status with the IRS, other than institutions of higher education)

20 (Private institutions of higher education)

22 (For profit organizations other than small businesses)

23 (Small businesses)

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

99 (Unrestricted (i.e., open to any type of entity above), subject to any clarification in text field entitled "Additional Information on Eligibility")

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)

Local governments or their bona fide agents

Territorial governments or their bona fide agents in 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

State controlled institutions of higher education

American Indian or Alaska Native tribal governments (federally recognized or state-recognized)

Non-government Organizations

American Indian or Alaska native tribally designated organizations

Other

Ministries of Health

2. Additional Information on Eligibility

(1) Foreign Institutions Non-domestic (non-U.S.) Entities (Foreign Institutions) are not eligible to apply. Non-domestic (non-U.S.) components of U.S. Organizations are not eligible to apply.

(2) Applicant must provide proof of ability to serve populations in one of the jurisdictions listed below:
(A) Commonwealth of the Northern Mariana Islands (CNMI)
(B) American Samoa
(C) Guam
(D) Federated States of Micronesia (FSM)
(E) Republic of the Marshall Islands (RMI)
(F) Republic of Palau

Evidence of ability may include documentation that applicant is a territorial government or a bona fide agent in the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau. Documentation must be provided in attachment labeled EvidenceofAbility.

A bona fide agent is an agency/organization identified by the state as eligible to submit an

application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required. Attach with “Other Attachment Forms” when submitting via www.grants.gov

If applicant is other than a Department/Ministry of Health in the specified jurisdiction, the applicant must submit a memorandum of agreement/memorandum of understanding with the Department/Ministry of Health in the jurisdiction for which it is applying. The memorandum of agreement/memorandum of understanding should include the authority to collect and submit surveillance data. Documentation must be provided in attachment labeled *MOUwith(insert name of Department/Ministry of Health)*. Attach with "Other Attachment Forms" when submitting via www.grants.gov.

Applications that do not comply with these requirements will be determined non-responsive and will not receive further review.

3. Justification for Less than Maximum Competition

N/A

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.

PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c). The UEI is generated as part of SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the GSA website, SAM.gov, and Grants.gov- Finding the UEI.

a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number by registering in SAM.gov prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned to the registering organization.

If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their UEI 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 and a Unique Entity Identifier (UEI). 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 SAM.gov and the SAM.gov Knowledge Base.

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 "Applicant Registration" 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	System for Award Management (SAM)	1. Go to SAM.gov and designate an E-Biz POC (You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.	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
2	Grants.gov	1. Set up an individual account in Grants.gov using organization's new UEI 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	It takes one day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	Register early! Applicants can register within minutes.

		password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization		

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.

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)

b. Application Deadline

Due Date for Applications 07/31/2022

07/31/2022
11:59 pm U.S. Eastern 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.

Due Date for Information Conference Call
An informational call will be held on June 28, 2022 at 7:00pm (EST)
Link to join call: https://www.zoomgov.com/webinar/register/WN_JV9XwkiuQ_ugCXh-iv5EOQ
Slides will be posted to the PS23-2302 website after the call
here: https://www.cdc.gov/nchhstp/funding/usapi/

5. Pre-Award Assessments

Risk Assessment Questionnaire Requirement

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS

(https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and UEI.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

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 the application for 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

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.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

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 45 CFR 75 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. 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.

15. 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.

16. 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.

- Recipients may not use funds for inpatient clinical care, drugs for TB treatment, or new construction, unless otherwise authorized.
- Recipients may not use viral hepatitis funds for travel.
- Funds may be used purchase drugs for the treatment of women and their partners to prevent STD-related infertility, as recommended in the STD treatment guidelines (https://www.cdc.gov/std/treatment-guidelines/default.htm).
- Funds may be used for out-patient TB services (e.g., tuberculin skin testing, Interferon-Gamma Release Assays, chest imaging, laboratory testing, and medical evaluation)

17. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their

evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the 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/additional-requirements/ar-25.html.

18. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

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 via email.

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:** 45

Evaluate the extent to which the applicant addresses the following:

Purpose and Outcomes: (5 points)

- Incorporates the five strategies of the NOFO and adequately describes how they will address the period of performance outcomes described in the logic model and Outcomes sections.

Strategies and Activities: For each strategy (4 points per strategy; 20 points total)

- Provides clear and concise description of the strategy
- Describes activities that are appropriate to achieve the period of performance outcomes
- Presents a work plan that is aligned with the strategies/activities, outcomes, and performance measures in the approach

Collaboration: (10 points)

- Describes how they will collaborate with CDC-funded programs and organizations not funded by CDC in their jurisdiction and how those collaborations will assist in achieving the NOFO period of performance outcomes
- Provides MOUs/MOAs to support collaborations. If applicant is other than a Department/ Ministry of Health, a MOU with the Department/ Ministry of Health must be provided, specifying access will be granted to surveillance data and through the collaboration, ensure complete data are submitted to CDC

Target Populations and Health Equity: (10 points)

- Proposes to serve populations in one of the six USAPI jurisdictions
- Describes how to reach and serve the priority population(s) in their jurisdiction and addresses how they will include specific populations who can benefit from the NOFO
- Explanation of how to support a health equity approach through services and activities

ii. Evaluation and Performance Measurement **Maximum Points:** 25

Evaluate the extent to which the applicant addresses the following:

- Describes the process (outputs) and outcome performance measures (indicators) specified by CDC in the Evaluation and Performance Measurement section including ability to collect data needed for the measures, data source(s), responsible party, and ability to meet reporting deadlines (10 points)
- Describes how performance measurement and evaluation findings will be reported and used for continuous program quality improvement (5 points)
- Discussion of how the recipient will use information gathering, monitoring, analysis, and dissemination to address priority activities (5 points)
- Includes a preliminary Data Management Plan (DMP) (5 points)

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

Evaluate the extent to which the applicant demonstrates relevant experience and capacity (management, administrative, and technical) to implement the activities and achieve the project outcomes. (10 points)

- Has experience in all of the focus areas (HIV, VH, STD, and TB)
- Has legal authority to collect and report surveillance data for the jurisdiction to CDC

- Has existing public health programs and provides a description of their mission, organizational budget and funding sources, staff size, and long-term sustainability plan
- Addresses the physical infrastructure as it relates to equipment, electronic information and data systems, ensuring data security and confidentiality, and communications systems
- Has experience conducting the required activities and providing direct patient care
- Has a history of working with CDC/NCHHSTP to facilitate collaboration/mentorship
- Has a history of working and collaborating with the World Health Organization and other international and non-governmental organizations

Demonstrates experience and capacity to implement the evaluation plan. (10 points)

Evaluate the extent to which the applicant provides a staffing plan and project management structure that will be sufficient to achieve the project outcomes, and which clearly defines staff roles. (10 points)

- Provides an organizational chart
- Identifies key staff to lead PCSI activities and represent HIV, VH, STD, and TB programs
- Provides a curriculum vitae or resume for each existing key personnel who will be affiliated with the project

Budget **Maximum Points:** 0

When reviewing or scoring budgets, CDC will assess whether the budget aligns with the proposed work plan

c. Phase III Review

The objective review will involve a full discussion panel, in which applications will be reviewed by several reviewers, scored, and subsequently discussed as part of a larger panel with a chairperson.

Applicants may be funded out of rank order to ensure one recipient is funded under this NOFO to address the prevention and control of HIV, Viral Hepatitis, STDs, and TB in the U.S.-Affiliated Pacific Island jurisdictions in each of the geographical areas:

- Commonwealth of the Northern Mariana Islands (CNMI)
- American Samoa
- Guam
- Federated States of Micronesia (FSM)
- Republic of the Marshall Islands (RMI)
- Republic of Palau

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

December 1, 2022

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 annual 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.

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.

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy).This includes taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html and https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.

- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and taking appropriate steps to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.

• HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.

• For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.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 Performance Measurement Plan, including Data Management Plan (DMP)	6 months into award	Yes
Annual Performance Report (APR)	No later than 120 days before end of budget period. Serves as yearly continuation application.	Yes
Data on Performance Measures (Interim Performance Report (IPR))	90 days after the end of the budget period.	Yes
Federal Financial Reporting Forms	90 days after the end of the budget period	Yes
Final Performance and Financial Report	90 days after end of period of performance	Yes

Payment Management System (PMS) Reporting	Quarterly reports due January 30; April 30; July 30; and October 30	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 publicly 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 than 120 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.

Unobligated federal funds remaining at the end of any budget period may be carried over to another budget period and used for any activity that is within the scope of this NOFO, regardless of the funding stream (i.e., HIV, VH, STD, or TB).

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 carryover request must:

- Express a bona fide need for permission to use an unobligated balance.

- Include a signed, dated, and accurate Federal Financial Report (FFR) for the budget period from which funds will be transferred (as much as 75% of unobligated balances); and
- Include a list of proposed activities, an itemized budget, and a narrative justification for those activities.

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.

In addition to the Annual Performance Report, recipients are required to submit data at the end of each budget year. More than annual reporting of performance measures is needed for timely routine technical assistance and monitoring for specific outputs and outcomes throughout the period of performance. The performance measures required are limited to those that are most timely for each reporting period. Recipients will be required to complete an Interim Performance Report (IPR) that captures the quantitative and qualitative data from the last six months of the previous budget period or the last 12 months for select indicators not available for the APR. The IPR is due 90 days after the end of the budget period. Additional details will be shared with recipients post 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 through the Payment Management System (PMS). 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)

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). 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.

6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency

or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
Tamika

Last Name:
Hoyte
Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:
1600 Clifton Rd. MS E-07
Atlanta, GA 30329-4027

Telephone:
(404) 639-6029

Email:
THoyte@cdc.gov

Grants Staff Contact

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

First Name:
Edna

Last Name:
Green
Grants Management Specialist
Department of Health and Human Services
Office of Grants Services

Address:
2939 Flowers Rd, MS TV-2
Atlanta, GA 30341

Telephone:
(770) 488-2858

Email:
EGreen@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.

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
- 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

Position descriptions

Letters of Support

Organization Charts

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Bona Fide Agent status documentation, if applicable

Evidence of Ability

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 .https://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.

Assistance Listings: A government-wide collection of federal programs, projects, services, and activities that provide assistance or benefits to the American public.

Assistance Listings Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency

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.

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. https://www.cdc.gov/grants/additional-requirements/index.html.

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 2030: 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.

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.

UEI: The Unique Entity Identifier (UEI) number is a twelve-digit number assigned by SAM.gov. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a UEI number as the Universal Identifier. UEI number assignment is free. If an organization does not know its UEI number or needs to register for one, visit www.sam.gov.

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

Amendments to PS23-2302 Accelerating the Prevention and Control of HIV, VH, STDs, and TB in the US-Affiliated Pacific Islands [December 14,2021]

Acid Fast Bacilli (AFB): A physical property of some bacteria referring to their resistance to decolorization by acids during staining procedures. Acid-fast organisms are difficult to characterize using standard microbiological techniques (e.g., Gram stain - if you gram stained an AFB the result would be an abnormal gram-positive organism, which would indicate further testing), though they can be stained using concentrated dyes, particularly when the staining process is combined with heat. Once stained, these organisms resist the dilute acid and/or ethanol-based de-colorization procedures common in many staining protocols—hence the name acid-fast.

Aggregate Reports for Tuberculosis Program Evaluation (ARPE): This report is an annual summary of the core activities of eliciting and evaluating contacts to TB cases and treating the contacts who have LTBI. The health department also may include results that are provided by partner or contract healthcare entities if the health department has assurance that the data are satisfactory. Generally, this means that the other entities have cooperated with the health

department in confirming the results from contact evaluations and in managing the treatment of contacts who have LTBI.

Assurance of Confidentiality (AOC): A formal confidentiality protection authorized under Section 308(d) of the Public Health Service Act. It is used for projects conducted by CDC staff or contractors that involve the collection or maintenance of sensitive identifiable or potentially identifiable information. This protection allows CDC programs to assure individuals and institutions involved in research or non-research projects that those conducting the project will protect the confidentiality of the data collected. The legislation states that no identifiable information may be used for any purpose other than the purpose for which it was supplied unless such institution or individual has consented to that disclosure.

Case conference meetings: Systematic review of the management and treatment of persons with suspected or confirmed TB disease currently under care and their contacts. Details regarding the management and outcomes of TB cases are reviewed in a group setting with the following information presented on each case by the case manager or DOT worker:

- Patient's clinical status
- Patient's treatment outcome
- Adequacy of the medication regimen
- Treatment adherence or completion
- Results of contact investigation

Case management: A strategy health departments can use to manage TB patient care and help ensure patients successfully complete treatment.

Case manager: A specific health care worker who is assigned primary responsibility for a TB patient.

Community based organization (CBO): Civil society non-profits that operate within a single local community.

Congregate setting: A setting in which a group of persons reside, meet, or gather either for a limited or extended period of time in close physical proximity. Examples include prisons, nursing homes, schools, and homeless shelters.

Contacts: Persons exposed to someone with infectious TB disease; can include family members, roommates or housemates, close friends, coworkers, classmates, and others.

Contact investigation: A systematic process to identify persons (contacts) who were exposed to someone with infectious TB disease; assess contacts for infection with M. tuberculosis and TB disease; and provide contacts with treatment for latent TB infection or TB disease, if necessary.

Diabetes mellitus: A disease in which blood glucose levels are above normal; diabetes can increase susceptibility to some infectious diseases, including TB.

Directly observed therapy (DOT): A strategy devised to help patients adhere to treatment; a

designated person watches the TB patient swallow each dose of the prescribed drugs to ensure adherence and tolerability of the regimen.

Disproportionately Affected Individuals: For HIV, these include: men who have sex with men (MSM), persons who inject drugs (PWID), transgender persons, and/or commercial sex workers.

Division of Tuberculosis Elimination (DTBE): A division in the National Center for HIV, Viral Hepatitis, STD and TB Prevention that has responsibility for TB elimination in the U.S.

Drug susceptibility testing (DST): Testing Mycobacterium tuberculosis derived from a clinical specimen (i.e., direct or from culture) obtained from a patient to see if the bacteria are resistant to any of the antituberculosis medications.

Enablers: Things that make it possible or easier for TB patients to receive treatment by overcoming barriers.

Expedited partner therapy (EPT): A clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the healthcare provider first examining the partner.

Federal Training Centers Collaboration: Collaboration between federal training centers

Gonorrhea or Neisseria gonorrhea (GC): A sexually transmitted disease (STD). Gonorrhea is caused by Neisseria gonorrhea, a bacterium that can grow and multiply easily in the warm, moist areas of the reproductive tract, including the cervix (opening to the womb), uterus (womb), and fallopian tubes (egg canals) in women, and in the urethra (urine canal) in women and men. The bacterium can also grow in the mouth, throat, eyes, and anus.

Health disparities (inequities): Systematic, potentially avoidable differences in health that are linked to social hierarchies according to wealth, power, or prestige. Health disparities happen when groups of people systematically experienced greater social or economic obstacles to health.

Health equity: When every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

Hepatitis B virus (HBV): The virus that causes Hepatitis B. Hepatitis B is a contagious liver disease that results from infection with the Hepatitis B virus. When first infected, a person can develop an "acute" infection, which can range in severity from a very mild illness with few or no symptoms to a serious condition requiring hospitalization. Acute Hepatitis B refers to the first 6 months after someone is exposed to the Hepatitis B virus. Some people are able to fight the infection and clear the virus. For others, the infection remains and leads to a "chronic," or lifelong, illness. Chronic Hepatitis B refers to the illness that occurs when the Hepatitis B virus remains in a person's body. Over time, the infection can cause serious health problems.

Hepatitis C virus (HCV): The virus that causes Hepatitis C, a contagious liver disease. When first infected, a person can develop an "acute" infection, which can range in severity from a very mild illness with few or no symptoms to a serious condition requiring hospitalization.

Human immunodeficiency virus (HIV): The virus that can lead to acquired immune deficiency syndrome, or AIDS.

Incentives: small rewards given to patients to encourage them to either take their medicine or keep their clinic or field DOT appointments.

Individual level data: Accurate information for locating and identifying index patients is essential for delivering partner services efficiently. Surveillance programs routinely collect and maintain individual-level data that can be provided directly to partner services programs. Data shared with partner services programs might include name, address, telephone number or other contact information, date of birth, race/ethnicity, test results, notification status of test results, sex, date of diagnosis, type of test, other laboratory data (e.g., CD4 cell counts and HIV viral load or syphilis titers), risk behaviors, and provider name. At a minimum, DISs need sufficient locating and identifying information to initiate partner services with index patients. In turn, effective index patient interviews might elicit information missing from the surveillance case report, which can be shared with the surveillance program. Certain surveillance programs might be able to provide individual-level data on all reported HIV cases to partner services programs, whereas others might be limited by law or regulation to providing data on a subset of cases (e.g., in persons who have not been notified of their positive HIV test results, persons diagnosed by public providers, persons with drug-resistant strains of HIV, or persons whose providers request partner services). Surveillance and partner services programs should identify which types of case information can be shared among programs and include this in their written policies.

International Air Transportation Association (IATA): IATA represents, leads, and serves the airline industry. Its members comprise all major passenger and cargo airlines.

Latent TB infection (LTBI): refers to the condition when a person is infected with M. tuberculosis but does not have TB disease. Persons with LTBI carry the organism that causes TB, but they do not have TB disease symptoms, and they cannot spread TB germs to others. Most persons with LTBI have a positive result to the tuberculin skin test or to an interferon-gamma release assay. M. tuberculosis, a bacterium transmitted by airborne droplet nuclei from patients with respiratory forms of the disease, causes TB, a contagious and potentially fatal disease. TB develops in 5%–10% of persons who get infected with M. tuberculosis, typically after a latency of 6–18 months, but after decades in some persons. Conditions that impair cellular immunity, especially HIV infection, increase the likelihood of TB developing at any interval after infection. Treatment during latency prevents TB during treatment and afterward. Latent TB infection (LTBI): Is when TB bacteria live in a person's body without making that person sick. This is called latent TB infection (LTBI). In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. People with LTBI do not feel sick and do not have any symptoms. The only sign of TB infection with LTBI is a positive reaction to the tuberculin skin test or special TB blood test (Immune Gamma Release

Assay (IGRA)). People with LTBI are not infectious and cannot spread TB bacteria to others. However, if TB bacteria become active in the body and multiply, the person can get sick with TB disease.

LTBI treatment: medication that is given to people who have LTBI to prevent developing TB disease.

National Center of HIV, Viral Hepatitis, STD and TB Prevention (NCHHSTP): One of the national centers of the Centers for Disease Control and Prevention

National HIV/AIDS Strategy (NHAS): Is a comprehensive coordinated HIV/AIDS plan with clear and measurable targets to be achieved within the US by 2025. To read more please go to: https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025.

National HIV Surveillance System (NHSS): A surveillance system within the United States to monitor the spread of HIV and its impact on the US population.

National Tuberculosis Indicators Project (NTIP): The National Tuberculosis Indicators Project (NTIP) is a monitoring system for tracking the progress of U.S. TB control programs toward achieving the national TB program objectives. This system will provide TB programs with reports to describe their progress, based on data already reported to the CDC. In addition, these reports will help programs prioritize prevention and control activities, as well as program evaluation efforts.

National Tuberculosis Surveillance System (NTSS): The National TB Surveillance System collects information on each newly reported case of tuberculosis (TB) disease in the U.S. The program is a cooperative effort of CDC and state and local health departments, who report cases of TB to CDC.

Point-of-Care: An HIV testing event which occurs during encounter with client. Test results available within 30 minutes.

Program Collaboration and Service Integration (PCSI): A mechanism for integrating health service activities, and prevention strategies to facilitate more efficient and comprehensive delivery of services.

Prevention Training Centers: Training centers across the U.S. for HIV and STD prevention activities.

Quality Assurance (QA): The systematic monitoring and evaluation of a project or program to maximize the probability that maximum standards of quality are being attained.

Regional Training and Medical Consultation Center (RTMCC): Medical consultation centers funded by the CDC to provide training and technical assistance, increase human resource development with regard to TB, develop TB training materials and provide medical consolations

to TB programs and medical providers. Currently there are four RTMCCs within the United States. In addition, there are four RTMCCS located throughout the United States.

Report of Verified Case of Tuberculosis (RVCT): TB is a nationally notifiable disease, in that reporting is mandated in all states. In 1953, a national surveillance system was established to collect information on new cases of active TB. Since 1985, all states have been reporting TB cases to the CDC using the RVCT, the national TB surveillance form. Data are collected by state and local TB programs and submitted electronically to CDC, DTBE. These data are used to monitor national TB trends, identify priority needs, and create the DTBE annual surveillance report, Reported Tuberculosis in the United States. Reports being used by jurisdictions such as the states, Washington, DC and USAPI to report TB surveillance data to CDC.

Sexually transmitted disease (STD): An illness that has a significant probability of transmission between humans by means of human sexual behavior, including vaginal intercourse, oral sex, and anal sex. Also known as a sexually transmitted infection (STI) or venereal disease (VD).

Sputum: phlegm from deep in the lungs, collected in a sterile container for processing and examination.

Surveillance: The ongoing systematic collection, analysis, and interpretation of health data for purposes of improving health and safety.

Tuberculosis (TB): Caused by a bacterium called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

Tuberculosis Education and Training Network (TB ETN): A network of TB professionals to network, share resources and build education and training skills. Membership includes representatives from TB programs, correctional facilities, hospitals, nursing homes, federal agencies, universities, the American Lung Association, Regional Training and Medical Consultation Centers, and other U.S. and international organizations interested in TB education and training issues.

U.S.-affiliated Pacific Island (USAPI): Includes the three Flag Territories: American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands, and three independent nations: The Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Viral Hepatitis: A group of viruses that cause inflammation of the liver. The viruses include hepatitis A, hepatitis B, and hepatitis C.