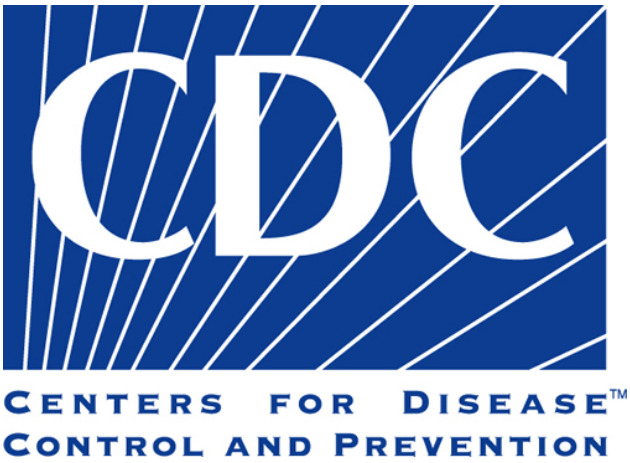


Centers for Disease Control and Prevention

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

Capacity Building Assistance (CBA) for HIV Prevention Programs to End the HIV Epidemic in the United States

CDC-RFA-PS-24-0020

04/30/2024

Table of Contents

A. Funding Opportunity Description 4
B. Award Information 41
C. Eligibility Information 43
D. Application and Submission Information 44
E. Review and Selection Process 55
F. Award Administration Information 61
G. Agency Contacts 68
H. Other Information 69
I. Glossary 71

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-PS-24-0020. 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:

Capacity Building Assistance (CBA) for HIV Prevention Programs to End the HIV Epidemic in the United States

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 purposes of this NOFO, research is defined as set forth in 45 CFR 75.2 and, for further clarity, as set forth in 42 CFR 52.2 (see eCFR :: 45 CFR 75.2 -- Definitions and *https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf*. In addition, for purposes of research involving human subjects and available exceptions for public health activities, please see 45 CFR 46.102(l) (*https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-46/subpart-A/section-46.102#p-46.102(l)*).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-PS-24-0020

E. Assistance Listings Number:

93.939

F. Dates:

1. Due Date for Letter of Intent (LOI):
03/31/2024

2. Due Date for Applications:
04/30/2024
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:
Conference calls related to the NOFO will be published on the NOFO website.
https://www.cdc.gov/hiv/funding/announcements/ps-24-0020/index.html

G. Executive Summary:

1. Summary Paragraph
CDC announces the competitive availability of fiscal year 2024 funds to implement a capacity building assistance (CBA) program to strengthen the capacity and improve the performance of the nation's HIV workforce. This notice of funding opportunity (NOFO) supports a network of funded providers, established and referenced as the CBA Provider Network (CPN), to implement the following six inter-related program components:

- Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions
- Component B: Instructor-led Training for High-Impact HIV Prevention Programs
- Component C: eLearning Training for High-Impact HIV Prevention Programs
- Component D: Technical Assistance for High-Impact HIV Prevention Programs
- Component E: Organization/Workforce Development and Management for Community-Based Organizations
- Component F: CPN Resource and Coordination Center

This NOFO promotes and supports the goals and strategies of the National HIV/AIDS Strategy for the United States 2022–2025, the Ending the HIV Epidemic in the United States (EHE) initiative, the HIV Care Continuum, and CDC's High-Impact Prevention (HIP) approach. This program also aligns with the Division of HIV Prevention's (DHP) health equity priorities of addressing social determinants of health (SDOH) and syndemics affecting HIV-related outcomes.

a. Funding Instrument Type:
CA (Cooperative Agreement)

b. Approximate Number of Awards
15

- Component A: 1 Award
- Component B: 1 Award
- Component C: 1 Award

- Component D: up to 10 Awards
- Component E: 1 Award
- Component F: 1 Award

c. Total Period of Performance Funding:
$127,500,000

Component	Approximate Annual Funding
Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions	$2,500,000
Component B: Instructor-led Training for High-Impact HIV Prevention Programs	$3,500,000
Component C: eLearning Training for High-Impact HIV Prevention Programs	$2,000,000
Component D: Technical Assistance for High-Impact HIV Prevention Programs	$14,000,000
Component E: Organization/Workforce Development and Management for Community-Based Organizations	$2,250,000
Component F: CPN Resource and Coordination Center	$1,250,000

d. Average One Year Award Amount:
$2,150,000
Based on the availability of funding, the approximate average award amounts per budget period are as follows:

- Component A: $2,500,000
- Component B: $3,500,000
- Component C: $2,000,000
- Component D: $1,400,000
- Component E: $2,250,000
- Component F: $1,250,000

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

f. Estimated Award Date:
July 01, 2024

g. 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

In the United States, an estimated 1.2 million people are living with HIV. In recent years, the number of people with HIV (PWH) has increased while deaths have declined. Of PWH, about 87% were aware of their HIV status. In 2021, among people with diagnosed HIV, an estimated 75% received HIV medical care and 66% were virally suppressed. Promising progress has been made in HIV prevention as the estimated annual new HIV infections were 12% lower in 2021 (32,100 infections) compared to 2017 (36,500 infections). This decline was largely driven by a substantial decrease (34%) in new infections among 13- to 24-year-olds, mostly among gay and bisexual males. However, HIV prevention efforts must go further, and progress must be faster, for gains to equitably reach all populations and end the HIV epidemic.

The National HIV/AIDS Strategy (NHAS) for the United States focuses on four goals: preventing new HIV infections, improving HIV-related health outcomes of people with HIV, reducing HIV-related disparities and health inequities, and achieving integrated, coordinated efforts that address the HIV epidemic among all partners. Successful HIV programs must recognize the syndemics that affect the people and places disproportionately affected by HIV. A syndemic is population-level clustering of social and health problems. In the context of HIV, a syndemic is when HIV clusters with one or more other diseases or health conditions within a specific population, driven by the contextual, structural and social factors that increase the adverse effects on the health of people and communities. Syndemics may include HIV, STIs, TB, viral hepatitis, overdose, and substance use, and other existing and emerging conditions or factors that may be related to or impact HIV.

The Ending the HIV Epidemic in the US (EHE) initiative focuses on scaling up four science-based strategies in communities most affected by HIV across the country. The strategies are to diagnose all people with HIV as early as possible; treat people with HIV rapidly and effectively to result in sustained viral suppression; prevent new HIV transmissions by using proven interventions, including condom distribution, pre-exposure prophylaxis (PrEP), postexposure prophylaxis (PEP), and syringe services programs (SSP); and respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them.

Toward achieving national HIV prevention goals, the Centers for Disease Control and Prevention (CDC) funds state and local health departments and community-based organizations (CBOs) to plan, integrate, implement, evaluate, and sustain HIV prevention and surveillance programs, prioritizing people disproportionately affected by HIV including gay, bisexual, and other men who have sex with men, in particular Black, Latino, and American Indian/Alaska Native men, Black women, transgender women, youth aged 13-24, and people who inject drugs. Racism, HIV stigma, discrimination, homophobia, poverty, and barriers to health care continue to drive disparities in HIV prevention.

Building individual competencies and technical expertise among staff, strengthening organizational capacities, and enabling supportive structural environments are critical strategies

in addressing operational challenges for more effective HIV prevention and surveillance programs. Reflecting CDC's continued investment in improving the performance of the nation's HIV workforce, this NOFO will support the provision of capacity building assistance (CBA) services, including training and technical assistance (TA).

b. Statutory Authorities
This program is authorized under Sections 301(a) and 318 of the Public Health Service Act, 42 U.S.C. Sections 241(a) and 247c, as amended.

c. Healthy People 2030
This NOFO addresses the Healthy People 2030:

HIV and STI: Reduce the number of new HIV infections — HIV-01 - Healthy People 2030 | health.gov

Reduce sexually transmitted infections and their complications and improve access to quality STI care: Sexually Transmitted Infections - Healthy People 2030 | health.gov

d. Other National Public Health Priorities and Strategies

- National HIV/AIDS Strategy 2022-2025. National HIV/AIDS Strategy for the United States 2022–2025 (HIV Plan)
- Ending the HIV Epidemic in the United States – (Ending the HIV Epidemic in the U.S. (EHE) | CDC)
- Sexually Transmitted Infections National Strategic Plan for the United States (2021–2025) – (Sexually Transmitted Infections (STI) National Strategic Plan: 2021-2025 (hhs.gov)
- Viral Hepatitis National Strategic Plan: A Roadmap to Elimination 2021-2025 – (New Federal Implementation Plan for Viral Hepatitis National Strategic Plan | HIV.gov)
- HIV/AIDS Care Continuum – (HIV Care Continuum | HIV.gov)
- Division of HIV Prevention Strategic Plan, Supplement 2022-2025 – (Division of HIV Prevention Strategic Plan Supplement—An Overview of Refreshed Priorities for 2022–2025 (cdc.gov)\)
- National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Strategic Plan 2022-2026 – (Strategic Plan 2022-2026 | NCHHSTP | CDC)
- National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Equity Initiative, Focus Area 3 (NCHHSTP Equity Initiative| NCHHSTP | CDC)

All NOFO activities must be consistent with current and future CDC-supported HIV prevention programmatic guidance, scientific advances, and recommendations.

e. Relevant Work
This NOFO builds on work performed under previous NOFOs and will support current and future CDC HIV prevention programs and initiatives. Previous NOFOs include:

- CDC-RFA-PS19-1904: Capacity Building Assistance (CBA) for High-Impact HIV Prevention Program Integration
- CDC-RFA-PS19-1906 Component A: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Strategies	**Short-term Outcomes**	**Intermediate Outcomes**	**Long-term Outcomes**
Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions			National highly skilled HIV workforce that promotes and supports the reduction of new HIV infections, increased access to care and improved health outcomes for people with HIV, reduction of HIV-related health disparities and health inequities, and a coordinated national
Facilitate communication and partnership engagement among HDs and other national organizations Provide TA to HDs on policy analysis and interpretation Provide TA to HDs to address challenges related to the planning, implementation and evaluation of integrated HIV activities	**Strengthened national partnerships to support implementation of HIV prevention and surveillance programs** Improved HD capacity for policy-informed, integrated HIV activities	Optimal HD planning, integration, implementation, evaluation, and sustainability of comprehensive HIV prevention and surveillance programs	
Training for High-Impact HIV Prevention Programs **Component B: Instructor-Led Training; Component C: eLearning**			
Provide instructor-led and/or eLearning training to HD and CBO staff on CDC-supported high-impact equitable HIV prevention interventions, public health strategies, and topics of national importance	**Increased HIV knowledge, skills and competencies and enhanced HD and CBO staff capacity for equitable HIV program planning, implementation, evaluation, and service delivery**	**Effective implementation and operation of equitable HIV prevention programs by HD and CBO staff**	
Component D: Technical Assistance for High-Impact HIV Prevention Programs			

Provide TA to HDs and CBOs to address challenges related to the planning, implementation, and evaluation of HIV prevention programs, reducing HIV-disparities, and addressing syndemic conditions and social determinants of health (SDOH)	**Strengthened HD and CBO organizational capacity to support comprehensive HIV programs to diagnose, treat, and prevent HIV and syndemic conditions, and address SDOH and inequities**	**Enhanced HD and CBO structural environments to support the effective operation of equitable HIV prevention programs and address syndemic conditions, SDOH and inequities**	response to end the HIV epidemic.
Component E: Organization/Workforce Development & Management for CBOs			
Provide training and TA on Organizational Development and Management to CBOs Develop and manage the National Learning Community for HIV CBO Leadership program for CBOs	**Increased capacity of CBOs in fiscal management, human resources, DEIA efforts, and other management functions** **Increased CBO leadership capacity**	**Enhanced CBO organizational capacity, sustainability, and quality of HIV prevention programs**	
Component F: CPN Resource and Coordination Center			
Promote CBA services through designing and implementing marketing campaigns, managing the Resource Center, and coordinating meetings	**Increased awareness of CBA services by HDs and CBOs**	**Increased utilization of CBA services by HDs and CBOs**	

i. Purpose

The NOFO supports a network of providers to implement a multi-component program that builds individual competencies, technical expertise, strengthens organizational capacities, and enables supportive structural environments for the nation's HIV workforce to plan, integrate, implement, evaluate, and sustain HIV prevention and surveillance programs. It promotes and supports national HIV prevention goals and strategies, CDC's HIP approach, and the Division of HIV Prevention's health equity priorities of addressing social determinants of health (SDOH) and syndemics affecting HIV-related outcomes.

ii. Outcomes

The program is expected to demonstrate measurable progress toward addressing short-term and intermediate outcomes that appear bolded in the logic model. The section entitled CDC Evaluation and Performance Measurement Strategy further describes the outputs and indicators

that quantify program outcomes. (*These are outcomes expected to be achieved under the NOFO only, i.e. bolded in the logic model).* A summary of short-term and intermediate outcomes to be measured and reported by recipients is as follows:

Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions

Short-Term Outcome:

- Strengthened national partnerships to support implementation of HIV prevention and surveillance programs

Component B: Instructor-Led Training for High-Impact HIV Prevention Programs

Short-term Outcome:

- Increased HIV knowledge, skills and competencies and enhanced HD and CBO staff capacity for equitable HIV program planning, implementation, evaluation, and service delivery

Intermediate Outcome:

- Effective implementation and operation of equitable HIV prevention programs and services by HD and CBO staff

Component C: eLearning Training for High-Impact HIV Prevention Programs

Short-term Outcome:

- Increased HIV knowledge, skills and competencies and enhanced HD and CBO staff capacity for equitable HIV program planning, implementation, evaluation, and service delivery

Intermediate Outcome:

- Effective implementation and operation of equitable HIV prevention programs and services by HD and CBO staff

Component D: Technical Assistance for High-Impact HIV Prevention Programs

Short-term Outcome:

- Strengthened HD and CBO organizational capacity to support comprehensive HIV programs to diagnose, treat, and prevent HIV and syndemic conditions, and address SDOH and inequities

Intermediate Outcome:

- Enhanced HD and CBO structural environments to support the effective operation of equitable HIV prevention programs and address syndemic conditions, SDOH and inequities

Component E: Organization/Workforce Development & Management for CBOs

Short-term Outcome:

- Increased capacity of CBOs in fiscal management, human resources, DEIA efforts and other management functions
- Increased CBO leadership capacity

Intermediate Outcome:

- Enhanced CBO organizational capacity, sustainability and quality of HIV prevention programs and services

Component F: CPN Resource and Coordination Center

Short-term Outcome:

- Increased awareness of CBA services by HDs and CBOS

Intermediate Outcome:

- Increased utilization of CBA training and TA by HDs and CBOs

iii. Strategies and Activities

This program will constitute a national Capacity Building Assistance (CBA) Provider Network (CPN) to deliver CBA services to an interdisciplinary HIV workforce (e.g., professional, technical, clinical, managerial staff, and community staff) within CDC-funded community-based organizations (CBOs), state and local health departments and their local partners. All recipients funded under Components A-E will be considered members of the CPN. Component F recipients will coordinate the CPN. The CBA program comprises the following six components:

1. Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions *(Year 1 Program Period of Performance Start Date – September 30, 2024)*
2. Component B: Instructor-led Training for High-Impact HIV Prevention Programs
3. Component C: eLearning Training for High-Impact HIV Prevention Programs
4. Component D: Technical Assistance for High-Impact HIV Prevention Programs
5. Component E: Organization/Workforce Development and Management for Community-Based Organizations
6. Component F: CPN Resource and Coordination Center

Applicants can only submit one application but may apply for a maximum of two (2) components. See "Additional Information on Eligibility" section for guidance for applying for more than one component.

Throughout the entire period of performance, recipients will be required to implement all activities as delineated for each component. In addition, all recipients must adhere to the following program implementation requirements regardless of the component for which they are funded:

1. Develop a workplan annually, in collaboration with CDC, that addresses all NOFO requirements including component-specific activities for which your organization is funded.
2. Collaborate with CDC and other PS24-0020 CBA providers.

3. Submit all developed CBA products (e.g., PowerPoint presentations, implementation manuals, instructional curriculum, web-based modules, products, tools, materials, outlines, storyboards, learning guides, video scripts, multimedia files, etc.) for CDC review and clearance in accordance with stated timelines. These materials should be carefully reviewed prior to CDC submission to ensure that they are formatted clearly and that they contain scientifically sound, grammatically correct, plain language and fully 508-compliant (https://www.hhs.gov/web/section-508/index.html).
4. Participate in all CPN meetings, conference calls, and other activities to enhance communication, coordination, and collaboration among all CPN members. Routinely exchange information regarding program implementation with other members of the CPN.
5. Comply with CDC data collection and reporting requirements.
6. Understand that all training curricula, web-based modules (including all eLearning development files), national TA products, and materials are the property of CDC, and all source files should be transferred to CDC upon completion of each developmental project.
7. Conduct monitoring, evaluation, and reporting activities as described in the NOFO.
8. In partnership with recipient funded under Component F, promote CBA services, to include the development and implementation of training and technical assistance products.
9. Ensure compliance with the Paperwork Reduction Act.

Note: As this NOFO supports a five-year program that must remain responsive to the changing capacity building needs of the HIV workforce, applicant's programs are expected to be flexible within and across funding components to address current and emergent programmatic focus areas. CDC may re-direct programmatic activities in an ongoing effort to ensure project outcomes. CDC will provide recipients with the PS24-0020 Program and Training Guidance that will support the NOFO and provide guidance on the implementation of the NOFO.

Component A - Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions *(Period of Performance Start Date – September 30, 2024 for Year 1 Only)*

CDC recognizes the benefit of collaborating with an organization that can assist with the critical and complex functions of bridging programs with national partners, emerging policies, and cutting-edge communications.

The primary focus of Component A is to fund an organization to assist CDC in supporting HIV programs in a changing public health landscape through the development and implementation of strategic national partnerships, enhanced communication efforts, policy analysis and interpretation, and integrated equitable HIV activities.

The Component A recipient will be responsible for actively assisting CDC-funded health department jurisdictions by supporting communication needs, facilitating partnerships and providing peer-to-peer TA to participants that include state and local HIV prevention, surveillance, care, and treatment programs, national partners, local community partners, and other potential collaborators. In addition, Component A will assist the HIV prevention workforce to understand the impact of laws and policies on integrated HIV programs and to support

communication between the HIV prevention workforce and policy makers to advance HIV prevention goals.

Required Strategies and Activities

Applicants must propose a program that describes how they will collaborate with CDC and other partners to implement the following strategies and activities:

1. Collaborate and engage with a broad spectrum of national partners, including organizations that represent hepatitis/sexually transmitted infection (STI) programs, that have common interests and that represent state, territorial, and local health department jurisdictions HIV prevention and surveillance programs.
2. Establish, cultivate, and maintain collaborative strategic partnership(s) with other national partner(s) in support of HIV prevention and surveillance programs.
3. Establish contractual partnerships(s) with other national partner(s) to strengthen the recipient's ability to support the required strategies and activities of this NOFO. Applicants may propose to execute contractual partnerships with up to two national partners to support the implementation of the NOFO requirements under Component A.
4. Develop and disseminate timely and relevant information on key HIV-related issues and topics, to include the integration of HIV and STI prevention and treatment, surveillance, cluster detection and response (CDR), science, policy (e.g., data sharing), and education to HIV program staff, national partners, and community partners.
    a. Support the development and roll out of guidance documents intended to support the implementation of HIV prevention and surveillance activities at state and local levels.
    b. Support the dissemination of information on strategies that address disparities in specific populations (see Populations of Focus section for additional details)
5. Use established communication channels and partnerships with CDC funded health department jurisdictions to assist CDC with addressing emerging issues, policies, new and innovative biomedical breakthroughs, HIV priority populations, and special projects that affect HIV prevention and surveillance programs nationwide.
6. Facilitate and host national planning and collaboration meetings with CDC-funded organizations in partnership and with guidance from CDC program staff.
    a. Provide educational advancement opportunities on topics relevant to advancements in HIV and STI prevention, such as community engagement, PrEP, Data-to-Care (D2C) models, surveillance, activities that address disparities in specific populations, CDR activities, etc.
    b. Support the dissemination of CDC social marketing campaign messaging, materials, and resources that support HIV prevention, care, and treatment, status neutral approach/sexual wellness, and/or syndemic messaging at the state and local levels through these activities.
7. Work with partners to increase visibility of HIV prevention and surveillance programs among potential audience.
8. Support and facilitate active communication and consultation between organizations and CDC, as well as between CDC and the HIV prevention and surveillance program staff (i.e., AIDS directors, managers and surveillance coordinators) within health department

jurisdictions, via the development and utilization of various communication strategies to support the implementation of high-impact HIV prevention and surveillance programs.

   a. Identify and establish mechanisms to promote and facilitate active and increased communication between national partners, federal partners, state and local health department jurisdictions, community-based organizations (CBO), and other relevant agencies. Focus should be on: 1) obtaining input in the development and implementation of HIV prevention activities; 2) educating state and local health departments on policies that are relevant to HIV programs; and 3) addressing health inequities.
   b. Maintain, broker, and enhance processes that allow for peer-to-peer TA, collaboration, communication, and information exchange between state and local health department AIDS directors, HIV prevention program managers, HIV surveillance coordinators, and epidemiologists about relevant issues (e.g., data sharing, CDR, etc.).

9. Collaborate with other federal and CDC-funded CBA providers in the dissemination of information and the provision of TA to health department jurisdictions, as appropriate.
   a. Examples of collaboration and coordination include, but are not limited to, facilitating peer-to-peer technical assistance opportunities to support the implementation of EHE program plans, participation on CBA specific webinars, presentations at CDC meetings and professional conferences.

10. Produce regular updates and other periodic communications to HIV programs, as well as maintain microsites, strong social media and website presence to serve HIV programs, its partner agencies, and the community. The recipient will produce communication materials such as press releases, fact sheets, infographics, and other educational materials as part of this program. To assist CDC with addressing emerging issues, the recipient may establish a mechanism to help CDC respond to urgent information needs related to pressing HIV program issues and sharing of critical HIV prevention and surveillance information.

Examples of ways the recipient may implement these strategies include (but are not limited to):

- Representing HIV program interests at relevant national meetings and workgroups; and
- Engaging in strategic partnerships with other agencies working in the areas of STI, family planning, maternal and child health, adolescent health, school health, violence prevention, substance use, mental health, Lesbian, Gay, Bisexual and Transgender (LGBTQIA+) health, correctional health, housing, and primary care.

Content Areas of Focus for Component A

Applicants should have experience and expertise in the content areas of focus for supporting HIV programs in a changing health care environment on a national level. Below are content areas for which the recipient will develop and deliver TA products and services for health departments throughout the period of performance.

Policy Analysis and Interpretation

1. State and local level activity on policies and laws relevant to HIV programs.

a. Disseminate state level activity on policies and reporting laws relevant to the implementation of HIV prevention and surveillance programs.
b. Establishing a central fiduciary agent, administering microgrants (distribution of small funds to organizations with the intent of enabling the recipient to develop capacity or leadership), and other fiscal structural interventions

2. Policy-related educational and informational products in support of the NOFO strategic partnerships and communication activities.
3. National and jurisdictional-level data in areas of HIV prevention, surveillance, and CDR policies and programs for analysis and interpretation.
    a. Analyze health department jurisdictions' policies nationally to support programmatic activities.
    b. Gather information nationally on the Integrated Planning process to inform the development of future guidance.
4. Jurisdictions' policies about HIV prevention, surveillance, care, and treatment programs, including their impact on health disparities. Work with jurisdictions, as needed, to develop or update comprehensive policies that support the implementation of jurisdictional End the Epidemic plans.

Examples of ways the recipient may implement these strategies include but are not limited to developing briefs, fact sheets, infographics, program impact reports, investment strategies, professional judgments, spotlight videos, etc., and/or success stories for HIV program staff and their community for the purpose of educating policy makers and informing policy setting.

Activities may also include forging new partnerships to advance HIV program interests, speaking at conferences and meetings attended by decision makers and HIV prevention colleagues, and providing information and guidance on policy issues and education to individual HIV programs.

Integrated HIV Activities

Integrated HIV programs, services, and activities allow for maximum impact of federal HIV prevention funding, strengthen implementation of CDC's High-Impact Prevention approach, align resources to better match the geographic burden of HIV infections, syndemics, and improve data-driven public health action. The recipient will be required to provide technical assistance to address implementation challenges for the following integrated HIV activities:

1. Integrated HIV prevention and care planning TA activities
    a. Partnerships to conduct HIV prevention and care planning (e.g., HIV Planning Group)
    b. Integrated HIV Prevention and Care Plan development, implementation, and monitoring
    c. Strategies to align planning processes within jurisdictional plans (e.g. National HIV/AIDS Strategy, Ending the HIV Epidemic (EHE) initiative, CDC/HRSA HIV Planning Guidance, etc.)
    d. Stakeholder identification to ensure parity, inclusion, and representation (PIR)

e. Facilitation of formal processes to broker peer-to-peer mentorship for, and in support of, health department jurisdictions and HIV Planning Groups (HPGs) to share lessons learned and best practices in HIV planning activities
f. HIV prevention and care networks for increased coordination of, availability of, and access to comprehensive HIV prevention, treatment, and support services including those that address SDOH when appropriate
g. Leveraging resources for integrated HIV prevention and care services within the jurisdiction

2. Linkage and Re-engagement in Care (Data-to-Care) TA Activities
    a. Use surveillance and other data sources to identify people with diagnosed HIV who are potentially not receiving HIV medical care or other prioritized groups, such as people not virally suppressed or experiencing virologic failure, to support the HIV care continuum
    b. Continuum of care analysis to quantify the percent of people with diagnosed HIV linked to care, retained in care, and virally suppressed

3. HIV Surveillance TA Activities to support complete, timely, and accurate and confidential reporting of persons with diagnosed HIV infection and all laboratory test results indicative of HIV infection.
    a. Support the development and implementation of jurisdiction laboratory assessment as described in the HIV Technical Guidance Reporting file
    b. Support the jurisdictions on the review and assessment of HIV data sharing and protections
    c. Develop provider communications and materials for HIV case reporters (e.g., care providers, laboratories) on topics such as case reporting, the laboratory diagnostic testing algorithm, HIV treatment guidelines, state reporting regulations, uses of surveillance data

4. Cluster Detection and Response (CDR) TA Activities
    a. Assisting health department jurisdictions and their local partners to build strong CDR programs, develop meaningful community partnerships to support CDR, and review and integrate data to guide the selection and implementation of response actions to address identified gaps and challenges in HIV prevention and care among communities affected by rapid HIV transmission. Provider will coordinate with Component D as needed related to TA for specific prevention and care interventions in the setting of a cluster or outbreak response.

5. New advances in HIV prevention and priority activities based on DHP initiatives.

Component B: Instructor-led Training for High-Impact HIV Prevention Programs

CDC has a continued investment to support the national HIV workforce and ensure that CDC-funded programs and their partners receive the support needed to successfully implement HIV prevention strategies and activities within their respective programs. DHP supports this mission by providing instructor-led trainings to facilitate the implementation of local programs.

The Component B recipient will be responsible for the development and delivery of a comprehensive instructor-led training program to increase the HIV prevention knowledge, skills,

and competencies of interdisciplinary staff (e.g., professional, technical, clinical, and managerial) within CDC-funded programs and their local partners. The recipient should be able to provide training using both in person and virtual instructor-led formats. Training development and delivery includes utilization of existing and newly developed training packages for CDC-supported High-Impact HIV Prevention (HIP) interventions and public health strategies (e.g., testing, surveillance, cluster detection and response activities, etc.). Trainings may also include, but not be limited to, topics that support meeting national HIV prevention goals such as the HIV care and prevention continuum, social determinants of health, syndemics, health equity, whole person approaches to care, community engagement, recruitment, retention, modification of curricula, and monitoring and evaluation (including logic models, evaluation design, performance measurement, and program and performance improvement).

The recipient should conduct an environmental scan to identify new and existing HIP interventions, public health strategies, and topics of national importance, and ways in which revised, or newly developed competency-based training can meet the capacity building needs of the HIV prevention workforce. CDC will prioritize HIP interventions, public health strategies, and topics of national importance for training development and dissemination.

Training curricula, products, and materials must be culturally, linguistically, and educationally appropriate to meet the capacity building needs of CDC-funded programs and their local partners as they serve PWH and populations at greatest risk for HIV infection.

Required Strategies and Activities

Applicants must propose a program that describes how they will collaborate with CDC and other partners to implement the following strategies and activities:

1. Develop new in person and/or virtual instructor-led training packages for a **minimum of four HIP interventions, public health strategies, and/or topics** of national importance per budget year. Provide a plan describing capacity to complete the development of these four courses within one year. All training packages must meet 508-compliance requirements and should include:
    a. Training of Facilitators (TOF) curriculum (e.g., trainer's manual, participant's workbook, PowerPoint slides and other job aids) to teach how to implement HIP interventions, public health strategies, and/or topics of national importance
    b. Training of Trainer (TOT) structured agenda for walkthrough of how to deliver TOF curriculum
    c. Implementation and promotional materials (e.g., guidelines, forms, checklists, factsheets, videos, posters, launch plans and marketing materials) needed for successful implementation
    d. A plan to pilot test trainings with intended audiences, revise, and finalize content for 508-compliant training packages.
2. In consultation with CDC, **maintain and/or update content for** existing in person and/or virtual instructor-led training curricula and related materials for HIP interventions, public health strategies, and topics of national importance to reflect the most advanced science and practice. Use updated content to develop and/or revise related implementation and promotional materials (e.g., guidelines, forms, checklists, videos).

3. Annually deliver a **minimum of 125** in person or virtual instructor-led trainings for existing and/or new HIP interventions, public health strategies, and/or topics of national importance throughout the U.S. and its territories. This activity includes promotion with Component F recipient, scheduling, dissemination of training materials, securing appropriate, state of the art training space or platform, provision of experienced trainers, and pre- and post-course communication with trainees for coordination, evaluation, and cross-component referrals.
4. Use evidence-informed models for instructional design and adult learning techniques to develop and deliver all instructor-led training. All training should be highly interactive and engaging.
5. Use CDC approved state-of-the-art platforms and interactive technology (e.g., multi-device formats, social media applications, gamification) in the development and/or delivery of all training.
6. Develop and maintain a community advisory board to review and inform development of training materials for cultural competency and relevance to the priority populations prior to submission to CDC. The community advisory board should have members that represent people with HIV and populations disproportionately affected by HIV and be approved by CDC.
7. Continually review content of all updated or newly developed courses, in partnership with CDC. This would include using feedback from CDC, CDC directly funded programs and their local partners, and other CPN members to inform continuous improvement of training.
8. In partnership with CDC and CPN Resource Center, contribute to the development and maintenance of a CDC approved web-based or electronic library of all final training curricula, products, and materials.
9. Develop a plan for recruitment of appropriate participants into in-person and virtual instructor-led trainings.
10. Provide a post-training follow-up activity (e.g., conference call, email) with each agency to introduce appropriate TA provider who in turn will contact agency to determine and address additional technical assistance needs related to organizational implementation of HIP interventions and public health strategies, within 60 days following each training.
11. Ensure in-house staffing capacity and expertise are in place to develop and implement classroom and/or virtual instructor-led training curricula and related materials for HIP interventions, public health strategies, and topics of national importance to reflect the most advanced science and practice in HIV prevention. At minimum, the following in-house staff or contractor positions should be in place: instructional designer(s), trainer(s) (in person and virtual – instructor-led expertise), HIV subject matter experts, copy editor, graphic designer, video developer and project manager.
12. In consultation with CDC, establish and implement requirements for acknowledgment or confirmation of completion for in person and virtual instructor-led training.
13. Secure professional continuing education units for in person and virtual instructor-led trainings.
14. In partnership with CDC, provide a review of the content of all updated or newly developed courses for CPN members and CDC staff.
15. Translate new (or update existing) in person and/or virtual instructor-led training packages developed in English into Spanish. Training curricula, products, and materials

must be culturally, linguistically, and educationally appropriate to meet the capacity building needs of CDC-funded programs and their local partners as they serve people with HIV and populations disproportionately affected by HIV.

16. In partnership with CDC and CPN Resource Center, post and maintain an up-to-date national training schedule to an existing CDC-approved learning management system (LMS) for web-based training registration and information for logistical coordination.

Component C: eLearning Training for HIV Prevention Programs

The primary focus of Component C is to provide self-paced eLearning training to staff within CDC funded HIV programs and their partners on HIV prevention interventions, public health strategies and topics of national significance. The eLearning training curricula, products and materials should directly support DHP's strategic priorities, including efforts towards ending the HIV epidemic.

The Component C recipient will be responsible for the development and delivery of a comprehensive eLearning training program to increase the HIV prevention knowledge, skills, and competencies of the interdisciplinary staff (e.g., professional, technical, clinical, and managerial) within CDC-funded programs and their local partners. eLearning trainings will address CDC-supported high-impact prevention (HIP) interventions and, public health strategies and topics of national importance related to meeting HIV prevention goals. eLearning trainings may also include, but not limited to, topics that support meeting national HIV prevention goals such as the HIV care and prevention continuum, social determinants of health, syndemics, health equity, whole person approaches to care, community engagement, recruitment, retention, modification of curricula, monitoring and evaluation, and other topics that support ending the HIV epidemic.

Conduct an environmental scan to identify new and existing high-impact HIV prevention (HIP) interventions, public health strategies and topics of national importance, and ways in which revised or newly developed competency-based training can meet the capacity building needs of the HIV prevention workforce. CDC will prioritize HIP interventions, public health strategies, and topics of national importance for training dissemination.

All eLearning training products, and materials must be culturally, linguistically, and educationally appropriate to meet the capacity building needs of CDC-funded programs and their local partners as they serve people living with HIV (PWH) and populations at greatest risk for HIV infection. All training curricula, products, and materials are the property of CDC, and all source files should be transferred to CDC upon completion of each developmental project.

Applicants should have demonstrated direct experience designing, developing and delivering comprehensive and accessible eLearning training modules. Each applicant should demonstrate through a description of their staffing resources the skills sets of those staff members who will directly develop eLearning modules and have the requisite skills needed to utilize the CDC-approved eLearning development authoring tool, Lectora Online to develop accessible (i.e., Section 508-compliant) modules.

Required Strategies and Activities

Applicants must describe how they will collaborate with CDC to implement the following strategies and activities:

1. Develop new asynchronous web-based training using CDC approved software (i.e., Lectora Online) for a **minimum of four courses that may comprise of HIP interventions**, public health strategies, and/or topics of national importance per budget year. Use new content to develop eLearning implementation and supporting materials (e.g., guidelines, forms, checklists, etc.). Provide plan for course development of four eLearning courses within one year.
    a. In collaboration with CDC staff, design and develop course content and storyboards.
    b. Pilot test new content with intended audiences, and based on pilot feedback revise, test, and finalize content for 508-compliant web-based training modules, implementation materials, and educational/promotional materials.
    c. Conduct User Acceptance Testing (UAT) with intended audiences, revise, and finalize 508-compliant web-based training modules and supporting materials (see Accessibility Conformance Checklists | HHS.gov).
    d. In consultation with CDC, establish and implement requirements for acknowledgment or confirmation of completion for eLearning training.
2. Maintain, update and transition existing content from classroom training to asynchronous web-based training using CDC approved software (i.e., Lectora Online). Use updated content to develop web-based implementation and supporting materials (e.g., guidelines, forms, checklists).
    a. Use updated content to develop and/or revise related web-based implementation and promotional materials (e.g., guidelines, forms, videos, checklists).
    b. Use feedback from CDC, CDC-funded programs and partners to inform continuous quality improvement of all eLearning training. Make updates as needed to ensure all courses reflect current scientific information and reflect needs of learners.
3. Use evidence-informed models for asynchronous eLearning instructional design, including utilizing adult learning techniques, to develop, update, and deliver all eLearning training. All training should be highly interactive and engaging.
4. Use a community advisory board to review and inform development of eLearning training materials for cultural competency and relevance to the priority populations prior to submission to CDC. The community advisory board should have members that represent persons with HIV and populations disproportionately affected by HIV and be approved by CDC.
5. Use state-of-the-art and interactive CDC-approved authoring tools (e.g., Lectora Online) and technology (e.g., responsive design for multi-device formats, social media applications, etc.) to develop innovative and engaging eLearning trainings. All training must meet Section 508 and HHS Accessibility standards (see Accessibility Conformance Checklists | HHS.gov). https://www.hhs.gov/web/section-508/accessibility-checklists/index.html).
6. Ensure in-house staffing capacity and expertise are in place to develop and launch asynchronous eLearning training. At a minimum, the following in-house staff or contractor positions should be in place: eLearning instruction designer(s), eLearning developer(s) familiar with accessible development in Lectora Online, HIV subject matter

experts (prevention and treatment), copy editor, graphic designer, video developer and project manager.

7. Routinely provide and exchange information regarding updated and new training with other members of the CPN.
8. Conduct a timely post-training activity (e.g., conference call, email) to determine status and challenges related to organizational implementation of HIP interventions and public health strategies. Share this feedback with CDC and partners to identify technical assistance needs.
9. Secure applicable professional continuing education units for eLearning courses (see Overview for CE Developers | Continuing Education | CDC).
10. In partnership with CDC, post and maintain all courses on the CDC approved LMS, CDC TRAIN, for training registration.
11. In partnership with funded recipient under Component F, develop a marketing plan to promote release of new or updated eLearning courses.
12. In partnership with CDC, provide a review of the content of all updated or newly developed courses for CPN members and CDC staff.
13. Translate new (or update) eLearning training packages developed in English into Spanish. Training curricula, products and materials must be culturally, linguistically and educationally appropriate to meet the capacity building needs of CDC-funded programs and their local partners as they serve people with HIV and populations at greatest risk for HIV infection.
14. In partnership with CDC, contribute to the development and maintenance of a CDC approved electronic library of all final eLearning curricula, products and supporting materials.

Component D: Technical Assistance for High-Impact HIV Prevention Programs

The primary focus of technical assistance (TA) under Component D is to address programmatic challenges to effectively plan, integrate, implement, evaluate and sustain HIV prevention programs. Recipients funded under this component will provide individualized and specialized TA for CDC funded organizations (health department jurisdictions and CBOs). TA should address Component D content areas and, as appropriate, social determinants of health related to inequities in HIV prevention, care and treatment (e.g., housing, insurance, medical mistrust, health literacy, stigma, transportation). TA should enhance the ability of CDC funded HIV prevention programs and their local partners to identify and address syndemic conditions, such as viral hepatitis, STIs, mental health disorders and substance use, as well as disparities in priority populations. TA should also address challenges in monitoring and evaluation, as needed, to improve the performance and effectiveness of CDC-funded HIV prevention programs.

The Component D recipients will assist CDC funded programs and their local partners to maximize limited program resources, collaborate to support provision of comprehensive HIV prevention and care, and implement effective program practices.

TA services include individualized training designed to meet specific needs such as mentoring, consultation, demonstration, skills building, information sharing, resource development and sharing (e.g., webinars, summits, institutes, etc.) and opportunities for reciprocal learning among peers (e.g., communities of practice). TA services, products, and materials must be culturally, linguistically, and educationally appropriate to meet the diverse capacity building needs of CDC

funded programs and their local partners. TA providers should include input from people with HIV and priority populations with disproportionate rates of HIV infection e.g., through community advisory boards or inclusion as CBA staff or consultants.

Note: To prevent duplication of services and leverage existing federally funded TA efforts, the development and delivery of TA services, products, and materials should occur in communication, coordination, and collaboration with the AIDS Education Training Centers and the National Network of STD/HIV Prevention Training Centers.

Required Strategies and Activities

Applicants must propose a program that describes how they will collaborate with CDC and other partners to implement the following strategies and activities:

1. Deliver customized technical assistance to meet the needs of directly funded entities and their partners as requested through the CBA tracking system.
2. In partnership with CDC, support implementation of interventions and public health strategies that are part of DHP's current HIV programmatic funding opportunities and programmatic priorities. DHP-identified effective behavioral, biomedical, and structural interventions, public health strategies, and social marketing campaigns are publicly available in the Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention. Throughout the program period, CDC may identify additional public health strategies and interventions for support through this NOFO.
3. Communicate, collaborate, and coordinate with other TA providers funded by CDC under this funding opportunity to develop and implement annual CBA plans based on TA and training needs assessments populated by CDC directly funded health department jurisdictions and CBOs. Similar TA needs identified by multiple agencies will be addressed together, as appropriate (e.g., through webinars, institutes, or summits). CDC must approve CBA plans prior to implementation.
    a. Foster consultative relationships with CDC-funded health department jurisdictions and CBOs to identify annual training and TA needs, propose remedial and follow up activities, negotiate mutual roles and responsibilities, and define progressive benchmarks, targets, and timelines.
    b. Communicate, collaborate and coordinate with other CBA providers funded by CDC under this funding opportunity to develop and deliver TA events, activities, products, resources, and materials tailored for CDC-funded health department jurisdictions and CBOs and their local partners including through virtual communities of practice and the CBO Summit.
4. Establish and conduct a recurring virtual community of practice (CoP) with CDC directly and indirectly funded programs and their local partners to share knowledge, best practices, and resources related to current DHP priorities and federal initiatives to improve HIV prevention and care inequities.
    a. Conduct at least four CoP sessions per budget year coordinated in collaboration with CDC.
    b. Use innovative approaches to engage CDC directly and indirectly funded programs and their local partners for participation in the CoP.
    c. Create and maintain an accessible virtual resource repository for CoP participants.

5. In coordination and collaboration with this NOFO, CBA Providers, and CDC and based on identified CBA needs; Component D recipients will plan and implement a CBO Summit annually for CDC directly funded CBOs. The goal of the CBO Summits will be to expand and provide technical assistance to attendees, enhance leadership and development within the organization, and promote networking and sharing opportunities among CDC directly funded CBOs.
    a. Collectively recipients will be expected to provide a **minimum of four (4) CBO Summits annually** dispersed across the geographic regions in the United States. The CBO Summit will provide tailored workshops and sessions that will provide technical assistance and knowledge sharing opportunities for attendees.
    b. Recipients will be required to co-host at least one of the planned regional summits annually in consultation and with approval by the CDC Program Consultant. Host CBA Providers would cover meeting logistics for the CBO Summit. Expenses will include, but may not be limited to; securing the venue, venue cost, materials, travel for staff/presenters, etc.
    c. Partner with Component E recipient in the planning and delivery of the CBO Summit to address CBO needs around organizational development and leadership in addition to topics related to content areas under component D.
6. Submit developed TA products, resources, and materials for CDC clearance that address needs of CDC directly and indirectly funded programs and their local partners to build workforce capacity to support HIV prevention.
    a. Create clearance-ready TA products, resources, and materials that are evidence-based, formatted, edited, grammatically correct, and contain clear language to address identified gaps and TA needs.
    b. Ensure all final products are 508-compliant (https://www.hhs.gov/web/section-508/index.html).
    c. If the audience of a TA product is not primarily comprised of English speakers or if a TA product will be used in an enduring fashion or for national use, it should be translated by CBA providers into Spanish or another language depending on HIV prevention workforce needs or as requested by CDC.
7. Use feedback from CDC, CDC-funded health departments, CBOs and their local partners, and the CPN to inform continuous improvement of TA delivery.
8. Provide a post-training or TA follow-up activity (e.g., conference call, email) with the agency to determine and address additional technical assistance needs.

During the entire period of performance, recipients must maintain the capacity to provide TA on all topics related to the HIV prevention program. Recipients will be expected to expedite technical assistance for CDC-funded health department jurisdictions implementing HIV cluster detection and response activities.

Content Areas of Focus for Component D

- Navigation to care, prevention, and other services to support whole person approaches to include (financial navigation, linkage and re-engagement in care or PrEP, retention in care, leveraging technology to provide navigation services, leveraging partner services and community health workers for navigation, navigation to services that address social

determinants of health and address syndemic conditions, such as STIs, viral hepatitis, substance use and mental health disorders)

- Recruitment methods for engaging persons from populations of focus for HIV testing and HIV prevention, including Social Network Strategy
- The Ending the HIV Epidemic in the U.S. (EHE) initiative four science-based strategies that together, can end the HIV epidemic:
    - *Diagnose Pillar* - HIV testing in non-clinical settings of persons from populations of focus, self-testing and self-collection to test for HIV, viral hepatitis, and STIs, HIV testing in clinical settings, integration of HIV testing with screening for STIs, viral hepatitis, and mpox, HIV testing technologies, conducting a needs assessment at the point of testing.
    - *Treat Pillar* - planning and implementation of rapid antiretroviral therapy (ART), support rapid initiation of ART, retention and adherence in HIV care.
    - *Prevent Pillar* - Increase awareness, access, uptake, and adherence to PrEP and PEP including through removal of structural barriers, condom distribution as a structural intervention, and harm reduction activities to include SSP awareness and implementation.
    - *Respond Pillar* - Implementation of specific prevention and care interventions from the other pillars or syndemic or structural interventions in the setting of a cluster or outbreak response. All related TA will be expedited.

For more information regarding CDC-supported HIV prevention interventions and public health strategies, review Effective Interventions | HIV/AIDS | CDC, the Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention, and the DHP strategic plan supplement.

Component E – Organization/Workforce Development and Management for Community-Based Organizations

The primary focus of Component E is to build the capacity of community-based organizations (CBOs) to operate optimally for the scaling up and sustainability of high-quality HIV prevention programs.

The Component E recipient will be required to deliver CBA services to CDC directly and indirectly funded CBOs and their local partners. There are two focus content areas for Component E, applicants must be responsive to all required strategies and activities.

Organizational Development and Management (ODM) for CBOs

The recipient will provide CBA services (inclusive of training and technical assistance) to directly and indirectly funded CBOs to strengthen organizational development and management activities and support HIV prevention program sustainability.

Required Strategies and Activities

1. Develop and deliver technical assistance products and services for CBOs to address organizational challenges related to Component E focus content areas.
2. Provide technical assistance for CBOs on the allocation and leveraging HIV prevention fiscal resources to implement, expand, and sustain whole person and syndemic approaches.

3. Provide technical assistance and support to CBOs on administering, implementing, and monitoring micro-grants.
4. Develop, facilitate, and evaluate peer-to-peer technical assistance and peer-to-peer mentorship opportunities for CBOs specific to ODM.
5. Establish and facilitate communities of practice for CBO staff to share ODM information, lessons learned and best practices. These recurring opportunities should foster peer to peer learning, mentorship, technical assistance, and support among CBOs.
6. Develop and promote self-paced trainings and resources to support ODM content areas (e.g., national learning collaborative and CDC TRAIN). This would include the delivery of ODM training for CBOs as needed.

Workforce Development and Sustainability for CBOs

National Learning Community for HIV CBO Leadership

In consultation with CDC, the recipient will develop, implement, maintain, sustain, and evaluate a national distance learning HIV leadership program, National Learning Community for HIV CBO Leadership. This distance-learning program supports the development of leadership within CDC directly and indirectly funded CBOs seeking continuous quality improvement of their HIV prevention programs and organizational sustainability.

Required Strategies and Activities

Develop, maintain, update, launch and sustain the distance-learning program that incorporates the following elements:

1. Adaptation and/or application of an evidence-based model that addresses programmatic continuous quality improvement (CQI) and organizational sustainability contextualized to address the capacity building needs of senior and mid-level managers of HIV prevention programs and services within CBOs.
2. The program cycle run-time should be structured and allow for a minimum of two cycles per budget year. Participants may represent CDC directly or indirectly funded CBOs and their partners. Each cycle should recruit a **minimum of 20 participants**. After each program cycle, provide follow-up with each participant to determine ODM training and TA needs and promote utilization of CBA services across the CPN.
3. Provide virtual or in-person learning communities for participants to receive further ODM TA and skills building training.
4. In consultation with CDC, implement requirements for acknowledgment or confirmation of completion for distance-learning program, and, as appropriate, secure professional continuing education units.
5. Use a community advisory board to review and inform development of training materials for cultural competency and relevance to the priority populations prior to submission to CDC. The community advisory board should have members that represent persons with HIV and populations disproportionately affected by HIV and be approved by CDC.
6. Must use state-of-the-art and interactive CDC-approved authoring tools (e.g., Lectora Online, Adobe Captivate) and technology (e.g., responsive design for multi-device formats, social media applications) to develop innovative and engaging trainings. All training must meet Section 508 and HHS Accessibility standards (see Accessibility

Conformance Checklists | HHS.gov). https://www.hhs.gov/web/section-508/accessibility-checklists/index.html).

7. Conduct User Acceptance Testing (UAT) of distance-learning technologies with intended audiences, revise, and finalize.
8. In partnership with CDC, develop, pilot test with intended audiences, and revise and finalize instructional curriculum and content for web-based modules, products, tools, and materials. All web-based modules, products, tools, and materials must meet CDC 508-compliance requirements and be verified to be CDC-compliant with existing systems.
9. All technology and software must be approved by CDC prior to use. Recipient must use only CDC approved, CDC compliant, accessible, distance-learning technologies that allow for the asynchronous (e.g., Lectora, Captivate) and synchronous (e.g., Zoom, MS Teams) delivery of the program to participants located throughout the United States.
10. Launch and maintain the National Learning Community for HIV CBO Leadership program on a CDC-approved learning management system, CDC TRAIN.
11. Use evidence-informed instructional design and adult learning techniques, systematically build knowledge, skills, and competencies through expert instruction, mentoring, and resource sharing; peer-to-peer learning and support opportunities (e.g., community of practice, learning collaborative, etc.); and periodic, experientially based assignments or Integrative Learning Experiences culminating in a final product. For example, participants can work to develop and operationalize a CQI plan for a specific HIV prevention program or service and/or an organizational sustainability plan for their respective CBOs. Consideration should be given to the unique responsibilities and differing needs of senior and mid-level managers of HIV prevention programs and services for PWH and populations at greatest risk for HIV infection. The distance-learning program must be culturally, linguistically, and educationally appropriate for participants.
12. Within three months of funding, evaluate the current data collection instruments and assess if changes are needed. Recipient should seek and obtain both CDC clearance and OMB approval as directed.
13. Use feedback from CDC, participants, and other CPN members to inform continuous quality improvement of the distance-learning program.
14. In collaboration with the Component F recipient, develop a marketing plan for recruitment into the National Learning Community for HIV CBO Leadership program.
15. Plan, coordinate, and host a minimum of one in-person skills building leadership training institute focused on ODM content areas per budget year.

Recipients funded for Component E should have the capacity to provide TA services in the following content areas.

Organizational development and management CBA content areas include, but are not limited to:

- Fiscal resource development and management
- Third-party billing systems for HIV prevention programs and services, may include 340B services
- Board development and training
- Strategic planning and change management
- Organizational needs assessment and planning

- DEIA prioritization, planning, and activity implementation
- Human resource development and management
- Executive coaching and leadership development
- Professional development of mid-level program managers
- Staff recruitment, retention, and team building and when appropriate, support for staff who are members of priority populations.
- Cultural humility and cross-training of staff to ensure cultural competency across populations and communities served by the organization
- Multi-sectorial partnership development and strategic communications (e.g., health, justice, labor, housing) to address health equity and HIV related social determinants of health
- Program collaboration and service integration
- Community advisory board (CAB) development, recruitment, and management
- Quality assurance, program monitoring and evaluation, logic models, evaluation design, performance measurement and improvement
- Program and Organizational Sustainability

Workforce Development and Sustainability for CBOs content areas include, but are not limited to:

- Sustaining programmatic successes through leadership and community partner engagement across public and private sectors
- Network analysis to identify opportunities for new and/or improved collaborative efforts for organizational sustainability
- Establishing, assessing, and sustaining strategic partnerships to improve program performance
- HIV prevention workforce and organizational sustainability (e.g., effective hiring, management, retention, and succession planning)
- Identification of processes and strategies to address programmatic challenges and social determinants of health associated with HIV-related health disparities

Component F: CPN Resource and Coordination Center

The primary focus of the Capacity Building Assistance Provider Network (CPN) and Coordination Center is to ensure continuity across the NOFO CBA Providers, marketing of CBA services and the maintenance of the CPN Resource Center. Capacity Building Provider Network membership (CPN) is comprised of CBA provider organizations funded under this NOFO. The recipient under Component F will work collaboratively with the CPN membership.

The Component F recipient will be responsible for the marketing of the CBA program to increase visibility and utilization of all CBA services. CBA marketing campaigns (e.g., events, activities, products, and materials) must be culturally, linguistically, and educationally appropriate for a diverse HIV prevention workforce. Additionally, the successful applicant will provide administrative and meeting support to facilitate communication, collaboration, and coordination among the CPN membership.

Required Strategies and Activities

1. Develop and implement national marketing plans to increase visibility, accessibility, and utilization of the CBA program and available services by CDC-funded jurisdictions, CBOs and their local partners. The plan should include identification of, inclusion of, and outreach to intended audiences; use of the most advanced and up to date practices for marketing and branding; and use of innovative, state-of-the-art technologies (e.g., interactive digital marketing, social media tools, etc.) to develop and deliver an effective marketing campaign (e.g., events, activities, products, and materials) for a CBA program. Recipient should be able to update and maintain universal marketing and branding throughout the CPN membership. If needed and under special circumstances, recipient may be required to develop tailored marketing approaches for specific program components, different national or regional messaging, specialty/intended audiences, etc.
    a. Collaborate with all CPN members to inform the collective marketing and branding of the CBA program, services, training, etc. Considerations should be given to ensure materials are useful and appropriate for intended audiences.
    b. Submit all developed marketing materials for CDC review and clearance, based on guidance provided by CDC. Clearance-ready web-based materials should be scientifically sound, formatted, edited, grammatically correct, and contain clear and plain language. Products and materials for CDC web-posting should be fully 508-compliant (https://www.hhs.gov/web/section-508/index.html). All marketing materials are the property of CDC, and all source files should be transferred to CDC upon completion of each developmental project.
    c. In partnership with CDC, post CDC-cleared marketing materials to existing CDC-approved website for ease of access and reference by the intended audiences.
2. Develop and/or implement a CPN Resource Center (repository of CBA documents and products) including allowing support and maintenance of an interactive and user-friendly platform for CBA Provider use. CPN Resource Center must be maintained on a CDC-approved platform.
3. Work collaboratively with NOFO recipients to develop a plan and promote trainings and TA activities developed under this NOFO. Activities may include development of timeline and process to best promote available trainings and TA activities to CDC-funded recipients.
4. Translate marketing materials as needed for the intended audience. Recipient should at a minimum have the capacity and ability to translate materials from English to Spanish.
5. In partnership with CDC, facilitate the planning and implementation of a minimum of two (2) meetings per quarter to coordinate activities to further support CBA providers and the HIV prevention workforce (i.e., health department jurisdictions, CBOs, and partners), such meeting administrative support and coordination may include but not be limited to:
    - Virtual and in-person meeting planning and event logistics management (site identification, marketing materials development, promotion and distribution; signage creation and placement for meeting site; registration processes prior to, and days of, meeting[s])
    - Programmatic support regarding content development (on-site agenda, presentations, breakout sessions, evaluation instruments); materials development and dissemination, and meeting evaluation summaries and final report write-ups.

- Teleconference and webinar coordination and management (support call/webinar leads by way of agenda development, call/webinar save-the-dates and reminder notifications, time-keeping, roll-taking, notes-recording, and providing technical support as needed)
- Archiving all meeting files and documents in centralized location for ease of access and reference via the CPN Resource Center website.

1. Collaborations

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

Upon funding, recipients are required to work extensively with CDC and other CPN members to implement an efficient and effective CBA program that is consistent with CDC standards and guidance. Recipients are expected to practice ongoing communication, collaboration, and coordination including, but not limited to the following:

- Components A and D recipients will work collaboratively to address the needs of health department jurisdictions, including expedited TA delivery supporting surveillance, HIV cluster detection and response activities.
- Components B and C recipients shall mutually exchange feedback to inform the design and delivery of their respective training.
- The Component B and C recipients shall consult with Components A and D recipients and CDC subject matter experts (SMEs) to inform subject matter content (i.e., HIV prevention science and practice) for training.
- Component D and E recipients shall consult with Component B and Component C recipient to inform the development and delivery of TA services and products. This may occur bidirectionally among the recipients.
- Working as a team, Component D recipients shall collaboratively develop and deliver comprehensive TA services and products tailored to meet CBA needs.
- Components D and E recipients shall work collaboratively to address the CBA needs of CBOs.
- Component F recipient shall collaborate with all funded CBA provider recipients (Component A-E) to facilitate the development of a marketing plan, cross-component promotion of CBA services, compilation of CBA products, and meeting and summit coordination.
- In partnership with Component F, all recipients shall participate in CPN meetings, webinars, events, activities, workgroups, committees, etc. as well as promotion of the CBA program.

Recipients will work with CDC-funded health department jurisdictions and/or CBOs implementing HIV prevention programs and services. Recipients must establish, build, and/or maintain these working partnerships to facilitate ongoing development and delivery of their respective services (i.e., training, TA, continuous quality improvement and sustainability for CBOs, and marketing and administrative support for CPN). Regarding other CDC-funded programs, recipients should identify and address capacity building opportunities for appropriate program coordination and service integration of prevention, diagnostic, and treatment services for HIV, STDs, viral hepatitis, and TB for overlapping populations at greatest risk of HIV.

In addition, recipients may also collaborate with the Division of STD recipients funded to provided TA/CBA services. CDC-RFA-PS23-0007 provides TA to public health programs on systems, policy and communication, partnerships, special and emerging STD program projects, and leadership education and training to advance STD prevention objectives Funding Opportunity Announcements (FOAs) | STDs | CDC

b. With organizations not funded by CDC:
Recipients may establish, build, and/or maintain collaborative relationships that will support the implementation of their proposed program. Consideration should be given to developing strategic partnerships with the following types of organizations: funded recipients of federal agencies (e.g., the Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, the Centers for Medicaid and Medicare Services); local and state education agencies; colleges and universities; CBOs, faith-based organizations; for-profit organizations; clinics and hospitals; non-government organizations, national partners (e.g., Council of State and Territorial Epidemiologists, HIV subcommittee); state and local governments; American Indian/Alaska Native tribal governments and/or tribally designated organizations; community advocates; community members; and other stakeholders that may have a vested interest in promoting health through HIV prevention, care, and treatment.

2. Population(s) of Focus
For purposes of this NOFO, the population of focus consists of the interdisciplinary HIV prevention workforce (e.g., professional, technical, clinical, and managerial staff) within current and future CDC-funded state and local health department jurisdictions and CBOs and their local partner organizations (e.g., healthcare organizations and non-CDC-funded CBOs). The HIV prevention workforce plans, integrates, implements, evaluates and sustains comprehensive HIV prevention and surveillance programs and services for people with and populations at greatest risk of HIV infection. Recipients must provide CBA services in a manner that is available, accessible, and acceptable to the HIV prevention workforce regardless of age, race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant social dimensions.

Applicants must demonstrate their ability to provide CBA services that advance HIV prevention goals for people with HIV and for populations with disproportionate rates of HIV infections. Applicants should demonstrate how their approach is inclusive of disproportionately affected populations such as through community advisory boards. You may be called upon to build the capacity of the HIV prevention workforce to serve populations disproportionately affected by HIV such as:

a. Transgender women
b. Cisgender Black or Latina Women
c. Young Black or Latino gay, bisexual and other MSM
d. People who use drugs
e. People who exchange sex
f. People with a history of incarceration
g. People in rural or frontier areas
h. American Indians/Alaskan Native people
i. People with HIV over the age of 50 years

This NOFO, including funding and eligibility, is not limited based on, and does not discriminate on the basis of race, color, national origin, disability, age, sex (including gender identity, sexual orientation, and pregnancy) or other constitutionally protected statuses.

a. Health Disparities

The goal of health equity is for everyone to have a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

Broadly defined, social determinants of health are non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces (e.g., racism, climate) and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. See content below and in other sections (e.g., Approach, Collaborations, Populations of Focus) for information on how this specific NOFO affects social determinants of health.

A health disparity is a preventable difference in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been socially, economically, geographically, and environmentally disadvantaged. Health disparities are inextricably linked to a complex blend of social determinants that influence which populations are most disproportionately affected by these diseases and conditions.

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, recipients 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
N/A

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC will use a two-pronged approach to monitoring, evaluation, accountability, and quality assurance for this NOFO: 1) recipient performance monitoring; and 2) CDC's evaluation of the collective impact of the NOFO across all recipients. This approach will use data to (a) monitor and evaluate the NOFO overall, (b) determine if NOFO strategies and activities are being implemented as expected, (c) assess whether intended short-term and intermediate outcomes are being achieved, (d) assess the effectiveness of key strategies, and (e) drive continuous program and system improvement.

1. Recipient performance monitoring will ensure quality and accountability by using data to track implementation of recipient strategies and activities (process monitoring) and to determine progress toward achieving the outcomes (outcome monitoring).
2. CDC's evaluation of the collective impact will use multiple methods, such as collection and analysis of quantitative and qualitative data on program implementation and performance submitted by recipients, and tracking of key standardized performance measures. During the project period, CDC may partner with recipients on evaluation activities.

Data collected will include data sources including but not limited to assessments of CBA service recipients after CBA service delivery such as post-training evaluation surveys, post-TA evaluation surveys, 6-month follow-up training and technical assistance surveys, and training recipient demographic and organizational data. CDC will work with recipients to document CBA service delivery and outputs using CDC-approved applications and systems, e.g., CDC Train, the online CBA tracking system (CTS), the Cleared Product Inventory Tool and other DHP branch clearance processes, End of Year (EOY) reports, and annual performance reports (APRs). Data collection requirements and instruments will be subject to OMB review and approval. All measures will be assessed annually through EOY performance reports.

Findings will be systematically reviewed by CDC to identify challenges encountered by recipients, identify capacity-building assistance needs and actions needed to improve overall project performance, compare methods and outcomes across recipients to identify promising practices for dissemination during the project period, demonstrate the value of the NOFO, and contribute to the evidence base for NOFO strategies and activities. Data will also be used to produce reports on project accomplishments, project feedback reports, fact sheets, and monitoring and evaluation reports. Findings may also be reported at national conferences, CDC and partner websites, in peer-reviewed journals, and in other public forums.

For each of the NOFO strategies, a partial list of short and intermediate outcomes and performance measures are presented below. A full list of proposed outcomes, measures, and targets will be included in the NOFO Evaluation and Performance Measurement Strategy which will be provided by CDC at the beginning of the project. CDC will finalize the performance

measures, their specific definitions, benchmarks, submission frequency, and data reporting templates in consultation with recipients within 6 months into the award.

Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions

Strategy: Facilitate communication sharing and partnership engagement among HDs and other organizations nationally

Short-Term Outcome: Strengthened national partnerships to support implementation of HIV prevention programs

- Measure: Number of national partners and staff reached through communications, educational opportunities, and national planning and collaboration meetings engaging national partners, federal partners, state and local health departments, and CBOs

Strategy: Provide TA to HDs on policy analysis and interpretation, and integrated HIV activities

Short-Term Outcome: Improved HD capacity for policy-informed, integrated HIV activities

- Measure: Number and percentage of HD staff who completed TA during the measurement period who reported (upon completion of TA) that they strongly agreed or agreed that the TA would contribute to improved HIV policy analysis and interpretation, or integrated HIV activities at their organization

Intermediate Outcome: Optimal HD planning, integration, implementation, evaluation, and sustainability of comprehensive HIV prevention programs and services

- Measure: Number and percentage of HDs engaged during the measurement period who reported improved program planning, integration, implementation, evaluation or sustainability of HIV prevention programs and services (6 months after initial engagement)

Component B: Instructor-Led Training for High-Impact HIV Prevention Programs

Strategy: Provide instructor led training to HD and CBO staff on CDC-supported high-impact HIV prevention interventions, public health strategies, and topics of national importance

Short-term Outcome: Increased HIV knowledge, skills and competencies and enhanced HD and CBO staff capacity for equitable HIV program planning, implementation, evaluation, and service delivery

- Measure: Number and percentage of HD and CBO staff who completed instructor-led training during the measurement period who report that they strongly agreed or agreed that the training improved their HIV-related knowledge, skills, or competencies
- Measure: Number and percentage of HD and CBO staff who completed instructor-led training during the measurement period who reported (upon completion of training) that they strongly agreed or agreed that the training would contribute to improved and more equitable HIV program planning, implementation, evaluation or service delivery at their organization

Intermediate Outcome: Effective implementation and operation of equitable HIV prevention programs and services by HD and CBO staff

- Measure: Measure: Number and percentage of HDs and CBOs, whose staff completed instructor led training during the measurement period who reported improved and more equitable program planning, implementation, or service delivery (6 months after training completion)

Component C: eLearning Training for High-Impact HIV Prevention Programs

Strategy: Provide eLearning training to HD and CBO staff on CDC-supported high-impact HIV prevention interventions, public health strategies, and topics of national importance

Short-term Outcome: Increased HIV knowledge, skills and competencies and enhanced HD and CBO staff capacity for equitable HIV program planning, implementation, evaluation, and service delivery

- Measure: Number and percentage of HD and CBO staff who completed an eLearning training course during the measurement period who reported that they strongly agreed or agreed that the training improved their HIV knowledge, skills, or competencies
- Measure: Number and percentage of HD and CBO staff who completed an eLearning training during the measurement period who reported (upon completion of training) that they strongly agreed or agreed that the training would contribute to improved and more equitable program planning, implementation, evaluation or service delivery at their organization

Intermediate Outcome: Effective implementation and operation of equitable HIV prevention programs and services by HD and CBO staff

- Measure: Measure: Number and percentage of HDs and CBOs, whose staff completed eLearning training during the measurement period who reported improved and more equitable program planning, implementation, or service delivery (6 months after training completion)

Component D: Technical Assistance for High-Impact HIV Prevention Programs

Strategy: Provide TA to HDs and CBOs to address challenges related to the planning, implementation, and evaluation of HIV prevention programs and services, and address syndemic conditions and social determinants of health (SDOH)

Short-term Outcome: Strengthened HD and CBO organizational capacity to support comprehensive HIV prevention programs and services to diagnose and treat HIV and syndemic conditions, and address SDOH and inequities

- Measure: Number and percentage of HD and CBO staff who completed their receipt of TA during the measurement period who reported (upon completion of TA) that they strongly agreed or agreed that the TA would contribute to improved organizational capacity to support comprehensive HIV prevention programs and services

Intermediate Outcome: Enhanced HD and CBO structural environments to support the effective operation of equitable HIV prevention programs and address syndemic conditions, SDOH and inequities

- Measure: Number and percentage of HDs and CBOs, with staff who completed receipt of technical assistance during the measurement period, who reported an improved structural environment at their organization to support the effective operation of equitable HIV prevention programs and services (6 months after TA completion)

Component E: Organization/Workforce Development & Management for CBOs

Strategy: Provide training and TA on Organization Development and Management to CBOs

Short-term Outcome: Increased capacity of CBOs in fiscal management, human resources, DEIA efforts and other management functions

- Measure: Number and percentage of CBO staff who completed training in fiscal management, human resources, DEIA efforts or other management function during the measurement period who reported (upon completion of the training) that they strongly agreed or agreed that the training would contribute to increased organizational capacity at their CBO

Intermediate Outcome: Enhanced CBO organizational capacity, sustainability, and quality of HIV prevention programs and services

- Measure: Number and percentage of CBOs with staff who completed training in fiscal management, human resources, DEIA efforts or other management function during the measurement period who reported that the training contributed to improved organizational capacity, sustainability and quality of HIV prevention programs and services at their CBO (6 months after training)

Strategy: Develop and manage the National Learning Community for HIV CBO Leadership for CBOs

Short-term Outcome: Increased CBO leadership capacity

- Measure: Number and percentage of CBO staff who completed leadership training during the measurement period who reported (upon completion of the training) that they strongly agreed or agreed that the training would contribute to increased leadership capacity at their CBO

Intermediate Outcome: Enhanced CBO organizational capacity, sustainability and quality of HIV prevention programs and services

- Measure: Number and percentage of CBOs with staff who completed leadership training during the measurement period who reported that the training improved their organizational capacity, sustainability and quality of HIV prevention programs and services (6 months after training)

Component F: CPN Resource and Coordination Center

Strategy: Promote CBA services through designing and implementing marketing campaigns, managing the Resource Center, and coordinating meetings

Short-term Outcome: Increased awareness of CBA services by HDs and CBOs

- Measure: Number of resources disseminated and meetings held during the measurement period through the Resource Center, and the number of HDs, CBOs, and staff reached
- Measure: Number and percentage of HD and CBO staff that completed receiving CBA services (under components A-E) during the measurement period who reported awareness of the CPN Resource Center, and the resources available through it

Intermediate Outcome: Increased utilization of CBA training and TA by HDs and CBOs

- Measure: Number of HDs and CBOs and staff that completed training and TA (under components A-E) during the measurement period

ii. Applicant Evaluation and Performance Measurement Plan

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

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement, including, as applicable to the award, how findings will contribute to reducing or eliminating health disparities and inequities.
- 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).
- How evaluation findings will be disseminated to communities and populations of interest in a manner that is suitable to their needs.
- 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.

The applicant's evaluation and performance measurement plan (EPMP) describes how the recipient will use data to monitor, evaluate, and continuously improve program performance. The recipient must provide an EPMP using a template provided by CDC that will be provided post funding. The EPMP will address all major program elements, outputs and outcomes, including all indicators required by CDC. At least quarterly, recipients should review and use the EPMP findings to monitor, evaluate, and continuously improve program activities, processes, and performance. Applicants will use data collected by recipients and CDC in their EPMP.

Applicants may allocate up to 10% of total budget to ensure sufficient staffing and resources to accomplish all approved EPMP activities, including planning, data collection, data entry, data management, reporting data to CDC, data analysis and interpretation, and using data for continuous program improvement.

All recipients are expected to comply with the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs. All standards included in the NCHHSTP Data Security and Confidentiality Guidelines should be implemented by recipients, unless otherwise justified. A Certification of Compliance statement signed by an overall responsible party or parties (ORP) will be submitted annually to the CDC Project Officer at the same time the Annual Performance Report (APR) is submitted. For information on the data security and confidentiality guidelines and example certification statement, please refer to: https://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf.

c. Organizational Capacity of Recipients to Implement the Approach

All applicants must demonstrate existing capacity (i.e., minimum of 2 years' experience, expertise, products, and resources) to execute selected component and all required activities as described in the NOFO. Applicants must demonstrate expertise, experience, and/or capacity to develop, implement, and evaluate the required program strategies and activities. Applicants should describe and submit documentation of their organizational mission and structure; physical space and equipment; relevant operational systems, protocols, and policies; overall budget and funding sources; program management and operational structure; expertise and experience of program management, staff, subcontractors, and consultants; current and recent relevant work; program working partnerships; program sustainability plan; and other information that would help CDC assess an applicant's capacity to execute their proposed program throughout the duration of the five-year project period. Organizational capacity will be weighed heavily during the review and selection process. Applicants are strongly encouraged to describe and submit documentation for the items listed below.

Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions

- Describe the organization's capacity to facilitate strategic communications among federal agencies, organizations, state, tribal, local, and/or territorial health departments, community health centers, health care providers, laboratories, and other stakeholders
- Describe the organization's capacity to facilitate partnerships among federal agencies, national organizations, state, tribal, local, and/or territorial health departments, community health centers, health care providers, laboratories, and other stakeholders
- Describe the organization's capacity to develop and deliver TA products and services, including HIV-related policy analysis and interpretation for health departments.

- Describe the organization’s capacity to develop and deliver TA products and services, including to address challenges implementing integrated HIV activities by health departments.
- Describe the organization’s relationship and history, to include number of years serving or working with state and local health departments HIV programs and their experience and expertise related to required strategies and activities.

Component B: Instructor-Led Training for High-Impact HIV Prevention Programs

- Describe the organization’s capacity to develop in person and virtual instructor-led training curricula, storyboards, products, tools, and other materials.
- Describe the organization’s capacity in relation to CDC supported HIV prevention interventions and public health strategies.
- Describe organization's staffing to effectively manage and develop training and curricula development (i.e., writer/editor, curriculum designer, trainer, HIV prevention content subject matter expert, etc.)
- Describe the organization’s capacity to deliver an instructor led training program with national reach for the HIV prevention workforce.
- Describe the organization’s capacity to launch and maintain an instructor led (in person and virtual) training program with national reach.

Component C: eLearning Training for High-Impact HIV Prevention Programs

- Describe the organization’s capacity to develop web-based training curricula, modules, storyboards, products, tools, and other materials.
- Describe the organization’s capacity in relation to CDC supported interventions and public health strategies to serve the national HIV prevention workforce.
- Describe the organization’s staffing needed to effectively manage and develop web-based training and curricula development (i.e., eLearning instruction designer(s), eLearning developer(s) familiar with accessible development in Lectora Online, HIV subject matter experts (prevention and treatment), copy editor, graphic designer, video developer and project manager)
- Describe the organization’s capacity to launch and maintain an eLearning training program with national reach, including use existing CDC approved web-based learning management system (LMS) and applicant's existing web-based LMS.

Component D: Technical Assistance for High-Impact HIV Prevention Programs

- Describe the organization’s capacity to develop TA services, products, and materials.
- Describe the organization’s capacity to build relationships with health departments jurisdictions, community-based organizations, and other public health partners.
- Describe the organization’s capacity to develop and maintain a community of practice.
- Describe the organization’s staffing to effectively manage and deliver TA as requested to CDC funded organizations.
- Describe the organization’s capacity to plan and deliver a multi-agency TA event such as a summit, institute, or conference.

- Describe the organization's capacity in relation to CDC supported interventions and public health strategies.
- Describe the organization's capacity in relation to the HIV prevention workforce.
- Describe the organization's capacity to deliver a TA program that addresses content areas of focus described in the component.
- Describe the organization's capacity to obtain and incorporate meaningful engagement and feedback from populations most affected by HIV into technical assistance work.

Component E: Organization/Workforce Development and Management (ODM) for Community-Based Organizations

- Describe the organization's capacity to develop ODM TA services, products, and materials.
- Describe the organization's demonstrated expertise, experience and/or capacity to provide information, training, and technical assistance to CDC funded CBOs to support HIV prevention interventions and public health strategies.
- Describe the organization's capacity to recruit participants into the distance learning program
- Describe the organization's demonstrated expertise, experience, and capacity to work with CBOs nationally and their priority populations in relation to HIV prevention
- Describe the organization's capacity to develop and manage a distance-learning program to build knowledge, skills, and abilities among adult learners.
- Describe the organization's capacity in relation to continuous quality improvement and organizational sustainability for HIV prevention programs and services.
- Describe the organization's capacity in relation to the national workforce of senior and mid-level managers of HIV prevention programs and services in CBOs.
- Describe the organization's capacity to deliver and sustain a distance-learning program, including use of a CDC approved learning management system (LMS).
- Describe the organization's staffing needed to effectively manage, develop, and maintain ODM TA services and workforce development programs.

Component F: CPN Resource and Coordination Center

- Describe the organization's capacity to develop and implement national marketing campaigns (e.g., activities, products, tools, and other materials).
- Describe the organization's capacity to facilitate coordination, communication, and collaboration among a national network of professional organizations (e.g., CPN).
- Describe the organization's capacity to plan, administer, and coordinate meetings annually designated by CDC.
- Describe the organization's staffing needed to effectively manage and develop marketing campaigns and facilitate meeting coordination.
- Describes and documents the organization's capacity in relation to creation and maintenance of an electronic repository database accessible to partners (5 points)

All applicants should ensure the following are detailed:

Workforce Capacity

Applicants must provide details on their workforce capacity, competence, expertise and experience as they relate to all specific program strategies and activities. Applicants must have a strategy to ensure that the development, implementation, and delivery of services are appropriate to meet the needs of the state and local health department jurisdictions.

Staffing

Applicants must provide evidence of adequate program management/staffing plans, performance measurement, evaluation, financial reporting, management of travel requirements, and workforce development and training. Applicants should identify key staff, including program management, with expertise in capacity building for HIV programs (Principal Investigator or Co-Principal Investigators) and must have a plan to ensure that program staff has adequate skills and relevant experience and capacity to implement the activities and achieve the project outcomes, including the evaluation plan. The staffing plan and project management structure should be sufficient to achieve the project outcomes (e.g., staff technical expertise, data management and data analysis capacity, and a plan for accessing capacity building assistance to support workforce development), inclusive of subcontractors and consultants if applicable, throughout the duration of the five-year project.

Staff must have the breadth of subject matter expertise and experience required to conduct all proposed work. Applicants should describe how they will assess staff competencies and develop a plan to address gaps through organizational and individual training and development opportunities. Additionally, a curriculum vitae 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.

Examples of appropriate staff members reflected in application include, but are not limited to and dependent on the component of application:

- CBA/TA specialist
- Instructional designers for training curricula
- Trainers (classroom and virtual instructor-led expertise)
- HIV subject matter experts (prevention and treatment)
- Copy editor
- Graphic designer
- Video developer
- Meeting coordinators

Note: The following documents do not count toward the page limit for the Project Narrative.

- If applicable, applicants must file contractual agreements with other national partners, name the file(s) "Contractual Partnership," and upload the document(s) as a PDF file under "Other Attachments Forms
- Organizational chart(s), name the file "Org Chart," and upload the document(s) as a PDF file under "Other Attachments Forms"

d. Work Plan

Applicants are required to provide a work plan that provides both a high-level overview of the entire five-year project period and a detailed description of the first year of award. In alignment with DHP priorities, work plans should include activities that advance health equity within the proposed program activities of CDC HIV prevention funded partners.

The work plan should address how the applicant proposes to execute all requirements for a selected component to meet outcomes as described in the NOFO. Applicants should provide specific, measurable, achievable, realistic, and time-based (SMART) objectives with corresponding action steps, timelines, parties responsible, desired outcomes or deliverables, process and outcomes measures, and other pertinent information. Post-award, proposed work plans may be adjusted in collaboration with CDC to better address the overarching goals of the NOFO.

Applicants should address the following outline in their work plan:

1. Five-Year Overview of Proposed Program (concise narrative)

    - Overarching approach to meet intended program outcomes during the five-year project period

2. Year 1 Detailed Work plan for Proposed Program

    - Intended program outcomes aligned with component requirements
    - Component requirements aligned with SMART objectives
    - SMART objectives aligned with action steps, timelines, responsible parties, deliverables, and performance measurement

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.

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.

Recipients performing at a less than sufficient level to achieve program objectives within stated timeframes will be placed on a time-phased Improvement Plan (IP) developed by the CDC Program Consultant in collaboration with the recipient. The IP 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.

In addition to those listed, other activities deemed necessary to monitor the award may be applied.

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. Foster communication, collaboration, and coordination between CDC and CPN members to ensure provision of needed CBA services to the HIV prevention workforce.
2. Work with recipients to identify and address program implementation challenges that may impede the success of the project. Recipients must work with the assigned CDC Program Consultant, and subject matter experts.
3. Provide access to technical guidance and training that will strengthen staff capacity relevant to implementation of all required activities of the program.
4. Provide guidance to recipients on data collection, use, and submission for monitoring and evaluation activities.
5. Facilitate coordination, collaboration, and where feasible, integration of CBA services among CDC-funded programs (i.e., health department jurisdictions, CBOs, local and

state planning groups, CPN members); other federal agencies and their recipients (e.g., training and TA providers, medical care providers, laboratories, pharmacies, substance use treatment centers, mental health clinics, etc.); and other partners working with people living with and at greatest risk for HIV infection toward common goals of risk reduction, disease detection, and a continuum of HIV prevention, care, and treatment.

6. Provide technical guidance to recipients to improve the quality and effectiveness of work plans, evaluation strategies, products and services, and collaborative activities with other organizations.
7. Collaborate in assessing measurable progress toward meeting program outcomes and in establishing measurement and accountability systems for documenting outcomes, such as increased performance improvements and best or promising practices.
8. Collaborate on components to ensure the provision of appropriate and effective CBA services to the HIV prevention workforce.
9. Collaborate to compile and publish accomplishments, best practices, and lessons learned during the project period (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).

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:
U65

3. Fiscal Year:
2024

4. Approximate Total Fiscal Year Funding:
$25,500,000

5. Total Period of Performance Funding:
$127,500,000
This amount is subject to the availability of funds.

Component	Approximate Annual Funding
Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions	$2,500,000
Component B: Instructor-led Training for High-Impact HIV Prevention Programs	$3,500,000

Component C: eLearning Training for High-Impact HIV Prevention Programs	$2,000,000
Component D: Technical Assistance for High-Impact HIV Prevention Programs	$14,000,000
Component E: Organization/Workforce Development and Management for Community-Based Organizations	$2,250,000
Component F: CPN Resource and Coordination Center	$1,250,000

Estimated Total Funding:
$127,500,000

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

year(s)

7. Expected Number of Awards:
15

- Component A: 1 Award
- Component B: 1 Award
- Component C: 1 Award
- Component D: up to 10 Awards
- Component E: 1 Award
- Component F: 1 Award

8. Approximate Average Award:

$2,150,000
Per Period of Performance

Based on the availability of funding, the approximate average award amounts per budget period are as follows:

- Component A: $2,500,000
- Component B: $3,500,000
- Component C: $2,000,000
- Component D: $1,400,000
- Component E: $2,250,000
- Component F: $1,250,000

9. Award Ceiling:
$0
Per Period of Performance

This amount is subject to the availability of funds.

10. Award Floor:
$0

Per Period of Performance

11. Estimated Award Date:
July 01, 2024

12. Budget Period Length:
12 month(s)

Throughout the period of performance, 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 (period of performance) 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.

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

2. Additional Information on Eligibility

Applicants are permitted to submit only **one application** but may apply for **a maximum of two (2) components**. An application with more than two (2) components will be deemed as nonresponsive, and the application(s) will receive no further review.

Applicants must submit the following documentation:

1. Applicant must submit documentation that demonstrates at least two years engagement and provision of training, technical assistance provision, and/or capacity building assistance with HIV prevention or care services to the selected population of focus. Examples include Progress Reports, Notice of Award or Media publications, or letter from an applicant's funding source, other than CDC, documenting the applicant's performance related to the component of which the applicant is applying. The evidence of prevention or care service should be uploaded as a PDF and named "Appendix_Evidence of Service".

2. Maximum of two (2) Letters of support or commitment to demonstrate an intended or prior relationships with the applicant. The letters should be saved as a pdf and uploaded as “Letters of Support”
3. An example of experience/related work to support the component of which the applicant is applying. The document or weblink must include recent examples of component relevant work products, materials, tools, etc. The reference should be saved as a pdf and uploaded as “Work Examples” Acceptable examples of work may include, but are not limited to:

- Examples of, or links to, in-person and virtual instructor-led training materials (e.g. Trainers Manual, Participant Manual/Handbook) that were designed, developed and implemented over the past three years.
- Examples of in-person and virtual instructor-led training coordination policies, processes or procedures for the past three years.
- Description of, or links to, electronic repositories and websites utilized or developed to house in-person and virtual instructor-led training materials.
- Examples of, or links to, eLearning training materials (e.g., eLearning course samples, eLearning storyboards, job aids or performance support files, animation or other multimedia examples, etc.) that were designed, developed, and implemented over the past three years.
- Technical assistance products for the HIV/STI workforce tailored to address prevention needs for one or more priority populations
- Examples of, or links to, marketing materials designed and developed for HIV/STI workforce.

If any of these required documents are missing, the application will be deemed nonresponsive and not considered for 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 associated with your organization's physical location prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned through SAM.gov registration. Some organizations may have multiple UEI numbers. Use the UEI number associated with the location of the organization receiving the federal 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	1. Go to SAM.gov and create an Electronic Business Point of Contact (EBiz POC). You will	7-10 Business Days but may take longer and must be renewed once a year	For SAM Customer Service

	Management (SAM)	need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.		Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
2	Grants.gov	1. Set up an account in Grants.gov, then add a profile by adding the organization's new UEI number. 2. The EBiz POC can designate user roles, including Authorized Organization Representative (AOR). 3. AOR is authorized to submit applications on behalf of the organization in their workspace.	Allow at least one business 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.

2. Request Application Package

Applicants may access the application package at www.grants.gov. Additional information about applying for CDC grants and cooperative agreements can be found here: https://www.cdc.gov/grants/applying/pre-award.html

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)

Number Of Days from Publication 10

03/31/2024

b. Application Deadline

Due Date for Applications 04/30/2024

04/30/2024

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

Conference calls related to the NOFO will be published on the NOFO website. https://www.cdc.gov/hiv/funding/announcements/ps-24-0020/index.html

5. Pre-Award Assessments

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

The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. *See Attachment A: Letter of Intent for PS24-0020*

LOI must be sent via email to:

Erica K. Dunbar

CDC, NCHHSTP, DHP

NOFOINFO@cdc.gov

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, Word, or Excel file format 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 period of performance, 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 period of performance. 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. Population(s) of Focus and Health Disparities

Applicants must describe the specific population(s) of focus in their jurisdiction and explain how to 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 Population(s) of Focus and Health Disparities requirements as described in the CDC Project Description, including (as applicable to this award) how to address health disparities in the design and implementation of the proposed program activities.

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 https://www.cdc.gov/os/integrity/reducepublicburden/index.htm.
- 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 or reaccreditation 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 essential public health services and ensure foundational capabilities are in place, such as activities that ensure a capable and qualified workforce, strengthen information systems and organizational competencies, build attention to equity, and advance 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. These goals may include supporting vital records offices participating in the Vital Records and Health Statistics Accreditation Program, certifying vital records offices to meet industry standards. 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; provide financial assistance to support accreditation related fees and/or support staff time to coordinate accreditation activities; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and can upload it as a PDF, Word, or Excel file format 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.

Indirect costs under grants to local government agencies (other than those designated as "major" pursuant to OMB Circular A-87) shall be budgeted and reimbursed on the basis of the rates computed and proposed by the local government in its grant application unless the awarding office requests Division of Cost Allocation, HHS (DCA) involvement. Indirect costs could

include the cost of collecting, managing, sharing and preserving data. Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). For guidance on completing a detailed budget, see Budget Preparation Guidelines at: https://www.cdc.gov/grants/documents/Budget-Preparation-Guidance.pdf.

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. Employee Whistleblower Rights and Protections

Employee Whistleblower Rights and Protections: All recipients of an award under this NOFO will be subject to a term and condition that applies the requirements set out in 41 U.S.C. § 4712, “Enhancement of contractor protection from reprisal for disclosure of certain information” and 48 Code of Federal Regulations (CFR) section 3.9 to the award, which includes a requirement that recipients and subrecipients inform employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. § 4712. For more information see: https://oig.hhs.gov/fraud/whistleblower/.

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 anti-lobbying restrictions 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 to purchase antiretroviral therapy.
- Federal funds used for the purchase of supplies or equipment related to injection drug use must comply with current federal law. Currently, federal law states that recipients may not use funds to purchase sterile needles or syringes for drug injection.
- Funding should not be used for construction purposes.

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. Intergovernmental Review

This NOFO is not subject to executive order 12372, Intergovernmental Review of Federal Programs. No action is needed.

19. 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. Application attachments can be submitted using PDF, Word, or Excel file formats. 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 review the Applicants section on www.grants.gov.

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

NOFO reviewers will follow CDC's merit review process by evaluating eligible and responsive applications in accordance with the criteria below. Reviewers may be external to the federal government (non-federal personnel), federal personnel, or a mix of federal and non-federal personnel.

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:** 35

The approach criteria applies to all Components of the NOFO.

Evaluate the extent to which the applicant:

1. Demonstrates a comprehensive understanding of the purpose and intended outcomes of the NOFO (5 points)
2. Describes an overarching five-year approach to efficiently and effectively execute one component and all required activities as described in the NOFO (10 points)
3. Presents a detailed Year 1 work plan that aligns each of the selected component's outcomes and requirements with proposed SMART objectives, action steps, and performance measurement as described in the NOFO (20 points)

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

Evaluate the extent to which the applicant:

1. Demonstrates the ability to collect evaluation and performance measurement data as specified by CDC in the project description and presented by the applicant in their approach (5 points)
2. Describes how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities (5 points)
3. Describes how evaluation and performance measurement findings will be used for timely continuous quality improvement of project activities (15 points)

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 40

Component A: Technical Assistance to Enhance Integrated HIV Activities for Health Department Jurisdictions

- Describes the organization’s capacity to facilitate strategic communications among federal agencies, organizations, state, tribal, local, and/or territorial health departments, community health centers, health care providers, laboratories, and other stakeholders (10 points)
- Describes the organization’s capacity to facilitate partnerships among federal agencies, national organizations, state, tribal, local, and/or territorial health departments, community health centers, health care providers, laboratories, and other stakeholders. (10 points)
- Describes the organization’s capacity to develop and deliver TA products and services, including HIV-related policy analysis and interpretation for health departments. (5 points)
- Describes the organization’s capacity to develop and deliver TA products and services, including to address challenges implementing integrated HIV activities by health departments. (5 points)
- Describes the organization’s relationship and history, to include number of years serving or working with state and local health departments HIV programs and their experience and expertise related to required strategies and activities. (10 points)

Component B: Instructor-Led Training for High-Impact HIV Prevention Programs

- Describes the organization’s capacity to develop in person and virtual instructor-led training curricula, storyboards, products, tools, and other materials. (15 points)
- Describes the organization’s capacity in relation to CDC supported HIV prevention interventions and public health strategies. (10 points)
- Describes the organization's staffing to effectively manage and develop training and curricula development (i.e., writer/editor, curriculum designer, trainer, HIV prevention content subject matter expert, etc.) (5 points)
- Describes the organization’s capacity to deliver a classroom-based training program with national reach for the HIV prevention workforce. (5 points)
- Describes the organization’s capacity to launch and maintain an instructor lead (classroom-based and virtual) training program with national reach. (5 points)

Component C: eLearning Training Center for High-Impact HIV Prevention Programs

- Describes the organization’s capacity to develop web-based training curricula, modules, storyboards, products, tools, and other materials. (10 points)
- Describes the organization’s capacity in relation to CDC supported interventions and public health strategies to serve the national HIV prevention workforce. (10 points)
- Describes the organization’s staffing needed to effectively manage and develop web-based training and curricula development (i.e., eLearning instruction designer(s), eLearning developer(s) familiar with accessible development in Lectora Online, HIV subject matter experts (prevention and treatment), copy editor, graphic designer, video developer and project manager) (10 points)
- Describes the organization’s capacity to launch and maintain an eLearning training program with national reach, including use existing CDC approved web-based learning management system (LMS) and applicant's existing web-based LMS. (10 points)

Component D: Technical Assistance for High-Impact HIV Prevention Programs

- Describes the organization's capacity to develop TA services, products, and materials. (7 points)
- Describes the organization's capacity to build relationships with health departments jurisidicitons, community-based organizations, and other public health partners. (5 points)
- Describes the organization's capacity to develop and maintain a community of practice. (3 points)
- Describes the organization's staffing to effectively manage and deliver TA as requested to CDC funded organizations. (5 points)
- Describes the organization's capacity to plan and deliver a multi-agency TA event such as a summit, institute, or conference. (3 points)
- Describes the organization's capacity in relation to CDC supported interventions and public health strategies. (5 points)
- Describes the organization's capacity in relation to the HIV prevention workforce. (5 points)
- Describes the organization's capacity to deliver a TA program that addresses content areas of focus described in the component. (5 points)
- Describes the organization's capacity to obtain and incorporate meaningful engagement and feedback from populations most affected by HIV into technical assistance work. (2 points)

Component E: Organization/Workforce Development and Management for Community-Based Organizations

- Describes the organization's capacity to develop ODM TA services, products, and materials. (5 points)
- Describes the organization's demonstrated expertise, experience and/or capacity to provide information, training, and technical assistance to CDC funded CBOs to support HIV prevention interventions and public health strategies. (5 points)
- Describes the organization's demonstrated expertise, experience, and capacity to work with CBOs nationally and their priority populations in relation to HIV prevention. (5 points)
- Describes the organization's capacity to develop and manage a distance-learning program to build knowledge, skills, and abilities among adult learners. (5 points)
- Describes the organization's capacity in relation to continuous quality improvement and organizational sustainability for HIV prevention programs and services. (5 points)
- Describes the organization's capacity in relation to the national workforce of senior and mid-level managers of HIV prevention programs and services in CBOs. (5 points)
- Describes the organization's capacity to deliver and sustain a distance-learning program, including use of a CDC approved learning management system (LMS). (5 points)
- Describes the organization's staffing needed to effectively manage, develop, and maintain ODM TA services and workforce development programs. (5 points)

Component F: CPN Resource and Coordination Center

- Describes the organization's capacity to develop and implement national marketing campaigns (e.g., activities, products, tools, and other materials). (10 points)
- Describes the organization's capacity to facilitate coordination, communication, and collaboration among a national network of professional organizations (e.g., CPN). (10 points)
- Describes the organization's capacity to plan, administer, and coordinate meetings annually designated by CDC. (10 points)
- Describes the organization's staffing needed to effectively manage and develop marketing campaigns and facilitate meeting coordination. (5 points)
- Describes and documents the organization's capacity in relation to creation and maintenance of an electronic repository database accessible to partners (5 points)

Budget **Maximum Points:** 0

Although not scored, budget is assessed whether it is reasonable and aligns with the proposed work plan.

c. Phase III Review

Applicants will be ranked based on scores from the Objective Review Panel. Not all applicants applying for funding will receive a Pre-Decisional Site Visit (PDSV). Applicants will be selected for a PDSV based on ranked scores from the Objective Review process.

The intent of the PDSV is to assess the applicant's capacity to implement the proposed program, this includes assessing the physical location, staffing, viable board of directors, access to priority population(s), potential partnerships and collaborators, etc.

During PDSVs, CDC staff will meet with appropriate project management and staff including representatives of governing bodies, executive director, program manager, trainers, curriculum developers, technical assistance specialists, evaluators, subject matter experts, consultants, contractors, etc. The PDSV 1) facilitates a technical review of the application and discussion of the proposed program, 2) further assesses an applicant's demonstrated capacity to implement the proposed program, and (3) identifies unique programmatic conditions that may require further training, technical assistance, or other resources from CDC.

The PDSV will address the following and applicants will be evaluated on this content during the PDSV.

- Organization Infrastructure – Assess the applicant's expertise, experience, and capacity to develop, implement, and evaluate the required NOFO program strategies and activities. In addition, this section will assess the applicant organization's ability to sustain the proposed program effectively and efficiently, to include collaboration and partnerships.
- Programmatic Infrastructure –This section will assess the applicant organization's ability to implement the proposed program activities and strategies effectively and efficiently. During PDSVs, CDC staff will meet with appropriate project management and other relevant staff, which may include representatives of governing bodies, executive director, program manager, etc.

Applicants can receive a maximum PDSV score of 100 points. If the applicant fails to score at least 75 points during the PDSV, the applicant will not be considered for funding. Additional guidance for applicants receiving a PDSV will be provided prior to the visit. For additional information, visit the NOFO website. https://www.cdc.gov/hiv/funding/announcements/ps24-0020/index.html

Final funding determinations will be based on application scores from the Objective Review and PDSV in rank order.

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 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 review of risk may impact reward eligibility.

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.

Additionally, we may ask for additional information prior to the award based on the results of the CDC's risk review.

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

Announcement of awards will occur on or before July 1, 2024

- Year 1 – July 1, 2024 – March 31, 2025
- Years 2 – 5: April 1, 2025 Award date

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

The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

AR-4: HIV/AIDS Confidentiality Provisions

AR-5: HIV Program Review Panel Requirements

AR-6: Patient Care

AR-8: Public Health System Reporting Requirements

AR-9: Paperwork Reduction Act Requirements

AR-10: Smoke-Free Workplace Requirements

AR-11: Healthy People 2030

AR-12: Lobbying Restrictions

AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities

AR-14: Accounting System Requirements

AR-15: Proof of Non-profit Status

AR-16: Security Clearance Requirement

AR-21: Small, Minority, And Women-owned Business

AR-23: Compliance with 45 CFR Part 87

AR-24: Health Insurance Portability and Accountability Act Requirements

AR-25: Data Management and Access

AR-27: Conference Disclaimer and Use of Logos

AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving", October 1, 2009

AR-30: Information Letter 10-006, - Compliance with Section 508 of the Rehabilitation Act of 1973

AR-32: Enacted General Provisions

AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS-690). To learn more, see the HHS Office for Civil Rights website.

3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that recipients encounter throughout the period of performance. 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
End of Year Performance Report	No later than 90 days after the end of the budget period.	Yes
Data on Performance Measures	CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.	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

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 specific 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.

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.

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. Recipients will be required to complete an End of Year (EOY) Performance and Standard Evaluation Report that captures the quantitative data from the last six months of the previous budget period and qualitative data for the entire 12-month budget period. The EOY Performance Report is due 90 days after the end of the budget period.

Recipients may be required to use a CDC provided data collection system for programmatic updates related to Technical Assistance provision. (i.e., CBA Tracking System (CTS)) The data provided in the system aids in the performance measure and monitoring of CBA services acquired by recipients receiving CBA services.

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 120 days after the end of the period of performance. The Final FFR is due 120 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 period of performance, 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).

Recipients will be required to complete a Program Close-out Report that captures the quantitative data from the last six months of the previous budget period and qualitative data for the entire project period. The Program Close-out Report is due 90 days after the end of the project period.

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 $30,000.

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:
Erica K.

Last Name:
Dunbar

Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:
1600 Clifton Road, NE Atlanta, GA 30333

Telephone:

Email:
NOFOINFO@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:
Chamblee Building 102

Room 1304

MS S102-1

Atlanta, Georgia 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 application attachments that can be submitted using PDF, Word, or Excel file formats 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:
Indirect Cost Rate, if applicable

In addition to the additional eligibility requirements listed in the NOFO, the following documents are required with the application:

- Resumes / CVs, and position descriptions to demonstrate component relevant expertise and two or more years experience for program manager(s), key staff, subcontractors, and consultants
- Position description
- Letters of Support
- Organization Chart
- Management and operational structure for proposed program (visual depiction)
- Memoranda of agreement or understanding demonstrating component relevant working partnerships for proposed program

Applying for more than one component guidance:

An applicant must adhere to the following guidance and page limits if applying for two components. If multiple applications or an application with more than two components are received, the application(s) will be deemed nonresponsive and not considered for further review.

- Project Abstract Summary
    - The 1-page summary should indicate the components of which the applicant is applying.
- Budget/Budget Narrative:
    - The applicant must submit a budget narrative for each component.
    - The Indirect Cost Rate (ICR) must be applied across the entire budget requested, the ICR can only be applied once.
- Project Narrative
    - The page limit if applying for one component is 20 pages, single spaced. If applying for two components, an additional 10 pages may be included to complete the required sections in the Project Narrative. The additional pages should be used to describe the Background, Approach, and Workplan for the

second component. Separate workplans must be submitted for each component. Be sure to clearly label the information for each component throughout the application.
    - The maximum number of pages for the project narrative is 30 pages, single spaced.

- Work Examples
    - Specific related work examples must be provided for each applicable component.

- Letters of Support
    - The applicant may submit a max of four (4) letters, two (2) for each applicable component.

All NOFO attachments are posted on the PS24-0020 website at https://www.cdc.gov/hiv/funding/announcements/ps24-0020/index.html.

- Attachment A: PS24-0020 Application Checklist
- Attachment B: PS24-0020 Letter of Intent (Optional)
- Attachment C: PS24-0020 Workplan Template (Optional use of template)
- Attachment D: CDC Assurance of Compliance (must be downloaded from www.grants.gov)

PS24-0020 application package and CDC Assurance of Compliance must be downloaded from www.grants.gov.

REFERENCES

National HIV/AIDS Strategy (2022-2025), Updated August 21, 2023 National HIV/AIDS Strategy (2022-2025) | HIV.gov

CDC Basic Statistics - Basic Statistics | HIV Basics | HIV/AIDS | CDC

HIV Surveillance Report, 2021 - Volume 34 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC

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 period of performance. 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.

Community engagement: The process of working collaboratively with and through groups of people to improve the health of the community and its members. Community engagement often involves partnerships and coalitions that help mobilize resources and influence systems, improve relationships among partners, and serve as catalysts for changing policies, programs, and practices.

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.

Equity: The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment (from Executive Order 13985).

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: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been socially, economically, geographically, and environmentally disadvantaged.

Health Equity: The state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

Health Inequities: Particular types of health disparities that stem from unfair and unjust systems, policies, and practices and limit access to the opportunities and resources needed to live the healthiest life possible.

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: The act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate. An inclusive and welcoming climate embraces differences and offers respect in words and actions for all people.

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 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.

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).

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: The non-medical factors that influence health outcomes. The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces (e.g., racism, climate) and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. https://www.cdc.gov/about/sdoh/index.html

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

Capacity Building Assistance (CBA) for High Impact HIV Prevention Program Integration Terms

Asynchronous Learning: Refers to a group of people learning the same things at their own individual pace. Web-based modules, products, tools, and materials can be accessed at any time.

Behavioral Health: A mental/emotional state of being and/or choices and actions that affect wellness, productivity, and the ability to function in major life activities and cope with normal stresses of life. Services to support behavioral health include mental health and substance use treatment.

Behavioral Interventions: The use of behavioral approaches designed to moderate intra-and interpersonal factors to prevent acquisition and transmission of HIV infection.

Biomedical Interventions: The use of medical, clinical, and public health approaches designed to moderate biological and physiological factors to prevent HIV infection, reduce susceptibility to HIV, and/or decrease HIV infectiousness.

Blended learning: Using a combination of teaching and learning approaches including but not limited to traditional, in-person, and instructor-led or self-led web-based courses, webinars, and podcasts.

Capacity Building Assistance (CBA): Activities that strengthen capacity to optimally plan, integrate, implement, and sustain HIV prevention programs and services. CBA should improve the performance of the HIV prevention workforce by building individual competencies and technical expertise, strengthening organizational capacities, and enabling supportive structural environments.

CBA Consumers: Community-based organizations, health department jurisidcitons, and their local partners (e.g., HIV planning groups, healthcare organizations and other community stakeholders) serving people living with and populations at high risk for HIV infection. CDC directly funded organizations are the prioritized consumers for HIV prevention CBA services.

CBA Providers: National and regional organizations funded by the CDC to provide expert programmatic, scientific, and technical support to health department jurisdictions, community-based organizations, and their local partners to optimally plan, integrate, implement, and sustain HIV prevention programs and services.

Centers for Disease Control and Prevention (CDC): The lead federal agency for protecting the health and safety of people, providing credible information to enhance health decisions, and promoting health through strong partnerships. Based in Atlanta, Georgia, this agency of the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Collaboration: Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity, often to achieve a common goal or purpose.

Condom Distribution: The means by which condoms are transferred, disseminated, or delivered from a community resource (e.g., health department jurisdictions, community-based organization, or health care organization).

Confidentiality: Ensuring that information is accessible only to those authorized to have access.

Continuous Quality Improvement: A process of creating an environment in which management and workers strive to create constantly improving quality in the planning, integration, implementation, and sustainability of HIV prevention programs and services.

Coordination: Aligning processes, services, or systems to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information, such as progress reports, with state and local health department jurisdictions or structuring prevention delivery systems to reduce duplication of effort.

Culturally and Linguistically Appropriate: Conforming to a culture's acceptable expressions and standards of behavior and thought. Interventions and educational materials are more likely to be culturally and linguistically appropriate when representatives of the intended target audiences are involved in planning, developing, and pilot testing them.

Determination of Need: Health department jurisdictions may request permission to use federal funds to build or expand syringe services programs (SSPs) by demonstrating the jurisdiction or an area is at risk for, or experiencing, a significant increase in HIV/HCV infections outbreak due to injection drug use.

Effective: Demonstrating the desired effect when widely used in practice or under real-world conditions that are considerably less rigorous and controlled, rather than in environments that test efficacy but are still designed to ensure that the desired effect can be attributed to the intervention in question.

Epidemic: The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.

Ethnicity: The cultural characteristics that connect a particular group or groups of people to each other, such as people of Hispanic/Latino origin.

Evidence-based Interventions: Behavioral, social, and structural interventions relevant to HIV risk reduction that have been tested using a methodologically rigorous design and have been shown to be effective in a research setting. These evidence-or science-based interventions have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group if a policy study); had no apparent bias when assigning people to interventions or control groups or were adjusted for any apparent assignment bias; and produced significantly greater positive results when compared to the control/comparison group(s), while not producing adverse consequences.

Gay, bisexual, and other men who have sex with men (MSM): Men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact), whether or not they identify as “gay.”

Health Equity: A desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. It requires continuous efforts focused on elimination of health disparities, including disparities in the living and working conditions that influence health, and continuous efforts to maintain a desired state of equity after particular health disparities are eliminated.

HIV cluster detection and response: HIV cluster detection and response (CDR) allows public health professionals and their partners to identify and respond to rapid HIV transmission. Responding includes identifying and closing gaps in prevention and care services for communities experiencing rapid transmission. Because rapid transmission can affect people beyond the identified cluster, responding at the individual, network, and systems levels is important.

HIV Planning Group (HPG): A group of local health officials, community stakeholders, representatives from HIV-affected communities, and technical experts who share responsibility for developing an integrated HIV prevention and care plan for their community (refer to Integrated Prevention and Care Plan definition).

HIV Medical Care/Evaluation/Treatment: Medical services that address HIV infection, including evaluation of immune system function and screening, treatment, and prevention of opportunistic infection.

HIV Screening: Conducting HIV testing on asymptomatic individuals to detect the presence of HIV. People who test positive should be referred for diagnostic testing.

Incidence: The number of new cases in a defined population within a certain time period (often a year). It is important to understand the difference between HIV incidence, which refers to new HIV infections, and new HIV diagnosis. New HIV diagnosis is a person who is newly diagnosed as HIV-infected, usually through HIV testing. These people may have been infected recently or at some time in the past.

Integrated Prevention Services: The concurrent provision of two or more CDC-recommended prevention, treatment, or care services across HIV/AIDS, sexually transmissible infections (STIs), viral hepatitis, or tuberculosis

Integrated Prevention and Care Plan (The Plan): The Plan is based on the Integrated HIV Prevention and Care Plan Guidance that requires a collaborative process between CDC and HRSA to identify and addresses: statewide goals for HIV prevention and care; emphasize the populations and communities most affected by the epidemic; highlight areas of need, service gaps, and barriers; identify health disparities and social and structural determinants of HIV-related health disparities; outline activities for implementing goals; and, identify factors for measuring success in achieving goals.

Intervention: A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and protocols outlining the steps for implementation.

Linkage to Medical Care: This occurs when a patient is seen by a health care provider (e.g., physician, a physician's assistant, or nurse practitioner) to receive medical care for his/her HIV infection, CDC recommends linkage occurs as soon as possible after diagnosis. Linkage to medical care can include specific referral to care service immediately after diagnosis and follow-up until the person is linked to long-term case management.

Medication Adherence: The extent to which patients take their medication as prescribed by their doctors.

MSM/PWID: Men who report both sexual contacts with other men and using a needle to inject drugs.

National HIV Monitoring and Evaluation (NHM&E) Data Set: The official database containing the full set of National HIV Prevention Program Monitoring and Evaluation data variables.

Navigation Services: Patient navigation assistance is the process of helping a person obtain timely and appropriate medical or social services, taking into account provider preferences, insurance status, scheduling issues, and other factors that may complicate access or utilization of services.

Organizational Sustainability: Endurance of organizational systems and process to optimally plan, integrate, implement, and sustain HIV prevention programs and services.

Outcome Evaluation: Outcome evaluations assess the effectiveness of a program in producing change through the collection of data. Determines if the delivery of the intervention or program resulted in the expected outcomes.

Outcome Monitoring: Involves the routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes, and behaviors or access to services; service delivery; community or structural factors) in order to determine whether the anticipated outcomes have occurred and thus define the extent to which program goals and objectives are being met.

Partner Services (PS): A broad array of services that should be offered to persons with HIV or other sexually transmitted diseases (STDs) and their sexual or substance-use equipment (i.e., needles, syringes, etc.) sharing partners.

People who Inject Drugs (PWID): Someone who uses a needle to inject drugs into his or her body.

Prevalence: The total number of cases of a disease in a given population at a particular point in time. HIV prevalence refers to people with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.

Prevention Services: Any service or intervention directly aimed at decreasing the transmission or acquisition of HIV and syndemic conditions (e.g., prevention counseling, behavioral interventions, substance use and mental health services, and other services focused on social determinants of health).

Previously Diagnosed HIV infection: HIV infection in a person who meets either of the following criteria: (1) self-reports having previously tested HIV-positive or (2) has been previously reported to the health department jurisdiction's surveillance registry as being infected with HIV.

Priority or Focus Populations: The primary groups of people or organizations that a program, strategy, or intervention is designed to affect. For purposes of this NOFO, the target population is composed of an interdisciplinary HIV prevention workforce (e.g., professional, technical, clinical, and managerial staff) within CDC-funded organizations and their local partner organizations (e.g., healthcare organizations and non-CDC-funded CBOs).

Qualitative Data: Non-numeric data, including information from sources such as narrative behavior studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of underlying meanings, common themes, and patterns of relationships, rather than numeric or statistical analysis. Qualitative data often complement and help explain quantitative data.

Quantitative Data: Numeric information, such as numbers, rates, and percentages, representing counts or measurements suitable for statistical analysis.

Recruitment: The process by which people are identified and invited to become participants in an intervention or other HIV prevention service, such as testing.

Referral: Directing clients to a service in person or through telephone, written, or other form of communication. Generally, a one-time event. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff, or as part of an outreach service program.

Social Determinants of Health: Conditions in the environments where 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.

Social Network: A map of the relationships between people, indicating the ways in which they are connected through various social familiarities, ranging from casual acquaintance to close familial bonds.

Social Networking: A recruitment strategy in which a chain of referrals is based on people from populations with disproportionately affected by HIV using their personal influence to enlist their peers they believe to be at high risk.

Structural Intervention: An intervention designed to implement or change laws, policies, physical structures, social or organizational structures, or standard operating procedures to effect environmental or societal change.

Synchronous Learning: Refers to a group of people learning the same things at the same time. Lecture, in a face-to-face environment or via Web-conference, is an example of synchronous learning.

Substance Use Disorder Services: Services for the treatment and prevention of drug or alcohol use.

Surveillance: The ongoing and systematic collection, analysis, and interpretation of data about occurrences of a disease or health condition.

Syringe Services Programs (SSPs): Community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases.

Technical Assistance (TA): Mentoring, consultation, demonstration, skills building, information, resource development and sharing, and opportunities for reciprocal learning among peers (e.g., communities of practice, learning collaborative, innovation think tanks) for the HIV prevention workforce to optimally plan, integrate, implement, and sustain HIV prevention programs and services.

Training: Utilization of existing and newly developed training packages for CDC-supported HIP interventions and public health strategies to increase the knowledge, skills, and competencies of the HIV prevention workforce) to optimally plan, integrate, implement, and sustain HIV prevention programs and services.