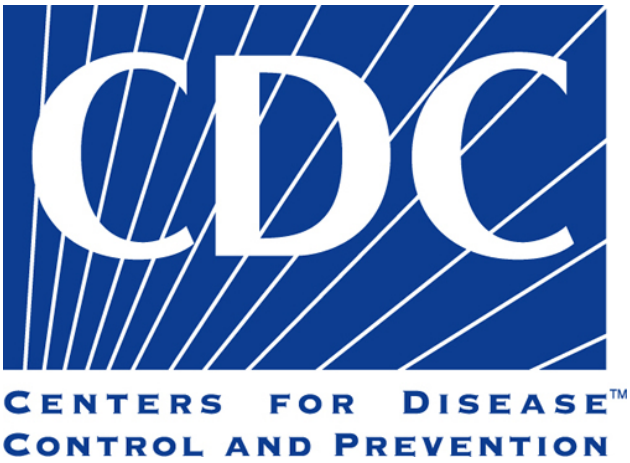


Centers for Disease Control and Prevention

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Rape Prevention and Education

CDC-RFA-CE-24-0027

11/30/2023

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Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-CE-24-0027. 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:

Rape Prevention and Education

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-CE-24-0027

E. Assistance Listings Number:

93.136

F. Dates:

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

The LOI date will generate once the Synopsis is published if Days or a Date are entered.

2. Due Date for Applications:
11/30/2023
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:
10/13/2023

2:00 p.m.-3:30 p.m. U.S. Eastern Standard Time

https://cdc.zoomgov.com/meeting/register/vJItcuyvqDMrE5Anpxa34ix9c35lBLpOsTw

The purpose of this informational conference call/webinar is to help potential applicants understand the scope and intent of this Program Announcement: Rape Prevention and Education. Participation on the conference call is not mandatory. Potential applicants are requested to call in using only one telephone line. This is a competitive process; therefore, applicants should follow the requirements for this program as they are laid out in the funding announcement and related amendments. Applicants who want to submit questions prior to the call, or should applicants find they have additional questions or need clarification after the call, please see the Agency Contact listed at the end of this Notice of Funding Opportunity (NOFO).

G. Executive Summary:

1. Summary Paragraph
The purpose of this NOFO CDC-RFA-CE19-1902, is to build on the previous RPE NOFO CE-23-0006, by continuing to enhance the capacity of state and territorial health departments (hereafter referred to as SHDs) to facilitate and monitor the implementation of sexual violence (SV) prevention programs, practices, and policies. This five-year funding opportunity requires that recipients build infrastructure for SV prevention; develop/enhance a state/territory action plan; implement community- and societal-level SV prevention strategies that promote health equity; and utilize data to inform action. Completing these activities should lead to increased capacity to promote health equity, implement/evaluate SV prevention at the community- and societal levels, increase partner and community awareness of effective prevention strategies, and increase partner coordination to prevent SV. Completing these activities should also result in the increased community-level implementation of SV prevention strategies that reach high-burden communities and address social determinants of health (SDOH), using data to understand inequities and monitoring and evaluation activities related to SV prevention. The actions outlined in this NOFO will build the foundation for recipients to decrease SV perpetration and victimization rates at the state/territory level and reduce disparities in SV by addressing associated inequities in social and structural determinants of health.

a. Eligible Applicants:
Open Competition

b. Funding Instrument Type:
CA (Cooperative Agreement)

c. Approximate Number of Awards
59

d. Total Period of Performance Funding:

$209,950,000

e. Average One Year Award Amount:
$803,000
Average $803,000.
Territories-$40,000
Awards will be made to states and territories using the following population based funding formula: U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, Palau, American Samoa and Guam with approved applications will receive $40,000; the 50 states, District of Columbia and Commonwealth of Puerto Rico with approved applications will receive a base of $150,000.

The remainder of the funds will be allocated utilizing the percentage of each state's population (50 states, DC and Puerto Rico) divided by the total US population, as stated in Violence Against Women Act.

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

g. Estimated Award Date:
January 31, 2024

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

Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary CDC Foundation funding; other U.S. government funding sources, including programs supported by HHS or other agencies (e.g., Department of Agriculture, Department of Education, Department of Housing and Urban Development, Department of Transportation, Environmental Protection Agency, National Park Service); and other funding sources. Applicants should coordinate with multiple sectors, such as public health, transportation, education, health care delivery, and agriculture.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview
Sexual violence (SV) is a complex public health problem that affects persons across their lifespan. Over half of women (54.3%) and nearly one-third of men (30.7%) in the U.S. reported contact sexual violence victimization during their lifetime. SV often begins early and can lead to adverse short and long-term mental and physical health outcomes, contributing to a substantial public health burden. Certain communities face a more significant burden of sexual violence due to systemic inequities, exacerbating these adverse outcomes. These disparities highlight the need to address social and structural determinants of health. Preventing sexual violence is crucial for

addressing various mental and physical health issues that disproportionately affect specific communities due to the negative health consequences linked to SV.

Achieving health equity means achieving a state in which everyone has a fair and just opportunity to attain the highest level of health. Some communities are more vulnerable to sexual violence due to social and structural factors. For example, half of the multiracial women in the U.S. (49.5%) and 45.6% of American Indian/ Alaska Native women experienced some form of contact SV during their lifetime compared to 38.9% of non-Hispanic white women. Disparities persist even when accounting for other demographic and socioeconomic factors, such as age or income. SDOH are the conditions in which people are born, live, learn, work, play, worship, and age. Equal education, employment, and income opportunities are crucial for optimal health, safety, and well-being. Lack of access to food and housing increases the risk of sexual violence.

Community-wide strategies can be more effective in reducing sexual violence than focusing solely on individuals. This is because they target settings that increase or buffer against the risk for violence, particularly the social, economic, and environmental characteristics of neighborhoods, schools, workplaces, and other organizational settings as indicated by the outer levels of the Social-Ecological Model (SEM). The SEM provides a framework for understanding the way risk and protective factors at one level interact with those at another level. Community and societal-level prevention approaches are crucial in reducing sexual violence and creating lasting change.

This NOFO, Rape Prevention and Education (RPE), aims to build upon lessons learned from CDC-RFA-CE19-1902 by encouraging the expansion of strategies implemented and evaluated at the community- and societal level using a comprehensive approach across the SEM. Under RPE, recipients will have an opportunity to: (1) continue to build program and partner capacity to facilitate and monitor the implementation of SV prevention programs, practices, and policies; (2) continue to support state and territorial health department's implementation of community-and societal-level programs, practices, and policies to prevent SV; (3) continue to support the implementation of data-driven, comprehensive, evidence-based SV primary prevention strategies, and approaches focused mainly on health equity; and to (4) continuously conduct data to action activities to inform changes or adaptations to existing SV strategies or on selected and implemented additional strategies. Ultimately, the RPE NOFO will seek to reduce SV victimization rates and risk factors while increasing the protective factors associated with SV perpetration and victimization.

b. Statutory Authorities

This award is authorized under the Violence Against Women Act Reauthorization Act of 2022, Section 393A of the Public Health Service Act [42 U.S.C. 280b-1b] and (d)(4)).

c. Healthy People 2030

This funding opportunity aims to reduce various forms of violence and abuse, including intimate partner violence, sexual violence, child abuse and neglect, bullying, and work-related assaults. The outcomes are aligned with Healthy People 2030 developmental goal and include reducing rates of violent crimes committed by minors and young adults, as well as victimization from

violent crimes https://health.gov/healthypeopleobjective-and-data/browse-objective/violence-prevention

d. Other National Public Health Priorities and Strategies

This NOFO aligns with the National Health Initiatives, Strategies & Action Plans. Specifically:

- HHS Action Plan to Reduce Racial and Ethnic Health Disparities (https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf)
- National Plan to End Gender-Based Violence (https://www.whitehouse.gov/wp-content/uploads/2023/05/National-Plan-to-End-GBV.pdf)
- WHO RESPECT Women: Preventing Violence Against Women (https://www.who.int/publications/i/item/WHO-RHR-18.19)
- Thriving Together: A Springboard for Equitable Recovery and Resilience in Communities Across America (https://thriving.us/explore-the-springboard/)
- National Stakeholder Strategy for Achieving Health Equity

e. Relevant Work

This NOFO builds on previous accomplishments and lessons learned from the Rape Prevention and Education Program, as well as other funding opportunities and guidance documents listed below but not limited to:

· CDC-RFA-CE19-1902 FY 2023 Supplement Funding Opportunity
· CDC-RFA-CE19-1902 FY 2022 Supplement Funding Opportunity-Health Equity Capacity Assessment
· CDC-RFA-CE19-1902 FY2021 Supplemental Funding Opportunity
· STOP SV: A Technical Package to Prevent Sexual Violence (cdc.gov)
· Violence Prevention in Practice | VetoViolence (cdc.gov)
· Connecting the Dots

For more information, visit https://www.cdc.gov/violenceprevention/index.html

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-CE-24-0027 Logic Model: Rape Prevention and Education

Bold indicates period of performance outcome

**SHDs includes both state and territorial health departments*

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy 1: Build Infrastructure for SV prevention 1A. Build internal capacity to facilitate and monitor implementation 1B.Build capacity for partner organizations 1C.Conduct prevention capacity assessment with health equity focus 1D.Participate in CDC sponsored activities Strategy 2: Develop State Action Plan 2A.Develop or enhance existing state/territory plan with partners 2B. Leverage multi-sector partners towards SV prevention 2C. Engage multi-sector partners including but not limited to Sexual Assault and Tribal Coalitions Strategy 3: Implement SV Prevention Approaches 3A. Identifying, implementing and adapting SV prevention strategies at the community and societal level focused on reducing disparities Strategy 4:	**1.1 Increased capacity to implement and evaluate primary prevention of SV at the community- and societal- levels within SHDs** **1.2 Increased capacity to promote and incorporate health equity program activities relevant to SV prevention among partners organizations** **2.1 Increased partner awareness of states/territories efforts to prevent SV.** **2.2 Increased partner and community awareness of effective primary prevention strategies and the disparate burden of SV** **2.3 Increased coordination and collaboration among partners and between SHDs, SA coalitions, Tribal SA coalitions, representatives from underserved communities and other sectors to prevent SV** **3.1 Increased community-level**	**1.3 Increased capacity for statewide program implementation and SV prevention** **2.4 Increased partner support to implement, evaluate, and adapt state- and community-level strategies to prevent SV.** **3.4 Increased reach of prevention strategies that impact communities and populations with disproportionately high rates of SV** **3.5 Increase in number of community- and societal-level strategies that promote health equity and reduce inequities in SV by addressing social and structural determinants of health** **3.6 Increase in protective factors and decrease in risk factors associated with SV** **4.3 Increased use of data-driven decision making to reduce inequities impacting populations and communities with**	Decrease in rates of SV, particularly in communities disproportionately burdened with high rates of SV. Decrease in rates of SV perpetration and victimization at the state or territory level. Reduce inequities in SDOH that impact disparities in SV rates

Use Data to Inform Action 4A. Gather and synthesize publicly available data 4B. Use data to identify and select prevention strategies 4C. Develop and implement equity focused evaluation plan 4D. Use monitoring and evaluation data to improve SV prevention implementation	**implementation of SV prevention strategies** **3.2 Increased implementation of prevention strategies among communities and populations with disproportionately high rates of SV** **3.3 Increased implementation of prevention strategies that seek to prevent SV by addressing social and structural determinants of health** **4.1 Increased access and use of data to understand inequities within populations and communities with disproportionately high rates of SV** **4.2 Increased monitoring and evaluation activities and sharing of data related to SV prevention**	**disproportionately high rates of SV** **4.4 Increased state- and community-level monitoring of trends in SV outcomes and SDOH**	

i. Purpose

This NOFO aims to promote health equity and prevent sexual violence by addressing social factors like poverty and discrimination that contribute to the prevalence of these factors. Additionally, it urges recipients to foster meaningful engagement and coordination among health departments and territories while building sustainable infrastructure.

ii. Outcomes

Measurable outcomes determine the extent to which implemented approaches and activities achieve their intended effects. Outcomes are results that the program intends to achieve and usually indicate the intended direction of change.

Recipients are expected to achieve the following short-term outcomes within the first two years

of the project:
Strategy 1: Build Infrastructure for SV Prevention

- Increased capacity to implement and evaluate primary prevention of SV at the community- and societal- levels within SHDs
- Increased capacity to promote and incorporate health equity program activities relevant to SV prevention among partner organizations

Strategy 2: Develop State Action Plan

- Increased partner awareness of states/territories efforts to prevent SV
- Increased partner and community awareness of effective primary prevention strategies and the disparate burden of SV
- Increased coordination and collaboration among partners and between SHDs, SA coalitions, Tribal SA coalitions, representatives from underserved communities and other sectors to prevent SV

Strategy 3: Implement Strategy

- Increased community-level implementation of SV prevention strategies
- Increased implementation of prevention strategies among communities and populations with disproportionately high rates of SV
- Increased implementation of prevention strategies that seek to prevent SV by addressing social and structural determinants of health

Strategy 4: Use Data to Inform Action

- Increased access and use of data to understand inequities within populations and communities with disproportionately high rates of SV
- Increased monitoring and evaluation activities and sharing of data related to SV prevention

Recipients are expected to achieve the following intermediate outcomes within three to five years of the project:

Strategy 1: Build Infrastructure for SV Prevention

- Increased capacity for statewide program implementation and SV prevention

Intermediate Outcomes Associated with Strategy 2: Develop State Action Plan

- Increased partner support to implement, evaluate, and adapt state- and community-level strategies to prevent SV

Strategy 3: Implement Strategy

- Increased reach of prevention strategies that impact communities and populations with disproportionately high rates of SV
- Increase in number of community- and societal-level strategies that promote health equity and reduce inequities in SV by addressing social and structural determinants of health
- Increase in protective factors and decrease in risk factors associated with SV

Strategy 4: Use Data to Inform Action

- Increased use of data-driven decision-making to reduce inequities impacting populations and communities with disproportionately high rates of SV
- Increased state- and community-level monitoring of trends in SV outcomes and SDOH

Recipients will be expected to submit a state-level logic model within 120 days of award. It is not required as part of the initial application. CDC will provide specific guidance after award, and the state-level logic model will be included in the evaluation plan.

Recipients will be expected to submit a state-level logic model as part of their evaluation plan within 120 days of award. It is expected that states implement their planned activities using a public health approach, which should align with the short-term, intermediate, and long-term outcomes provided in the logic model template.

Recipients should utilize the provided outcomes in the logic models as a guide to align their activities and should also expand on and add details to these outcomes and additional outcomes specific to their activities and state/community context. The logic model should illustrate linkages across activities, short-term outcomes, intermediate outcomes, and long-term outcomes to paint a cohesive understanding of your program.

When expanding and adjusting an outcome to better fit their program activities, recipients should indicate specific details such as connections and relationships among state and local level activities, and specific risk and protective factors.

Some example risk factors include media violence, harmful norms around masculinity and femininity, cultural norms that support aggression toward others, diminished economic opportunities/high unemployment rates, poor neighborhood support and cohesion, and high alcohol outlet density.

Some example protective factors include community support/and connections/commitment to school.

With technical guidance and support from CDC, recipients will identify, measure, and monitor indicators aligned with the outcomes related to the activities and strategies specified in their logic model. While recipients are only expected to achieve the short-term and intermediate outcomes during the NOFO period of performance. CDC will work with recipients to identify and develop strategies for measuring outcomes that track long-term impact on SV and health equity. Recipients are required to report their progress and accomplishments using the DVP Partners Portal. The Evaluation and Performance Measurement section further describes the methods for evaluation and performance monitoring of this NOFO.

** Territory recipients should contact their assigned RPE Project Officer to further discuss capacity and TA needs to fulfill outcomes after funding is awarded. **

iii. Strategies and Activities

This section of the NOFO describes the Strategies and Activities from the Approach section and expands on specific activities under each Strategy in detail. These strategies are designed to increase the sustainability of the program beyond the performance period and were selected for their potential to advance health equity.

Recipients of this NOFO will be expected to use and ensure their sub-recipients use the public health approach and conduct prevention strategy implementation of program or policy-related activities. RPE funds may be used for policy-related activities such as analyzing data to identify trends and opportunities; analyzing and understanding policy options; collaborating with partners to educate about policy issues; providing evidence and education to key partners and policymakers; educating the public about existing policies; and evaluating the impact of policies. For example, a state health department recipient may choose to work with partners to conduct a health impact assessment on a certain policy or benefit and then disseminate the results of that assessment to relevant partners. Please see the following guidance concerning prohibitions on the use of CDC award funds for impermissible lobbying: see Anti-Lobbying Restrictions for CDC Grantees

Required Strategies and Activities

Recipients are required to implement all Strategies and Activities below.

Funded recipients are strongly encouraged to coordinate these activities with the RPE-funded SA Coalitions and Tribal Coalitions when appropriate in their state or territory. Some examples of how recipients can meaningfully engage SA and Tribal Coalitions in their work are provided within the activities below.

At the time of application, each applicant will submit a detailed Work plan for the first year of the project, and a high-level work plan for the subsequent years of funding. This work plan should include details on how applicants plan to implement each of the activities listed below. More details on the work plan are provided in the Work plan section.

Strategy 1: Build Infrastructure for SV prevention.

Activity 1A: Continue to build internal program capacity to facilitate and monitor the implementation of prevention programs/policies by acquiring, training, and retaining staff

Recipient organizations are required to continually build their internal capacity to facilitate and monitor SV prevention efforts and to achieve the strategies and activities of this NOFO. Recipients should work with their state/territory organization, their state or territorial sexual assault coalition, as well as other local, state, and national sexual violence partners to build their capacity for SV prevention. Examples of capacity building activities can include:

- Increasing education, support, and training provided to internal staff around health equity, data to action, and primary prevention of SV
- Hiring, contracting, or partnering with evaluators to expand capacity for tracking SV indicators and monitoring and evaluation of implementation efforts
- Organizing/participating in learning collaborative or coalitions
- Attending/presenting at conferences related to sexual violence prevention and health equity

Activity 1B: Conduct/promote training's to build capacity of partner organizations to promote health equity

Recipients are required to maintain strong and collaborative working relationships with partner organizations including sexual assault coalitions to achieve the strategies and activities of this

NOFO. Recipients are expected to work with and educate local-level coalitions, community organizations, and service providers to build local capacity to engage communities at an increased risk for violence and develop plans for population-specific implementation efforts. Examples of supportive educational and capacity building activities can include:

- Integrating primary prevention into the education, support and technical assistance provided to service providers and local coalitions.
- Including prevention information in the resources provided to service providers and local coalitions.
- Informing service providers and local coalitions about relevant webinars and events related to SV prevention that are accessible to them.
- Disseminating information about primary prevention efforts occurring in the state to local coalitions and service providers.

Activity 1C: Conduct, or leverage, an existing primary prevention capacity assessment with a focus on health equity

Recipients are required to conduct or leverage an existing health equity capacity assessment to determine current capacity to enhance and expand health equity work. The assessment should reflect:

- Current internal capacity to meet the current and future needs of the program related to advancing health equity. Data availability, use of available data, and access to additional data needs to advance health equity.
- Current capacity to provide training and technical assistance on health equity and opportunities for improvement.
- Current distribution of program activities across the SEM and capacity to shift work towards the outer layers.
- Once completed, the assessment should be used in a variety of ways and findings should be incorporated into the State Action Plan and Evaluation Plan.

Examples of how the capacity assessment can be used includes:

- To determine where gaps exist in capacity to address health equity in the implementation of SV prevention strategies and identify recommendations to fill those gaps.
- To increase the use of information and data in decisions around ways to integrate health equity into programming.
- To be used as a jumping off point for discussions about health equity within organizations and with partners
- To identify needed resources.

Upon award, CDC will provide further guidance for conducting a health equity capacity assessment.

Activity 1D: Participate in CDC-sponsored programs and activities.

Recipients are required to participate in the following activities that are designed to support implementation of the NOFO.

- Attendance at the Annual Recipient's Meeting

- Participation in CDC-provided regularly scheduled technical assistance and training, including but not limited to, monthly Project Officer calls, Evaluation office hours, webinars, and routine site visits.

Recipients are additionally expected to participate in the following training and technical support activities.

- RPE leadership and/or regional training's for the purposes of training, technical assistance, and sharing lessons learned. Participation in e-learning collaborative's on sexual violence prevention and evaluation, facilitated by a CDC-funded technical assistance provider.
- Participation in sexual violence prevention and evaluation training, technical assistance, and resources provided in-person or virtually by CDC-funded National Technical Assistance Resource Center for the Prevention of Sexual Violence, Violence Prevention Technical Assistance Center (VPTAC), and other funded TA providers.

Recipients are also expected to participate in CDC's initiative-level evaluation of this NOFO. The purpose of the initiative-level evaluation is to observe and document the progress, achievements, and lessons learned of recipients as they work toward NOFO activities and outcomes through implementing and evaluating community- and societal-level SV primary prevention approaches. Through the duration of the cooperative agreement, recipients are required to participate in the CDC-requested data collection activities. Initiative-level data collection activities may include but are not limited to focus groups, surveys, and interviews.

In the approach section of their project narrative, applicants must clearly describe how they will build internal program capacity to facilitate and monitor implementation of prevention programming through staffing, partnerships, and training. In addition, applicants should describe how they will conduct or leverage an existing primary prevention capacity assessment with a focus on health equity.

Strategy 2: Develop State Action Plan

Activity 2A: Develop or enhance an existing state/territory action plan (in collaboration with SA coalitions, Tribal SA coalitions, and representatives from underserved communities of the State or Territory) to support state- and community-level implementation and sustainability of SV prevention

Within the first six months, all states and territories must work with identified state-level partners to either develop or enhance an existing state action plan (SAP) to help them strategically and intentionally plan, prioritize, and establish a portfolio of SV prevention approaches based on the best available evidence to prevent SV. The SAP should not exceed 50 pages; however, exceptions may be made on a case-by-case basis. A final SAP is due with the Annual Progress Report (APR) submission, due 120 days before the end of the fiscal year. Any updates made to the final SAP will be reported by recipients in their APRs each year.

The following components must be included in the SAP:

- The ways in which the recipient and partners will prioritize primary prevention at the outer layers of the SEM to reduce health inequities associated with SV through the

implementation of primary prevention strategies intended to address SDOH and the root causes of violence to prevent SV.

- The ways in which health disparities and disproportionate burden will be addressed using state or local level data
- The ways in which coordination with partners will be increased and/or maintained
- The ways in which the recipient plans to leverage partnerships and resources to increase and sustain primary prevention efforts in the state
- Plans for expanding the tracking and use of statewide data, including, but not limited to, SV indicators and SDOH
- A summary of current primary prevention program or policy strategies being implemented in the state, with an emphasis on increasing community and societal level strategies
- A sustainability section that describes how RPE work will be sustained at the state and local level

Plans for implementation of the strategies selected for each focus area which should include:

- The selected strategies and corresponding focus areas and level of the SEM
- Description of the population of focus and setting for each strategy
- The evidence, theory, or rationale to support the selection of each strategy
- The essential elements and complementary components
- The risk and protective factors and social determinants of health to be addressed by each strategy and how they relate to the population of focus
- A high-level description of how the recipient or sub-recipient intends to implement the strategy

Upon award, CDC will provide further guidance for completing the State Action Plan.

Activity 2B: Leverage multi-sector partners and resources toward SV prevention

All states and territories must engage in a systematic process of identifying potential public and private partnerships that can provide assistance on program implementation and evaluation. In addition, all recipients should ensure that their sub-recipients engage in a systematic process of identifying partnerships. Once potential partners are identified, recipients should establish formal partnerships (through mechanisms such as contracts, consultations, or memorandums of understanding). Some examples of functions that partners could perform include:

- Collaborating on program selection and implementation.
- Providing guidance on program evaluation and data use
- Providing population specific support
- Providing technical assistance in building program implementation and evaluation capacity of sub-recipients

Activity 2C: Participate in meaningful engagement with SA coalitions, Tribal SA coalitions, representatives from underserved communities of the State or Territory and other collaborators working to prevent SV

The RPE program seeks to increase the SV primary prevention knowledge and capacity of all SV prevention organizations through the sharing of information from RPE recipients. Additionally, sharing program results, evaluation findings, tools, and lessons learned will contribute to the building of practice-based evidence in the field of SV prevention.

To contribute to this aim and goal recipients are expected to serve as leaders in the field of SV prevention at both national and state levels by sharing resources, lessons learned, and participating in relevant conferences and meetings. The CDC specifically encourages recipients to share and collaborate with their state's SA coalitions, Tribal SA coalitions, and local communities.

Some examples of how funded recipients can meaningfully engage with SV collaborators include:

- Providing technical assistance to SA coalitions, Tribal SA coalitions, and other SV partners
- Including SV partners in SV Action Planning to align SV work across the State/Territory
- Collaboration with RPE-funded SA Coalitions and Tribal Sexual Assault Coalitions
- Sharing data and making data available to SA coalitions and Tribal SA coalitions

In the approach section of their project narrative, applicants should clearly describe how they will collaborate with SA coalitions, Tribal SA coalitions, and representatives from underserved communities in their State or Territory to develop or enhance a state/territory action plan to support state- and community-level implementation and sustainability of SV prevention. In addition, applicants should describe how they will identify and leverage multi-sector partners and resources towards SV prevention and meaningfully engage with SA coalitions, Tribal SA coalitions, representatives from underserved communities of the State or Territory and other collaborators working to prevent SV

Strategy 3: Implement SV Prevention Approaches

Activity 3A: Identify, implement, and adapt SV prevention approaches that increase health equity through reduced disparities in targeted SDOH, with a focus on implementation at the community- and societal-levels

Recipients are required, with coordination of their sub-recipients, to implement programs and policies within the following focus areas: Focus Area 1- Strengthen economic supports, Focus Area 2 - Create protective environments, and Focus Area 3 – Promote social norms that protect against violence. Recipients are required to implement at least one program/policy effort from each of the 3 Focus Areas.

While some elements of the approaches and programs in these focus areas are focused on the individual- or relationship-level, recipients are encouraged to focus the majority of their implementation efforts on the community- and societal-level. Rather than individual- and relationship-level programs and policies that target characteristics of individuals or individual behaviors (e.g., social-emotional learning, increasing severity of punishment for alcohol offenses, bystander knowledge), community- and societal-level programs and policies focus on contextual or environmental factors that promote population health and well-being (e.g., laws around where alcohol can be sold or advertised, greening activities) as fundamental drivers of public health problems such as sexual violence.

SV Prevention Strategy Focus Areas

The specific focus areas for the SV prevention strategies and approaches of interest are based on guidance from CDC's VetoViolence Violence Prevention in Practice tool (https://vetoviolence.cdc.gov/apps/violence-prevention-practice/#!/). The Violence Prevention in Practice tool encompasses violence prevention strategies and approaches from all of CDC's Violence Prevention Resource for Action (previously referred to as Technical Packages). This includes the Sexual Violence Prevention Resource for Action (previously referred to as STOP SV). Violence Prevention in Practice provides information about selecting, implementing and evaluating strategies, approaches, and programs based on the best available evidence. Communities and states can use these resources to prioritize their efforts on activities with the greatest potential to reduce multiple forms of violence.While the focus of this NOFO is on prevention of Sexual Violence, we encourage applicants to utilize CDC's Connecting the Dots framework (https://www.cdc.gov/violenceprevention/about/connectingthedots.html) and other relevant research to understand the causes and connections between different forms of violence.

Recipients should identify, implement, and adapt prevention strategies that reduce SV and increase health equity through reduced disparities in targeted SDOH.

Recipients are required to select example program or policy efforts from the NOFO Focus Areas listed below OR continue/propose a program or policy area that is not included as an example below, but meets the following criteria:

- Fits within one of the Focus Areas of this NOF
- Has documented evidence of effectiveness, OR includes one or more of the following criteria:
  a. Is grounded in theory of primary prevention of SV
  b. Has demonstrated evidence of preventive effects on SV or associated community or societal level risk and protective factors through a less rigorous evaluation for the population of focus
  c. Has been successfully implemented prior to the time of application
- Addresses risk and protective factors for SV
- Demonstrates a link between the theory of the program/policy effort and targeted outcomes addressing SV
- Is feasible to implement and evaluate

Once funded, recipients can work with their assigned Project Officer for review of any proposed programs or policy areas that are not included as an example below.

Focus Area 1: Strengthen economic supports

Employment, stable housing, financial stability, and food security are important protective factors for women's risk of SV victimization. _Policies and programs that work to improve financial stability can also reduce the risk factors associated with SV victimization. Two approaches with existing evidence are Strengthen Household Financial Security and Family-Friendly Policies. Strengthening household financial security addresses some violence risk factors, including poverty, unemployment, financial stress and hardship, childcare instability, parental stress, family conflict, depression, and gender inequality. Providing income supports

(e.g., tax credits, childcare subsidies, livable wages), income-generating opportunities to empower and support women, and decreasing the gender pay gap directly target these risk factors. Family-friendly policies may change the context for households by improving the balance between work and family responsibilities, while helping ensure economic security. These supports help individuals and families increase household income and buffer against risk for multiple forms of violence. Programs and policies that address this approach at the community- and societal-level have the potential to decrease gender inequality and economic instability, both risk factors for SV.

The list below includes the approaches and corresponding example programs, practices and policies under Focus Area 1:

- Strengthen household financial security
    - Family assistance programs such asTANF and SNAP
    - Tax Credits such as Earned IncomeTax Credit (EITC) and Child Tax Credit
    - Subsidized/Affordable Child Care
    - Livable Wages
    - Microfinance programs
    - Comparable worth policies
- Family-friendly policies
    - Paid leave policies
    - Workplace flexibility policies

Focus Area 2: Create Protective Environments

In order to achieve population-level reductions in SV rates, SV prevention should include community- and societal-level strategies that change community characteristics, so they are safe, healthy, and protective. Community- and societal-level prevention strategies go beyond changing individual attitudes, beliefs, and behaviors, and focus on modifying community structures, social norms, environment, and policies. Approaches with existing evidence are Improve School Climate and Safety, Improve Organizational Environments, Reduce Exposure to Community-level Risks, and Modify the Physical and Social Environment. Improving safety and monitoring in schools includes modifying the school environment to reduce SV and to increase safety and support for students. Organizational policies establish and enforce standards of behavior in the work environment and create healthy organizational climates, which in turn can help prevent sexual harassment, child sexual abuse, and gender-based bullying. Community-level risks for SV include concentrated poverty, housing insecurity, economic and residential instability, violence exposure, high numbers of alcohol retailers in an area, and weak neighborhood support and cohesion (like a lack of mutual support among community members). Implementing programs and policies that address these risks can reduce the risk for SV by changing the community environment and incentivizing behavioral expectations. Modifications to the physical and social environment can include increasing lighting, managing accessibility of buildings and public spaces, repairing or replacing abandoned buildings, creating green spaces, and organizing events and activities that bring together community members and provide them with opportunities for more community involvement.

The list below includes the approaches and corresponding example programs, practices and policies under Focus Area 2:

- Improve school climate and safety
    - Environmental approaches at the building level (e.g., Shifting Boundaries intervention program)
    - School Restorative Justice Programs

- Improve organizational environments
    - Proactive sexual harassment prevention policies and procedures Reduce exposure to community-level risks
    - Assisted Housing Mobility
    - Low Income Housing Tax Credits
    - Alcohol-related policies

- Modify the physical and social environment
    - Greening activities
    - Business Improvement Districts (BIDs)
    - Crime Prevention Through Environmental Design

Focus Area 3: Promoting Social Norms That Protect Against Violence

Approaches that focus on changing the social norms (group-level beliefs and expectations of members behavior) related to the acceptance of violence and restrictive gender norms of priority groups have the potential to reduce rates of SV perpetration and victimization. The approaches with existing evidence for this strategy are Bystander Approaches and Men and Boys as Allies in Prevention. Bystander approaches are designed to build peer leadership for promoting social norms that protect against violence and that encourage safe intervention for all forms of SV. Approaches that mobilize men and boys as allies focus on promoting positive norms around masculinity, gender, and violence, which are then diffused through peer social networks. In order to be considered community-level, programs proposed within this focus area should focus on components which aim to change social norms (e.g., a social norms or social marketing campaign), thereby addressing social norms at the setting-level (school or community).

The list below includes the approaches and corresponding example programs, practices and policies under Focus Area 3:

- Bystander Approaches
    - Green Dot
    - Bringing in the Bystander

- Men and Boys as Allies in Prevention
    - Coaching Boys Into Men

For more information on each of the evidence informed approaches and example program/policy efforts listed below, please use the Approach search tool on VetoViolence (https://vetoviolence.cdc.gov/apps/violence-prevention-practice/approach-search#!/).

Adaptations to Programs and Policies

Recipients should consider and plan for future program and policy adaptations when possible. Adaptations may include additions, deletions, modifications to content and/or delivery methods such as changes to sequence or other adaptations that could impact program fidelity. Recipients are expected to utilize the Essential Elements Framework to assess whether those adaptations

may affect a strategy's effectiveness and whether adaptations being considered are congruent with the underlying theory and intent of the strategy. Recipients can reference this resource: Select, Adapt, Evaluate | VetoViolence (https://vetoviolence.cdc.gov/apps/adaptation-guidance/) for more information on how to adapt programs while retaining the Essential Elements of the program.

Recipients may determine that one or more adaptations are necessary for the purposes of:

- Increasing implementation feasibility given limited time and resources
- Improving the intended community's ability to understand and engage with the program content
- Increasing the relevancy of the program given cultural characteristics of the intended population and delivery setting

Recipients must indicate and track any planned adaptations in the implementation and evaluation plans for each impacted program or policy. Recipients should also track any additional adaptations made during implementation (i.e., field adaptations) and document the rationale to support the need for these changes. In addition, adaptations to implementation efforts will require consideration of the impact on evaluation of those efforts. Adaptations that change the essential elements of a program/policy may require a more rigorous evaluation. CDC will provide guidance and tools for tracking and planning adaptations after the start of the period of performance.

In the approach section of their project narrative, applicants must clearly describe how they will identify, implement, and adapt SV prevention strategies that increase health equity through reduced disparities in targeted SDOH, with a focus on implementation at the community- and societal-levels. Applicants should describe plans for implementing at least one program/policy effort in each of the 3 Focus Areas and describe how any new program/policy efforts not listed as examples in the VetoViolence approach search tools meet the required criteria for new program/policy efforts listed in the NOFO. In addition, applicants should describe how they will make their programs accessible and available to participants regardless of age, race/ethnicity, sexual orientation, gender identity, sex, ability, or socioeconomic status. Applicants should also describe how the proposed programs or policy efforts will address inequities in social and structural determinants of health to advance health equity and prevent SV before it starts (primary prevention).

Strategy 4: Use Data to Inform Action

Activity 4A: Gather and synthesize publicly available state-, territory- and community-level data to inform SV prevention, track disparities in targeted SDOH and rates of SV in priority populations, and use this data to select communities and populations for intervention and to improve programmatic activities.

Recipients must identify, track, and report on state-level SV indicators for this NOFO. Indicators, for the purpose of this NOFO, are measures or other factors with empirical or theoretical links to SV. These should include SV outcomes, risk and protective factors, SDOH, or conditions that can serve as proxies for SV and are periodically available to track over time. Selected indicators must link back to the outcome evaluation component of the state-level evaluation plan. See "Evaluation and Performance Measurement" section of this NOFO for more

information about specific measurement requirements. Recipients are expected to do the following for this NOFO activity:

- Select SV indicators to track and include them in the state-level evaluation plan, due six months following the award date. Selection of final indicators must be submitted with the final state-level evaluation plan, due with the first APR. Recipients are encouraged to select indicators for which there are publicly accessible state-level and local-level data that can measure SV outcomes (e.g., SV perpetration or victimization), risk and protective factors related to SV (e.g., proxies for gender norms), and SDOH (e.g. income inequality, policies).
- Select indicators that help them to identify how social and structural determinants of health inequities are linked with disproportionate risk of violence within their state and intended communities.
- Develop a data dissemination plan for the monitoring and tracking of selected indicators (in collaboration with SA coalitions and Tribal SA coalitions). This plan should also include actions that will be taken to disseminate this information to partners and communities.

Some examples of data dissemination activities include:

- Developing a data dashboard or community-level reports highlighting populations and communities with the highest burden of SV for the purpose of identifying priority areas and intervention needs
- Sharing data with partners and other organizations doing SV prevention work
- Using data to inform prevention activities such as education and social marketing campaigns
- Track and report annually the selected SV indicators, using CDC's DVP Partners Portal no later than the beginning of year 2 of this period of performance.

CDC recommend recipien use guidance provided by CDC and support and consultations with CDC or CDC-supported technical assistance providers to support these evaluation activities. Recipients may use existing guidance on selecting indicators from VetoViolence's Violence Indicator Guide & Database (https://vetoviolence.cdc.gov/apps/violence-indicators-guide-database/home).

Activity 4B: Utilize state and community-level data to identify and select SV prevention strategies for populations and communities with disproportionately high rates of SV

To address root causes of violence, recipients are expected to consider how social and structural determinants of health inequities (SDOH) interact with risk and protective factors related to SV. Recipients should access any publicly available and relevant data (e.g. YRBSS County Health Rankings, BRFSS) from their state and communities of focus to consider how SDOH have contributed to SV-related risk and protective factors in their state and communities. Additionally, they should address the identified SDOH and risk/protective factors through the selection and implementation of appropriate program or policy efforts for populations and communities with disproportionately high rates of SV.

Recipients are required to use data to:

- Support and describe how health inequities are linked with disproportionate risk of violence within their state and intended communities
- Identify specific SDOH and risk/protective factors where inequities are leading to disproportionately high rates of SV within populations and communities in their state/territory
- Explain how the implementation of complementary programs and policies may influence the conditions (e.g., discrimination and biases in societal values, public policy, etc.) contributing to these health inequities
- Describe how impacting the SDOH that influence these conditions affecting health equity can decrease risk for and increase protection against SV

Activity 4C: Develop and implement an equity-focused evaluation plan (in collaboration with SA coalitions & Tribal SA coalitions)

Recipients are required to develop and implement a state/territory-level equity-focused evaluation plan that includes process and outcome evaluation. An equity-focused evaluation plan should not just look at population level improvements in health but also the effects of recipients prevention efforts on addressing health disparities and inequities. Recipients should incorporate health equity considerations throughout their evaluation plan to better understand how well their SV prevention efforts are working for specific populations and communities, the conditions they are being implemented in, and how they are affecting health inequities.

Recipients are encouraged to include any RPE-funded SA coalitions and Tribal Sexual Assault Coalitions in their State/Territory in the development of this evaluation to plan to coordinate SV evaluation efforts across the State/Territory. The state-level evaluation should describe how the recipient plans to evaluate the SV prevention efforts per NOFO and indicated performance measurement requirements (see "Evaluation and Performance Measurement" Section of this NOFO). Those NOFO efforts include the State Action Plan, specific strategies or approaches, and collaboration and partnerships. Recipients are expected to do the following for this NOFO activity:

- Submit a state-level logic model within 120 days of award with their evaluation plan. As described in the "Outcomes" Section, the logic model must demonstrate the overall efforts of the NOFO, State Action Plan, state and sub-recipient efforts, and specific programs or approaches. The logic model must also demonstrate linkages between those efforts and specified short, intermediate, and long-term outcomes, which include specified risk and protective factors and SDOH.
- Develop and submit a **final state-level evaluation plan** will be due with the annual APR, due 120 days before the end of the first fiscal year. Recipients' evaluation plan should include both process and outcome evaluation components, which will provide measures and indicators to assist recipients in determining the extent to which selected SV prevention strategies are implemented, the quality of implementation and changes in outcomes including, but not limited to changes in risk and protective factors and SDOH at the state level.
- Begin implementation of state-level evaluation plan no later than the beginning of year 2 of this period of performance and are expected to report annually on measures and indicators described in the "Evaluation and Performance Measurement" Section of this NOFO, which include state-level achievement of NOFO activities, progress on the State

Action Plan, implementation measures related to program efforts, and SV outcome indicators and measures.

- Support sub-recipients to track implementation measures and outcomes and use those data for the state-level evaluation and reporting per the Evaluation and Performance Measures requirements of this NOFO. This support may include providing technical assistance, evaluation support, or ensuring adequate local evaluation capacity. This also may include qualitative and quantitative program evaluation methods, as well as review of existing data and documents.
- Ensure sub-recipients' implementation and evaluation activities align with and contribute to state action and evaluation plans and efforts, including identifying and tracking SV indicators aligned with strategies, and choosing populations of interest to target based specific indicators identified in Activity 4.1.
- Report progress on program evaluation activities as part of the annual reporting as well as any findings to date using CDC's DVP Partners Portal. As part of annual reporting recipients will provide any updates made to the state-level evaluation plan, especially as program efforts change, to ensure alignment between program evaluation and prevention efforts. The evaluation plan is a living document that describes and should reflect program evaluation activities being conducted. Recipients will submit any updates made to their evaluation plan annually as part of the annual performance report.

Recipients may use guidance provided by CDC and support and consultations with CDC or CDC-supported technical assistance providers to support these evaluation activities. Recipients may use existing guidance on evaluation from VetoViolence's EvaluACTION tool (https://vetoviolence.cdc.gov/apps/evaluaction/home).

Upon award, CDC will provide specific guidance for the finalizing the logic model and state-level evaluation plan. CDC will provide feedback on materials submitted as part of the application to facilitate completion of these deliverables

Activity 4D: Use program monitoring and evaluation data and other available data to improve SV prevention strategy implementation

To promote continuous quality improvement in implementation of prevention activities and strategies, as well as establishing feedback loops among recipients, sub-recipients and other state/territory partners, recipients are required to develop an approach and method for program improvement. This may include using existing program data (e.g., process evaluation information) and collecting new information as needed. Recipients are expected to do the following for this NOFO activity:

- Develop a plan for how evaluation findings and data will be used for continuous program improvement (e.g., adjusting activities and implementation for the NOFO or for selected prevention strategies and approaches)
- Engage and promote continuous program improvement practice among sub-recipients
- Share lessons learned with sub-recipients and other partners within the state/territory as well as the other NOFO recipients.

In the approach section of their project narrative, applicants must clearly describe How they will gather and synthesize data that will be used to identify specific SDOH and risk/protective factors where inequities are leading to disproportionately high rates of SV within populations and

communities in their state/territory. Applicants should describe plans for identifying priority populations and communities (including relevant data sources that will be used) and how they will use data to select complementary programs and policies to influence the conditions contributing to health inequities and impact SDOH that can decrease risk for and increase protection against SV. Applicants should also describe how they will address inequities based on race, ethnicity, gender identity, sex, sexual orientation, geography, socioeconomic status, disability status, primary language, and health literacy as well as issues of health equity facing their selected population(s) and communities of focus.

1. Collaborations

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

This NOFO supports meaningful engagement, coordination, and capacity building across statewide organizations and partners to adapt, implement, and evaluate state and community-level strategies to prevent SV. Recipients are strongly encouraged to work multi-sectoral partners with expertise in SV and health equity/SDOH, including RPE-funded state and territorial health departments, funded sub-recipients, state SA coalitions, Tribes and Tribal sexual assault coalitions, rape crisis centers; sexual assault coalitions; local health departments; faith-based organizations; military; culturally specific organizations, Tribal organizations; national organizations that target the selected population, community, or health disparities; and/or university/academic institutions. To foster and sustain SV primary prevention at the national level by sharing program results (including but not limited to lessons learned, challenges, successes, evaluation findings, and tools developed). Sharing should occur through multiple mechanisms such as CDC and technical assistance provider-sponsored webinars, listservs, conference calls, recipient meetings, trainings, and regional and national conferences. Recipients are strongly encouraged to assist in facilitating collaboration among RPE funded sub-recipients, sexual assault coalitions and Tribes to maximize reach and impact of the NOFO strategies. Recipients are also strongly encouraged to collaborate with CDC-funded technical assistance providers for capacity building technical assistance and training.

Applicants should describe how they intend to work and build strong partnerships with other RPE-funded state and territorial health departments and CDC-funded technical assistance providers. Applicants should also describe how they intend to encourage and facilitate collaboration among RPE-funded sub-recipients, sexual assault coalitions, Tribes and Tribal sexual assault coalitions.

Recipients are strongly encouraged to collaborate with DELTA Impact (CE23-2301) State Domestic Violence Coalition recipients and Core State Injury Prevention Program (Core SIPP) (CE21-2101) recipients if they are funded in their states. Recipients should also collaborate with any other CDC-funded programs in their jurisdiction who serve the same priority populations and have a vested interest in achieving the NOFO-related outcomes. Recipients who collaborate with other CDC-funded programs in their jurisdiction are encouraged to plan their activities in a manner that is complementary with the other programs operating in the community.

Applicants should describe their current or potential plans for collaborating with DELTA AHEAD recipients, Core SIPP recipients, or any other CDC-funded programs in their

jurisdiction. A list of CDC-funded violence programs is available at the CDC Violence Prevention Funded Programs and Initiatives website.

A few of those CDC-funded programs are highlighted below:
· DELTA AHEAD
· Rape Prevention and Education: Assessing Coalition Capacity (CDC-RFA-CE-23-0006)
· Essentials for Childhood (EfC): Preventing Adverse Childhood Experiences through Data to Action
· Preventing Violence Affecting Young Lives (PREVAYL)
· National Centers of Excellence in Youth Violence Prevention (YVPC)
· National Violent Death Reporting System (NVDRS)
· Core State Injury Prevention Program (Core SIPP)
· Injury Control Research Centers (ICRCs)

b. With organizations not funded by CDC:
Recipients should engage in partnerships with multi-sector agencies and organizations to advance SV prevention and evaluation efforts that will maximize reach and impact of the NOFO strategies. Recipients are strongly encouraged to sustain partnerships and collaborate with non-CDC funded entities such as, sexual assault coalitions, national partners, as well as state and community organizations, including but not limited to organizations in the business community, universities, emergency management, hospitals, media, non-government organizations, nonprofit agencies, other federal, state, or local government agencies, the public health community and Tribes or Tribal organizations.

Applicants must describe how their organization has already established, or will establish, strategic multi-sectoral partnerships at the state level with these organizations and other partners that demonstrate commitment and buy-in towards working with the applicant's selected populations of focus. Applicants must also describe how they will sustain strong and consistent partnerships that they identify as necessary for the success of the NOFO, as well as any key state-level partners who would likely partner in the development of the State Action Plan.

Once funded, recipients are strongly encouraged to participate in, and facilitate sub-recipients' participation in, national opportunities for sharing information by compiling and disseminating RPE program results (including but not limited to lessons learned, successes, challenges, evaluation findings, and tools developed), via multiple mechanisms such as applicable CDC and technical assistance provider-sponsored webinars, listservs, conference calls, recipient meetings, web conferences and regional and national conferences.

2. Population(s) of Focus
SV affects millions of people each year, yet some populations and communities are at an inequitable risk for SV victimization. Similarly, certain risk factors increase the likelihood of SV perpetration. To make a significant impact on SV perpetration and victimization rates, it is important to address social and structural determinants of health that influence SV. Together with CDC, recipients should work to reduce disparities and inequities to promote health equity among populations and communities disproportionately affected by SV, including, but not

limited to: racial/ethnic minorities, people with disabilities, non-English speaking populations, Tribal populations, rural communities and other geographically underserved areas, people otherwise adversely affected by persistent poverty or inequality, sexual and gender minorities, and people with limited health literacy.

CDC does not define specific priority populations or communities of focus. However, applicants are expected to use data to identify priority populations, communities, and environments that experience inequities and are at risk for sexual violence due to disproportionate access to conditions for health and safety (e.g., Social and Structural Determinants of Health). Specific priority populations or communities may vary by applicant. To demonstrate populations and communities disproportionately burdened by SV, applicants should describe evidence indicating which populations are at the highest risk for SV using the following data when data is available. Sources of evidence may include:

Applicants should provide a detailed description in their application of how they intend to identify priority populations and communities describe relevant data sources that will be used for this process.

- Map of the community data (such as census tract, zip code, and neighborhoods) relevant to the selected population
- Demographic composition of the selected areas or communities of focus
- The percent of population in the area with income at or below 100% of the federal poverty level
- SV prevalence, risk, and protective factor data for selected populations demonstrating disproportionate risk for SV.

Applicants should also describe the elevated risk in selected populations or communities of focus and track other data describing them, such as socioeconomic status, health literacy, geography, and other relevant indicators. Applicants must describe how data has been used to prioritize and select the priority population. To demonstrate the populations or communities of focus at the highest risk for SV, applicants should describe the sources of data cited in their application narrative using data when it is available. Sources for this data can include:

- National Intimate Partner and Sexual Violence Survey (NISVS)
- Youth Risk Behavior Surveillance System (YRBSS)
- County Health Rankings and Road maps
- Law enforcement data
- Interactive state, county, city, level data dashboards
- Socioeconomic indicators like poverty rates, population change, unemployment rates, and education levels

Applicants should include a description of how they will address inequities based on race, ethnicity, gender identity, sex, sexual orientation, geography, socioeconomic status, disability status, primary language, and health literacy. Applicants should also describe how they plan to address issues of health equity facing their selected population(s) and communities of focus. Finally, applicants should describe how they will make their programs accessible and available to participants regardless of age, race/ethnicity, sexual orientation, gender identity, sex, ability, or socioeconomic status.

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.

Addressing SDOH and promoting health equity is essential to preventing sexual violence in communities and populations. CDC recognizes that the circumstances into which people are born, grow, live, work and age are shaped by a wider set of forces (economics, social policies, and politics), which greatly impact health outcomes. Health inequities are differences in burden of disease, disability, injury, or violence between more socially advantaged and less socially advantaged groups, caused by systemic differences in social conditions and processes that effectively determine health.

Applicants must describe in their applications how their NOFO activities as well as their proposed programs or policy efforts will address inequities in social and structural determinants of health to advance health equity. Recipients should work to reduce sexual violence perpetration and victimization risk factors across the entire population of focus but should place special emphasis on eliminating the health inequities that contribute to higher rates of violence victimization and perpetration. Recipients are expected to use data to identify populations at risk for sexual violence due to inequitable access to the conditions needed for health and safety. By eliminating inequities in access to SDOH, funded recipients directly reduce risk factors and/or increase protective factors for sexual violence. This NOFO will support recipients in addressing social determinants of health and promoting health equity in prevention efforts and will foster meaningful engagement and coordination among state health departments, territories, sexual assault coalitions, and Tribal coalitions.

Additional resource to help communities address social determinants of health: https://stacks.cdc.gov/view/cdc/11130/cdc_11130_DS1.pdf

iv. Funding Strategy

Average $803,000.

High-$4,200,000

Low-$210,00

Territories-$40,000

Awards are made using a population-based formula that is based on 2020 census data: U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, Palau, American Samoa and Guam will receive $40,000; the 50 states, District of Columbia and Commonwealth of Puerto Rico will receive a base of $150,000 plus funding using a population-based funding formula.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC's evaluation and performance measurement approach for this NOFO is to assess the process and outcomes of the RPE program through the recipient's state/territory-level evaluation, which includes evaluation of sub-recipient activities; and CDC's evaluation of the NOFO activities and the initiative.

Recipient's State/Territory-Level Evaluation

The recipient's equity-focused State/Territory Evaluation Plan (hereafter referred to as the evaluation plan) must describe how the applicant will fulfill the NOFO evaluation and performance measurement requirements described in this section (with guidance and technical assistance from CDC). As part of the evaluation plan, recipients must provide a logic model that describes their overall NOFO strategies and activities and expected outcomes for this work. The recipients logic model must demonstrate the overall efforts of the NOFO and include the state/territory and sub-recipient selected strategies and approaches, as well as expected short-term, intermediate, and long-term outcomes. The logic model also must demonstrate state/territory-level alignment efforts between activities and outcomes, as well as alignment between sub-recipient strategies and activities with state/territory-level outcomes.

Recipients must develop and submit ONE evaluation plan that addresses these three components:

1. Evaluation of the implementation (process) and outcomes for the state/territory action plan
2. Evaluation of the implementation (process) and outcomes for the selected prevention focus areas and approaches implemented by the recipient and all sub-recipients.
3. The approach and methods for continuous program improvement

The plan will include SV indicators identified to track. Recipients are also expected to support sub-recipients in the development of their local-level evaluation plans. These local-level evaluation plans should inform state-level evaluation but will not be collected annually by CDC.

In addition, recipients will be required to submit a Data Management Plan within the first 6 months of award. The Data Management Plan must include a description of all the data to be

used for this award including data obtained for the purposes of evaluation. The Data Management Plan must include, at minimum, a description of the data; the quality standards and data elements to be used for the data; mechanisms for, or limitations to, providing access to the data, including a description of the provisions of privacy, confidentiality, security, and intellectual property; information about the use of data standards and documentation to ensure data are used with fidelity and dissemination of the data are transparent in what the data collection; plans for archiving and long-term preservation of the data; data suppression standards to ensure dissemination of data do not compromise confidentiality; and description of how data will be securely transmitted to CDC, if applicable given the data source. Data Management Plans should be updated at least annually and provided as part of the Evaluation Plan in annual reporting. For more information, see CDC's DMP policy: https://www.cdc.gov/grants/additional-requirements/ar-25.html.

Components of the Evaluation Plan

At the state/territory-level, CDC expects recipients to identify, measure, track, and report on:

1. Achievement of NOFO activities as outlined in their annual work plan related to their prevention activities and sub-recipient activities
2. Progress on the state/territory action plan, including resource realignment efforts, coordination, and collaboration with other state/territory partners
3. State/territory- and local-level indicators that measure short-term and intermediate outcomes of community- and societal-level primary prevention approaches, including but not limited to targeted risk and protective factors; and capacity, coordination, and evaluation to prevent SV and promote health equity.

CDC expects that evaluation plans include a description of how recipients will track the progress of their state/territory action plan, the implementation of recipient and sub-recipient selected prevention strategies and approaches, and the outcomes identified in the NOFO logic model. The state/territory action plan includes, but is not limited to, the following elements, which should be addressed in the evaluation plan:

- The ways in which the recipient and partners will prioritize primary prevention at the outer layers of the SEM The ways in which capacity to promote health equity will be increased.
- The ways in which health disparities and disproportionate burden will be addressed using state/territory or local level data.
- The ways in which coordination with partners will be increased and/or maintained.
- The ways in which the recipient plans to leverage partnerships and resources to increase and sustain primary prevention efforts in the state/territory.
- Tracking and use of statewide data, including, but not limited to, SV indicators.
- Plans for implementation of the strategies selected for each focus area including tracking of indicators related to NOFO activities; use of data for prevention strategy and priority population selection; and specifying potential risk and protective factors that are the intended outcomes of their selected strategies. The evaluation plan also should include indicators and description of how sub-recipient prevention activities align with state/territory-level strategies, activities and outcomes.

To track progress on building public and private partnerships, recipients should consider indicators that measure the extent to which recipients coordinate across sectors, engage and collaborate with multi-sector partnerships formed to promote SV prevention, and share and link data sources to increase evaluation of SV prevention activities.

CDC expects recipients to focus (as much as possible) on the use of publicly available state/territory- and local-level data to develop the evaluation plan. One-way recipients can accomplish this is by identifying and tracking indicators that address state/territory risk and protective factors for SV that align with the prevention strategies and approaches they are implementing. CDC will consult with recipients and provide feedback on identified indicators and data sources. Specific indicators do not need to be proposed at the time of the application.

Although CDC expects recipients to track indicators that assess long-term outcomes, CDC does not expect recipients to achieve long-term outcomes during the funding period.

To promote continuous quality improvement in implementation of prevention activities and strategies, as well as establishing feedback loops among recipients, sub-recipients and other state/territory/Tribal partners, recipients should develop an approach and method for program improvement. This may include using existing program data (e.g., process evaluation information) and collecting new information as needed. The program improvement component should describe the following:

- The process and plan for how evaluation findings and data will be used for continuous program improvement (e.g., adjusting activities and implementation for the NOFO or for selected prevention strategies and approaches)
- The process by which the recipient will engage and promote continuous program improvement practice among sub-recipients.
- The methods for continuous program improvement (e.g., rapid cycle, Plan, Do, Study, act) and how lessons learned will be shared with particularly sub-recipients within the state/territory as well as the other recipients and sub-recipients.
- How to produce, translate, disseminate, and communicate information about their prevention approach, from their evaluation, and other lessons learned to scientific, health care and public health audiences, and to the public

Recipients will work with CDC to finalize their evaluation plan. The final state/territory-level evaluation plan, which must include final SV indicators to track, is due with the APR (120 days before the end of the first fiscal year). Upon award, CDC will provide recipients with guidance and a template for the evaluation plan. CDC highly recommends that recipients use the template to describe their approach to the evaluation, data collection, and data sources, as required annual reporting templates will have a similar format.

The evaluation plan must propose methods to answer the following evaluation questions at the state/territory- and local-level, which includes tracking and reporting on sub-recipient activities (including, but not limited to):

- To what extent has the recipient accomplished the short term and intermediate outcomes in the NOFO logic model?

- To what extent has the recipient increased internal and partner capacity to facilitate/monitor the implementation of SV prevention strategies and promote health equity?
- To what extent has the recipient leveraged multi sector partnerships and resources toward SV prevention?
- To what extent has the recipient implemented strategies that address SDOH?
- To what extent has the recipient achieved high-quality implementation of SV prevention strategies that increase health equity at the community- and societal levels?
- To what extent has the recipient increased use of data-driven decision-making, as well as state/territory- and community-level monitoring of trends, related SV prevention and SDOH?
- Which factors are critical for implementing selected prevention strategies and approaches?

Recipients should include specific measures for the required outcomes and included in their evaluation plan. Examples of process and outcome indicators or measures that recipients may use to measure the short-term and intermediate outcomes are provided in the table below. Additional guidance and technical assistance will be provided after award to help recipients select specific and appropriate process and outcome measures.

Example Process and Outcome Indicators or Measures

Short-Term Outcomes	**Intermediate Outcomes**	**Example Outcome Indicators or Measures**
Increased capacity to implement and evaluate primary prevention of SV at the community- and societal- levels within SHDs. **Increased capacity to promote and incorporate health equity program activities relevant to SV prevention among partners organizations.**	**Increased capacity for statewide program implementation and SV prevention**	# of new staff acquired % of staff retained # of training's conducted to build internal capacity to facilitate and monitor SV prevention strategy implementation # of staff who have attended a training/workshop related to facilitating and monitoring SV prevention strategy implementation # of training's conducted to build capacity of partner organizations to prevent SV #of training's conducted to promote health equity # of staff who have attended a training/workshop related to health equity

		# of staff who have participated in a CDC-sponsored program or activity Types of CDC-sponsored programs and activities that staff have participated in
Increased partner awareness of states/territories efforts to prevent SV. **Increased partner and community awareness of effective primary prevention strategies and the disparate burden of SV** **Increased coordination and collaboration among partners and between SHDs, SA coalitions, Tribal SA coalitions, representatives from underserved communities and other sectors to prevent SV.**	**Increased partner support to implement, evaluate, and adapt state- and community-level strategies to prevent SV.**	# and type of partners (sectors) # and type of partners (new vs. established) # and type of partners (SA coalitions vs. Tribes vs. other collaborators) # and types of methods used to engage partners
Increased community-level implementation of SV prevention strategies **Increased implementation of prevention strategies among communities and populations with disproportionately high rates of SV** **Increased implementation of prevention strategies that seek to prevent SV by addressing social and structural determinants of health.**	**Increased reach of prevention strategies that impact communities and populations with disproportionately high rates of SV.** **Increase in number of community- and societal-level strategies that promote health equity and reduce inequities in SV by addressing social and structural determinants of health.** **Increase in protective factors and decrease in**	# of individuals from high-burden communities reached Types of high-burden communities reached. # and type of community- or societal-level strategies addressing SDOH identified, implemented, or adapted # and type of community-level risk factors addressed # and type of community-level protective factors addressed Prevalence of community-level risk factors

	risk factors associated with SV.	Prevalence of community-level protective factors
Increased access and use of data to understand inequities within populations and communities with disproportionately high rates of SV. **Increased monitoring and evaluation activities and sharing of data related to SV prevention.**	**Increased use of data-driven decision-making to reduce inequities impacting populations and communities with disproportionately high rates of SV.** **Increased state- and community-level monitoring of trends in SV outcomes and SDOH**	Types of data used to identify and select prevention strategies. Types of data used to identify priority populations. Types of data used to identify inequities. Types of data used to improve SV strategy implementation. Types of data used to monitor SV strategy implementation. # and types of data used to track SV outcomes # and types of data used to track changes in SDOH # and types of data sharing agreements with partners # and types of partners engaged in evaluation plan development # and types of partners engaged in data dissemination plan development

There is NO expectation that recipients must conduct statewide primary data collection for the purpose of the evaluation. However, recipients evaluation activities may include collecting additional qualitative and quantitative data to measure strategy efforts. CDC will expect recipients to use state/territory-and/or local-level publicly available data (e.g., school administrative, and state/territory-or national-level data) to track indicators related SV outcomes. Upon award, CDC will work with recipients to identify indicators and potential data sources they can use to track key outcomes and will provide technical assistance to recipients to help them identify additional indicators and measures that support the evaluation of the specific NOFO activities.

Recipients are expected to implement their state/territory-level evaluation plan and track the selected SV indicators no later than the beginning of year 2 of this period of performance. They are expected to report annually on the selected SV indicators and on their evaluation findings as well as progress on their NOFO activities, including evaluation and efforts to enhance capacity to track and report on SV indicators.

CDC's Program Evaluation of the NOFO Initiative

Using recipients information provided through their annually submitted process, outcomes, and performance indicators and related measures, CDC will aggregate and synthesize those data to inform the CDC evaluation of the NOFO initiative across all recipients to capture program impact in addition to performance monitoring and continuous program improvement. These data will also inform the cross-initiative program evaluation that examines connections between multiple forms of violence and cross-cutting strategies and approaches. CDC's program evaluation activities may include collection of additional quantitative and qualitative data. In addition to identifying barriers and facilitators and guiding future TTA offerings, this effort will inform and highlight the progress and achievements that recipients are making toward NOFO goals of using the best available evidence to address risk and protective factors for SV prevention.

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.

At the time of application, applicants must provide a summary of their approach to the state/territory-level evaluation indicating how they plan to address requirements for their evaluation and performance measurement (up to 5 pages-as an appendix to the application).

At a minimum, the summary of the evaluation plan must include:

- A brief discussion of the problem and population(s) of focus.
- A description of the process evaluation to be conducted.
- A description of the outcome evaluation to be conducted.
- Key components of the state/territory-level evaluation and evaluation questions to be addressed by the evaluations

Upon award, CDC will provide further guidance, templates, and support to help recipients develop and submit a draft state/territory-level evaluation plan with their APR (120 days before the end of the first fiscal year).

c. Organizational Capacity of Recipients to Implement the Approach

All applicants should describe a clear vision and approach for effectively implementing all aspects of this NOFO. Applicants must provide specific detail about their capacity to implement the NOFO activities within the following areas:

General Capacity: Applicants must demonstrate that they have adequate and appropriate organizational infrastructure and capacity at the state and territorial health department (SHDs) to lead RPE efforts and support the requirements of this cooperative agreement, including the proposed staffing plan to implement the program activities and achieve project outcomes successfully. This includes expertise in SV prevention, health equity, and partnership development, as well as capacity in program planning, program evaluation, performance monitoring, budget management, financial reporting, personnel management, and the ability to develop, award, and manage required procurement efforts. Applicants will describe their capacity to initiate the activities required under this cooperative agreement immediately. In addition, applicants should describe their capacity to successfully implement and evaluate programming at the community and societal levels.

The applicant should describe in their project staffing plan who will have day-to-day responsibility for key tasks such as leadership of the project; monitoring of the project's ongoing progress; training and technical assistance; preparation of reports; program evaluation; and communication with partners and CDC. The applicant should also provide information about the

role of any contractual organizations, consultants, or partner organizations in implementing program strategies and activities and achieving project outcomes.

Applicants should provide CVs/resumes for SHD staff who will have a substantial role in the leadership of this project. Applicants should also provide organizational charts for significant partners or contractors as part of this application. Applicants must name this file, "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov. Attachments can be submitted using PDF, Word, or Excel file formats. Applicants must describe experience in or capacity to provide training and technical assistance in SV primary prevention and health equity. In addition, applicants must describe experience in or willingness to support sub-recipients to implement SV primary prevention approaches.

Partnership and Collaboration: Applicants should describe successful collaboration with a broad range of multi-sectoral partners such as RPE-funded state and territorial health departments, funded sub-recipients, state SA coalitions, Tribes and Tribal sexual assault coalitions, rape crisis centers; sexual assault coalitions; local health departments; faith-based organizations; military; culturally specific organizations, Tribal organizations; national organizations that target the selected population, community, or health disparities; and/or university/academic institutions.

Applicants must describe existence of an established, successful collaborative effort with a broad range of partners or entities such as the state SA Coalition; criminal justice organizations; health organizations; youth organizations; local health departments; community health centers; faith-based organizations; culturally specific organizations, Tribal organizations; national organizations that target the selected population, community or health disparities; or university/academic institutions. If these partnerships do not currently exist, the applicant must discuss how they will develop them as part of the NOFO activities.

Training and Technical Assistance: Applicants must describe experience in or capacity to provide training and technical assistance in SV primary prevention and health equity. Applicants describe experience in or willingness to support local SA coalitions, Tribes and Tribal SA coalitions, and other partners to implement community and societal-level approaches to the prevention of SV. Throughout the period of performance, recipients are expected to participate in CDC's annual meeting or site visits, communities of practice, monthly monitoring meetings or conference calls, technical assistance, or training events (e.g., webinars) provided through the Violence Prevention Technical Assistance Center (VPTAC), and other check-ins to increase recipients' capacity to implement the activities for the NOFO. Applicants will reflect the current and/or intended capacity to provide training and technical assistance in their organizational chart at the time of application.

Sub-Recipient Capacity: Recipients must demonstrate that selected sub-recipients have adequate capacity to implement the selected programs, practices, or policy efforts. This may include current or previous experience implementing similar approaches or articulation of the skills of the sub-recipient staff in carrying out required activities.

Sustainability and Leverage: The applicant must have clear plans for leveraging funds and resources to sustain and expand SV primary prevention work during the NOFO period of performance and beyond. Applicants must also provide an organizational chart, including notation of where the work will reside, resumes of key staff, and documentation of partners for this NOFO. If CDC requires CVs/Resumes or Organizational Charts then indicate that the

Applicants must name this file "CVs/Resumes" or "Organizational Charts" and upload it at www.grants.gov. Attachments can be submitted using PDF, Word, or Excel file formats.

Evaluation Capacity: Applicants must demonstrate that they have capacity to develop and implement an evaluation plan in collaboration with SA coalitions, Tribes and Tribal SA coalitions that includes evaluation of sub-recipient activities. This includes access to data, as well as staff/personnel or contractors that has/have experience in evaluation methodology. The applicant's staff experience must include measuring, tracking, and evaluating the implementation of specific efforts, implementation of activities related to the SAP, improvements in organizational and community capacity, and trends and rates related to SV and its associated risk and protective factors. CDC recommends that the applicant have the capacity to be able to design and implement evaluations of the state and local program approaches selected in the SAP as well as design and implement an evaluation of the collective NOFO activities within the state.

For a more detailed list of competencies, see the American Evaluation Association's website for Competencies & Standards. For more guidance on evaluating violence prevention programs, visit CDC VetoViolence EvaluACTION

d. Work Plan

The work plan is a program management tool intended to provide direction and structure for the entire program as well as each required activity. It should be used for program planning and implementation as well as evaluation and monitoring the progress toward reaching program goals. At the time of application, each applicant will submit a detailed work plan for the first year of the project, and a high-level work plan for the subsequent years of funding. Post award, CDC will work with recipients to finalize the format and content of the work plan. Each year recipients will submit an updated work plan as part of their Annual Performance Report (APR) and continuation application.

Additionally, the work plan should describe any anticipated challenges that will be addressed to successfully complete the activities in the NOFO, particularly related to development of the state action plan and state level evaluation plan as well as implementation of selected prevention approaches.

The following work plan format (see table below) is offered as an example to show the essential elements that should be included in the work plan submitted with the application. The work plan goals and objectives align with the strategies and activities shown in the logic model. Applicants may submit the work plan in a format that is most conducive for them; however, the essential elements must be included, and it must be clear how the components in the work plan crosswalk to the strategies and activities, outcomes, and evaluation and performance measures presented in the logic model and the narrative sections of the NOFO. Post award, CDC will provide further details and standard tools or templates for an enhanced work plan to monitor recipients activities as part of Evaluation and Performance Measurement.

Required work plan Goals and Objectives

Goal 1: Build Infrastructure for Sexual Violence Prevention

- Objective 1A: Continue to build internal program capacity to facilitate and monitor the implementation of prevention programs/policies by acquiring, training, and retaining staff
- Objective 1B: Conduct/promote training to build capacity of partner organizations to promote health equity.
- Objective 1C: Conduct or leverage an existing primary prevention capacity assessment with a focus on health equity.
- Objective 1D: Participate in CDC-sponsored programs and activities.

Goal 2: State/Territorial Action Plan

- Objective 2A: Develop or enhance an existing state/territory action plan (in collaboration with SA coalitions, Tribal SA coalitions, and representatives from underserved communities of the State or Territory) to support state- and community-level implementation and sustainability of SV prevention.
- Objective 2B: Leverage multi-sector partners and resources toward SV prevention
- Objective 2C: Participate in meaningful engagement with SA coalitions, Tribal SA coalitions, representatives from underserved communities of the State or Territory and other collaborators working to prevent SV

Goal 3: Implement SV Prevention Approaches
• Objective 3A: Identify, implement, and adapt SV prevention strategies that increase health equity through reduced disparities in targeted SDOH, with a focus on implementation at the community- and societal-levels.

Goal 4: Data to Action

- Objective 4A: Gather and synthesize publicly available state-, territory- and community-level data to inform SV prevention, track disparities in targeted SDOH and rates of SV in priority populations and use this data to select communities and populations for intervention and to improve programmatic activities.
- Objective 4B: Utilize state and community-level data to identify and select SV prevention strategies for populations and communities with disproportionately high rates of SV
- Objective 4C: Develop and implement an equity-focused evaluation plan (in collaboration with SA coalitions & Tribal SA coalitions).
- Objective 4D: Use program monitoring and evaluation data and other available data to improve SV prevention strategy implementation

SAMPLE WORK PLAN TEMPLATE
Goal #:

Objective #: ***(Corresponds to Logic Model Activity)***			
Process Measures		**Outcome Measures**	
Milestone Description	**Key Activities** *(Provide a brief description of activities that will be*	**Start Date**	**End Date**

(Provide a concise statement of the milestone)	*conducted to complete the milestone.)*	*(Anticipated Milestone Start Date)*	*(Anticipated Milestone End Date)*

Applicant work plans must include all bold-titled sections from the sample work plan template above for each goal and objective.

e. CDC Monitoring and Accountability Approach

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

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

Monitoring may also include the following activities deemed necessary to monitor the award:

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

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

CDC will collect recipient financial and performance reporting data annually through the end of the period of performance. 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.

Throughout the period of performance, recipients are expected to participate in CDC's annual. Meeting, site visits, communities of practice, monthly monitoring meetings or conference calls, technical assistance or training events (e.g., webinars) provided through the Violence Prevention

Technical Assistance Center (VPTAC), and other check-ins to increase recipients capacity to implement NOFO strategies and activities.

CDC Project Officers will conduct a monthly review from the date of the award. The review will be a telephone call or video conference to ensure the recipient's compliance with using the funding for the approved activities and to identify additional technical assistance needs. CDC may also conduct site visits as needed to best facilitate management of the cooperative agreement and oversight duties.

Post-award cooperative agreement monitoring and reporting activities will include, but are not limited to:

- Communicating as needed, or at a minimum monthly.
- Emailing monthly programmatic and fiscal updates to assigned project officer prior to scheduled monthly conference calls.
- Participating in webinars and mandatory recipient meetings
- Participating in national conferences (such as NSAC)
- Establishing a process for monitoring continuous program improvement over time
- Monitoring of award to ensure that recipients are conducting activities outlined in the NOFO on a routine basis (e.g., data collection and analysis, partnership engagement, strategic communication, etc.)
- Reviewing annual APRs including documentation of successes, challenges, and lessons learned as prescribed by CDC and provide feedback to the recipients.
- Providing recipients with timely feedback based on monitoring, performance, and evaluation data.
- Participating in relevant meetings, committees, conference calls, and working groups related to the cooperative agreement requirements to achieve outcomes.
- Site visits as needed

f. CDC Program Support to Recipients

CDC will have substantial involvement beyond site visits and regular performance and financial monitoring during the period of performance to ensure the success of the project. CDC will use monitoring and performance data to provide feedback to recipients, and to tailor technical assistance as needed. This may include direct technical assistance, rapid feedback, tools and resources, facilitating information sharing among recipients, and consultation on all aspects of recipient activities. CDC will provide technical assistance and feedback in the following ways:

1. Provide CDC-developed tools and resources such as VetoViolence, CDC Violence Prevention Resources for Action (previously referred to as Technical Packages), SV Indicator Tools, RPE Evaluation Plan Guidance, RPE Implementation Guidance, Community-Level Guidance, etc.

2. Provide individual technical assistance to recipients as needed.

3. Review APRs, evaluation plans and tools, and SAPs, and provide feedback.

4. Facilitate Collaborative Learning opportunities including:

- Routine conference calls, webinars, and information exchange between recipients
- Collaborative meetings with state and national partners

- Develop mechanism for documenting and sharing lessons learned.

5. Evaluation: Facilitating successful evaluation of the outcomes and implementation of the collective activities in the state as described in the NOFO. Examples of resources and tools provided by CDC or CDC-funded TTA providers include, but are not limited to:

- Identifying local and state data available to monitor SV indicators.
- Using collected performance measures, reports, and/or data to provide recipients with feedback for continuous program improvement.
- Assisting with planning and identifying measures to evaluate the selected programs and state and local efforts.
- Providing guidance on evaluating recipient's performance of program activities and compliance with award performance standards.

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:
UF2
Rape Prevention and Education Cooperative Agreement

3. Fiscal Year:
2024

4. Approximate Total Fiscal Year Funding:
$41,990,000

5. Total Period of Performance Funding:
$209,950,000
This amount is subject to the availability of funds.

Estimated Total Funding:
$209,950,000

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

year(s)

7. Expected Number of Awards:
59

8. Approximate Average Award:

$803,000
Per Budget Period

Average $803,000.
Territories-$40,000
Awards will be made to states and territories using the following population based funding formula: U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, Palau, American Samoa and Guam with approved applications will receive $40,000; the 50 states, District of Columbia and Commonwealth of Puerto Rico with approved applications will receive a base of $150,000.

The remainder of the funds will be allocated utilizing the percentage of each state's population (50 states, DC and Puerto Rico) divided by the total US population, as stated in Violence Against Women Act.

9. Award Ceiling:
$4,200,000
Per Budget Period

This amount is subject to the availability of funds.

Ceiling amount is subject to the availability of funds.

10. Award Floor:
$40,000
Per Budget Period

11. Estimated Award Date:
January 31, 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 not 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:
00 (State governments)

Additional Eligibility Category:

Government Organizations:

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

Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

2. Additional Information on Eligibility

The Notice of Funding Opportunity (NOFO) is funded under the Violence Against Women Act (VAWA) and Section 393A(a) of the PHS Act (42 USC § 280b-1b(a) and Section 392(a)(1) of the PHS Act (42 USC § 280b-1(a)(1)) legislative authority. Eligible entities are based on the VAWA legislation. The legislative authority requires CDC to fund the Rape Prevention and Education Program (RPE) and allocate funds in each fiscal year for:

- Each of the States, the District of Columbia, Puerto Rico, and the U.S. Territories.
- State health departments or their Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the US 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).
- A Bona Fide Agent is an agency/organization identified by the state as eligible to apply under the state eligibility in lieu of a state application. This should be stated in the project abstract. If applying as a bona fide agent of a state or local government, a legal, binding agreement from the state or local government as documentation of the status is required.

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 exists for this NOFO, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Consistent with the cited authority for this announcement and applicable grants regulations, sources for cost sharing or matching may include complementary CDC Foundation funding; other U.S. government funding sources, including programs supported by HHS or other agencies (e.g., Department of Agriculture, Department of Education, Department of Housing and Urban

Development, Department of Transportation, Environmental Protection Agency, National Park Service); and other funding sources. Applicants should coordinate with multiple sectors, such as public health, transportation, education, health care delivery, and agriculture.

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Application and Submission Information

1. Required Registrations

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

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

a. Unique Entity Identifier (UEI):

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

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

b. System for Award Management (SAM):

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

c. Grants.gov:

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

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

Step	System	Requirements	Duration	Follow Up
1	System for Award Management (SAM)	1. Go to SAM.gov and create an Electronic Business Point of Contact (EBiz POC). You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.	7-10 Business Days but may take longer and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
2	Grants.gov	1. Set up an 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)

b. Application Deadline

Due Date for Applications 11/30/2023

11/30/2023
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
10/13/2023

2:00 p.m.-3:30 p.m. U.S. Eastern Standard Time

https://cdc.zoomgov.com/meeting/register/vJItcuyvqDMrE5Anpxa34ix9c35lBLpOsTw

The purpose of this informational conference call/webinar is to help potential applicants understand the scope and intent of this Program Announcement: Rape Prevention and Education. Participation on the conference call is not mandatory. Potential applicants are requested to call in using only one telephone line. This is a competitive process; therefore, applicants should follow the requirements for this program as they are laid out in the funding announcement and related amendments. Applicants who want to submit questions prior to the call, or should applicants find they have additional questions or need clarification after the call, please see the Agency Contact listed at the end of this Notice of Funding Opportunity (NOFO).

5. Pre-Award Assessments

Risk Assessment Questionnaire Requirement

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

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

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be

labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

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

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission

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

7. Letter of Intent

LOI is not requested or required as part of the application for this NOFO

8. Table of Contents

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

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF, 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. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and 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.

Applicants are expectations to include funding for:

 At least one SHD RPE FTE to attend one meeting annually with the CDC

 Conducting program evaluation and performance monitoring

 Potential costs for reasonable disability accommodations and/or services for attendees of CDC-funded programs or meetings related to the NOFO requirements

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.

Applicants must adhere to Congressional legislation (Section 393B of the Public Health Service Act [42 U.S.C. 280b-1c]). The legislation stipulates the following:

- Applicants may not use more than five percent of the amount received for each fiscal year for administrative expenses. This five percent limitation is in lieu of, and replaces, the indirect cost rate. Recipient can still submit and use an IDC rate as long as after calculations the total IDC is no more than 5% of total received in the fiscal year.
- An applicant may not use more than two percent of the amount received for each fiscal year for surveillance studies or prevalence studies.
- Amounts provided to applicants must be used to supplement, and not supplant Preventive Health and Health Services Block grant, other Federal, State, and local public funds expended to provide the activities described above.
- Funds may not be used to provide direct counseling, treatment, or advocacy services to victims or perpetrators of sexual violence (with the exception of hotlines).
- Funds may not be used for media or awareness campaigns that exclusively promote awareness of where to receive victim services.

17. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additional-requirements/ar-25.html.

18. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. 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

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

i. Approach

ii. Evaluation and Performance Measurement

iii. Applicant's Organizational Capacity to Implement the Approach

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

i. Approach	**Maximum Points:** 0
ii. Evaluation and Performance Measurement	**Maximum Points:** 0
iii. Applicant's Organizational Capacity to Implement the Approach	**Maximum Points:** 0

Approach **Maximum Points:** 0

Strategy 1: Build Infrastructure for SV prevention	
Applicant describes:	Yes/No
How they will build internal program capacity to facilitate and monitor implementation of prevention programming through staffing, partnerships, and training.	
How they will train and support partner organizations to promote health equity.	
How they will conduct or leverage an existing primary prevention capacity assessment with a focus on health equity.	
Strategy 2: Develop State Action Plan	
Applicant describes:	Yes/No
How they will collaborate with SA coalitions, Tribal SA coalitions, and representatives from underserved communities in their State or Territory to develop or enhance a state/territory action plan to support state- and community-level implementation and sustainability of SV prevention	
How they will identify and leverage multi sector partners and resources towards SV prevention.	
How they will meaningfully engage with SA coalitions, Tribal SA coalitions, representatives from underserved communities of the State or Territory and other collaborators working to prevent SV	
Strategy 3: Implement Strategy	
Applicant describes:	Yes/No
How they will identify, implement, and adapt SV prevention strategies that increase health equity through reduced disparities in targeted SDOH, with a focus on implementation at the community- and societal-levels	
Plans for implementation of program/policy effort in each of the 3 Focus Areas	
How new program/policy efforts not listed as examples in the VetoViolence approach search tools meet the required criteria for new program/policy efforts listed in the NOFO.	
How they will make their programs accessible and available to participants regardless of age, race/ethnicity, sexual orientation, gender identity, sex, ability, or socioeconomic status.	

How proposed programs or policy efforts will address inequities in social and structural determinants of health to advance health equity and prevent SV before it starts (primary prevention)	
Strategy 4: Use Data to Inform Action	
Applicant describes:	Yes/No
How they will gather and synthesize data that will be used to identify specific SDOH and risk/protective factors where inequities are leading to disproportionately high rates of SV within populations and communities in their state/territory	
How they intend to identify priority populations and communities and provide relevant data sources that will be used for this process	
How they will use data to select complementary programs and policies to influence the conditions contributing to health inequities and impact SDOH that can decrease risk for and increase protection against SV	
How they will address inequities based on race, ethnicity, gender identity, sex, sexual orientation, geography, socioeconomic status, disability status, primary language, and health literacy as well as issues of health equity facing their selected population(s) and communities of focus.	
Work Plan	
Applicant:	Yes/No
Provides a detailed work plan for the first year of award which: • Describes how the applicant will address all strategies and activities to achieve NOFO outcomes. • Provides start and end dates for each Milestone Provides process and outcome measures for each Activity	
Provides a high-level work plan for subsequent years of funding.	
Collaboration	
Applicant describes:	Yes/No
How they intend to work and build strong partnerships with other RPE-funded state and territorial health departments and CDC-funded technical assistance providers	
How they intend to encourage and facilitate collaboration among RPE-funded sub-recipients, sexual assault coalitions, Tribes and Tribal sexual assault coalitions.	

Their current or potential plans for collaborating with DELTA AHEAD recipients, Core SIPP recipients, or any other CDC-funded programs in their jurisdiction.	

Evaluation and Performance Measurement **Maximum Points:** 0

Evaluation and Performance Measurement	
Applicant:	Yes/No
Provides an Evaluation Summary describing their approach to the state/territory-level evaluation indicating how they plan to address requirements for their evaluation and performance measurement including: • A brief discussion of the problem and population(s) of focus. • A description of the process evaluation to be conducted. • A description of the outcome evaluation to be conducted. • Key components of the state/territory-level evaluation and evaluation questions to be addressed by the evaluation. • How the applicant will collect data and use evaluation findings for continuous quality improvement. • Available data sources, feasibility of collecting evaluation and performance data, and other relevant information (e.g., proposed measures).	
Demonstrates how they will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of the NOFO	

Applicant's Capacity to Implement the Approach **Maximum Points:** 0

Organizational Capacity to Implement the Approach	
Applicant:	Yes/No
Demonstrates that they have adequate and appropriate organizational infrastructure and capacity at the state and territorial health department (SHDs) to lead RPE efforts and support the requirements of this cooperative agreement, including the proposed staffing plan to implement the program activities and achieve project outcomes successfully.	

Describes their capacity to manage programs and resources ensuring the administrative, financial, and staff support necessary to sustain activities. This includes describing an adequate staffing plan, providing CVs/Resumes for proposed personnel, an organizational chart, and a project management structure that clearly defines staff roles and reporting structure, as it applies to this funding opportunity.	
Describe their internal experience in or capacity to provide training and technical assistance in SV primary prevention and health equity.	
Describes how selected sub-recipients have adequate capacity to implement the selected programs, practices, or policy efforts.	
Describes their capacity to develop and implement an evaluation plan in collaboration with SA coalitions, Tribes and Tribal SA coalitions that includes evaluation of sub-recipient activities	

Budget **Maximum Points:** 0

Budget	
Applicant:	Yes/No
Describes how the budget supports the work plan and evaluation plan.	
Provides an accurate and reasonable budget consistent with their stated planned strategies and activities	
Describes how the budget is allocated to evaluation efforts.	

Budget **Maximum Points:** 0

c. Phase III Review

A technical review will be conducted for all eligible applicants, based on the phase II review criteria.

Review of risk posed by applicants.

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

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined

in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

The anticipated award notification date is January 31, 2024

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.

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*
Data on Performance Measures	*CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.*	N/A
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 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.

d. Federal Financial Reporting (FFR) (required)

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

e. Final Performance and Financial Report (required)

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the 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).

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:
Phillip
Last Name:
Williams
Project Officer

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

Address:
Centers for Disease Control and Prevention

National Center for Injury Prevention and Control

Division of Violence Prevention

4770 Buford Highway NW, Building 106

MS F-64

Atlanta, GA 30341

Telephone:
770 488-0548

Email:
dpz4@cdc.gov

Grants Staff Contact

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

First Name:
Monique

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

Address:
2920 Brandywine Rd

Atlanta GA. 30341

Telephone:
770 488-2617

Email:
itn8@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:
Resumes / CVs

Position descriptions

Letters of Support

Organization Charts

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Bona Fide Agent status documentation, if applicable

These are optional attachments applicants can submit as part of the application.

- Map of the community data (such as census tract, zip code, and neighborhoods) relevant to the selected population
- Demographic composition of the selected areas or communities of focus
- The percent of population in the area with income at or below 100% of the federal poverty level
- SV prevalence, risk, and protective factor data for selected populations demonstrating disproportionate risk for SV

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

Program Specific Glossary:

Capacity Assessment: A Primary Prevention Capacity Assessment of state and territorial health departments readiness to plan and implement equity-focused strategies.

Data Management Plan (DMP): A written description of the plan for the collection, protection, sharing, and long-term preservation of public health data. DMP Extramural Guidance (cdc.gov) (https://www.cdc.gov/chronicdisease/pdf/nofo/extramural-guidance-dmp-508.pdf)

Division of Violence Prevention Partner's Portal: A resource for the Prevention Practice & Translation Branch and other involved in their programmatic initiatives. This application supports program monitoring and reporting.

Equity-Focused Evaluation: An evaluation that seeks to understand what works, for whom, and under what conditions, as well as to reveal whether health inequities have decreased, increased, or remained the same. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease; Section 1: Addressing Health Equity in Evaluation Efforts (cdc.gov) (https://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity-guide/pdf/health-equity-guide/Health-Equity-Guide-sect-1-7.pdf)

Goal: A broad statement about the long-term expectation of what should happen as a result of your program (the desired result). Serves as the foundation for developing your program objectives. Developing Program Goals and Measurable Objectives (cdc.gov) (https://www.cdc.gov/std/program/pupestd/developing%20program%20goals%20and%20objectives.pdf)

Indian tribe; Indian Tribe: Any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. 34 USC 12291: Definitions and grant provisions (house.gov) (https://uscode.house.gov/view.xhtml?req=(title:34%20section:12291%20edition:prelim)

Indicators: Measurable information used to determine if a program is implementing their program as expected and achieving their outcomes. Indicators - Program Evaluation - CDC (https://www.cdc.gov/evaluation/indicators/index.htm)

Long-Term Outcomes: The desired program results. State Heart Disease and Stroke Prevention Program Evaluation Guide: Developing and Using a Logic Model Evaluation Guide (cdc.gov) (https://www.cdc.gov/dhdsp/docs/logic_model.pdf)

Monitoring: A process used to track implementation progress through periodic data collection. Program Evaluation Home - CDC (https://www.cdc.gov/evaluation/index.htm)

National Intimate Partner Violence and Sexual Violence Survey (NISVS):

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

Objectives: Statements describing the results to be achieved, and the manner in which they will be achieved. You usually need multiple objectives to address a single goal. Developing Program Goals and Measurable Objectives (cdc.gov)

(https://www.cdc.gov/std/program/pupestd/developing%20program%20goals%20and%20objectives.pdf)

Policy Effort: Policy-related activities such as analyzing data to identify trends and opportunities; analyzing and understanding policy options; collaborating with partners to educate about policy issues; providing evidence and education to key partners and policymakers; educating the public about existing policies; and evaluating the impact of policies. For example, a coalition may choose to work with partners to conduct a health impact assessment on a certain policy or benefit and then disseminate the results of that assessment including to large businesses and/or other partners.

Practice-Based Evidence: An approach to integrating research and practice by engaging practitioners in the collection of data and in analyses of that data which can inform subsequent research inquiry and practice.

Process Evaluation: A type of evaluation used to track implementation of recipient strategies and activities.

Primary Prevention: Approaches that take place before intimate partner violence has occurred to prevent initial perpetration or victimization.

Protective Factor: Characteristic that decreases the likelihood of a person becoming a victim or perpetrator of violence because it provides a buffer against risk.

Public Health Approach: The public health approach is a four-step process that is rooted in the scientific method. It can be applied to violence and other health problems that affect populations. Step 1: Define the Problem, Step 2: Identify Risk and Protective Factors, Step 3: Develop and Test Prevention Strategies and Step 4: Assure Widespread Adoption. For additional information on The Public Health Approach to Violence Prevention go to: The Public Health Approach to Violence Prevention (cdc.gov) (https://www.cdc.gov/violenceprevention/pdf/PH_App_Violence-a.pdf)

Recipient: A successful applicant whose application was approved and funded.

Resources for Action (formerly known as Technical Packages: Compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome. Resources for Action help communities and states prioritize prevention activities based on the best available evidence. Resources for Action are included as one of six key components for effective public health program implementation. Frieden, T. R. (2014). Six components necessary for effective public health program implementation. American Journal of Public Health, 104(1), 17-22.

Risk Factor: Characteristic that increases the likelihood of a person becoming a victim or perpetrator of violence.

Sexual Violence (SV): Sexual activity when consent is not obtained or freely given.

Short-Term Outcomes: The immediate effects of the program or intervention activities. State Heart Disease and Stroke Prevention Program Evaluation Guide: Developing and Using a Logic Model Evaluation Guide (cdc.gov) (https://www.cdc.gov/dhdsp/docs/logic_model.pdf)

Social Ecological Model (SEM): The ultimate goal is to stop violence before it begins. Prevention requires understanding the factors that influence violence. CDC uses a four-level social ecological model to better understand violence and the effect of potential prevention strategies. This model considers the complex interplay between individual, relationship, and community factors. It allows us to understand the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The overlapping rings in the model illustrate how factors at one level influence factors at another level. By acting across multiple levels at the same time, prevention efforts are more likely to be sustained than any single intervention. Prevention strategies at the individual level are usually designed to promote attitudes, beliefs, skills, and behaviors that ultimately prevent violence. Prevention strategies at the relationship level focus on parenting, family, mentoring, or peers to reduce conflict, foster problem-solving skills, promote healthy relationships, and address factors related to the social circle, peers, partners, family members and other adult allies who influence an individual behavior and experience. Prevention strategies at the community level are designed to impact characteristics of the settings (e.g., school, workplace, and neighborhood) in which social relationships occur, or social and physical environment factors such as reducing social isolation, improving economic and housing opportunities, and improving climate within school and workplace settings. The Social-Ecological Model: A Framework for Prevention |Violence Prevention|Injury Center|CDC (https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html)

State Action Plan (SAP): A state action plan is used to guide the implementation and evaluation of state-level and local-level IPV prevention strategies. The action plan is to be developed or enhanced with identified state-level partners. The following are components that should be included in the state action plan: 1) tracking and use of statewide data, 2) ways in which the coalition and partners will prioritize primary prevention at all layers of the Social Ecological Model (SEM), and 3) the ways in which coordination with partners will be increased and/or maintained.

State Sexual Assault Coalition: A program determined by the Center for Injury Prevention and Control of the Centers for Disease Control and Prevention under the Public Health Service Act (42 U.S.C. 280b et seq.). 34 USC 12291: Definitions and grant provisions (house.gov) (https://uscode.house.gov/view.xhtml?req=(title:34%20section:12291%20edition:prelim)

STOP SV Technical Package: A document to help states and communities to take advantage of the best available evidence and to prioritize efforts to prevent sexual violence.

Sub-recipients Per CFR 200: A non-Federal entity that receives a sub-award from a pass-through entity to carry out part of a Federal program; but does not include an individual that is a beneficiary of such program. A sub-recipient may also be a recipient of other Federal awards directly from a Federal awarding agency.

Technical Assistance: The process of providing targeted support to an organization with a development need or problem, which is typically delivered over an extended period of time.

Theory of Change: Used to provide a rationale for the expected links between program resources, activities, and outcomes. It explains how and why activities are expected to lead to outcomes in the particular order depicted. State Heart Disease and Stroke Prevention Program

Evaluation Guide: Developing and Using a Logic Model Evaluation Guide (cdc.gov) (https://www.cdc.gov/dhdsp/docs/logic_model.pdf)

Training: Training as a process for turning awareness and knowledge into mastered skills and practices to prevent sexual violence and/or intimate partner violence by:

Teaching based on organizational context.

Providing opportunities for skill development through participatory learning.

Following up to assess progress and determine level of mastery.

Tribal Coalition: An established nonprofit, nongovernmental Indian organization, Alaska Native organization, or a Native Hawaiian organization that— (A) provides education, support, and technical assistance to member Indian service providers in a manner that enables those member providers to establish and maintain culturally appropriate services, including shelter and rape crisis services, designed to assist Indian women and the dependents of those women who are victims of domestic violence, dating violence, sexual assault, and stalking; and (B) is comprised of board and general members that are representative of— (i) the member service providers described in subparagraph (A); and (ii) the tribal communities in which the services are being provided. 34 USC 12291: Definitions and grant provisions (house.gov) (https://uscode.house.gov/view.xhtml?req=(title:34%20section:12291%20edition:prelim)