Centers for Disease Control and Prevention

Center for Global Health

Strengthening immunization program implementation in sub-national consequential geographies

CDC-RFA-GH-24-0058

03/04/2024

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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-GH-24-0058. 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)

B. Notice of Funding Opportunity (NOFO) Title:

Strengthening immunization program implementation in sub-national consequential geographies

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-GH-24-0058

E. Assistance Listings Number:

93.318

F. Dates:

1. Due Date for Letter of Intent (LOI):
01/26/2024

Recommended but not Required
A Letter of Intent (LOI) is requested but not required. The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. If known, the LOI should include the country component(s) to which the applicant will apply.

LOI must be sent via email to:

Karen Clackum

CDC, CGH

Email address: KClackum@cdc.gov

2. Due Date for Applications:
03/04/2024
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call
CDC will host two informational calls for interested applicants. The content of both calls will be identical. Questions and answers from each session will be compiled and amended in the NOFO. The two times are offered as a way to help accommodate the schedules of interested applicants and their locations in varying time zones. Due to limited space, applicants should only register for Webinar 1 or 2, but not both.

- When: Jan 17, 2024 8:00 AM Eastern Time (US and Canada)
- Topic: Informational Call #1 - NOFO CDC-RFA-GH-24-0058
- Register in advance for this webinar:
  https://cdc.zoomgov.com/webinar/register/WN_1eM6P8ROScyZKO80ehGzLA

- When: Jan 17, 2024 8:00 PM Eastern Time (US and Canada)
- Topic: Informational Call #2 - NOFO CDC-RFA-GH-24-0058
- Register in advance for this webinar:
  https://cdc.zoomgov.com/webinar/register/WN_MeU7BbDGTEKGiP91d6hJMw

F. Executive Summary:

Summary Paragraph
The purpose of this NOFO is to increase immunization program capacity in high priority countries and targeted sub-national areas to identify underserved populations and implement tailored interventions to vaccinate underserved populations; implement comprehensive vaccine preventable disease (VPD) surveillance systems; improve preparedness and response to outbreaks of VPDs; and strengthen quality and sustainability of immunization delivery systems. This cooperative agreement will address targeted sub-national areas in the Democratic Republic of the Congo, Ethiopia, Nigeria, Brazil, Indonesia, and the Philippines. Applicants may apply to work in one or more countries, and must clearly indicate the country or countries in their application. Work conducted under this NOFO will be critical to achieve VPD control,

elimination, and eradication targets (i.e., polio eradication, measles and rubella elimination, hepatitis B elimination, maternal and neonatal tetanus elimination) and more broadly reduce VPD-related morbidity and mortality.

a. Eligible Applicants:
Open Competition

b. NOFO Type:
CA (Cooperative Agreement)

c. Approximate Number of Awards
12
Up to 12 applicants may be awarded with a maximum of two awards per country component.

d. Total Period of Performance Funding:
$225,000,000

e. Average One Year Award Amount:
$7,500,000
The average annual award amount varies, depending on the country. Estimated annual funding per country:

1. DRC: $10,000,000
2. Ethiopia: $10,000,000
3. Nigeria: $10,000,000
4. Brazil: $5,000,000
5. Indonesia: $5,000,000
6. The Philippines: $5,000,000

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

g. Estimated Award Date:
May 01, 2024

h. Cost Sharing and / or Matching Requirements:
No

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview
***Definitions for terminology are listed in the Glossary, section I.*

The U.S. Centers for Disease Control and Prevention (CDC) has a long-standing commitment to support and implement global immunization priorities and lifesaving, cost-effective public health interventions to reduce the risk of disease, disability, and death from vaccine preventable diseases (VPDs). While the U.S. has reduced the domestic VPD burden, the nation remains at risk from importation of VPDs abroad. CDC’s Global Immunization Division (GID) prioritizes activities in countries at the highest risk for VPDs to prevent outbreaks, limit disease transmission and importation and ultimately protect the lives of the American people.

The 2022 WHO/UNICEF estimates of routine immunization coverage (WUENIC) show a significant decline from levels achieved in 2019 (Vaccination and Immunization Statistics - UNICEF DATA), leaving large numbers of children susceptible to VPDs. Large outbreaks of VPDs have increased during 2021-2023, underscoring the global health security threat for the U.S. The largest number of unprotected children (i.e., children who have not received any doses of routine childhood vaccines) live in just ten countries, including Nigeria (2.3 million), Ethiopia (1.1 million), Democratic Republic of the Congo (DRC) (753,000), the Philippines (637,000), Indonesia (571,000), and Brazil (431,000), and concerted efforts to reach and immunize these children are critical to reverse the global declines in immunization coverage and reduce the risk of large and disruptive outbreaks.

Sub-national areas with weak immunization program infrastructures play a large role in continued VPD outbreaks and exportation of VPD pathogens to other geographic areas. Outbreaks in these sub-national areas, or "consequential geographies" (CGs), are more likely to affect neighboring geographies, giving them significant – or "consequential" – impacts beyond their geographic size or population. A CG has multiple overlapping risks, often rooted in social, economic, ecological, and health system factors that result in combinations of low vaccination coverage, high pathogen exposure, and worse health outcomes from VPDs. Activities must be tailored to individual country contexts and challenges that may include, but not be limited to:

- mobile populations
- internally displaced persons (IDPs)
- hard-to-reach areas (e.g., insecurity/conflict, geography)
- difficulty in retaining high-performing health staff
- geographic areas with large inflows/outflows of people to other countries resulting in exportation of VPD cases/outbreaks
- vaccine hesitancy and/or inequitable or low access to care resulting in chronic areas of un- and under-immunized populations

To address these issues, this NOFO will enable CDC and partners to strengthen immunization systems, comprehensive VPD surveillance, and VPD outbreak response in sub-national areas of the following countries:

- Democratic Republic of the Congo (DRC)
- Ethiopia
- Nigeria
- Brazil
- Indonesia
- The Philippines

Sub-national geographies will be determined in consultation with Ministries of Health and CDC after the award is made, and geographic prioritization within countries may change over the course of the period of performance.

In FY 2023, CDC/GID provided funds to Nigeria, Ethiopia, and DRC to implement consequential geography activities in sub-national areas. The activities under this NOFO will leverage FY 2023 investments and activities.

b. Statutory Authorities

Section 307 of the Public Health Service Act, as amended [42 USC 242l]; Section 301 (a) [42 USC 241 (a)] of the Public Health Service Act, as amended; Section 317(k)(1) [42 USC 247b(k)(1)] of the Public Health Service Act, as amended.

c. Healthy People 2030

This program addresses the "Healthy People 2030" focus areas of Global Health (Global Health - Healthy People 2030 | health.gov), Infectious Disease and Vaccinations (Infectious Disease — Evidence-Based Resources - Healthy People 2030 | health.gov), Global Polio Eradication Initiative (GPEI) (https://polioeradication.org), Immunization Agenda 2030 (IA 2030) (https://www.who.int/publications/m/item/immunization-agenda-2030-a-global-strategy-to-leave-no-one-behind) and CDC's Health Equity Strategy (https://www.cdc.gov/globalhealth/equity/).

d. Other National Public Health Priorities and Strategies

This NOFO will support the US Government-endorsed Global Polio Eradication Initiative (GPEI) GPEI Strategy 2022-2026 – GPEI (polioeradication.org) and the Immunization Agenda 2030 (IA2030). In addition, this NOFO will support CDC's Global Health Strategy, which focuses on: 1) improving the health and well-being of people around the world; 2) improving capabilities to prepare for and respond to infectious diseases, other emerging health threats and public health emergencies; and, 3) maximizing the potential of CDC's global programs to achieve public health impact.

e. Relevant Work

This announcement supports the CDC Global Immunization Strategic Framework (GISF) 2021–2030 and expands on previous work to strengthen sub-national capacities. Through Fiscal Year (FY) 2023 funds, GID is implementing CG activities to strengthen sub-national capacity. Funds were provided in sub-national geographies in Nigeria, DRC, and Ethiopia. Activities will include but are not limited to the following: 1) microplanning including with satellite and geographic information systems (GIS) mapping, 2) intensified routine immunization, 3) urban-tailored interventions; and 4) communications to improve immunization confidence and uptake.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-GH24-0058 Logic Model: Strengthening immunization program implementation in sub-national consequential geographies. This logic model applies to each country included in the NOFO: DRC, Nigeria, Ethiopia, Brazil, Indonesia, and the Philippines.

STRATEGY	SHORT-TERM OUTCOMES (CDC GISF Priority #)	INTERMEDIATE-TERM (CDC GISF Priority #)	LONG-TERM

1. Strengthen immunization services in targeted sub-national areas	**Improved capacity to:** • **characterize underserved populations with immunity gaps* and implement tailored delivery strategies to reach them across the life-course (1.1, 1.3)** • **enhance implementation of strategies that address barriers, facilitators, and solutions to improve demand and uptake of immunization (1.2)** • **introduce vaccines and monitor and evaluate post-introduction (1.4)** • **strengthen immunization data accuracy, timeliness, and use (1.5)**	• **Increased identification of un-/ under-immunized populations (1.1),** • **Improved tailored delivery strategies implemented to reach un- /under-immunized populations (1.1)** • **Increased demand for routine and campaign immunization services (1.2)** • **Improved access to, and utilization of, immunization across the life-course (1.3)** • **Increased number of new or under-utilized vaccines introduced (1.4)** • **Improved recording, reporting, and use of immunization program data (1.5)**	Improvements towards sustainable, high, and equitable vaccination coverage*** Progress towards and achievement of VPD control, elimination, and eradication targets*** Reduced mortality and morbidity from VPDs***
2. Support and continuously improve comprehensive VPD surveillance systems in targeted sub-national areas	• **Improved comprehensive VPD surveillance system capacity (across surveillance system functions) (2.1)** • **Increased capacity to generate, interpret, and use VPD**	• **Improved comprehensive VPD surveillance system performance (2.1)** • **Increased use of VPD surveillance data to improve immunization program performance (2.1, 2.3)**	

	surveillance data (2.3)		
3. Prepare for and respond to VPD outbreaks in targeted sub-national areas	• **Improved capacity, quality, and timeliness for VPD outbreak preparedness and response (3.2-3.3)**	• **Reduced number of large or disruptive VPD outbreaks (3.2-3.3)**	
4. Foster immunization program sustainability in targeted sub-national areas	• Improved evidence-based, translation, and use of immunization economic and financing information, including on vaccine pricing and procurement (4.1) • Improved functionality and effectiveness of technical advisory groups to support evidence-based decision making for immunization policy and programs (4.2) • **Increased capacity for and implementation of vaccine safety surveillance and response (4.3)** • **Improved immunization workforce** development strategies**	• **Improved effectiveness of immunization safety monitoring and risk communication (4.3)** • **Improved capacity, performance, and accountability of immunization workforce (4.4)**	

	implemented and evaluated (4.4)		
5. Collaborate with government and implementation partners	• **Improved government and implementation partner coordination and communication (GISF Partnership-based principle)**	• **Sustained coordination and collaboration between government and immunization partners (GISF Partnership-based principle)**	

** according to the WHO Standard Competencies Framework for the Immunization Workforce, including workforce for advocacy and communications; disease surveillance, investigation, and response; human resources and performance management; monitoring, evaluation, information system management and data use; policy, planning, and finance; safety of vaccines and immunization; vaccines, supplies, and logistics; vaccination service delivery; and leadership and management.

i. Purpose

Available NOFO funding will support critical immunization efforts to achieve global VPD goals in specified consequential geographies. The goals are to 1) identify and vaccinate un- and under-immunized children, 2) support polio eradication, measles and rubella elimination, and hepatitis B and maternal and neonatal tetanus elimination, 3) strengthen comprehensive VPD surveillance, 4) support outbreak preparedness and response, including planning and implementation of supplemental immunization campaigns, and 5) strengthen immunization delivery systems and capacities in high priority countries.

ii. Outcomes

Short-Term Outcomes

Strategy 1. Strengthen Immunization Services in targeted sub-national areas

Improved capacity to:

- characterize underserved populations with immunity gaps and implement tailored delivery strategies to reach them across the life-course (1.1). For example:
    - target populations accurately mapped through walk-through microplanning supplemented with geo-spatial analysis
    - targeted polio, measles, or other VPD high-quality campaigns using innovative strategies in conflict or fragile settings
    - enhanced implementation of intensification of routine immunization (IRI) in an integrated primary health care system
    - un- and under-immunized populations in hard to reach, conflict, fragile, displaced, urban settings, or other complex settings identified and reached though tailored delivery strategies across the life-course

    - behavioral, social, and access-related drivers are identified in general and key populations
    - key insights on any prevalent mis/disinformation related to routine or new vaccines are available in a timely manner to inform infodemic management strategies

- enhance implementation of strategies that address barriers, facilitators, and solutions to improve demand and uptake of immunization (1.2). For example:
    - community insight on demand and uptake through engagement with religious and community leaders
    - implementation of evidence-based, tailored strategies that address gender-related barriers to immunization to improve caregiver health-seeking behavior and vaccine demand
    - implementation of evidence-based, tailored strategies to improve quality of immunization service delivery and responsiveness to community needs
    - improved capacity of community actors for defaulter tracing and effectively linking those data with health facilities
    - improved capacity to identify and respond to Adverse Events Following Immunization (AEFI)/safety concerns
    - implementation of targeted strategies based on systematic assessments of the immunization program
    - address system barriers to catch up vaccinations (e.g., policies, information systems, health worker training, demand)
    - infodemic management strategies implemented to reduce mis/disinformation

- introduce vaccines and monitor and evaluate post-introduction (1.4). For example:
    - novel oral poliovirus vaccine 2 (nOPV2) introduced in geographies with circulating vaccine-derived poliovirus type 2
    - high catch-up campaign coverage achieved for rubella vaccine introductions
    - a reduced number of breakthrough infections post human papillomavirus vaccine (HPV) and malaria vaccine introduction

- strengthen immunization data accuracy, timeliness, and use (1.5). For example:
    - improved knowledge and skills on use of immunization data to prevent, detect and respond to VPDs
    - improved knowledge and skills of facility, district, regional, and national immunization staff on how to triangulate immunization-related data from multiple data sources (e.g., administrative data, surveillance data, logistics data, survey data, etc.) and analyze, visualize, and interpret these data to inform immunization programs
    - strengthened interoperability and integration of EPI health information system to support data use and data quality improvement strategies
    - expanded evidence base on implementation of EPI information systems to inform development of operational tools, guidelines, and technical standards documents.
    - development of standardized templates for data management and analytics to use in routine EPI programs, VPD surveillance, and campaigns

Strategy 2. Support and continuously improve VPD surveillance systems in targeted sub-national areas

- Improved comprehensive VPD surveillance system capacity (across surveillance system functions) (2.1). For example:
    - trained staff in comprehensive VPD surveillance to perform supportive supervision of facility-based staff responsible for case detection and reporting
    - support for representative and complete detection of VPDs among the intended populations and geographic areas
    - strengthen and support integration of polio surveillance with other VPD surveillance systems

- Increased capacity to generate, interpret, and use VPD surveillance data (2.3). For example:
    - trained national and sub-national health staff in triangulation of multiple data sources
    - development of a workforce appropriately trained in surveillance core competencies, including data analysis and interpretation
    - support for the development of interoperability between VPD Surveillance, laboratory, and immunization information systems to support collection, analysis, sharing and programmatic use of data

Strategy 3. Prepare for and respond to VPD outbreaks in targeted sub-national areas

- Improved capacity, quality, and timeliness for VPD outbreak preparedness and response (3.2-3.3). For example:
    - periodic, standardized training delivered to front-line staff on outbreak detection, case investigation, and timely response
    - high quality immunization campaigns implemented immediately following outbreak declaration according to standard operating procedures
    - implementation of enhanced surveillance during outbreak response
    - work plans developed to prevent future outbreaks that address issues identified by root cause analysis
    - systems developed that ensure every child is reached with polio, measles and other VPD antigen campaigns

Strategy 4. Foster immunization program sustainability in targeted sub-national areas

- Increased capacity for and implementation of vaccine safety surveillance and response (4.3). For example:
    - staff trained in reporting and interpretation of passive surveillance data
    - active surveillance for AEFI has been established along with standard operating procedures for investigation and response
    - countries development of vaccine related event (VRE) plans to support local response to immunization safety concerns in a timely manner

- Improved immunization workforce development strategies implemented and evaluated (4.4). For example:

    - improved immunization program capacity to assess (e.g., improved capacity to conduct and interpret root cause analysis, rapid performance assessments) and improve workforce performance (e.g., supportive supervision, upskilling, reskilling, training, skills assessment, competency and position/career path alignment, etc.)
    - performance improvement strategies for immunization workforce identified, assessed, and scaled up
    - improved workforce capacity to generate and use immunization economic and financing information to inform immunization program planning, budgeting, and resource mobilization
    - improved understanding of immunization staff perceptions of safety

Strategy 5. Collaborate with Government and Implementation Partners

- Improved government and implementation partner coordination and communication (GISF Partnership-based principle). For example:
    - EPI managers at sub-national levels understand their immunization and PHC priorities and collaborate on interventions to address them

<u>Intermediate-Term Outcomes</u>

Strategy 1. Strengthen Immunization Services in targeted sub-national areas

- Increased identification of un-/ under-immunized populations (1.1)
- Improved tailored delivery strategies implemented to reach un- /under-immunized populations (1.1). For example:
    - using digitized maps to regularly update location of un- and under-immunized populations
    - proportion of un- /under-immunized populations reached, and uptake of immunization

- Increased demand for routine and campaign immunization services (1.2). For example:
    - increased vaccine confidence and demand in health authorities and communities
    - support periodic intensification of routine immunization to build immunity levels for polio and other antigens

- Improved access to, and utilization of, immunization across the life-course (1.3). For example:
    - catch-up and keep-up vaccination policies and strategies adopted and implemented
    - additional platforms across the life course established, strengthened and integrated into routine programming (e.g., second year of life, health care worker, school-based platforms and others)

- Increased number of new or under-utilized vaccines introduced (1.4). For example:
    - recommended new vaccines are introduced into the routine immunization schedule
    - new vaccine coverage data regularly monitored and used to target immunization activities

- Improved recording, reporting, and use of immunization program data (1.5). For example:
    - improved immunization campaign data quality and use

Strategy 2. Support and continuously improve VPD surveillance systems in targeted sub-national areas

- Improved comprehensive VPD surveillance system performance (2.1). For example:
    - increased sensitivity and timeliness of VPD case detection through active, comprehensive surveillance
    - faster detection of and response to VPD outbreaks through use of VPD surveillance data
- Increased use of VPD surveillance data to improve immunization program performance (2.1, 2.3).

Strategy 3. Prepare for and respond to VPD outbreaks in targeted sub-national areas

- Reduced number of large or disruptive VPD outbreaks (3.2-3.3). For example:
    - faster outbreak detection and response
    - reduced duration and magnitude of outbreaks

Strategy 4. Foster immunization program sustainability in targeted sub-national areas

- Improved effectiveness of immunization safety monitoring and risk communication (4.3). For example:
    - strengthened capacity among health care workers for prevention, identification, reporting and responding to serious AEFI
    - improved surveillance sensitivity for AEFI
    - improved capacity to respond to immunization safety concerns
- Improved capacity, performance, and accountability of immunization workforce (4.4). For example:
    - strengthened workforce performance
    - improved workforce capacity to estimate budgets, secure adequate and timely resources for immunization service delivery, and track budget execution

Strategy 5. Collaborate with Government and Implementation Partners

- Sustained coordination and collaboration between government and immunization partners (GISF Partnership-based principle). For example:
    - regular national-level meetings of the Interagency Coordinating Committee

iii. Strategies and Activities

For FY 2024-28, the specific sub-national geographies and immunization activities for implementation within the six countries (i.e., DRC, Nigeria, Ethiopia, the Philippines, Indonesia, and Brazil) will be identified in agreement between the CDC and host governments. Once impact is demonstrated (by defined annual monitoring and evaluation indicators, including but not limited to increased immunization coverage), additional funding and technical assistance may be

made available in future budget periods to expand the geographic footprint to other high-priority areas in these countries, in agreement between the CDC and host governments.

In the application, applicants are encouraged to use the examples of activities described below if they are appropriate to the applicant's proposed approach and their assessment of the needs in the relevant geographic area(s). Additionally, applicants may propose activities not listed below which are appropriate to the geographic area(s) and their suggested approach. All proposed activities must align with the logic model in the NOFO.

While all recipients are expected to carry out a mix of national and regionally focused activities, it is expected that recipients working in DRC, Nigeria, and Ethiopia will implement a greater proportion of locally focused activities than broader, national-level activities, and that recipients working in Indonesia, Brazil, and the Philippines will implement a greater proportion of national-level activities than locally focused activities.

Activities may include but are not limited to:

Strategy 1. Strengthen immunization services in targeted sub-national areas

- Characterize underserved populations with immunity gaps and implement tailored delivery strategies to reach them across the life-course (1.1)
    - Conduct regular microplanning (with digitization, when available) to accurately characterize underserved populations, plan for future immunization campaigns, and plan for mobile and outreach immunization services where possible.
    - Use tailored interventions to deliver polio, measles, and other recommended vaccines in settings with underserved, hard to reach or population in security compromised areas known for sustained VPD transmission
    - Implement tailored interventions to improve quality of immunization service delivery and responsiveness of services to community needs

- Enhance implementation of strategies that address barriers, facilitators, and solutions to improve demand and uptake of immunization (1.2)
    - Identify local barriers to equitable and high vaccine coverage through measuring the behavioral, social, and operational drivers of vaccination access, demand & uptake and utilizing this information to develop evidence-based strategies to improve vaccine uptake.
    - Measure behavioral and social determinants of vaccine uptake using context-appropriate tools such as surveys, rapid community assessments, and/or qualitative methods
    - Measure prevalence and trends in mis/disinformation through activities such as social listening and related insights generation
    - Evaluate the status of implementation of catch-up immunization guidelines/policies and make recommendations for strengthening
    - Tailor targeted vaccination interventions to improve uptake of and demand for immunizations based on identified barriers and community context
    - Develop and evaluate community-based strategies to improve demand for immunization and the quality and reach of vaccination services.
    - Develop and evaluate systems-based strategies such as building healthcare worker capacity for interpersonal communication/ motivational interviewing for

improving quality of caregiver/beneficiary interaction and improving vaccine demand and uptake among healthcare workers
    - Develop and evaluate strategies that incorporate addressing gender barriers to immunization at the caregiver level and health system level

- Introduce vaccines and monitor and evaluate post-introduction (1.4)
    - Provide technical assistance to National Immunization Technical Advisory Groups (NITAGs) for decision making on making recommendations for new vaccines.
    - Provide personnel support and technical assistance to targeted sub-national areas to introduce the recommended new and under-utilized vaccines.
    - Conduct post-introduction evaluations (PIEs) to generate evidence-based recommendations.
    - Conduct assessments of behavioral and social drivers to understand high and low performing areas.
    - Implement training for new vaccines introduction into routine immunization.

- Strengthen immunization data accuracy, timeliness, and use for decision-making (1.5)
    - Evaluate the accuracy, completeness, and timeliness of immunization data
    - Implement strategies – including tools to facilitate data entry, analysis, interpretation, and visualization - to improve the accuracy, completeness, and timeliness of immunization data
    - Strengthen use of immunization data to target program activities to prevent, detect, and respond to VPDs, including analysis with triangulation of multiple data sources where appropriate
    - Where appropriate, integrate immunization information systems with other health information systems and support data quality improvement strategies

Strategy 2. Support and continuously improve comprehensive VPD surveillance systems in targeted sub-national areas:

- Improve comprehensive VPD surveillance system capacity (across surveillance system functions) (2.1)
    - Support enhanced case detection through trained community informants and health-care workers, including training on VPD case reporting procedures and VPD case definitions
    - Strengthen timely specimen collection, transport to qualified laboratory national lab, testing, and result sharing
    - Support the implementation of innovative technologies (e.g., multi-bead assays, rapid diagnostic tests) for rapid detection of VPDs from specimens and the environment through operational research and technical assistance
    - Strengthen and sustain workforce capacity to test and report laboratory diagnostics from submitted specimens

- Increase capacity to generate, interpret, and use VPD surveillance data (2.3)
    - Support and strengthen sustained workforce capacity for improved VPD surveillance data quality, management, analysis and visualization (including

triangulation of multiple data sources), dissemination, and use, including for outbreak detection
    - Improve data linkages between VPD laboratories and surveillance units to facilitate analysis and visualization of surveillance data
    - Improve routine reporting of VPD surveillance data even in the absence of cases, i.e., zero case reporting

Strategy 3. Prepare for and respond to VPD outbreaks

- Improve capacity, quality, and timeliness in targeted sub-national areas for VPD outbreak preparedness and response (3.2-3.3)
    - Strengthen local workforce capacity for case detection and investigation, and response readiness, planning, implementation, and evaluation
    - Conduct risk assessments to identify populations and/or communities at high risk of VPD outbreaks and develop evidence-based recommendations to mitigate outbreak risk
    - Promote the use of data collected during supplemental immunization activities (SIAs) and geospatial data, where possible, to update microplans
    - Increase community awareness and participation in detecting and reporting potential VPD outbreaks
    - Support outbreak response immunization, evaluation, and development of quality improvement plans
    - Contribute to routine immunization and surveillance strengthening in the outbreak response settings, including identification and implementation of interventions to address root causes of outbreaks

Strategy 4. Foster immunization program sustainability in targeted sub-national areas:

- Increase capacity for and implementation of vaccine safety surveillance and response (4.3)
    - With local government, strengthen vaccine safety surveillance systems
    - Collect and analyze routine immunization safety monitoring data to improve immunization safety surveillance and response quality
    - Improve risk communication by developing and implementing vaccine-related event response plans
    - Implement innovative methodologies (including active surveillance for AEFIs) to collect, visualize, and analyze immunization surveillance data
    - Identify vaccine safety risks for special populations or settings as needed
    - Reduce barriers for reporting of AEFIs among frontline health care workers

- Improve immunization workforce development strategies to be implemented and evaluated (4.4)
    - Use evidence-based program-wide practices and approaches to strengthen workforce capacity. Focus areas include but are not limited to the following: supportive supervision, worker performance improvement, workforce preparedness during public health emergencies, health worker interactions with caregivers, gender equity, safety and motivation, and health worker vaccination.

- Identify, implement, and evaluate best practices; leverage opportunities (e.g., collaborations); and address gaps in workforce development strategies
- Identify and address factors (e.g., incentives and consequences) and strengthen tools and resources affecting workforce performance
- Improve the quality, use, and standardization of immunization workforce resources (e.g., assessments; management tools; standard operating procedures; trainings; job aids)
- Support immunization health workers and volunteers to effectively collaborate and coordinate with local communities
- Build capacity for the generation and use of economic and financial information, including economic evaluation of vaccination and immunization system interventions

Strategy 5. Collaborate with government and immunization partners

- Improve government and partner coordination and communication (GISF Partnership-based principle)
  - Strengthen the Interagency Coordinating Committee (ICC) by ensuring cross-partnership consensus on:
    - ICC mission, financial support, and standard operating procedures
    - Member representation, selection, and terms of reference
  - Support the government to convene the ICC, at least monthly, and regularly share meeting summaries and the status of follow-ups across immunization partners
  - Facilitate information sharing between and within MOH, partners, and non-governmental organizations (NGOs) to increase collaboration on VPD control/elimination/eradication, VPD surveillance, routine immunization and related data system activities
  - Participate in monitoring and evaluation of programs and activities in collaboration with MoH and partners

1. Collaborations

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

Recipient is expected to collaborate with other immunization partners including CDC programs and CDC-funded organizations. Organizations may include but not be limited to:

- WHO regional and country teams
- UNICEF regional and country teams
- International Federation of Red Cross and Red Crescent Societies (IFRC)
- African Field Epidemiology Network (AFENET)
- Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET)
- Eastern Mediterranean Public Health Network (EMPHNET)
- Stop Transmission of Polio Program (STOP)
- National Stop Transmission of Polio Program (NSTOP)
- Field Epidemiology Training Program (FETP)
- Integral Global Health and Integral Global Consulting (IGH/IGC)

- Global Health Development (GHD)
- CDC subject matter experts in other Centers and Offices (required when applicable)
- CDC staff in specific countries (required when applicable)
- CDC Incident Command leadership and staff (required when applicable)

b. With organizations not funded by CDC:
Recipient may collaborate with other organizations external to CDC as deemed necessary to achieve project outcomes. Example organizations may include but not be limited to:

- Bill & Melinda Gates Foundation
- Medecins Sans Frontieres (MSF)
- National Red Cross/Crescent Societies
- USAID
- Gavi, the Vaccine Alliance
- Rotary International
- Ministries of Health
- Other non-state actors/non-governmental organizations

Effective implementation will require close coordination with the government immediately following the award decision.

2. Population(s) of Focus
The CDC Global Health Equity Strategy builds upon CDC's global public health mission and agency-wide principles and goals. Health equity (HE) for CDC is realized when everyone can achieve their highest attainable level of health and no one is disadvantaged from achieving this potential because of social position or any other socially, economically, demographically, or geographically defined circumstances or physical condition.

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.

This NOFO supports GID's efforts to improve the health of populations disproportionately affected by VPDs by maximizing the health impact of immunization services, reducing disease prevalence, and promoting health equity by reducing or eliminating systematic disparities in health and healthcare systems and services. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage.

In an effort to ensure that activities funded through this NOFO (1) affirm and advance, as appropriate, the role of health equity and an equitable, diverse, and inclusive workforce as core principles, and (2) advance the reduction of stigma and discrimination through the promotion, consistent with applicable laws, of civil and human rights to improve the health outcomes in support of the elimination or reduction of vaccine preventable diseases, the awards resulting from this NOFO may address the following activities, where and when appropriate:

- Engage with local area organizations including establishing community boards. Support community level involvement in the design, implementation, monitoring of immunization and services targeting underserved and hard-to-reach populations.
- Engage with members of the community and use human centered design principles with sensitivity to local language, customs and culture to support activity success.
- Conduct training for implementing partners involved in the design, implementation, and/or monitoring of activities on stigma, discrimination, gender equitable norms, human rights, and community engagement to minimize the likelihood for activities that unintentionally increase stigma and discrimination of marginalized communities.
- Design, implement, monitor, and evaluate programs to address evidenced health disparities and social barriers.
- Use data to monitor disparities and implement strategies to improve access, service use, and outcomes.

For more information, visit: CDC Global Health Equity Strategy

iv. Funding Strategy

The geographic distribution of VPDs is widespread. This NOFO focuses on improving public health outcomes in six specific countries and, within those countries, targeted sub-national areas (also known as "consequential geographies") because those areas have experienced sustained transmission of specific VPDs, not achieved vaccine coverage targets, and/or have important unaddressed barriers to disease control or elimination goals. The sub-national areas and specific activities will be determined at the time of award by the current needs in-country in order to improve the morbidity and mortality from vaccine preventable diseases and target those who are most vulnerable (un- and under-vaccinated).

This 5-year NOFO is divided into six components. Each component is specific to the indicated country, including sub-national area(s) to be defined as follows:

1. DRC: Estimated annual funding is $10,000,000.
2. Ethiopia: Estimated annual funding is $10,000,000.
3. Nigeria: Estimated annual funding is $10,000,000.
4. Brazil: Estimated annual funding is $5,000,000.

5. Indonesia: Estimated annual funding is $5,000,000.
6. The Philippines: Estimated annual funding is $5,000,000.

This NOFO will provide funds for immunization activities at both the national level and in targeted sub-national areas. The proportion of funding awarded for activities conducted at the national level (versus the sub-national level) may be higher in Brazil, Indonesia, and the Philippines than in DRC, Ethiopia, and Nigeria. Overall funding amounts per country also reflect the need for larger amounts of funding in DRC, Ethiopia, and Nigeria, due to these countries having weaker immunization systems. For all countries, the bulk of funds will be awarded for sub-national activities.

Applicants are required to apply for work under at least one country component under the NOFO and may apply for multiple country components. For each country component proposal, the applicant must submit a separate and clearly marked project narrative including work plan, and a separate and clearly marked budget narrative. The work plan should be included with the project narrative for each country component, as described in section *D. Required Registrations, 11. Work Plan*. The budget narrative should be submitted as a separate attachment following the naming convention and guidance listed in section *D. Required Registrations, 12. Budget Narrative*. Applicants are encouraged to submit a country-specific budget(s) at or near the Year 1 estimated funding level as detailed above. Proposed Year 1 budgets should not exceed the Year 1 estimated funding level. Years 2-5 will be awarded on an annual basis after submission of a non-competing continuation application.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Strategy

The purpose of evaluation and performance measurement is to: (1) Monitor the extent to which activities were successfully completed; (2) Demonstrate progress toward achieving program outcomes (e.g., Were outcomes of interest described in the logic model achieved in targeted sub-national areas?); and (3) Inform decisions about future programming that drive continuous program improvement for more efficient and effective program performance (e.g., What and how could performance be improved?). Evaluation and performance measurement can also determine if the intended populations are reached. CDC's evaluation strategy is grounded in the CDC Evaluation Framework for Public Health, MMWR, September 18, 1999, Vol. 48 / No. RR-11.

CDC requires ongoing evaluation and performance measurement under this NOFO. CDC expects recipients to maintain sufficient staffing and analytic capacity to meet these requirements. With support from CDC, recipients will be required to submit a more detailed Evaluation and Performance Measurement Plan (EPMP) within the first 6 months of receiving the award, as described in the Reporting Section of this NOFO. 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 and for compliance with the monitoring and evaluation guidance established by CDC or other guidance otherwise applicable to this cooperative agreement. As a living document, the EPMP should be reviewed and can be updated on an annual basis to reflect changes resulting from program activities, feedback and lessons learned throughout the NOFO award period, and/or changing realities on the ground.

The primary objective of the EPMP implementation is to determine the progress of activities under this NOFO and indicate how they relate to the desired outcomes. A secondary objective of the EPMP is to track and report on expenditures of funds. The results will be used for program improvement, accountability and reporting. The data CDC collects for performance measurement and evaluation are directly related to the implementation of the strategies and/or the desired outcomes indicated in the logic model and may be used for sharing with partners and other stakeholders.

Performance Measures Monitoring:

The data reported to CDC should be related to the implementation of the strategies and/or the desired outcomes indicated in the NOFO logic model. Recipient should consider adaptations of the following proposed performance measures in Table 1 for monitoring the activities and outcomes described in the logic model. The following measures included in Table 1 are proposed and can be modified by the recipient in their proposal. Not all process measures included in the below table may be relevant for the recipient.

Table 1: Proposed Performance Measures for Activities

Outcome Number **(NOFO strategy)**	**Process indicators** **(Proposed process measures for the strategies and activities in the NOFO)** **All process indicators ate intended to measure activities supported with use of CDC funds.** *** *Implementation status to include a qualitative description of the progress the partner has made in implementing agreed upon activities, including barriers and facilitators to implementation.**	**Outcome indicators** **(Proposed outcome measures for the period of performance outcomes in the logic model)**
1.1 & 1.3 (Strategy 1)	1) Number and implementation status* of relevant activities. 2) Reports on microplan validation of accuracy and completeness. 3) Description of identified characteristics of underserved populations in targeted sub-national areas. 4) Number and description of targeted interventions employed to reach populations with each of the identified characteristics.	1) Number of zero-dose children in targeted sub-national geographies reached. 2) Percent of SIAs in targeted sub-national areas that reach greater than 90% coverage overall and greater than 50% coverage in un- or under-immunized children, as measured by independent coverage surveys 3) Breadth of protection in targeted sub-national areas: mean coverage for the following antigens recommended by WHO: Diphtheria, Tetanus, Pertussis, Hepatitis B, Hib, Measles, Measles

	5) Number of children reached with vaccination through targeted interventions, by antigen.	second dose, Pneumo, OPV, IPV, Rubella, Rotavirus, HPV. 4) Number of un- and under-immunized children identified that are added to routine immunization rosters in targeted sub-national areas.
1.2 (Strategy 1)	1) Number and implementation status* of relevant activities. 2) Number and description of community-based strategies implemented to improve demand for immunization. 3) Number of un- and under-immunized children reached through community-based strategies, by antigen. 4) List of identified barriers and facilitators to demand and uptake in targeted sub-national areas. 5) Description of strategies developed to improve vaccination uptake in targeted sub-national areas, including listing of identified barriers and community context addressed. 6) Change in prevalence/trends in mis/disinformation before and after supporting implementation of social listening activities in targeted sub-national areas. 7) List of insights generated from social listening activities in targeted sub-national areas 8) Change in healthcare worker capacity for interpersonal communication/ motivational interviewing following development and implementation of relevant activities. 9) Description of strategies and communities reached by incorporating addressing gender barriers into targeted immunization strategies in targeted sub-national areas.	1) Vaccine refusal rate related to implemented strategies to reach un- and under-served children in targeted sub-national areas.

1.4 (Strategy 1)	1) Number and implementation status* of related activities. 2) Post-introduction evaluation reports, including coverage assessments and list of recommendations generated. 3) Number of trainings conducted to support new and under-utilized vaccine introduction and description of content and participants. 4) Measured change in knowledge, attitudes, or practices of training participants.	1) Coverage of new and under-utilized vaccines introduced
1.5 (Strategy 1)	1) Number and implementation status* of related activities. 2) Evaluation report of accuracy, completeness, and timeliness of immunization data in targeted sub-national areas. 3) Number and description of strategies implemented and tools developed to facilitate data entry, analysis, interpretation, and visualization in targeted sub-national areas.	1) Change in immunization staff capacity following participation in informatics capacity-building activities supported with CDC funds. 2) Timely use of immunization data in targeted sub-national areas.
2.1 (Strategy 2)	1) Number of community informants and health-care workers trained on enhanced case detection. 2) Increased timeliness of specimen collection, transport to laboratory, testing and result sharing. 3) Number of innovative technologies implemented for rapid detection of VPDs from specimens and the environment. 4) Increased number of reports even in the absence of cases, i.e., zero case reporting, where applicable.	1) Non-measles/non-rubella discard rate (compared to target of ≥2/100,000) in targeted sub-national areas. 2) Non-polio acute flaccid paralysis (AFP) rate of >=2/100,000 among <15 years population in a 12-month period in targeted sub-national areas. 3) Timeliness and completeness of case-based VPD surveillance data, by VPD in targeted sub-national areas.
2.3 (Strategy 2)	1) Number and implementation status of relevant activities. 2) Reports on quality and completeness of VPD surveillance data in targeted sub-national areas.	1) Timeliness and completeness of VPD surveillance reports. 2) Change in knowledge, attitudes, and practices of healthcare workers related

	3) Data management plans generated. 4) Description of improvements made to data linkages between VPD laboratories and surveillance units. 5) Description of how surveillance data was used to improve outbreak detection, including success stories and barriers to use.	to generation, interpretation, and use of VPD surveillance data. 3) Retention of healthcare workers trained in data management and informatics in targeted sub-national areas.
3.2 & 3.3 (Strategy 3)	1) Number and proportion of VPD outbreaks in targeted sub-national areas with timely detection and response (IA2030 indicator), by VPD 2) Proportion of districts in targeted sub-national areas which are affected by large or disruptive outbreaks, by VPD. 3) Average timeliness of outbreak detection and response in targeted sub-national areas compared to disease-specific timeliness targets, as defined in IA2030 M&E framework.	1) Number and implementation status* of relevant activities. 2) Number of immunization workers trained in case detection and investigation, and response readiness, planning, implementation, and evaluation. 3) Risk assessment report, including the characteristics of populations and/or communities identified and geographic locations, level of risk, and recommendations. 4) Number of microplans that have been updated with recent SIA data and geospatial data. 5) Number of community informants trained in VPD case detection in targeted sub-national areas. 6) Number of suspected VPD cases reported by community informants to health facilities in targeted sub-national areas. 7) Number of quality improvement plans developed or updated to support outbreak response in targeted sub-national areas. 8) Description of interventions identified and implemented to address root causes of VPD outbreaks.
4.3 (Strategy 4)	1) In targeted sub-national areas, number of detected and assessed AEFIs.	1) Number of documented individual serious AEFI case safety reports (with reporting form and/or line list)

	2) In targeted sub-national areas, proportion of AEFI clusters with responses; and description of mitigation efforts of AEFIs on public confidence in immunization programs. 3) Percent of targeted sub-national areas with completed immunization safety surveillance assessment reports. 4) Number of staff trained on reporting and interpretation of passive surveillance data 5) Description of collaboration with local government in targeted sub-national areas to strengthen vaccine safety surveillance. 6) In targeted sub-national areas, number of active AEFI surveillance sites collecting data. 7) Description of identified safety risks for special populations or settings within targeted sub-national areas.	including, if relevant, data from sub-national areas. 2) Timeliness and completeness of immunization safety surveillance reports in targeted sub-national areas. 3) Increased case-based reporting of AEFI in targeted sub-national areas. 4) Increased national partner (e.g. EPI/regulatory) support for immunization safety surveillance
4.4 (Strategy 4)	1) Reports describing the outputs and findings of assessments conducted in targeted sub-national areas to identify workforce performance, factors influencing performance, and recommended actions (baseline/endline). 2) Number and type of training activities (e.g., formal group training, on-the-job training/supportive supervision, mentorship, sensitization) and quality check assistance. 3) Immunization workforce resources developed and used in targeted sub-national areas. 4) Number of immunization staff trained to generate and use economic and financial information in targeted sub-national areas.	1) Proportion of strategies developed, strengthened, or tailored with CDC funds that led to improvement in worker performance outputs and/or outcomes. 2) Measured improvements in immunization workforce skills, outputs, and/or practices.

Partnerships-based principle (Strategy 5)	1) Effective oversight and coordination of VPD activities with government, NGO and community-based partners aligned with ICC guidelines 2) Timeliness of information sharing of VPD activities with partners at the sub-national level	1) Reports with mission developed, type of financial support agreed upon between partners, and SOPs developed. 2) ICC Terms of Reference (TORs). 3) Situational awareness analysis/priority plans and actions for targeted sub-national areas. 4) Key indicators developed for monitoring VPD activities. 5) Evaluation outcomes and continuous quality improvement implemented. 7) Total number of ICC meetings per month at the national level and proportion that recipient supported government to convene. 8) Number of ICC meetings per month which had meetings disseminated among in-country partners.

Expenditure Monitoring:

Tracking and reporting expenditures of funds covering the 12 months of the Cooperative Agreement award year will be required for each budget period: interim expenditure reporting is to be submitted along with the annual progress report in the continuation application package, and final expenditure reporting is to be submitted 3 months after the close of the budget period along with annual report submission. Expenditure reporting must include any expenditure of funds carried over from a previous year. CDC has a sample template for expenditure reporting available upon request. Recipients are not required to use this template but must include disaggregation of expenditures by at least the minimum elements. The minimum elements required for expenditure reporting are: (i) object code/budget category (aligned with CDC budget categories), and (ii) geographic location of expenditures (i.e, global-level; regional-level with region name; country-level with country name, name of targeted sub-national area (as relevant)). Additional disaggregation of expenditures is not required; however, the additional disaggregation assists the CDC in reporting funding on a sub-national and strategic priority level. The additional reporting elements are: (iii) object code/budget category by geographic location (cross-tab), (iv) Immunization Agenda 2030 Strategic Priority, and (v) Logic Model Short- or Intermediate-Term Outcome.

Data Management Plan:

Since this NOFO does not involve the generation or collection of public health data, a Data Management Plan (DMP) is not required for this NOFO.

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.

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 DMP, if applicable, as new pertinent information becomes available, if applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual 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, 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 within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Work Plan

The work plan allows the CDC project officer to monitor implementation of activities and progress on project period outcomes. Applicants should provide a high-level work plan that covers the duration of the project, with more detail for the first year of the project period. The work plan must be country-specific, and if applicants are applying for work in more than one country, separate work plans are required. The work plan must include, at minimum:

- Activities and timelines to support achievement of NOFO outcomes. These activities must be in alignment with the NOFO logic model and have appropriate performance measures or milestones for accomplishing tasks.
- Staff and administrative roles and functions to support implementation of the award.
- Monitoring and evaluation plan to determine quality and effectiveness of program activities within each country (as per previous section).

A suggested work plan format is provided below. If using this format, the table should be completed for each project period outcome. If a particular activity leads to multiple outcomes, it should be described under each outcome measure. The format arranging the Workplan by outcome is intended to show how each proposed activity will feed into the outcomes.

Applicant may use a different work plan format (MS Excel format is preferred but not required) as long as it is 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.

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

c. Organizational Capacity of Recipients to Implement the Approach

The applicant must describe their experience in the following areas:

- Past and current engagement in immunization program implementation and staff presence in sub-national areas of country components for which the applicant is submitting their application(s) (e.g. Ethiopia, DRC, Nigeria, Brazil, Indonesia, and/or the Philippines).
    - Flexibility to work in any complex sub-national geography within each country, based on current trends as recommended by CDC in consultation with Ministries of Health. *Geographic prioritization may change over the course of the period of performance.
- Collaboration with immunization partners, public health programs, and National Ministries of Health in the country(ies)/component for which the applicant is applying.
    - **Implementation should be country driven based on defined technical and programmatic needs. Effective implementation will require close coordination with the government and CDC immediately following the award decision and for the duration of the agreement.
- Designing and implementing public health action and programs in geographies with complex challenges which may include, but are not limited to, the following:
    - mobile populations
    - IDPs
    - hard-to-reach areas (e.g., insecurity/conflict, geography)
    - difficulty in retaining high-performing health staff
    - geographic areas with large inflows/outflows of people to other countries resulting in exportation of VPD cases/outbreaks
    - vaccine hesitancy and/or inequitable or low access to care resulting in chronic areas of un- and under-immunized populations

- Immunization systems strengthening (including data systems, visualization, and use) and workforce performance improvement/development
- Routine immunization intensification and outreach programs, including vaccine demand and uptake
- Conducting outbreak response and strengthening surveillance of VPDs (including, but not limited to: poliovirus, measles, rubella, and neonatal tetanus)
- Key personnel with demonstrated immunization experience (e.g., routine immunization, surveillance, outbreak response) in a similar project or activity. Technical assistance will be required by award recipient.
- Conducting evaluation and performance monitoring
- Conducting budgeting, management, and administration activities
- Conducting personnel management activities

Applicants should be legally registered to work in countries for which the applicant is applying. The strongest candidates will have a minimum of 5 years of immunization experience working with the host Ministry of Health.

e. CDC Monitoring and Accountability Approach

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

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

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

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

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

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be

included in post-award monitoring for cooperative agreements, in the context of consequential geographies:

- 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 should 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 Cooperative Agreement Monitoring Activities:

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

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

CDC Approaches for Performance Measurement:

The recipient is required to collaborate with CDC in monitoring implementation of their programs and conducting evaluation activities, as needed, throughout the five-year period of performance. This includes:

- To conduct process and outcome evaluations of the funded activities.
    - Process Evaluation: Process evaluation will assess the extent to which the agreed NOFO activities have been implemented as planned. Limitations, barriers, and key success factors of the implementation will be explored. It is expected that this evaluation will be conducted during Years 2-3.
    - Outcome Evaluation: Outcome evaluation will be conducted to determine whether the funded activities are leading to the expected outcomes. It is expected that this evaluation will be conducted during Years 3-4.

- To finalize the evaluation protocols and plan for implementation at the designated timeframe, a system for collecting data over time to answer evaluation questions should be established during program implementation.
- To ensure that all evaluations are consistent with established frameworks and program specific requirements. Submission of Non-research Determination (NRD) CDC-ADS for ethical clearance is required. CDC will assist the submission process.
- To report the evaluation findings to relevant stakeholders and will make these publicly available to enhance the utilization of the findings to improve program effectiveness, and continued program improvement upon completion of the award.
- To identify and develop impact statements and/or success stories arising from their programs.

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

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

f. CDC Program Support to Recipients

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

- Providing technical assistance to recipient in support of the activities implemented under this NOFO.
- Supporting the recipient to effectively plan, design, implement, and monitor activities under this NOFO.
- Collaborating with the recipient in the identification and analysis of CGs, including potential evolution in the designated CGs throughout the 5 year implementation period.
- Collaborating with recipient to provide programmatic support to national and sub-national governments for planning, implementing, and evaluating polio eradication, measles and rubella elimination and other globally agreed-upon VPD control activities.
- Assisting in providing technical training, support, and consultation to expert staff hired by recipient to assist in the polio eradication, measles and rubella elimination and Global Vaccine Action Plan strategies.

- Providing expertise for the maintenance and development of disease surveillance structures, including assessment, strategy design, evaluation and assistance in priority countries.
- Providing laboratory expertise to recipient for the strengthening and expansion of laboratory-based surveillance systems.

Collaborating with and providing technical assistance to recipient to determine appropriate strategies to address other mutually agreed global health priorities that may be addressed through this agreement, as required.

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:
U66 - Immunization Demonstration Projects Cooperative Agreements

3. Fiscal Year:
2024

Estimated Total Funding:
$225,000,000

4. Approximate Total Fiscal Year Funding:
$45,000,000
This amount is subject to the availability of funds.

5. Approximate Period of Performance Funding:
$225,000,000

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

7. Expected Number of Awards:
12
Up to 12 applicants may be awarded with a maximum of two awards per country component.

8. Approximate Average Award:

$7,500,000
Per Budget Period

The average annual award amount varies, depending on the country. Estimated annual funding per country:

1. DRC: $10,000,000
2. Ethiopia: $10,000,000

3. Nigeria: $10,000,000
4. Brazil: $5,000,000
5. Indonesia: $5,000,000
6. The Philippines: $5,000,000

9. Award Ceiling:
$0
Per Budget Period

10. Award Floor:
$0
Per Budget Period

11. Estimated Award Date:
May 01, 2024

12. Budget Period Length:
12 month(s)

Throughout the period of performance, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (period of performance) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance
Direct Assistance (DA) is 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)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

05 (Independent school districts)

06 (Public and State controlled institutions of higher education)

07 (Native American tribal governments (Federally recognized))

08 (Public housing authorities/Indian housing authorities)

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

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

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

20 (Private institutions of higher education)

22 (For profit organizations other than small businesses)

23 (Small businesses)

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

Additional Eligibility Category:

Government Organizations:

State (includes the District of Columbia)

Local governments or their bona fide agents

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

State controlled institutions of higher education

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

American Indian or Alaska native tribally designated organizations

Other:

Private colleges and universities

Community-based organizations

Faith-based organizations

2. Additional Information on Eligibility

- Ministries of Health (MOH) are eligible to apply and should follow instructions for Block 9 of the SF424. They must select option X: Other from the drop-down list in block 9. The MOH applicant will fill in the Other field. The applicant should describe their organization as a MOH.
- **All applications will be reviewed for responsiveness:** Applicants are required to apply for work under at least one country component and may apply for multiple country components. For each country component, the applicant must submit separate project and

budget narrative. The work plan should be included with the project narrative for each country component, as described in section *D. Required Registrations, 11. Work Plan*. The itemized country-specific budget narrative should be submitted as an attachment using the naming convention and guidance in section *D. Required Registrations, 12. Budget Narrative*.

- Applications not including country-specific project narratives with work plan, and country-specific budget narratives, will be non-responsive and not reviewed.
- Late submissions will be non-responsive and not be reviewed further. See section *D. Required Registrations, part 4. Submission Dates and Times*, for the application deadline. See section *15. d. Technical difficulties* and *15. e. Paper Submission* for additional information. Requests for paper application must be received 3 days prior to the application deadline.
- The applicant's proposed budget for year one must not exceed the estimated annual funding of each component listed in section *B. Award Information*. If a funding amount exceeds the estimated amount of the country component, the application will be considered non-responsive and not reviewed.
- Applicants must prepare a single application including all countries for which they wish to apply. The application must specify the country on the title page of each project narrative. Applicants must specify the country(ies) in the project title in Block 15 of the SF424. Applicants must use the SF424 at link: http://apply07.grants.gov/apply/forms/sample/SF424_2_1-V2.1.pdf. Failure to indicate the country on the title page of the project narrative will result in non-responsive determination.
- Applicants must abide by the page number limitation in section *D. Required Registrations, 10. Project Narrative*. Any pages above the number of pages listed for the project narrative will not be reviewed.
- Appendices must have page numbers and be identified in the Table of Contents as appendices.

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:
No

5. Maintenance of Effort

Maintenance of Effort is not required for this program.

D. Application and Submission Information

1. Required Registrations

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

PLEASE NOTE: Effective April 4, 2022, applicants must have a Unique Entity Identifier (UEI) at the time of application submission (SF-424, field 8c). The UEI is generated as part of

SAM.gov registration. Current SAM.gov registrants have already been assigned their UEI and can view it in SAM.gov and Grants.gov. Additional information is available on the GSA website, SAM.gov, and Grants.gov- Finding the UEI.

a. Unique Entity Identifier (UEI):

All applicant organizations must obtain a Unique Entity Identifier (UEI) number associated with your organization's physical location prior to submitting an application. A UEI number is a unique twelve-digit identification number assigned through SAM.gov registration. Some organizations may have multiple UEI numbers. Use the UEI number associated with the location of the organization receiving the federal funds.

b. System for Award Management (SAM):

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

c. Grants.gov: The first step in submitting an application online is registering your organization atwww.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option atwww.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	Allow at least one business day (after you enter the EBiz POC name and EBiz POC	Register early! Applicants can

		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.	email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	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 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)

Due Date for Letter Of Intent 01/26/2024

01/26/2024

A Letter of Intent (LOI) is requested but not required. The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications. If known, the LOI should include the country component(s) to which the applicant will apply.

LOI must be sent via email to:

Karen Clackum

CDC, CGH

Email address: KClackum@cdc.gov

b. Application Deadline

Due Date for Applications 03/04/2024

03/04/2024

11:59 pm U.S. Eastern Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which Grants.gov operations resume.

*****5. Pre-Award Assessments - Risk Assessment Questionnaire Requirement*****

CDC has retired the Risk Assessment Questionnaire Requirement and applicants are no longer required to submit the CDC Risk Questionnaire as part of their NOFO application. CDC continues to conduct the review of risk posed by applicants as described in the Review and Selection Process. We may ask for additional information prior to the award based on the results of the review. Risk Questionnaires that are submitted will not be included in this risk review.

Due Date for Informational Conference Call

CDC will host two informational calls for interested applicants. The content of both calls will be identical. Questions and answers from each session will be compiled and amended in the NOFO. The two times are offered as a way to help accommodate the schedules of interested applicants and their locations in varying time zones. Due to limited space, applicants should only register for Webinar 1 or 2, but not both.

- When: Jan 17, 2024 8:00 AM Eastern Time (US and Canada)
- Topic: Informational Call #1 - NOFO CDC-RFA-GH-24-0058
- Register in advance for this webinar: https://cdc.zoomgov.com/webinar/register/WN_1eM6P8ROScyZKO80ehGzLA

- When: Jan 17, 2024 8:00 PM Eastern Time (US and Canada)
- Topic: Informational Call #2 - NOFO CDC-RFA-GH-24-0058
- Register in advance for this webinar: https://cdc.zoomgov.com/webinar/register/WN_MeU7BbDGTEKGiP91d6hJMw

5. Pre-Award Assessments

Duplication of Efforts

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

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

6. Content and Form of Application Submission

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

7. Letter of Intent

Is a LOI:
Recommended but not Required

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

Multi-component NOFOs may have a maximum of 15 pages for the “base” (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for

Project Narrative subsections that are specific to each component.

Text should be single spaced, 12 point font, 1-inch margins, and number all pages. Page limits include work plan; content beyond specified limits may not be reviewed.

Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity Announcement. 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.

Page Limitations - Applications have a maximum of 20 pages per country applied for in this NOFO. Page limits include the project narrative/work plan for each country. Any additional pages beyond 20 for the project narrative/work plan for a country will not be reviewed.

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 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. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain). (See the logic model in the Approach section of the CDC Project Description.)

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 CDC Project Description: Strategies and Activities section.)

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 public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. These goals may include supporting vital records offices participating in the Vital Records and Health Statistics Accreditation Program, certifying vital records offices to meet industry standards. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; provide financial assistance to support accreditation related fees and/or support staff time to coordinate accreditation activities; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and can upload it as a PDF, Word or Excel file format at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect

cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

13. 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/.

13a. 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.

13b. 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.

13c. 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.

14. 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.

15. Intergovernmental Review

16. Other Submission Requirements

a. Electronic Submission: Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity atwww.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 whenwww.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 bywww.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 atwww.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 thatwww.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call thewww.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 the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

b. Phase II Review

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

i. Approach

ii. Evaluation and Performance Measurement

iii. Applicant's Organizational Capacity to Implement the Approach

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

i. Approach **Maximum Points:** 40

Criteria applies to all country components.

- To what extent does the applicant define and demonstrate an understanding of the public health problems relevant under this NOFO? (10 points)
- To what extent does the applicant describe an approach and activities that will leverage and strengthen existing public health systems? (5 points)
- To what extent does the applicant describe how they will coordinate activities with and build the capacity of the ministry(-ies) of health and/or other relevant host government institutions? (5 points)
- To what extent does the applicant describe activities that are tailored to and appropriate for the given context (e.g., sub-national locations)? (10 points)

- To what extent does the applicant describe activities that are evidence-based, achievable, and linked to the specified outcomes? (10 points)

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

Criteria applies to all country components.

- To what extent does the applicant demonstrate a system and process to meet administrative, technical, and programmatic reporting requirements as stated in the NOFO? (10 points)
- Are performance measures (i.e., indicators) defined in the NOFO incorporated into proposed financial and programmatic reports and are reasonable programmatic milestones included in the submission? (5 points)
- To what extent does the applicant demonstrate a system able to generate financial and program reports to show disbursement of funds and spending towards achieving the objectives of this NOFO? (5 points)
- To what extent does the applicant demonstrate a process for and ability to use monitoring data for quality improvement of subsequent (i.e., Years 2-5) activities and interventions? (5 points)

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 35

Criteria applies to all country components.

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

- How well does the applicant describe past and current engagement and staff presence in sub-national areas of the CG, including the flexibility to work in any complex sub-national geography? (5 points)
- How well does the applicant describe experience collaborating in immunization programs with priority country national and sub-national governments and immunization partners in complex settings? (5 points)
- How well does the applicant describe accomplishments in addressing and implementing immunization systems strengthening needs and immunization-related activities (including workforce development, improving immunization coverage, outbreak response, and surveillance strengthening) in national and sub-national settings? (5 points)
- To what extent does the applicant provide clear monitoring and evaluation procedures and how evaluation and performance measurement will be incorporated into the planning and implementation, and reporting of project activities? (5 points)
- To what extent does the applicant provide a staffing plan, organizational chart, and project management structure that will be sufficient to meet the goals of the proposed immunization activities in the defined consequential geographies, and which clearly defines staff roles? (5 points)
- To what extent are key staff involved in the project qualified to provide leadership, technical and management expertise required for effective and efficient program implementation? (Reference Key Staff Curriculum Vitae) (5 points)
- To what extent does the applicant describe the ability to manage financial reporting, budget management and administration of personnel, as well as management of grants and contracts? (5 points)

- A strong applicant will demonstrate key personnel multi-year immunization experience at national and sub-national levels

Budget **Maximum Points:** 0

Criteria applies to all country components.

- Is the itemized budget for conducting the project, along with justification, reasonable and consistent with stated objectives, planned program activities, and goals of the Global Immunization Strategic Framework?

Applicants must only apply for the first budget period funding.The proposed budget for the first budget period must not exceed the estimated annual funding for the component. If a funding amount greater than the estimated annual funding for the component is requested, the application will be considered non-responsive and will not be entered into the review process.

c. Phase III Review

Applications will be reviewed and scored based on direct consideration of the findings from an Objective Review Panel. Final decisions on partners and activities to be funded will be made at the time of award.

Applications which were approved but unfunded (ABU) will remain on file for a period of 12 months after the date the first award is issued. If additional funding becomes available during the 12-month period, CDC may elect to fund ABU applications.

The following factor may affect an applicant's final score:

Funding Preference Points: 10

Funding Preference 1: Preference for local organizations located within the country(-ies) for which the applicant is applying. **(10 points)**

Local partners are encouraged to apply. Applicants wishing to demonstrate that they meet the definition of a local partner below must submit supporting documentation and a narrative letter by and through an authorized representative on the organization's official letterhead. This documentation must demonstrate how the prime application organization meets one or more of the criteria below:

1. Individual: An individual must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country in which the individual is or may become involved, and a sole proprietorship must be owned by such an individual, or
2. Entity other than a sole proprietorship (such as, a corporation or not-for-profit) must meet all three areas of eligibility:
    a. either must be incorporated or legally organized under the laws of, and have its principal place of business in the country with which the entity is involved OR must exist in the country where the entity's funded program is implemented.
    b. either must be at 75% beneficially owned at the time of the application by individuals who are citizens or lawfully admitted permanent residents of the county, OR at least 75% of the entity's staff (senior, mid-level, support) at the

time of application must be citizens or lawfully admitted permanent residents of the county, and

c. where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of the country.

3. Government Ministries and Parastatals: Partner government ministries (e.g., Ministry of Health), subunits of government ministries, and parastatal organizations in the country are considered local partners. A parastatal organization may be fully or partially government-owned or government-funded organization. Such enterprises may function through a board of directors, like private corporations.

Deliverable 1: Legal documentation supporting organization type and location, along with narrative letter

Label for Deliverable 1: Funding preference as local organization

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

CDC retains the option to fund partners and activities out of rank order to 1) respond to an unforeseen public health emergency; 2) align with USG and/or agency-prioritized technical areas, activities, and geographies; 3) align with funding availability at the time of award; and 4) avoid duplication of activities with other CDC funding mechanisms.

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

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

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207. CDC’s review of risk may impact reward eligibility.

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

(1) Financial stability;

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

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

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

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

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

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

2. Announcement and Anticipated Award Dates

The anticipated announcement date is December 29, 2023. The anticipated award date is May 1, 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.

The following Administrative Requirements (AR) apply to this project:

Generally applicable ARs:

NOTE: AR-37 is required on all NOFOs

- *AR-1: Human Subjects Requirements*
- *AR-8: Public Health System Reporting Requirements*
- *AR-10: Smoke-Free Workplace Requirements*
- *AR-11: Healthy People 2030*
- *AR-12: Lobbying Restrictions*
- *AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities*
- *AR-14: Accounting System Requirements*
- *AR-15: Proof of Non-profit Status*
- *AR-23: Compliance with 45 CFR Part 87*
- *AR-25: Data Management and Access*
- *AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020*

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

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS will be required to complete an HHS Assurance of Compliance form (HHS 690) in which you agree, as a condition of receiving the grant, to administer your programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, sex and disability, and agreeing to comply with federal conscience laws, where applicable. This includes ensuring that entities take meaningful steps to provide meaningful access to persons with limited English proficiency; and ensuring effective communication with persons with disabilities. Where applicable, Title XI and Section 1557 prohibit discrimination on the basis of sexual orientation, and gender identity. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider- obligations/index.html and https://www.hhs.gov/civil-rights/for- individuals/nondiscrimination/index.html.

- For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.

- HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.

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	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	Performance measures and reporting timelines will be agreed upon within 6 months	Yes

	of award, as defined in the final Evaluation and Performance Measurement Plan. Annually, an interim report of Data on Performance Measures will be required with the APR; a final annual report will be due 90 days after the end of the budget period. Expenditure Analysis will be required annually.	
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 than120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

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

- Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.

- **Administrative Reporting** (No page limit)
  - SF-424A Budget Information-Non-Construction Programs.
  - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
  - Indirect Cost Rate Agreement.

The recipient must submit the Annual Performance Report via https://www.grantsolutions.gov 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).

no additional requirements

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 NOFO.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
Karen

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

Address:

Telephone:

Email:
KClackum@cdc.gov

Grants Management Office Information

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

First Name:
Rhonda

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

Address:

Telephone:

Email:
ito1@cdc.gov
For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

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

H. Other Information

Following is a list of acceptable attachments **applicants** that can be uploaded as a PDF, Word, or Excel file format 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

Non-profit organization IRS status forms, if applicable

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

Questions and Answers regarding the NOFO:

Administrative questions	
Project Narrative/Page limits	
Question	**Answer**
What is the page limitation for applicants that are intending to work in more than one country (component)? For applicants that are intending to work in more than one country, should applicants still prepare a single project narrative that includes a) background, b) approach, c) applicant evaluation and performance measurement	The page limitation per country component applied for is 20 for the project narrative. For each country component proposal, a separate project narrative including the work plan are required and must be clearly labeled.

plan, d) organizational capacity of applicants to implement the approach, and the work plan(s)?	
On page 30, CDC discusses page limitation for multi-component applicants. The notice of funding states that, “Multi-component NOFOs may have a maximum of 15 pages for the “base” (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for Project Narrative subsections that are specific to each component”. Can you please clarify the relationship between the page 15 base plus four additional pages per component and the 20-page limitation for the single project narrative?	The section of the NOFO listed above noting a 15-page limit is standard language in our NOFO templates and could not be edited or deleted. This sentence should be disregarded. The page limit for each country component's project narrative is 20 pages
On page 39 of the NOFO it states, "Multi-component NOFOs may have a maximum of 15 pages for the 'base' (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for Project Narrative subsections that are specific to each component." This requirement indicates that applications may have a maximum of 19 pages for an application for one country. However, later on page 39, the NOFO states, "Page Limitations - Applications have a maximum of 20 pages per country applied for in this NOFO." Please clarify the	Maximum is 20 pages for Project Narrative.

page count requirements for this application.	
On page 39 of the NOFO it states, "Multi-component NOFOs may have a maximum of 15 pages for the 'base' (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to 4 additional pages per component for Project Narrative subsections that are specific to each component." However, later on page 39, the NOFO states, "Page Limitations - Applications have a maximum of 20 pages per country applied for in this NOFO." If an applicant is applying for two countries, please confirm that the applicant should submit one country's project narrative, which is immediately followed by the other country's project narrative. Or, should the applicant submit the content simultaneously, such as describing the Population(s) of Focus and Health Disparities for both countries together in one section?	The verbiage for the 15 pages for the "base" should be disregarded. Applications for each country component should include all required documents in one "package", clearly labeled, so that objective reviewers can review only one country at a time. For example, each country application should have its own project narrative, budget narrative, appendix, table of contents, etc.
For formatting the proposal submission, does the page limit for the project narrative expand to 15 pages + 4 additional pages per country or should separate documents/narratives be submitted for the base and for each separate country applied for? Mainly inquiring if the activities can be integrated in the project narrative	The verbiage for the 15 pages for the "base" should be disregarded. Applications for each country component should include all required documents in one "package", clearly labeled, so that objective reviewers can review only one country at a time. For example, each country application should have its own project narrative, budget narrative, appendix, table of contents, etc.

and submission for all countries as they fall under the same strategies	
Please clarify the number of pages allowed for each country specific submission - Is it 4 or 20 pages?	Project narratives (which include work plans) for each country have a 20-page limit.
Can you clarify the number of pages allowed for each country submission, is it 4 pages or narrative or 20?	20 pages for project narrative
Per page 20, “Applicants are required to apply for work under at least one country component under the NOFO and may apply for multiple country components. For each country component proposal, the applicant must submit a separate and clearly marked project narrative including work plan and budget.” For applicants responding to multiple country components, could CDC clarify how this will work when we upload the documents into the grants.gov package. Is it multiple country component proposals within one grants.gov package (with each country component’s name listed in the uploaded attachment)? For the project abstract and budget summary sections of the grants.gov package will there be different sections per country?	Each country component applied for should include a separate table of contents, project narrative, budget narrative, and appendix, with all attachments clearly labeled with the country name. For the budget form SF424-A, each country budget should be listed in one of the four columns/rows designated for components. If an applicant is applying to more than four country components, a separate SF424-A form will need to be completed and attached for the budgets for the additional country components. The Project Abstract Summary form should list the names of all country components applying for in the Project Abstract field.
For applicants responding to multiple country components, could CDC clarify how this will work when we upload the documents into the grants.gov package. Is it multiple country component proposals within one grants.gov package (with each country component’s name listed	(see previous answer above)

in the uploaded attachment e-file name? How should we upload on screens with one page e.g., budget summary.	
Is the organizational capacity included in the 20 page limit and can a more detailed version be included in the appendix?	Yes, organizational capacity of applicants to implement the approach is part of the 20-page limit in the Project Narrative. Yes, a more detailed version may be included in the appendix.
We observed that the NOFO document does not explicitly mention the inclusion of the organizational capacity and MEL Sections within the page limit of the primary document for submission. Could these sections be incorporated into the appendix? Furthermore, could you provide clarity on the specific expectations for the content in the appendix, outlining both inclusions and exclusions?	All items listed in the NOFO under 10. Project Narrative (a thru d) are required to be included in the Project Narrative. This includes the organizational capacity and the EPMP. If necessary, a more detailed version of either may be included in the appendix.
If applying for more than one component, should we have a different table of contents for each component?	Yes
Please clarify, for each component, are we required to submit a 20 page project narrative with all sections-background, approach, outcomes, strategies and activities, M&E, workplan and organization capacity?	Yes
Page 35 of 67 references a Title Page for the Project Narrative. Is it correct to assume this title page is not included in the 20-page limit? Is there required information for the title page in addition to the name of the country in which we propose to work? Is there a required format/template for the title page?	A separate title page in the project narrative is not required. The first page of the project narrative can be used to place the title of the country at the top/heading.

May we submit a list of acronyms for the project narrative? Can this list be submitted in the Appendix?	Yes, a list of acronyms for the project narrative may be submitted and can be included in the Appendix, as long as there is a note in the project narrative to reference the list of acronyms in the appendix.
Budget Narrative, Budget questions	
Page 18 of the RFA indicates that applicants "must submit a separate and clearly marked project narrative including work plan and budget." However, further on in the RFA, including on page 18 and under the Responsiveness Criteria on page 34 it indicates that applicants "must submit a separate and clearly marked project narrative including workplan and budget narrative." Additionally, section H indicates only a budget narrative is included in the list of acceptable attachments for submission. Could you please confirm that applicants are only required to submit a budget narrative and that a budget is not required?	A budget narrative is required and is uploaded as an attachment with the application submission. While not required, the budget spreadsheet is strongly encouraged. The budget spreadsheet may either be uploaded as an attachment or included in the appendix.
Section D.10 (page 39) indicates that page limitations of 20 pages per county apply and include the work plan and project narrative. Could you please clarify if the budget narrative is in addition to the 20 pages for the work plan and project narrative or if the 20 pages is inclusive of the budget narrative?	The budget narrative is not included in the project narrative. The budget narrative is submitted as a separate document.
Could you please confirm if there is a template for the budget narrative and if applicable, the budget? For the budget, can you please confirm that a high-level line item budget and/or budget narrative is expected and not a full detailed budget?	The detailed line-item budget information should include all the costs associated with implementing the proposed work plan, acknowledging that it will need to be revised once subnational areas and actives are decided after awards are made. While there is not a template for the budget narrative or the budget, the CDC Budget Guidelines has been added to the attachments/additional documents link in the NOFO. A budget spreadsheet, while not required, is encouraged and may either be uploaded as an attachment or included in the appendix.

Do we have specific budget template (detailed)?	While there is not a template for the detailed budget, the CDC Budget Guidelines has been added to the attachments/additional documents link in the NOFO. A budget spreadsheet, while not required, is encouraged and may either be uploaded as an attachment or included in the appendix.
Normally in the application package, the budget and the budget narrative are uploaded onto a different form from the rest of the appendices. Is the format different for this NOFO?	The Budget Narrative is required and is uploaded as an attachment with the application submission. The budget spreadsheet, while not required, is encouraged and may either be uploaded as an attachment or included in the appendix.
Based on guidance in section D.12, it is envisioned that subcontractors would be included under the Contractual Costs line. Could you please confirm that a summary description by the lead bidder outlining the subcontractors envisioned is sufficient and that separate budget narratives for each subcontractor are not needed?	Separate budget narratives for each subcontractor are not required for the application.
Section E.1(b) indicates that a maximum of 0 points may be awarded for the Budget. Could you please confirm if it is correct that the budgetary components of the proposal are not being assigned a weight when it comes to assessing proposals during Phase II review?	Budgets are not scored or assigned a weight. Objective reviewers may review budgets and provide comments, but there is no scoring of budgets.
Page limits for appendices	
Can CDC please clarify what is expected and allowable in the 20-page appendix for the technical narrative, and whether the budget narrative is a separate document or if it must be included in that same page limit? If it is included in that singular appendix, this will not leave adequate space for required materials such as CVs, financial management statements, and experience that are required and	The appendix will no longer have a page limit. All supporting documents for the application (CVs, Position Descriptions, Letters of Support, Org Charts, NICRAs, etc.) may be included in the appendix or uploaded as separate attachments. Funding preference deliverables, if applicable, should be placed in the appendix. All documents in the appendices should be clearly labeled and include page numbers.

typically included in the appendix of the technical narrative.	
We understand that the 20 page limit for appendices will be removed. Can you provide a list of required appendices in addition to the Budget Narrative and Funding Preference Deliverable? We also understand we may now submit CVs, Letters of Support, and Legal Registrations if applicable in the Appendix. Is this correct?	The appendix will no longer have a page limit. All supporting documents for the application (CVs, Position Descriptions, Letters of Support, Org Charts, NICRAs, etc.) may be included in the appendix or uploaded as separate attachments. Funding preference deliverables, if applicable, should be placed in the appendix. All documents in the appendices should be clearly labeled and include page numbers.
On page 48 the scoring criteria reference the need for Key Staff CVs and organizational charts - can these be included within the 20 pages allotted for appendices?	Yes; the page limit for appendices is being removed.
Can CDC clarify whether job descriptions for key personnel are required? If so, are they meant to be a part of the 20 pages for appendices?	Position descriptions are not required but may be included either in the appendices or uploaded as an attachment. The page limit for appendices is being removed.
Can CDC clarify whether financial management statements are required? If so, is it meant to be a part of the 20 pages for appendices?	Financial management statements are not required but may be included either in the appendices or uploaded as an attachment. The page limit for appendices is being removed.
Can CDC clarify whether a statement of experience or organizational capacity is required? If so, is it meant to be a part of the 20 pages for appendices?	Statement of experience or organizational capacity is not required; however, some evidence of organizational capacity should be given to support the criteria listed under the Phase II review. These documents may be included in the appendices. The page limit for appendices is being removed.
If any of the previous items are required, would CDC consider whether the 20-page limit can be expanded to accommodate these requirements?	Answered previously.
Pages 58-59 lists the acceptable attachments for applications. The NOFO states on page 59 that	Yes, resumes and/or biographies of key personnel and letters of support are acceptable as attachments.The NOFO will be updated to include these as acceptable attachments.

"documents other than those listed; if other documents are attached, applications will not be reviewed." Will the CDC consider allowing resumes and/or biographies of key personnel as acceptable attachments? What about letters of support?	
May we submit a list of references/Endnotes as an Appendix?	Yes
Requirements for organizations legally registered in country	
On page 29 of the NOFO, it states the following, "Applicants should be legally registered to work in countries for which the applicant is applying and have a minimum of 5 years of immunization experience working with the host Ministry of Health." Please clarify whether the definition of "applicants" is applicable to the prime awardees, subrecipients, or both.	The strongest candidates will have a minimum of 5 years of immunization experience working with the host government. The candidates may include both awardees and subrecipients.
If the prime applicant is applying with consortium partners and the prime is not legally registered in country but a consortium partner is, will that qualify the application for implementation in that country?	Yes, at least one partner in a joint application should be legally registered in the country.
(Page 48) If the primary application organization is international but will be working with subs that are local partners - do the subs need to "to demonstrate that they meet the definition of a local partner below must submit supporting documentation and a narrative letter by and through an authorized representative on the organization's official letterhead."	At least one partner in a joint application should be legally registered in the country.

Related to question 5, If an organization applies with a local partner in a country where they are not registered, does the local partner's presence in the country suffice?	At least one partner in a joint application should be legally registered in the country.
Can the requirements of strong expertise working in immunization program can reside on a sub-recipient and not on its prime applicant? This expert sub-recipient has this significant immunization expertise in the targeted country. Please advise	At least one partner in a joint application should meet the requirements for strong expertise working in immunization programs.
Does the prime have to be registered in country?	At least one partner in a joint application should be legally registered in the country.
Is an US based international organization working in target countries eligible to apply as prime/lead?	At least one partner in a joint application should be legally registered in the country.
If prime applicant intends to collaborate with in country partners, do those partners need to submit any application to CDC or does CDC expect only an application from the prime applicant.	We only need one application, which can include multiple partners.
On page 29 of the NOFO, it states the following, "Applicants should be legally registered to work in countries for which the applicant is applying and have a minimum of 5 years of immunization experience working with the host Ministry of Health." Please clarify whether the CDC will accept immunization experience working with organizations at the subnational level to satisfy this requirement.	At least one partner in a joint application should meet the requirements for strong expertise working in immunization programs at either the country or subnational levels.
On page 29 of the NOFO, it states the following, "Applicants should be legally registered to work in countries for which the applicant	At least one partner in a joint application should be legally registered in the country.

is applying." Please clarify whether the prime, subrecipients, or both are required to be legally registered to work in the countries in which the applicant is applying.	
can we get clarification on if lead applicant not registered in target country eligible to apply?	See previous responses
Is the requirement for local registration an eligibility requirement or a scored variable? Is it required for a primary applicant in a consortium application or for all or perhaps for at least one of the consortium members?	At least one partner in a joint application should be legally registered in the country. Funding preference of 10 additional points in the Phase III Review is allowable for local organizations located within the country.
Under C. Phase III Review (page 48), there is a funding preference to local organizations worth 10 points. Is a local organization who primes an application allowed to have an international subgrantee and still receive these points?	If the prime is a local organization located within the country to which the applicant is applying, they would qualify for 10 additional points in the Phase III Review, assuming the required documentation is provided. If the prime is submitting a joint application with other partners and one of the partners meets the local organization criteria, the prime's application would still qualify for 10 additional points, according to the requirements in the Phase III Review section of the NOFO.
a) Can MoH be part of a consortium partnering with a NGO? b) If yes, in that case, does the MoH need to be the prime applicant or needs to be sub?	Yes; MOH can be either the prime applicant or the sub.
Can host governments included in the NOFO be applicants or co-applicants on submitted proposals?	Yes
Is it ok to partner with a Ministerial partner to the application even though they may be in the decision process for sub national priorities?	Yes, MOH's are eligible to submit applications for this NOFO. MOH's will work with CDC to determine subnational areas and activities only after awards have been made.
Would CDC welcome applications where an NGO partner and Government agency engage in independent applications that are thematically supported but funding	CDC welcomes applications from all organization types; however, if a recipient is selected for funding, they would not also be able to receive funding under another recipient’s award for the same activities/same country under this NOFO.

would contract separately to the different primes?	
Regarding the “Funding Preference 1: Preference for local organizations located within the country(-ies) for which applicant is applying”, is this preference only applicable to the prime applicant or does it also apply to sub-recipients proposed?	At least one partner in a joint application should be legally registered in the country.
Will applicants with less than 5 years of experience working with the host country on immunization be considered for funding?	Applicants with less than 5 years experience may still be considered, although candidates with 5 years or more will be stronger candidates in this area.
Can an organization apply to more than one country, and can it apply with different partners in these countries? Can an organization submit multiple applications with different partners?	While an organization may apply with different partners in each country, only one application can be submitted per organization. In other words, an organization may only be the "prime" organization on one application for the NOFO. Grants.gov will not allow more than one application to be submitted by an organization per NOFO. Organizations may be included on other applications, but only in the role of a secondary applicant, not the primary.
If an organization is submitting a proposal as a prime, can they also be a sub on another's prime application?	Yes. CDC welcomes applications from all organization types; however, if a recipient is selected for funding as a prime, they would not also be able to receive funding under another recipient’s award as a sub for the same activities/same country under this NOFO.
Questions about submissions on Grants.gov	
When trying to apply and hitting the “apply” tab - it comes up with an error message reading “Bad request, the page you requested was not found on this site.” How do we access the application package?	From the Grants.gov support page: If you receive a BAD REQUEST, blank page or other errors when clicking on the APPLY button, it indicates that you don't have the necessary roles. If you are an organizational applicant, please make sure you have added the organization's Unique Entity Identifier (UEI) as an Organization profile to your Grants.gov account. If you are an individual applicant, please make sure you have added an Individual profile to your account.
On page 45, it states “that the validation process after application submission can take 2 days. Applicants are strongly encouraged to check the status of	Yes, it is a good idea to plan to submit completed applications as early as possible to allow for any system issues or validation delays. Applicants are strongly encouraged not to wait until March 4th to start the

their application to ensure that submission of their package has been completed and no submission errors have occurred." Do you suggest that the package is submitted several days prior to March 4th, as this is a possibility?	submission, as issues could prevent a successful application submission.
Eligibility of certain types of organizations	
In terms of eligibility, are UN organizations eligible? It doesn't seem very clear in the NOFO	Yes, UN organizations are eligible to apply.
Clarification please that in NOFO it says that organization like UNICEF, WHO are not eligible to apply.	UN organizations, like UNICEF and WHO are eligible to apply.
Hi. Can INGO and indigenous NGOs prime?	The question is not clear; however, all organizations are eligible to apply for this NOFO.
Can host country governments be eligible for funding, either as prime applicants or sub-recipients?	Yes
Miscellaneous questions	
Page 51 of the NOFO states, "This includes ensuring that entities take meaningful steps to provide meaningful access to persons with limited English proficiency." Since the scope of this NOFO includes non-English speaking countries, then does this requirement still apply to this NOFO?	This requirement is for US-based recipients with US-based (domestic) funding. It does not apply to this international NOFO but is a required part of our NOFO template language.
If an applicant applies for Brazil, then will the applicant be responsible for implementing General Data Protection Law (LGPD in Portuguese) compliance within existing systems in Brazil?	If an applicant is selected for an award in Brazil, the applicant would work with CDC and the MOH regarding any system compliance requirements for Brazil.
Could CDC please clarify expectations for the presentation of key project staff in the application. Are we to understand that we can propose the position types and number of key staff	CDC does not have a set minimum of key staff that should be included in the application; however, the Project Director and Authorizing Official should be designated in the key staff listing.

composition per our design and include CVs in the appendix or does CDC have a set minimum of key staff that should be included?	
For applicants who apply for multiple countries, is it possible to build in costs for technical assistance that may cut across countries?	Costs for technical assistance should be budgeted as needed per country component.
Section D.12 (page 42) of the RFA indicates that "a copy of the indirect cost-rate agreement is required." Could you please confirm if copies of negotiated federal indirect cost rate agreements are required to be submitted for all subcontractors as well? For organizations without a negotiated indirect cost rate, is there certain documentation that is required to be submitted documenting the indirect cost rate applied?	Indirect Cost Rate Agreements are not required for subcontractors. If applicant does not have a NICRA, no documentation is required. US-based organizations are allowed to claim up to 10% in indirect costs and foreign organizations are allowed to claim up to 8% in indirect costs, as per 45 CFR 75.
Per page 42, "Indirect costs could include the cost of collecting, managing, sharing, and preserving data". Please confirm that applicants with NICRAs may follow their established cost accounting standards in terms of cost allocation and treatment.	US-based applicants with NICRAs may follow their established cost accounting standards as long as they are not in conflict with 45 CFR 75.
1. If the recipient requires technical support or seeks international collaborators or institutions to execute the program, is there an established policy specifying the allowable amount of funds that can be transferred through a subcontract? 2. Is the granted award for a fixed five-year duration, or does it necessitate annual renewal?	A recipient may authorize federal funds to another entity to provide support for the performance of any portion of the program. This information, if known, should be included in the initial application. After the period of performance has begun, a prior approval would be required for substantive programmatic work being transferred to a subcontract. The CDC guideline is no more than 50% for substantive transfer of activities. Funding for awards will be made annually for each budget period over the 5-year period. The amount of funding is not guaranteed each year. Recipients must submit annual progress report applications each subsequent year (years 2-5).

Will initial awards be made as multi-year, i.e. if there were a hypothetical award of $10m for the first year of a country program, will that be done as incremental funding of a full five-year $50m award, or will it be a one-year award with possibility for subsequent renewal(s)?	Funding for awards will be made annually for each budget period over the 5-year period. The amount of funding is not guaranteed each year. Recipients must submit annual progress report applications each subsequent year (years 2-5).
If two applicants are selected for a country, lets say, Nigeria, exceeds 10 million per year, will CDC come back to the two awardees and ask them to revise their annual budget?	If two applicants receive awards for Nigeria, and both have applied for $10M, if available funds for Nigeria are less that the total $20M requested, both applicants will be asked to revise their budgets. Any funding amount less than what was budgeted requires a revised budget.
On p. 38 of the NOFO, under the section titled, "Risk Assessment Questionnaire Requirement," it states that the "CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire [...] along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement." However, this questionnaire is not listed on pages 58-59 in the list of acceptable attachments. Please clarify whether the risk assessment questionnaire is required to submit as an attachment to the application.	The Risk Assessment Questionnaire is no longer required. This is standard language in the template and can be disregarded.
Per page 44, purchase of furniture or equipment is indicated as a funding restriction. Please confirm applicants may budget for reasonable furniture and equipment costs for project offices and/or other project implementation needs as aligned with the technical approach and implementation strategy.	Furniture or equipment costs included in the original budget would need approval of the CDC program office and the office of grant services if applicant is chosen for the award.

Is equipment purchase allowed for this NOFO	Furniture or equipment costs included in the original budget would need approval of the CDC program office and the office of grant services if applicant is chosen for the award.
Regarding personnel costs (in terms of FTE), what is the maximum allowable percentage of the total funding amount that can be allocated for this purpose?	There is no set percentage allocated for personnel; however, the budget will need to be reasonable, necessary for the work proposed, and allocable to the activities of the award. Personnel positions should be clearly linked to the NOFO strategies and outcomes.
How will funding be distributed to country governments after awards are made?	Funding will only be made available to selected recipients of awards under the NOFO. Distribution to country governments by non-governmental recipients would require an approved sub-award.
Are the objective reviewers from across CDC or from within GID/GHC?	Across CDC or other Federal agencies. No one in GID is allowed to participate as an objective reviewer due to conflict of interest.
If governments or semi-affiliated units with government will be part of the application review process, how would conflict of interest be managed by CDC in the selection of applicants or more than one applicant per country?	Governments or government units will not be a part of the objective reviews. These reviews will be conducted internally at CDC, and country governments will only become involved once CDC has selected recipients for the countries.
Would CDC support procurement of lab equipment or infrastructure improvements in conflict-affected areas?	Lab equipment is allowable; however, infrastructure improvements cannot include construction, as CDC does not have overseas construction authority. Minor alterations and renovations are allowable with approval of CDC.
Can CDC clarify eligibility information from #13 on pg. 33 about direct assistance?	Direct assistance (a financial assistance mechanisms whereby good or services are provided to recipients in lieu of cash) is not available through this NOFO.
is there any chance the govt would consider extending the deadline?	Unfortunately, no. We published the NOFO later than planned, causing the schedule to be pushed further than expected.
Application due date of March 4, 2024 - will there be a chance of submission extension?	Unfortunately, no. We published the NOFO later than planned, causing the schedule to be pushed further than expected.
The revised RFP notes the LOI was due Jan 17, but the slide deck said Jan 26. Is the deadline now Jan 26?	Yes, the LOI date has been extended to Friday, Jan. 26. Potential applicants are encouraged to submit an LOI along with the country(ies) to which applicant plans to apply.
Is there a template for the LOI due on the 26th?	No, there is not a template. The LOI can be as simple as an email sent to notify intentions of applying.

Per page 56, successful applicants will receive information on VAT requirements via their notice of award. To enable realistic budgeting, will CDC please confirm which, if not all, component locations are expected to have VAT exemptions in place by the time of award?	CDC does not currently have this information available. However, we recommend that applicants contact the tax agency for the countries to which they are applying to receive the information.
Programmatic Questions	
Definitions/clarifications	
On page 2, the NOFO states, "Work conducted under this NOFO will be critical to achieve VPD control, elimination, and eradication targets and more broadly reduce VPD-related morbidity and mortality." Please clarify how the CDC defines elimination and eradication.	Standard definitions are found at: https://www.cdc.gov/mmwr/preview/mmwrhtml/su48a7.htm
On page 9 of the NOFO, it states that applicants must "introduce vaccines and monitor and evaluate post-introduction (1.4)" Please clarify the definition of "introduce."	It is the Ministry of Health (MOH) that would be introducing the HPV vaccine nationally. In the case of the NOFO recipient, “introduce” would mean assistance to the MOH and jurisdictions in the subnational areas to implement the introduction with the goal for a quality and sustained introduction. This will also include evaluation of the implementation – efforts such as a Post- Introduction evaluation (PIE) and other evaluation measures of the quality of the introduction.
On page 42 of the NOFO, it states, "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." Please clarify whether this requirement applies to this NOFO.	This is not a requirement.

Can CDC please elaborate on the reasoning behind using “a reduced number of breakthrough infections” as the key short-term outcome measure after human papillomavirus and malaria vaccine introductions? Is this preferred above other post-introduction outcome measures?	CDC is not looking to measure disease burden for either HPV or malaria in this NOFO. Here CDC would be looking for measures of a quality and sustained introduction of the vaccines or identifying barriers/issues to a quality and sustained vaccine program. This could include the qualitative measures found in a PIE or quantitative measures such as coverage and drop out rates (for the malaria vaccine).
On page 41, the NOFO states, "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)." Additionally, it states on page 30, that it is expected that evaluations will be conducted during years 2-3 and 3-4. However, on page 44 of the NOFO, it states that "recipients may not use funds for research." Please clarify whether evaluations and evaluation studies are included under the definition of research for this NOFO.	Evaluation is not being considered research for this NOFO.
Can you please clarify the concept of consequential geographies?	Please see page 4 of NOFO.
Section 13 b. Copyright Interests Provisions, the NOFO states," 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	If a manuscript is developed based on CG-funded work, then the requirement applies, since the language does not refer to “research” but to “any such work developed under this award”.

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." Since research is not be funded, does this requirement still apply?	
The NOFO does not fund research but what about modeling exercises to identify zero-dose?	Modeling exercises to identify zero-dose individuals are not considered research if they are conducted to increase vaccination coverage and improve implementation of activities.
Is an approach using human centred design and co-creations of interventions with the beneficiaries applicable to improve interventions? Or is this considered research?	Similar to the question above, if these activities are conducted to increase vaccine coverage and improve program implementation, they would not be considered research.
What does this mean? e. Average One Year Award Amount: $7,500,000 The average annual award amount varies, depending on the country.	The ceiling for DRC, ETH and NIE is $10m per year per country. The ceiling for IDN, PHL, and BRZ is $5m per year per country. (10+10+10+5+5+5)/6 countries = $7.5m
The RFA mentions eligibility of organizations with at least 5 years of immunization experience in country. Can you be more specific in terms of what counts as immunization experience?	Goals of this award are to: identify and vaccinate un- and under-immunized children; support polio eradication, measles and rubella elimination, and hepatitis B and maternal and neonatal tetanus elimination; strengthen comprehensive VPD surveillance; support outbreak preparedness and response, including planning and implementation of supplemental immunization campaigns; and strengthen immunization delivery systems and

	capacities. Subnational work towards the achievement of these goals counts as immunization experience.
Is the recipient expected to procure vaccines and related materials to deliver vaccinations or will this be provided through another mechanism?	No. Recipient(s) are not expected to procure vaccines and related materials.
On page 25, the NOFO states, "Since this NOFO does not involve the generation or collection of public health data, a Data Management Plan (DMP) is not required for this NOFO." However, on page 26, under Section ii., the NOFO provides instructions for "plans for updating the Data Management Plan (DMP) as new pertinent information becomes available." Please clarify whether a data management plan is required for this NOFO.	A DMP is not required.
On page 25, the NOFO states under the Data Management Plan heading “Since this NOFO does not involve the generation or collection of public health data, a Data Management Plan (DMP) is not required." We are under the impression that this project will involve the generation or collection of public health data. Please clarify the definition of "public health data" and whether a Data Management Plan is required for this NOFO.	The focus of the NOFO is non-research. Data will be needed to evaluate the impact of program activities that are implemented. A DMP is not required.
Could the CDC provide information on the noted FY 2023 investments and activities in Nigeria, Ethiopia, and the DRC to implement consequential	Activities were funded in consultation with host governments and include those similar to examples given in the NOFO.

geographical activities in subnational areas and investment alignment?	
Are you able to share which partners received the FY funding for similar activities in DRC, Ethiopia, and Nigeria?	Some funding in FY23 was awarded to a few recipients who currently have cooperative agreements with CDC/GID. The funding was of an emergency nature and had to be expedited quickly. As a result, there was no time to solicit new partnerships. Please note that there will be no bias towards the recipients who were previously funded, particularly since the objective reviewers will have no knowledge of this funding or the recipients.
Number of awards per country/subnational geographies	
How will the subnational geographies be decided upon? Can they change during the 5-year award?	Subnational geographies will be selected by the host government and CDC based on government priorities at the time of award. Subnational geographies will be assessed on an annual basis by the host government and CDC and may change over the 5-year award period.
If two organizations receive an award in each country, will the recipients need to collaborate?	When two awards are made within a country, funded activities will likely be related but non-overlapping. As such, collaboration and communication between the host government, CDC, and NOFO awardee(s) will be essential.
On page 2, the NOFO states, "Up to 12 applicants may be awarded with a maximum of two awards per country component." Please clarify the definition of "country component" and whether the country components are the same as the CDC's mechanisms for component funding. Additionally, please clarify whether each country will have one or multiple component funding mechanisms.	Country component is referring to the six countries to which applicants may apply. Each country is considered a separate "component" for this NOFO. There is a possibility of up to two awards (two different recipients) per each of our six targeted countries.
Could you clarify the term "country component"? Is component used as a synonym for subnational geography?	Country component is referring to the six countries to which applicants may apply. Each country is considered a separate "component" for this NOFO. There is a possibility of up to two awards (two different recipients) per each of our six targeted countries.
“For all countries, the bulk of funds will be awarded for sub-national activities.” Another location indicates something fairly contradictory, esp. for Asian countries (namely that the focus	The overall priorities (i.e., capacity building, reaching zero dose communities, outbreak response, surveillance) will remain the same for all countries. However, the intensified technical assistance countries (Philippines, Indonesia, Brazil) have more mature immunization infrastructures and

will be more at national level). Could this be clarified? Will the activities differ between heavy investment and intensified technical assistance countries?	likely different needs. All funded activities will reflect country priorities.
Since subnational scope is to be decided later, what hypotheses are appropriate to use for the sake of proposal? Eg, make initial case for allocation in a certain way and write proposal with that in mind while being flexible to adapt if CG changes? Because the plannning of work (eg what priorities and what bottlenecks to target), allocation of resources or even of the best consortium partner and budgeting would be heavily impacted by the subnational focus.	Funds are available for program (implementation) activities. What those are, and where they will be targeted geographically will be decided by the host government and CDC. Applicants may propose subnational areas in their application for the purpose of developing activities and budgets, with an understanding that subnational areas will be decided by the government and CDC after awards are made.
I know this question was asked and answered but the answer wasn't clear. How should we present planned programming if the locations and activities will be determined later? Should various options be presented? Best guesses? Hypotheticals? Illustrative? Other?	CDC is looking to see demonstrated evidence of immunization program experience in subnational areas in the targeted country. These subnational areas where the applicant has experience may be different than what is agreed to by the host government and CDC after awards have been made. Applicants may propose subnational areas in their application for the purpose of developing activities and budgets, with an understanding that subnational areas will be decided by the government and CDC after awards are made.
With the potential of two awards per country would CDC prefer applications that suggest limited geographies? How would CDC propose programming be costed and impact estimated when geographies are to be established with CDC after award?	Applicants may propose subnational areas in their application for the purpose of developing activities and budgets, with an understanding that subnational areas will be decided by the government and CDC after awards are made.
We can propose an illustrative budget and personnel without knowing the sub national geographies. However the people may be different after selection of geog. Is that ok? Are adjustments to budgets allowed after sub national geog are identified?	Yes

Requirements for applying/Miscellaneous clarifications	
Are applicants required to apply for all strategies with a country?	Yes, applicants must apply for all strategies within a country.
would a proposal that address a limited number of strategies (i.e. less than the stated five strategies) in a given country be eligible for funding?	All strategies must be applied for in the application.
Is a consortium expected to bid for the entire technical scope in a country? What if some aspects are seen less relevant in that country by govt? or certain activities have been largely covered by traditional partners (e.g. in many countries surveillance activities are often largely covered by WHO)?	Applicants are expected to apply for all strategies. Decisions regarding activities and subnational areas will be decided by the host government and CDC based on government priorities and needs.
How would several awards be made if everyone bids on everything in the country?	Awards will be determined based on an independent review and scoring of criteria specified in the NOFO. The review process will result in a ranked list of applications; CDC retains the option to fund out of rank order under the circumstances described in the NOFO under Phase III Review. Once applicants have been selected and notified, CDC will meet with the host governments to determine priority subnational areas and activities.
Should the applicant engage with the host country MoH?	The applicant can engage with the host government, as needed/appropriate.
Will CDC engage in discussions with government directly? Or with the partner?	Yes, CDC will engage in discussions with the government directly after awards are made to determine the priority subnational areas.
Guiding principle: CDC will involve country counterparts – who does “country counterparts” refer to specifically?	Country counterparts, in this context, refers to host government.
Page 18 of the RFA indicates that “the bulk of funds will be awarded for sub-national activities.” Is there a target allocation between national and sub-national activities that bidders should be aware of? Additionally, do assumptions about this allocation need to be noted in the budget narrative?	There is no target allocation between national and subnational activities.

Can you clarify if Philippines, Indonesia and Brazil are Technical Assistance countries under this NOFO	Yes, they are considered intensified technical assistance countries.
Where Two awards are made within a select country -how is the funding split across the 2 awards in country?	Funding decisions and allocations will be determined by CDC and the host government based on country priorities and needs. There is no a priori split if/when two awards are made to a targeted country.
1. The NOFO mentions on page 18, “The proportion of funding awarded for activities conducted at the national level (versus the sub-national level) may be higher in Brazil, Indonesia, and the Philippines than in DRC, Ethiopia, and Nigeria.” Can CDC please provide further guidance on the proportional breakdown of expected national and subnational costs in targeted countries?	There is no a priori split between subnational and 'higher' level activities. Activity decisions will be made on a country-by-country basis by CDC and the host government.
1. Will the country funding allocation stated below be split between each award per annum? meaning that each award will be $5,000,000 based on each country receiving two awards? 1. DRC: $10,000,000 2. Ethiopia: $10,000,000 3. Nigeria: $10,000,000 4. Brazil: $5,000,000 5. Indonesia: $5,000,000 6. The Philippines: $5,000,000 2.Does the preference for local organizations located within the country on p48 refer to local partners as a Prime partner or as a member of a consortium?	1. No. Up to two awards will be funded per country per year. For DRC, ETH, and NIE, the maximum award per country per year is $10,000,000. For BRZ, IDN, and PHL, the maximum award per country per year is $5,000,000. Funds will be allocated to awardees based on country needs and priorities; there is not an a priori 'split' between multiple awardees in a given target country. 2. Local partners may be either a prime applicant or a member of a consortium included in the application. At least one partner in the application must be legally registered to work in the country applied for.
Could CDC please clarify whether the 2 awardees per country will be made from Year 1?	CDC may fund up to 2 awardees per country. This will depend on the applications received and country priorities.
On page 2, it mentions that a maximum of two awards per country will be awarded “Up to 12	All strategies must be applied for in the application.

applicants may be awarded with a maximum of two awards per country component." Is it possible to apply only for part of the strategies but not for others (i.e without addressing all the strategies on the NOFO) when we apply for a country?	
Please clarify whether the CDC will consider partially funding applications for multiple countries, such as accepting the application for one country, but not the rest.	Applications for each country component will be evaluated and reviewed separately, so it is possible that one country component could be awarded for an applicant but not others. Funds available reflect funding ceilings, that is, the maximum amount of funds available. We anticipate providing funds for each of our six targeted countries.
Should the applicant apply in consortium?	Applicants may apply in consortium; however, it is not a requirement.
We have experience and local presence in the country that we are applying for but not in all subnational geographies. Can we still apply?	Yes, it is only necessary to have a local presence in the country, not in all subnational geographies. However, experience working in challenging subnational geographies in the country is important.
Our organization has worked in the specified country; however, we are new to the vaccine-preventable disease work. Can we still apply?	Applicants should be legally registered to work in countries for which the applicant is applying. The strongest candidates will have a minimum of 5 years of immunization experience working with the host government.
The initial release had lab sample transport. It is included in the final nofo?	Yes. Lab transport is referenced under section 2. CDC Project Description, a. Approach, iii. Strategies and Activities, Strategy 2.
Is it intensified investment + intensified TA or intensified investment and less intense TA?	1 intensified invested and TA (NIE, ETH, DRC) 2. intensified TA (IDN, PHL, BRZ)
Will CDC engage in discussions with government directly? Or with the partner?	Yes, CDC will engage in discussions with the government directly after awards are made to determine the priority subnational areas.
Will applicants with less than 5 years of experience working with the host country on immunization be considered for funding?	Applicants with less than 5 years experience may still be considered, although the candidates with 5 years or more will be stronger candidates in this area.
Will CDC also be working and coordinating the interventions and geographies with other donors, like GAVI or BMGF?	Yes

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 Definitions

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

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

Adverse Event Following Immunization (AEFI): any untoward medical occurrence which follows immunization, and which does not necessarily have a causal relationship with the usage of the vaccine.

Catch-up vaccination: the action of vaccinating an individual who, for whatever reason, is missing or has not received doses of vaccines for which they are eligible, per the national immunization schedule. Catch-up vaccination can be conducted through regular routine immunization service delivery (fixed, outreach, mobile, school-based), periodic intensification of routine immunization (PIRI) activities, or through innovative local strategies that ensure individuals have the opportunity to receive routine immunizations for which they are overdue and eligible.

Consequential geography: A specified country with sub-national geographic areas that have a large proportion of zero-dose or under-vaccinated children, and/or vaccine-preventable disease outbreaks.

Fragile Settings: a geographic area particularly vulnerable to humanitarian, political, and/or public health crises (e.g., natural disasters, conflict, infectious disease outbreaks, widespread food insecurity).

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

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

- **Herd or Population immunity:** indirect protection from an infectious disease that happens when a population is immune either through vaccination or immunity developed through previous infection
- **Immunity Gap: a** group of susceptible individuals who avoided infection and therefore lack pathogen-specific immunity to protect against future infection

Immunization Schedule: outline which each vaccine should be administered and when during the life course.

Immunization workforce functions: according to the WHO Standard Competencies Framework for the Immunization Workforce, including workforce for advocacy and communications; disease surveillance, investigation, and response; human resources and performance management; monitoring, evaluation, information system management and data use; policy, planning, and finance; safety of vaccines and immunization; vaccines, supplies, and logistics; vaccination service delivery; and leadership and management.

Integrated Service Delivery – The organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money.

Integration: The sharing of all or specific campaign components or functions by a specific program addressing a disease or health need with the broader health system and ongoing delivery of interventions through general health services.

Life-course approach: A life course approach to health aims to ensure people's well-being at all ages by addressing people's needs, ensuring access to health services, and safeguarding the human right to health throughout their lifetime.

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

- **Measles clinical case definition:** Any person with fever and maculopapular rash and cough, coryza (runny nose) or conjunctivitis (red eyes), or any person in whom a clinician suspects measles.
- **Measles - clinically confirmed:** A case that meets the clinical case definition and for which no adequate blood specimen was collected.
- **Measles – discarded:** A suspect case that meets the case definition, but laboratory results are IgM negative.
- **Measles – epidemiologically linked:** those people with febrile rash illness who had direct or indirect exposure to a clinically –or laboratory-confirmed measles case during time when disease transmission was possible.
- **Measles – laboratory confirmed:** A case that meets the clinical case definition and is laboratory confirmed by a positive IgM antibody test.

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

Sub-national: Occurring at one or more administrative units or levels below the national level.

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

- **Active surveillance -** when data are sought out by visiting or contacting a site and reviewing the medical records and registers of the site to identify cases
- **Aggregate surveillance –** surveillance of a disease or health event by collecting summary data on groups of cases (e.g., in many general practice surveillance schemes clinicians are asked to report the number of cases of specified diseases seen over a period of time).
- **Case-based surveillance –** surveillance of a disease by collecting specific data on each case (e.g., reporting of details on each case of AFP).
- **Community-based, facility-based, and laboratory-based surveillance –** surveillance involving detection and notification by communities, health facilities and laboratories respectively.
- **Comprehensive surveillance -** when data are collected from as many sites as possible throughout a country in order to achieve representativeness.
- **Comprehensive VPD surveillance -** the country, regional and global systems that meet the World Health Organization (WHO)-recommended standards for surveillance of priority VPDs (as defined by each country), with integration of surveillance functions across VPDs and other diseases wherever possible. (from Global strategy for comprehensive Vaccine-Preventable Disease (VPD) surveillance (who.int)).
- **Facility-based surveillance -** surveillance where the starting point for a report is a patient with a particular disease or syndrome who visits a health facility (hospital or health center).
- **Passive surveillance -** when data are routinely collected and forwarded to more central levels on a routine basis, i.e., the data do not have to be requested on each occasion.

Under-immunized: (1) status of immunization which is suboptimal for a person; (2) those missing the third dose of diphtheria, tetanus and pertussis (DTP)-containing vaccine (DTP3); (3) people who have missed out entirely or partially on routine immunization.

Vaccine-related Events: any event related to vaccines that can negatively affect a vaccination program.

Vaccine coverage: the proportion of children in the Region receiving the recommended vaccines.

Vaccine demand: actions of individuals and communities to seek out, support the use of and/or advocate for vaccines and vaccination services. Demand is dynamic and varies by context, vaccine, vaccination services provided, time and place. Demand is fostered by governments, immunization program managers, public and private sector providers, local leadership, and civil society organizations hearing and acting on the voices of individuals and communities.

Walk-through microplanning: a bottom-up planning exercise where persons travel through communities to identify and map all individuals eligible for vaccination in order to account for human and material resources needs to provide immunization services to every single individual

Zero dose children: children who have not received the first dose of diphtheria-tetanus-pertussis vaccine (DTP1)

*Underserved populations with immunity gaps have disproportionately high risk for vaccine-preventable diseases. They include zero-dose children, populations affected by conflict, disaster and humanitarian crisis, populations living in insecure or compromised settlements, refugee and internally displaced populations, nomadic populations, populations with gender related barriers to immunization, other populations without access to recommended vaccines, and populations living in geographically isolated areas.