Centers for Disease Control and Prevention

Center for Global Health

Enhancing Global Health Security: Expanding Efforts and Strategies to Protect and Improve Public Health Globally

CDC-RFA-GH20-2110

Application Due Date: 04/27/2020

Enhancing Global Health Security: Expanding Efforts and Strategies to Protect and Improve Public Health Globally

CDC-RFA-GH20-2110

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Part I. Overview Information

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-GH20-2110. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:

Enhancing Global Health Security: Expanding Efforts and Strategies to Protect and Improve Public Health Globally

C. Announcement Type: New - Type 1

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

See edits to the following sections:

- Section 2. Project Description
  - Funding Strategy Section, pg. 32: Added the following Country and Regions:
    - Country: Mexico
    - Regions: Southern Africa Region (SA) Region, Central & East Africa (CEA) Region, Western Pacific (WP) Region, and the Caribbean Region
  - Expected Number of Awards, pg. 42: 15
  - Approximate Average Award pg. 43: $5,000,000

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-GH20-2110

E. Assistance Listings (CFDA) Number:

93.318

F. Dates:

1. Due Date for Letter of Intent (LOI):	**N/A**
2. Due Date for Applications:	**04/27/2020**, 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Date for Informational Conference Call:

G. Executive Summary:

1. Summary Paragraph:

This Notice of Funding Opportunity (NOFO) seeks to build upon activities funded by CDC to support Global Health Security (GHS) through implementation of programs and activities that

focus on protecting and improving health globally through partnerships with Ministries of Health and other governmental institutions.

After five years of implementing and strengthening global health security systems, the U.S. Government (USG) will continue to advance prevent, detect, and respond strategies to mitigate threats. This NOFO's main outcomes are to:

- Improve prevention of avoidable epidemics including naturally occurring outbreaks and intentional or accidental releases of dangerous pathogens
- Improve ability to rapidly detect threats early, including detecting, characterizing, and reporting emerging biological threats
- By responding rapidly and effectively to public health threats of international concern

a. Eligible Applicants:	Open Competition
b. NOFO Type:	Cooperative Agreement
c. Approximate Number of Awards:	15
d. Total Period of Performance Funding:	$500,000,000
e. Average One Year Award Amount:	$5,000,000
f. Total Period of Performance Length:	5
g. Estimated Award Date:	09/30/2020
h. Cost Sharing and / or Matching Requirements:	N

Part II. Full Text

A. Funding Opportunity Description

Part II. Full Text

1. Background

a. Overview

The U.S. Government's (USG) Global Health Security (GHS) envisions a world safe and secure from global health threats posed by infectious diseases, where it is possible to prevent or mitigate the impact of naturally occurring outbreaks and intentional or accidental releases of dangerous pathogens, rapidly detect and transparently report outbreaks when they occur, and employ an interconnected global network that can respond effectively to limit the spread of infectious disease outbreaks in humans and animals, mitigate human suffering and the loss of human life, and reduce economic impact.

In partnership with Ministries of Health and other public and private stakeholders, the CDC seeks to accelerate progress toward a world safe and secure from infectious disease threats and to promote global health security as an international security priority.

In 2005, International Health Regulations (IHR) established a legally binding global framework

for preparing and responding to public health emergencies of international concern (PHEICs). To date, the world has made great progress in strengthening local, regional, and international capacity for addressing emerging infectious disease threats. Ongoing vulnerabilities include geographic areas with limited disease surveillance systems, institutional and logistic barriers to adequate delivery of services and interventions, reluctance to share outbreak information or biological samples, emergence of new pathogens and development of drug-resistance, limited border public health security measures, and intentional or accidental release of biological agents. These vulnerabilities illustrate the critical need to improve prevention, detection, and response efforts for infectious disease outbreaks, PHEICs, and other health threats.

This funding opportunity seeks to build upon previously funded GHS activities by CDC to collaboratively work with Ministries of Health to develop a roadmap to IHR compliance and achievement of the GHS targets and action packages.

CDC has been a leader in improving global health security (GHS) for many decades and plays an important role in the Global Health Security Agenda. CDC's strategy is rooted in science and based on three concepts long embedded in the agency's mission to protect public health worldwide: 1) Prevent, 2) Detect, 3) Respond (http://www.cdc.gov/globalhealth/security/cdc.htm).

The Department of Health and Human Services' (HHS) Global Health Strategy articulates three strategic goals that support HHS' global health vision of a healthier, safer world: 1) protect and promote the health and well-being of Americans through global health action; 2) provide leadership and technical expertise in science, policy, programs and practice to improve global health; and 3) advance United States interests in international diplomacy, development, and security through global health action. http://www.globalhealth.gov/global-programs-and-initiatives/global-health-strategy/

b. Statutory Authorities

Section 301(a) of the Public Health Service Act [42 USC § 241(a)], as amended and Section 307 of the Public Health Service Act [42 USC §242*l*], as amended.

c. Healthy People 2030

This project supports the following Healthy People 2030 goal and objectives:

- Increase the number of public health events of international importance that are monitored and reported
- Increase the number of individuals trained globally to prevent, detect, or respond to public health threats
- Increase the laboratory diagnostic testing capacity, surveillance system, and routine reporting in countries and regionally.

d. Other National Public Health Priorities and Strategies

Activities funded through this cooperative agreement must align with the following USG and HHS/CDC strategies and policies:

CDC's strategy for improving global health security (GHS), based on three concepts embedded

in the agency's mission to protect public health worldwide: 1) Prevent 2) Detect 3) Respond https://www.cdc.gov/globalhealth/security/index.htm

The Department of Health and Human Services' (HHS) Global Health Strategy

https://www.hhs.gov/about/agencies/oga/about-oga/why-hhs-works-globally/hhs-global-strategy/index.html

International Health Regulations (IHR) (2005) and supporting policies and frameworks https://www.who.int/topics/international_health_regulations/en/

e. Relevant Work

This NOFO will support GHS and its targets, and will facilitate national collaboration toward specific public health protection objectives, including IHR (2005) compliance (http://www.cdc.gov/globalhealth/security/).

This NOFO expands the scope of activities previously awarded under GH15-1632: Global Health Security Partner Engagement: Expanding Efforts and Strategies to Protect and Improving Public Health Globally.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Component 1 – Core Global Health Security Priorities

Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy 1: National Laboratory Systems	**Improved quality and timeliness of diagnostic and reporting for prioritizes animal and human diseases** **-Improved specimen referral and transport system** Increased laboratory and point-of-care diagnostic methodologies available to identify and characterize	**Improved capacity to detect and control infectious disease outbreaks, PHEICs, or other health threats** **Established national laboratory system with effective modern point-of-care and laboratory-based diagnostics incorporating effective quality assurance and quality control measures**	**Improved prevention of avoidable epidemics: including naturally occurring outbreaks and intentional or accidental releases.** **Improved ability to rapidly detect threats early: including detecting,**

	infectious disease agents Improved system for rapid and safe transport of specimens from site of collection to testing facility Increased identification of drug resistant specimens Improved ability to identify, hold, secure, and monitor collections of especially dangerous pathogens in a minimal number of facilities with biosafety and biosecurity best practices in place Increased geographic coverage and maximum load of specimen referral network Improved lab information systems Improved laboratory information and supply chain management systems Decreased service		**characterizing, and reporting biological threats.** **Improved interconnected global network that can respond rapidly and effectively to biological threats of international concern**

	gaps / stock-outs Improved participation in national and international Quality Assurance schemes/Proficiency Testing		
Strategy 2: Surveillance	Strong and timely routine and event-based surveillance Increased capacity of sites to submit accurate, timely reports **Strengthened foundational indicator and event-based surveillance systems** Increased coverage of surveillance systems Increased capacity to collect, analyze, and disseminate data Improved linkages of surveillance systems across sectors and levels	Improved accurate and timely IHR reporting Improved capacity to detect and control infectious disease outbreaks, PHEICs, or other health threats Improved capacity to prevent infectious disease transmission **Strengthened and integrated global networks for real-time bio surveillance.** **Improved capacity to detect and control infectious disease outbreaks, PHEICs, or other health threats** Improved capacity to prevent infectious disease transmission	

	Improved accurate and timely IHR reporting Improved access to comprehensive data Increased access to internet and electronic platforms **Improved electronic systems to collect, report, and analyze data** Decreased loss to follow-up Increased linkages of surveillance and laboratory data via electronic reporting systems or other sustainable platforms		
Strategy 3: Human Resources	**Improved comprehensive Public Health Workforce strategy is established for animal and human sectors** Identified appropriate public health training and human resource activities for animal and human sector	**Strengthened Public Health Workforce Strategy is implemented for prioritized diseases for animal and human sector** Increased number of public health workers to serve the population at all levels Increased human resources available at national level for	

	Enhanced ability of country to fulfill relevant core competencies Increased knowledge and skills of public health workforce to prevent, detect, and respond to public health emergencies Increased trained/certified workforce and laboratories Increased number of laboratory staff that have certified safety training Increased laboratories with workforce that have had quality management training	epidemic preparedness and control Increase number of trained physicians, veterinarians, biostatisticians, laboratory scientists, farming/livestock professionals, and field epidemiologists. Basic Applied Epidemiology training program is in place Public Health Workforce Strategy system is fully developed, reviewed regularly, and implemented consistently **Increased number of trained human resources exist in the relevant animal and human sectors**	
Strategy 4: Emergency Response Operations	**Improved EOC infrastructure** **Established EOCs; trained, functioning, multi-sectoral rapid response teams, with access to a real-time information system**	**Strengthened Emergency Operations Center (EOC) according to standards** Emergency management program established (facility, staff, and systems) Dedicated EOC that houses doctrinal emergency management	

	Trained, functioning, multi-sectoral rapid response teams, with access to real-time information systems Increased number of emergency response exercises conducted Improved sector coordination during public health emergency **Increased skills and abilities of staff to respond to emergency outbreaks** Decreased time to identify and respond to a public health threat Improved risk communication during a public health emergency	functions that is regularly used for exercise and emergency management Decreased transmission in healthcare facilities Decreased transmission in communities	
Strategy 5: Strengthen implementation of the IHR (2005) Monitoring and Evaluation Framework in countries	**Improved Joint External Evaluations (JEEs)** **Strengthened National Action Plan for Health Security (NAPHS)**	**Strengthened evidence-based priority actions based on JEE and NAPHS to improve health security**	

Component 2 Rapid Response to Small Scale Infectious Disease Outbreaks or other Public

Health Emergencies

Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy 1: Intensify active surveillance, case finding, contact tracing, monitoring and other outbreak response measures at local levels Strategy 2: Strengthen capabilities for epidemiologic and laboratory analysis and program evaluation Strategy 3: Intensify social mobilization, community and professional education and engagement. Strategy 4: Improve outbreak case management and infection control Strategy 5: Strengthen non-outbreak related public health activities that are	**Improved time to deploy healthcare workers to respond and control the spread of infectious diseases** **Strengthened coordination and robust emergency preparedness and response capacities** **Improved disease outbreak case management and infection control** **Shortened time to detect highly infectious disease outbreaks through active surveillance and case finding** **Reduced transmission of highly infectious diseases in clinical and community settings** **Increased awareness, knowledge, and support for local disease outbreak**	**Reduced time to reinvigorated public health activities that have been interrupted or slowed due to outbreak response** Improved access to health services by individuals in outbreak affected areas **Increased capacity of countries for early warning, risk reduction and management of national and global health risks**	**Sustained improvements in timeliness of achieving outbreak/epidemic/pandemic control** **Reduced morbidity and mortality attributed to disease outbreaks or other public health threats** Reduced spread of infectious outbreaks into other countries **Improved preparedness for potential future outbreaks and other highly infectious diseases**

impacted by the outbreak Strategy 6: Increase security and logistics for local responders Strategy 7: Strengthen capabilities for preparedness and response to highly infectious diseases	**response and prevention efforts at the community level** **Rapid identification of and containment of highly infectious disease outbreaks**		

Component 3 - Rapid Response to Large-Scale Infectious Disease Outbreaks or other Public Health Emergencies

Strategies and Activities	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Strategy 1: Intensify active surveillance, case finding, contact tracing, monitoring and other outbreak response measures at local levels Strategy 2: Strengthen capabilities for epidemiologic and laboratory analysis and program evaluation Strategy 3: Intensify social mobilization, community and professional education and engagement. Strategy 4: Improve outbreak case management and infection control Strategy 5: Strengthen non-outbreak related public health activities that are impacted by the outbreak	**Improved time to deploy healthcare workers to respond and control the spread of infectious diseases** **Strengthened coordination and robust emergency preparedness and response capacities** **Improved disease outbreak case management and infection control** **Shortened time to detect highly infectious disease outbreaks through active surveillance and case finding** **Reduced transmission of highly infectious diseases in clinical and community settings** **Increased awareness, knowledge, and support for local disease outbreak response and**	**Reduced time to reinvigorated public health activities that have been interrupted or slowed due to outbreak response** Improved access to health services by individuals in outbreak affected areas **Increased capacity of countries for early warning, risk reduction and management of national and global health risks**	**Sustained improvements in timeliness of achieving outbreak/epidemic/pandemic control** **Reduced morbidity and mortality attributed to disease outbreaks or other public health threats** Reduced spread of infectious outbreaks into other countries **Improved preparedness for potential future outbreaks and other highly infectious diseases**

Strategy 6: Increase security and logistics for local responders Strategy 7: Strengthen capabilities for preparedness and response to highly infectious diseases	**prevention efforts at the community level** **Rapid identification of and containment of highly infectious disease outbreaks**		

i. Purpose

CDC seeks to support the achievement of the Global Health Security (GHS) targets that focus on protecting and improving health globally through regional, national, and local partnerships. Its purpose is to:

1. improve prevention of avoidable epidemics including naturally occurring outbreaks and intentional or accidental releases of dangerous pathogens
2. improve ability to rapidly detect threats early, including detecting, characterizing, and reporting emerging public health threats
3. respond rapidly and effectively to public health threats of international concern

ii. Outcomes

Component 1 Core Global Health Security Priorities

Strategy 1: National Laboratory Systems

Short-Term Outcomes:

- Improved quality and timeliness of diagnostic and reporting for prioritizes animal and human diseases
- Improved specimen referral and transport system

Intermediate Outcomes:

- Improved capacity to detect and control infectious disease outbreaks, PHEICs, or other health threats
- Established national laboratory system with effective modern point-of-care and laboratory-based diagnostics incorporating effective quality assurance and quality control measures

Long-term Outcome:

- Improved prevention of avoidable epidemics: including naturally occurring outbreaks and intentional or accidental releases.
- Improved ability to rapidly detect threats early: including detecting, characterizing, and reporting biological threats.
- Improved interconnected global network that can respond rapidly and effectively to biological threats of international concern

Strategy 2: Surveillance:

Short-Term Outcomes:

- Strengthened foundational indicator and event based surveillance systems
- Improved electronic systems to collect, report, and analyze data

Intermediate Outcomes:

- Strengthened and integrated global networks for real-time biosurveillance
- Improved capacity to detect and control infectious disease outbreaks, PHEICs, or other health threats

Long-term Outcome:

- Improved prevention of avoidable epidemics: including naturally occurring outbreaks and intentional or accidental releases.
- Improved ability to rapidly detect threats early: including detecting, characterizing, and reporting biological threats.
- Improved interconnected global network that can respond rapidly and effectively to biological threats of international concern

Strategy 3: Human Resources

Short-Term Outcomes:

- Improved comprehensive Public Health Workforce strategy is established for animal and human sectors
- Enhanced ability of country to fulfill relevant Human Resource core competencies for animal and human sectors. including epidemiologic and laboratorian staff

Intermediate Outcomes:

- Strengthened Public Health Workforce Strategy is implemented for prioritized diseases for animal and human sector
- Increased number of trained human resources exist in the relevant animal and human sectors

Long-term Outcome:

- Improved prevention of avoidable epidemics: including naturally occurring outbreaks and intentional or accidental releases.
- Improved ability to rapidly detect threats early: including detecting, characterizing, and reporting biological threats.
- Improved interconnected global network that can respond rapidly and effectively to biological threats of international concern

Strategy 4: Emergency Response Operations

Short-Term Outcomes:

- Improved EOC infrastructure
- Established EOCs; trained, functioning, multi-sectoral rapid response teams, with access to a real-time information system
- Increased skills and abilities of staff

Intermediate Outcomes:

- Strengthened Emergency Operations Center (EOC) according to standards

Long-term Outcome:

- Improved prevention of avoidable epidemics: including naturally occurring outbreaks and intentional or accidental releases.
- Improved ability to rapidly detect threats early: including detecting, characterizing, and reporting biological threats.
- Improved interconnected global network that can respond rapidly and effectively to biological threats of international concern

Strategy 5: Strengthen implementation of the IHR Monitoring and Evaluation Framework in countries

Short-term outcomes

- Improved Joint External Evaluations (JEEs)
- Strengthened National Action Plan for Health Security (NAPHS)

Intermediate Outcomes:

- Strengthened evidence-based priority actions based on JEE and NAPHS to improve health security

Long-term Outcomes:

- Improved prevention of avoidable epidemics: including naturally occurring outbreaks and intentional or accidental releases.
- Improved ability to rapidly detect threats early: including detecting, characterizing, and reporting biological threats.

- Improved interconnected global network that can respond rapidly and effectively to biological threats of international concern

Component 2 Rapid Response to Small Scale Infectious Disease Outbreaks or other Public Health Emergencies

Short-Term Outcomes:

- Improved time to deploy healthcare workers to respond and control the spread of infectious diseases
- Strengthened coordination and robust emergency preparedness and response capacities
- Improved disease outbreak case management and infection control
- Shortened time to detect highly infectious disease outbreaks through active surveillance and case finding
- Reduced transmission of highly infectious diseases in clinical and community settings
- Increased awareness, knowledge, and support for local disease outbreak response and prevention efforts at the community level
- Rapid identification of and containment of highly infectious disease outbreaks

Intermediate Outcomes:

- Reduced time to reinvigorated public health activities that have been interrupted or slowed due to outbreak response
- Increased capacity of countries for early warning, risk reduction and management of national and global health risks

Long-Term Outcomes:

- Sustained improvements in timeliness of achieving outbreak/epidemic/pandemic control
- Reduced morbidity and mortality from disease outbreak or public health threat & emergencies
- Improved preparedness for potential future outbreaks and other highly infectious diseases

Component 3 Rapid Response to Large Scale Infectious Disease Outbreaks or other Public Health Emergencies

Short-Term Outcomes:

- Improved time to deploy healthcare workers to respond and control the spread of infectious diseases
- Strengthened coordination and robust emergency preparedness and response capacities
- Improved disease outbreak case management and infection control
- Shortened time to detect highly infectious disease outbreaks through active surveillance and case finding
- Reduced transmission of highly infectious diseases in clinical and community settings
- Reduced morbidity and mortality attributed to disease outbreaks or other public health

threats
- Increased awareness, knowledge, and support for local disease outbreak response and prevention efforts at the community level
- Rapid identification of and containment of highly infectious disease outbreaks

Intermediate Outcomes:

- Reduced time to reinvigorated public health activities that have been interrupted or slowed due to outbreak response
- Increased capacity of countries for early warning, risk reduction and management of national and global health risks

Long-Term Outcomes:

- Sustained improvements in timeliness of achieving outbreak/epidemic/pandemic control
- Reduced morbidity and mortality from disease outbreak or public health threat & emergencies
- Improved preparedness for potential future outbreaks and other highly infectious diseases

iii. Strategies and Activities

Component 1 – Core Global Health Security Priorities

With support from the CDC and international partners, the World Health Organization (WHO) developed the Joint External Evaluation (JEE) as a voluntary process as part of International Health Regulations Monitoring and Evaluation Framework (IHR MEF) to help countries identify gaps in health security capacity, through a collaborative, transparent process that leverages international expertise.

The Joint External Evaluation Tool was developed to measure progress toward attaining the targets of the 19 technical areas that cover the GHSA Action Packages and IHR Core Capacities and Hazards. The JEE tool divides each technical area into a set of indicators with levels of capacity scores ranging from 1-5. Completing the JEE process establishes a score for indicators for the 19 technical areas.

The WHO Benchmarks for International Health Regulations Capacities Tool was developed to provide technical guidance on how to build the capacities necessary to improve the JEE levels of capacity scores. The document is organized by JEE technical area and contains a number of actions that define the steps that need to be taken to move from one JEE level of capacity score to the next JEE level of capacity score.

The outcomes expected in this NOFO under Component 1 correspond to stepping up the JEE levels of capacity scores, utilizing the suggested intermediate steps between the levels of capacity in the WHO Benchmarks for International Health Regulations Capacities Tool. Capacitation strategies & activities below are targeted to JEE level of capacity scores two to four. Support provided to these areas must be in line with a country's National Action Plan for Health Security or other post-JEE plans or health security frameworks.

Strategy 1: National Laboratory Systems

- Establish clear SOPs and necessary agreements with international laboratories to perform diagnostic and confirmatory testing of specimens and support outbreak detection and responses when local capacity is not available.
- Define 10 core tests based on the priority diseases list (link this with the surveillance benchmark).
- Select at least five priority diseases for testing using the results of risk analysis, surveillance data and prioritization methodologies.
- Assess laboratory algorithms, standards and testing capacity including equipment inventory for the 10 priority diseases. Assess the capacity and essential functioning of target human and animal health laboratories to meet diagnostic and confirmatory requirements for priority diseases.
- Develop plan, based on assessment, to target human and animal health laboratories for capacity building and essential functioning to meet diagnostic and confirmatory requirements for priority diseases, ensuring that proficiency is demonstrable for bacteriology, serology, polymerase chain reaction and others.
- Establish domestic external quality assessment programs for all priority tests or cover them with international external quality assessment schemes.
- Develop a national laboratory policy that identifies expected capacities at each level of the national laboratory system.
- Develop a hands-on-training curriculum for all laboratory staff that includes task-based training, refresher training and mentoring in their appropriate technical and administrative areas.
- Conduct a hands-on training or refresher training session for public health laboratory staff on techniques to diagnose the country's priority diseases.
- Develop and disseminate testing SOPs and quality control SOPs for all core tests for priority diseases; and establish supply and procurement chains.
- Train relevant laboratory staff on techniques used for core testing and document quality control results.
- Review existing specimen referral and transportation networks for priority diseases, map existing laboratory capacity for priority diseases and establish referral networks for each pathogen.
- Convene human and animal health sectors and other stakeholders to assess referral mechanisms and linkages among various levels of health facilities, including international networks with guidance and tools for dissemination.
- Develop SOPs (as part of disease outbreak investigation protocols) for specimen collection, management and transportation and share with all levels.
- Train staff of courier company and health facility on appropriate management of specimens from suspected cases of priority diseases.
- Establish a service agreement with a courier company (public or private) for specimen transportation from at least 50% of health facilities in the public sector throughout all major subdivisions of the country.
- Establish a mechanism to ensure transportation of specimens from 50% of all health facilities to national laboratories. Provide preposition outbreak investigation kits (sample

collection and transportation kits) in at least 50% of health facilities.

- Identify international laboratories with testing capacity for confirmatory laboratory diagnostics when they are not currently available in the country.
- Develop a national laboratory policy that identifies the expected capacities at each level of the national laboratory system.
- Assess national diagnostic capability, and based on the findings, develop a national plan for achieving goals stated in the policy.
- Conduct a review of existing point-of-care/rapid diagnostic tests that are available to the country for detection of priority diseases.
- Conduct a laboratory and field validation of the use of point-of-care/rapid diagnostic tests for some priority diseases. Develop and implement point-of-care diagnostic testing strategies for priority diseases.
- Develop and disseminate testing SOPs and procurement chains to conduct testing for at least 10 priority diseases.
- Make available external quality assessment for at least three/four core tests for priority diseases at national or central laboratories.
- Begin establishing a comprehensive quality management system in laboratories that conduct core tests for priority diseases.
- Regularly train staff on the testing, and document quality control results.
- Expand a service agreement with a courier company (public or private) for specimen transportation from at least 80% of the health facilities.
- Establish a mechanism to ensure transportation of specimens from 50–80% of all health facilities to national laboratories. Implement staff training programs and standards at the national level for the safe shipment of infectious substances following available WHO guidance.
- Provide preposition outbreak investigation kits (sample collection and transportation kits) at 80% or more health facilities.
- Develop and disseminate SOPs for tiered testing, including point-of-care/rapid diagnosis and specimen referral systems to the appropriate laboratory ideally within the framework of a national laboratory policy, for each priority disease.
- Develop in-service training plans for all staff that include task-based training, refresher training and mentoring in their appropriate technical and administrative areas.
- Allocate resources (human and material) to conduct appropriate diagnostic testing at the subnational level in line with the national laboratory policy.
- Establish an independent unit at the central level with a specific budget line and personnel to oversee laboratory services and develop national laboratory quality standards.
- Establish a quality assessment program for national or central laboratories for diagnostics of diseases with epidemic potential.
- Develop a roadmap for laboratory inspections, licensing and accreditation, in line with the national laboratory strategy.
- Establish a national quality assessment program for peripheral laboratories for diagnosis of diseases with epidemic potential.
- Develop minimum standards for certification or licensing, as a part of the system for regulation of laboratories.

- Implement a system of inspecting and licensing laboratories, including using local adaptations of international standards and norms and obtaining required funding and human resources.
- Develop expertise by training selected laboratory staff in the inspection of laboratories based on the standards.
- Develop and disseminate testing SOPs; procurement chains should conduct testing for at least 15 priority diseases.
- Conduct quality assurance for all core tests.
- Develop a strategic framework to prioritize national investments into laboratory system sustainability.
- Conduct monitoring and evaluation to document diagnostics, data quality and staff performance, and incorporate recommendations into the national laboratory strategic plan.
- Establish a national external quality assessment program for public health laboratories.
- Establish a mechanism to ensure transportation of specimens from at least 80% of all health facilities to national laboratories covering all geographic areas of the country.
- Provide preposition outbreak investigation kits (sample collection and transportation kits) at all the health facilities.
- Conduct regular reviews of specimen transportation systems to confirm that specimens are being transported promptly and in a manner that maintains safety and specimen quality.
- Establish a system to collect and test specimens from hard-to-reach areas.
- Develop a mechanism to ensure that staff at the national level have internationally recognized certification to ship potentially infectious specimens.
- Monitor implementation of the tiered testing approach, including validation/quality assurance of point-of-care testing. Train laboratory staff on relevant novel diagnostic procedures to detect priority diseases.
- Use point-of-care diagnostic testing for some of the priority diseases and further confirm by tiered testing approach from referral laboratories.
- Obtain sustainable funding for laboratory procurement, capacity building and point-of care diagnostics.
- Implement a mandatory licensing program for national and subnational public health laboratories.
- Establish national quality standards that follow international norms and standards.

Strategy 2: Surveillance

- Develop national communicable disease surveillance strategy based on IHR (2005) requirements, which includes a list of priority/epidemic-prone diseases and syndromes most relevant to the country.
- Establish a disease surveillance unit or department and finalize the operational plan 44 and process.
- Designate surveillance focal persons at subnational levels.
- Identify resources for control of priority diseases.
- Develop training materials for disease surveillance for national and subnational levels.

- Disseminate case definitions and process of detection, assessment, and reporting of cases (user manual or guidelines) at national and intermediate levels.
- Develop and implement indicator based surveillance or event-based surveillance (refer to respective column for their benchmarks)
- Establish indicator-based surveillance
- Develop guidelines and SOPs for indicator-based surveillance.
- Establish a designated unit at all levels, with operational plan and procedures.
- Include country priority diseases in indicator-based surveillance.
- Disseminate case definitions and ensure that process of detection, assessment and reporting of cases (user manual or guidelines) are in place at national and subnational levels.
- Establish event-based surveillance
- Develop guidelines and standard operating procedures for event-based surveillance.
- Establish a designated unit at all needed levels, with operational plan and procedures.
- Develop and put in place case definitions and the process of detection, assessment and reporting of the event (clusters or outbreaks) for country priority diseases and disseminate to national and subnational levels.
- Establish a process to identify potential events from community-based reporting (people identified from the community, verification teams at facilities identified, SOP and flow of information available) and make the data available at all needed levels.
- Establish systems to identify potential events from various other sources (such as media, social media, private sector)
- Use ad hoc electronic tools (such as Excel spreadsheets) to report and analyse surveillance data, while a more sophisticated system is under development.
- Pilot available electronic tools.
- Develop a strategy for integrated electronic real-time reporting system for public health surveillance with the involvement of multisectoral stakeholders and partners.
- Develop operational plan, standards for data, and plans for interoperability and data sharing.
- Establish a link of the electronic system under development to the existing health information management system.
- Develop standards and expectations for analysis of surveillance data, with an operational plan.
- Develop a training package for data management (data collation, analysis, trend analysis and developing reports or summaries).
- Develop and disseminate guidelines and procedures to assess the risk of unusual case reports and surveillance signals at all levels.
- Produce ad hoc reports of analyzed surveillance data for outbreaks or other public health events and disseminate from the national level.
- Develop a tool and standards for data quality assessment.
- Implement actions (described above) for both indicator- and event-based surveillance systems at national and intermediate levels (district, province, region or state).
- Train 70% of health workers (clinicians, laboratorians, surveillance officers) in detection, monitoring and evaluation of events and cases, with clear guidance for follow-up disseminated at national and intermediate levels; document that health workers have

received training.

- Establish a process of immediate and weekly reporting from every reporting unit, although reports may not be available for every week.
- Establish a process to ensure that reported cases or events with outbreak potential are investigated and assessed for public health response and linked to the laboratory results, and that data from the investigation are managed in a standardized timeframe and manner.
- Conduct regular training for surveillance staff on SOPs, guidelines, procedures and best practices at national and intermediate levels
- Implement an electronic surveillance system at the national level for both indicator- and event-based surveillance. Develop an electronic event management system at the national level.
- Link electronic tools with the laboratory information management system at the national level.
- Develop and disseminate SOPs, procedures and guidelines at all levels.
- Train 80% of national- and intermediate-level surveillance staff on application/software for surveillance.
- Conduct training on data analysis at national and intermediate levels.
- Produce and disseminate annual and monthly reports based on some analysis (i.e. not only numerical case information) from the national surveillance team.
- Develop a training package and train staff on the assessment of risk of unusual case reports and surveillance signals at national and intermediate levels.
- Develop a process and publish routine reports of epidemiological information for priority diseases at the national level.
- Develop standards, content and format of an epidemiological bulletin for national, intermediate and local levels.
- Develop capacity to conduct periodic assessment of data quality at the national level.
- Train more than 90% local health workers, volunteers or both on detection and reporting of cases, clusters, outbreaks or events, and document that health workers are trained.
- Implement the immediate and weekly reporting mechanism in all health facilities (public and private) from all levels, and ensure that weekly reports are received.
- Train surveillance staff at all levels on monitoring and evaluating events, and develop and implement a clear follow-up of the process at national, intermediate and local levels.
- Develop a mechanism for cross-border surveillance by means of an agreed cross-border surveillance system at points of entry, or some other mechanism of regularly sharing data and information between neighboring countries.
- Conduct regular training on SOPs, guidelines, procedures and best practices at all levels, including at the local/health facility level, for surveillance staff.
- Implement the electronic system in 80% levels of the health system.
- Develop an electronic event management system at all levels of the health system.
- Link electronic tools with the laboratory information management system at all levels.
- Conduct routine training on application or software for surveillance staff at all levels, including 100% of national- and intermediate-level surveillance staff.
- Conduct training on data analysis for surveillance staff at all levels.
- Produce weekly epidemiological reports with analyzed data on priority diseases and

disseminate to all levels.

- Conduct a training assessment of the risk of unusual case reports and surveillance signals at all levels.
- Produce analyses and disseminate epidemiologic interpretation of all major events at all levels.
- Operationalize a mechanism for monitoring data quality and analysis at national and intermediate levels.

Strategy 3: Human Resources

- Assess and develop/document country's current health workforce strategy.
- Build planning capacity to develop or improve human resources for health policy and strategies that quantify health workforce needs, demands and supply under varied future scenarios.
- Develop a mechanism for multisectoral action on health workforce issues to generate required support from all relevant health sectors, ministries of finance, education and labor (or equivalent), collaborating partners and stakeholders.
- Develop a plan to fund and implement the health workforce strategy (animal and human health sector), and donor contributions.
- Document and disseminate the public health workforce/human resource strategy.
- Identify a responsible unit and advisory committee for the development of human resource capacity to meet IHR capacity needs.
- Conduct engagement meetings with the human, animal and environmental health sector workforce and other stakeholders to expand the multisectoral public health workforce strategy to include IHR capacity needs, such as public health training programs, human resource infrastructure, existing and required professional staffing levels, administrative support and funding requirements.
- Identify the needs as well as current availability and distribution of human resources for health capacities: (Global Strategy on HRH 2030 Obj1.28, Obj4.75): Surveillance officers (including field epidemiology short-course trained and longer course trained) and biostatisticians; Clinicians and clinical assistants ; Nurses ; Laboratory specialists and technicians ; veterinarians, veterinary technicians and para-veterinarians ; Information specialists and assistants ; Social scientists ; Other relevant public health personnel.
- Establish or strengthen national rapid response teams so that it is multidisciplinary and multilevel.
- Identify and address training needs for various professions/cadres.
- Identify and document training programs specific to professions within each preservice training curricula and joint training programs.
- Publish a national list of in-service training available in the country including national training institutes, professional bodies, schools of public health, nursing, midwifery, veterinary medical colleges and universities that provide in-service training courses.
- Identify and document all trainings related to contingency planning, management of emergency situations, risk communications, and joint exercises for multidisciplinary teams.
- Conduct engagement meeting with the health ministry, agriculture ministry and other

relevant stakeholders to determine readiness for a field or applied epidemiology program and potential career paths for its graduates.

- Document the need for applied epidemiology competencies by reviewing the educational system, public health training programs, workforce gaps and stakeholder interests.
- Review and document current field epidemiology capacity in the country.
- Evaluate existing field or applied epidemiology programs in the regional context and identify the host country where national public health professionals can be sent for training.
- Secure an agreement with another country to host participants and establish funding mechanisms to support the training. Conduct recruitment and selection of participants for field or applied epidemiology training in host country.
- Track the training and rostering of field or applied epidemiology participants and graduates in host country.
- Ensure availability of at least one trained epidemiologist per two million population.
- Develop protocols, SOPs, and technical guidelines to ensure regular review and update of the multisectoral workforce strategy with final approval from other relevant sectors or other relevant government agencies.
- Develop minimum standards for animal (domestic and wildlife), environmental and human health staffing levels. Document a separate workforce strategy for human resources for the animal and environmental health sectors, if not already included as part of the public health workforce strategy.
- Create appropriate job classification and job description for health workers at all levels of the relevant ministries, and clear career ladder.
- Establish a national case for investment in human resources for health as a vital component of the Sustainable Development Goals, Universal Health Coverage and universal access to healthcare (Global Strategy on HRH 2030 Obj3.59).
- Conduct advocacy to implement the strategy to relevant stakeholders, including ministries of health, finance, planning and administration/civil service.
- Develop a human resources for health unit in the human and animal health sectors that can monitor policies and plans to increase the multisector animal and human health workforce, and to promote the recruitment and retention of qualified multidisciplinary staff.
- Develop a database of in-country multidisciplinary subject matter experts relevant to IHR.
- Map relevant public health multidisciplinary workforce and review curriculum, with universities and partners, for all IHR human resource requirements (such as for the field epidemiology training program curriculum, training materials, mentors, evaluation procedures, accreditation).
- Develop continuing professional education programs, in priority One Health disciplines, at the national and subnational levels within the strategic framework that also tracks workforce retention and performance.
- Establish terms of reference and job descriptions for intermediate level (provincial, district) rapid response teams and public health officer in-charge of outbreak preparedness and response.

- Train or recruit human resources for the implementation of IHR capacities for all relevant sectors at the national level.
- Develop and implement a continuing professional education program that includes outbreak preparedness and control, for at least one group of professionals, such as public health officers, surveillance officers, nurses, midwives, general medical practitioners, veterinarians, para-veterinarians.
- Develop and implement at least at the national level short in-service trainings on surveillance, outbreak preparedness and response for specific cadres.
- Convene a field or applied epidemiology technical working group and establish goals for program staffing (both technical and administrative), with roles and responsibilities including leadership roles and mentorship of trainees.
- Develop a strategic plan for development of field or applied epidemiology program that includes an advisory group and governance structure with stakeholders, that allows the development of goals and objectives of national (or participation in regional) applied epidemiologists.
- Establish an advisory committee to maintain broad-based support from stakeholders and partners.
- Secure an acceptable location for field or applied epidemiology management.
- Identify a sustainable funding mechanism for field or applied epidemiology; consider basic level field or applied epidemiology with a plan for expansion into intermediate and advanced levels of field or applied epidemiology, as determined by country needs.
- Develop course curriculum, maintain scientific excellence in training, monitoring and evaluating trainees, and consult on epidemiological methods.
- Designate field supervisors and mentors for field or applied epidemiology and prepare guidelines for mentorship designated to monitor trainee activity, development of projects, barriers to training, among others.
- Develop training and SOPs for mentors and supervisors.
- Disseminate field or applied epidemiology training materials, protocols, SOPs and toolkits.
- Establish accreditation mechanisms for health training institutes.
- Conduct recruitment and selection of candidates for training including consideration for participation of veterinarians in the epidemiology training program.
- Track field or applied epidemiology capacity in the country including graduates and positions after training.
- Establish a partnership with other countries in the region to share epidemiology training program graduates during emergency events.
- Ensure availability of at least one trained epidemiologist per one million population.
- Monitor and evaluate the implementation of the multisectoral workforce strategy to track progress and barriers.
- Document how the national public health workforce is financed within the country (Global Strategy on HRH 2030 Obj2.38).
- Develop a strategic framework to nationally prioritize resources and investments in One Health workforce development.
- Map and align investment in human resources for health with the current and future needs of the population and health systems to address shortages and enhance distribution

of health workers, to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth (Global Strategy on HRH 2030 Obj2).

- Document and disseminate annual reports of the multisectoral workforce strategic plan which is completed and has been implemented consistently.
- Expand the multisectoral strategic workforce plan nationwide to the subnational level.
- Implement the multisectoral strategic workforce plan consistently at the national, and subnational levels, with regular reviews to track progress and barriers, and at least annual updates.
- Mobilize resources to ensure each local level has some capacity for epidemiology, case management, laboratory services, One Health, and others as needed.
- Develop and implement SOPs on how professionals at the national and subnational levels communicate during an infectious disease outbreak.
- Establish a database of human resources in all relevant sectors and levels of the public health system that can provide multidisciplinary health personnel during public health emergencies with SOPs for updating and maintaining it.
- Implement at national and subnational levels short-/long-term in-service training programs to help expand the number of qualified public health professionals within the country, i.e. Physicians (public health and/or clinical care) ; Nurses (public health and/or clinical care) ; Veterinarians (public health, agricultural and/or private practice) and para-veterinarians ; Biostatisticians ; Other public health officers/surveillance officers ; Laboratory assistants and specialists ; Livestock professionals.
- Implement at national and subnational levels short in-service trainings on surveillance, outbreak preparedness, response, incident command system and risk communication for specific cadres.
- Recruit specialists as part of IHR implementation at the next recruitment to strengthen human resources.
- Explore and implement measures to organize and finance specialization and continuous professional education in public health, including epidemiology, laboratory, animal and environmental health.
- Implement two levels of field or applied epidemiology including the basic, intermediate and/or advanced level at designated sites that comprise trainees from human and animal health professionals.
- Integrate a trained epidemiologist into core public health competencies (frontline surveillance, epidemiology, biostatistics, laboratory and biosafety, veterinary, communication).
- Map field or applied epidemiology capacity at intermediate level/district (or other similar administrative division) and track to inform updates to the national public health workforce strategy.
- Ensure availability of at least one trained epidemiologist per 500 000 population.

Strategy 4: Emergency Response Operations

- Establish a national health emergency coordination department or unit that maintains regular contact with experts from human, animal (domestic and wildlife), and environmental health as well as other sectors.
- Provide key potential informants and response partners for health emergency operations

that can have 24/7 coverage in all major health systems.

- Develop a capacity to ensure that the IHR NFP and other responsible parties are available 24/7 to receive information about potential health threats and to report a public health emergency of international concern as outlined in IHR (2005).
- Develop and implement SOPs for an ad-hoc emergency coordination mechanism during the events.
- Conduct a baseline assessment of emergency operations capacity including infrastructure, systems, workforce and legislation.
- Develop a health EOC activation plan that includes scaled level of response with health, communication and other resource requirements at the national level.
- Establish a functioning health EOC with the capacity to coordinate emergency operations in the event of an emergency
- Establish an incident management system for managing emergency response at the national level, including participation of relevant sectors.
- Develop a plan and SOPs, including thresholds and levels for activating the emergency response coordination mechanism. Establish and maintain a roster of emergency operations staff with defined roles and functions.
- Develop a training plan for emergency response staff, including on the incident management system, and implement it at least at the national level.
- Finalize SOPs for coordination of key health sector actors (such as surveillance, health facilities, emergency medical teams, mental health departments).
- Identify, train and roster a pool of surge staff for emergency response coordination.
- Form a steering committee or other management structure to develop objectives, essential functions and core components; oversee the EOC and monitor and evaluate its use.
- Develop an EOC implementation plan that includes both the planning and development of the EOC (as outlined in public health emergency operations center network framework) and the costing, funding and sustainability of the EOC.
- Develop an EOC activation plan that includes scaled level of response with resource requirements at each level.
- Develop a mechanism to ensure that the national emergency response plan lays out the concept of operations for the entire emergency response system.
- Establish a functional national EOC that includes dedicated plan and procedures, a secure physical space, an information and communication technology infrastructure for information management and support of emergency operations, and trained staff.
- Develop and implement a training program for national EOC staff including management, communications, finance and logistics. D
- Develop standardized forms and templates for data/information management, reporting, briefing and record-keeping.
- Develop a database of subject matter experts for consultation on priority hazards.
- Identify critical pieces of information to inform emergency response, such as epidemic intelligence, and develop systems to capture and manage this information.
- Develop plans to link laboratory and surveillance information to the emergency response communications structure
- Establish a health sector emergency response coordination mechanism with participation

from health and other sectors for managing emergency response at the subnational and local levels.
- Train subnational and local level health sector staff on the emergency response coordination mechanism.
- Conduct, at least every two years, an emergency response exercise or after-action review with a focus on coordination between national and subnational levels.
- Conduct a simulated exercise or demonstrate in response to a real event that the national EOC can be activated within 120 minutes of receiving an early warning or information of an emergency requiring EOC activation.
- Develop EOCs at the subnational level (based on the risks and geographical need) with plans and SOPs.
- Train EOC staff of subnational levels on SOPs and allocate dedicated resources.
- Develop and implement a tracking of decision-making procedure for the activation of an EOC

Strategy 5: Strengthen implementation of the IHR Monitoring and Evaluation Framework in countries

- Support governments, WHO, and other stakeholders to conduct Joint External Evaluations (JEE)
- Support governments, WHO, and other stakeholders to implement National Action Plans for Health Security (NAPHS)
- Support governments, WHO, and other stakeholders to conduct Simulation Exercises and/or After Action Reviews
- Provide TA to MoH and other host government institutions to implement activities to conduct JEEs
- Provide TA to MoH and other host government institutions to develop or implement evidence-based priority actions based NAPHS to improve health security
- Provide TA to MoH, WHO, and other host government institutions to conduct Simulation Exercises and/or After Action Reviews
- Support governments, WHO, and other stakeholder to monitor implementation of JEE and NAPHS
- Provide continued technical assistance in implementation of evidence-based activities that help the countries improve their JEE score and implementation of NAPHS in order to achieve prevent, detect, and respond framework

Strategy 6: Strengthen service delivery and implementation science programs and platforms

- Develop specific SOPs to strengthen the delivery of public health programs.
- Conduct trainings of healthcare workers to increase quality of public health programs.
- Use of data to strengthen public health programs.
- Conduct public health evaluations to improve quality of programs
- Developing technical and management capacity of National Institutes of Public Health (NPHI)
- Supporting leadership and managementf capacity development in areas such as,

financial management systems, data for policy development
- Leadership and management skills development in areas such as organizational development, strategic and operational planning, and fiscal management

<u>Component 2 Rapid Response to Small Scale Infectious Disease Outbreaks or other Public Health Emergencies</u>

Strategy 1: Intensify active surveillance, case finding, contact tracing, monitoring, and other critical response efforts at local levels

- Conduct and improve ongoing active surveillance, with laboratory confirmation to ensure rapid identification of missed, new or newly imported outbreak cases
- Strengthen capacity for general surveillance including support for personnel required for surveillance and epidemiology activities.
- Strengthen surveillance at entry points (border posts, airports and maritime ports) from countries with ongoing transmission

Strategy 2: Strengthen capabilities for epidemiologic and laboratory analysis and program evaluation

- Improve operational and technical analysis, coordination and monitoring of interventions.
- Assess the impact of the epidemic on health care seeking and health care provision.

Strategy 3: **Intensify social mobilization, community and professional education and engagement, and psychosocial care for infected persons and their families, where applicable**

- Conduct intensified social mobilization and community engagement to enhance awareness and gather community support, acceptance and participation in implementation of containment measures
- Provide psychosocial first aid training for community agents and their supervisors so they can provide direct psychosocial support to contact cases and their families.
- Develop and conduct communications to contain the outbreaks and enforce the theme of "Staying at Zero Cases."
- Develop and disseminate key health risk communication messages.

Strategy 4: Improve outbreak case management and infection control

- Develop plans for patient management as community and clinical settings.
- Improve infection control practices, particularly in facilities that might receive outbreak cases for example, on a border with a country with ongoing transmission

Strategy 5: Strengthen non-outbreak related public health activities that are impacted by the outbreak

- Restore priority aspects of the health/public health system such as surveillance and

assessment of vaccination coverage for epidemic-prone disease (e.g., measles), that are negatively impacted or stalled due to the outbreak.

Strategy 6: Increase security and logistics for local responders

- Strengthen field security to ensure operational security, and protect national and international staff involved in the response

Strategy 7: Strengthen capabilities for preparedness and response to highly infectious diseases

- Develop/implement partnership mechanisms for a more robust and responsive global health emergency workforce.
- Train frontline responders on emerging infectious diseases.
- Strengthen critical International Health Regulations (IHR) and health systems capacities in affected region and elsewhere.

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1. Collaborations

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

Recipients are required to work with other CDC implementing partners, including non-governmental organizations, universities, Ministry of Health and other host governmental bodies and multi-lateral organizations that receive CDC funds. The recipient should ensure their proposed activities are not duplicating activities already implemented by other CDC-funded organizations.

b. With organizations not funded by CDC:

The recipient(s) will work primarily and directly with partner governments specifically with the Ministries of Health and other government entities who are working towards the objectives of this NOFO. In addition, the recipient will be expected to work with other stakeholders in country and at the global level including but not limited to other government entities, non-governmental organizations, universities, civil society, the private sector, and other USG agencies.

2. Target Populations

The target populations for this NOFO include, but are not limited to, those individuals infected and affected by infectious diseases, or at risk for becoming infected by an infectious disease. The target population for this NOFO may also include at-risk population for non-communicable diseases and/or other public health emergencies.

The work under this NOFO may also target increased capacity at the national and sub-national level to implement activities in alignment with the objectives of this NOFO.

Recipients are expected to use epidemiologic, social determinants, and linked laboratory, epidemiological, and surveillance data to identify communities disproportionately affected by infectious diseases or non-communicable diseases in the target areas to ensure that program activities appropriately cover these populations. Recipients should ensure that supported services are accessible and available to all patients regardless of age, sex, race/ethnicity, sexual orientation, gender identity, or socio-economic status in order to achieve the objectives of this NOFO.

a. Health Disparities

N/A

iv. Funding Strategy

This NOFO is divided into three components - the applicant is required to propose work in a country, or region with a clearly marked budget, and work plan for each component.

Each country/and or regional budget and work plan should be submitted as an appendix with application.

<u>Component 1: Core Global Health Security Priorities</u>

These GHS activities are intended to be funded on an annual basis. The estimated YR1 funding available is $5,000,000/recipient. Future years funding level will be dependent on funding availability.

While applicants can submit applications supporting GHS activities in any country, for Year 1 applicants are encouraged to submit applications for the following countries or regions:

Countries: Bangladesh, Burkina Faso, Cambodia, China, Columbia, Ghana, Guinea, Haiti, Liberia, Mali, Mexico, Mozambique, Pakistan, South Africa, Thailand, Ukraine, Zambia.

Central America Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Guatemala, Honduras, Belize, El Salvador, Nicaragua, Costa Rica, Panama and Dominican Republic.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Eastern Europe & Central Asia (EECA) Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Armenia, Azerbaijan,

Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

South America (SA) Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, French Guiana, Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

West Africa (WA) Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Burkina Faso, Benin, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Eastern Mediterranean (EM) Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Afghanistan, Algeria, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Israel, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, State of Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, Turkey, United Arab Emirates, and Yemen.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Southeast Asia (SE) Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Vietnam, Thailand, Cambodia, Myanmar (Burma), Laos, Malaysia, Singapore, Brunei, Indonesia, and Papua New Guinea.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Southern Africa Region (SA) Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Angola, Botswana, Comoros, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Zambia and Zimbabwe.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Central & East Africa (CEA) Region: Applicants are encouraged to apply for activities covering

the objectives of this NOFO in the following countries: Burundi, Cameroon, Central African Republic, Chad, Republic of Congo, Equatorial Guinea, Gabon, Kenya, Rwanda, Sao Tome and Principe, South Sudan, Tanzania, and Uganda.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Western Pacific (WP) Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: China, Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia, Mongolia, Nauru, Niue, Palau, Philippines, Republic of Korea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Caribbean Region: Applicants are encouraged to apply for activities covering the objectives of this NOFO in the following countries: Bahamas, Turks and Caicos Islands, Haiti, Dominic Republic, Jamaica, Antigua and Barbuda, Saint Kitts and Nevis, Dominica, Saint Lucia, Saint Vincent and Grenadines, Grenada, Barbados, and Trinidad & Tobago.

Applicants are not required to apply for all countries in this region, however, priority will be given to applicants who can demonstrate the capacity in working in most of the countries in this region.

Component 2: Rapid Response to small scale infectious disease outbreaks or other Public Health Emergencies

This is intended to be approved but unfunded (ABU) as a baseline practice. It would be funded to support additional activities needed within a budget period when a disease outbreak or other public health emergency reaches a scale that requires a moderate response.Estimated planning level is $10,000,000.

Component 3: Rapid Response to Large Scale Infectious Disease Outbreaks or other Public Health Emergencies

This is intended to be approved but unfunded (ABU) as a baseline practice. It would be funded to support additional activities needed within a budget period when a disease outbreak or other public health emergency reaches a scale that requires a substantial response. Estimated planning level is $15,000,000.

Final decision on which countries and activities to be funded will be made at the time of award. Applications will be ranked order by each country. CDC can fund out of rank order in order: 1) to respond to an unforeseen public health emergency in any country of an international concern; 2) to align with USG and/or agency prioritized technical areas and activities; 3) to align with funding availability for countries or geographic area at the time of the award; 4) to ensure maximum coverage of GHS activities geographically; and 5) to avoid duplication of activities in other CDC funding mechanisms.

There is no minimum number of countries an applicant can apply for, however, CDC seeks to maximize coverage of GHS activities geographically and can fund out of order in order ensure maximum coverage of GHS activities geographically (based on funding availability for those countries at the time of award).

Emergency Funding

The ability to respond rapidly and effectively to public health emergencies is a key component of global health security. International public health emergencies including humanitarian crises are by nature unpredictable, requiring fulfilment of changing and often unpredictable needs that vary widely according to context. Consequently, funding for public health emergencies is also unpredictable and based on external factors. In recent years, there has been a sharp rise in the number of people living in regions of the world affected by public health emergencies, including humanitarian emergencies, which has often led to additional funding resources from the USG to respond to these threats. Given this unpredictability and the resulting need for rapid, flexible, and efficient process to award funding under an emergency situation, recipients that are selected for funding under this NOFO may be eligible to receive additional supplemental funding when a public health emergency occurs to scale up activities included within the scope of work of this NOFO.

Definition of public health emergency:

In order to qualify for supplemental emergency funding, one of the following situations must apply:

1. When UN or WHO classifies the emergency as a Level 3 (L3)
2. When the US Congress appropriates funding for an international response related to humanitarian or public health crisis with the words containing "emergency" in the program title. The appropriated funding could be for CDC directly or is transferred to CDC through an Interagency Agreement (IAA) by HHS or another USG agency
3. When the US government (Congress, White House, National Security Council etc) declares a public health emergency as national security priority
4. When HHS Secretary declares an emergency
5. When the CDC Director activates Emergency Operation Center (EOC) in response to an international public health threat
6. When Department of State or U.S. Agency for International Development (USAID) transfer funds to CDC to respond to an international disaster or humanitarian assistance under 2 FAM 060 (International Disaster and Humanitarian Assistance)

If a public health emergency situation meets any one criteria listed above, then selected recipients under this NOFO may be eligible to receive supplemental emergency funding to scale up public health activities included in the scope of work of this NOFO on a single-source basis, i.e., without additional competition. There is no limit on the number of emergency supplemental funding that a recipient may receive within a budget period or period of performance, however, emergency funding request cannot exceed a recipient's budget period or period of performance. In addition, all reporting requirements listed under this NOFO still applies to any emergency supplemental funding.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

The applicant should describe how they plan to measure and collect data on the funded activities and bolded outcomes identified in the logic model. The purpose of collecting and reporting these data is to determine the progress toward achieving the NOFO activities and outcomes. The results will also be used for program planning, development and improvement, accountability and reporting, and for sharing with partners and other stakeholders. CDC will work with the recipient throughout the life of this award to ensure that all activities and expected outcomes are in alignment with current USG and the recipient's strategies and goals. The recipient should dedicate funds made available under this NOFO for evaluation and performance monitoring within each project. The final funding amount will be agreed upon by both CDC and the recipient; however, it should be expected that approximately 3% (of a given project's funding) will be dedicated to monitoring, reporting, and evaluation activities. CDC and the recipient will agree upon the specific funding amounts within review of each project's work plan and budget.

Monitoring

CDC expects that the work conducted under this NOFO will be structured as a series of discrete projects oriented at achieving elements of the NOFO's strategic objectives. CDC and the recipient will jointly develop formal performance measures shortly after award based on activities within each project. For each project, these performance measures must include CDC's Division of Global Health Protection's Division-wide Indicators (DWIs), as well as other CDC or recipient's standard indicators relevant to the intended outcomes of the project. The DWIs include indicators that are required reporting for CDC, such as for OMB, HHS, USG Global Health Security Agenda (GHSA) interagency, and Healthy People. At a minimum, applicants should describe proposed process measures for the strategies and activities in the logic model, and proposed outcome measures for the period of performance outcomes in the logic model.

While recipients will be responsible for reporting on DWIs relevant to proposed strategies and activities, they are not limited to only DWIs listed below. Applicants can, and are encouraged to, propose additional relevant indicators that, combined with relevant DWIs, will be monitored over the life of the NOFO. Recipients will also be encouraged to identify relevant USG GHSA Interagency Metrics, WHO Joint External Evaluation (JEE), and/or Healthy People 2030 standardized metrics and WHO benchmarks.

Technical Area	**Division of Global Health Protection (DGHP) Division-wide Indicators (DWIs)** **as of April 2019**
Workforce Development (WD)	**WD#1:** Number of individuals trained by CDC to prevent, detect and respond to public health threats
	WD#2: Number of Field Epidemiology Training Program (FETP) residents trained by CDC that have participated in outbreak investigations and responses
	WD#3: Number and proportion of subnational jurisdictions per country

	that have had at least one staff member trained by FETP-Frontline
	WD#4: Number of CDC staff ready to provide emergency management and response assistance
Emergency Management and Response (EMR)	**EMR#1:** Number of public health events of international importance monitored and reported
	EMR#2: Number of public health events and other global health emergency responses supported by CDC
	EMR#3: Number of outbreaks investigated and responded to by the country
	EMR#4: Number and proportion of countries with an established Public Health Emergency Operations Center (PHEOC) that have used their PHEOC for a real-world response or simulation
Surveillance Systems (SS) and Laboratory Systems (LS)	**SS/LS#1:** Number and proportion of country-prioritized diseases and pathogens with laboratory testing capacity, surveillance system, and routine reporting to public health authorities
	SS#2: Number and proportion of countries with a centralized national database that includes linked suspect case reports and laboratory data from subnational jurisdictions for the country's priority notifiable diseases/syndromes
	LS#2: Number and proportion of designated laboratories that have bio-risk management policies, physical security controls and inventories for potential high consequence pathogens and toxins
	LS#3: Number of new diagnostic tests established in national or regional laboratories with CDC support
	LS#4: Number of new strains or pathogens detected or discovered with CDC support
	LS#5: Number and proportion of countries that have developed a national laboratory specimen referral system and transport networks
	LS#6: Number and proportion of laboratory facilities, designated in the national action plan for antimicrobial resistance (AMR) or as part of a national surveillance system, that conduct antimicrobial susceptibility testing (AST) and have reported susceptibility data to a designated national body
	LS #7: Number and proportion of countries that have adopted and implemented a national program of quality management systems (QMS)
Institutional Development (ID)	**ID#1:** Number of countries with a National Public Health Institute (NPHI) that was strengthened with CDC support

	ID#2: Number of countries whose core public health functions (laboratory, surveillance, workforce development and emergency management and response) are coordinated by the NPHI

Performance reports will be based on which NOFO activities and outcomes are identified in the logic model. Performance reports will be submitted to CDC in accordance with the requirements listed under this NOFO and overall performance will be reviewed on regular technical calls as well as through joint strategic review meetings.

Evaluation

The potential evaluation questions and/or topics below are examples of what the applicant may be expected to answer through evaluation(s). Applicants should include at least 1, but no more than 3 potential evaluation questions, or evaluation topics if specific questions are unknown. It is acceptable to provide only evaluation questions, only evaluation topics, or a combination of both evaluation questions and topic, as needed. Applicants should consider but are not limited to the following areas when developing evaluation questions and/or topics.

Sample Evaluation Topics:

- Program evaluations to measure the differences in outbreak responses, or other public health responses, in a country, before and after public health investments (in terms of days of outbreak start, days to outbreak detection, laboratory confirmation of outbreak, days to control outbreak, etc.).
- Extent to which enhancements in public health surveillance in a country improved outbreak response (in terms of outbreak(s) controlled, cases averted, and time lags from specimen detection to collection).
- Extent to which enhancements of the public laboratory systems, such as addition of a specific laboratory capacity in a country, improved outbreak response (in terms of outbreaks detected controlled, cases averted, and time lags from specimen collection to detection).
- Program evaluations to measure if the coverage and capacity of the specimen referral network increased

Final evaluation questions and data sources will be determined together with CDC within 6 months after the award and will be included in the submission of the evaluation and performance measurement plan (EPMP). Evaluations are expected to align with national, USG, and agency priorities and programmatic gaps, and maybe be reviewed by global action committees. As such, the evaluation topics listed in this announcement may be amended.

ii. Applicant Evaluation and Performance Measurement Plan

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

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.

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

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

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

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

c. Organizational Capacity of Recipients to Implement the Approach

The applicant should provide as part of their appendix the following documents:

1. Curricula vitae (CVs)/Resumes for positions related to Principal Investigator, Project Director, Business Official, and other key staff related to program planning and implementation, finance, and monitoring and evaluation .
2. Job descriptions (maximum 1 page per job description) for key positions including: Principal Investigator, Project Director, Business Official, and other key staff related to program planning and implementation, finance, and monitoring and evaluation.
3. Organizational chart (maximum 1 page)
4. Capacity statement to be able to implement the activities proposed under this NOFO (maximum 1 page).
5. Financial management statement that demonstrates experience in managing USG or CDC funds that are similar in size and scope of this NOFO (maximum 1 page).

The above referenced documents to be submitted in the appendix should demonstrate the organization's capacity to address the requirements of the NOFO.

Applicants must title these documents in their appendix as follows: "CVs/Resumes," "Job Descriptions," "Organizational Chart," "Capacity," "Financial Statement" and upload it at www

.grants.gov.

d. Work Plan

Applicants are required to apply for all three components for each country they are submitting an application for. Only one application with clearly marked workplan and budget for each component will be accepted. In addition, applicant's workplan for each component must clearly indicate what country and activities they are applying for as well as the proposed budget for each country.

Applicant must include a work plan that demonstrates how the outcomes, strategies, activities, timelines, and staffing will take place over the course of the award. Applicants must submit a detailed work plan for the first year of the project. An example work plan is shown below. Applicants are not required to use this format, as long as they include the information above.

Period of Performance Outcome:		**Outcome Measure:**	
Strategies and Activities	**Process Measure**	**Responsible Position /Party**	**Completion Date**
1.			
2.			
3.			
4.			
5.			
6			

e. CDC Monitoring and Accountability Approach

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

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

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

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.

- Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

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

The recipient(s) will be required to collaborate with CDC in-country offices for technical oversight of project activities to be implemented under this NOFO. For countries where there is no in-country CDC office, the recipient will be required to work with CDC headquarters (HQ) for technical oversight of project activities to be implemented under this NOFO. In addition to the project officer, the recipient will collaborate with in-country or HQ contacts, Subject Matter Experts (SMEs) and technical leads. The project officer for this award will provide relevant contacts of CDC staff and coordinate discussions with the award recipients.

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

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring. CDC activities for this program include, but are not limited to, the following:

1. Organize an orientation meeting with the recipient for a briefing on applicable U.S. Government and HHS/CDC expectations, regulations and key management requirements, as well as report formats and contents. The orientation could include meetings with staff from HHS agencies and/or other parts of the USG.
2. Review and make recommendations as necessary to the process used by the recipient to select key personnel and/or post-award subcontractors and/or sub recipients to be involved in the activities performed under this agreement.
3. Provide technical assistance, as mutually agreed upon, and revise annually during validation of the first and subsequent annual work plans. This could include expert technical assistance and targeted training activities in specialized areas, such as surveillance, use of data for program planning purposes, lab programs etc.
4. Provide technical assistance, where applicable, to help the recipient meet U.S. Government financial and reporting requirements approved by the Office of Management and Budget (OMB).
5. Collaborate with the recipient on designing and implementing the activities listed above, including, but not limited to: the provision of technical assistance to develop program activities, data management and analysis, quality assurance, surveillance program, the presentation and possibly publication of program results and findings, and the management and tracking of finances.
6. CDC offices in-country, where applicable, may assist the recipient in identifying and connecting with other partners working towards the objective of this NOFO and the recipient shall ensure work is not duplicative but complementary and supportive to existing efforts funded by CDC and the rest of the USG.
7. CDC, via project officer, will provide contact for in-country staff, Subject Matter Experts

(SMEs) and technical leads from CDC where applicable for the recipient to coordinate activities at the country level.
8. Provide technical assistance or advice on any data collections on 10 or more people that are planned or conducted by the recipient. All such data collections-- where CDC staff will be or are approving, directing, conducting, managing, or owning data-- must undergo OMB project determinations by CDC and may require OMB Paperwork Reduction Act (PRA) clearance prior to the start of the project.
9. Provide consultation and scientific and technical assistance based on appropriate HHS/CDC documents to promote the use of best practices known at the time.
10. Assist the recipient in developing and implementing quality-assurance criteria and procedures.
11. Serve as co-authors on manuscripts and dissemination products developed as part of this project.
12. Facilitate in-country planning and review meetings for technical assistance activities.
13. Provide technical oversight for all activities under this award.
14. Ensure the recipient's Evaluation and Performance Measurement Plan is aligned with the strategic information guidance established by HHS/CDC and USG.
15. Provide ethical reviews, as necessary, for evaluation activities, including from HHS/CDC headquarters. Evaluations can be process, outcome or impact
a. Process Evaluation: measures how the intervention was delivered, what worked/did not, differences between the intended population and the population served, and access to the intervention
b. Outcome Evaluation: determines effects of intervention in target population(s) (e.g., change in knowledge, attitudes, behavior, capacity, etc.)
c. Impact Evaluation: measures net effects of program and prove of causality
16. Supply the recipient with protocols for related evaluations and/or assessment

B. Award Information

1. Funding Instrument Type:	Cooperative Agreement CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.
2. Award Mechanism:	U2H
3. Fiscal Year:	2020
4. Approximate Total Fiscal Year Funding:	$75,000,000
5. Approximate Period of Performance Funding:	$500,000,000

This amount is subject to the availability of funds.

Estimated Total Funding:	$500,000,000
6. Approximate Period of Performance Length:	5 year(s)
7. Expected Number of Awards:	15

8. Approximate Average Award: $5,000,000 Per Budget Period

9. Award Ceiling: $0 Per Budget Period

This amount is subject to the availability of funds.

There is no award ceiling for this NOFO.

10. Award Floor: $0 Per Budget Period

11. Estimated Award Date: 09/30/2020

12. Budget Period Length: 12 month(s)

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

13. Direct Assistance

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

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:

State governments
County governments
City or township governments
Special district governments
Independent school districts
Public and State controlled institutions of higher education
Native American tribal governments (Federally recognized)
Public housing authorities/Indian housing authorities
Native American tribal organizations (other than Federally recognized tribal governments)
Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education
Nonprofits without 501(c)(3) status with the IRS, other than institutions of higher

education
Private institutions of higher education
For profit organizations other than small businesses
Small businesses
Others (see text field entitled "Additional Information on Eligibility" for clarification)
Unrestricted (i.e., open to any type of entity above), subject to any clarification in text field entitled "Additional Information on Eligibility"

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)
Local governments or their bona fide agents
Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.
State controlled institutions of higher education
American Indian or Alaska Native tribal governments (federally recognized or state-recognized)

Non-government Organizations:

American Indian or Alaska native tribally designated organizations

Other:

Ministries of Health

2. Additional Information on Eligibility

This is an open competition NOFO

3. Justification for Less than Maximum Competition

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.

a. Data Universal Numbering System:

All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.

The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at http:// fedgov.dnb. com/ webform/ displayHomePage.do. The DUNS number will be provided at no charge.

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

b. System for Award Management (SAM):

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

c. Grants.gov:

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

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

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http://fedgov.dnb.com/ webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http://fedgov.dnb.com/webform) or call 1-866-705-5711
2	System for Award Management (SAM) formerly Central Contractor Registration (CCR)	1. Retrieve organizations DUNS number 2. Go to https://www.sam.gov/SAM/ and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a DUNS number and SAM	Register early! Log into grants.gov and check AOR status until it shows you have been approved

			account before applying on grants.gov)	

2. Request Application Package

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

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this notice of funding opportunity at www.grants.gov.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by OGS.

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

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

b. Application Deadline

Due Date for Applications: **04/27/2020** , 11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Date for Information Conference Call

5. CDC Assurances and Certifications

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

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

(S(mj444mxct51lnrv1hljjjmaa))/ Homepage.aspx

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

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

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and DUNS.
When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

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

budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.
Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission

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

7. Letter of Intent

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

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.
Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

(Maximum 1 page)
A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)
Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients

should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

a. Background

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

b. Approach

i. Purpose

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

ii. Outcomes

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

iii. Strategies and Activities

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

1. Collaborations

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

2. Target Populations and Health Disparities

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

c. Applicant Evaluation and Performance Measurement Plan

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

plan must describe:

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

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

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

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

d. Organizational Capacity of Applicants to Implement the Approach

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

11. Work Plan

(Included in the Project Narrative's page limit)
Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

Applicants must submit an itemized budget narrative. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs could include the cost of collecting, managing, sharing and preserving data. Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.
If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.
Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve

vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.
Applicants must name this file "Budget Narrative" and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

13. Funds Tracking

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

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

14. Intergovernmental Review

Executive Order 12372 does not apply to this program.

15. Pilot Program for Enhancement of Employee Whistleblower Protections

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

16. Copyright Interests Provisions

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

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

17. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
    - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
    - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order

proposed or pending before any legislative body

- See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.
- In accordance with the United States Protecting Life in Global Health Assistance policy, all non-governmental organization (NGO) applicants acknowledge that foreign NGOs that receive funds provided through this award, either as a prime recipient or subrecipient, are strictly prohibited, regardless of the source of funds, from performing abortions as a method of family planning or engaging in any activity that promotes abortion as a method of family planning, or to provide financial support to any other foreign non-governmental organization that conducts such activities. See Additional Requirement (AR) 35 for applicability (https://www.cdc.gov/grants/additionalrequirements/ar-35.html).

Indirect Cost for Foreign Organization

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. Indirect costs will not be reimbursed under grants to foreign organizations, international organizations, and foreign components of grants to domestic organizations (does not affect indirect cost reimbursement to the domestic entity for domestic activities). All requests for funds contained in the budget shall be stated in U.S. dollars. Once an award is made, CDC will not compensate foreign recipients for currency exchange fluctuations through the issuance of supplemental awards.

Public Financial Management Clause

The Parties acknowledge that HHS/CDC has the authority to assess the recipient's systems required to manage the activities supported with US Government funds under this Agreement and that this NOFO is expressly conditioned upon that assessment, as well as any measures, mitigation or means by which the recipient has or will address the vulnerabilities or weaknesses, if any, found in that assessment. The recipient agrees to take the necessary action(s) to address the recommendations or requirements of the assessment as agreed separately in writing with HHS/CDC in accordance with an action plan to be jointly developed to address such recommendations or as otherwise contained in this agreement.

Conference Costs and Fees

U.S. Government funds under this award must not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government's delegation to an international conference sponsored by a multilateral organization, as defined below, unless approved by CDC in writing.

- Definitions:
    - A foreign government delegation is appointed by the national government (including ministries and agencies but excluding local, state and provincial entities) to act on behalf of the appointing authority at the international conference. A conference participant is a delegate for the purposes of this provision, only when there is an appointment or designation that the individual is authorized to officially represent the government or agency. A delegate may be a private citizen.
    - An international conference is a meeting where there is an agenda, an organizational structure, and delegations from countries other than the conference location, in which country delegations participate through discussion, votes, etc
    - A multilateral organization is an organization established by international agreement and whose governing body is composed principally of foreign governments or other multilateral organizations

Trafficking in Persons Provision

- No contractor or sub-recipient under this Agreement that is a private entity may, during the period of time that the award is in effect:

    o engage in trafficking in persons, as defined in the Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children, supplementing the UN Convention against Transnational Organized Crime;

    o procure any sex act on account of which anything of value is given to or received by any person; or

    o use forced labor in the performance of this award.

- If HHS/CDC determines that there is a reasonable basis to believe that any private party contractor or subrecipient has violated paragraph 1 of this section or that an employee of the contractor or subrecipient has violated such a prohibition where that the employee's conduct is associated with the performance of this award or may be imputed to the contractor or subrecipient, HHS/CDC may, without penalty, (i) require the Recipient to terminate immediately the contract or subaward in question or (ii) unilaterally terminate this Agreement in accordance with the termination provision.
- For purposes of this provision, "employee" means an individual who is engaged in the performance in any part of the Project as a direct employee, consultant, or volunteer of any private party contractor or subrecipient.
- The Applicant must include in all subagreements, including subawards and contracts, a provision prohibiting the conduct described in subsection a by private party subrecipients, contractors, or any of their employees.

Prohibition on Assistance to Drug Traffickers

- HHS/CDC reserves the right to terminate assistance to, or take other appropriate

measures with respect to, any participant approved by HHS/CDC who is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

- The Applicant agrees not to disburse, or sign documents committing the Applicant to disburse funds to a sub-recipient designated by HHS/CDC ("Designated Sub-recipient") until advised by HHS/CDC that: (1) any USG review of the Designated Sub-recipient and its key individuals has been completed; (2) any related certifications have been obtained; and (3) the assistance to the Designated Sub-recipient has been approved.
- The Applicant shall insert the following clause, or its substance, in its agreement with the Designated Sub-recipient:
- The Applicant reserves the right to terminate this Agreement or take other appropriate measures if the [Sub-recipient] or a key individual of the [Sub-recipient] is found to have been convicted of a narcotic offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

Financing of Terrorism

Consistent with numerous United Nations Security Council resolutions, including UNSCR 1267 (1999) (http://www.undemocracy.com/S-RES-1269(1999).pdf), UNSCR 1368 (2001) (http://www.undemocracy.com/S-RES-1368(2001).pdf), UNSCR 1373 (2001) (http://www.undemocracy.com/S-RES-1373(2001).pdf), and UNSCR 1989 (2011), both HHS/CDC and the applicant are firmly committed to the international fight against terrorism, and in particular, against the financing of terrorism. It is the policy of HHS/CDC to seek to ensure that none of its funds are used, directly or indirectly, to provide support to individuals or entities associated with terrorism. In accordance with this policy, the Applicant agrees to use reasonable efforts to ensure that none of the HHS/CDC funds provided under this Agreement are used to provide support to individuals or entities associated with terrorism, including those identified on the U.S. Department of Treasury Office of Foreign Assets Control Specially Designated Nationals List. This provision must be included in all subagreements, including contracts and subawards, issued under this award.

Restriction on Assistance for Military or Paramilitary Purposes or for Police and Prisons

No funds or other support provided under the award may be used for support to any military or paramilitary force or activity, or for support to any police, prison authority, or other security or law enforcement forces without the prior written consent of HHS/CDC.

UN Security Council Sanctions List

It is the policy of HHS/CDC to seek to ensure that none of its funds are used, directly or indirectly, to provide support to individuals or entities designated for United Nations Security Council sanctions. In accordance with this policy, the applicant agrees to use reasonable efforts to ensure that none of the funds provided under this grant are used to provide support of individuals or entities designated for UN Security Council sanctions (compendium of Security Council Targeted Sanctions Lists at: http://www.un.org/sc/committees/list_compend.shtml). This provision must be included in all sub-agreements, including contracts and sub-awards, issued under this award.

Worker's Rights

No funds or other support provided hereunder may be used for any activity that contributes to the violation of internationally recognized workers' rights of workers in the recipient country.

In the event the Applicant is requested or wishes to provide assistance in areas that involve workers' rights or the Applicant requires clarification from HHS/CDC as to whether the activity would be consistent with the limitation set forth above, the Applicant must notify HHS/CDC and provide a detailed description of the proposed activity. The Applicant must not proceed with the activity until advised by HHS/CDC that it may do so.

The Applicant must ensure that all employees and subcontractors and sub-recipients providing employment-related services hereunder are made aware of the restrictions set forth in this clause and must include this clause in all subcontracts and other sub-agreements entered into hereunder.

The term "internationally recognized worker rights" includes-- the right of association; the right to organize and bargain collectively; a prohibition on the use of any form of forced or compulsory labor; a minimum age for the employment of children, and a prohibition on the worst forms of child labor; and acceptable conditions of work with respect to minimum wages, hours of work, and occupational safety and health.

The term "worst forms of child labor" means-- all forms of slavery or practices similar to slavery, such as the sale or trafficking of children, debt bondage and serfdom, or forced or compulsory labor, including forced or compulsory recruitment of children for use in armed conflict; the use, procuring, or offering of a child for prostitution, for the production of pornography or for pornographic purposes; the use, procuring, or offering of a child for illicit activities in particular for the production and trafficking of drugs; and work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety, or morals of children, as determined by the laws, regulations, or competent authority of the country.

Investment Promotion

No funds or other support provided hereunder may be used to provide a financial incentive to a business enterprise currently located in the United States for the purpose of inducing such an enterprise to relocate outside the United States if such incentive or inducement is likely to reduce the number of employees of such business enterprise in the United States because United States production is being replaced by such enterprise outside the United States.

In the event the Applicant requires clarification from HHS/CDC as to whether the activity would be consistent with the limitation set forth above, the Applicant must notify HHS/CDC and provide a detailed description of the proposed activity. The Applicant must not proceed with the activity until advised by HHS/CDC that it may do so.

The Applicant must ensure that its employees and subcontractors and sub-recipients providing investment promotion services hereunder are made aware of the restrictions set forth in this clause and must include this clause in all subcontracts and other sub-agreements entered into hereunder.

Contract Insurance Requirement

To the extent that a host government partner enters into contracts expressly approved by the U.S. government, the host country government partner shall ensure that its contractors or subcontractors (a) provide, before commencing performance under any contracts or

subcontracts funded under this agreement, such workers' compensation insurance or security as required by HHS/CDC and (b) continue to maintain such insurance until performance is completed. The host country government partner shall insert, in all contracts and subcontracts under this agreement, a clause similar to this clause (including this sentence) imposing upon those contractors and subcontractors the obligation to obtain workers' compensation insurance or security as required by HHS/CDC.

Source and Nationality and Other Procurement Restrictions

Disbursements will be used exclusively to finance the costs of goods and services

required for this Agreement [in accordance with 22 CFR 228, and] having their source and nationality in countries [included in Geographic Code [937 or 935]] OR [identified in subsection 6 below], except as HHS/CDC may otherwise agree in writing and as follows:

- Ocean transportation costs must be financed under the Agreement only on vessels under flag registry of [countries included in Code 935] OR [the following countries: LIST. Also see subsection 7 below on use of U.S.-flag vessels.
- Any motor vehicles financed under the Agreement will be of United States manufacture, except as HHS/CDC may otherwise agree in writing.
- The nationality of the contractor providing ocean and air shipping services will be deemed to be the ocean vessel's or aircraft's country of registry at the time of shipment.
- Provisions concerning restricted and ineligible goods and services may be provided in subsequent written communications between the parties. Special procurement rules apply to agricultural commodities, pharmaceuticals, pesticides, and fertilizer, none of which may be procured without advance written consent of HHS/CDC.
- Transportation by air of property or persons financed under this agreement will be on carriers holding United States certification to the extent service by such carriers is available under the Fly America Act. This requirement may be further described by HHS/CDC in subsequent written communications between the parties.
- Eligibility Date. No goods or services may be financed under the Agreement which are procured pursuant to orders or contracts firmly placed or entered into prior to the date of this Agreement, except as the Parties may otherwise agree in writing.
- Eligible countries for procurement: HHS/CDC to identify for specific agreement.
- Transportation

    o In addition to the requirements in subsection 1 above, costs of ocean or air transportation and related delivery services may not be financed under this Agreement, if the costs are for transportation under an ocean vessel or air charter which has not received prior HHS/CDC approval.

    o Unless HHS/CDC determines that privately owned U.S. -flag commercial ocean vessels are not available at fair and reasonable rates for such vessels, or otherwise agrees in writing:

- At least fifty percent (50%) of the gross tonnage of all goods (computed separately for dry bulk carriers, dry cargo liners and tankers) financed by HHS/CDC which may be transported on ocean vessels will be transported on privately owned U.S.-flag

commercial vessels; and

- At least fifty percent (50%) of the gross freight revenue generated by all shipments financed by HHS/CDC and transported to the territory of the Recipient on dry cargo liners shall be paid to or for the benefit of privately owned U.S.-flag commercial vessels. Compliance with the requirements of (1) and (2) of this subsection must be achieved with respect to both any cargo transported from U.S. ports and any cargo transported from non-U.S. ports, computed separately.

Monitoring and Evaluation Section

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, must require a provision to this effect in all sub-awards or contracts financed by funds under this Agreement.

Monitoring Reporting and Evaluation

CDC programs must ensure that recipient's Evaluation and Performance Measurement Plan is aligned with the guidance established by HHS/CDC and CDC's Data for Partner Monitoring Program (DFPM). All evaluations conducted must submit an evaluation report using a format agreed upon by HHS/CDC.

Human/Animal Subjects Restriction

All plans for data collection from persons, animals or personal records and for laboratory specimen collection and testing that are expected to result in public reports will require protocols for technical review and review of institutional human or animal subjects protection considerations by CDC. Funds for implementing these activities will be restricted until all necessary institutional protocol approvals have been obtained. Funds for preparatory activities (e.g., protocol development, training, equipment, reagents, and site preparation) may be provided prior to protocol approval. To facilitate the early availability of funding, the budget and narrative should clarify which activities are preparatory.

Data collection protocols required for release of human/animal subjects funding restrictions must be submitted to the DGHP Science Office within 6 months of notification of such restrictions, but no later than the end of the first budget year. Requests for exceptions to these deadlines will need to be submitted in writing to the Grants Management Officer.

All protocol approvals should be obtained no later than the end of the subsequent budget period after the award or continuation has been made, provided that the Recipient has not been granted an exception to the deadlines specified above.

18. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan. The DMP is the applicant's assurance of the quality of the public health data through the data's lifecycle and plans to deposit data in a repository to

preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additionalrequirements/ar-25.html

19. Other Submission Requirements

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

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

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the NOFO. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Grants.gov Online User Guide.
https:// www.grants.gov/help/html/help/index.htm? callingApp=custom#t=
Get_Started%2FGet_Started. htm

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

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants

should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.
An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered.

   If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

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

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

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.
i. Approach
ii. Evaluation and Performance Measurement
iii. Applicant's Organizational Capacity to Implement the Approach
Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements.

i. Approach Maximum Points:35

To what extent does the applicant demonstrate a clear and concise understanding of the current public health problem and context relevant to the programmatic areas targeted? **(5 points)**

To what extent does the applicant describe activities that are evidence-based, realistic, achievable, measurable, and culturally appropriate to meet the objectives of this NOFO in the

different contexts and challenges of the health system in the proposed country (or countries)? **(10 points)**

To what extent does the application include an overall strategy, including measurable timelines, clear M&E procedures, and specific activities for meeting the proposed outcomes? **(5 points)**

To what extent did the applicant's approach describe in detail the proposed methodology/technical approach to meet the requirements of this NOFO? **(5 points)**

To what extent does the application propose to build on and complement the current national program response? **(5 points)**

To what extent does the applicant demonstrate experience and ability to coordinate with and build capacity of Ministries of Health and/or other relevant host government institutions? **(5 points)**

ii. Evaluation and Performance Measurement Maximum Points:35

To what extent does the evaluation and performance measurement plan (EPMP) appropriately address performance measures (i.e., indicators), how often performance measures must be reported, how evaluation and performance measurement will track how target populations are affected by NOFO strategies, how evaluation findings and performance measures will be used and yield findings to demonstrate the value of the NOFO, and how results will be disseminated? **(10 points)**

To what extent does the applicant describe a performance monitoring system used to routinely review data and adjust program activities accordingly? **(5 points)**

Are there performance measures (i.e. indicators) developed for each program milestone, and incorporated into the financial and programmatic reports? **(5 points)**

To what extent does the applicant demonstrate a system to meet administrative, technical, and programmatic reporting requirements as stated in this NOFO? **(5 points)**

To what extent does the applicant demonstrate a system able to generate financial and program reports to show disbursement of funds and progress towards achieving the objectives of this NOFO? **(5 points)**

To what extent does the applicant describe an adequate and measurable plan to progressively strengthen the capacity of host government and target beneficiaries to respond to the public health problem? **(5 points)**

iii. Applicant's Organizational Capacity to Implement the Approach Maximum Points:0

To what extent did the applicant demonstrate local experience and institutional capacity in implementing GHS activities in program areas and countries where the applicant has applied for? **(5 points)**

To what extent did the applicant describe their ability to work with the host government in implementing activities? **(5 points)**

Did the applicant propose qualified staff, with appropriate technical experience, local experience, and language fluency to meet the goals of this NOFO? **(5 points)**

To what extent are the staff roles clearly defined and did the applicant include CVs of key

staff? **(5 points)**

Did the management structure for the project demonstrate a clear plan for administration and management of the proposed activities, to manage the resources of the program, prepare reports, monitor and evaluate activities, audit expenditures and produce collect and analyze performance data? **(5 points)**

To what extent did the applicant demonstrate ability to submit quarterly financial and programmatic reports in a timely manner to the HHS/CDC office? **(5 points)**

Budget

The budget will not be scored but will be reviewed. Is the itemized budget for conducting the project, along with justification, reasonable and consistent with stated objectives and planned program activities? Is the budget itemized, well justified and consistent with the goals of the NOFO? If applicable, did the Applicant clearly indicate activities and budget for each component in their submitted workplan? Did the applicant clearly indicate the proposed budget for each country?

c. Phase III Review

Final decision on which countries and activities to be funded will be made at the time of award. CDC can fund out of rank order in order: 1) to respond to an unforeseen public health emergency in any country of an international concern; 2) to align with USG and/or agency prioritized technical areas and activities; 3) to align with funding availability for countries or geographic area at the time of the award; 4) to ensure maximum coverage of GHS activities geographically; and 5) to avoid duplication of activities in other CDC funding mechanisms.

In addition, the following factors also may affect funding decision: Funding Preferences

Funding Preference 1 Points: 10

Funding Preference 1: Preference for organizations that are legally registered to work in countries where the applicant has applied for.

Deliverable 1: Proof of Legal documentation of registration by the applying entity for the countries the applicant has applied for. Applicants must submit documentation for each country they have applied for in order to qualify for this funding preference.

Label for Deliverable 1: Funding Preference for existing organizations

Funding Preference 2 Points: 5

Funding Preference 2: Preference to local and indigenous organizations

Deliverable 2: Letter from the PI clearly demonstrating how the organization meets the published criteria for local/indigenous partner

Label for Deliverable 2: Local Partner Preference

Local Partner Definition

To be considered a local partner under this NOFO, the applicant must submit supporting

documentation demonstrating how their organization meets one of the three criteria listed below under the "Local Partner definition." The supporting documentation must be included in the Appendices of the application and must be labeled as "Eligibility Documentation for Local Partner Definition." Applicants that do not provide and/or label the supporting documentation required to meet the Local Partner definition above will not be considered eligible for review.

A "local partner" may be an individual or sole proprietorship, an entity, or a joint venture or other arrangement. However, to be considered a local partner in a given country under this NOFO, the partner must meet the criteria under paragraph (1), (2), or (3) below:

- an individual must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country served by the country program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; or

- an entity (e.g., a corporation or partnership):

1. must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the country program with which the entity is or may become involved;

1. must be at least 75% beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), or by other corporations, partnerships or other arrangements that are local partners under this paragraph or paragraph (3);
    3. at least 75% of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), and at least 75% of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; and
2. 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 such country; or
3. a joint venture, unincorporated association, consortium, or other arrangement in which at least 75% of the funding under this award is or will be provided to members who are local partners under the criteria in paragraphs (1) or (2) above, and a local partner is designated as the managing member of the organization. Partner government ministries (e.g., Ministry of Health), sub-units of government ministries, and parastatal organizations in the country are considered local partners. A parastatal organization is defined as a fully or partially government-owned or government-funded organization. Such enterprises may function through a board of directors, similar to private corporations. However, ultimate control over the organization rests with the government.

Note: To be considered a local partner, the applicant must submit supporting documentation demonstrating their organization meets at least one of the three criteria listed above.

Review of risk posed by applicants.

Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.
In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.
CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.
In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:
(1) Financial stability;
(2) Quality of management systems and ability to meet the management standards prescribed in this part;
(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;
(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and
(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.
CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

9/30/2020

F. Award Administration Information

1. Award Notices

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

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements

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

AR-9: Paperwork Reduction Act Requirements

AR-10: Smoke-Free Workplace Requirements

AR-11: Healthy People 2020

AR-12: Lobbying Restrictions (June 2012)

AR-14: Accounting System Requirements

AR-25: Data Management and Access

AR-27: Conference Disclaimer and Use of Logos

AR-35: Protecting Life in Global Health Assistance

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

3. Reporting

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

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

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

Report	**When?**	**Required?**
Recipient Evaluation and Performance Measurement Plan, including Data Management Plan	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
Performance Measure Reporting	Annual reports due 90 calendar days after the award year; and quarterly reports due 30 days after the reporting period	Yes
Audit, Books, and Records	When applicable, within 30 days of completion of the audit and no later than nine months after the end of the period under audit	Yes, as applicable
Reporting of Foreign Taxes	Reports due April 15, July 15, October 15, and Jan 15	Yes
Expenditure Report	Financial reports due to CDC for each country and program area funded under this NOFO	Yes
Federal Financial Reporting Forms	90 days after the end of the budget period	Yes

Final Performance and Financial Report	90 days after end of period of performance	Yes
Payment Management System (PMS) Reporting	Reports due January 30; April 30; July 30; and October 30	Yes

a. Recipient Evaluation and Performance Measurement Plan (required)
With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

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

Performance Measurement

• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.
• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

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

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)

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

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

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

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

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

The recipient is responsible for managing and monitoring each project, program, sub award,

function or activity supported through this Agreement. Recipients must monitor sub awards to ensure that sub recipients have met the programmatic impact requirements as set forth in the sub recipient's agreement.

Performance reports must contain, for each award, brief information on each of the following:

• A comparison of actual accomplishments with the goals and objectives previously established for the period, including metrics outlined in the monitoring and evaluation plan any findings of an external entity, or both.
• Reasons why established goals for the performance period were not met, if appropriate.
• Other pertinent information including, when appropriate, statutory or Congressional reporting requirements, analysis and explanation of cost overruns or high unit costs reported in financial reports.
• The recipient must immediately notify the awarding agency of developments that have a significant impact on or adverse conditions which materially impair the award-supported activities.
• The recipient must submit the original and two copies of annual and quarterly Performance reports and quarterly pipeline analysis. Annual reports must be due 90 calendar days after the award year and quarterly reports must be due 30 days after the reporting period. The final performance reports are due 90 calendar days after the expiration or termination of this Agreement.

Additionally, the following terms apply to all performance measure and evaluation plans and reports:
• CDC programs must ensure that recipient's Evaluation and Performance Measurement Plan is aligned with the guidance established by HHS/CDC.
• 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 of the Activities and use of HHS/CDC funding under this Agreement, must require a provision to this effect in all sub-awards or contracts financed by funds under this Agreement.
• The recipient is required to submit in a timely manner all program results for all relevant programmatic indicators in accordance with U.S. government guidance. All evaluation reports (with or without CDC authors) must adhere to HHS/CDC evaluation standard of practice and must be published on a publically available Internet website, upon approval from CDC offices.

Audit, Books, and Records Clause (required):
A. Reports and Information. The recipient must furnish HHS/CDC accounting records and such other information and reports relating to the Agreement as HHS/CDC may reasonably request.

B. The Recipient Agreement Books and Records. The recipient must maintain accounting books, records, documents and other evidence relating to the Agreement, adequate to show, without limitation, all costs incurred by the recipient, the receipt and use of goods and services acquired by the recipient, agreed-upon cost sharing requirements, the nature and extent of solicitations of prospective suppliers of goods and services acquired by the recipient, the basis of award of recipient contracts and orders, and the overall progress of the Agreement toward completion ("Agreement books and records"). The recipient must maintain Agreement books and records in accordance with generally accepted accounting principles prevailing in the United States, or at the recipient's option, with approval by HHS/CDC, other accounting

principles, such as those (1) prescribed by the International Accounting Standards Committee (an affiliate of the International Federation of Accountants), or (2) prevailing in the country of the recipient. Agreement books and records must be maintained for at least three years after the date of last disbursement by HHS/CDC or for such longer period, if any, required to resolve any litigation, claims or audit findings.

C. Partner Government Audit. If $300,000 or more of USG funds are expended by the recipient in its fiscal year under the Agreement, the recipient must have financial audits made of the expenditures in accordance with the following terms, except as the Parties may otherwise agree in writing:
i. The recipient must use its Supreme Audit Institution (SAI), if the SAI is approved by HHS/CDC, or select an independent auditor to perform the audit in accordance with the guidelines issued by HHS/CDC.
ii. The audit must determine whether the receipt and expenditure of the funds provided under the Agreement are presented in accordance with generally accepted accounting principles agreed to in Section 2 above and whether the recipient has complied with the terms of the Agreement. Each audit must be submitted to HHS/CDC no later than nine months after the close of the recipient's year under audit.

D. Sub-recipient Audits. The recipient, except as the Parties may otherwise agree in writing, must ensure that "covered" sub-recipients, as defined below, are audited, and submit to HHS/CDC, no later than the end of the recipient's year under audit, in form and substance satisfactory to HHS/CDC, a plan for the audit of the expenditures of "covered" sub-recipients, as defined below, that receive funds under this Agreement pursuant to a direct contract or agreement with the recipient.
i. "Covered" sub-recipient is one who expends $300,000 or more in its fiscal year in "US Government awards" (i.e. as recipients of US Government cost reimbursable contracts, grants or cooperative agreements).
ii. The plan must describe the methodology to be used by the recipient to satisfy its audit responsibilities for covered sub-recipients. The recipient may satisfy such audit responsibilities by relying on independent audits of the sub-recipients; expanding the scope of the independent financial audit of the recipient to encompass testing of sub-recipients' accounts; or a combination of these procedures.
iii. The plan must identify the funds made available to sub-recipients that will be covered by audits conducted in accordance with audit provisions that satisfy the recipient's audit responsibilities.
iv. The recipient must ensure that covered sub-recipients under direct contracts or agreements with the recipient take appropriate and timely corrective actions; consider whether sub-recipients' audits necessitate adjustment of its own records; and require each such sub-recipient to permit independent auditors to have access to records and financial statements as necessary.

E. Audit Reports. The recipient must furnish or cause to be furnished to HHS/CDC an audit report for each audit arranged for by the recipient in accordance with this Section within 30 days after completion of the audit and no later than nine months after the end of the period under audit.

F. Cost of Audits. Subject to HHS/CDC approval in writing, costs of audits performed in accordance with the terms of this Section may be budgeted for, and charged to, the Agreement so long as such costs are allowable, allocable, and reasonable as defined in the Cost

Allowability section of this Agreement.

G. Audit by HHS/CDC. HHS/CDC retains the right to perform the audits required under this Agreement on behalf of the recipient conduct a financial review, or otherwise ensure accountability of organizations expending US Government funds regardless of the audit requirement.

H. Opportunity to Audit or Inspect. The recipient must afford authorized representatives of HHS/CDC the opportunity at all reasonable times to audit or inspect activities financed under the Agreement, the utilization of goods and services financed by HHS/CDC, and books, records and other documents relating to the Agreement.

I. Sub-recipient Books and Records. The recipient will incorporate paragraphs (A), (B), (D), (E), (F), (G) and (H) of this provision into all sub-agreements with non-U.S. organizations which meet the $300,000 threshold of paragraph (C) of this provision. Sub-agreements with non-U.S. organizations, which do not meet the $300,000 threshold, must, at a minimum, incorporate paragraphs (G) and (H) of this provision. Sub-agreements with U.S. organizations must state that the U.S. organization is subject to the audit requirements contained in 2 CFR 200 and 45 CFR 75.

Expenditure Report (required):
Recipients is required to report quarterly on program expenditures. The quarterly report must report on funds expended by the recipient at the country and program/activity-level.

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

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

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results

and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

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

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov. Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.
For the full text of the requirements under the FFATA and HHS guidelines, go to:

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

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

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) (“United States foreign assistance funds”). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during

the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
"Commodity" means any material, article, supplies, goods, or equipment;
"Foreign government" includes any foreign government entity;
"Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:
a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

Regan Hartman , Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
Center for Global Health

1600 Clifton Road, MS V18-3

Atlanta, GA 30329

Email: gqv9@cdc.gov

Grants Staff Contact

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

Phinda Hillmon, Grants Management Specialist
Department of Health and Human Services
Office of Grants Services
Telephone: 770.488.1577
Email: lwg4@cdc.gov

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

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

H. Other Information

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

- Project Abstract
- Project Narrative
- Budget Narrative
- CDC Assurances and Certifications
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Due to the multiple components for multiple countries, and or regions, the Project Narrative will be allowed a maximum of 60 - pages, single spaced, 12 point font, 1-inch margins, and should have all pages numbered.

Amendments, Questions and Answers (Q&As)

Applicants must submit their Q&As, if any, to the Project Officer listed under the Agency Contacts Section of this announcement. CDC will address questions sent to the Agency point of contact 30 days after NOFO publication through an amendment to the NOFO. All changes,

updates, and amendments to the NOFO will be posted to www.grants.gov following the approval of CDC.

For additional information on reporting requirements, visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm. Other CDC NOFOs can be found on Grants.gov website, at the following internet address: http://www.grants.gov.

I. Glossary

Activities: The actual events or actions that take place as a part of the program.
Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).
Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.
Assistance Listings (CFDA): A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.
Assistance Listings (CFDA) Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency
Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.
Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.
Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.
CDC Assurances and Certifications: Standard government-wide grant application forms.
Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established period of performance (i.e., extends the "life" of the award).
Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.
Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.
Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal

programmatic collaboration or participation in carrying out the effort under the award.
Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.
Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants /additionalrequirements /index.html.
DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at http://fedgov.dnb.com/ webform/displayHomePage.do.
Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.
Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.
Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.
Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.
Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.
Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.
Grants Management Officer (GMO): The individual designated to serve as the HHS official

responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Healthy People 2030: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Intergovernmental Review: Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: https://www.whitehouse.gov/wp-content/uploads/2017/11/Intergovernmental_-Review-_SPOC_01_2018_OFFM.pdf.

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

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

participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

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

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

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

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

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

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

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

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use

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

NOFO-specific Glossary and Acronyms	
AEFI	Adverse event following immunization
AMP	Assessment, Migration and Performance
AMR	Antimicrobial Resistance

AST	Antimicrobial Susceptibility Testing
BHS	Border Health Security
BTWC	Biological and Toxin Weapons Convention
CDC	U.S. Centers for Disease Control and Prevention
CGH	Center for Global Health
CIO	CDC Center, Institute, and Offices
CoAg	Cooperative Agreement
CTU	Care and Treatment Units
DARRT	Detecting and Responding to Respiratory Disease Threats
DGHP	Division of Global Health Protection
DOD	U.S. Department of Defense
DOD CBEP	U.S. Department of Defense Cooperative Biological Engagement Program
DoS	U.S. Department of State
DoS BEP	U.S. Department of State Biosecurity Engagement Program
DTRA	U.S. Defense Threat Reduction Agency
EBS	Event-based Surveillance

EM	Emergency Management
EMPHNET	Eastern Mediterranean Public Health Network
EMR	Electronic Medical Records
EMRO	Regional Office for Eastern Mediterranean WHO
EMT	Emergency medical team
EOC	Emergency Operations Center
EPI	Expanded Program on Immunization
EPT	Emerging Pandemic Threats
EQA	External Quality Assessment
ESC	Executive Steering Committee
EUCAST	European Committee on Antimicrobial Susceptibility Testing
EVD	Ebola Viral Disease
FAO	Food and Agriculture Organization of the United Nations
FAO	Food and Agriculture Organization
FETP	Field Epidemiology Training Program
FOSS	Free and Open-Source Software
FY	Fiscal Year

GHS	Global Health Security
GHSA	Global Health Security Agenda
GHS-IS	Global Health Security Information Systems
GISRS	Global Influenza Surveillance and Response System
GLASS	Global Antimicrobial Resistance Surveillance System
GMO/GMS	Grants Management Officer/Specialist
GOARN	Global Outbreak Alert and Response Network
GOARN	Global Outbreak Alert and Response Network
GPHIN	Global Public Health Intelligence Network
HAI	Healthcare Associated Infection
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HMN	Health Metrics Network
IAEA	International Atomic Energy Agency
IAG	Implementation Advisory Group
IANPHI	International Association of Public Health Institutes
IATA	International Air Transport Association

IBS	Indicator-based Surveillance
ICAO	International Civil Aviation Organization
ICT	Information and Communication Technology
IDP	Internally Displaced Person
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
INFOSAN	International Food Safety Authorities Network
INTERPOL	International Criminal Police Organization
IOM	International Organization for Migration
IPC	Infection Prevention and Control
IPCAT	Infection prevention and control (IPC) assessment tool
IQC	Internal Quality Control
IS	Information Systems
IT	Information Technology
ITU	International Telecommunication Union
JEE	Joint External Evaluation
LIMS	Laboratory Information Management System

M&E	Monitoring and Evaluation
MBDS	Mekong Basin Disease Surveillance Network
MCV	Measles-containing Vaccine
MedISys	Medical Information System
MERS-CoV	Middle East respiratory syndrome coronavirus
MoH	Ministry of Health
MVP	Meningitis Vaccine Project
NAPHS	National Action Plan for Health Security
NaTHNaC	National Travel Health Network and Centre
NCC	National Coordinating Centre
NFP	IHR national focal point
NGO	Non-Governmental Organization
NICs	National Influenza Centers
NPHI	National Public Health Institute
NPHL	National Public Health Laboratory
OIE	World Organization for Animal Health
OIE	World Organization for Animal Health

OPCW	Organization for the Prohibition of Chemical Weapons
PHEM	Public Health Emergency Management
POC	Point-of-Care
POE	Points of Entry/Exit
PON	Point-of-Need
PPE	Personal Protective Equipment
PPHSN	Pacific Public Health Surveillance Network
ProMED	Program for Monitoring Emerging Diseases
PULS	Pattern-based Understanding and Learning System
PVS	Performance of Veterinary Services
QA	Quality Assurance
QSP	Quarterly Spend Plan
RA	Resident Advisor
SARS	Severe Acute Respiratory Syndrome
SEARO	Regional Office for South-East Asia
SIA	Supplemental Immunization Activity
SMART	Specific, Measurable, Achievable, Realistic and Time-bound

SME	Subject Matter Expert
SOP	Standard Operating Procedure
SPAR	IHR self-assessment annual reporting tool
TAL	Technical Area Lead
TDY	Temporary Duty
TEPHINET	Training Programs in Epidemiology and Public Health Interventions Network'
TST	Technical Support Team
UNICEF	United Nations Children’s Fund
USG	United States Government
VPD	Vaccine-Preventable Disease
VTC	Video Teleconference
WASH	Water, Sanitation and Hygiene
WASH FIT	Water and sanitation for health facility improvement tool
WHA	World Health Assembly
WHO	World Health Organization
WHO CC	World Health Organization Collaborating Center

WHO-AFRO	World Health Organization Regional Office for Africa
WPRO	Regional Office for Western Pacific