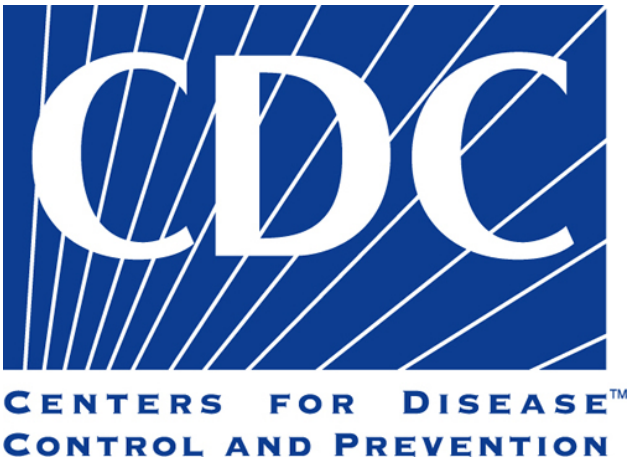

Centers for Disease Control and Prevention

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

High-Impact HIV Prevention and Surveillance Programs for Health Departments

CDC-RFA-PS-24-0047

04/29/2024

Table of Contents

Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-PS-24-0047. 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:

High-Impact HIV Prevention and Surveillance Programs for Health Departments

C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For purposes of this NOFO, research is defined as set forth in 45 CFR 75.2 and, for further clarity, as set forth in 42 CFR 52.2 (see eCFR :: 45 CFR 75.2 -- Definitions and *https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf*. In addition, for purposes of research involving human subjects and available exceptions for public health activities, please see 45 CFR 46.102(l) (*https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-46/subpart-A/section-46.102#p-46.102(l)*).

New - Type 1

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-PS-24-0047

E. Assistance Listings Number:

93.940

F. Dates:

1. Due Date for Letter of Intent (LOI):
02/23/2024

2. Due Date for Applications:
04/29/2024
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:

Topic: Informational Call

Time: Feb 22, 2024 02:00 PM Eastern Time (US and Canada)

Join Zoom Meeting

https://us02web.zoom.us/j/85624447625?pwd=Tlp1UnFHdlFjZVFkeWFjOUh2ZUs5QT09

Meeting ID: 856 2444 7625

Passcode: 826099

G. Executive Summary:

1. Summary Paragraph
CDC announces the availability of fiscal year 2024 funds for a cooperative agreement for health departments to implement high-impact HIV prevention and surveillance programs. The purpose of this notice of funding opportunity (NOFO) is to implement a comprehensive HIV prevention and surveillance program to prevent new HIV infections and improve the health of people with HIV. The NOFO aligns with CDC's Division of HIV Prevention (DHP) strategic focus areas to bolster community engagement, health equity, syndemic and whole-person approaches to HIV prevention. Applicants will have the opportunity to build their proposed HIV prevention and surveillance programs by identifying and implementing activities within the jurisdiction, based on need and resources, to reach the stated goal(s) for each strategy. This NOFO allows for flexibility while ensuring that funding resources are reaching the geographic areas with the highest HIV burden and greatest need. The NOFO priorities are to increase knowledge of HIV status, reduce HIV transmission, prevent new HIV infections, improve linkage to care and viral suppression and maintain elimination of perinatal transmission. The integration of core prevention, surveillance, and Ending the HIV Epidemic (EHE) funding resources allows each jurisdiction to align resources to better match the geographic burden of HIV infections within their jurisdictions and maximize the impact of federal HIV prevention funding.

a. Eligible Applicants:
Open Competition

b. Funding Instrument Type:

CA (Cooperative Agreement)

c. Approximate Number of Awards

60

Additional Information: 60 awards for eligible health departments for core prevention and surveillance funding. Approximately 32 additional awards for eligible health departments representing the 57 jurisdictions (48 counties, District of Columbia (DC), San Juan, PR, and 7 states) included in the Ending the HIV Epidemic in the US initiative.

d. Total Period of Performance Funding:

$2,900,000,000

Refer to funding tables on NOFO website at https://www.cdc.gov/hiv/funding/announcements/ps24-0047/index.html

e. Average One Year Award Amount:

$0

Refer to the funding tables on the NOFO website.

f. Total Period of Performance Length:

5 year(s)

g. Estimated Award Date:

August 01, 2024

h. Cost Sharing and / or Matching Requirements:

No

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

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

In the United States, an estimated 1.2 million people are living with HIV. In recent years, the number of people with HIV (PWH) has increased while deaths have declined. Of PWH, about 87% were aware of their HIV status. In 2021, an estimated 66% received HIV medical care and 58% were virally suppressed. Promising progress has been made in HIV prevention as the estimated annual new HIV infections were 12% lower in 2021 (32,100 infections) compared to 2017 (36,500 infections). This decline was largely driven by a substantial decrease (34%) in new infections among 13- to 24-year-olds, mostly among gay and bisexual males. However, HIV prevention efforts must go further, and progress must be faster, for gains to equitably reach all populations and end the HIV epidemic.

The National HIV/AIDS Strategy (NHAS) for the United States focuses on four goals: preventing new HIV infections, improving HIV-related health outcomes of people with HIV,

reducing HIV-related disparities and health inequities, and achieving integrated, coordinated efforts that address the HIV epidemic among all partners.

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

Since the late 1980s, CDC has partnered with state and local health departments to conduct HIV surveillance and expand the impact and reach of HIV prevention activities in affected communities. Health departments work with HIV prevention and community partners to build community-driven HIV prevention plans that use tailored strategies to meet jurisdictional and national HIV goals.

This funding opportunity endorses high-impact prevention (HIP) with a focus on a comprehensive whole-person approach that supports scientifically proven, cost-effective, and scalable structural, behavioral, and biomedical interventions. Additionally, HIP allows jurisdictions to address the barriers to care and prevention of people with HIV and without HIV, including stigma, discrimination, and the social determinants of health in geographic areas where infections are most concentrated. Through this new funding cycle, CDC is seeking to promote flexibility in the use of resources to implement HIV surveillance and prevention programs. Using complete and timely data, jurisdictions will have the ability to tailor prevention approaches; improve the quality of HIV surveillance and prevention data; support community engagement, address health equity, and implement whole-person approaches to HIV prevention.

b. Statutory Authorities

Statutory Authorities: Section 318(b-c) of the Public Health Service Act (42 USC § 247c(b-c)), as amended, and the Consolidated Appropriation Act of 2016 (Pub. L. 114-113).

c. Healthy People 2030

This NOFO addresses the “Healthy People 2030” focus on HIV, STI, and Health Equity.

Healthy People 2030 has a strong focus on eliminating health disparities and creating equitable opportunities for people to live healthy lives.

https://health.gov/healthypeople/priority-areas

d. Other National Public Health Priorities and Strategies

The National HIV/AIDS Strategy for the United States: 2022 – 2025

https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025/

Ending the HIV Epidemic in the U.S. (EHE)

https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview/

National Stakeholder Strategy for Achieving Health Equity

https://asprtracie.hhs.gov/technical-resources/resource/10323/national-stakeholder-strategy-for-achieving-health-equity

CDC's Data Modernization Initiative (DMI)

https://www.cdc.gov/surveillance/data-modernization/index.html

Health Equity Initiatives

https://www.cdc.gov/healthequity/whatis/index.html

National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Strategic Plan, 2022- 2026

https://www.cdc.gov/nchhstp/strategicpriorities/docs/nchhstp-strategic-plan-508.pdf

Division of HIV Prevention (DHP) Strategic Plan Supplement

https://www.cdc.gov/hiv/pdf/division-of-hiv-prevention/cdc-hiv-dhap-external-strategic-plan-2022.pdf

e. Relevant Work

CDC-RFA-PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments https://www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html

CDC-RFA-PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States

https://www.cdc.gov/hiv/funding/announcements/ps20-2010/index.html

CDC-RFA-PS23-2302: Accelerating the Prevention and Control of HIV, Viral Hepatitis, STDs, and TB in the U.S.–Affiliated Pacific Islands:
https://www.cdc.gov/nchhstp/funding/usapi/index.html

CDC-RFA-PS22-2211: Enhanced Surveillance of Persons with Early and Late HIV Diagnosis:
https://www.cdc.gov/hiv/funding/announcements/ps22-2211/index.html

CDC-RFA-PS20-2005: Medical Monitoring Project (MMP)

https://www.federalgrants.com/Medical-Monitoring-Project-MMP-83696.html

CDC-RFA-PS18 1805: Secure Data Sharing Tool to Support De-duplication of Cases in the National HIV Surveillance System (NHSS)

https://www.cdc.gov/hiv/division-of-hiv-prevention/hsb/index.html

CDC-RFA-PS-23-0011: Enhancing STI and Sexual Health Clinic Infrastructure (ESSHCI)

https://www.cdc.gov/std/funding/default.htm

CDC-RFA-PS-24-0003: Support and Scale Up of HIV Prevention Services in Sexual Health Clinics

https://www.cdc.gov/std/funding/default.htm

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

<table>
<tr><th>Strategies and Activities</th><th>Short-term Outcomes</th><th>Intermediate Outcomes</th><th>Long-term Outcomes</th></tr>
<tr><td colspan="3">Strategy 1. Diagnose – Ensure all people with HIV receive a diagnosis as early as possible</td><td rowspan="4">Reduced new HIV infections
Improved health outcomes for PWH, including sustained viral suppression
Reduced HIV-related health disparities</td></tr>
<tr><td>1A. Implement HIV testing in health care settings, including routine opt-out HIV screening

1B. Implement HIV testing in non-health care community settings, including HIV-self testing

1C. Support integrated screening of HIV in conjunction with STIs, TB, viral hepatitis, and mpox</td><td>Increased routine opt-out HIV screenings in health care settings
Increased availability of and accessibility to HIV testing in health care and non-health care settings, including HIV self-testing
Increased identification of people with new HIV diagnoses and people with HIV who are not in care or not virally suppressed
Increased integrated screening of HIV with other STIs, TB, viral hepatitis, and mpox</td><td>Increased knowledge of HIV status
Reduced late HIV diagnoses</td></tr>
<tr><td colspan="3">Strategy 2. Treat – Implement a comprehensive approach to treat people with diagnosed HIV infection rapidly and reach viral suppression</td></tr>
</table>

2A. Link to HIV medical care within 30 days all people who test positive for HIV, provide HIV partner services, and refer to or provide prevention and essential support services to support improved quality of life 2B. Support people with diagnosed HIV infection to receive rapid and effective treatment	• **Increased rapid linkage to HIV medical care** • **Increased receipt of HIV partner services** • **Increased engagement in HIV prevention, medical care, and treatment services for PWH who are not in care or not virally suppressed** • **Increased early initiation of ART** • **Increased receipt of essential support services to improve quality of life**	• **Increased receipt of HIV medical care** • Increased retention in HIV medical care • **Increased HIV viral suppression**	
Strategy 3. Prevent – Reduce new HIV transmission by increasing PrEP and PEP services and supporting HIV prevention, including, condom distribution, perinatal transmission prevention and harm reduction services			
3A. Support and promote awareness and access to PrEP/PEP services 3B. Conduct condom distribution	• **Increased linkage to PrEP services** • **Increased linkage to PEP services** • Increased availability of condoms	• **Increased PrEP prescriptions and use** • **Increased PEP prescriptions and use** • **Increased use of SSPs**	

3C. Support harm reduction services, including syringe services programs (SSPs) 3D. Support and promote social marketing campaigns and other communication efforts 3E. Conduct perinatal, maternal, and infant health prevention and surveillance activities	• **Increased availability of harm reduction services, including SSPs** • **Increased awareness of PrEP/PEP and other prevention approaches** • **Improved completeness, timeliness, and accuracy of perinatal HIV surveillance data** • **Improved provision and coordination of perinatal HIV services**	• Increased knowledge of evidence based SSPs • **Reduced perinatally acquired HIV infection**	
Strategy 4. Respond – Identify and quickly respond to HIV clusters and outbreaks to address gaps and inequities in services for communities who need them			
4A. Develop and maintain a cluster detection and response (CDR) leadership and coordination group 4B. Communicate and	• Improved plans and policies to respond to HIV clusters and outbreaks • Increased health department and community engagement for CDR • **Improved early identification and investigation of**	• **Improved response to HIV clusters and outbreaks at individual, network, and system levels**	

collaborate about CDR 4C. Detect and prioritize clusters 4D. Respond to prioritized clusters and outbreaks to identify and address gaps and inequities in services	**HIV clusters and outbreaks** • **Improved completeness and timeliness of data about clusters and response to clusters**		
Strategy 5. Conduct HIV Surveillance activities			
5A. Conduct data collection and reporting 5B. Maintain data systems and conduct data management activities 5C. Conduct data analysis, dissemination, and evaluation 5D. Support data for action and special considerations	• **Improved completeness, timeliness, and accuracy of HIV surveillance data for public health action** • **Improved monitoring of trends in HIV infection** • **Improved data security, confidentiality, and protections for data sharing**	• **Improved use of HIV surveillance data to identify populations affected by relevant syndemics** • **Improved electronic data exchange capacity** • **Improved visualization of HIV surveillance data for public health action**	

Strategy 6. Support community engagement and HIV planning			
6A. Conduct strategic community engagement 6B. Establish and maintain an HIV planning group 6C. Conduct and facilitate the HIV planning process and the development of integrated HIV prevention and care plan	• **Increased collaborations and engagement with local partners, people with HIV, and communities** • **Increased coordination, availability, and access to comprehensive HIV prevention, treatment, and support services**	• **Sustained community partnerships to inform strategic planning and implementation**	

i. Purpose

The purpose of this NOFO is to implement a comprehensive, person-centered HIV prevention and surveillance program to prevent new HIV infections and improve the health of people with HIV. Additionally, the NOFO aligns with DHP's strategic focus areas to bolster community engagement, health equity, and focus on whole-person approaches to HIV prevention. Applicants will have the opportunity to build their proposed HIV prevention and surveillance program by identifying and implementing activities within the jurisdiction, based on need and resources, to reach the stated goal(s) for each strategy.

ii. Outcomes

The programs supported by this NOFO are expected to demonstrate measurable progress toward addressing the short-term and intermediate outcomes that appear in bold in the NOFO logic model. Indicators that quantify these outcomes are described in the section entitled CDC Evaluation and Performance Measurement Strategy. Please note that EHE-specific program

activities and outcomes may vary by jurisdiction and are not shown in the logic model. For each of the strategies of this NOFO, it is expected that efforts will be made to continuously monitor progress in reducing disparities using appropriate measures.

Expected short-term and intermediate outcomes include the following:

Strategy 1: Increase knowledge of status to 95% by ensuring all people with HIV receive a diagnosis as early as possible.

- Short-term Outcomes:
    - Increased routine opt-out HIV screening in health care settings
    - Increased availability of and accessibility to HIV testing in health care and non-health care settings, including HIV self- testing
    - Increased identification of people with new HIV diagnoses and people with HIV who are not in care or not virally suppressed
    - Increased integrated screening of HIV in conjunction with other STIs, viral hepatitis, TB, and testing for mpox
- Intermediate Outcomes:
    - Increased knowledge of HIV status
    - Reduced late HIV diagnoses

Strategy 2: Implement a comprehensive approach to treat people with diagnosed HIV infection rapidly (increase linkage to care up to 95%) and effectively to achieve viral suppression up to 95%.

- Short-term Outcomes:
    - Increased rapid linkage to HIV medical care
    - Increased receipt of HIV partner services
    - Increased engagement in HIV prevention, medical care, and treatment services for people with diagnosed HIV infection who are not in care or not virally suppressed
    - Increased early initiation of antiretroviral therapy (ART)
    - Increased receipt of essential support services to improve quality of life
- Intermediate Outcomes:
    - Increased receipt of HIV medical care among people with diagnosed HIV infection
    - Increased HIV viral suppression among people with diagnosed HIV infection

Strategy 3: Prevent new HIV transmission, by increasing PrEP coverage to 50% of estimated people with indications for PrEP, increasing PEP services, and supporting HIV prevention, including prevention of perinatal transmission, harm reduction and syringe services program (SSP) efforts.

- Short-term Outcomes:
    - Increased linkage to PrEP services among people with indications for PrEP
    - Increased linkage to post-exposure prophylaxis (PEP) services among people who likely have been exposed to HIV
    - Increased availability of harm reduction services, including SSPs

- Increased awareness of PrEP and PEP and other prevention approaches among clients and providers
- Improved completeness, timeliness, and accuracy of perinatal HIV surveillance data (for case and exposure reporting)
- Improved provision and coordination of perinatal HIV services among pregnant and postpartum persons with HIV infection and their infants

- Intermediate Outcomes:
  - Increased PrEP prescriptions and use among people with indications for PrEP
  - Increased PEP prescriptions and use among people who likely have been exposed to HIV
  - Increased use of SSPs
  - Reduced perinatally acquired HIV infection

Strategy 4: Respond quickly to HIV clusters and outbreaks to address gaps and inequities in services for communities who need them.

- Short-term Outcomes:
  - Improved early identification and investigation of HIV clusters and outbreaks
  - Improved completeness and timeliness of data about clusters and response to clusters

- Intermediate Outcome
  - Improved response to HIV clusters and outbreaks at individual, network, and system levels to reduce transmission and improve care and prevention

Strategy 5. Conduct HIV surveillance activities as described in the Technical Guidance (TG) for HIV surveillance programs to ensure accurate, timely, complete, and actionable data.

- Short-term Outcomes:
  - Improved completeness, timeliness, and accuracy of HIV surveillance data for public health action
  - Improved monitoring of trends in HIV infection including geographic distribution of HIV, social determinants of health, and HIV-related health disparities
  - Improved data security, confidentiality, and protections for data sharing

- Intermediate Outcome
  - Improved use of HIV surveillance data to identify the populations affected by relevant syndemics and HIV-related health disparities
  - Improved electronic data exchange capacity
  - Improved visualization of HIV surveillance data for public health action

Strategy 6: Support community engagement and HIV planning.

- Short-term Outcome
  - Increased collaborations and engagement with local partners (both traditional and non-traditional organizations), people with HIV and communities to inform HIV and sexual health services

    - Increased coordination, availability, and access to comprehensive HIV prevention, treatment, and support services

- Intermediate Outcome
    - Sustained community partnerships to inform strategic planning and implementation

iii. Strategies and Activities

Recipients are required to develop and implement a comprehensive HIV prevention and surveillance program within their jurisdiction. The program consists of six core strategies, foundational requirements, and related activities. Implementation of all strategies and activities is required. Recipients will have the opportunity and flexibility to build their comprehensive core HIV prevention program, based on program need, policies, and resources. Recipients may select additional recommended or locally identified activities needed to support HIV prevention implementation within their jurisdiction to reach the stated goals and objectives. In addition to core funding, recipients receiving resources for EHE must implement two or more strategies (not implemented under the core funding) to support the stated goal(s).

Workforce Competencies and Partnerships

Recipients must establish and/or strengthen an infrastructure that supports development of HIV workforce competencies and capacities for a sustained collaborative network of local health departments, community-based organizations (CBOs), clinical providers, nurses, community health workers, pharmacists, etc. This is a mechanism to build organizational and jurisdictional capacity to support program implementation efforts. Recipients should support training to build HIV prevention expertise among local health workers and upskill the HIV workforce at the community level. This mechanism to build organizational and jurisdictional capacity may include partnering with grassroot CBOs and providing support through microgrants. It also includes working with CDC, national organizations, universities, and other training agencies to ensure a comprehensive approach. This support can also include securing personnel direct assistance (DA).

Recipients will implement strategies to strengthen policies and protocols to support and facilitate HIV surveillance and prevention activities at state, local and territorial levels. This includes conducting assessments of and strengthening data protections to prevent release of HIV public health data for non-public health purposes.

Disruption in CDC Funding

In the event of a disruption in the provision of direct funding by CDC to the recipient, CDC will take appropriate action to ensure the continuity of HIV prevention and surveillance programs. Flexibility will be necessary for the facilitation and funding of program activities, based on need, resources and local policies/legislation. In the event a state or local health department is unable to carry out the program, CDC may consider the application of a fiduciary entity on behalf of the health department, as evidence by a letter or memorandum of agreement (MOA) with the health department. If a MOA is not provided by the designated health department and the identified fiduciary or bona fide agent, CDC will consider an alternative partner or funding agreement that will be addressed outside of this NOFO. Furthermore, CDC and the recipient should consider continued flexibility and needed modification of the program model throughout the period of performance.

Note: If applicable, the following MOA documents do not count toward the page limit for the Project Narrative. Applicants must file MOA with the health department and fiduciary agent, as appropriate, name the file(s) “MOA Fiduciary" and upload the document(s) as a PDF file under "Other Attachments Forms".

The following foundational and operational activities are required to support the high-impact, HIV prevention and surveillance program. Applicants should include these operational activities within their overall program model.

Ensure Resources Follow the HIV Epidemic *(required)*

Recipients must utilize current epidemiological data for a data-driven approach for distributing funding resources throughout the jurisdiction. Funded jurisdictions must also ensure resources are being directed to both urban and non-urban/rural areas with an emphasis of achieving health equity among disproportionately affected communities and populations. To ensure that resources are reaching the areas of greatest need, funded jurisdictions will be required to report annually to CDC on the amount of core funding resources allocated to the areas (i.e., city, county, Metropolitan Statistical Area [MSA]) accounting for 30% or greater of the HIV diagnoses within the jurisdiction and how the funds were used *[see table with the identified counties per state representing 30% or greater of the cumulative HIV diagnosis, 2021 data]*. Local jurisdictions accounting for 30% or greater of the HIV diagnoses will be expected to develop local jurisdictional plans, if not already in place for the identified areas, and should incorporate prevention and treatment within the planning process.

Surveillance and program data should inform and support the proposed program models. Recipients may reallocate funds as needed to address clusters and outbreaks, in consultation with their project officer. Recipients should also design their funding agreements with sub-recipients to incorporate similar flexibility to address unexpected needs related to clusters and outbreaks.

In jurisdictions with one or multiple EHE counties, at least 70% of EHE funding should be directed to the local EHE counties supporting local health entities and community organizations; up to 30% of funding resources may be retained by the funded jurisdiction for EHE infrastructure, coordination and oversight of activities and services, to include surveillance and cluster detection and response support, that will be provided by the recipient. If an EHE county health department does not have the capacity to manage the funds, the recipient may request to provide less than 70% of funding to ensure adequate oversight and implementation of program activities within that respective county. However, the recipient must submit, with the application, a letter of concurrence or agreement (LOC/LOA), obtained from the respective county in the health department jurisdiction, indicating: 1) the current inability to manage the funds and/or fully implement the required EHE activities, in accordance with the NOFO; and 2) their preference for the recipient to retain full or partial funding until a time in which the necessary capacity is established. For statewide EHE jurisdictions, recipients may maintain up to 30% of funding for state-level coordination and oversight activities, to include support for surveillance and cluster detection and response. The remaining funding (70%+) should be directed to areas within the state with the highest disease morbidity, including rural areas, and support local health entities and community organizations.

Note: The following LOC/LOA documents do not count toward the page limit for the Project Narrative. Applicants must file LOC/LOA with the EHE County(s), as appropriate, name the file(s) “LOC" and upload the document(s) as a PDF file under "Other Attachments Forms".

HIV Data Collection and Reporting and Ensuring Data Security, Confidentiality, and Sharing *(required)*

Recipients will be responsible for HIV surveillance data collection, reporting, analysis, dissemination, and evaluation with focus on complete, accurate, timely, and actionable data. Applicants should refer to Strategy 5 and the Technical Guidance for HIV Surveillance Programs for recommended HIV surveillance practices and revised process and outcome standards. Recipients will be responsible for transmitting to CDC surveillance data, outcomes, assessments, and plans via CDC approved system(s). It is recommended that applicants have at least one designated full-time employee (FTE) as HIV surveillance coordinator to lead surveillance activities including data collection and reporting, data systems and management, data analysis, dissemination, and evaluation and uses of surveillance data for public health action. A designated full-time employee (FTE) as data manager can be considered, based on the size and complexity of the surveillance program. In addition to core surveillance funding, EHE funding may be used to support surveillance activities.

Recipients will need to communicate with CDC about cluster detection and response activities. This will include timely and complete submission of cluster report forms and other evaluation information and engaging in CDC-organized meetings about cluster detection and response activities.

Recipients will be responsible for data collection, reporting, analysis and dissemination of HIV program performance monitoring and evaluation data via CDC approved data collection system(s). Recipients will be required to report both qualitative and quantitative data on HIV prevention program performance measures and outcomes. Quantitative data requirements will include aggregate- and person-level data for which CDC will provide guidance. Recipients will be required to report on performance progress on meeting the stated NOFO goals and objectives via the required programmatic progress report templates. Applicants should refer to the progress report guidance, once it is available. To support program evaluation activities, it is recommended that applicants have at least one designated full-time employee (FTE) to support HIV prevention-related evaluation activities.

Recipients are required to ensure that security and confidentiality procedures/policies are in place and all policies, procedures and data sharing agreements comply with standards described in the CDC NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action (cdc.gov), 2011 (hereafter referred to as the CDC Security and Confidentiality Guidelines). It is anticipated that the 2011 CDC Security & Confidentiality Guidelines will be updated in 2024. CDC will provide additional program guidance on implementation of the revised guidelines. Recipients will be expected to update their policies and procedures if necessary to comply with the revised guidelines and CDC will provide programs technical assistance to meet new standards as needed.

Recipients will adhere to the following programmatic standards consistent with CDC Security and Confidentiality Guidelines 1) conduct an assessment of data security and confidentiality

protections during the project period, 2) submit an annual Overall Responsible Party (ORP) Certification indicating the recipient's adherence to the data security, confidentiality, and sharing standards (including sub-recipients and sub-contractors), 3) provide assurance that any breaches of data security protocol are investigated immediately and reported to the ORP, CDC, and (if warranted) enforcement agencies, 4) develop and implement secure procedures for data sharing within the context of existing laws, and use data sharing agreements for collaborative partnerships where applicable, and 5) conduct assessments of HIV data protections and strengthen data protections as needed to prevent release of public health data for non-public health purposes.

CDC supports efforts to modernize core data and surveillance infrastructure across the federal, state, territorial, and local public health landscape, to include strengthening of data reporting, management, and analytics by public health programs. Applicants should support and prioritize data modernization and data integration efforts.

Addressing Social and Structural Factors *(required)*

Recipients should ensure that program implementation activities are culturally appropriate and consider social and structural factors that create barriers to optimal provision of HIV prevention services, to include addressing social determinants of health, and supporting equity in access to HIV services. When designing HIV programs within the jurisdiction, recipients should ensure that whole-person approaches to HIV prevention, health equity, and syndemic approaches are embedded in the program. This NOFO supports efforts to improve the health of populations disproportionately affected by HIV by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity.

> Whole-Person Approaches to HIV Prevention: Applicants should consider a whole-person approach to HIV prevention and care that emphasizes high-quality care to engage and retain people in services while addressing health equity (state in which everyone has a fair and just opportunity to attain their highest level of health). Public health initiatives and funded HIV programs should include strategies that can reduce or prevent health disparities when addressing the needs of people and community. Please also refer to https://health.gov/healthypeople/priority-areas/social-determinants-health.
>
> Health Equity: The impact of racism, homophobia, transphobia, and stigma significantly exacerbates the health disparities experienced among communities disproportionately affected by HIV. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. Social determinants of health affect disparities in HIV, viral hepatitis, STIs, and TB. Environmental factors such as housing conditions, social networks, and social support are also key drivers for infection with HIV, viral hepatitis, STIs, and TB.
>
> Syndemic Approaches to Prevention: Successful HIV programs recognize the syndemics that affect the people and places disproportionately affected by HIV. A syndemic is population-level clustering of social and health problems. In the context of HIV, a syndemic is when HIV clusters with one or more other diseases or health conditions within a specific population, driven by the contextual, structural and social factors that increase the adverse effects on the health of people and communities. Syndemics may include HIV, STIs, TB, viral hepatitis, overdose, and substance use, and other existing

and emerging conditions or factors that may be related to or impact HIV. These syndemics are often exacerbated by social and structural factors such as poor access to and quality of healthcare, poverty, education, housing, transportation, racism, sexism, homophobia, transphobia, stigma, violence, and incarceration. As well as intermediary outcomes, such as substance use, mental health disorders, housing instability, and adverse childhood experiences (ACEs) that reinforce health disparities. To address the HIV-related syndemics, programs should use surveillance, program, and other data to identify the populations affected by the relevant syndemics as well as the geographic areas where there is an intersection of higher disease burden, morbidity, and the underlying social and structural factors leading to this clustering. Activities to diagnose, treat, and prevent syndemic infections should be incorporated into HIV-related strategies as appropriate. Applicants with the capacity to implement syndemic strategies as described in the strategies and activities sections are strongly encouraged to do so and are eligible to utilize up to 10% of the requested total funding amount to enhance these efforts.

The following six HIV program strategies and activities are required to support the high-impact HIV prevention program. HIV surveillance and program data should inform the strategies described below.

Strategy 1: Increase knowledge of status to 95% by ensuring all people with HIV receive a diagnosis as early as possible.

Activity 1a: Implement HIV testing in health care settings, including routine opt-out HIV screening.

- Promote and conduct routine opt-out HIV screening in health care settings (example: outpatient clinic, emergency department, urgent care, inpatient hospitalization, county hospitals, correctional facilities) located in high HIV prevalence communities (>0.1% per the recommendation). Refer to the Revised Recommendations for HIV Testing in Health-Care Settings (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm) or more recent guidance as available.
- Conduct repeat annual testing of people from communities with disproportionately higher prevalence of HIV, per the recommendations for HIV testing in health care settings.
- Promote or enact policies to facilitate the implementation of HIV testing at health care settings that implement routine standing orders.
- Promote routine perinatal HIV testing of all pregnant persons and diagnostic HIV testing for HIV-exposed infants per CDC and HHS recommendation

Activity 1b: Implement HIV testing in non-health care community settings, including HIV self-testing.

- Conduct HIV testing in community settings utilizing various methods such as outreach, mobile testing units, venue-based, community-based, jail, detention, and other community correctional settings, and large-scale testing events. Refer to the Implementing HIV Testing in Nonclinical Settings Guide (https://www.cdc.gov/hiv/pdf/testing/CDC_HIV_Implementing_HIV_Testing_in_Nonclinical_Settings.pdf) or more recent guidance as available.

- Promote and implement HIV self-test distribution programs. If implementing self-testing, programs should utilize FDA approved technology as well as provide information on how to obtain medical or prevention services as part of a self-test program. Programs could include self-tests that clients can take away for themselves or distribute to others in their network. Programs not setting up their own program can leverage other national or regional self-testing programs by promoting them in the community.
- Promote HIV testing program services through social marketing and media efforts and other communication efforts to increase awareness of HIV and reduce stigma.

Activity 1c: Support integrated screening of HIV in conjunction with STIs, TB, viral hepatitis, and mpox for a syndemic and person-centered approach.

- Provide integrated screening by supporting voluntary testing for other STIs (e.g., syphilis, gonorrhea, chlamydia), viral hepatitis, TB, and testing for mpox, in conjunction with HIV testing, including referral and linkage to appropriate services, where feasible and appropriate, and in accordance with current CDC guidelines and recommendations.
- Implement testing at events (e.g., sex venues, gay pride events, or pop-up testing events) where appropriate, whereby HIV testing is offered as a service bundled with screening for other conditions relevant to the local population (e.g., STI and mpox testing, mpox vaccination events, HBV and HCV testing) to reduce stigma and normalize HIV testing. Promote take-away of self-tests for attendees to distribute to those in their network at events where appropriate.

Additional Activities for Implementation: *Applicants may implement additional activities to support this strategy, based on need and available resources. Applicants receiving resources for EHE must implement two or more activities to enhance or expand HIV testing efforts within the local EHE jurisdictions with new and non-traditional partners. Consider public-private partnerships or contracting options to move quickly and maximize established processes and mechanisms.*

Proposed activities for EHE implementation should be enhanced or localized activities not currently implemented under the core funding. If the activities are conducted under the core funding, then it is expected that there is an increased focus on implementation of these activities under EHE. Examples are included below; however, applicants may propose other activities to support increasing knowledge of status by ensuring all people with HIV receive a diagnosis as early as possible.

- *Adopting sustainable, routine HIV testing programs in select health care facilities using all available mechanisms to obtain reimbursement for HIV testing from third-party payers (e.g., Medicare, Medicaid, private insurance, health maintenance organization [HMO] programs).*
- *Expand or implement routine opt-out HIV screening in health care and other institutional or retail settings (e.g., retail health clinics, emergency departments, urgent care facilities) located in high prevalence communities, including bundling with screening for other relevant conditions.*
- *Collaborate with county or city jails located in EHE jurisdictions and promote routine opt-out screening as part of medical intake evaluation in jails, particularly in large jails*

located in high prevalence communities, as well as in prison systems if HIV testing is not yet routinely performed, in accordance with state and local policy.

- *Normalize HIV testing in non-traditional settings (e.g., pharmacies and retail venues) by advertising broadly and providing residents multiple options to receive HIV tests in venues, including self-tests, that do not traditionally promote tests.*
- *Establish systems whereby people with elevated risk for HIV acquisition are routinely identified and HIV tests are ordered at least yearly. In some settings, more than annual screening of all people (e.g., every three months) could be considered. Please refer to the gay and bisexual men who have sex with men (MSM) testing guidelines as a resource (https://www.cdc.gov/mmwr/volumes/66/wr/mm6631a3.htm).*
- *Identify "champions" or key staff (e.g., nurses and other medical staff performing intake medical examinations) to lead activities to routinize HIV screening at intake.*
- *Modify the electronic medical records in selected facilities to routinize the offer of screening and screen all people (at least once) for HIV regardless of risk.*

Strategy 2: Implement a comprehensive approach to treat people with diagnosed HIV infection rapidly (increase linkage to care up to 95%) and effectively to achieve viral suppression (increase viral suppression up to 95%).

Activity 2a: Link to HIV medical care within 30 days all people who test positive for HIV, provide HIV partner services, and refer to or provide prevention and essential services to support improved quality of life.

- Ensure people with diagnosed HIV infection are linked to or reengaged in care, immediately but no later than 30 days following diagnosis.
- Provide ongoing partner services (PS) for all people with newly diagnosed HIV infection, those with previously diagnosed infection, and their partners.
- Support re-engagement in HIV medical care (e.g., using data to care (D2C) public health strategy that uses HIV surveillance and other data to support the HIV Care Continuum, by identifying people with HIV who need HIV medical care or other services and facilitating linkage to these services).
- Refer to or implement HIV risk reduction strategies and activities to prevent HIV transmission (e.g., effective behavioral interventions, refer to https://www.cdc.gov/hiv/effective-interventions/index.html or compendium of evidence-based interventions and best practices for HIV prevention, refer to https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html), when appropriate.
- Promote linkage to HIV medical care services by establishing or co-locating HIV navigators or linkage to care coordinators at high volume health care and community settings and through social marketing and media efforts and other communication efforts to increase awareness of available HIV services, promote health equity, and to reduce stigma.
- Refer to or provide essential support services (e.g., housing, substance abuse treatment services, mental health services, employment, food security).

Activity 2b: Support people with diagnosed HIV infection to receive rapid and effective treatment (and increase viral suppression to 95%).

- Support rapid antiretroviral therapy (ART) initiation for all people with newly diagnosed HIV.
- Support retention in HIV medical care and treatment adherence.
- Improve quality of life in people with diagnosed HIV infection.

Additional Activities for Implementation: *Applicants may implement additional activities to support this strategy, based on need and available resources. Applicants receiving resources for EHE must implement two or more activities to enhance or expand efforts to support treating people with diagnosed HIV infection rapidly and effectively for viral suppression with the local EHE jurisdictions, local counties, and new and non-traditional partners. Consider public-private partnerships or contracting options to move quickly and maximize established processes and mechanisms.*

Proposed activities for EHE implementation should be enhanced or localized activities not currently implemented under the core funding. Examples are included below; however, applicants may propose other activities to support implementing a comprehensive approach to treat people with diagnosed HIV infection rapidly.

- *Develop programs to support and promote rapid linkage (within 7 days).*
- *Develop and implement a plan to ensure early ART initiation for all people with newly diagnosed HIV infection.*
- *Support community health worker/lay health advisor networks as part of the HIV treatment team, that can provide outreach to people not in care to facilitate re-entry into care. Community health worker programs may be supported by social media and health communication campaigns that emphasize the importance of HIV treatment adherence.*
- *Develop partnerships between HIV clinical medicine teams and community pharmacists so that HIV patient care is enhanced due to increased communication around development of a medication adherence plan for individuals and to facilitate notices when those individuals have not refilled prescriptions.*
- *Conduct a rapid needs assessment (housing, transportation etc.) for all people with new HIV diagnoses and link to a disease intervention specialist and/or case manager as needed in support of receiving needed services for improved quality of life.*
- *Develop, expand, and scale up Data to Care programs using surveillance data and other data sources including pharmacy data (Data to Care Rx), to identify people not in care and develop re-engagement strategies (e.g., utilizing linkage specialists, disease intervention specialists). Refer to https://www.cdc.gov/hiv/effective-interventions/treat/data-to-care/index.html.*
- *Develop electronic based approaches (e.g., text messaging, virtual case management) to support retention in care activities, patient navigation and distribution of strengths-based case management (e.g., Anti-Retroviral Treatment and Access to Services [ARTAS]).*
- *Create and maintain an easily accessible provider-initiated retention in care support service (e.g., encrypted online reporting system) for providers to request health department support when people miss appointments or appear to be lost to follow up.*

- *Develop robust telemedicine programs that use electronic information and telecommunications technologies (e.g., videoconferencing, the internet, store-and forward imaging, streaming media) to support and promote long-distance clinical health care and patient health-related education.*

Strategy 3: Prevent HIV transmission by increasing PrEP coverage to 50% of estimated people with indications for PrEP, increasing PEP services, and supporting HIV prevention, including condom distribution, prevention of perinatal transmission, harm reduction, and syringe services program (SSP) efforts.

Activity 3a: Support and promote awareness and access to PrEP and PEP services.

- Increase awareness, availability, access, and use of PrEP.
- Increase non-occupational post-exposure prophylaxis (PEP) awareness and access, where appropriate, including activities with clinicians, non-clinical CBOs, and people at risk for HIV acquisition.
- Identify resources and refer populations with ongoing risk of HIV acquisition to PEP, and PrEP services.
    - Ancillary support services can be provided to include: support for laboratory costs for screening or monitoring PrEP per CDC guidelines for uninsured or underinsured people receiving PrEP; use of mobile units and other novel engagement strategies, assistance with transportation, communication with clinicians, and navigating other support services; and support limited personnel costs related to the provision of PrEP medication if coupled with other supportive PrEP services, e.g., eligibility assessments, risk reduction education, referral and navigation support to other essential services, etc. The funded percentage for these duties may not exceed 75% of the FTE.
    - Recipients may provide assistance, no more than 15% of the overall award amount, to support PrEP ancillary support services. Recipients are required to notify CDC, if coverage demands exceed the allotted percentage, to secure permission to redirect additional resources to meet the projected demand.
    - Please refer to the CDC PrEP Program and Ancillary Support Services Guidance for HIV Prevention Health Department Recipients at: https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/cdc-hiv-ps18-1802-prep-program-ancillary-support-services-guidance-for-health-departments-2021.pdf.

Activity 3b: Conduct condom distribution

- Conduct condom distribution efforts, including the promotion of and provision of condoms, within communities, venues, and other settings to prevent HIV transmission. Please refer to https://www.cdc.gov/hiv/effective-interventions/prevent/condom-distribution-programs/index.html.

Activity 3c: Support harm reduction services, including syringe services programs (SSPs) and whole-person approach to HIV prevention services.

- Increase availability, use, and access to comprehensive harm reduction services, to include syringe services programs (SSPs), as an effective public health approach to reduce the spread of infectious diseases. In addition to improving access to sterile injection equipment, SSPs often provide other services important in supporting people who inject drugs (PWID), to include harm reduction counseling, integrated screening/testing for HIV, viral hepatitis, STI and mpox testing and TB testing; hepatitis A and hepatitis B and mpox vaccination, linkage to medical and mental health care and treatment, the provision of naloxone; and referrals to substance use treatment and PrEP and PEP for HIV prevention. This can include the provision of SSP services at fixed or mobile unit locations. Please refer to the CDC Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016, https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf and the SSPs Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation, 2020, at https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf,
- Develop partnerships with non-traditional public health partners (e.g., law enforcement or emergency responders) to support harm reduction and SSP efforts.
- Refer to or implement HIV risk reduction strategies and activities to prevent the acquisition of HIV (e.g., effective behavioral interventions, refer to https://www.cdc.gov/hiv/effective-interventions/index.html or compendium of evidence-based interventions and best practices for HIV prevention, refer to https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html), where appropriate.
- Refer to essential support services (e.g., housing, substance use treatment, mental health services, employment, food security) to enhance health equity efforts, address social determinants of health (SDOH), and support whole-person approaches to HIV prevention.

Activity 3d: Support and promote social marketing campaigns and other communication efforts to increase awareness of HIV, reduce stigma, and promote testing, prevention, and treatment.

- Support and promote social marketing, educational and informational campaigns, and social media messages focused on HIV prevention, HIV awareness, or other related topics focused on relevant audiences (e.g., providers, focused populations, or communities impacted by HIV), including prioritizing the use of campaign materials developed and tested by CDC. Recipients can support and promote CDC's Let's Stop HIV Together (Together) campaign and other future CDC campaign efforts, when appropriate. Together is an evidence-based campaign that aims to empower communities, partners, and health care providers to reduce HIV stigma and promote HIV testing, prevention, and treatment. There are a range of Together materials available for cobranding and/or adaptation. Adaptation may include 1) adding local contact information, 2) featuring local campaign participants, and 3) adaptation of formats to meet local needs. Please refer to https://www.cdc.gov/stophivtogether/index.html for detailed information on the Together campaign.

Activity 3e: Conduct perinatal, maternal, and infant health prevention and surveillance activities and support maintaining the national goals of perinatal HIV incidence of <1 per 100 000 live births and a perinatal transmission rate of <1%.

- Conduct perinatal, maternal, and infant health prevention and surveillance activities per CDC recommendations *[refer to the TG Pediatric Surveillance file]*
- Jurisdictions with an increased number of perinatal HIV exposures, increased number of females (sex assigned at birth) of childbearing age with HIV, or increased rates of females (sex assigned at birth) with diagnosed primary or secondary syphilis (*refer to the Perinatal Program Guidance*) must conduct focused perinatal, maternal, and infant health HIV prevention and exposure reporting activities. Refer to the HIV Perinatal Program Guidance, such as:
    - Conduct Perinatal HIV Exposure Reporting (PHER), where laws and regulations allow.
    - Develop and implement standard operating procedures for identifying and conducting follow-up of perinatally HIV-exposed infants according to CDC guidance.
    - Support perinatal HIV services coordination to address local issues that lead to missed perinatal HIV surveillance and prevention opportunities.
    - Assess and improve perinatal HIV systems using the Fetal Infant Mortality Review (FIMR) Prevention Methodology National Resource Center for case review (refer to http:// www.fimrhiv.org/) or similar process and incorporate congenital syphilis reviews and systems improvement to address local syndemics, as appropriate.
    - Regardless of HIV or syphilis prevalence, all jurisdictions are strongly encouraged to conduct these focused activities.

Additional Activities for Implementation: *Applicants may implement additional activities to support this strategy, based on need and available resources. Applicants receiving resources for EHE must implement two or more activities to reduce and prevent HIV transmission within the local EHE jurisdictions. Activities should be conducted with new and non-traditional partners. Consider public-private partnerships or contracting options to move quickly and maximize established processes and mechanisms.*

Proposed activities for EHE implementation should be enhanced or localized activities not currently implemented under the core funding. Examples are included below; however, applicants may propose other activities to support preventing new HIV transmission, promoting PrEP and PEP services, and supporting HIV harm reduction services, including SSPs.

- *Partner with new community-based organizations (CBOs) and/or federally qualified health centers (FQHCs) to offer PrEP and PEP services as part of their routine, normal menu of services.*
- *Direct mail PrEP and PEP toolkits to clinicians in participating jurisdictions*
- *Use CDC social media assets on local/regional channels to reach clinicians with PrEP and PEP messaging.*
- *Conduct on-the-ground outreach and PrEP and PEP navigation at events in local EHE jurisdictions.*

- *Establish or expand a PrEP and PEP Navigator Training Program geared toward addressing the needs of populations with indications for PrEP that are currently underserved by PrEP and PEP programs (e.g., Black cisgender and transgender women, Black and Latino gay and bisexual men, etc.).*
- *Partner with a healthcare provider or agency with staff that have prescribing authority and the ability to host a 24 hour/7 day a week "hotline" to facilitate patient-level access to HIV PEP and use of doxycycline post-exposure prophylaxis for bacterial sexually transmitted infection prevention (aka Doxy PEP), as well as 7-day PrEP starter kits and on-going PrEP access.*
- *Incentivize PrEP or PEP provision that is appropriate to locally specific demographics of people while maintaining provision of PrEP to all people with indications for its use.*
- *Increase PrEP and PEP training among private and safety-net clinical providers by increasing the number of trained PrEP and PEP detailers (i.e., clinical educators) through collaboration with organizations that have demonstrated success in providing ongoing training and support and adapting resources from CDC and others to meet local provider training needs.*
- *Partner with a Historically Black College and University (HBCU) or Hispanic Serving Institution to sponsor HIV testing events and linkage to PrEP and PEP.*
- *Develop or support existing comprehensive SSP service delivery by prioritizing specific "building block" components that can lead to more robust service delivery, such, education, community health worker or peer models, assessing structural and environmental barriers, increasing access to sterile needles and syringes for PWID through non-prescription syringe sales in community pharmacies, where allowed by law, establishing vending machines for increased access to harm reduction materials, or by promoting training or providing tools to support nonprescription syringe sales.*
- *Integrate a comprehensive service needs assessment (e.g., mental health, housing, food security, employment) to achieve a person-centered, holistic care approach to PrEP and PEP services.*

Strategy 4: Respond quickly to HIV clusters and outbreaks to address gaps and inequities in services for communities who need them.

Cluster detection and response (CDR) is an essential public health service. All applicants should develop and maintain strong programmatic readiness, including performing routine cluster detection activities. Applicants should also be ready to respond, when clusters are detected, to identify and address gaps and inequities in prevention and care services and access for communities experiencing rapid transmission. Required activities include the following (refer to CDR guidance at https://www.cdc.gov/hivcluster/guidance for more detail):

Activity 4a: Develop and maintain a cross-program CDR leadership and coordination group to oversee CDR activities. This group should:

- Include, at a minimum, HIV prevention, surveillance, and partner services leadership and staff.
- Create a CDR plan and update plan at least annually, as needed.

- Meet routinely to review and prioritize clusters, determine actions for cluster response, and identify and address gaps and inequities in prevention and care.

Activity 4b: Communicate and collaborate about CDR.

- Communicate and collaborate with community members and partners for input on CDR activities and on designing responses to specific clusters and outbreaks.
- Include people with HIV and organizations that represent them, people who would benefit from HIV prevention services and organizations that represent them, providers caring for people with HIV, other community-based organizations that provide services to priority populations, tribal councils and communities, and HIV planning groups or community advisory boards.
- Share summary information about clusters and CDR activities (for example, in an annual report or public dashboard).

Activity 4c: Detect and prioritize clusters.

- Analyze, link, and review data to detect clusters and prioritize clusters for further investigation and response.
- Ensure compliance with data protections and, where needed, enhance or improve processes or procedures for protecting privacy and confidentiality.

Activity 4d: Respond to prioritized clusters and outbreaks to identify and address gaps and inequities in services.

- Respond to prioritized clusters to identify and address gaps and inequities in prevention and care services at individual, network, and systems levels.
- Use an approach tailored to the cluster and the local context**.**
- Provide timely and complete submission of cluster report forms and other cluster data.

Additional Activities for Implementation: *Applicants may implement additional activities to support this strategy, based on need and available resources. Applicants receiving resources for EHE must implement two or more activities to enhance or expand CDR efforts within the local EHE jurisdictions with new and non-traditional partners.*

Proposed activities for EHE implementation should be enhanced or localized activities not currently implemented under the core funding. Examples are included below; however, applicants may propose other activities to support respond activities.

- *Hire and retain dedicated staff for response activities.*
- *Implement a CDR dashboard or another approach at the state/directly funded jurisdiction level to routinize and automate analysis, integration, visualization, and secure sharing of data from diverse sources, including surveillance, prevention, care, partner services, and syndemic data.*
- *Enhance community engagement through a subcommittee or dedicated session of an existing planning group or another relevant mechanism to gather input on CDR activities in the jurisdiction.*
- *Use lessons learned from responses and engage in tabletop or other planning exercises to refine CDR plans and address gaps identified in CDR activities.*

- *Establish a dedicated CDR fund that can be quickly re-allocated to address unexpected needs identified through response efforts (e.g., funding community partners, expanding self-testing, implementing messaging campaigns).*

Strategy 5: Conduct HIV surveillance activities as described in the Technical Guidance (TG) for HIV Surveillance Programs to ensure accurate, timely, and actionable data. All activities in this strategy are required. HIV surveillance is a core public health function defined as the ongoing systematic collection, analysis, and interpretation of HIV data for public health purposes, and the timely dissemination of HIV data to characterize trends in HIV infection, assess and implement public health response to reduce HIV morbidity and mortality. Required activities include the following (refer to Technical Guidance (TG) for HIV Surveillance Programs available at DHP HIV Surveillance Branch external partner SharePoint site or per request for more detail):

Activity 5a: Conduct Data Collection and Reporting.

- Collect HIV surveillance data for all people with diagnosed HIV infection using active and passive surveillance methods [*TG Reporting* file], according to the standards defined in the Adult HIV Confidential Case Report Form [*TG ACRF* file] and Pediatric HIV Confidential Case Report Form [*TG PCRF* file].
- Implement and maintain activities to ensure complete case and laboratory reporting per program guidance [*TG ACRF* file; *TG Reporting* file] using electronic methods.
- Conduct death ascertainment activities to identify deaths among all people with HIV and HIV-related causes of death. [*TG Death Ascertainment* file].
- Conduct risk factor ascertainment for all cases of HIV infection, including prevalent cases. [*TG Risk Factor Ascertainment* file].
- Maintain date and place of residence of all people with diagnosed HIV infection [*TG Date and Place of Residence* file].
- Leverage available geocoding tools (geocoding functionality within the CDC-approved system, CDC-provided geocoding SAS programs, or other geocoding methods/tools on hand at the jurisdiction level) and geocode to the census tract level places of residence for persons with HIV infection diagnosed during the specified period (regardless of vital status) and persons living with diagnosed HIV infection in accordance with the *TG Geocoding and Data Linkage* files.
- Conduct case surveillance activities for pregnant and post-partum persons with diagnosed HIV infection and their infants [*TG Pediatric Surveillance* file].
- Conduct annual matching of people with diagnosed HIV reported to surveillance with the state birth registry and tribal birth registry, as applicable, and report data to CDC. Incorporate a match process with syphilis surveillance, as appropriate [*TG Pediatric Surveillance* file].

Activity 5b: Maintain Data Systems and Conduct Data Management Activities.

- Transfer HIV surveillance data to CDC and process acknowledgement in required format by required deadlines [*TG Data Management* file], this includes census tract information. If unable to submit to CDC due to a law, regulation, written policy, or rule, then submit

to CDC Social Determinants of Health (SDOH) data in accordance with the required data submission methodology and timeline described in the *TG Geocoding and Data Linkage* files. The applicant should cite in application the law, regulation, written policy, or rule that prohibits submission of census tract data to CDC.

- Integrate HIV data sources and other relevant data sources and enhance data linkage capacity to ensure completeness and improve usability of data [*TG Record Linkage* file].
- Incorporate the use of analytic pipelines and data processing tools, where feasible and appropriate, as recommended by CDC.
- Use CDC recommended tools and systems (e.g., Soundex Match Application, Secure Data Sharing Tool to support de-duplication of cases), conduct intrastate de-duplication, routine interstate duplicate review (RIDR) and cumulative interstate duplicate review (CIDR) identification and resolution for all cases reported [*TG Duplicate Review* file].
- Leverage existing electronic laboratory reporting (ELR) and electronic case reporting (eCR) infrastructure and processes to reduce duplication and manual efforts [*TG Reporting* file].
- Enhance capacity for analytics, visualization, and reporting for HIV data and activities.
- Work towards a more flexible, efficient, and automated approach to exchanging data between electronic health records (EHRs) and public health, with a goal of automating data extraction for use in HIV surveillance [*TG Reporting* file].

Activity 5c: Conduct Data Analysis, Dissemination and Evaluation.

- Ensure data release policies are in place and up to date to respond to data requests and provide a secure mechanism to share the minimum relevant HIV data with internal health department partners and external partners for decision-making and public health action (promote and support data sharing within the jurisdiction).
- Develop annual HIV surveillance reports and a jurisdictional Epidemiologic Profile to inform program planning, implementation, and improvement [*TG Data Analysis and Dissemination* file; Integrated Guidance for Developing Epidemiologic Profiles (cdc.gov)].
- Routinely assess and improve data quality and conduct annual evaluation of the HIV surveillance system to assess progress towards meeting the outcome and process standards [*TG Evaluation and Data Quality* file].
- Conduct routine assessments to ensure that HIV surveillance data and activities are conducted and maintained, protected, secure, and confidential.
- Support and prioritize data modernization of core data and surveillance infrastructure to strengthen data reporting, management, analytics, and data integration.
- Engage with community, care providers and other partners to increase awareness of the regulations, practices, uses and protections of HIV surveillance data.

Activity 5d: Support Data for Action and Special Considerations.

- Routinely analyze HIV surveillance data for public health action [*TG Overview of HIV Surveillance* file, *Data Analysis and Dissemination* file].
- Investigate cases of public health importance (COPHI) [*TG COPHI* file].

- Identify people who are presumptively not in care and relink those truly out of care to HIV medical care and other needed services [*TG* Data to Care Reporting Guidance]
- Strengthen identification and investigation of acute/early HIV infection [*TG Early HIV Infection, HIV-2, and Other Diagnostic Considerations* file].
- Conduct molecular, time-space, and other relevant analysis to detect clusters for further prioritization, investigation, and response. [*TG Detecting HIV Clusters* file].
- HIV surveillance programs conducting the Medical Monitoring Project (MMP) should collaborate with local MMP staff to support secure sharing and use of data needed to conduct MMP, to update core surveillance data with data obtained through MMP (including but not limited to data on residency, laboratory test results, and transmission risk), and to enhance data quality and use.

Strategy 6: Support community engagement and HIV planning.

Community engagement and mobilization are essential to HIV programs. Recipients must continually engage community members and community groups (traditional and non-traditional partners) including people with HIV to gain insights to inform their HIV programmatic efforts within the jurisdiction and local communities and establish multidirectional communication and information sharing for a coordinated response to ending the HIV epidemic. The engagement process involves the collaboration of key partners and broad-based communities who work together to identify strategies to increase awareness and coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas. Health departments funded by CDC, through their federally funded state and local level HIV prevention programs, are required to have an HIV prevention planning process that includes the establishment of an HIV planning group (HPG) and the development of a jurisdictional HIV prevention and care plan.

Activity 6a: Conduct strategic community engagement.

- Develop new strategic partnerships and ensure that people from local communities experiencing disproportionate HIV diagnosis and rapid HIV transmission and other lived/living experience are brought to the table for meaningful discourse and subsequent programmatic action.
- Provide opportunities for bidirectional engagement with community members especially those with lived HIV experience.
- Conduct continual community and partner engagement with various partners and community members (traditional and non-traditional partners and organizations), at the local/county level, through various engagement mechanisms throughout the period of performance (e.g., local jurisdictional meetings, town halls). Refer to Principles of Community Engagement (Principles of Community Engagement (Second Edition) (cdc.gov)) or more recent guidance as available.

Activity 6b: Establish and maintain an HIV Planning Group (HPG).

- Identify community members, key partners, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in the process. Ensure planning groups include representation of people from local communities experiencing disproportionate HIV diagnosis and rapid HIV transmission.

- Establish and maintain an HPG that convenes on a routine basis (recommend quarterly; at a minimum twice per year). Funds may be used to create an HIV planning, community planning, or integrated planning group, if one does not exist. Ensure the HPG has in place a health department and community co-chair. Please refer to the HIV Planning Guidance for details on the HPG process (https://www.cdc.gov/hiv/pdf/p/cdc-hiv-planning-guidance.pdf).

Activity 6c: Conduct and facilitate an HIV planning process and the development of the Integrated HIV Prevention and Care Plan.

- Conduct and facilitate an HIV planning process through which people from different walks of life and involvement in HIV come together as a group to inform and support the development and implementation of a jurisdictional or local HIV plan or roadmap. HIV planning is based on the belief that local planning is the best way to respond to local HIV prevention needs and priorities, adhering to the basic tenets of HIV planning - parity, inclusion, and representation (PIR).
- Ensure health departments work in partnership with the community and key partners to enhance prevention and care planning, improve the scientific basis of program decisions, enhance access to HIV prevention, care, and treatment services and focus resources to those communities and for populations disproportionately impacted by HIV.
- Ensure that HIV planning is a participatory process, to include participating in the development and review of the Integrated HIV Prevention and Care Plan and submitting a letter to CDC signed by the HPG co-chairs on behalf of the HPG membership documenting the group's involvement in the process.
- Develop, monitor, and update the jurisdiction's Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need. The Integrated HIV Prevention and Care Plan serves as a jurisdictional HIV strategy or roadmap for all HIV-related resources and activities and assists with identifying ways to measure progress toward goals and objectives to improve HIV prevention, care, and treatment efforts within the jurisdiction. The development of the jurisdictional prevention and care plan should be done in conjunction with the HIV Planning Group, Ryan White Care Planning Council, and other advisory bodies, such as EHE advisory bodies or Fast Track Cities, where appropriate. Recipients should leverage existing engagement groups and incorporate community engagement efforts with integrated HIV planning activities.
- Support the implementation of a local planning process with the counties that represent 30% or greater of the HIV epidemic within the jurisdiction *[see table with the identified counties per state representing 30% or greater of the cumulative HIV diagnosis, 2021 data]*. Each county should engage local partners, conduct a planning process resulting in the development of a locally developed jurisdictional plan that can be included in the overall Integrated Plan as an addendum or update or can be provided as a separate plan. Counties designated as EHE counties should have EHE plans in place that can be updated, if needed; however, continual HIV planning, and community engagement should occur in all the identified counties.

  For additional details, please refer to:

  The HIV Planning Group Guidance (https://www.cdc.gov/hiv/pdf/p/cdc-hiv-planning-guidance.pdf).

The CDC HRSA Integrated HIV Prevention and Care Plan Guidance (https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/cdc-hiv-Integrated-HIV-Prevention-Guidance.pdf);

The EHE Plan Program Guidance (https://www.cdc.gov/hiv/pdf/funding/announcements/ps19-1906/cdc-hiv-PS19-1906-component-B-program-guidance.pdf).

Additional Requirements for EHE jurisdictions: *Applicants receiving resources for EHE will be required to support and ensure community engagement efforts are taking place within the local EHE jurisdictions with new and non-traditional partners.*

For applicants receiving EHE funding, it is expected that they conduct the following: 1) establish and maintain an EHE Coordinator (1.0 FTE) and 2) establish and maintain an EHE advisory group, representative of the local EHE jurisdiction(s) and communities. Engaging the community is a key factor in the recipients' ability to successfully implement their EHE programs. Community and partner engagement should focus on bringing new voices to the discussion. Applicants should ensure that funding resources are disseminated to community organizations (with an emphasis on non-traditional and new partners) to support and implement EHE efforts. Therefore, all recipients must allocate at least 25% of the total funds directed to the local EHE jurisdiction(s) to support planning and implementation of EHE activities by community organizations. Recipients are encouraged to establish new funding relationships with community organizations that have traditionally not received funding and that: have experience working with communities most affected by HIV, including experience addressing the social determinants that influence populations most severely affected by HIV; and possess the capacity to implement the EHE activities. Furthermore, recipients may continue funding relationships with community organizations that have proven experience working with communities most affected by HIV, including experience addressing the social determinants that influence populations most severely affected by HIV.

Supplemental or Optional Programs of Significance (unfunded)

Advances in HIV prevention and new initiatives or priorities may occur during the period of performance. Applicants can enhance their programs by requesting funding to implement a supplemental activity or project to expand, bring to scale, or advance high-impact HIV prevention and surveillance interventions and strategies. This optional funding will support implementation of innovative programs or activities that are particularly novel or require additional resources for evaluation or implementation that would not be conducted under the core funding. Potential optional activities include data modernization efforts, supporting the transition to a new data system, interoperability of data systems to support syndemic approaches, etc. Should additional funding become available to support this optional program of significance, CDC will provide guidance and solicit supplemental or program-initiated funding requests.

1. Collaborations

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

Recipients are required to collaboratively partner with CDC. Recipients must also establish, build, and/or maintain working partnerships with other CDC recipients (e.g., directly funded

CBOs, capacity-building assistance providers, STD programs, TB and Viral Hepatitis programs, Medical Monitoring Project, Epidemiology and Laboratory Capacity (ELC) Program, Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant, National Electronic Disease Surveillance System (NEDSS), HIV CDR Implementation Learning Collaborative) to ensure communication, collaboration, and coordination for the national delivery of a comprehensive and integrated HIV surveillance and prevention program that is consistent with CDC standards and guidance. For implementing activities, recipients should collaborate with local community-based organizations, tribal governments and/or tribally designated organizations, local health departments, medical institutions, federally qualified health centers (FQHCs), LGBT health centers, STD clinics, hospitals, specialty clinics, institutions of higher education, faith-based institutions, racial and social justice organizations, correctional institutions, etc. Recipients are expected to collaborate with other health departments (e.g., state and local) within the jurisdiction. If necessary, memoranda of agreements/memoranda of understandings (MOAs/MOUs), should be established by the recipient and submitted to CDC, upon request post award.

b. With organizations not funded by CDC:

Recipients may establish, build, and/or maintain collaborative relationships with organizations not funded by CDC that will support the implementation of the proposed program. Consideration should be given to developing strategic partnerships with the following types of organizations: federal agencies (e.g., the Health Resources and Services Administration, the Centers for Medicaid and Medicare Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Housing and Urban Development (HUD)) and their recipients, public health departments, tribal governments and/or tribally designated organizations, local and state education agencies, colleges and universities, non-CDC funded CBOs, capacity building assistance organizations, faith-based organizations, for-profit organizations, clinics and hospitals, non-governmental organizations, state and local governments, correctional facilities, community advocates, community members, and other partners that may have a vested interest in promoting health through HIV prevention, care, and treatment. If necessary, MOAs/MOUs, should be established.

2. Population(s) of Focus

Focus populations may vary by jurisdiction. Applicants must provide HIV services to populations within the jurisdiction that are disproportionately impacted by HIV as identified by their epidemiological data, gaps in services, or need. Applicants should use epidemiologic data, social determinants data, data on clusters of rapid HIV transmission, and other relevant data sources to identify communities within their jurisdictions disproportionately affected by HIV and syndemic diseases and conditions. Applicants should also take into consideration multiple approaches, resources, and changing landscape of HIV when focusing on specific populations. Examples to consider based on national and local data, include transgender women, cisgender Black or African American women, gay and bisexual men, Black or African American gay and bisexual men, Hispanic or Latino gay and bisexual men, American Indian or Alaska Native gay and bisexual men, people who inject drugs (PWID), youth, pregnant and postpartum persons and their infants, and other populations with disproportionally higher rates of HIV diagnosis including individuals involved in the justice system and people experiencing housing insecurity.

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

a. Health Disparities

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

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

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

Health disparities in HIV are inextricably linked to a complex interaction of social determinants that influence populations most severely affected by this disease. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. Social determinants of health affect disparities in HIV, viral hepatitis, STIs, and TB. Environmental factors such as housing conditions, social networks, and social support are also key drivers for infection with HIV, viral hepatitis, STIs, and TB. This NOFO supports efforts to improve the health of populations disproportionately affected by HIV by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity. Please also refer to The U.S. Playbook to Address Social Determinants of Health (SDOH-Playbook-3.pdf (whitehouse.gov)).

iv. Funding Strategy

For Core HIV Surveillance and Prevention Programs: Anticipated award levels are allocated using a funding algorithm reflecting a base funding amount and the proportionate share of each eligible jurisdiction to the number of people living with diagnosed HIV infection in 2021 (Volume 34 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC and AtlasPlus | NCHHSTP | CDC). The funding strategy guarantees a minimum funding base of $1,220,000.00 to support organizational infrastructure for the program. Funds should be used to support surveillance and prevention activities. However, applicants must direct a minimum of 14% and a maximum of 24% of the overall funds to support surveillance activities. Applicants may exceed the 24% allocation if necessary, and approved by CDC through the budget review process, to support the program; however, remaining funds must be used to support HIV prevention activities and service delivery.

For Ending the HIV Epidemic (EHE) Activities: Funding is based on a data driven formula developed to align funding with the EHE initiative. Funding levels were determined by a formula reflecting a base funding amount, number of people living with diagnosed HIV infection in 2021, and number of counties within the health department jurisdiction (if applicable). EHE funds must be used to enhance HIV prevention efforts with the EHE jurisdictions; funds may be used to support surveillance activities associated with these enhanced efforts, as needed. EHE funds will be tracked and delineated separately within the reporting.

Refer to NOFO funding tables for additional information.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

CDC will use a three-pronged approach to monitoring, evaluation, accountability, and quality assurance for PS24-0047: 1) recipient performance monitoring; 2) local evaluation; and 3) CDC's evaluation of the collective impact of the NOFO across all recipients. This approach will use data to (a) monitor and evaluate NOFO overall, (b) determine if NOFO strategies and activities are being implemented as expected, (c) assess whether intended short-term and intermediate outcomes are being achieved, (d) assess the effectiveness of key prevention strategies, and (e) drive continuous program and system improvement.

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

Data collected will include National HIV Surveillance System, HIV Surveillance Standard Evaluation Report, Annual Performance Reports, and National HIV Prevention Program Monitoring and Evaluation, and Cluster Report Form data. Recipients will collect the required quantitative and qualitative data using CDC approved applications (software) and submit to CDC, according to an established schedule and via CDC approved systems. Guidance on data collecting, reporting, and analysis is provided in the HIV Surveillance Technical Guidance for HIV Surveillance Programs, the National HIV Prevention Program Monitoring and Evaluation Guidance for HIV Prevention Programs, and the Cluster Detection and Response (CDR) Guidance. Data collection for the HIV program has been approved by the Office of Management and Budget (OMB) under OMB Number 0920-0573, National HIV Surveillance System, Expiration Date: February 28, 2026, and OMB Number 0920-0696, National HIV Prevention Program Monitoring and Evaluation, Expiration Date: October 31, 2024, and OMB Number 0920-1132, Performance Progress and Monitoring Report, Expiration Date: 3/31/2026. Changes to data collection requirements during the project period will be subject to review and approval by OMB.

Findings will be systematically reviewed by CDC to identify challenges encountered by recipients, identify capacity-building assistance needs and actions needed to improve overall project performance, compare methods and outcomes across recipients to identify promising practices for dissemination during the project period, demonstrate the value of the NOFO (e.g., improved public health outcomes, effectiveness of key prevention strategies and activities), and contribute to the evidence base for NOFO strategies and activities. Data will also be used to produce surveillance reports, reports on project accomplishments, project feedback reports, fact sheets, and monitoring and evaluation reports. Within two to three months after recipients report their data to CDC, CDC will provide them with a report that summarizes each recipient's performance as well as the performance of all other recipients. This report will be reviewed and discussed by the recipient and the project officer or program consultant, and among CDC staff involved in the NOFO. Findings may also be reported at national conferences, CDC and partner websites, in peer-reviewed journals, and in other public forums.

For each of the NOFO strategies, a partial list of short and intermediate outcomes and performance measures are presented below. A full list of proposed outcomes, measures, and targets will be included in the CDC-RFA-PS24-0047 Evaluation and Performance Measurement Strategy which will be provided by CDC at the beginning of the project. EHE activities should be novel more cutting edge and therefore likely have slightly different outcomes. CDC will finalize the performance measures, their specific definitions, benchmarks, submission frequency, and data reporting templates in consultation with recipients within 6 months into the award. CDC will also provide guidance on how these measures are to be stratified by demographic, geographic, and other factors to monitor progress in reducing HIV-related disparities.

Strategy 1: Increase knowledge of status to 95% by diagnosing all people with HIV infection as early as possible.

Short-term Outcomes

1.1: Increased routine opt-out HIV screening in health care settings

- Measure: Number and percentage of people screened for HIV among all people served in health care facilities conducting routine opt-out HIV screening during the measurement period
- Measure: Number and percentage of people receiving a new diagnosis of HIV infection among all people screened in a health care facility conducting routine opt-out HIV screening during the measurement period
- Measure: Among all people screened during the measurement period, number and percentage of people with a previous diagnosis not in care who were identified through routine opt-out HIV testing in health care settings

1.2: Increased availability of and accessibility to HIV testing services, including HIV self-testing

- Measure: Among all people tested during the measurement period, number and percentage of people tested in health care settings
- Measure: Among all people tested during the measurement period, number and percentage of people tested in non-health care settings (i.e., outreach, mobile, venue-based, jail, community/large scale event)

- Measure: Number of HIV self-test kits distributed during the measurement period
- Measure: Number of people who received at least one HIV self-test kit during the measurement period

1.3: Increased identification of people with new HIV diagnosis and people with HIV who are not in care or not virally suppressed

- Measure: Number and percentage of people tested during the measurement period who are newly diagnosed with HIV infection
- Measure: Number and percentage of people tested during the measurement period who are identified with a previous HIV diagnosis and are not in care or not virally suppressed

1.4: Increased integrated screening of HIV in conjunction with testing for other STIs, viral hepatitis, TB, and mpox

- Measure: Number and percentage of people who received an HIV test during the measurement period conducted in conjunction with testing for an STI, hepatitis B and C, TB, or mpox

Intermediate Outcomes

1.5: Increased knowledge of HIV status

- Measure: Estimated percentage of people aged ≥13 years with HIV who know their HIV status during the measurement period (EHE/NHAS national target: at least 95% by 2025. Data source NHSS)

1.6: Reduced late HIV diagnoses

- Measure: Number and percentage of people ≥13 years receiving a Stage 3 HIV (AIDS) diagnosis during the measurement period (Data Source NHSS)

Strategy 2: Implement a comprehensive approach to treat people with diagnosed HIV infection rapidly (increase linkage to care up to 95%) and effectively achieve viral suppression (up to 95%).

Short-term Outcomes

2.1: Increased rapid linkage to HIV medical care

- Measure: Number and percentage of people diagnosed with HIV infection during the measurement period who were linked to HIV medical care (received a CD4 or viral load test) within 7 days after diagnosis
- Measure: Number and percentage of people linked to HIV medical care (received a CD4 or viral load test) within 30 days after diagnosis among people aged ≥13 years with HIV infection diagnosed during the measurement period (EHE/NHAS national target: at least 95% by 2025. Data source NHSS)

2.2: Increased receipt of HIV partner services

- Measure: Number and percentage of people with HIV infection diagnosed during the measurement period who were interviewed for HIV partner services within 30 days after diagnosis

2.3: Increased immediate engagement in HIV prevention, medical care, and treatment adherence services for people with diagnosed HIV infection who are not in care

- Measure: Number and percentage of people living with diagnosed HIV infection who were confirmed during a specified 6-month evaluation time period not to be in care and are linked to HIV medical care within 30 days of being confirmed not in care
- Measure: Percentage of people with diagnosed HIV infection linked to HIV medical care during a specified 6-month evaluation time period with HIV viral suppression within six months (180 days) after being linked to care

2.4: Increased early initiation of ART

- Measure: Number and percentage of people diagnosed with HIV infection during the measurement period who were prescribed ART within 7 days after HIV diagnosis
- Measure: Number and percentage of people diagnosed with HIV infection during the measurement period who were prescribed ART within 30 days after HIV diagnosis

2.5: Increased receipt of essential support services to improve quality of life

- Measure: Number and percentage of people with diagnosed HIV infection who were screened for mental health services, substance use treatment services, or housing assistance needs during the past 12 months
- Measure: Number and percentage of people with diagnosed HIV infection with unmet needs who were referred to or provided mental health services, substance use treatment services, or housing assistance during the past 12 months

Intermediate Outcomes

2.6: Increased receipt of HIV medical care among people living with diagnosed HIV infection

- Measure: Number and percentage of people aged ≥13 years with diagnosed HIV infection who received any HIV medical care as measured by documentation of ≥1 CD4 or viral load tests performed during the measurement period Data source NHSS)

2.7: Increased HIV viral suppression among people living with diagnosed HIV infection

- Measure: Number and percentage of people aged ≥13 years with diagnosed HIV who were virally suppressed at the last test performed during the measurement period (EHE national target: at least 95% by 2025. Data source NHSS)

Strategy 3: Prevent new HIV transmission, by increasing PrEP coverage to 50% of estimated people with indications for PrEP, increasing PEP services, and supporting HIV prevention, including prevention of perinatal transmission, harm reduction, and syringe services program (SSP) efforts.

Short-term Outcomes

3.1: Increased linkage to PrEP services among people with indications for PrEP

- Measure: Number and percentage of people testing negative for HIV infection with indications for PrEP who were referred to a PrEP provider during the measurement period
- Measure: Number and percentage of people referred to a PrEP provider who were linked to a PrEP provider during the measurement period

3.2: Increased linkage to PEP services among people who likely have been exposed to HIV

- Measure: Number and percentage of PEP eligible people who likely have been exposed to HIV who were referred to an HIV medical provider during the measurement period
- Measure: Number and percentage of PEP eligible people who likely have been exposed to HIV who were linked to an HIV medical provider during the measurement period

3.3: Increased availability of harm reduction services, including SSPs

- Measure: Number of SSPs operating in the jurisdiction during the measurement period
- Measure: Number of syringes distributed by SSPs during the measurement period

3.4: Increased awareness of Prep, PEP, and other prevention approaches

- Measure: To be determined

3.5: Improved completeness, timeliness, and quality of perinatal HIV surveillance data (for case and exposure reporting)

- Measure: Meets standards detailed in the Technical Guidance for HIV Surveillance Programs for Pediatric HIV Surveillance and Perinatal HIV Exposure Reporting, as required by CDC standards

3.6: Improved provision and coordination of perinatal HIV services among pregnant persons and postpartum persons with HIV infection and their infants

- Measure: Of all pregnant persons with diagnosed HIV infection, the percentage receiving perinatal HIV care
- Measure: Number of breastfeeding/chestfeeding infants born to persons with HIV and the proportion who receive appropriate HIV diagnostic testing

Intermediate Outcomes

3.7: Increased PrEP prescriptions and use among people with indications for PrEP

- Measure: Number and percentage of people with indications for PrEP who were prescribed PrEP during the measurement period

3.8: Increased PEP prescriptions and use among people who likely have been exposed to HIV

- Measure: Number and percentage of PEP eligible people (i.e., people who likely have been exposed to HIV) who were prescribed PEP within 72 hours of potential HIV exposure

3.9: Increased accessibility and use of SSPs

- Measure: Number of unique people who received SSP services during the measurement period

3.10: Reduced perinatally acquired HIV infection

- Measure: Number and percentage of all pregnant people with diagnosed HIV infection who have a suppressed viral load within 4 weeks prior to delivery (Data Source NHSS)
- Measure: Percentage of post-partum persons with diagnosed HIV infection who have a suppressed viral load at 6-months post-partum (Data Source NHSS)
- Measure: Number of perinatally acquired HIV infections among 1) all live births in the jurisdiction, and 2) by HIV-exposed live births by year of birth (Goal: Perinatal HIV incidence of <1 per 100,000 live births and a perinatal HIV transmission rate of <1%. (Data Source NHSS).

Strategy 4: Respond quickly to HIV clusters and outbreaks to address gaps and inequities in services for communities who need them.

Short-term Outcomes

4.1: Improved early identification and investigation of HIV clusters and outbreaks

- Measure: Of all clusters that meet CDC's cluster report form criteria detected during the evaluation period, ≥90% had an initial cluster report form submitted to CDC by the submission deadline

4.2: Improved completeness and timeliness of CDR data

- Measure: Of people with HIV in clusters for which a cluster report form was submitted during the evaluation year, ≥90% had cluster variables entered in eHARS

Intermediate Outcome

4.3: Improved response to HIV clusters and outbreaks at individual, network, and system levels to reduce transmission and improve care and prevention

- Measure: Of clusters that meet CDC's criteria for an annual or closeout cluster report form, ≥90% had an annual or closeout cluster report form submitted to CDC by the submission deadline

Strategy 5: Conduct HIV surveillance activities as described in the Technical Guidance (TG) for HIV surveillance programs to ensure accurate, timely, complete, and actionable data.

Short-term Outcomes

5.1: Improved completeness, timeliness, and accuracy of HIV surveillance data for public health action

- Measure: Meet all process and outcome standards detailed in the Technical Guidance for HIV Surveillance Programs

5.2: Improved monitoring of trends in HIV infection, including geographic distribution of HIV, social determinants of health and HIV-related health disparities

- Measure: Meet data analysis and dissemination standards according to the Technical Guidance for HIV Surveillance Programs

5.3: Improved data security, confidentiality, and sharing

- Measure: Full compliance with CDC NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs

Intermediate Outcome

5.4: Improved use of HIV surveillance data to identify the populations affected by relevant syndemics

- Measure: Analyze and disseminate reports that describe relevant syndemics according to the Technical Guidance for HIV Surveillance Programs

5.5: Improved electronic data exchange capacity

- Measure: Expanded electronic data exchange capacity according to the Technical Guidance for HIV Surveillance Programs

5.6: Improved visualization of HIV surveillance data for public health action

- Measure: Increased availability and accessibility of data displays according to the Technical Guidance for HIV Surveillance Programs and in compliance with data release policies.

Strategy 6: Support community engagement and HIV planning.

Short-term Outcome

6.1: Increased collaborations and engagement with local partners and communities (both traditional and non-traditional organizations) to inform HIV and sexual health services

- Measure: Qualitative measures (To be determined)

6.2: Increased coordination, availability, and access to comprehensive HIV prevention, treatment, and support services

- Measure: Qualitative measures (To be determined)

Intermediate Outcome

6.3: Sustained community partnerships to inform strategic planning and implementation

- Measure: Qualitative measures (To be determined)

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance

Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement, including, as applicable to the award, how findings will contribute to reducing or eliminating health disparities and inequities.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant).
- How evaluation findings will be disseminated to communities and populations of interest in a manner that is suitable to their needs.
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additional-requirements/ar-25.html.

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

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

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

As listed above, applicants must provide an initial evaluation and performance measurement plan (EPMP) of no more than 5 pages that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO.

Recipients will be required to use the CDC template to develop their jurisdiction-specific Evaluation and Performance Measurement Plan (EPMP) and submit a detailed EPMP within the first 6 months into the award. This will be updated at least twice during the NOFO period per CDC guidance. CDC will work with recipients to finalize their detailed EPMP, including a Work Plan and Data Management Plan (DMP), in accordance with CDC program guidance. Additionally, CDC will work with recipients to develop additional program specific outputs, outcomes, and measures. An EPMP template will be provided to recipients at the beginning of the project period.

Applicants should plan for sufficient staffing and resources to accomplish all evaluation activities, including planning, data collection, data entry, data management, reporting data to CDC, data analysis and interpretation, use of data for program improvement, development and dissemination of reports, and attendance at monitoring and evaluation meetings.

Focused Evaluation Plan (Recommended)

Recipients are encouraged to identify local evaluation needs and conduct focused evaluation throughout the life of the award.

CDC encourages recipients to develop a focused evaluation plan to assess their jurisdiction-specific activities and outcomes for NOFO strategies. The purpose of the focused evaluation plan is to systematically obtain new insights regarding program implementation approaches and support program improvement. Applicants who elect to do a focused evaluation will determine the topic, methods, scale, scope, and duration of their focused evaluation projects, based on their capacity and program needs, in consultation with CDC within six months into the NOFO or anytime over the course of the NOFO period. CDC will provide evaluation technical assistance and support recipients on their local evaluation project or plans to build local evaluation capacity. The evaluation plan should include formative, process, and outcome and quality improvement measures and strategies. Recipients who elect to do a focused evaluation will need to:

- Submit focused evaluation plans to CDC
- Implement focused evaluation project(s)
- Provide updates to CDC on the project(s)
- Share findings and insights from the project(s) locally and with CDC
- Describe barriers, facilitators, and program improvements associated with the project(s)
- Respond to any feedback provided by CDC on the plans submitted, on implementation, and on dissemination and use of the findings from their project(s)

Applicants should provide a brief description (no more than ½ page) of their proposed focused evaluation project concept including:

- Topic, strategy, or intervention that the applicant intends to evaluate
- Key evaluation questions for the focused evaluation project
- Approximate duration and timeline for the focused evaluation project
- Any contextual or organizational factors that may affect their approach to this requirement (e.g., description of staffing and analytic capacity to carry out project)

c. Organizational Capacity of Recipients to Implement the Approach

Describe the applicant's Organizational Capacity needed to implement the award:

- Applicant should describe relevant experience and capacity (management, administrative, and technical) to implement the strategies and activities listed and achieve the project outcomes.
- Applicants should describe experience and capacity to implement the evaluation plan, and a staffing plan and project management structure sufficient to achieve the project outcomes.

- Applicants should describe their ability to reach the population(s) of focus and effectively implement activities with them, as applicable to this NOFO; this should include describing collaborators and partnerships, contractual agreements, and sub-recipients with whom the recipient will work to provide services to the population(s) of focus.
- Applicants should describe their ability to manage the required procurement efforts, including the ability to write and award contracts in accordance with applicable grants regulations.
- Make sure that the information presented in this section aligns to the requirements listed for this NOFO.
- Provide an organization chart where this program will reside. For Open or Limited competition NOFOs, applicants must name this file "Organizational Charts" and upload it at www.grants.gov. Attachments can be submitted using PDF, Word, or Excel file formats.

d. Work Plan

No specific work plan format is required, as long as it is clear how the elements in the work plan crosswalk to the strategies and activities, outcomes, and evaluation and performance measures presented in the logic model and the narrative sections of the NOFO. Applicants should provide a detailed work plan for the first year of the project and a high-level work plan for subsequent years. Applicants are to use Specific, Measurable, Achievable, Realistic, and Timely “SMART’ objectives or indicators.

e. CDC Monitoring and Accountability Approach

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

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

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

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

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

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

f. CDC Program Support to Recipients

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

1. Collaborate to ensure coordination and implementation of strategies to support the implementation of HIV surveillance and prevention activities.
2. Work with recipients to identify and address capacity building assistance (CBA) and TA needs that are essential to the success of the project. Recipients must work with the assigned Project Officer to establish a mechanism to request direct CDC TA via the designated CDC system or portal.
3. Provide access to training and TA that will strengthen staff capacity relevant to all required strategies and activities of the program.
4. Provide guidance to recipients and set standards on data collection, use, and submission requirements.
5. Facilitate coordination, collaboration, and, where feasible, service integration among federal agencies, other CDC funded programs, other health departments, community based organizations, local and state planning groups, other CDC directly funded programs, national capacity building assistance providers, medical care providers, laboratories, recipients of the Ryan White HIV/AIDS Treatment Extension Act of 2009, and other partners working with people with HIV and at greatest risk for HIV infection toward common goals of risk reduction, disease detection, and a continuum of HIV prevention, care, and treatment.
6. Monitor recipient program performance using multiple approaches, such as site visits, emails, conference calls, and standardized review of performance, recipient feedback and other data reports, to support program development, implementation, evaluation, and improvement.
7. Provide guidance and coordination to funded organizations to improve the quality and effectiveness of work plans, evaluation strategies, products and services, and collaborative activities with other organizations.
8. Collaborate to compile and publish accomplishments, best practices, performance criteria, and lessons learned during the project period.

9. Collaborate in assessing progress toward meeting strategic and operational goals/objectives and in establishing measurement and accountability systems outcomes, such as increased performance improvements and best or promising practices.
10. Collaborate on strategies to ensure the provision of appropriate and effective HIV prevention services to populations of focus.
11. Provide requirements and expectations for standardized and other data reporting and support monitoring and evaluation activities.
12. Share information, best practices, lessons learned, and evaluation results (e.g., through conferences, guidance, material development, webinars, data sharing publications, other social media, participation in meetings, committees, conference calls, and working groups related to the cooperative agreement and its projects).
13. Validation-Completion of a comprehensive Assessment of Data Security and Confidentiality Protections at least once during the project period. See Appendix B of the guidance (pages 43-54) for a more detailed description of the process and content. Upon completion and submission, the assessment will be reviewed and validated by CDC program monitors.

B. Award Information

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

2. Award Mechanism:
U62

3. Fiscal Year:
2024

4. Approximate Total Fiscal Year Funding:
$484,474,481

5. Total Period of Performance Funding:
$2,900,000,000
This amount is subject to the availability of funds.

Refer to funding tables on NOFO website at
https://www.cdc.gov/hiv/funding/announcements/ps24-0047/index.html

Estimated Total Funding:
$2,900,000,000

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

year(s)

7. Expected Number of Awards:
60
Additional Information: 60 awards for eligible health departments for core prevention and surveillance funding. Approximately 32 additional awards for eligible health departments representing the 57 jurisdictions (48 counties, District of Columbia (DC), San Juan, PR, and 7 states) included in the Ending the HIV Epidemic in the US initiative.

8. Approximate Average Award:

$0
Per Budget Period

Refer to the funding tables on the NOFO website.

9. Award Ceiling:
$0
Per Budget Period

This amount is subject to the availability of funds.

10. Award Floor:
$0
Per Budget Period

11. Estimated Award Date:
August 01, 2024

12. Budget Period Length:
12 month(s)

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

13. Direct Assistance
Direct Assistance (DA) is available through this NOFO.

Applicants may request federal personnel, equipment, or supplies, including SAS licenses, as Direct Assistance (DA) to support HIV surveillance and prevention activities, in lieu of a portion of financial assistance (FA). To address staffing and/or program expertise deficits, applicant may convert FA to DA to recruit staff with the requisite training, experience, expertise (e.g., Public Health Associate Program [PHAP]).

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in

effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:
00 (State governments)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

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

2. Additional Information on Eligibility

See funding tables for list of eligible health department jurisdictions for core and EHE funding.

Additionally, a fiduciary entity may request funding on behalf of the health department, as evidence by a letter or memorandum of agreement (MOA) with the health department. If a MOA is not provided by the health department and the identified fiduciary or bona fide agent, CDC will consider an alternative funding agreement for the provision of HIV prevention funding resources to that health department jurisdiction.

If applicable, applicants must submit MOA with the health department and fiduciary agent, as appropriate, name the file(s) “MOA Fiduciary" and upload the document(s) as a PDF file under "Other Attachments Forms".

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:
No

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

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Application and Submission Information

1. Required Registrations

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

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

a. Unique Entity Identifier (UEI):

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

b. System for Award Management (SAM):

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

c. Grants.gov:

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

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

Step	System	Requirements	Duration	Follow Up
1	System for Award Management (SAM)	1. Go to SAM.gov and create an Electronic Business Point of Contact (EBiz POC). You will need to have an active SAM account before you can register on grants.gov). The UEI is generated as part of your registration.	7-10 Business Days but may take longer and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/fsd-gov/home.do Calls: 866-606-8220
2	Grants.gov	1. Set up an account in Grants.gov, then add a profile by adding the organization's new UEI number. 2. The EBiz POC can designate user roles, including Authorized Organization Representative (AOR). 3. AOR is authorized to submit applications on behalf of the organization in their workspace.	Allow at least one business day (after you enter the EBiz POC name and EBiz POC email in SAM) to receive a UEI (SAM) which will allow you to register with Grants.gov and apply for federal funding.	Register early! Applicants can register within minutes.

2. Request Application Package

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

3. Application Package

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

4. Submission Dates and Times

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

a. Letter of Intent Deadline (must be emailed)

Number Of Days from Publication 14

02/23/2024

b. Application Deadline

Due Date for Applications 04/29/2024

04/29/2024
11:59 pm U.S. Eastern Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which Grants.gov operations resume.

Due Date for Information Conference Call

Topic: Informational Call

Time: Feb 22, 2024 02:00 PM Eastern Time (US and Canada)

Join Zoom Meeting

https://us02web.zoom.us/j/85624447625?pwd=Tlp1UnFHdlFjZVFkeWFjOUh2ZUs5QT09

Meeting ID: 856 2444 7625

Passcode: 826099

5. Pre-Award Assessments

Duplication of Efforts

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

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

6. Content and Form of Application Submission

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

7. Letter of Intent

The LOI is intended to provide CDC with an estimated number of applicants in preparation for the objective review process. Please provide a LOI if you plan to or do not plan to apply for funding. Please include your intentions on applying for funding and location/contact information. LOIs should be emailed to NOFOINFO@cdc.gov, This LOI is strongly recommended; however, it is not required or scored.

LOI sent via email to:

Erica Dunbar

CDC, NCHHSTP/DHP

NOFOINFO@cdc.gov

8. Table of Contents

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

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF, Word, or Excel file format under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

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

10. Project Narrative

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)

Applicants must submit a Project Narrative with the application forms. Applicants must name this file “Project Narrative” and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use

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

a. Background

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

b. Approach

i. Purpose

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

ii. Outcomes

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

iii. Strategies and Activities

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

1. Collaborations

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

2. Population(s) of Focus and Health Disparities

Applicants must describe the specific population(s) of focus in their jurisdiction and explain how to achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Population(s) of Focus and Health Disparities requirements as described in the CDC Project Description, including (as applicable to this award) how to address health disparities in the design and implementation of the proposed program activities.

c. Applicant Evaluation and Performance Measurement Plan

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

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

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

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

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

d. Organizational Capacity of Applicants to Implement the Approach

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

11. Work Plan

(Included in the Project Narrative's page limit)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the recipient plans to

carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

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

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

Indirect costs could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation or reaccreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver essential public health services and ensure foundational capabilities are in place, such as activities that ensure a capable and qualified workforce, strengthen information systems and organizational competencies, build attention to equity, and advance the capability to assess and

respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

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

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

Applicants must allocate funding for each of the three core initiatives; Prevention, Surveillance, and EHE (if applicable) on separate columns of the 424A documents and provide a detailed justification for all activities. The required core strategies and activities should be appropriately reflected under the prevention and surveillance budget. EHE supported activities should be reflected under the EHE budget, if applicable. Applicants should identify where funds are redirected to support other Surveillance or Prevention activities (e.g., direct assistance for personnel, SAS licenses or cluster detection and response). Direct Assistance allocations require a separate 424A document.

Applicants are eligible (and encouraged) to utilize up to 10% of the requested total funding amount to enhance integrated screening efforts and promoting syndemic approaches.

13. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

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

14. Employee Whistleblower Rights and Protections

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

15. Copyright Interests Provisions

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

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

16. Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
    - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
    - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on anti-lobbying restrictions for CDC recipients.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Recipients may not use funds to purchase antiretroviral therapy.
- Federal funds used for the purchase of supplies or equipment related to injection drug use must comply with current federal law.
- Funding should not be used for construction purposes.

17. Data Management Plan

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

18. Intergovernmental Review

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

19. Other Submission Requirements

a. Electronic Submission:

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

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

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

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or review the Applicants section on www.grants.gov.

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

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail

CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application must:

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

   If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application via email.

E. Review and Selection Process

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

a. Phase 1 Review

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

b. Phase II Review

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

i. Approach

ii. Evaluation and Performance Measurement

iii. Applicant's Organizational Capacity to Implement the Approach

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

i. Approach **Maximum Points:** 45

Approach (45 points for core program; 25 points for EHE)

Evaluate the extent to which the applicant:

1. Demonstrates a comprehensive understanding of the purpose and intended outcomes of the NOFO (5 points)
2. Describes an overall strategy consistent with the Project Description and logic model, including describing how the applicant will promote health equity, whole-person approaches to HIV prevention, syndemic approaches, and community engagement within their program model (10 points)
3. Describes an overarching six-year approach to execute all required strategies and activities efficiently and effectively as described in the NOFO. Please include the proposed approach that will be implemented for executing the required foundational and operational strategies and the six program strategies and related activities. (10 points)
4. Presents a detailed Year 1 work plan that aligns each of the selected component's outcomes and requirements with proposed SMART objectives, action steps, and performance measurement as described in the NOFO (20 points (3 points for each of the six strategies (18) and 2 points for the foundational strategies)
5. For EHE, describe the approach for identifying and selecting activities to implement (two or more activities per pillar strategy) for EHE implementation. Describes the rationale that explains why the proposed innovative activities will successfully advance the corresponding strategy. (20 points)

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

Evaluation and Performance Measurement (25 points to core program; 10 points for EHE)

Evaluate the extent to which the applicant:

1. Demonstrates the ability to collect data on the process and outcome performance measures specified by CDC in the project description and presented by the applicant in their approach (5 points)
2. Describes how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities (5 points)
3. Describes how evaluation and performance measurement findings will be reported and used to demonstrate the outcomes of the NOFO and continuous quality improvement of project activities (15 points)
4. For EHE, describes clear monitoring and evaluation procedures and how evaluation and performance measurement will be incorporated into planning, implementation, and reporting of project activities (10 points)

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

Applicant's Organizational Capacity to Implement the Approach (30 points for core program; 15 points for EHE)

1. Demonstrates relevant experience and capacity (management, administrative, and technical) to implement the approach (each of the required strategies and associated activities) within the jurisdiction and achieve the project outcomes. (15 points)
2. Describe proposed partnerships and collaborations that exist or will be established to build capacity for implementing the program. (5 points)

3. Provides capacity building needs (5 points)
4. Provides a staffing plan and project management structure that will be sufficient to achieve the project outcomes, and which clearly defines staff roles. Provides an organizational chart. (5 points)
5. For EHE, describes the applicant's capacity to implement the selected activities (up to two per strategy) for EHE implementation. Describe partnerships and collaborations that exist or will be established to build local capacity for implementing the EHE program (15 points)

Budget **Maximum Points:** 0

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

Applicants must allocate funding for each of the 3 core initiatives; Prevention, Surveillance, and EHE (if applicable) on separate columns of the 424A documents and provide a detailed justification for all activities. Applicants should identify where funds are redirected to support other Surveillance or Prevention activities (e.g., direct assistance for personnel, SAS licenses or cluster detection and response). Direct Assistance allocations require a separate 424A document.

Applicants are eligible (and encouraged) to utilize up to 10% of the requested total funding amount to enhance integrated screening efforts and promoting syndemic approaches.

c. Phase III Review

All applications will be initially reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements. For the Phase II Review, a technical acceptability review panel will evaluate complete, eligible applications in accordance with the criteria listed in the NOFO.

Review of risk posed by applicants.

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

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

the non-Federal entity's risk in accordance with 45 CFR §75.207. CDC's review of risk may impact reward eligibility.

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

(1) Financial stability;

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

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

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

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

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

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

2. Announcement and Anticipated Award Dates

Awards will be announced before or by the award start date of August 1, 2024.

F. Award Administration Information

1. Award Notices

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

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

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

2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at https://www.cdc.gov/grants/additional-requirements/index.html.

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

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

3. Reporting

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

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

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

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

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

Report	When?	Required?
Recipient Evaluation and Performance Measurement Plan	6 months into award	Yes
Annual Performance Report (APR)	No later than 120 days before end of budget period. Serves as yearly continuation application	Yes
End of Year (EOY) Progress Report	No later than 90 after the end of the budget period (annual progress report).	Yes
Data on National HIV Prevention Program Monitoring and Evaluation	At least every 6 month and no more than quarterly within the budget period	Yes
Standard Evaluation Report for HIV Surveillance *	Annually for the entire previous 12-month calendar year.	Yes
Federal Financial Reporting Forms	90 days after end of calendar quarter in which budget period ends	Yes
Final Performance and Financial Report	90 days after end of project period	Yes
Payment Management System (PMS)	Reporting As determined by OGS	Yes

Surveillance Performance Reporting

Recipients will be required to submit a yearly *Standard Evaluation Report (SER) Form for HIV surveillance approved OMB No: 0920-0573, Expiration Date: 02/08/2026. The process and outcome standards included in the SER are described in the TG *Evaluation and Data Quality* file. The SER will also capture qualitative data and a work plan (as appropriate) for the entire previous 12-month calendar year.

Prevention Program Performance Reporting

Recipients will be required to submit performance reports, approved OMB Number 0920-1132, Performance Progress and Monitoring Report, Expiration Date: 3/31/2026. Annual Performance

Report and End of Year Reports will capture qualitative and quantitative data and a work plan (as appropriate) for the specified budget year.

a. Recipient Evaluation and Performance Measurement Plan (required)

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

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

Performance Measurement

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

Evaluation

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

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

b. Annual Performance Report (APR) (required)

The recipient must submit the APR via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

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

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

c. Performance Measure Reporting (optional)

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

d. Federal Financial Reporting (FFR) (required)

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

e. Final Performance and Financial Report (required)

The Final Performance Report is due 120 days after the end of the period of performance. The Final FFR is due 120 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the period of performance, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

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

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $30,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

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

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

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

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

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

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

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

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

5) Contents of Reports: The reports must contain:

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

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

6. Termination

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

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

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

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

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

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
Erica

Last Name:
Dunbar

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

Address:
1600 Clifton Rd. NE, Atlanta, GA 30333

Telephone:
404-639-5230

Email:
NOFOINFO@cdc.gov

Grants Staff Contact

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

First Name:
Arthur

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

Address:
1600 Clifton Rd. NE, MS S102-1

Atlanta, GA 30333

Telephone:
770-488-2865

Email:
cmx3@cdc.gov

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

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

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

H. Other Information

Following is a list of acceptable application attachments that can be submitted using PDF, Word, or Excel file formats as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative

- Budget Narrative
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:
Organization Charts

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Bona Fide Agent status documentation, if applicable

I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see https://www.cdc.gov/grants/additional-requirements/index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

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

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

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the period of performance. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget

period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

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

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established period of performance (i.e., extends the "life" of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. https://www.cdc.gov/grants/additional-requirements/index.html.

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

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is

used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

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

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

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

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

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

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

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

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

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

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

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

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

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

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

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and

obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

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

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

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

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

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

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.

Program Official: Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.

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

Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil

law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

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

Work Plan: The summary of period of performance outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

NOFO-specific Glossary and Acronyms

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Adult Case Report Form (ACRF): The ACRF is designed to collect information for persons with diagnosed HIV 13 years of age or older. The ACRF supports standard data collection, which is important for ensuring accurate HIV surveillance data that can guide public health action.

Active Surveillance: Active surveillance involves regularly and proactively contacting reporting facilities (hospitals, clinics, physician offices, laboratories) to identify potential/suspected HIV cases (or confirm no cases). It also includes review of medical records at provider sites or eliciting information that can be received by telephone, secure fax, secure e-mail, other sources, or U.S. mail to establish an HIV case or complete a case report form. This surveillance method is initiated by the health department.

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

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

Cases of Public Health Importance (COPHI): HIV cases involving (1) unusual transmission circumstances; (2) unusual strains of HIV, including HIV-2; and 3) special diagnostic situations (e.g., persons with false-positive or false-negative test results) that should be a priority for

reporting to CDC, investigation and follow-up, and ensuring the collection of high-quality information.

Case Reporting: The transmission of case reports from health care provider's medical record to HIV surveillance programs.

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

Cluster or Outbreak: An HIV cluster or outbreak refers to rapid HIV transmission among people in a sexual or drug-using network. This can occur because communities have limited or no access to HIV prevention and care services. Stigma, discrimination, racism, poverty, and other social and structural factors all contribute to limiting access to these services. Health departments, community-based organizations, and other partners use cluster detection and response (CDR) to address these service gaps and improve health equity.

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

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

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

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

Death Ascertainment Activities: Collecting data on the deaths of persons with HIV infection to: (1) update vital status (from alive or unknown to deceased); (2) ascertain cause(s) of death among persons with HIV; and (3) identify persons with HIV infection not previously reported to HIV surveillance programs.

Deduplication: The process of identifying and correcting duplicate case reports within a state (intrastate) or between states (interstate).

Electronic Case Reporting (eCR): The electronic transmission of case reports from health care provider's electronic health record (EHR) to HIV surveillance programs.

Electronic Laboratory Reporting (ELR): The electronic transmission of laboratory reports from laboratories to HIV surveillance programs.

Ending the HIV Epidemic (EHE): Ending the HIV Epidemic in the U.S. (EHE) is a bold plan announced in 2019 that aims to end the HIV epidemic in the United States by 2030.

Evidence-based Interventions: Behavioral, social, and structural interventions relevant to HIV risk reduction that have been tested using a methodologically rigorous design and have been

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

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

Geocoding: Process of converting street addresses to coordinates (i.e., latitude and longitude) so that data can be mapped. Geocoding uses a database of properly formed addresses, a reference database of streets, and a set of rules for matching them.

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

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

Laboratory Reporting: The transmission of laboratory reports from laboratories to HIV surveillance programs. The laboratory reports identify reportable conditions. Laboratory reporting supports case reporting at the state or local level.

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

Passive Surveillance: Passive surveillance is the receipt of information about cases of HIV infection from health care providers, laboratories, or other persons or institutions without regular prompting of the reporting source. This surveillance method is provider or laboratory initiated.

Pediatric Case Report Form (PCRF): The PCRF is designed to collect information for persons with diagnosed HIV less than 13 years of age who are perinatally exposed to HIV or diagnosed with HIV.

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

Prevalence: The total number of cases of a disease in a given population at a particular point in time. HIV prevalence refers to people with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be

used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.

Risk Factor Ascertainment Activities: Risk factors for HIV infection as defined by HIV surveillance that are collected through the patient history variables, and how to summarize the information to convey the risk factor most likely responsible for transmission (transmission category) or all the known ways a person could have been exposed to HIV (exposure category).

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

Technical Guidance (TG): Guidance document on a specific topic that provides detailed instructions or guides recipients on what is needed to implement or complete the specified topic area.