Each application will be evaluated individually against the following criteria by an independent review group appointed by CDC:

1. Program Capacity (25 percent)

The proposal should demonstrate capacity and experience needed to implement a project of this magnitude and scope including infrastructure, staffing levels and laboratory capacity.

2. Technical and programmatic approach (25 percent)

The extent to which the applications proposal demonstrates an understanding of how to develop, implement, monitor and evaluate a care program of this complexity.

3. Program Plan (20 percent)

The proposal should demonstrate capacity and plans to rapidly roll out this program to multiple sites in the country.

4. Personnel (15 percent)

The extent to which professional personnel involved in this project are qualified. Provide evidence of experience in working with HIV/AIDS and specifically in the management of opportunistic infections in HIV/AIDS.

5. Understanding of the problem (15 percent)

The extent in which the applicant describes a clear, concise understanding of the HIV/AIDS epidemic in Uganda, and specifically addresses the gaps in the clinical management of people with HIV/AIDS.

6. Budget. (reviewed, but not scored)

The extent to which the itemized budget for conducting the project is reasonable and well justified.

K. Other Requirements

Technical Reporting Requirements

Provide CDC with original plus two copies:

1. Annual progress report (The progress report will include a data requirement that demonstrates measures of effectiveness).

2. Financial status report, no more than 90 days after the end of the budget period.

3. Final financial and performance reports, no more than 90 days after the end of the project period.

Awardee is required to obtain an annual audit of these CDC funds (program specific audit by a U.S. based audit firm with international branches and current licensure/authority in country, and in accordance with the international accounting standards of equivalent standards approved in writing by CDC).

Projects that involve the collection of information from ten or more individuals and funded by cooperative agreement will be subject to review by the office of management and budget (OMB) under the paperwork reduction act. A fiscal recipient capability assessment may be required with the potential awardee, prior or post award, in order to review the business management and fiscal capabilities regarding the handling of U.S. Federal funds.

Send all reports to both the program contact in Uganda and Grants Management Specialist identified in the ''Where to Obtain Additional Information'', section of this announcement.

The following additional requirements are applicable to this program. For a complete description of each, see Attachment I of the announcement. Some of the more complex requirements have additional information provided below:

AR–1 Human Subjects Requirements
AR–2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research
AR–4 HIV/AIDS Confidentiality Provisions
AR–6 Patient Care
AR–9 Paperwork Reduction Act Requirements
AR–10 Smoke-Free Workplace Requirements
AR–14 Accounting System Requirements

L. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under section 307 of the Public Health Service Act, [42 U.S.C. section 2421], as amended. The Catalog of Federal Domestic Assistance number is 93.118.

M. Where To Obtain Additional Information

This and other CDC announcements can be found on the CDC home page Internet address—*http://www.cdc.gov* Click on ''Funding'' then ''Grants and Cooperative Agreements.''

To obtain business management technical assistance, contact: Dorimar Rosado, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone: (770) 488–2782, E-mail: *dpr7@cdc.gov.*

For program technical assistance, contact: Jonathan Mermin, MD, MPH, GAP, Uganda Country Team, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, PO Box 49, Entebbe, Uganda, Telephone: +256–410320776, E-mail: *jhm@cdc.gov.*

Dated: June 2, 2002.

Sandra R. Manning,

CGFM, Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 02–15541 Filed 6–19–02; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 02153]

REACH 2010 Demonstration Programs; American Indian/Alaska Native Core Capacity Programs; Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2002 funds for cooperative agreements for Racial and Ethnic Approaches to Community Health 2010 (REACH 2010) and American Indian/Alaska Native (AI/AN) Core Capacity. This program addresses the ''Healthy People 2010'' focus areas of maternal, infant, and child health; diabetes; heart disease and stroke; HIV; immunization and infectious Disease; and cancer.

The Centers for Disease Control and Prevention is issuing this program announcement in an effort to simplify and streamline the grant pre-award and post-award administrative process, provide increased flexibility in the use of funds, measure performance related to each grantee's stated objectives and identify and establish the long-term goals of the REACH 2010 and AI/AN Core Capacity programs through stated performance measures. Some examples of the benefits of the streamlined process are: elimination of separate documents (continuation application and semi-annual progress report) to issue a continuation award; consistency in reporting expectations; and increased flexibility within approved budget categories.

Existing grantees under program announcement numbers 00121, 01123, 01132, and US002 will have their grant project periods extended to FY 2007 upon receipt of a technically acceptable application.

The purpose of this program is to support demonstrations projects for

racial and ethnic minority populations at increased risk for infant mortality, diabetes, cardiovascular diseases, HIV infection/AIDS, deficits in breast and cervical cancer screening and management, or deficits in child and/or adult immunization rates to develop, implement, and evaluate innovative community level intervention demonstrations that could be effective in eliminating health disparities.

The collective goal of all demonstrations is to advance knowledge of and increase the effectiveness of future efforts to eliminate racial and ethnic health disparities.

Measurable outcomes of the program will be in alignment with the following performance goal for the National Center for Chronic Disease Prevention and Health Promotion: To support prevention research to develop sustainable and transferable community-based behavioral interventions.

B. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under Section 301(a)and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Section 241 (a) and 247b(k)(2)], as amended. The Catalog of Federal Domestic Assistance number is 93.945.

C. Eligible Applicants

Assistance will only be provided to grantees currently receiving CDC funds under program announcements 00121 and 01123 REACH 2010 Phase II, 01132 entitled AI/AN Core Capacity Building Programs, US002 entitled REACH 2010 for the Elderly, and who are the Central Coordinating Organization (CCO) with direct fiduciary responsibility over the administration and management of the project.

Applications received from applicants that do not meet the CCO requirement will not be considered for an award under this program announcement. All applications received from current grant recipients under program announcement 01121, 01123, 01132 and US002 will be funded pending approval of a technically acceptable application. No other applications are solicited.

Note: Public Law 104–65 states that an organization described in section 501(c)(4) of the Internal Revenue Code of 1986 which engages in lobbying activities shall not be eligible for the receipt of Federal funds constituting an award, grant, contract, or any other form.

D. Availability of Funds

Approximately $31,000,000 is available in FY 2002 to fund approximately 40 awards. Approximately $28,000,000 million is available to fund approximately 31 existing REACH 2010 grantees under Program Announcement numbers 00121 and 01123. Approximately $1,500,000 is available to fund five existing American Indian/Alaska Native grantees under Program Announcement number 01132. Approximately $1,000,000 is available to fund four existing REACH 2010 Elderly grantees under Program Announcement number US002. It is expected that the awards will begin on or about September 30, 2002, and will be made for a 12-month budget period within a project period of up to five years.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds.

Use of Funds

Funds may not be used for research involving human subjects until Protection of Human Subjects Assurance/Certification is approved. Funds for research activities involving human subjects will be restricted until appropriate requirements are in place.

Funds may be used for the six health priority areas only. Funds may not be used to support direct patient medical care, facilities construction, or to supplant or duplicate existing funding.

Although applicants may contract with other organizations under these cooperative agreements, recipients must perform a substantial portion of the activities (including program management and operations) for which funds are requested.

E. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under 1. Recipient Activities, and CDC will be responsible for the activities listed under 2. CDC Activities. Recipient Activities a. and c. apply to REACH 2010 applicants only, the remaining recipient activities apply to both REACH 2010 and REACH 2010 Elderly applicants. REACH 2010/REACH 2010 ELDERLY—PHASE II

1. Recipient Activities

a. Implement the Community Action Plan (CAP) that addresses the selected health priority area(s) for the target population. The Grantee must target one or more specific racial or ethnic minority communities that is African American, American Indian or Alaska Native, Hispanic American, Asian American, or Pacific Islander. Initiate actions to assure the interventions are administered effectively, appropriately and in a timely manner. Document how the CAP was modified to address contingencies encountered during the developmental process. [REACH 2010 Only]

b. Conduct ongoing evaluations that will document innovative strategies; monitor coalition activities, community, and environmental changes; and assess the effects of the intervention.

c. Establish data systems to collect data necessary to monitor and fully capture the effects of all project activities. [REACH 2010 Only]

d. Maintain a coalition that develops and sustains linkages and collaborations with local, State, and national partners.

e. Collaborate with academic or other appropriate institutions in the collection, analysis, and interpretation of the data.

f. Establish mechanisms with other public and/or private groups to maintain financial support for the program at the conclusion of Federal support.

g. Participate in conferences and workshops to inform and educate others regarding the experiences and lessons learned from the project and collaborate with appropriate partners to publish the results of the project to the public health community.

h. Participate in up to three yearly CDC workshops for technical assistance, planning, evaluation and other essential programmatic issues.

2. CDC Activities

a. Provide consultation and technical assistance in the planning and evaluation of program activities.

b. Provide up-to-date scientific information on the basic epidemiology of the priority area(s), recommendations on promising intervention strategies, and other pertinent data and information needs for the specified priority area(s), including prevention measures and program strategies.

c. Assist in the collection and analysis of data and evaluation of program progress.

d. Assist recipients in collaborating with State and local health departments, community planning groups, foundations and other funding institutions, and other potential partners.

e. Foster the transfer of successful prevention interventions and program models through convening meetings of grantees, workshops, conferences, and communications with project officers.

f. Assist in the development of a research protocol for Institutional Review Board (IRB) review by all

cooperating institutions participating in the research project.

g. Monitor recipient compliance with the protection of human research subjects requirement.

American Indian/Alaska Native Core Capacity

1. Recipient Activities for Core Capacity Building Programs.

a. Develop/enhance scientific capacity in epidemiology, statistics, surveillance, and data analysis from new or existing data systems (e.g., vital statistics, hospital discharges, Survey of AI/AN, Behavioral Risk Factor Surveillance System [BRFSS], etc.) to correctly identify the AI/AN population(s) and existing health disparity and to monitor the effectiveness of public health interventions targeting these groups. Scientific capacity should include, but not be limited to, efforts to determine:

(1) Disease trends, including age of onset of disease, age at death, etc.

(2) Geographic distribution of related health priority area disparities.

(3) Behavioral, social, or ecological risk factors related to the occurrence of disease.

(4) Ways to integrate systems to provide comprehensive data needed for assessing and monitoring the health of populations and program outcomes. Monitoring and program evaluation are considered essential components of building scientific capacity. Scientific capacity may also extend to developing access to outside databases, such as medical care and access to laboratory capacity consistent with the overall direction of the program.

b. Develop and implement a Community Capacity Plan (CCP), which includes specific objectives for building capacity to reduce disparities in health outcomes for selected health priority area(s)and related risk factors.

The plan should consider culturally appropriate behavioral, policy, and community approaches to reducing morbidity and mortality for the selected health priority area(s).

The CCP should include, but not be limited to, understanding the context, causes, and solutions for the health disparity; community needs assessment to identify and develop training and technical assistance; forming partnerships and engaging in community planning; accumulating resources; plans to develop and implement a culturally appropriate intervention(s) believed to bring about desired effects; planning community and systems changes that alter the environmental context within which individuals and groups behave; and documenting changes in knowledge, attitudes, beliefs, or behaviors among influential individuals or groups, with an intent of diffusing similar changes to a broader community population.

c. Design and implement an evaluation plan to track and measure process and progress in developing a core capacity program. The plan should address measures considered critical to determine the readiness or ability of the AI/AN Community and its members to take action aimed at protective behaviors or changing risk, transforming community conditions and systems so that a supportive context exists to sustain behavior changes over time. In addition, the plan should include time-specific objectives which account for the major activities of the CCP, the means of tracking and measuring the collaborative work with partners, and any other relevant process measures. Time lines, objectives, and other supporting documentation should be included in the evaluation plan.

2. CDC Activities

a. In collaboration with the recipient, provide appropriate training on developing prevention strategies (*e.g.,* building scientific capacity, collaboration and partnerships, implementing guidelines and model programs on disease prevention, *etc.*), which prepare tribes to mobilize and engage in prevention initiatives for the health priority area(s) selected.

b. Provide technical assistance through conference calls, resource material, training, and updated information, as needed. Facilitate communications locally, regionally, and nationally regarding resources and other opportunities involving capacity building activities.

c. Participate in the evaluation of activities and initiatives.

F. Application Content

The program announcement title and number must appear in the application. Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them when describing your program plan. In developing this plan, applicants must describe a community-based program within at least one of the six following health priority areas: (1) infant mortality, (2) diabetes, (3) cardiovascular diseases, (4) HIV infection/AIDS, (5) deficits in breast and cervical cancer screening and management, or (6) deficits in child and/or adult immunizations, that specifically focuses on a geographically defined racial or ethnic minority community that is African American, American Indian, Alaska Native, Hispanic American, Asian American, or Pacific Islander.

The narrative should be no more than 31 double-spaced pages, printed on one side, with one-inch margins, and 12 point font. The 31 page narrative does not include budget, appended pages, or items placed in appended pages (resumes, agency descriptions, etc.). The narrative should include:

REACH 2010/REACH 2010 Elderly

1. One Page Abstract

Describe (a) the existing Central Coordinating Organization; and members of the coalition that meet the requirements from Phase I; (b) target racial/ethnic minority population(s) to be served, and (c) the health priority area(s) to be addressed.

2. Background and Need

Based on accomplishments from Phase I activities, describe how data and community input were coordinated and used to document the level of health disparity among the target population and the extent of the disparity. Using local data collected, provide adequate documentation of the level of health disparity among the target population and the extent of the disparity including any data in support of the priority area that defines the degree of disparity in terms of mortality or morbidity or other measures appropriate to the priority area(s), such as risk conditions and social determinants of health. Provide a brief summary of the population size of the racial or ethnic group(s) and the total population of the catchment area of the applicant and its partners, and the geographic boundaries in which the applicant will operate.

It has been calculated that a minimum of 3,000 persons with the disease or health priority condition per community will be necessary to find statistically significant results between baseline and completion of intervention. Since many of the target populations will have considerably smaller sample sizes, for the purpose of this announcement, a target population size of 3,000 is desirable but not mandatory. Applicants are encouraged to include as large a population as possible in order to ensure statistically significant results once the intervention is completed. All sources of data and information must be referenced.

3. Description and Justification of Community Action Plan (CAP)

Provide a clear CAP that addresses the following:

a. Justification/Rationale for the CAP, including identification of the intervention strategy, theoretical and empirical rationale that the intervention will have the desired effect on the disparity identified, and/or if the intervention selected is based on any research conducted during Phase I.

b. A time line detailing initiation and completion of all activities in the intervention strategy.

c. A description of methods that will be used for ongoing program documentation and feedback to the program.

d. Description of how community members and other stakeholders were included in the development of the CAP and how they will be involved in the implementation of the CAP.

e. An explanation of how the intervention strategies relate to the activities of agencies/organizations outside of the coalition that might also effect the outcome in the targeted community.

f. Measurable impact objectives leading to the desired long-term outcome objectives.

g. Appropriateness and thoroughness of the data collection for proposed activities.

h. Resources needed to carry out proposed activities in the intervention strategy.

i. The proposed plan for the inclusion of women, ethnic, and racial minorities in research and proposed justification when representation is limited or absent.

4. Ability To Implement the Community Action Plan (CAP)

This should include:

a. A description of the members of the coalition, community members and other stakeholders and how each relates to implementation of the CAP.

b. A description of how and who will provide resources (e.g., financial, in-kind or other) commensurate with roles described in ''a.''

c. Examples of accomplishments that occurred during Phase I as a result of working with the coalition, community members, and other stakeholders.

d. The potential for the CAP to leverage additional public/private resources to support the overall prevention effort.

e. The potential for the CAP to assure their ability to sustain the effort.

5. Evaluation Plan

The evaluation plan should provide a description of the evaluation and monitoring process that the applicant will use to track and measure progress in Phase II. Describe who will be conducting and managing the evaluation plan. Describe how data will be collected, analyzed, used and disseminated to improve the program.

Items covered in the evaluation plan should address at minimum the following stages: (a) Capacity building, (b) targeted action, (c) community system change and change among change agents, and (d) widespread risk/protective behavior changes.

6. Management Plan

Briefly describe how the program will be managed effectively, including staff, their qualifications, and organizational structure. This section should also describe the Memoranda of Agreement, of which a copy should be provided in the appendix. In accordance with Phase I, coalitions (including the CCO) must have at minimum a community-based organization and three other organizations, of which at least one must be:

REACH 2010:

a. local or state health department.

b. university or research organization.

REACH 2010 Elderly:

a. state and/or area agency on aging.

b. local or state health department.

c. national and/or local minority aging organizations.

d. Indian tribal organizations and national Indian Organizations.

e. university or research organization.

The applicant must be able to show strong representation by the minority community in the coalition.

7. Budget

Provide a detailed line-item budget and narrative justification for all operating expenses consistent with and clearly related to the proposed objectives and planned activities of this cooperative agreement. Applicants should budget for out of state travel to attend up to three CDC workshops/conferences during the budget year for technical assistance, evaluation, and other essential programmatic issues.

8. Human Subjects

Adequately address the requirements of Title 45 CFR Part 46 for the protection of human subjects.

American Indian/Alaska Native Core Capacity

The application should include the following:

1. One Page Abstract

Describe (a) the applicant's tribe, organization or consortia, (b) target racial/ethnic minority population(s) to be served, and (c) the health priority area(s) to be addressed.

2. Introduction—Applicant Description

a. Describe the applicant's tribe, organization or consortia, including purpose or mission (if applicable), years of existence (if applicable), and experience in representing the health-related interests of the represented tribe(s).

b. Describe the represented tribe(s), including:

(1) The total population size of the tribe(s) represented.

(2) The represented tribe's geographical locations, their proximity to you and how you plan to reach the tribe(s).

c. Applicants should describe their experience in community development, including, but not limited to:

(1) Current and past experience in providing leadership in the development of health-related programs, training programs or health promotion campaigns.

(2) Current and past experience related to one or more of the health priority area(s) or public health disease prevention and control programs, including descriptions of activities and initiatives developed and implemented.

(3) Current and past experience in networking and in building partnerships and alliances with other organizations.

(4) Ability to provide support, outreach, and technical assistance on health-related matters to the represented tribes.

d. Submit a letter of commitment from the represented tribe's leadership, which indicates the tribe's willingness to participate in the program, including a copy of the signed original in the Appendix.

3. Need To Address Health Priority Area(s)

Describe the specific community's health problem(s) and need for building capacity to address the selected health priority area(s) among the represented tribe(s). Discuss data needs and how the applicant will assist the tribe(s) in addressing these identified needs. The information provided should describe the following:

a. The extent to which the tribe(s) is impacted by the health priority area(s), including discussion of prevalence rates and any variations in prevalence among represented tribe(s), morbidity and/or mortality, and other evidence of the health disparity.

b. The need to strengthen existing data and add new data.

c. The need for disease prevention and control strategies that are culturally appropriate for their populations, including discussion of the challenges, limitations and/or opportunities for implementing effective prevention programs.

d. The need to develop a comprehensive and sustainable CCP among the represented tribe(s).

4. Community Capacity Plan

Submit a comprehensive and detailed CCP that is realistic and achievable over the project period with objectives that are specific, measurable, achievable, and time-phased. The CCP should clearly address the following:

a. A description of how the applicant will conduct and use results of a community needs assessment to develop local or regional, culturally competent training and technical assistance programs to increase the skill-level of tribes and partners in areas such as epidemiologic investigative methods, surveillance, public health policy, and other relevant topics as identified through the needs assessment process.

b. A description of how the applicant will identify and develop culturally-competent intervention strategies, designed to enhance program efforts to reduce the selected health disparity. Strategies should focus on public policy and community approaches, but may include interventions that alter the context within which individuals and groups behave, increase awareness of the disease burden and risk factors, and promote healthy behaviors to reduce the selected disparity.

c. A description of who will be the target of selected activities and how each proposed activity will be achieved.

d. A description of proposed linkages with appropriate partners (e.g., tribal, state, local health departments, and other public or private organizations) in carrying out the proposed activities in the CCP.

e. A description of how the applicant will include affected community members in the development and implementation of the CCP.

f. A description of how the applicant will communicate and disseminate information and guidance to the represented tribes and their memberships (e.g., newsletters, conferences, and meeting minutes).

g. A time line detailing initiation and completion of all activities in the CCP for the three-year project period.

5. Management Plan

a. Provide a description of how the applicant will manage the project to accomplish all proposed activities.

b. Provide a description of how the applicant proposes to staff the project. Provide job descriptions and indicate if they are existing or proposed positions. Staffing should include the commitment of at least one full-time staff member to provide direction for the proposed activities. Demonstrate that the staff member(s) have the professional background, experience, and organizational support needed to fulfill the proposed responsibilities. Where possible, identify staff responsible for completing each activity.

c. Describe the letters of commitment from the represented tribe(s) leadership which indicates the tribe's willingness to participate in the program. Be sure to include the signed original in the Appendix.

d. Submit a copy of the applicant's organizational chart and describe the existing structure and how it supports the development of the proposed CCP for the health priority area(s) selected.

6. Evaluation

a. Applicants should describe how they plan to measure the implementation and progression of various capacity building activities in achieving the objectives during the project period (e.g., understanding the context, causes, and solutions for health disparities; transforming community conditions and systems so that a supportive context exists to form and maintain an effective infrastructure; accumulating resources needed to implement the CCP, etc.).

b. Describe how the applicant will document success in building capacity for the tribe(s) (e.g., surveys conducted, group(s) formed, number of trainings conducted, level of difficulty of the training and their rationale, evidence of acquired skills through application, and the impact on program objectives).

c. Describe how the applicant will assess the quantity and quality of networking efforts (e.g., number of planning meetings or meeting with leadership, the degree of collaboration with leadership and other disease prevention and control programs, and the degree of collaboration with other organizations).

7. Budget and Accompanying Justification

Provide a detailed budget and line-item justification that is consistent with the stated objectives and planned activities. To the extent possible, applicants are encouraged to include budget items for the following:

a. Travel for a minimum of one or two persons to attend up to one national conference on health promotion and disease prevention related to the selected health priority area(s).

b. Up to two trips to Atlanta, GA, for a minimum of one or two persons, to attend training and technical assistance workshops.

G. Submission and Deadline

Submit the original and two copies of PHS form 5161–1. Forms are available at the following Internet address: *http://www.cdc.gov/od/pgo.forminfo.htm.*

The application must be received on or before 5 p.m. July 27, 2002. Submit the application to:

Technical Information Management-PA02153, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Rd, Room 3000, Atlanta, GA 30341–4146.

Deadline: Applications shall be considered as meeting the deadline if they are received on or before the deadline date.

Late Applications: Applications which do not meet the criteria above are considered late applications, will not be considered, and will be returned to the applicant.

H. Evaluation Criteria

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. Measures of effectiveness must relate to the performance goal stated in section ''A. Purpose'' of this announcement. Measures must be objective and quantitative and must measure the intended outcome. These measures of effectiveness shall be submitted with the application and shall be an element of evaluation.

Each application will be reviewed by CDC staff utilizing the Technical Acceptability Review (TAR) process which is a non-competitive process.

REACH 2010/REACH 2010 Eldery

1. Description and Justification of the Community Action Plan (CAP): (35 Points) [REACH 2010 Only]

a. The extent to which the applicant provides a justification/rationale for the CAP, including identification of the intervention strategy, theoretical and empirical rationale that the activity/intervention will have the desired effect on the disparity identified, and/or if the intervention selected is based on any research conducted during Phase I. [REACH 2010 Only]

b. Extent to which the applicant provides a time line detailing initiation and completion of all activities in the intervention strategy. [REACH 2010 Only]

c. Extent to which the applicant describes methods that will be used for on-going program documentation and feedback to the program.

d. Extent to which the applicant demonstrates how community members and other stakeholders were included in the development of the CAP and how they will be involved in the implementation of the CAP. [REACH 2010 Only]

e. Extent to which the applicant explains how the intervention strategies relate to the activities of agencies/organizations outside the coalition that might also effect the outcome in the targeted community.

f. Extent to which the applicant presents reasonable measurable impact objectives leading to the desired long-term outcome objectives.

g. Extent to which the data collected for the proposed activities is appropriate and thorough. [REACH 2010 only]

h. Adequacy of resources needed to carry out activities in the intervention strategy.

i. The degree to which the applicant has met the CDC policy requirements regarding the inclusion of women, ethnic, and racial minorities in research and proposed justification when representation is limited or absent. This includes:

(1) The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation.

(2) The proposed justification when representation is limited or absent.

(3) A statement as to whether the design of the study is adequate to measure differences when warranted.

(4) A statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships with community(ies) and recognition of mutual benefits.

2. Ability to Implement the Community Action Plan: (30 Points) [REACH 2010 Only]

a. Extent to which the applicant describes members of the coalition, community members and other stakeholders and how each relates to implementation of the CAP. [REACH 2010 Only]

b. Extent to which the applicant describes how and who will provide resources (e.g., financial, in-kind, or other) commensurate with roles described in ''a.''

c. Extent to which the applicant provides examples of accomplishments that occurred during Phase I as a result of working with the coalition, community members, and other stakeholders.

d. Extent to which the applicant demonstrates the potential for the CAP to leverage additional public/private resources to support overall prevention effort. [REACH 2010 Only]

e. Extent to which the applicant demonstrates the potential for the CAP to assure sustainability of the effort.

3. Evaluation Plan (15 Points)

a. The extent to which the applicant provides a description of the evaluation and monitoring process that the applicant will use to track and measure progress in Phase II.

b. Extent to which the applicant describes who will be conducting and managing the evaluation plan.

c. Extent to which the applicant describes how data will be collected, analyzed, used and disseminated to improve the program.

4. Background and Need: (10 Points)

a. The extent to which the applicant, based on accomplishments from Phase I activities, describes how data and community input were coordinated and used to document the level of health disparity among the target population and the extent of the disparity.

b. The extent to which the applicant, using data collected locally, provides adequate documentation of the level of health disparity among the target population and the extent of the disparity. Provide any data in support of the priority area that defines the degree of disparity in terms of mortality, morbidity, or other measures appropriate to the priority area(s) such as risk conditions and social determinants of health.

[REACH 2010 Only]

c. The extent to which the applicant describes the population size of the racial or ethnic group(s) and the total population of the catchment area of the applicant and its partners, and the geographic boundaries in which the applicant will operate. All sources of data and information must be referenced.

5. Management Plan (10 Points)

Extent to which the applicant adequately describes how the program will be managed effectively, including staffing and their qualifications and organizational structure. This section should also describe the Memoranda of Agreement of which the signed original should be provided in the appendix. In accordance with Phase I, Coalition (including the CCO) must have at a minimum a community-based organization and three other organizations, of which at least one must be:

REACH 2010

a. local or state health department
b. university or research organization

REACH 2010 Elderly:

a. state and/or area agency on aging
b. local or state health department
c. national and/or local minority aging organizations
d. Indian tribal organizations and national Indian Organizations
e. university or research organization

The applicant must be able to show strong representation by the minority community in the coalition.

6. Budget: (Not Scored)

Extent to which a line-item budget is reasonable, clearly justified, and is consistent with the purposes and objectives of the cooperative agreement.

7. Human Subjects: (Not Scored)

The applicant should adequately address the requirements of Title 45, CFR Part 46 for the protection of human subjects.

American Indian/Alaska Native Core Capacity

1. Community Capacity Plan (25 points) **REACH 2010 Only

a. The extent to which CCP is realistic and the extent to which the objectives are specific, measurable, achievable, relevant, time-phased, and likely to be accomplished during the three-year budget period.

b. Extent to which a community needs assessment will be conducted and used to develop culturally-competent training and technical assistance programs to increase the skill level of tribes and partners in areas such as epidemiologic investigative methods, surveillance, public health policy, and other relevant topics as identified through the needs assessment process and organizational involvement in program activities.

c. Extent to which the applicant identifies culturally competent intervention strategies designed to enhance program efforts to reduce the selected health disparity.

d. Extent to which the applicant describes who the program will target and how each proposed activity will be achieved.

e. Extent to which the applicant describes proposed linkages with appropriate partners (e.g., tribal, state,

local health departments, and other public or private organizations) in carrying out the Community Capacity Plan.

f. Extent to which the applicant describes how affected community members will be included in the development and implementation of the CCP.

g. Extent to which the applicant describes how communication and dissemination of information and guidance will be conducted with the represented tribe(s) and their memberships (e.g., newsletters, conferences, and meeting minutes).

h. Extent to which the applicant provides time lines for initiation and completion of all proposed activities for the three-year period.

2. Management Plan (25 points)

a. Extent to which the applicant describes how the project will be managed to accomplish all proposed activities.

b. Extent to which the applicant provides a description of proposed staffing for the project, including providing job descriptions and indicating if they are existing or proposed positions. Staffing should include the commitment of at least one full-time staff member to provide direction for the proposed activities. Demonstrate that the staff member(s) have the professional background, experience, and organizational support needed to fulfill the proposed responsibilities. Where possible, identifying staff responsible for completing each activity.

c. Extent to which the applicant describes the letters of commitment from the represented tribe leadership which indicates the tribe's willingness to participate in the program. Inclusion of signed originals should be provided in the Appendix.

d. Extent to which the applicant submits a copy of the applicant's organizational chart, and describes the existing structure and how it supports the development of the proposed CCP for the health priority area(s) selected.

3. Need To Address Health Priority Area(s) (20 points)

The extent to which the applicant documents the need for building capacity to address the selected health priority area(s) for an AI/AN population, including:

a. The extent to which the tribe(s) is impacted by the health priority area(s), including discussion of prevalence rates and any variations in prevalence among represented tribe(s), morbidity and/or mortality, and other evidence of the health disparity.

b. The need to strengthen existing data and add new data.

c. The need for disease prevention and control strategies that are culturally appropriate for their populations, including discussion of the challenges, limitations and/or other opportunities for implementing effective prevention programs.

d. The need to develop a comprehensive and sustainable CCP among the represented tribe(s).

4. Introduction—Applicant Description (15 points)

a. The extent to which the applicant clearly describes the tribe, organization or consortia, including purpose or mission (if applicable), years of existence (if applicable), and experience in representing the health-related interests of the represented tribe(s).

b. The extent to which the applicant describes the population size of the total tribe(s) represented, geographic location(s) and proximity to the applicant (if applicable).

c. The extent of the applicant's capacity and ability to conduct the activities as evidenced by the:

(1) Current and past experience in providing leadership in the development of health-related programs, training programs or health promotion campaigns.

(2) Current and past experience related to one or more of the health priority area(s) or public health disease prevention and control programs, including descriptions of activities and initiatives developed and implemented.

(3) Current and past experience in networking and in building partnerships and alliances with other organizations.

(4) Ability to provide support, outreach, and technical assistance on health-related matters to the represented tribes.

5. Evaluation (15 points)

a. The extent to which the applicant describes how they plan to measure the implementation and progression of various capacity building activities in achieving the objectives during the three-year project period (e.g., understanding the context, causes, and solutions for health disparities; transforming community conditions and systems so that a supportive context exists to form and maintain an effective infrastructure; accumulating resources needed to implement the Community Capacity Plan, etc.).

b. Extent to which the applicant documents success in building capacity for the tribe(s) (e.g., number of training conducted, level of difficulty of the training and their rationale, evidence of acquired skills through application, and the impact on program objectives).

c. Extent to which the applicant describes the quantity and quality of networking efforts (e.g., number of planning meetings or meeting with leadership, the degree of collaboration with leadership and other disease prevention and control programs, and the degree of collaboration with other organizations).

6. Budget and Accompanying Justification (Not Scored)

The extent to which the applicant provides a detailed and clear budget consistent with the stated objectives and work plan.

I. Other Requirements

Technical Reporting Requirements

Provide CDC with the original plus three copies of:

1. Semi-annual progress reports. The first report is due by April 30, 2003, and subsequent reports will be due on the 30th of April each year through April 30, 2006. The second report is due 90 days after the end of the budget period. The semi-annual progress report and accompanying budget and budget justification will be used to process your continuation award. Semi-annual progress reports should include the following information:

a. A succinct description of the program accomplishments/narrative and progress made in meeting each program objective during the first six months of the budget period (June 30 through December 31) and should consist of no more than 50 pages.

b. The reason for not meeting established program goals and strategies to be implemented to achieve unmet objectives.

c. A one-year line item budget and budget justification.

d. For all proposed contracts, provide the name of contractor, period of performance, method of selection, method of accountability, scope of work, and itemized budget and budget justification. If the information is not available when the application is submitted, please indicate TO BE DETERMINED until the information is available. When the information becomes available, it should be submitted to the CDC Procurement and Grants Management Office contact identified in this program announcement. The semiannual progress report will be used as evidence of the Program's attainment of goals and objectives.

2. Financial status report, no more than 90 days after the end of the budget period.

3. Final financial and performance reports, no more than 90 days after the end of the project period.

Fiscal Reporting Requirements

a. Awardee is required to obtain annual audit of these CDC funds (program-specific audit) by a United States based audit firm with international branches and current licensure/authority in country, and in accordance with International Accounting Standards or equivalent standard(s) approved in writing by CDC.

b. A Fiscal Recipient Capability Assessment may be required, pre or post award, with potential awardee in order to review their business management and fiscal capabilities regarding the handling of U.S. funds.

Send all reports to the Grants Management Specialist identified in the ''Where to Obtain Additional Information'' section of this announcement.

The following additional requirements are applicable to this program. For a complete description of each, see Addendum I in the application kit.

AR–1 Human Subjects Requirements (if applicable)
AR–2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research (if applicable)
AR–4 HIV/AIDS Confidentiality Provisions (if applicable)
AR–5 HIV Program Review Panel Requirements (if applicable)
AR–7 Executive Order 12372 Review
AR–8 Public Health System Reporting Requirements
AR–9 Paperwork Reduction Act Requirements
AR–10 Smoke-Free Workplace Requirements
AR–11 Healthy People 2010
AR–12 Lobbying Restrictions
**AR–15 Proof of Non-Profit Status
**American Indian/Alaska Native Core Capacity

J. Where To Obtain Additional Information

This and other CDC announcements can be found on the CDC home page Internet address—*http://www.cdc.gov.* Click on ''Funding'' then ''Grants and Cooperative Agreements.''

If you have questions after reviewing the contents of all the documents, business management technical assistance may be obtained from: Sylvia Dawson, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Announcement Number 00121, Centers for Disease Control and Prevention, Room 3000, 2920 Brandywine Road, Mailstop E–18, Atlanta, Georgia 30341–4146, Telephone number: 770–488–2771, E-mail address: snd8@cdc.gov.

For program technical assistance, contact: Letitia Presley-Cantrell, Health Education Specialist, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), 4770 Buford Hwy, NE, Mailstop K–30, Atlanta, Georgia 30341, Telephone: (770) 488–5426, E-mail Address: *LRP0@cdc.gov.*

Dated: June 14, 2002.

Sandra R. Manning, CGFM,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 02183]

Monitoring Prevalence of STDs and TB Infection in Persons Entering Corrections Facilities; Part A: Building Capacity for Monitoring STD and TB Prevalence; Part B: Enhanced Activities for Monitoring STD and TB Prevalence in Existing Sites; Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2002 funds for a cooperative agreement program for monitoring prevalence of sexually transmitted diseases (STDs) and tuberculosis (TB) infection in corrections facilities. This program addresses the ''Healthy People 2010'' focus area of Sexually Transmitted Diseases (STDs). Measurable outcomes of the program will be in alignment with one or more of the following performance goals for National Center for HIV, STD and TB Prevention:

(1) Reduce the incidence of primary and secondary syphilis.

(2) Reduce the incidence of congenital syphilis.

(3) Eliminate tuberculosis in the United States.

This program has two Parts. The purpose of Part A—Building Capacity for Monitoring STD and TB Prevalence is: (1) To develop systems for collecting and reporting STD and TB screening data in persons entering jails and juvenile detention facilities; and (2) to develop methods utilizing these data to help guide STD and TB prevention and intervention activities.

The purpose of Part B—Enhanced Activities for Monitoring STD and TB Prevalence in Existing Sites is: (1) To enhance existing systems for collecting and reporting STD and TB screening data in persons entering jails and juvenile detention facilities; and (2) to develop, refine and identify the programmatic benefit of epidemiologic methods utilizing these data for prevention and intervention activity planning.

B. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under sections 317E and 318 of the Public Health Service Act (42 U.S.C. sections 247b–6 and 247c). The Catalog of Federal Domestic Assistance number is 93.978.

C. Eligible Applicants

Part A

Assistance will be provided only to the health departments of States or their bona fide agents, including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, the Republic of Palau, and federally recognized Indian tribal governments. In consultation with States, assistance may be provided to political subdivisions of States. Project areas awarded funds in FY 1999, FY 2000, or FY 2001 under Program Announcement 99000, ''Comprehensive STD Prevention System (CSPS), Monitoring Prevalence of STDs and TB Infection in Persons Entering Corrections Facilities' are not eligible for funding under Part A.

Part B

Only project areas awarded funds in FY 1999, FY 2000, or FY 2001 under Program Announcement 99000, ''Comprehensive STD Prevention System (CSPS), Monitoring Prevalence of STDs and TB Infection in Persons Entering Corrections Facilities,'' (i.e., Alabama, Arizona, Arkansas, Louisiana, Massachusetts, Missouri, North Carolina, Oregon, San Francisco, Rhode Island, Wisconsin) are eligible to apply for funds under Part B.

D. Availability of Funds

Part A

Approximately $125,000 is available in FY 2002 to fund two to four awards.