

field experience and demonstrated capacity in areas directly related to all principal objectives of this proposed program: (1) Identification of cases of plague through clinic-based surveillance in areas with a high incidence of plague; (2) systematically evaluate optimal treatment regimens while ensuring patient safety; (3) evaluate the performance of newly available rapid tests for the diagnosis of plague under field conditions, and (4) confirm the diagnosis of suspected plague using state of the art laboratory techniques.

- UVRI has a history of successful collaborations with CDC on large and complicated health research projects, particularly in the areas of HIV/AIDS and vector-borne infectious diseases over the years.

### C. Funding

Approximately \$150,000 is available in FY 2003 to fund this award. It is expected that the award will begin on or before August 1, and will be made for a 12-month budget period within a project period of up to five years. Funding estimates may change.

### D. Where To Obtain Additional Information

For general comments or questions about this announcement, contact: Technical Information Management, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341-4146, Telephone: 770-488-2700.

For technical questions about this program, contact: Jacob Kool, MD, Ph.D., Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, Centers for Disease Control and Prevention, Rampart Road (Foothills Campus), Fort Collins, CO 80521, Telephone: 970-266-3540, E-mail: [jkool@cdc.gov](mailto:jkool@cdc.gov).

Dated: July 11, 2003.

**Edward Schultz,**

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

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**BILLING CODE 4163-18-P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

[Program Announcement 04015]

#### Effective Strategies to Reduce Motor Vehicle Injuries Among American Indians/Alaska Natives; Notice of Availability of Funds

*Application Deadline:* October 16, 2003.

#### A. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under 391, 317 and 301 of the Public Health Service Act [42 U.S.C. 280b, 247b, and 241]. The Catalog of Federal Domestic Assistance number is 93.136.

#### B. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2004 funds for a cooperative agreement program to develop, implement, and evaluate community-based interventions with demonstrated effectiveness to reduce motor vehicle-related injuries among American Indians and Alaska Natives (also referred to as Native Americans). This program addresses the "Healthy People 2010" focus area of Injury and Violence Prevention.

The purpose of the program is to design/tailor, implement, and evaluate Native American community-based interventions with demonstrated effectiveness for preventing motor vehicle injuries within the following areas: (1) Strategies to reduce alcohol-impaired driving among high risk groups; (2) strategies to increase safety belt use among low-use groups; and (3) strategies to increase the use of child safety seats and booster seats among low use groups. (see Attachment 1 for additional background)

In addition, the program should gather information on the process of implementing and evaluating these strategies, including any challenges and barriers for tribes. An overriding intent of this funding is to assist tribes in designing/tailoring (as well as implementing and evaluating) these evidence-based effective strategies in programs, which take into consideration the unique culture of American Indians and Alaska Natives.

**Note:** Attachments are posted with the Program Announcement at the CDC web site, Internet address: <http://www.cdc.gov>. Click on "Funding," then "Grants and Cooperative Agreements'.

This project will fund the formation of coalitions of tribal health departments, tribal injury prevention programs, law enforcement, and tribal transportation and traffic safety agencies. These coalitions will work with other community groups, organizations, state agencies, and the Indian Health Service (IHS) to design/tailor, implement, and evaluate at least two selected interventions. Collaborations may include schools, youth organizations, safety advocates, local media, health care providers, academic researchers, IHS staff, state traffic safety agencies and social service agencies, among others.

Measurable outcomes of the program will be in alignment with one or more of the following performance goals for the National Center for Injury Prevention and Control (NCIPC): (1) Increase the capacity of injury prevention and control programs to address the prevention of injuries and violence; and (2) monitor and detect fatal and non-fatal injuries. In addition applicants should address the following research priorities in transportation safety from the NCIPC Research Agenda: (1) Evaluate strategies to implement known, effective interventions to reduce alcohol-impaired driving and test the effectiveness of new, innovative strategies; (2) develop and evaluate interventions that address the proper and consistent use of measures to protect child occupants in motor vehicles; and (3) develop and evaluate interventions to increase the use of occupant protection devices, such as seat belts, in high-risk and hard-to-reach populations.

The CDC report, "Motor-Vehicle Occupant Injury: Strategies for increasing use of child safety seats, increasing use of safety belts, and reducing alcohol-impaired driving: a report on recommendations of the Task Force on Community Preventive Services," may be useful in understanding these effective strategies and in preparing applications. The report can be found on the CDC Web site at: [www.cdc.gov/mmwr/pdf/rr/5007](http://www.cdc.gov/mmwr/pdf/rr/5007).

#### C. Eligible Applicants

Any federally recognized American Indian/Alaska Native tribe or tribal organization is eligible to apply for these cooperative agreements. Applicants may include tribal injury prevention programs, tribal health departments, groups of tribes, and others. Tribes and tribal organizations must have a minimum population size of 2,500 people, or serve 2,500 American Indian or Alaska Native people in order to be eligible to apply.

The 2,500 minimum population size is needed in order to be able to demonstrate effectiveness of the program. A signed and dated tribal council resolution in support of the tribal motor vehicle injury prevention program is required. For the Navajo Nation, where getting a tribal resolution signed is often difficult, signed resolutions from a local governing body, such as a Chapter House, will be acceptable for the intent to participate. Those tribes that cannot get a resolution signed in time to meet the deadline should submit a draft of the resolution in the appendix. A signed resolution from the tribe will be required prior to award if selected.

American Indians/Alaska Natives have the highest motor vehicle-related death rates of all racial and ethnic groups (Web-based Injury Statistics Query and Reporting System (WISQARS, NCIPC, CDC)), with rates two-three times greater than rates for all other Americans (Indian Health Focus, Injuries 1998–99; Indian Health Service, 2002). These funds are targeted to American Indians/Alaska Natives in order to help reduce this disparity.

**Note:** Title 2 of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant or loan.

#### D. Funding

##### *Availability of Funds*

Approximately \$186,000 is available in FY 2004 to fund three awards. It is expected that the average award will be about \$62,000. It is expected that the awards will begin on or about January 2004, and will be made for a 12-month budget period within a project period of up to four years. Funding estimates may change.

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*

The intent of this funding is not to support existing activities. The recipient should provide evidence that there is an unmet need in their community for these interventions. This can be done by describing the target groups for the selected interventions and documenting the size of the problem. Examples of approved funding uses include police overtime pay for sobriety checkpoints and enhanced enforcement, media and awareness activities, evaluation

consultants, salary for a project coordinator, etc.

##### *Recipient Financial Participation*

Matching funds are not required for this program.

##### *Funding Preferences*

Applicants will be expected to implement and evaluate at least two community-based interventions with demonstrated effectiveness during the four-year project period. Preference will be given to applicants who propose implementing one or more community-based interventions from the list below. This list contains interventions that have strong evidence of effectiveness according to "The Guide to Community Preventive Services" ([www.thecommunityguide.org](http://www.thecommunityguide.org)) (see Attachment 2). If applicants propose strategies that are not on the list below, then they must summarize and cite the evidence of effectiveness (see Attachment 2):

1. Sobriety checkpoints to reduce alcohol-impaired driving. Key components of the intervention: officer training in appropriate practices; implement or increase the frequency of sobriety checkpoints (or roving patrols if checkpoints are not feasible); develop a strategy for publicizing checkpoints through media such as news stories and/or paid media.

2. Efforts to lower blood alcohol concentrations among drivers (e.g., .08 blood alcohol content (BAC) or below). Key components: Publicize the BAC limit and work with tribal (or Bureau of Indian Affairs) police to communicate the importance of the law and ensure active enforcement.

3. Efforts to enforce lower blood alcohol content (e.g., .02 BAC) for young drivers. Key components: Publicize the BAC limit, importance of a low BAC for young drivers to prevent crashes, and enforcement efforts in local media; work with tribal (or Bureau of Indian Affairs) police to actively enforce the law.

4. Efforts to enforce existing safety belt and child occupant restraint laws. Key components: Work with local police to understand the importance of enforcing the use of occupant restraints, and the effectiveness of safety belts and child restraints in preventing injuries during a crash.

5. Enhanced enforcement campaigns (such as Click It or Ticket-style campaigns) to increase safety belt use or child occupant restraint use. Key components of the intervention include: implement or increase the frequency of citations for violations of the law; implement or increase safety belt or child occupant restraint checkpoints (or

roving patrols if checkpoints are not feasible); develop a strategy for publicizing the enhanced enforcement efforts through earned media (e.g., news stories) and/or paid media.

6. Distribution and education programs to increase child safety seat and booster seat use. Key components of the intervention include: distribution of child safety seats and/or booster seats among low use groups, and education on appropriate use.

#### E. Program Requirements

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities listed in 1. Recipient Activities, and CDC will be responsible for the activities listed in 2. CDC Activities.

##### *1. Recipient Activities*

a. Develop a motor vehicle injury prevention program in the recipient's tribal health department to enhance opportunities for the motor vehicle injury prevention program to collaborate with other tribal public health programs. If this is not practical, then state the reason why the tribal motor vehicle program will not be located in the health department.

b. Provide a coordinator who has the authority, responsibility, and expertise to conduct and manage the tribal motor vehicle injury prevention program.

c. Establish the coalition or advisory group that will help tailor, implement, and evaluate the selected interventions. This group may consist of public and private individuals, medical staff, Emergency Management Service staff, injury prevention experts, academic researchers, organizations, State and Federal agencies. At a minimum, the coalition must include the recipient tribal health department or organization, local highway safety department representative, local law enforcement, IHS Injury Prevention Specialists (state reason if not available), and others interested in traffic safety. Applicants are encouraged to work with existing programs, such as "Safe Communities," or with coalitions such as "SAFE KIDS."

d. At least one of the intervention choices should include working with local police departments to conduct enforcement activities regarding occupant restraint use, or alcohol-impaired driving.

e. Collect or obtain and analyze baseline data that will guide the planning process and serve as the pre-intervention measures of effectiveness (e.g., number of alcohol-related crashes; number of impaired driving arrests and convictions; conduct observational

surveys to determine safety belt use, booster seat use, or child restraint use).

f. If the recipient proposes to implement enhanced enforcement campaigns to increase safety belt use or child safety seat use, the recipient must first determine baseline use rates for safety belts, child safety seats, or booster seats. At a minimum, a comparison of observed use rates determined from observational surveys in the intervention communities before and after implementation of the intervention activities will be necessary for evaluation purposes. The recipient would also need to determine baseline police citations given before and during the enhanced enforcement activities.

g. If the recipient proposes to implement sobriety checkpoints to reduce alcohol-impaired driving, the recipient must first determine rates of alcohol-impaired driving using appropriate survey methods before implementation of the intervention. Acceptable methods include direct assessment of driver BAC levels in roadside surveys; determining the number of single-vehicle nighttime fatal crashes; or determining all nighttime fatal crashes before the checkpoint campaign.

h. Analyze existing data to define the magnitude of the motor vehicle injury problem within the Native American target population, including those at greatest risk. Potential data sources include hospital discharge data, clinic and emergency department data, police reports, and State Department of Transportation reports.

i. Develop a detailed plan for the tailoring of the intervention for their community, implementation, and evaluation of the selected evidence-based interventions to reduce motor vehicle-related injuries. This would include specific process, impact, and outcome objectives and action steps to accomplish each. Obtain approval for the plan from the coalition, and present the plan to CDC for approval.

j. Implement, sustain, and rigorously evaluate the selected interventions.

k. Attend and participate in conference calls and technical assistance and planning meetings coordinated by the CDC for all tribal cooperative agreement recipients (one meeting per year in Atlanta; two days per meeting).

l. Submit required reports on time.

m. The first year of the cooperative agreement will include several activities: establishing the coalition; collecting and analyzing baseline data (e.g., alcohol-related crashes, driving under the influence (DUI) arrests and convictions, conducting observational

surveys of safety belt use); evaluating perceptions of stakeholders regarding barriers to implementation and perceived benefits of the intervention; and developing a detailed plan for implementing and evaluating two or more interventions.

n. Noncompetitive continuation funding will be available for the second year, contingent upon successful progress in year one, and a detailed budget for implementing and evaluating the selected interventions. Years two-four will be dedicated to implementing, sustaining, and evaluating the selected interventions. The evaluation should include information regarding any barriers that were encountered in implementing the interventions.

## 2. CDC Activities

a. Provide technical assistance, training, and guidance in the design/tailoring, implementation, and evaluation of the selected interventions. This will be done early in the first year of funding with CDC conducting an initial training and planning meeting with all grantees.

b. Review, provide feedback, and approve plans for the design/tailoring, implementation, and evaluation of the selected interventions.

c. Conduct regular conference calls and annual site visits to provide training, technical assistance, and monitoring of the tribal motor vehicle injury program.

d. Assist in developing a research protocol for annual Institutional Review Board (IRB) review by all cooperating institutions participating in the project. The CDC IRB will review and approve the protocol initially and on at least an annual basis until the project, including analyses, is completed.

e. Assist in ensuring human subjects assurances are in place as needed.

f. Assist in analysis and dissemination of results including the preparation of manuscripts, as needed.

g. Organize an annual grantee meeting to provide technical assistance, training, facilitate communication, and assist with program planning and evaluation.

## F. Content

### Applications

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 in laying out your program plan. The narrative should be no more

than 20 pages, double-spaced, printed on one side of standard size 8.5-inch × 11-inch paper with consecutively numbered pages, with 1.5 inch-left, 1 inch-top, bottom, and right margins, and unreduced 12-point font. The applicant should provide a detailed description of first-year activities and briefly describe future year objectives and activities for years two, three, and four.

The narrative should consist of, at minimum:

1. Applicant's Organization History, Description and Capacity
2. Applicant's Plan for Designing/Tailoring, Implementing, and Evaluating the Selected Interventions
3. Applicant's Management and Staffing
4. A Plan for Collaboration
5. Measures of Effectiveness
6. First Year Budget

## G. Submission and Deadline

### Application Forms

Submit the signed original and two copies of PHS 5161-1 (OMB Number 0920-0428). Forms are available at the following Internet address: [www.cdc.gov/od/pgo/forminfo.htm](http://www.cdc.gov/od/pgo/forminfo.htm).

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, you may contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIM) at: 770-488-2700. Application forms can be mailed to you.

### Submission Date, Time, and Address

The application must be received by 4 p.m. Eastern Time October 16, 2003. Submit the application to: Technical Information Management-PA# 04015, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341-4146.

Applications may not be submitted electronically.

### CDC Acknowledgement of Application Receipt

A postcard will be mailed by PGO-TIM, notifying you that CDC has received your application.

### Deadline

Applications shall be considered as meeting the deadline if they are received before 4 p.m. Eastern Time on the deadline date. Any applicant who sends their application by the United States Postal Service or commercial delivery services must ensure that the carrier will be able to guarantee delivery of the application by the closing date and time. If an application is received after closing due to (1) carrier error, when the carrier accepted the package

with a guarantee for delivery by the closing date and time, or (2) significant weather delays or natural disasters, CDC will upon receipt of proper documentation, consider the application as having been received by the deadline.

Any application that does not meet the above criteria will not be eligible for competition, and will be discarded. The applicant will be notified of their failure to meet the submission requirements.

## H. Evaluation Criteria

### Application

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 goals stated in the purpose section of this announcement. Measures must be objective and quantitative and must measure the intended outcome. These measures of effectiveness must be submitted with the application and will be an element of evaluation. Examples include: conducting observational surveys before and after the intervention to determine any change in occupant restraint use and over time; changes in citations and convictions given for not using seat belts or child safety seats pre-intervention, post-intervention, and over time; changes in citations and convictions given for DUI pre-intervention, post-intervention, and over time; changes in alcohol-related crashes or single vehicle nighttime fatal crashes pre-intervention, post-intervention, and over time.

An independent review group appointed by CDC will evaluate each application individually against the following criteria:

#### 1. Applicant's Plan for Designing/Tailoring, Implementing, and Evaluating the Selected Interventions (35 points)

The extent to which the applicant's work plan and timetable includes:

a. The identification of representatives to be named as members of the coalition, including a description of the areas of expertise covered by each; the specific roles and responsibilities of each in implementing this cooperative agreement; etc.

b. A reasonable and complete schedule/timeline for implementing all first year activities with action steps and persons responsible. A brief description of future year objectives and activities for years two through four.

c. Plans for collecting or obtaining and analyzing baseline (pre-intervention) and follow-up data for the measures of effectiveness.

d. A description of the process used in selecting the interventions to be implemented.

e. A description of the process to be used in preparing the detailed plan for implementing and evaluating the selected interventions.

f. Evidence of a partnership with an academic institution or expert evaluation consultant to provide expertise and technical assistance in the design and implementation of the evaluation plan. Evaluation is important to these cooperative agreements, so it is recommended that approximately 15 percent of project resources be devoted to evaluation activities. Letters of support or agreement should be included in the appendix.

g. Initial plans to evaluate the interventions including measures of effectiveness that will demonstrate the accomplishment of the identified objectives of the cooperative agreement. Measures should be objective/quantifiable and measure the intended outcome. Describe how the academic institution or evaluation consultant will be involved in the evaluation activities.

h. Plans to train and support staff regarding the responsibilities of this cooperative agreement and the availability of staff and facilities to carry out this cooperative agreement.

#### 2. Applicant Organization History, Description and Capacity (25 points)

The extent to which the applicant has documented:

a. A description of the target population to be served, and proof of a minimum reservation or tribal population size of 2,500.

b. An overview of the tribe's motor vehicle injury problem.

c. An inventory of existing tribal traffic safety laws for seat belt use, child restraint use, and alcohol impaired driving.

d. Their history and current capacity to provide a leadership function in convening and facilitating the work of the coalition.

e. Evidence of prior experience in designing/tailoring, implementing, and where possible, evaluating community-based interventions. This evidence will be stronger if some type of documentation is included such as publications from journal articles or technical reports in the appendix of the application.

f. The description of positive progress in any related past or current injury prevention activities or programs. Evidence of access to the target populations.

g. Their organizational capacity to meet the objectives of the cooperative agreement.

h. The extent to which the applicant has shown tribal or organizational support for the proposed motor vehicle injury prevention program.

#### 3. Applicant's Management and Staffing (20 points)

The extent to which the applicant has included:

a. Their management operation, structure and/or organization. An organizational chart of the applicant's organization should be included as an appendix. Additionally, the applicant should include within their management plan the specific role and mechanisms to be established to ensure effective coordination, communication and shared decision making among the involved agencies/organizations.

b. A staffing plan for the project, noting existing staff as well as additional staffing needs. The responsibilities of individual staff members including the level of effort and allocation of time for each project activity by staff position should be included. The specific staff positions within the other involved tribal or local agencies, both in-kind and funded, should be described.

c. Resumes and/or position descriptions (*i.e.* for current staff, in-kind, and proposed positions to be funded under this cooperative agreement) should be included as an appendix. This should include the use of consultants, as appropriate.

d. A continuation plan in the event that key staff leave the project, how new staff will be smoothly integrated into the project, and assurances that resources will be available when needed for this project.

#### 4. Collaboration (20 Points)

The extent to which the applicant demonstrates:

a. Experience with working with community leaders, tribal health boards, tribal councils, local police departments, and community-level groups.

b. Evidence of effective and well-defined collaborative relationships within the performing organization and among the coalition members that will ensure implementation of the proposed activities. Model collaborations should include at least a tribal Health Department or organization, local law enforcement, IHS Injury Prevention staff, and a tribal traffic safety agency (if available). Letters of support from these collaborating organizations describing the specific commitments and

responsibilities that will be undertaken by the coalition members and community organizations should be included in the appendix.

5. Proposed Budget Justification (Reviewed, but not scored)

The extent to which the applicant's budget includes funds to participate in the CDC required meetings (at least one person, such as the Project Coordinator, must attend one meeting per year in Atlanta to last for two days). The applicant should provide a detailed budget request and complete line-item justification of all proposed operating expenses consistent with the stated activities under this program announcement. Applicants should be precise about the purpose of each budget item and should itemize calculations wherever appropriate. The use of budget guidance posted on the CDC website with this announcement is encouraged.

6. Measures of Effectiveness (Reviewed, but not scored)

The extent to which the applicant has provided appropriate measures of effectiveness.

7. Human Subjects (Reviewed, but not scored)

The extent to which the applicant adequately addresses the requirements of Title 45 CFR part 46 for the protection of human subjects. Not scored; however, an application can be disapproved if the research risks are sufficiently serious and protection against risks is so inadequate as to make the entire application unacceptable.

**I. Other Requirements**

*Technical Reporting Requirements*

Provide CDC with original plus two copies of:

1. Interim progress report, no less than 90 days before the end of the budget period. The progress report will serve as your non-competing continuation application, and must contain the following elements:
  - a. Current Budget Period Activities Objectives.
  - b. Current Budget Period Financial Progress.
  - c. New Budget Period Program Proposed Activity Objectives.
  - d. Detailed Line-Item Budget and Justification.
  - e. Additional Requested Information.
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. Send all

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

*Additional Requirements*

The following additional requirements are applicable to this program. For a complete description of each, see Attachment III of the program announcement, as posted on the CDC Web site.

- AR-1 Human Subjects Requirements
- 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-13 Prohibition on Use of CDC Funds for Certain Gun Control Activities

**J. Where To Obtain Additional Information**

This and other CDC announcements, the necessary applications, and associated forms can be found on the CDC web site, Internet address: <http://www.cdc.gov>. Click on "Funding," then "Grants and Cooperative Agreements".

For general questions about this announcement, contact: Technical Information Management, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341-4146, Telephone: 770-488-2700.

For business management and budget assistance, contact: Nancy Pillar, 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 number: 770-488-2721, e-mail address: [nfp6@cdc.gov](mailto:nfp6@cdc.gov).

For program technical assistance, contact: David Wallace, MSEH, Technical Adviser, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway NE, MS K-63, Atlanta, GA 30341-3724, Telephone number: 770-488-4712, e-mail address: [dwallace2@cdc.gov](mailto:dwallace2@cdc.gov).

Dated: July 2, 2003.

**Edward Schultz,**

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

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**BILLING CODE 4163-18-P**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Disease Control and Prevention**

[Program Announcement 03189]

**Blindness and Vision Loss Prevention Program; Notice of Availability of Funds**

*Application Deadline:* August 18, 2003.

**A. 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, 317H of the Public Health Service Act 42 U.S.C. 247 (b)(9), and section 301(a) of the Public Health Service Act, 42 U.S.C. 241(a) and 247b(k)(2), as amended. The Catalog of Federal Domestic Assistance number is 93.988.

**B. Purpose**

The Centers for Disease Control and Prevention (CDC), announces the availability of fiscal year (FY) 2003 funds for a cooperative agreement program for a Blindness and Vision Loss Prevention Program. This program addresses the "Healthy People 2010" focus area of Diabetes and Vision.

The purpose of this program is to develop, deliver, and evaluate a program of comprehensive vision screening, outreach and referral, public education, and surveillance of vision problems. This program is intended to serve persons at risk of blindness and vision loss including persons with diabetes, the elderly, racial and ethnic minorities, and children. This program is also intended to increase awareness nationwide of the need for routine eye examinations, screenings for vision loss, and the need for action to preserve and protect eyesight by developing a national model prevention program to:

- (a) Raise awareness of the risks of vision loss and eye disease;
- (b) recognize the early signs of eye disease;
- (c) identify appropriate and effective prevention practices;
- (d) implement screenings and eye examinations in target populations;
- (e) locate and identify where to find services for prevention, treatment, and rehabilitation; and
- (f) develop and maintain a national database which defines the extent of eye disease and vision loss.

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: Increase the capacity of state diabetes control