guidance to this policy is contained in the **Federal Register**, Vol. 60, No. 179, pages 47947–47951, and dated Friday, September 15, 1995.

Paperwork Reduction Act

Projects that involve the collection of information from 10 or more individuals and funded by the cooperative agreement will be subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Application Submission and Deadline

The original and two copies of the application PHS Form 5161–1 (Revised 7/92, OMB Control number 0937–0189) must be submitted to Joanne Wojcik, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 300, Mailstop E–13, Atlanta, GA 30305, on or before July 14, 1998.

1. Deadline: Applications shall be considered as meeting the deadline if they are either:

a. Received on or before the deadline date; or

b. Sent on or before the deadline date and received in time for submission to the independent review committee. For proof of timely mailing, applicant must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks will not be acceptable as proof of timely mailing.

2. Late Applications: Applications that do not meet the criteria in 1.a. or 1.b. above are considered late applications. Late applications will not be considered in the current competition and will be returned to the applicant.

Where To Obtain Additional Information

The program announcement and application forms may be downloaded from internet: www.cdc.gov (look under funding). You may also receive a complete application kit by calling 1–888-GRANTS4. You will be asked to identify the program announcement number and provide your name and mailing address. A complete announcement kit will be mailed to you.

If you have questions after reviewing the forms, for business management technical assistance contact Joanne Wojcik, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Mailstop E–13, Atlanta, GA 30305, Internet: jcw6@cdc.gov, telephone (404) 842–6535.

Programmatic assistance may be obtained from Mark Jackson, R.S., National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop K–63, Atlanta, GA 30341–3724, telephone (770) 488–4652.

Please refer to Announcement 98054 when requesting information and submitting an application.

The potential applicant may obtain a copy of ''Healthy People 2000'' (Full Report, Stock No. 017–001–00474–0) or ''Healthy People 2000'' (Summary Report, Stock No. 017–001–00473–1) referenced in the INTRODUCTION through the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325, telephone (202) 512–1800.

A copy of American Society for Testing and Materials (ASTM) Number 1292 may be obtained from ASTM, Customer Services, 1916 Race Street, Philadelphia, PA 19103–1187, telephone (215) 299–5585.

Dated: May 7, 1998.

Joseph R. Carter,

Acting Associate Director for Management and Operations Centers for Disease Control and Prevention (CDC).

[FR Doc. 98–12644 Filed 5–12–98; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 98046]

National Comprehensive Cancer Control Program; Notice of Availability of Fiscal Year 1998 Funds

Introduction

The Centers for Disease Control and Prevention (CDC) announces the availability of funds in fiscal year (FY) 1998 for cooperative agreements to implement comprehensive cancer control plans.

CDC is committed to achieving the health promotion and disease prevention objectives of ''Healthy People 2000,'' a national activity to reduce morbidity and mortality and to improve the quality of life. This announcement is related to the priority area of Cancer. (To order a copy of ''Healthy People 2000,'' see the section ''Where To Obtain Additional Information.'')

Authority

This program is authorized by Sections 317 and 1507 [42 U.S.C. 247b] and [42 U.S.C. 300n–3] of the Public Health Service Act, as amended.

Smoke-Free Workplace

CDC strongly encourages all grant recipients to provide a smoke-free workplace and to promote the nonuse of all tobacco products, and Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive federal funds in which education, library, day care, health care, and early childhood development services are provided to children.

Eligible Applicants

Assistance will be provided only to the official public health agencies 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, federally recognized Indian tribal governments, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of the Palau. In consultation with States, assistance may be provided to political subdivisions of States.

Applicants must complete the Eligibility Assurance Form included in the application packet and must attach a reproducible copy of the State/Tribe/Territory's comprehensive Cancer Control Plan to that form. Only one eligible application from a State/Tribe/Territory will be funded. Applicants from each State/Tribe/Territory are encouraged to coordinate and combine their efforts prior to submitting the application for their State/Tribe/Territory.

Availability of Funds

Approximately $1.5 million is available in FY 1998 to fund approximately 5 awards. It is expected that the average award will be $300,000 ranging from $250,000 to $350,000. It is expected that these awards will begin on or about September 30, 1998, and will be made for 12-month budget periods within a project period of up to 4 years. Funding estimates may vary and are subject to change.

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

Use of Funds

These funds are intended for comprehensive cancer control and

should not be used to directly support other existing programs such as breast and cervical cancer programs, cancer registry programs, laboratory or clinical services, or tobacco control programs. These funds should be used to assist with the coordination of these and other categorical programs into comprehensive cancer control activities. Funds awarded under this program announcement may not be used to supplant existing program efforts.

Comprehensive cancer control activities should adhere to current accepted public health recommendations by the U.S. Preventive Services Task Force, or current Division of Cancer Prevention and Control (DCPC) guidance (See Section on Where To Obtain Additional Information).

In the event that additional federal categorical funding becomes available under this announcement, Grantees must coordinate and integrate newly funded activities into the existing National Comprehensive Cancer Control Program.

Restrictions on Lobbying

Applicants should be aware of restrictions on the use of HHS funds for lobbying of Federal or State legislative bodies. Under the provisions of 31 U.S.C. Section 1352 (which has been in effect since December 23, 1989), recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participants to lobby or to instruct participants on how to lobby.

In addition, the FY 1998 Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act (Public Law 105–78) states in Section 503 (a) and (b) that no part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State Legislature, except in presentation to the Congress or any State legislature itself. No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

Background

In the United States, cancer is the second leading cause of death, exceeded only by heart disease. Among adults younger than 65 years, cancer is the leading cause of death and is rapidly overtaking heart disease as the primary cause of death among older Americans (Kennedy 1994). One of every four deaths in the United States is from cancer with approximately 564,800 people expected to die of cancer this year (American Cancer Society 1998). The overall cancer death rate has been steadily rising in the United States during the last 50 years. The age-adjusted death rate in 1950 was 127.7 per 100,000 population (National Center for Health Statistics 1968); it rose to 129.9 per 100,000 in 1995 (National Center for Health Statistics 1997).

While cancer currently is a major cause of morbidity and mortality in the United States, a large proportion of cancer could be controlled through prevention, early detection, and treatment. In recent years, DCPC has worked with state and local health agencies to increase the number and quality of cancer-related programs that are available to the U.S. population. New organizational structures, increased professional expertise, improved understanding of the challenges of delivering community-based health education and health promotion and an increased ability to demonstrate program accountability to program funders have reinforced the public health infrastructure available for cancer prevention and control at the national, State and community levels. In addition, in 1997, an American Cancer Society-appointed Blue Ribbon Advisory Group on Community Cancer Control recommended that prevention be a primary goal and focus. (American Cancer Society 1997).

The majority of the programs developed by CDC are categorical in nature, i.e., built around specific cancer sites or risk factors. For example, CDC has developed important initiatives and programs to address breast and cervical cancer, skin cancer, colorectal cancer, prostate cancer, oral cancer, nutrition and physical activity, and tobacco control; these categorical programs indicate impressive accomplishments in their areas. However, coordination and collaboration among these programs are uncommon, often leading to duplication of effort and missed opportunities for cancer prevention and control at the community level.

In 1994, DCPC initiated discussions related to the coordination and integration of cancer prevention and control programs across categorical boundaries. DCPC sponsored a number of activities to explore options for comprehensive cancer control. One of the key tasks was to develop a working definition of comprehensive cancer control. The following definition was determined to be encompassing and appropriate for future planning and implementation activities:

Comprehensive cancer control—an integrated and coordinated approach to reduce the incidence, morbidity and mortality [of cancer] through prevention, early detection, treatment, rehabilitation, and palliation.

Purpose

The purpose of this program is to support States/Tribes/Territories in the implementation of up-to-date State/Tribe/Territory wide comprehensive cancer control plans. (See Glossary for definitions of comprehensive cancer control plan and comprehensive cancer control program.)

Program Requirements

Recipients of this funding should adhere to current accepted public health recommendations based on the U.S. Preventive Services Task Force, or current DCPC guidance (See Section on Where To Obtain Additional Information).

In conducting activities to achieve the purpose of this program, the recipient of this cooperative agreement will be responsible for the activities under A. (Recipient Activities), and CDC will be responsible for conducting activities under B. (CDC Activities).

A. Recipient Activities

1. Identify and hire necessary key staff to implement the comprehensive cancer control plan.

2. Maintain or enhance a broad-based state/tribe/territorywide cancer control coalition that includes representation from throughout the state/tribe/territory health department, as well as key private, professional, voluntary, and nonprofit cancer control organizations, policymakers, consumers (including cancer survivors), payors, media, State and federal agencies, cancer registries, research and academic institutions, schools, etc.

3. Implement priorities as established by the State/Tribe/Territory's comprehensive cancer control plan, which provides a framework for

planning and action to reduce the burden of cancer in the State/Tribe/Territory. Implementation should be guided by goals and objectives documented in the implementation plan included in this application.

4. Promote collaboration and coordination among existing State/Tribe/Territory-based surveillance systems (e.g., the statewide Central Cancer Registry, Surveillance, Epidemiology, and End Results, (SEER), vital statistics, and other databases, including Behavioral Risk Factor Surveillance System (BRFSS), for use in monitoring changes in cancer disease burden and programmatic impact of the comprehensive cancer control efforts. Data should be used for program modifications and improvements, evaluation, and updating the comprehensive cancer control plan, as appropriate.

5. Evaluate progress and impact of the program based on a systematic evaluation plan. In addition to evaluating progress in meeting goals, process and impact objectives as stated in the implementation plan, the programs should develop performance indicators to use as benchmarks for improvement and to determine the success of the overall comprehensive cancer control effort.

6. Promote the development and dissemination of information and education programs that will contribute to comprehensive cancer control; and participate in CDC-developed national cancer prevention, early detection, and control campaigns. Programs should use existing education resources as well as develop materials and activities that address specific needs of their populations, as necessary and appropriate. School health education and policies should be considered as part of these strategies. In addition to addressing educational needs of the targeted populations, programs should also consider activities that attempt to make individual, policy, organizational or environmental interventions and changes that can encourage primary prevention at all levels, e.g., organizational changes that can reinforce and support individual behavior changes.

7. Participate in CDC-sponsored trainings, meetings, site visits, and conferences.

B. CDC Activities

1. Convene meetings for information-sharing or training among recipients of cooperative agreements.

2. Facilitate the exchange of information and collaboration among recipients.

3. Disseminate to recipients relevant state-of-the-art research findings and public health recommendations related to comprehensive cancer control.

4. Provide ongoing guidance, consultation, and technical assistance in conducting Recipient Activities.

5. Conduct site visits to assess program progress, and mutually resolve problems, as needed, and coordinate reverse site visits to CDC in Atlanta, Georgia.

6. Identify and develop national cancer prevention and control campaigns and materials that can be integrated into comprehensive cancer control programs; facilitate coordination between programs and CDC on national campaigns.

Technical Reporting Requirements

An original and two copies of an annual progress report must be submitted 30 days after the end of each budget period. These progress reports must include: (1) a comparison of actual accomplishments to the goals and objectives established for the period; (2) activities and other issues to be addressed during the subsequent reporting period. The final performance report is required no later than 90 days after the end of the project period.

Annual financial status report (FSR) must be submitted no later than 90 days after the end of each budget period. The final financial status and progress reports are required no later than 90 days after the end of the project period. All reports are submitted to Grants Management Branch, CDC.

Application Content

All applicants must develop their applications in accordance with information contained in this program announcement and the instructions below. Applications should not exceed 30 double-spaced pages (no smaller than 10 point type) including budget and justification. Applicants should also submit appendices (including CVs, job descriptions, organizational chart, and any other supporting documentation), which should not exceed an additional 20 pages. All materials must be provided in an unbound, one-sided, 8½ x 11″ print format, suitable for photocopying (i.e., no audiovisual materials, posters, tapes, etc.). A reproducible copy of the State/Tribe/Territory's comprehensive cancer control plan (attached to the Eligibility Assurance Form), and the letters of support should be included in separate tabbed sections of the application. (The comprehensive cancer control plan and letters of support are not included in the page limit for the application or appendices.)

I. Executive Summary

The applicant should provide a clear, concise one to two page written summary to include:

A. The need for implementing the comprehensive cancer control plan.

B. The major proposed objectives and activities for implementation of the comprehensive cancer control plan.

C. The requested amount of federal funding.

D. Applicant's capability to implement the comprehensive cancer control plan.

II. Background and Need

The applicant should describe:

A. The cancer disease burden for their State/Tribe/Territory:

1. The most recently available State/Tribe/Territory, age-adjusted, overall cancer incidence and mortality rates by age, gender, and racial and ethnic groups. Please cite the source for and time period covered by these data.

2. The estimated State/Tribe/Territory cancer incidence and mortality rates for 1998.

(Please refer to the section on ''Where To Obtain Additional Information'' for possible data sources.)

B. Relevant experiences in the development and implementation of cancer prevention and control programs.

C. Relevant experiences in coordination and collaboration between and among existing programs.

D. Existing initiatives, capacity, and infrastructure (e.g., coalition and partnerships; surveillance activities and systems; evaluation activities; information, media and health communications, education and outreach strategies) on which a coordinated comprehensive cancer control program will be established.

E. Description of the need for comprehensive cancer control funding to enhance existing efforts.

III. Collaborative Partnership and Community Involvement

The applicant should include:

A. A description of proposed linkages to coordinate within the State/Tribe/Territory health department (e.g., across risk factors, categorically funded programs, disciplines), with other key private, professional, voluntary, and non-profit cancer control organizations, policymakers, consumers (including cancer survivors), payors, federal, State and local agencies, research and academic institutions, schools, and other groups, agencies, and businesses in the community that provide health care and related human services.

B. A description of the proposed broad-based State/Tribe/Territory wide coalition that will advise and support the program, including the identification of current members or proposed representatives, their charge, and proposed roles and responsibilities. Taking a broad cancer prevention and control perspective, the State/Tribe/Territory should consider including a wide range of representatives from risk factor and other public health programs that address cancer-related issues such as, nutrition, environmental, oral health, and school health activities. Specific subcommittees and the rationale for these subcommittees of the coalition should be described.

C. Letters of support (in a separate tabbed section of the application) that indicate the nature and extent of existing or planned collaborative support.

IV. Cancer Control Plan

The applicant should:

A. Submit a copy of the (a) current existing state/tribe/territory wide comprehensive cancer control plan, or (b) a current detailed final draft plan. Attach a reproducible, one-sided, 8½ x 11″ unbound copy of the plan, to the completed Eligibility Assurance Form. A comprehensive cancer control plan should include:

1. An assessment of cancer burden in the State/Tribe/Territory using population-based data.

2. Short-term and long-term goals and objectives to address cancer control issues within the State/Tribe/Territory based on identified needs.

3. Proposed strategies to meet the objectives.

4. An assessment of existing and needed resources to implement the comprehensive cancer control priorities.

5. The full range of cancer prevention and control activities, including primary prevention, early detection, diagnosis, treatment, rehabilitation and palliation.

B. Describe the process by which the plan was developed. (If the plan is in draft, describe the process for assuring readiness for implementation by September 30, 1998.) Include a description of the participating agencies' and organizations' involvement in the development of the plan. Clearly describe a mechanism to review, evaluate, and update the plan to meet evolving needs.

C. Describe who will be responsible for maintaining the comprehensive cancer control plan and assuring that the coalition is involved throughout the process, and that comprehensive cancer control efforts proceed according to the State/Tribe/Territory's plan.

V. Implementation of the Comprehensive Cancer Control Plan

The successful coordination and integration of cancer activities, based on the comprehensive cancer control plan, requires that priorities be determined based on a clear data-driven rationale and justification.

The applicant should include an implementation plan that:

A. Describes the process for determining priorities to be addressed in implementing the comprehensive cancer control plan, the process for assuring that these decisions are data-based and grounded in sound science, and the role of the coalition and/or collaborators in the priority-setting process.

B. Includes specific, measurable, attainable, realistic, and time-framed process and outcome objectives designed to achieve goals identified in the comprehensive cancer control plan. The implementation plan for this RFA need not address each goal and objective outlined in the comprehensive cancer control plan; the applicant should make clear how goals and objectives resulting from the priority-setting process relate to the comprehensive cancer control plan.

C. Provides a description of the process for implementing goals and objectives for the identified priorities of the comprehensive cancer control plan. This should include discrete timeframes; responsible agencies, organizations, or organizational units; and activities proposed to meet the objectives within the comprehensive cancer control plan. It should also include a description of how the proposed activities will facilitate coordination and cooperation among existing categorical program efforts. The applicant should include goals for all four years, and specific objectives for Year 01.

D. Describes how surveillance data will be integrated into program activities and used to assess program progress, and inform program decision making.

Description should include evidence that existing surveillance systems enable programs to do the following:

1. Collect population-based information on the demographics, incidence, staging of cancer at diagnosis, morbidity and mortality from cancer. Mechanisms should be in place to ensure timeliness, quality, and completeness of data.

2. Identify segments of the population who are at higher risk for incidence, morbidity, and mortality.

3. Identify factors contributing to the disease burden, such as behavioral risk factors and limited or inequitable access to services.

4. When appropriate, monitor the number and characteristics of people served by relevant programs.

5. When appropriate, develop linkages between the above-mentioned data bases and routinely monitor to determine the effectiveness of interventions.

E. Includes the current or proposed plan for evaluating (1) the program's progress in meeting specific objectives outlined in the implementation plan, and (2) overall success of the comprehensive cancer control effort, based on indicators established by the applicant. Describe the types of indicators to be used to assess outcomes such as coordination, integration and collaboration that have occurred as a result of this funding. Such indicators might assess organizational or institutional changes, reduced duplication of effort, environmental and policy changes. Baseline measures should be identified and assessed, to allow for comparisons after implementation has begun. For each type of evaluation, specify the kind of data/indicator that will be used, how the data will be obtained, how information will be used to improve the overall program, as well as individual program components, who is responsible for each evaluation task, and a time line for accomplishing each evaluation task.

F. Describes proposed information and education efforts. Identify the mechanisms through which information, material, and successful strategies will be consistently and systematically shared and disseminated at the State/Tribe/Territory and local levels, as well as with other cooperative agreement recipients. Include in this description a discussion of plans for collaborating with CDC on national campaigns or educational efforts.

G. Describes mechanism for assuring that the core components of a comprehensive cancer control program including primary prevention/risk factor reduction; education, outreach, health communications; screening, diagnostic, and treatment services; surveillance; and evaluation are consistent with accepted science and prevailing standards of public health practice. The primary prevention components should address risk factors that will have the greatest impact on reducing the overall disease burden of cancer and are not limited to prevention activities of the specific cancers addressed in the State/Tribe/Territory's comprehensive cancer control program.

H. Describes existing programs funded by other sources that will be coordinated with the comprehensive cancer control effort.

VI. Management and Organization

The applicant should:

A. Submit a management plan that includes a description of the proposed management structure that addresses the use of qualified and diverse technical, program, and administrative staff (including in-kind staff), organizational relationships including lines of authority, internal and external communication systems, and a system for sound fiscal management. Minimal staffing should include a full-time program coordinator. The management structure description should include discussion of the integration and coordination of risk factor and cancer-related programs and activities. It is important that the management plan address how coordination and cooperation among existing categorical program efforts will be facilitated, while allowing each program to maintain individual integrity and identity.

B. Provide (in the appendices) a copy of the organizational chart indicating the placement of the proposed program in the department or agency. The chart should clearly demonstrate internal linkages necessary for comprehensive cancer control planning, implementation and evaluation.

C. Provide (in the appendices) CVs and job descriptions of key staff to be partially or fully funded through this RFA, as well as any staff to be providing in-kind support. Applicant should clearly indicate who is responsible for overall direction of the program.

VII. Budget With Justification

The applicant should provide a detailed budget request and complete line item justification of all proposed operating expenses consistent with the Recipient Activities. If in-kind contributions are being provided by the applicant, these should be documented.

The annual budget should include funds for two staff members to make two two-day trips to Atlanta.

Non-Competing Continuation Application Content

In compliance with 45 C.F.R. 92.10(b)(4), as applicable, noncompeting continuation applications submitted within the project period need only include:

A. A progress report describing the accomplishments made from award date to the date of the continuation application. These progress reports must include: (1) a comparison of actual accomplishments with the goals and objectives established for the period, and

(2) other activities and issues to be addressed during the subsequent reporting period.

B. Any new or significantly revised items or information (objectives, scope of activities, operational methods, evaluation, etc.) not included in the Year 01 application.

C. An annual budget and justification. Existing budget items that are unchanged from the previous budget period do not need rejustification. Simply list the items in the budget and indicate that they are continuation items. Supporting justification should be provided where appropriate.

Evaluation Criteria (Total 100 Points)

Objective Review panels evaluate the scientific and technical merit of applications and their responsiveness to the information requested in the Application Content section above. Applications will be reviewed and evaluated according to the following criteria:

I. Background and Need (10 points)

The extent of need based on disease burden by age, gender, and racial and ethnic groups, mortality rates, incidence, cancer program experience, existing capacity and infrastructure, and funding need.

II. Collaborative Partnership and Community Involvement (15 points)

The comprehensiveness and appropriateness of:

A. Existing or proposed linkages within and outside the State/Tribe/Territory health department to coordinate diverse cancer control, risk factor and other primary prevention programs and activities among various agencies, organizations, professional groups, and individuals.

B. The current or proposed broad-based State/Tribe/Territory wide coalition to advise and support the program, including defined roles, responsibilities, and specified subcommittees.

C. Letters of support that indicate the nature and extent of existing or planned collaborative support.

III. Cancer Control Plan (15 points)

The quality of the comprehensive cancer control plan in terms of:

A. An integrated and coordinated State/Tribe/Territory wide approach to prevention, early detection, treatment, rehabilitation, and palliation of cancer; assessment of the State/Tribe/Territory's cancer burden; short-term and long-term goals, objectives, and strategies to address cancer control issues; assessment of existing and needed resources to develop the comprehensive cancer control program; the full range of cancer prevention and control activities, including primary prevention, early detection, diagnosis, treatment, rehabilitation and palliation.

B. The extent to which a broad range of partners and stakeholders are included throughout the process to develop, implement, review, and update the plan; mechanisms to review, evaluate and update the plan to meet evolving needs, and personnel who will be responsible for maintaining the plan, assuring that it is current and regularly reviewed and updated are clearly identified.

IV. Implementation of the Comprehensive Cancer Control Plan (35 points)

The extent to which the applicant's implementation plan describes:

A. Process, justification, and rationale for priorities established for implementation.

B. Specific, measurable, realistic, time-framed objectives based on the comprehensive cancer control plan.

C. The process for implementing priorities identified in the plan, to include discrete time frames, responsible agencies and organizations, linkages of activities to objectives, and how the proposed activities will facilitate coordination and collaboration among existing categorical program efforts.

D. How surveillance data will be integrated into program activities and used to assess program progress and assist program decision making; the surveillance systems and collection of relevant and appropriate population-based information on the demographics, behavioral, disease burden and incidence, etc.; and any linkages between databases and routine monitoring to determine effectiveness of interventions.

E. Plans for evaluating the program's progress in meeting specific objectives outlined in the implementation plan, and overall success of the comprehensive cancer control effort.

F. Proposed information and education efforts, including collaborating with CDC on national campaigns.

G. Methods for assuring that: the core components of a comprehensive cancer control program including primary prevention/risk factor reduction; education, outreach, and health communications; screening, diagnostic, and treatment services; surveillance;

and evaluation are consistent with accepted science and prevailing public health practice; the primary prevention components address risk factors that will have the greatest impact on reducing the overall disease burden of cancer and are not limited to prevention activities of the specific cancers addressed in the State/Tribe/Territory's comprehensive cancer control program.

H. Description of other existing programs funded by other sources that will be coordinated with the comprehensive cancer control effort.

V. Management and Organization (25 points)

A. The feasibility and clarity of the proposed management plan that addresses the use of qualified and diverse technical, program, and administrative staff, organizational relationships including lines of authority, internal and external communication systems, cooperation and coordination among categorical cancer-related programs, and a system for sound fiscal management.

B. The appropriateness of the organizational structure and the existing and proposed internal and external linkages.

C. The quality and appropriateness of CVs and job descriptions of current and proposed key staff, to include who is responsible for overall direction of the program.

VI. Budget With Justification (Not Weighted)

The extent to which the proposed budget is adequately justified, reasonable, and consistent with this program announcement.

Executive Order 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs as governed by Executive Order 12372. This order sets up a system for State/Territory/Tribe and local review of proposed federal assistance applications. Applicants should contact their State Single Point of Contact (SPOC) as early as possible to alert them to expected announcements of cooperative agreement funds and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each State. A current list of SPOCs is included in the application kit. Indian territories are strongly encouraged to request tribal government review of the proposed application. If tribal governments have any tribal process recommendations or if SPOCs have any State process recommendations on applications submitted to CDC, they should send them to Sharron P. Orum, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 305, Mailstop E–18, Atlanta, GA 30305, no later than 60 days after the application deadline date. The Program Announcement Number and Program Title should be referenced on the document. The granting agency does not guarantee to accommodate or explain the State or tribal process recommendations it receives after that date.

Public Health System Reporting Requirements

This program is not subject to the Public Health System Reporting Requirements.

Catalog of Federal Domestic Assistance Number

The Catalog of Federal Domestic Assistance Number is 93.919.

Other Requirements

Paperwork Reduction Act

Projects that involve the collection of information from 10 individuals or more and funded by cooperative agreement will be subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Application Submission and Deadline

The original and two copies of the completed application Form CDC 0.1246(E) (OMB Number 0348–0043) must be submitted to Sharron P. Orum, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 314, Mailstop E–18, Atlanta, GA 30305 on or before July 1, 1998.

1. Applications shall be considered as meeting the deadline if they are either:

a. Received on or before the stated deadline date; or

b. Sent on or before the deadline date and received in time for submission to the objective review group. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks shall not be accepted as proof of timely mailing.)

2. Late Applications. Applications that do not meet the criteria in 1.a. or 1.b., above, are considered late applications. Late applications will not be considered in the current competition and will be returned to the applicant.

3. Acceptable Materials. Applicants must send all materials in an unbound, one-sided 8½ x 11″ printed format, suitable for photocopying. All other application materials will not be reviewed.

4. Only one eligible application from a State/Tribe/Territory will be funded. Applicants from each State/Tribe/Territory are encouraged to coordinate and combine their efforts prior to submitting the application for their State/Tribe/Territory.

Where To Obtain Additional Information

Complete information on application procedures is contained in the application package. Business management technical assistance may be obtained from Gladys T. Gissentanna, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 314, Mailstop E–18, Atlanta, GA 30305, telephone (404) 842–6801; by fax (404) 842–6513; by Internet or CDC WONDER electronic mail at gcg4@cdc.gov.

Programmatic technical assistance may be obtained from Jeannette May, MPH, or Diane Narkunas, MPH, Program Services Branch, Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), 4770 Buford Highway, NE., Mailstop K–57, Atlanta, GA 30341–3717, telephone (404) 488–4880 and by fax (404) 488–4727; by Internet or CDC WONDER electronic mail at jxm5@cdc.gov or dxn3@cdc.gov.

Please refer to Program Announcement Number 98046 when requesting information and submitting an application.

Potential applicants may obtain a copy of ''Healthy People 2000'' (Full Report, Stock No. 017–001–00474–0) or ''Healthy People 2000'' (Summary Report, Stock No. 017–001–00473–1) referenced in the Introduction through the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325; telephone (202) 512–1800.

Copies of the U.S. Preventive Services Task Force Guide to Clinical Preventive Services, 2nd ed. (Williams & Wilkins, October 1995) referenced above may be obtained by calling 1–800–358–3538, or from the world wide web at http://www.wwilkins.com/books/data/0–683–08508–5.html.

Data on cancer incidence and mortality can be obtained from the following sources:

1. The State Cancer Registry.

2. The American Cancer Society, Facts and Figures, 1998. 1–800–ACS–2345.

3. Mortality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention at (301) 436–8884, fax (301) 436–7066. Available at http://www.cdc.gov/nchswww/about/major/dvs/mortdata.htm.

4. SEER Cancer Statistics Review, 1973–1994, NIH Pub. No. 97–2789. Available at http://www-seer.ims.nci.nih.gov/Publications/CSR7394/index.html or by calling the Cancer Statistics Branch Cancer Control Research Program Division of Cancer Prevention and Control, National Cancer Institute at (301) 496–8510.

CDC suggests using the Internet, following all instructions in this announcement and leaving messages on the contact person's voice mail for more timely responses to any questions.

Eligibility Assurance Form

All applicants MUST complete this check-list and attach appropriate documentation supporting eligibility (the state/tribe/territory wide comprehensive cancer control plan). The plan must be attached to this check-list, should not be incorporated into the body of the application or the appendices, and therefore does not affect the page limit for the application (30 pages) or appendices (20 pages). A copy of this form, with an attached reproducible plan, should be included with each copy of the application as a separate tabbed section.

____A state/tribe/territory wide comprehensive cancer control plan has been developed. Plan is either:

____an existing up-to-date plan ready for implementation, or

____an up-to-date detailed final draft ready for implementation by September 30, 1998.

At a minimum,

____Plan documents an integrated and coordinated state/tribe/territory wide approach to prevention, early detection, treatment, rehabilitation, and palliation of cancer (i.e., not a summation or compilation of categorical risk factor/specific cancer programs).

____ Plan identifies priorities to be addressed based on needs identified through assessment of the burden of the major detectable/preventable cancers in the State/Tribe/Territory.

____Copy of the State/Tribe/Territory wide comprehensive cancer control plan document is attached. (A reproducible, unbound, one-sided, 8½ x 11″ copy of the plan should be attached to this form.)

Glossary

Terms are defined by DCPC in this Glossary to clarify issues for applicants under this RFA only. They are not meant to apply to all DCPC or CDC programs, activities, or RFAs.

Comprehensive Cancer Control: An integrated and coordinated approach to reduce the incidence, morbidity, and mortality [of cancer] through prevention, early detection, treatment, rehabilitation, and palliation.

Comprehensive Cancer Control Plan: Document that is developed as an optimal blueprint for achieving comprehensive cancer control in that State/Tribe/Territory. It should address information on cancer burden; short-and long-term goals and objectives; proposed strategies to meet objectives; assessment of existing and needed resources; and a plan for promoting access to full range of cancer control services.

At a minimum, a Comprehensive Cancer Control Plan: (1) documents an integrated and coordinated state/tribe/territory wide approach to prevention, early detection, treatment, rehabilitation, and palliation of cancer (i.e., not a summation or compilation of categorical risk factor/specific cancer programs); and (2) identifies the priorities to be addressed based on an assessment of the burden of the major detectable/preventable cancers in the State/Tribe/Territory.

Comprehensive Cancer Control Program: Based on goals and objectives established in the comprehensive cancer control plan, the overall set of actions that are conducted with available resources to translate the optimal plan into feasible reality.

Implementation: Conducting activities that are designed to achieve goals and objectives outlined in the Comprehensive Cancer Control Plan. Implementing the Plan is the same thing as conducting comprehensive cancer control activities or programs. For the purposes of programs funded under this RFA, implementation of the plan does not require that all goals and objectives in the State/Tribe/Territory wide comprehensive cancer control plan be implemented; implementation will be guided by the goals and objectives in the implementation plan developed for this RFA.

Indicator: A performance measure used to track critical processes over time to signify progress toward a particular desired outcome of the program. For example, one ''indicator'' for better coordination among categorical programs might be a certain number of meetings held among categorical program staff to assure that efforts are being coordinated. Another ''indicator'' for the same outcome might be that each related program has a representative on the coalition that advises and directs the program.

State/Tribe/Territory wide: Covering the entire State/Tribe/Territory, rather than just limited 34 metropolitan or county areas within the State/Tribe/Territory. For example, State/Tribe/Territory wide comprehensive cancer control plan addresses cancer, programs, activities, and services throughout the State/Tribe/Territory.

U.S. Preventive Services Task Force Guide to Clinical Preventive Services, 2nd ed.: The Guide clearly outlines and establishes, for the clinician, the current state of research on the efficacy of the major preventive interventions. A well-specified methodology based on scientific evidence is used to assess efficacy. Based on the work of a distinguished panel of nationally recognized experts, and reviewed by more than 650 federal and nonfederal experts, it provides recommendations on screening, counseling, and immunizations according to patients' personal characteristics and health risk factors.

Dated: May 7, 1998.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement 98037]

Initiatives by Organizations To Strengthen National Tobacco Control Activities in the United States; Notice of Availability of Funds for Fiscal Year 1998; Amendment

A notice announcing the availability of Fiscal Year 1998 funds for cooperative agreements for Initiatives by Organizations to Strengthen National Tobacco Control Activities in the United States was published in the **Federal Register** on April 23, 1998, [63 FR 20197]. The notice is amended as follows:

On page 20202, second column, under the heading ''Application Submission