Request for Applications (RFA)

No. 23-10480

Rape Prevention and Education (RPE) Program

October 12, 2023

Injury and Violence Prevention Branch

MS Code 7214

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PART ONE: FUNDING OPPORTUNITY DESCRIPTION

A. PURPOSE

The California Department of Public Health (CDPH), Injury and Violence Prevention Branch (IVPB), Rape Prevention and Education (RPE) Program is seeking applications from eligible local rape crisis centers (RCCs) and community-based organizations (CBOs) to implement and evaluate community/societal-level strategies for sexual violence (SV) prevention.[1] Strategies are to be implemented using a core community engagement approach to advance health equity for priority populations.

The CDPH RPE Program receives funding from the Centers for Disease Control and Prevention (CDC) RFA-CE24-0027 and the Rape Set-Aside (RSA) portion of CDC's Preventive Health and Health Services (PHHS) Block Grant Program to prevent the first-time perpetration and victimization of SV using a public health approach. The RPE Program prioritizes primary prevention at the broader community and societal levels, as opposed to prevention services for individuals, to shift social norms, policies, and practices. The focus of this RFA is on community/societal-level strategies that 1) Strengthen economic security/mobility for women, gender expansive people, and families; 2) Transform gender norms; and 3) Improve the community environment. Community engagement is also vital to changing social norms and environments to prevent SV, where community members and leaders inform program and policy development. In this RFA, the following community engagement approaches will be the mechanisms to implement strategies within communities: 1) Community Mobilization, 2) Promotores, or 3) Coalition Building.

To advance racial and gender equity, this RFA focuses on priority populations and under-resourced communities that face disproportionately higher rates of violence and adverse health outcomes. To achieve health equity, the root causes of sexual violence and underlying factors that increase or decrease the likelihood of SV or other forms of violence need to be addressed. These underlying conditions are referred to as social determinants of health (SDoH).

[1] Refer to Appendix 1: Definitions and Frameworks

Strategies and partners that address the social, economic, and environmental conditions in our communities and society can help reduce health inequities.

The Department has authority to grant funds for the Project under Health and Safety Code § 131085. The purpose of the Grant is to implement and evaluate community/societal-level strategies to prevent sexual violence in California communities in accordance with federal grant requirements of the national RPE Program.

Eligible applicants will select one (1) of the three (3) community engagement approaches with the following maximum funding amounts annually:

1-Community Mobilization	**2-Promotores**	**3-Coalition Building**
Open to RCCs Only with CBO Subgrantee **Maximum of $170,000 annually for 5 years**	Open to RCCs with CBO Subgrantee and CBOs with RCC Subgrantee **Maximum of $170,000 annually for 5 years**	Open to RCCs with CBO Subgrantee and CBOs with RCC Subgrantee **Maximum of $170,000 annually for 5 years**

B. BACKGROUND

❖ *Sexual Violence as a Public Health Issue*

The CDC defines sexual violence as sexual activity without obtaining consent, consent given freely, or with someone unable to consent or refuse, including "rape" or "sexual assault." This type of violence can be committed by a friend, intimate partner, co-worker, neighbor, or family member. It includes forced or alcohol/drug facilitated penetration of a victim, forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else, non- physically pressured unwanted penetration, intentional sexual touching, or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party.[2]

[2] *Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0,* Centers for Disease Control and Prevention; 2014.

The consequences of sexual violence, have a range of implications including physical, psychological, depression, anxiety, and suicidal thoughts. Chronic issues may arise, such as post-traumatic stress disorder, sexual health problems, negative health behaviors (e.g., smoking, abusing alcohol/drugs, risky sexual activity). A person's economic wellbeing (e.g., employment, work performance) can also suffer due to sexual violence. These health and economic consequences affect individuals, communities, and society overall, making it a *significant public health issue* to address.

In California, more than 1 in 3 women and 1 in 4 men report experiencing sexual violence involving physical contact in their lifetime. Nationally, an estimated 23 million women have experienced completed or attempted rape in their lifetime.[3] This does not encompass how significant the problem is with many occurrences of sexual violence going unreported. The estimated cost per rape victim is $122,461 over their lifetime.[4] In 2012, tangible costs such as medical and health costs added up to over $9 billion. When considering intangible costs such as lost productivity, the cost increases to $140 billion making it a serious public health concern.[5]

❖ *The California Department of Public Health (CDPH), Injury and Violence Prevention Branch (IVPB)*

The CDPH/IVPB violence prevention efforts were started as part of the California 1994 Women's Health Initiative. IVPB violence prevention initiatives aim to "provide leadership in the application of public health principles and practices to prevent violent injuries." CDPH/IVPB seeks to address SV and domestic violence (DV) through shifting social norms, policies, and practices to create a climate free from violence. Rather than focusing on individuals and victims, IVPB focuses on community and population-based prevention that works to prevent violence before it is initiated, as opposed to concentrating solely on service provision after victimization has occurred. This primary prevention public health approach is a systematic process that promotes healthy behaviors and

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[3] *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report,* Centers for Disease Control and Prevention; 2017.

[4] *Fast Facts: Preventing Sexual Violence,* Centers for Disease Control and Prevention; 2022.

[5] *The Cost and Consequences of Sexual Violence in California Full Report,* California Coalition Against Sexual Assault; 2018.

environments and reduces the likelihood and/or frequency of violence. Primary prevention is distinguished from secondary prevention because it explicitly focuses on action before there is a threat of violence.

The CDPH/IVPB currently administers the following violence prevention programs and surveillance projects: Rape Prevention and Education Program, Domestic Violence Prevention Program, Essentials for Childhood Initiative, Comprehensive Suicide Prevention Program, Office of Suicide Prevention, California Violent Death Reporting System, and the Violence Prevention Initiative. Strategies administered by IVPB seek to address multiple forms of violence through an intersectional approach to prevent violence.

❖ *The Rape Prevention and Education (RPE) Program*

In 2002, as a result of a change in federal law, RPE funds were removed from the Preventive Health and Health Services (PHHS) Block Grant, creating a new categorical grant program within the CDC's, National Center for Injury Prevention and Control. State health departments became the only eligible applicants to receive these funds, and CDPH began administering the RPE Program in California. The purpose of this change was to bring a public health approach to SV prevention throughout the nation, shifting to primary prevention and changing social norms instead of relying exclusively on a secondary criminal justice approach. The public health approach is a four-step process that is rooted in the scientific method. It can be applied to violence and other health problems that affect populations. It includes the following steps: 1) Define and monitor the problem; 2) Identify risk and protective factors; 3) Develop and test prevention strategies; and 4) Assure widespread adoption.

Funds are contingent upon annual appropriations from Congress for the CDC's RPE Program, as well as appropriations for the Rape Set-Aside portion of the CDC's PHHS Block Grant. Federal legislation outlines the permitted uses of RPE funds. Since 2013, CDC has used a funding mechanism that provides a specific minimum baseline amount for RPE to all states and territories and distributes the remaining funds according to a population-based formula.

The RPE Program provides funding for local assistance, training and technical assistance (TTA), and evaluation. Since the inception of the RPE Program, CDPH has partnered with ValorUS (VALOR, formerly the California Coalition Against Sexual Assault), to provide TTA to increase the capacity of local grantees to implement effective SV primary prevention projects through a public health

approach. Since 2019, CDPH has partnered with the University of California, San Diego, Center on Gender Equity and Health (UCSD GEH) to administer a state-wide evaluation of the RPE Program.

Currently, RPE funds local rape crisis centers to implement primary prevention strategies across the individual, relationship, community and societal levels within their local communities and populations in need. Prevention strategies include community mobilization projects and school-based projects focusing on gender equity, active bystander, and healthy relationships. Building on the findings of the Environmental Scan of Leadership Opportunities and Economic Supports (December 2021), RPE subsequently also funded five pilot projects for economic security/mobility and leadership as strategies to prevent sexual violence and domestic violence. The primary purpose of these pilots is to build organizational capacity in workplace policies that address economic security/mobility and leadership to staff and the communities they serve.

C. RPE PROGRAM PRIORITIES

1. Proposed strategies are based on best available evidence to achieve community/societal-level change

The RPE Program aligns its strategies with the CDC Sexual Violence Prevention Resource for Action (previously referred to as STOP SV) which includes a list of evidence-based approaches for sexual violence. RPE strategies promote programs, policies, and practices according to the CDC focus areas in creating protective environments, promoting social norms, teaching skills, and empowering girls and women.[6] The RPE Program uses the social ecological model (SEM) which maps different levels of influence on people's behaviors: individual, interpersonal relationships, the community, and society. This model ensures prevention strategies have as broad as an impact on communities as possible.

Over the years, there has been an increased focus on prevention strategies that impact changes at the community or societal levels. According to the CDC, community-level change means influencing "the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur." Community-level SV prevention involves changing community level risk and/or protective factors. Risk

[6] *Prevention Strategies,* Centers for Disease Control and Prevention; 2022.

factors are influences that increase the risk of perpetrating or experiencing violence. Protective factors are influences that create a buffer against risk. It is important to note that reaching most or all individuals in a community with strategies for changing *individual* or *relationship level* risk and/or protective factors is *not* enough on its own to constitute community-level change. Strategies for community-level change often include improving organizational policies, institutionalizing sustainable prevention activities, changing the physical environment, and increasing community connectedness.

Societal-level change involves improving societal level risk and/or protective factors for sexual violence. Strategies often include changing public policies and social and cultural norms. These strategies aim to contribute to a climate that prevents, rather than encourages, sexual violence.[7] At the same time, as progress has been made in understanding more about the underlying causes of health inequities and violence, preventing sexual violence also involves addressing deep-rooted abuses of power that contribute to inequities in health, safety, and well-being. A health equity approach to preventing sexual violence means that we need to both understand and address the factors that contribute to violence and safety and factors that expose some communities — especially communities that have been historically oppressed — to higher rates of sexual violence.[8] To this end, the focus of the RPE Program has shifted to prioritize this type of work.

RPE promotes use of evidence-based and evidence-informed strategies whenever possible. Given there is not a robust evidence base in the sexual violence prevention field for community/societal-level strategies, the CDPH RPE Program promotes strategies for sexual violence and other forms of violence (i.e., domestic violence, teen dating violence, child maltreatment, suicide) in the following three (3)

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[7] *The Social-Ecological Framework for Prevention,* Centers for Disease Control and Prevention; 2022.

[8] A *Health Equity Approach to Preventing Sexual Violence,* Prevention Institute & National Sexual Violence Resource Center; 2021.

areas (listed in the table below).[9] More information on these strategies with example activities can be found in Appendix 2: RPE Program Strategies & Approaches.

RPE Strategies

Economic Security/Mobility for Women, Gender Expansive People & Families
Economic insecurity is linked to gender inequality. The economic security of families depends on women and gender expansive people to access full and equal labor force participation, including having comparable salaries to people who identify as men, income generating options, and work supports such as affordable quality childcare through vouchers, lower cost childcare, or cash-transfers to off-set the cost of quality, full-time childcare. Provision of these types of supports to ensure women can remain in and contribute substantially to the workforce not only improves their economic conditions and promotes family stability, but also decreases gender inequality, which has been linked to risk for SV. Paid family and medical leave is also critical because it provides income replacement to workers for life events such as the birth of a child or a short- or long-term illness. When these life events arise, families can become vulnerable to financial, employment, and housing instability, increasing their risk for SV victimization. Additionally, evidence suggests that people who are bisexual and transgender have lower incomes and higher poverty than people who are lesbian, gay, and cisgender heterosexual people. Although people who are lesbian and gay may be less impacted by income inequality, they still face discrimination in the labor force.[10]

[9] The CDPH/IVPB team underwent a strategic planning process to prioritize shared risk and protective factors and connect these areas with community and societal-level change approaches.

[10] National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education; Committee on Population; Committee on Understanding the Well-Being of Sexual and Gender Diverse Populations; White J, Sepúlveda MJ, Patterson CJ, editors. *Understanding the Well-Being of LGBTQI+ Populations*. Washington (DC): National Academies Press (US); 2020 Oct 21. 10, Economic Well-Being.

Transforming Gender Norms
Changing social norms that accept or allow indifference to violence is necessary to prevent SV. Gender norms define appropriate behaviors for people who identify as men and women, and girls and boys, in terms of roles, behavior, and how to relate to one another. Restrictive gender norms (i.e., rigid ideas about the appropriate roles and behavior of men and women) can serve to support or condone violent behavior in intimate and other relationships. Research has shown that individuals and communities adhering to restrictive and harmful social norms are more likely to perpetrate physical, sexual, and emotional violence against women.
Improving Community Environment
Creating protective community environments is a necessary step towards achieving population-level reductions in SV. Communities can include any defined population with shared characteristics and environments, including schools, neighborhoods, cities, organizations (e.g., workplaces), or institutions. Approaches that operate by modifying characteristics of the community, rather than individuals within the community, are considered community-level approaches. Such approaches can involve, for example, changes to policies, institutional structures, or the social and physical environment in an effort to reduce risk characteristics and increase protective factors that affect the entire community. Characteristics of the social and physical environment can have a significant influence on individual behavior, creating a context that can promote positive behavior or facilitate harmful behavior.

2. Promote community engagement approaches

A community engagement approach refers to the mechanism of how communities will be engaged in implementing the selected strategies (i.e., involve, collaborate with and/or empower community member in decision-making) to address issues affecting their wellbeing. To achieve the goal of making change in diverse communities, it is critical to: engage communities from the outset to build social capital; use a comprehensive approach of community engagement which accounts for culture and historical inequities; and makes sustainability

a priority.[11] The CDPH RPE Program prioritizes the following three (3) community engagement approaches where community members and leaders inform program and policy development (listed on the table below):

RPE Community Engagement Approaches

1-Community Mobilization
The importance of engaging, mobilizing, and empowering communities to prevent violence is shown by evidence that community cohesion can be protective against violence. Engagement and mobilization of community can increase the likelihood that prevention programs will be sensitive to a community's needs and barriers, and garner increased community support, which can help sustain prevention efforts. Since 2010, CDPH has supported the Close to Home (C2H) community mobilization approach as an evidence-informed prevention strategy for domestic and sexual violence. Through a participatory process, youth and adult organizing teams/networks engage organizational and community leaders to develop community-driven campaigns, actions, or policies across four phases (Assess, Talk, Build, Act). C2H is also the focus of a current CDC-funded evaluation research project administered by the University of California, San Diego, Center on Gender Equity and Health. Results from this multi-year evaluation are forthcoming. • Close to Home (c2-home.org) • Evaluation of the Close to Home Program in California: Assessing the impact of community mobilization to prevent sexual violence at the individual, social network, and community levels • Community Mobilization Project Brief • Community Mobilization to Prevent Youth Violence and to Create Safer Communities

[11] *Community Engaged Leadership to Advance Health Equity and Build Healthier Communities,* National Library of Medicine; 2016.

2-Promotores

Promotores are community health workers (CHWs). They are characterized as lay health workers with the ability to provide linguistically and culturally appropriate services informed by their lived experiences in the community. They often serve Spanish-speaking communities but can also work in other distinct communities where they share ethnicity, language, socioeconomic status, and lived experiences. Key to their definition is connection and trust building within the target community. Promotores are frontline agents of change, helping to reduce health disparities in underserved communities.

Promotores are uniquely qualified to provide social support and help decrease stigma surrounding mental health and other topics that the community may deem sensitive, such as sexual and intimate partner violence. Using the expert knowledge of the cultural norms of their communities, they can tackle stigma and develop meaningful, trust-worthy relationships to address equity and prevent violence within priority populations. Overall, they can increase community resiliency and make major impacts on health outcomes in their own communities.

- Role of Community Health Workers
- Promotores and Promotoras de Salud
- Integrating the Promotores Model to Strengthen Community Partnerships

3-Coalition Building

A coalition is a union of community members and organizations working to educate about a specific problem and define the solutions. Coalition goals range from information sharing to coordination of services, from community education to community engagement in advocacy working to undertake policy, system, and environmental change. Partnering with community, education, housing, media, planning and economic development, transportation, business partners, and engaging with these sectors, can work to improve the underlying community conditions that make healthy living easier, particularly in underserved communities.

3-Coalition Building (Continued)
• Developing Partnerships and Coalitions to Advance Health Equity • Developing Effective Coalitions: An Eight Step Guide • Creating and Maintaining Coalitions and Partnerships | Community Tool Box • What Makes An Effective Coalition: Evidence Based Indicators of Success • Coalition Building Toolkit

3. Advance racial and gender health equity for priority populations

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to: address historical and contemporary injustices; overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities.[12] Racial and ethnic inequities pervade all the social determinants of health, so addressing structural racism is essential to achieving health equity.

Given the CDC's focus to integrate health equity into violence prevention programs, RPE works to advance racial and gender health equity for priority populations through an intersectional approach. Intersectionality describes how people experience the interconnected nature of different facets of their identities—such as their race, gender, sexual orientation, and class—and how those identities are valued within existing systems of power. Intersectionality can also refer to the interconnected nature of all forms of discrimination or disadvantage against historically oppressed or marginalized groups.[13]

CDPH recognizes that priority populations have a long history of being overlooked, oppressed, marginalized, and under-resourced for prevention and services for different forms of violence. The focus of the RPE Program will include the priority populations listed below, which were informed by the Statewide Collaborative for DV, SV, and TDV

[12] *What is Health Equity?,* Center for Disease Control and Prevention; 2022.

[13] *Racial and Health Equity Glossary of Terms,* California Department of Public Health; 2020.

Prevention, in which CDPH participates along with VALOR, the California Partnership to End Domestic Violence, and the California Governor's Office of Emergency Services; a literature review on populations that experience inequity due to various forms of oppressions such as racism, classism, ableism, sexism, transphobia, and homophobia, and review of Social Determinants of Health (SDoH) related to risk and protective factors among these populations.

The RPE Program focuses on the following priority populations for people who are:

- Black
- Latino/a/e
- Native-American/Indigenous
- Asian/Pacific Islander
- LGBTQ
- Residents living in rural communities
- Experiencing low socioeconomic status
- Women, girls, and gender expansive
- Non-US-born
- Disabled
- Intersections of these identities

4. Address social determinants of health (SDoH).

SDoH are the conditions in which people live, learn, work, and play. These conditions include a broad range of socioeconomic and environmental factors, including racism, classism, sexism, able-ism, homophobia, xenophobia, and other social determinants. Violence itself is a SDoH; violence may also be a result of the environments where people live, and children grow. For example, those who grow up and live in environments with limited social, educational, and economic opportunities and where violence, racism, and community and domestic instability are daily stressors are at increased risk of multiple forms of violence. In order to prevent violence, the underlying SDoH need to be addressed, including root causes of inequity and social disadvantage. CDPH utilizes the public health framework produced by the Bay Area Regional Health Inequities Initiative

(BARHII)[14] to address SDoH such as living conditions, institutional inequities, and social inequities.

Working on these underlying conditions is an upstream approach to violence prevention. By addressing root causes of violence, programs can address shared risk and protective factors (SRPF) across different forms of violence. These shared factors are certain influences that have been identified through research to affect the likelihood of multiple forms of violence, including sexual violence. As a result of these shared factors, multiple forms of violence often co-occur in the same communities and settings. The CDPH RPE Program is specifically focused on preventing sexual violence; however, IVPB also recognizes the potential for increased impact by focusing on shared risk and protective factors. This approach involves partnering with community organizations and stakeholders – including organizations that may not specifically work on SV prevention but address the SDOH that are associated with SV. Implementing prevention efforts to address multiple forms of violence is an efficient way to leverage resources and allows for an increased reach and scale of prevention efforts.[15] It may also help develop and sustain new partnerships and better align with the needs and strengths of their communities.

D. ELIGIBILITY CRITERIA

1. Eligible organizations

a. Local RCCs and CBOs. CBOs applying for funding must have a subgrant with their local RCC through an MOU to demonstrate commitment to the SV field. RCCs applying for funding must have a subgrant with a CBO through an MOU. An RCC is defined as a Rape Crisis Center funded by the California Office of Emergency Services (CalOES) Rape Crisis (RC) Program.

[14] *Applying Social Determinants of Health Indicators to Advance Health Equity: A Guide for Local Health Department Epidemiologists and Public Health Professionals*, Bay Area Regional Health Inequities Initiative. 2015.

[15] *Connecting the Dots,* Centers for Disease Control and Prevention, 2017.

There are three (3) options to apply as follows:

1-Community Mobilization	2-Promotores	3-Coalition Building
Open to RCCs Only with CBO Subgrantee	Open to RCCs with CBO Subgrantee and CBOs with RCC Subgrantee	Open to RCCs with CBO Subgrantee and CBOs with RCC Subgrantee

b. Subgrantees/Joint Applications**:** Organizations can partner with other organizations and submit a joint application, with one (1) organization serving as the lead and partner organizations named as subgrantees, should the subgrantees meet the eligibility requirements as the Lead Applicant.

c. Applicants may submit only one application

d. Non-profit Status: CBOs, RCCs, and Subgrantees must be a 501(c)(3) organization of the Internal Revenue Code. The definition of "CBOs" is only limited in that the organizations must have a 501(c)(3) non-profit tax-exempt status. This requirement also applies to subgrantees. Non-profit organizations must certify their eligibility to claim non-profit status.

e. Applicants must be financially stable and solvent and have adequate cash reserves to meet all financial obligations while awaiting reimbursement from the State.

f. Applicants must be in good standing with the State of California Secretary of State, California Franchise Tax Board, and California State Board of Equalization.

g. Applicants must provide a copy of current insurance policy documents.

2. Minimum Requirements

Organizational readiness and fit for the selected strategy and community engagement approach is critical for the project success. Successful applications will demonstrate:

a. An understanding of current needs in the selected population(s) and community; knowledge of what SDoH and root causes are contributing to disparities and impacting SV in the population(s) and community.

b. Experience with community/societal-level strategies, including staff competencies in policy, community organizing, coalition facilitation, supporting collaboratives, and supporting communities to take action.

c. Experience with community engagement or organizing approaches.

d. Organizational capacity to work with the selected priority population(s) or partnership with another organization that has experience working with the population. Organizations that are led by individuals who self-identify with one or more historically marginalized populations are encouraged to apply.

E. FUNDING GUIDELINES

1. Funding is available from CDC's RPE Program with leveraged funding from the Rape Set-Aside (RSA) portion of CDC's PHHS Block Grant during the 60-month grant term to fund grantees with annual budgets as indicated below. The number of awardees to be funded will be based on the total funding available and the number of applications that meet the minimum requirements. Once agencies have been selected through the RFA scoring process, CDPH will award funds to the highest scores with geographic area considerations until the total funding is reached. CDPH anticipates up to 14 awards in the amount of $170,000 each in annual funding for a five-year period. CDPH will seek a balance between funding as many agencies as possible and providing sufficient level of funding to implement effective programming.
2. CDPH does not have the authority to disburse funds until the grant between CDPH and an applicant is fully executed. If full funding is not available, or the total available funding is reduced, CDPH will either cancel the resulting agreement or amend it to reflect reduced funding and reduced activities. CDPH expects to make

approximately $2,400,000.00 available annually, totaling $12,000,000.00 for this RFA, contingent on the availability of federal funds.

3. If changes are required by legislation, court action, or other administrative action affecting CDPH, the grants, as applicable, will be amended or terminated accordingly to comply with these actions.

4. CDPH reserves the right to extend the term and increase the funding amount of the resulting agreement via an amendment as necessary to complete or continue the services. Grant extensions are subject to satisfactory performance, funding availability, and approval by the California Department of General Services (DGS).

CDPH has established the following annual funding amounts:

Year	Budget Periods	Maximum Funding Amount
1	February 1, 2024 to January 31, 2025	$170,000
2	February 1, 2025 to January 31, 2026	$170,000
3	February 1, 2026 to January 31, 2027	$170,000
4	February 1, 2027 to January 31, 2028	$170,000
5	February 1, 2028 to January 31, 2029	$170,000

CDPH anticipates that most agencies can accomplish the work required by this RFA at the funding levels listed above. However, CDPH will consider requests for funding up to 10 percent higher than these levels based on salary requirements within the agency, as long as they do not exceed salaries of state positions and funding is available. Applicants must demonstrate the need for the additional funds to meet the minimum Full Time Equivalent (FTE) requirements described in this RFA.

F. TENTATIVE RFA TIME SCHEDULE

Below is the tentative* time schedule for this RFA application process.

EVENT	DATE	TIME
RFA Release Date	10/12/2023	12:00 p.m.
Voluntary RFA Informational Webinar	10/19/2023	2:00 p.m.
Voluntary RFA Questions Due	10/24/2023	5:00 p.m.
Post Frequently Asked Questions (FAQ)	11/02/2023	5:00 p.m.
Mandatory Non-Binding Letter of Intent	11/09/2023	5:00 p.m.
Application Due Date	**11/29/2023**	**5:00 p.m.**
Notice of Intent to Award Posted	12/22/2023	1:00 p.m.
Letter to Appeal to IVPB	01/02/2024	5:00 p.m.
Final Announcement of Award	01/16/2024	--
Proposed Grant Start Date	02/01/2024	--

*CDPH reserves the right to amend dates at any time during the RFA process.

It is the Applicant's responsibility to check for notices and addenda for this RFA via (share this will be posted here) throughout the RFA process.

G. INFORMATIONAL WEBINAR

A voluntary informational webinar has been scheduled to provide guidance related to the RFA requirements:

Date: Thursday, October 19, 2023

Time: 2:00 p.m.

Zoom Registration Link: https://cdph-ca-gov.zoom.us/webinar/register/WN_OhM06U5AQS6E3Ge6T8B9rQ

Prospective applicants that intend to submit an application are encouraged to participate in the webinar. Technical assistance regarding programmatic content will not be available.

It is each prospective applicant's responsibility to join the webinar promptly at the time stated. CDPH reserves the right to not repeat information for participants that join the webinar after it has begun. The webinar is a public event or meeting, and anyone can join.

All questions asked during the webinar and those sent to RapePrevention@cdph.ca.gov by October 24, 2023 will be compiled and answered in a posted Frequently Asked Questions (FAQ) document by November 2, 2023 on the CDPH SV Prevention website. Spontaneous verbal remarks provided in response to questions are considered unofficial and do not hold binding authority for CDPH, unless later confirmed in writing. Please note that individual responses to inquiries will not be provided.

PART TWO: PROGRAM AND GRANT REQUIREMENTS

A. Select One (1) of Three (3) Community Engagement Approaches

Engagement of the community is central to changing social norms and environments around SV. It facilitates learning about the populations and issues that are most important to communities, honors the experience and knowledge of community residents, and builds community ownership and empowerment through shared power and resources. When communities are engaged, they are more likely to develop sustainable solutions which create long-term social norm change. A community engagement approach refers to the mechanism of how communities will be engaged in implementing the strategies. Organizations will select one (1) of the following community engagement approaches:

1. Close to Home (C2H) Community Mobilization

Using the Close to Home (C2H) approach, youth and adult organizing teams/networks develop community-driven campaigns, actions, or policies across four phases (Assess, Talk, Build, Act).

The organization is required to recruit and maintain a C2H network of youth, adults, and organizational/civic life that at minimum incorporates the following:

b) Youth organizing team (ongoing weekly meetings and activities)
c) Adult organizing team (ongoing weekly meetings and activities)
d) Intergenerational team/network (as needed through C2H phases)
e) Orientation training to new adult and youth leaders
f) Completion of a cycle of the four phases of the C2H approach (Assess, Talk, Build, Act) every 18-24 months for the selected strategy
g) Participation in community meetings, activities, events, and coalitions
h) Meetings with community leaders, partners, organizations, and businesses to build the network
i) Priority population representation in the organizing teams and network
j) Trainings to build necessary skills of the leaders and network
k) Stipends to offset the cost of volunteerism (to be negotiated with CDPH) for adult and youth leaders.

2. Promotores

The organization is required to recruit and maintain a network of Promotores (community health workers) that at minimum incorporates the following:

a) Promotores who represent members from the priority populations and have a relationship with the community including their daily experiences and cultural norms
b) Ongoing weekly meetings and activities
c) Orientation training to Promotores
d) Building positive, respectful rapport with community members through mutual conversations about the community's needs and sharing findings and feedback
e) Sharing information and resources with community members in response to real needs and navigate access for the selected strategy
f) Community participation through individual and collective action for the selected strategy
g) Participation in community meetings, activities, events, and coalitions
h) Trainings to build necessary skills of the Promotores and network
i) Stipends to offset the cost of volunteerism (to be negotiated with CDPH) or compensation and resources for Promotores

3. Coalition Building

The organization is required to maintain a coalition that at the minimum incorporates the following:

a) Individuals who work on behalf of priority populations and/or individuals with lived experiences representation, diverse alliances, and partnerships for the selected strategy
b) Individuals or organizations who can educate about policy change and engage with policy champions (Note: lobbying activities are prohibited under funding provided by this RFA)
c) Goals, objectives, and an Action Plan of the coalition
d) Coalition structure and bylaws, including decision-making processes
e) Building diverse coalition membership, including community members and/or youth with stipends to offset the cost of volunteerism (to be negotiated with CDPH).

f) Participation in network activities that lead to partnering with organizations on efforts to address SDoH and implement the selected RPE strategy
g) Trainings for the coalition on the selected RPE strategy and to build necessary skills of the community to achieve coalition and project objectives
h) Meetings to carry out the coalition's activities, including subcommittee meetings as needed

B. Implement One (1) or Two (2) Community/Societal-Level Strategies

CDPH RPE Program promotes community/societal-level strategies for sexual violence and other forms of violence (domestic violence, teen dating violence, child maltreatment, suicide) in the following three (3) areas[16]:

- Economic security/mobility for women/gender expansive people/families
- Transforming gender norms
- Improving community environment

Organizations are required to select strategies from Appendix 2: RPE Program Strategies & Approaches. Implementation of the selected strategies are required for the term of the grant. Examples of policies, programs, and practices under each strategy are also provided. Applicants may also implement more than one policy, program, and practice for each strategy, as staffing and resources allow.

Organizations will develop and implement campaigns, policies, practices, protocols, and/or action plans that address the selected strategy over the course of the grant and submit information on these activities and deliverables to CDPH.

[16] The CDPH team underwent a strategic planning process to prioritize shared risk and protective factors and connect these areas with community and societal-level change approaches.

C. Implement within a Defined Area Based on Need within the Priority Population

The targeted community must be a defined geographic area or neighborhood and cannot be solely a school setting. Although schools serve as place-based settings to access youth, prevention projects should not only focus on schools as a place to reach youth, but also involve the broader school district and community, in order to develop strategies at a community/societal-level.

A focus on one or more of the following priority populations for people who are/have:

- Black
- Latino/a/e
- Native-American/Indigenous
- Asian/Pacific Islander
- LGBTQ
- Residents who live in rural communities
- Experiencing low socioeconomic status
- Women, girls, and gender expansive
- Non-US born
- Disabilities
- Intersections of these identities

D. Conduct a Planning Process

The initial six (6) months of the project will focus on program planning to assess the appropriateness or responsiveness of the proposed strategies with the priority population and to build partnerships based on the submitted application. This process could include review of community assets, network mapping, needs assessments, strategic planning, Key Informant Interviews, surveys, focus groups, listening sessions, evaluation results, or other data, that are relevant to understanding the current context of SV prevention within the community. Resources and assets may include community leaders, coalitions, local businesses, faith leaders, collaborations, local policies, youth programs, the availability of violence prevention programs and services, or other initiatives related to the proposed project. Organizations are encouraged to reassess the fit of the strategies with the priority population on an annual basis. Any changes to the strategies or the priority population must be approved by CDPH before implementation.

E. Collaborate with Partner(s), Coalitions, and/or Collaboratives

Partners for the selected community/societal-level strategies are critical in creating broader change in the community, especially for those communities facing inequities. Organizations are required to have formalized agreements [e.g., Memoranda of Understanding MOUs] from partners for the selected strategy and priority population. Formal partnership or an MOU with a RCC is required if the lead Applicant is not an RCC. Participation in existing coalitions or collaboratives that address different forms of violence may include sexual violence, domestic violence, teen dating violence, child maltreatment, youth violence, community violence, or suicide. Partnering with the All Children Thrive, California (ACT-CA) (https://act-ca.org/) coalitions is encouraged, if such coalitions exist in the community of focus. ACT-CA is a community-led movement in jurisdictions throughout California to address childhood trauma, focusing on improving child and family wellbeing. CDPH collaborates with Public Health Advocates and the University of California, Los Angeles on administering and evaluating ACT-CA.

F. Ensure Organizational Capacity and Qualified Staffing

Organizational readiness and fit for the selected strategy and community engagement approach with the selected priority population are critical for project success. Organizations need to demonstrate:

- Experience in community/societal-level prevention strategies
- Sharing power and decision-making with community members
- Experience and strong connections in working with the selected priority population
- Support from the Board of Directors and all levels of management
- Flexible scheduling to allow staff to work in the community in evenings, weekends, or other non-traditional hours
- Support for livable wages and/or other supports for prevention staff due to the high rate of attrition in the field

Staffing

Organizations shall ensure adequate staffing with competencies are hired to complete the project activities. The following staffing patterns are required:

- Minimum 1.0 – 1.5 FTE program staff and .10 FTE manager. The staffing can be allocated or distributed among partners.

- A designated primary staff for all program and evaluation activities as part of the total FTE. It is strongly recommended that this staff person not be an entry level position.
- Subgrants to community agencies with expertise in working with the selected priority population, strategy, and/or approach when the organization does not have qualified program staff.

Staff Competencies

Given that community/societal-level strategies require skills to develop relationships with community leaders, partners, and members, prevention staff need to hold the following competencies:

- Experience or interest in community/societal-level strategies
- Experience in facilitating community and/or youth groups and interest or capacity in developing community leadership
- Capacity in forming relationships with partners, organizations, and community leaders
- Experience with priority populations and ability to provide linguistically and culturally appropriate services
- Ability to deal with complex issues to facilitate social change and transformation
- Self-direction, adaptability, creativity, and initiative

Entry-level prevention educator positions are not recommended for this type of work, especially for the designated primary staff.

G. Conduct a Health Equity Organizational Capacity Assessment

The Health Equity Organizational Capacity Assessment will be completed within the initial six (6) months to identify areas of improvement for their organizations and community context in supporting and advancing health equity. This assessment is expected to help organizations develop recommendations to increase capacity to reduce health inequities in their community. It is recommended that the assessment be completed in collaboration with partners. CDPH will provide a template that includes suggested capacity areas to address, guiding questions for assessing these capacity areas, and additional resources.

H. Participate in Training and Technical Assistance (TTA)

The organization is required to have all program staff participate in CDPH sponsored TTA events to foster professional development and networking. Annual TTA activities include two (2) in-person trainings; quarterly TA calls; quarterly peer networking calls or communities of practice; and quarterly web conferences. In addition, program staff and managers are required to participate in grant monitoring/TA calls with CDPH every six (6) months. The Executive Director (or designee) is required to attend one (1) virtual meeting every year.

Organizations are required to budget travel for two (2) yearly two-day trainings, one (1) in Northern California and one (1) in Southern California. There are no registration fees associated with these trainings.

- The designated primary staff is required to attend two (2) in-person trainings per year.
- Managers are required to attend at minimum one (1) in-person training per year.
- All program staff assigned to the project are required to attend at minimum one (1) in-person training per year.
- Community leaders are encouraged to attend in-person training when possible and their travel is to be budgeted by the organization.

In addition, the organization will develop, implement, and maintain a training and professional development plan for staff to ensure that all staff have the capacity to implement the project.

I. Comply with Administrative and Evaluation Reporting

Implementation Work Plan

The organization will develop and submit an initial Work Plan within the first 45 days of the Grant and update it annually. The Work Plan includes the activities that the organization will carry out each year to meet the Scope of Work (SOW) requirements (Attachment B: SOW). A Sustainability Plan will also be a required activity and deliverable in the final year of the performance period. Any changes to the Work Plan must be approved by CDPH. Additional details are outlined in the SOW (Attachment B). Further instructions will be provided upon award.

Logic Model

Organizations will develop and submit a Logic Model specific to their project based on the selected strategy and community engagement approach within 90 days of award. Components of a Logic Model consist of inputs, activities, and short, medium, and long-term outcomes pooled from the overarching CDPH RPE Logic Model (Appendix 3).

The RPE Program's intended outcomes include the following:

Short-term outcomes

- Increase in grantee's and partners' organizational capacity for:
  - community engagement and leadership
  - using a health equity approach that addresses gender and racial equity
- Increase in organizational partnerships and engagement in other community collaborations
- Increase in community dialogue around SV prevention Increase in visibility of SV as a problem in community through media, events, public art, dialogue etc.
- Increase in number and diversity of partnerships engaged in the community network implementing trauma-informed SV prevention work
- Increase in individual-level community leadership skills

Medium-term outcomes

- Increase in community awareness of SV as a preventable problem for the community
- Increase community connection and engagement in collective actions to prevent SV
- Increase in community-level protective factors
- Increased efforts to promote equitable leadership and hiring practices

Distal outcomes

- Increase in community connection and support
- Community level shift in norms protective against SV
- Increase in policies and procedures that are protective against SV

Long-term outcomes

- Reduction in perpetration and victimization of SV, health inequities, and discrimination in priority populations to achieve health, racial, and gender equity

- Reduction in sexual violence, domestic violence, teen dating violence, and other forms of violence with shared risk and protective factors
- Sustained community-wide protective environment for preventing SV

Evaluation Plan

The organization will be required to participate in data collection and evaluation activities according to the CDPH Evaluation Plan and provide evaluation results on a yearly basis in the Annual Report. This data is used by CDPH to submit it to the CDC. The organization will be required to allocate at least five (5) percent of its RPE staff time to implement CDPH evaluation activities. This time can be allocated among multiple RPE-funded staff as necessary. The organization will be provided with standardized outcome evaluation tools and reporting templates, utilizing both qualitative and quantitative methods. Ongoing TA will be provided to ensure that the organization's staff have the capacity to administer and document evaluation according to the minimum requirements documented in the Evaluation Plan. Grantees may choose to develop more extensive evaluation or documentation for their projects above and beyond these minimum requirements. The Evaluation Plan and evaluation tools will be provided upon award.

Bi-Annual Progress Report

This report collects information and data for evaluation, analysis, and monitoring of project performance and project objectives outlined in the Scope of Work, Implementation Work Plan and Evaluation Plan. Components include, but are not limited to, reports and updates related to: project activities; staffing; training; focus groups/stakeholder interviews; and outcome data. The grantee is required to complete and submit the Bi-Annual Progress Report using the approved Implementation Work Plan Template on or before the due date, determined by CDPH.

PART THREE: APPLICATION REQUIREMENTS AND SUBMISSION

A. GENERAL INSTRUCTIONS

All Applicants are to follow the instructions provided herein, using the attached forms. All sections, including Attachments, must be completed and submitted in the order requested. Any application that does not comply with this requirement will be considered non-responsive and will not be reviewed.

1) Develop applications by following all RFA instructions and clarifications issued by CDPH in the form of question and answer notices, clarification notices, Administrative Bulletins or RFA addenda.

2) Before submitting an application, seek timely clarification through participation in the Informational Teleconference of any requirements or instructions that are unclear or not fully understood.

3) Read all instructions carefully. Be sure to include all of the information required in the RFA, including all attachments. Re-check the application and utilize the included RFA Checklist to ensure completeness. Do not provide additional materials that are not requested, such as brochures or samples of materials. These will be discarded and not reviewed.

4) In preparing an application response, all narrative portions should be straightforward, detailed, and precise. Answer all questions in the order presented with clear titles for each section. CDPH will determine the responsiveness of an application by its quality, not its volume, packaging, or colored displays.

5) Arrange for the timely delivery of the application package(s) to the email address specified in this RFA. Do not delay until shortly before the deadline to submit the application.

6) Submit one (1) RFA Application package in PDF format which includes all required exhibits, attachments, documentation, and completed forms. Do not attach multiple files to your submission email. Your final application should be one (1) attachment to your message. Please use the following naming convention for the name of your attached file:

Your Agency Name_RPE RFA_2023

B. FORMAT REQUIREMENTS

Format the narrative portions of the application as follows:

- Single-spaced with one-inch margins at the top, bottom, and both sides.
- Use "Century Gothic" 12 point font.
- All RFA attachments that require a signature must be signed in blue ink or signed via secure Adobe Docu-Sign service. Signature stamps and generic "Fill and Sign" signatures within Adobe are not acceptable.

C. MANDATORY NON-BINDING LETTER OF INTENT

Prospective applicants are **required** to indicate their intent to submit an application. **Failure to submit the mandatory Non-Binding Letter of Intent will result in application rejection.** The mandatory Letter of Intent is not binding and prospective applicants are not required to submit an application merely because a Letter of Intent is submitted.

The Letter of Intent must be submitted on the applicant's letterhead and must be received no later than Thursday, November 9, 2023 by 5:00 p.m. PST. Submit the Letter of Intent using email (PDF with electronic signature) to:

Email: RapePrevention@cdph.ca.gov

The Subject Line should read as follows:

Letter of Intent RFA No. 23-10480 and include your agency's name.

D. SUBMISSION OF APPLICATION

All Applicants are required to submit one (1) signed application to the RPE general email inbox at:

Email: *RapePrevention@cdph.ca.gov*

- Applications must be *received and timestamped* by CDPH on or before November 29, 2023, no later than 5 p.m. PST. It is the sole responsibility of the applicant to ensure that CDPH receives the complete application package by the stated deadline.
- **Fax and US Mail applications are not acceptable.**
- Applications will have the date and time stamped upon receipt. Each application received by the due date will be reviewed for completeness and compliance with the instructions provided in this document. Incomplete, late, or non-compliant applications will not be reviewed or considered for funding.
- It is important to note that there is no guarantee that submission of an application will result in funding, or that funding will be allocated at the level requested. Expenses associated with preparing and submitting an application are solely the responsibility of the applicant agency and will not be reimbursed by CDPH.

PART FOUR: APPLICATION REVIEW AND SELECTION

The application review process will be conducted by CDPH staff to ensure that applicants meet the RFA eligibility criteria described in Part One, D., Eligibility Criteria and submitted all required documentation as described in Part Three, Application Requirements and Submission.

A. ADMINISTRATIVE AND COMPLETENESS SCREENING

CDPH will review applications for on-time submission and compliance with administrative requirements and its completeness. A late or incomplete application will be considered non-responsive and will be disqualified and eliminated from further evaluation. Applications submitted from non-eligible entities will not be reviewed.

Omission of any required document or form, failure to use required formats for response, or failure to respond to any requirement will lead to rejection of the application prior to review.

B. APPLICATION SCORING

Each application passing the Administrative and Completeness Screening will be evaluated and scored according to the selection criteria by CDPH staff on a scale of **0 to 150 points**. Each application will be scored for technical merit and potential for success, using the scoring system in the below table. Evaluation of the application will be based on the quality and appropriateness of the responses and elements in Part Five, Project Narrative and Corresponding Attachments. Scores will be based on the application's adequacy, thoroughness, and the degree to which it complies with the RFA requirements, meets CDPH's program needs, and demonstrates existing capacity and commitment to build capacity in SV primary prevention and equity.

The following table describes the value of each question to be used in the review.

5 Point Scoring	10 Point Scoring	15 Point Scoring	Interpretation	General basis for point assignment
0	0	0	Inadequate	Application response (i.e., content and/or explanation offered) is inadequate or does not meet CDPH's needs/requirements or expectations. The omission(s), flaw(s), or defect(s) are significant and unacceptable.
1-2	1-4	1-6	Somewhat Adequate	Application response (i.e., content and/or explanation offered) is barely adequate or barely meets CDPH's needs/requirements or expectations. The omission(s), flaw(s), or defect(s), are noticeable but manageable.
3-4	5-8	7-12	Fully Adequate	Application response (i.e., content and/or explanation offered) is fully adequate or fully meets CDPH's needs/requirements or expectations. The flaw(s), or defect(s), if any, are minor and acceptable.
5	9-10	13-15	Excellent or Outstanding	Application response (i.e., content and/or explanation offered) is above average or exceeds CDPH's needs/requirements or expectations. Minimal weaknesses, if any, are negligible. Applicant offers one or more enhancing feature, method or approach that will enable performance to exceed CDPH's basic expectations.

PART FIVE: PROJECT NARRATIVE AND CORRESPONDING ATTACHMENTS

A. TABLE OF REQUIRED DOCUMENTS

Applicants must complete the applicable narrative questions and attachments as outlined in the table below. Follow all requirements below carefully, including designated page limits. Any section of an Applicant's narrative that exceeds the page limit will not be reviewed. There are no page limits for Attachments.

Number	Required Document	Page Limit
1	RPE Application Checklist	--
2	Application Cover Sheet (Attachment A)	--
3	Justification for Selected Priority Population(s), Strategy, and Approach	2
4	Organizational Capacity	4
5	Organizational Chart	--
6	Project Description	4
7	Proof of 501 (c)(3) Status (Non-Profit)	--
8	Scope of Work (Attachment B)	--
9	Letter of Commitment from Your Agency	--
10	Memorandum of Understanding(s) (MOU) or Letters of Commitment from Participating Partner(s)	--
11	Budget Details – Year One (Attachment C)	--
12	Budget Narrative – Year One (Attachment D)	--
13	Livable Wage Print Out (from Your Agency's Location)	--

B. APPLICATION COVER SHEET (Attachment A)

Complete all sections of the Application Cover Sheet (Attachment A). A person authorized to legally bind the applicant must sign the Application Cover Sheet. If the applicant is a corporation, a person authorized by the Board of Directors to sign on behalf of the Board must sign the Application Cover Sheet.

C. JUSTIFICATION FOR SELECTED PRIORITY POPULATION(S), STRATEGY, AND APPROACH (30 points)

1. **(10 pts.)** Indicate the geographic boundaries for the primary community you will be engaging for your proposed RPE project and describe the community and priority population(s) of focus. Applicants should demonstrate an understanding of what current needs, SDoH, and root causes are contributing to disparities and impacting SV in the community and population(s).

   At minimum, applicants should provide their Healthy Places Index – Overall Score (HPI) for the geographic area for the primary community that you will be focusing on for your community engagement approach. The HPI score is reported on a scale of 0 to 100, with higher scores indicating better overall health outcomes and access to resources within a particular geographic area. The score is calculated based on a variety of indicators related to community health, including factors such as access to healthcare, environmental quality, housing affordability, and educational attainment. The HPI Score should be based on the geographic area where the proposed project will take place. Be as specific as possible about what your geographic area is. For example, if you are working in a neighborhood in South Sacramento, and not within the greater Sacramento area, use the zip code(s) of the neighborhoods where you are focusing your efforts.

   If no Healthy Places Index (HPI) is available for this geographic community, or the HPI does not fully show the need in your community of focus, please provide additional quantitative or qualitative data to demonstrate social, environmental, cultural, and structural conditions leading to inequities in this community. Examples of other data that

could be used include: California Safety, Health, Resilience, and Equity dashboard, community mapping; needs assessments; strategic planning results; Key Informant Interviews; focus groups; interviews; and evaluation results and lessons learned from current prevention programs that are relevant to the community.

2. **(10 pts.)** Demonstrate why your organization selected the proposed community/societal-level strategy for your community and selected priority population(s). Describe the project's appropriate "fit" with the community's culture, needs, and level of readiness.

   To demonstrate "fit" with the proposed focus area/strategy, provide data for at least one indicator from one (1) of the below categories to demonstrate why you chose the strategy area for your community:

   - Economic security
     Potential data sources: Healthy places index - Economic; California Safety, Health, Resilience, and Equity dashboard, any local survey, qualitative data, or other from examples listed for the question above.
   - Transforming gender norms
     Potential data sources: California Safety, Health, Resilience, and Equity dashboard, any local survey, qualitative data, or other from examples listed for the question above.
   - Improving community environments
     Potential data sources: Healthy places Index – Education, Housing, Neighborhood; California Safety, Health, Resilience, and Equity dashboard, any local survey, qualitative data, or other from examples listed for the question above.

3. **(10 pts.)** Demonstrate why your organization selected the community engagement approach. Describe what needs, assets and resources exist in your proposed community and how they will be addressed and/or leveraged during the implementation of this project.

D. ORGANIZATIONAL CAPACITY FOR SV PREVENTION AND HEALTH EQUITY APPROACHES (45 points)

1. **(10 pts.)** Describe your organization's commitment to SV primary prevention through a description of its history and experience with primary prevention and community-level strategies. Describe how the proposed project fits into your organization's goals and complements other efforts, and how the organization's leadership will support the proposed project.

2. **(10 pts.)** Describe your organization's commitment to SV primary prevention strategies that address health equity, and culturally responsive approaches that address health disparities to achieve equity for under-resourced populations in your community.

3. **(5 pts.)** Describe how your organization has engaged with or partnered with community members in your community, *with particular emphasis on your selected priority population(s)*. Include any formal agreements in place regarding partnerships with youth and adults in the community; specific roles of community members; and plans to recruit, retain, and engage youth and adult community members. Be specific about how, where, and for what periods of time your organization has worked with and included community members in your previous prevention work.

4. **(10 pts.)** Describe the organizational structure and staffing pattern that will support and implement the project requirements and work with your identified audience/community. Attach an organizational chart. Specify staff who will provide supervision and oversight. Discuss how primary staff designated for the project and key partners/subgrantees who will be implementing the project possess the necessary skills and competencies related to SV primary prevention, social change, and health equity approaches.

5. **(10 pts.)** Describe existing partnerships with diverse community-based organizations, community leaders, and organizations/members representing your selected priority population(s), demonstrating a commitment to comprehensive, community-level prevention. Include

your organization's history of involving both traditional and "non-traditional" partners in SV prevention work, such as: coalitions, task forces, the business community; associative life (e.g., clubs, organizations); local government; parks and recreation; youth organizations or sports teams; faith leaders; job development agencies; or other sectors of the community. Describe how existing partnerships will be leveraged and new and existing partnerships and collaborations will be fostered to achieve success in the proposed project.

E. PROJECT DESCRIPTION (50 points)

The project description narrative must demonstrate the applicant's knowledge, experience and ability to successfully design, implement, and evaluate the proposed project. The narrative should include enough detail to demonstrate how the activities will build upon community strengths and resources, thereby enhancing community capacity for the long-term work of increasing health equity; and why this project was chosen for the intended audience and community. The description should include the program requirements as described in PART TWO (2) of the RFA for the selected strategy and approach.

1. **(15 pts.)** Provide a comprehensive description of the proposed project, including the proposed strategy (from Appendix 1), community engagement approach, setting, risk and protective factors for violence that are addressed, proposed outcomes, intended audience(s), and major project activities. This description should align with the SOW (Attachment B) and Logic Model (Appendix 1). The application should demonstrate the link between the community's needs and how the proposed strategy and approach will meet the strategy's intended outcomes.

2. **(10 pts.)** Describe the roles, responsibilities and engagement of key stakeholders and partners in the community in planning, implementing, and evaluating this project. How will community members and organizations engage in decision-making and how will your organization share power with community?

   IF YOUR ORGANIZATION IS NOT A RAPE CRISIS CENTER: Describe how you are partnering with your local rape crisis center for this project. Your

organization must have a subgrant with the RCC in your community, as defined by the CalOES RC Program.

IF YOUR ORGANIZATION IS A RAPE CRISIS CENTER: Describe how you are partnering with other community-based organizations in your community for this project. Your organization must have a subgrant with a CBO.

3. **(10 pts.)** Describe how the project activities will address health disparities, SDoH, and increase equity among the selected priority population(s) in your community.

4a. **(15 pts.) IF APPLYING FOR C2H OR PROMOTORES/CHW APPROACH**: Describe how the project will be tailored to the culture of the selected community; how the project builds upon existing community strengths and assets; how community members will be engaged in prevention efforts, with particular emphasis on members representing your selected priority population; and how the project cultivates project participants to become leaders regarding your selected prevention strategy.

4b. **(15 pts.) IF APPLYING FOR COALITION BUILDING APPROACH:** Describe how your organization will leverage existing coalitions, build coalition membership, and include individuals who work on behalf of priority populations or are those with lived experience, specifically those representing your selected priority population. Describe how you will engage individuals or organizations within the coalition that can educate about the need for policy change and/or engage in decision-making around the selected prevention strategy.

F. DOCUMENTATION OF NON-PROFIT STATUS

Certify eligibility to claim non-profit status and include this documentation as an Attachment. Any of the following is acceptable evidence of nonprofit status:

1) A reference to the applicant organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code;
2) A copy of a currently valid IRS tax exemption certificate;
3) A statement from a State taxing body, State Attorney General, or other appropriate State Official certifying that the applicant organization has a

nonprofit status and that none of the net earnings accrue to any private shareholders or individuals;

4) A certified copy of the organization's certificate of incorporation or similar document that clearly establishes nonprofit status.

G. SCOPE OF WORK (Attachment B)

A Scope of Work (SOW) template is provided as Attachment B that includes the required components of the project activities and deliverables for the five (5) budget periods. For the purpose of this RFA, attach the SOW template provided and check the boxes for the selected strategy and community engagement approach.

H. LETTERS OF COMMITMENT/MEMORANDA OF UNDERSTANDING (10 points)

1) **(5 pts.)** Attach a Letter of Commitment (LOC) from the Executive Director, Board Chair, or other organizational leadership demonstrating the following:

- ❖ Support for the project and a commitment to identify opportunities for additional funding or resources;
- ❖ How primary prevention and equity is integrated into the mission of the organization;
- ❖ Support for organizational change that will embrace engaging in a process that may necessitate transformation;
- ❖ Integration and engagement of community into organizational, prevention, and community-based work;
- ❖ Assurance of primary RPE prevention staff and Executive Director or designee attendance at all CDPH required TTA activities, participation in CDPH evaluation activities, and presentation of project results at grantee meetings convened by CDPH.
- ❖ Commitment to flexible scheduling to allow staff to work in the community, which may include evenings and weekends or other non-traditional hours
- ❖ Support for livable wages and/or other forms of support for prevention staff due to the high attrition in the field

2) **(5 pts.)** Attach a minimum of one (1) MOU or Letter of Commitment from a community partner who will be directly participating in the proposed project, stating their readiness and commitment to support the proposed project.

IF YOUR ORGANIZATION IS NOT A RAPE CRISIS CENTER: Provide a MOU or LOC from a local rape crisis center as a subgrantee.

IF YOUR ORGANIZATION IS A RAPE CRISIS CENTER: Provide a MOU or LOC from a CBO as a subgrantee.

If a MOU is not available at time of application submission, it must be provided within 30 days of notice of grant award. See Appendix 4 for a sample MOU.

I. BUDGET/BUDGET NARRATIVE (Attachments C and D) (15 points)

1. **(5 pts.)** Develop a detailed budget for the first year of the grant. The project budget request must be submitted on the budget forms provided. You may use either Word or Excel format. Round all dollar amounts and percentage figures to whole numbers.

2. **(10 pts.)** Provide a brief narrative explanation that correlates with the proposed project, for each line item in the budget, such as major responsibilities for personnel and operating expenses. For personnel line items, explain the time allocation by objective for each position in the budget. For operating expenses, explain the expenditures for each line item and justify their inclusion.

Budget and Budget Narrative should adhere to all requirements detailed below.

❖ *PERSONNEL*

Personnel includes all personnel costs to operate the project. Follow the project requirements for staffing outlined for each community engagement approach.

a. List personnel by job category or classification not by name to allow for staff turnover.

b. Indicate total monthly salary or salary range for full time equivalents (FTEs). The salary range stated should include any anticipated

increases (i.e., cost-of-living adjustments and merit salary adjustments). Demonstrate your organization's commitment to providing a livable wage for staff. RPE staff, especially the designated primary staff, should not be entry level positions based on the skills and competencies needed to effectively implement the strategies.

c. For the purposes of this application, use the livable wage calculator found here: **https://livingwage.mit.edu/** for a family size of *2 adults (both working) with 1 child*. **Print the page(s) results for your city/region and attach following your Budget Detail page of your application.**

d. Indicate percentage of time the position will be utilized in this project (e.g., 20 hours of work within a 40-hour week is 50 percent). All percentages should be in whole numbers. If biweekly pay periods cause the monthly salary amount to vary, indicate the variance in a footnote at the bottom of the page. Note that organizations must ensure that a minimum of five (5) percent of staff time is dedicated to evaluation activities.

e. Indicate the amount requested per position based upon the monthly salary ranges and total amounts. If the percentage rate for benefits differs for various positions, indicate the specific amount for each position on a separate detail sheet.

f. Subtotal all personnel costs.

g. Fringe Benefits should be calculated and include your agency's costs for the employee's health, vision, dental premiums, and other fees incurred that contribute to the Overall Personnel Costs.

❖ *OPERATING EXPENSES*

Operating Expenses include all costs except personnel/fringe costs. List only those items of operating expenses that apply to this project.

Project funds cannot be used for purchase or renovation of buildings, facilities or land, or the purchase of major equipment. Major equipment is defined as property costing over $5,000 with a life expectancy of one (1) or more years.

Examples of common operating expense line items are provided in the template. The following is a list of operating expense items most commonly recognized by the State:

a) **General Expenses** – Includes office supplies, books, manuals, and publications.

b) **Other Expenses** – Includes utilities, telephone, space, insurance, equipment rental, postage, and duplication. These expenses must be itemized identifying the cost for each.

c) **Equipment** – Minor equipment is described as equipment with a unit price of under $5,000 and a life expectancy of less than one (1) year.

d) **Travel** – Is reimbursed at current California Department of Human Resources rates (CalHR). Mileage should indicate the number of miles for ground transportation and rate per mile as defined by CalHR at the beginning of every year. For airfare, indicate the number and destination of trips and expected cost per trip. Current Per Diem rates may also be found on the CalHR webpage and should be verified at the beginning of every year. Travel should specify the number of days and rate per day. Grantees are required to pay for travel and lodging for all budgeted staff to attend training activities sponsored by CDPH and should budget according to the project requirements in the Travel line item. For this five (5) year performance period, RPE will hold two (2) annual training events to include one (1) located in Southern California and one (1) located in Northern California. There are no registration fees for these CDPH-sponsored training events. For more details, please refer to Part Three, Project Requirements under the section describing required training, technical assistance, and professional development. No out-of-state travel is allowed without prior written approval of CDPH.

e) **Subgrantees** – Applicants planning to use subgrantees in the performance of the work must identify each proposed subgrantee, if known, at the time of application submission; each known subgrantees's expertise; and describe the responsibilities to be assigned to each subgrantee. RCC Applicants must include a CBO subgrantee, and CBO Applicants must include an RCC subgrantee, that aligns with the SOW activities. Include a description of plans for overseeing the performance of subgrantees. Notwithstanding the use of any subgrantees, the applicant will ultimately be responsible

for performance of all terms and conditions of the resulting grantee. The State reserves the right to approve changes in subgrantee selection. *Generally, subgrantees are not to be paid over $350 per eight-hour day. Special subgrantees may be paid at a higher rate per day based on prevailing rates and other special considerations addressed in the blanket justification. In no event is the subgrantees to be paid more than the hourly salary rate established for state employees in similar classifications.* Include in the application the subgrantee's title, hourly rate, and number of hours to be worked (e.g., per week, per month). Each subgrantee must be detailed within your SOW. Next to the subgrantee's name, list the SOW goal and objective of each subgrantee's responsibilities.

f) **Staff Training** – Costs and fees for meetings, trainings and conferences not provided by CDPH, but attended by project staff are reimbursable.

g) **Scholarships/Stipends** - Funds provided to offset the cost of volunteerism for community members, and the amount is to be negotiated with CDPH.

h) **Indirect Costs** – In accordance with Congressional legislation, Section 393B of the Public Health Service Act [42 U.S.C. 280b-1c], in lieu of indirect costs, the recipient may not use more than five percent of the amount received for each fiscal year for administrative costs. Express either as a percentage rate and total, or as a total cost only, and specify how total costs were calculated. **The reimbursable rate for Indirect Costs may not exceed 5% for any given year.** The maximum percentage will never change. These are overhead costs that are not directly identifiable to the applicant or to the applicant's project and are generally expressed as a percentage of total personnel costs plus fringe benefits.

J. NON-REIMBURSABLE ITEMS – RPE FUNDING CANNOT BE USED TO:

- Pay for more than five (5) percent of the total award received each fiscal year for administrative expenses. This five percent cap is in lieu of, and replaces, the indirect cost rate.
- Provide direct counseling, treatment, or advocacy services to victims or perpetrators of sexual violence (with the exception of rape crisis center [RCC] hotlines).

- Pay for media or awareness campaigns that exclusively promote awareness of where to receive victim services.
- Fund research.
- Pay for furniture or equipment. Any proposed spending must be clearly identified in the budget.
- Equipment is defined in 45 CFR 75 which states that equipment has a useful life of more than one (1) year and has a per-unit cost of $5,000 or more.
- Pay for lobbying or election-related activities.
- Project funds cannot be used for meals or refreshments served at meetings, workshops, training sessions, etc. and/or conducted by grantees or subgrantees.
- Pay for swag/promotional items defined as "gifts" or "giveaway items" used to promote projects (such as mugs, cups, lapel or stickpins, pens or pencils, clothing, and key chains) are also not allowed.
- Support religious activities, including, but not limited to, religious instruction, worship, prayer, or proselytizing.
- Reimbursement of costs that are not consistent or allowable according to local, state, or federal guidelines or regulations.
- Reimbursement of costs incurred prior to the effective date of the Agreement.
- Purchase or improvement of land, or building alterations, renovations, or construction.
- Fundraising activities.

PART SIX: AWARD ADMINISTRATIVE INFORMATION

A. GRANT AWARD PROCESS

The award of the grant is based upon a competitive application review and selection process. All applicants will be notified directly of their application status by **December 22, 2023**. The State reserves the right to negotiate the agreement and not to award a grant if negotiations are unsuccessful. If an Applicant fails to finalize the grant, the State reserves the right to fund another application. Once an application is selected for funding, the applicant will receive a grant with CDPH. Grant documents that will be required can be viewed in Appendix 5. The grant will incorporate the proposed SOW and budget. During the course of the grant, if unanticipated changes occur that impact the SOW or budget, those changes must be approved prior to implementing those changes and it must be submitted via email to CDPH. A formal grant amendment may be required based on those changes.

B. GRANT TERMS

The term of the resulting grant is expected to be sixty (60) months and is anticipated to be effective from February 1, 2024 through January 31, 2029. The grant term may change if CDPH cannot execute the agreement in a timely manner due to unforeseen delays. CDPH reserves the right to extend the term and increase the funding amount of the resulting agreement via an amendment as necessary to complete or continue the services. Grant amendments are subject to satisfactory performance and funding availability.

Following the award notification, grant negotiations will occur with the potential grantor in a timely manner. Following grant negotiations, the grantor is required to submit a final Budget and Budget Justification in accordance with CDPH requirements, which will become part of the formal grant. A standard SOW will also become part of the formal grant. Upon completion and approval of these documents, the grant will be fully executed and work will commence. The resulting grant will be of no force or effect until it is signed by both parties and approved by CDPH. The grantor is hereby advised not to commence performance until all approvals have been obtained. Should performance commence before all approvals are obtained, said services may be considered to have been volunteered if all approvals have not been obtained.

The grantee is to expend funds in accordance with the negotiated line item budget. If changes in line items, salary ranges, or staffing patterns requires modifications, the grantee must request a budget modification. It is up to the discretion of CDPH whether or not to approve the modification.

C. AWARD APPEAL PROCESS

Notice of the intent to award shall be posted on the IVPB website on December 22, 2023. If any Applicant prior to the Final Award Announcement, appeals the award, on the grounds that the Applicant would have been awarded the grant had CDPH correctly applied the evaluation standard of the RFA, or if CDPH had not followed the scoring methods in the RFA, the grant shall not be awarded until either the appeal has been withdrawn or CDPH has decided the matter. Only those submitting an application consistent with the requirements of the RFA and are not awarded a grant may appeal. There is no appeal process for applications that are submitted late, noncompliant, or incomplete. No award Applicant may appeal the grant award-funding amount.

An Applicant may appeal the award decision. The Applicant must submit an appeal letter to RapePrevention@cdph.ca.gov by **Tuesday, January 2, 2023 by 5:00 p.m. PST.** Appeals must include a detailed written statement specifying the grounds for the appeal. The Chief of CDPH/IVPB, or designee, will decide based on the written appeal letter. The decision of the Branch Chief of IVPB, or designee, shall be the final remedy. Applicants will be notified by e-mail within 15 days of the consideration of the written appeal letter. CDPH reserves the right to withdraw or respond to the satisfaction of CDPH.