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Request for applications (RFA) Terms of reference (ToR)

**Provision of Sub-Recipient (SR) Services to Implement Prevention
Programmes for Adolescent & Young People (AYP),
Global Fund Grant: Apr 2022 – Mar 2025**

Closing date: 25 May 2022, 16h00

Please note:

- Check AFSA website (www.aids.org.za) for updates related to this RFA
- Email enquiries with the correct bid number as the subject line to:
 - applications@aid and
- Answers to frequently asked questions will be posted on the AFSA website, for those received before the stipulated date.
- Non-compulsory briefing sessions were held in the district.

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Abbreviations

AYP	Adolescents and Young People
AFSA	AIDS Foundation of South Africa
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
B-BBEE	Broad- Based Black Economic Empowerment
CCM	Country Coordinating Mechanism
CSE	Comprehensive Sexuality Education
DOH	Department of Health
ECD	Early Childhood Development
GBV	Gender Based Violence
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General Practitioner
HTS	HIV Testing Services
HIV	Human Immunodeficiency Virus
HIVSS	HIV Self Screening
IEC	Information, Education, Communication
KP	Key Populations
LSA	Learner support agent
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MSP	Male Sexual Partners
MSM	Men who have sex with Men
NSP	National Strategic Plan
PCA	Provincial Council for AIDS
PEP	Post-Exposure Prophylaxis
PHP	Primary Health Care
PLHIV	People Living with HIV
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
QA	Quality Assurance
RFA	Request for Application
SA	South Africa

SAPS	South African Police Services
SAW	Social Auxiliary Worker
SGB	School Governing Body
SMT	School Management Teams
SR	Sub-Recipient
SSR	Sub-sub-recipient
SW	Sex Worker
TB	Tuberculosis
TG	Transgender
TOR	Terms of Reference
TVET	Technical, Vocational, Education and Training

1. INTRODUCTION AND BACKGROUND

The South Africa Global Fund Country Coordinating Mechanism (GF CCM) provides oversight for the implementation of HIV and TB programmes funded by the Global Fund to Fight AIDS, TB and Malaria (GF) in the country. The GF CCM has recommended that AIDS Foundation South Africa (AFSA) be appointed by the GF as one of the four Principal Recipients (PRs) that will implement programmes to be funded by the grant. The other three PRs are: Beyond Zero, NACOSA and Department of Health. PR serves as a grant manager while sub-recipients (SRs) will be the main implementers of the programmes.

AFSA therefore invites interested non-profit organisations, organisations, and government departments, experienced in the modules listed under the scope of work and with presence in the districts identified, to apply to be considered as SRs. It is important to note that SRs are recommended by the PR but appointment is subject to GF CCM approval.

Applicants are not required to submit implementation plans and budgets as part of this call for applications.

2. SUB-RECIPIENTS

2.1. The role of sub-recipients

SRs have a contractual relationship with, and are accountable to the PR. They are the direct implementers of programmes financed by GF but can sometimes work through SSRs.

The responsibilities of SRs include the following:

- Sign grant agreements with the PR and contract with SSRs, where necessary, under the guidance of PR.
- Implement grants under the oversight of the PR and GF CCM and manage SSRs and take responsibility for their performance where applicable.
- Propose changes to the PR on work plans and budgets when necessary.
- Participate in performance review meetings to improve grant performance and impact.
- Report on programme progress and challenges to the PR through regular reports.
- Identify key issues and implementation bottlenecks and escalate to the PR for guidance.
- Provide information to the PR, GF CT, and GF CCM and its structures when requested to do so.

2.2. Organisational requirements

The minimum requirements to serve as an SR include:

- Sound governance frameworks, demonstrated by, inter alia, by a diversified board and management team, and at least one year audited financial statements.
- Appropriate staffing in key areas (programme and financial management, human resources, programme implementation and management, monitoring and evaluation and procurement management).
- Experience of managing grants and SSRs, where applicable.
- A track record of effective and efficient implementation of similar activities, preferably in the target district.
- A sound system of management and financial controls.
- A sound monitoring and evaluation system, tools and procedures amongst other requirements.

These organisational requirements will be assessed during the evaluation process. Further information can be found on the Global Fund website (www.theglobalfund.org) including the GF Grants Regulations.

2.3. Minimum Requirements for SRs

A potential SR must have proven ability to manage programmes in the specific modules in the RFP and must also be capable of performing the functions of an SR which includes the following:

Effective leadership and governance structures

- Legal status such as voluntary association, trust, non-profit company (NPC) etc. to enter into contracts.
- If submitting as a consortium, then documents corresponding to the consortium must be submitted (including joint B-BBEE certificate). If submitting as a partnership that is not legally constituted, then one organisation must submit as the applicant (SR) and then specify the other partner/s as its sub-sub-recipients (SSRs). In this case, AFSA will contract and liaise with the SR and the SR will contract and liaise with its SSRs.
- Have a properly constituted board that provides oversight over organisational matters.
- Effective organizational leadership using transparent decision-making processes.

- Adequate skilled and experienced staff to manage implementation of the modules, including procurement, monitoring and evaluation, and finance.
- Knowledge about and ability to communicate and network with relevant district stakeholders and structures such as government departments, local and district AIDS Councils.
- Appropriate internal control systems, including policies and procedures, to prevent and detect fraud or misuse of resources.

Financial management system

- Accounting system that can correctly record all transactions and balances by source of funds with clear references to budgets and work plans.
- Ability to monitor actual spending in comparison to budgets and work plans.
- Ability to manage disbursement of funds to SSRs and suppliers in a timely, transparent and accountable manner.
- Ability to produce timely and accurate financial reports.

Monitoring and evaluation

- Monitoring and Evaluation (M&E) system for routine monitoring of activities/interventions.
- Mechanisms and tools to collect and analyse data, and report on programme performance.
- Ability to produce timely and accurate programmatic reports.

Promoting participation from supported communities and key populations

To encourage participation of communities served by the programme, some modules /activities of the programme will be reserved for implementation by emerging community-based organisations led by women, youth, people living with HIV (PLHIV), women living with HIV (WLHIV), key populations and people with disabilities. These include certain components of the human rights and advocacy module, awareness campaigns, community mobilization and community-led monitoring of programmes. Applicant SRs in this category must meet the same criteria as the other categories, but consideration will prioritise organisations falling in the category highlighted above.

3. SCOPE OF WORK

3.1.HIV epidemic

South Africa has the largest HIV epidemic in the world, with an estimated 7,640,000 people living with HIV (PLHIV) (all ages) in 2019. This equates to an HIV prevalence of 19% among those aged 15-49 years. Women experience a disproportionate HIV burden throughout the life cycle, but this gender disparity is most pronounced among adolescent girls and young women (AGYW) aged 15-24 years, whose HIV prevalence is three times greater than their male peers (10.2% compared to 3.4%) (Figure 1).

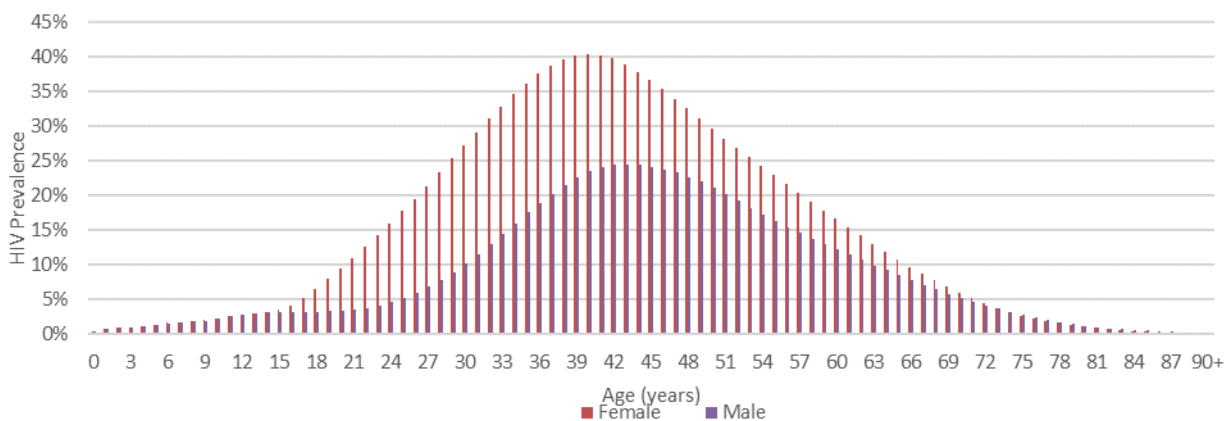


Figure 1: HIV Prevalence in South Africa, by age and sex (2019)

The country has made great strides reducing new HIV infections. Between 2010 and 2019, HIV incidence fell by 56.8% overall, and by 54.2% among AGYW aged 15-24 years, 49.8% among female sex workers (FSW), and 54.1% among men who have sex with men (MSM). Seventy percent of adolescent boys and young men (ABYM) aged 15-24 years are circumcised, and South Africa has effectively eliminated mother-to-child transmission with a rate of 3.3%. In 2019, 92% of the condom distribution need was met, primarily through support from the government.

In 2020, South Africa began pre-exposure prophylaxis (PrEP) scale-up into public facilities, expanding from 128 sites in 2019 to 1428 today. Since June 2016, 164,537 people have been initiated onto PrEP (106,401 in 2020), 77% of whom are female. Despite great progress, prevention remains a top priority. In 2019, South Africa had 190,000 new

HIV infections. Vulnerability to HIV peaks among adolescent girls around age 18 years, however, the age and gender disparity is greatest among 16-year-olds, when girls are 13 times more likely to get HIV than their male peers (Figure 2).

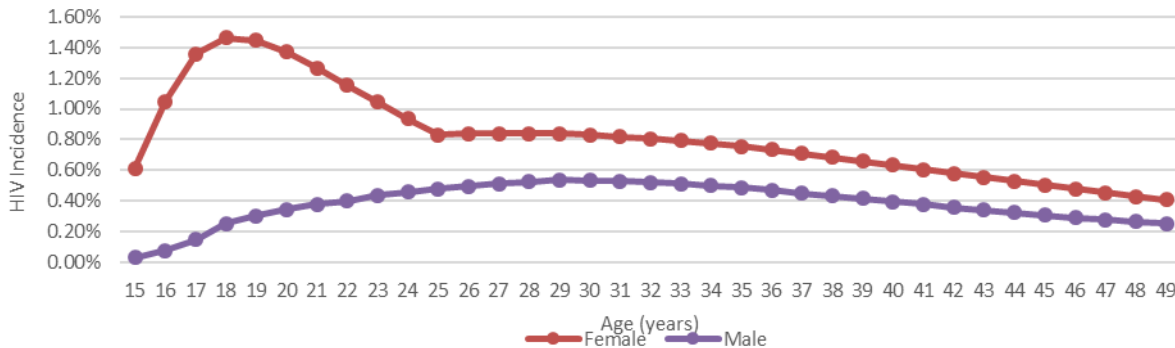


Figure 2: HIV Incidence in South Africa, by age and sex (2019)

The response is guided by the National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022, which aims to reduce new HIV infections by more than 60% and cut TB incidence by at least 30%. The country is developing a NSP catch-up plans to revitalize HIV and TB Programmes in 2021 and 2022, ahead of developing the NSP for 2023-2028.

At the heart of the NSP is the strategy to “focus for impact”, using the most granular information and insights available. The country combines district-level data about HIV from several sources in a statistical model (Naomi) to generate real-time geospatial maps (Figure 3). Given the geographic variance in South Africa’s epidemic, the NSP prioritizes concentrated efforts in the 27 districts that account for 82% of all PLHIV and the majority of new infections.

3.2.HIV Incidence

Given that nearly one in three new HIV infections in South Africa occurs among Adolescent Girls and Young Women (AGYW) aged 15-24 years (55,000 in 2019) HIV prevention efforts among this vulnerable population is critically important. Comprehensive Sexuality Education (CSE) was introduced in 2000 within the subjects of Life Orientation and Life Skills to ensure that learners get accurate messages about sex, sexuality, gender and relationships.

Yet, HIV knowledge among AGYW remains low, at 46.1%.ⁱ South Africa's ongoing Gender Assessment points to numerous other social, structural and behavioral risk-factors that make AGYW vulnerable to HIV. These include low condom use (49.8%ⁱⁱ), teenage pregnancy (5.2% among 14-19-year-olds), alcohol and drug use, child marriage (4%), gender inequality (South Africa ranks 114th out of 189 countriesⁱⁱⁱ), harmful gender norms (hegemonic masculinity), and gender-based violence (GBV).

South Africa's Gender Assessment notes that ABYM are neglected in the HIV response.^{iv} Few interventions target this group, except circumcision programs. As a consequence, the epidemic among Adolescent Boys and Young Men (ABYM) is surging. HIV prevalence has increased almost 7-fold among adolescent boys aged 15-19 years, from 0.7% in 2012 to 4.7% in 2017.^v

This increase is likely attributable to new infections, not the aging of the cohort.^{vi} While HIV incidence has declined by 26% among AGYW aged 15-24 years (from 2.04% in 2012 to 1.51% in 2017), HIV incidence has increased by 11% among ABYM (from 0.44% in 2012 to 0.49% in 2017).^{vii}

Compared to AGYW, ABYM are more likely to have sex before the age of 15 years (19.5% vs. 7.6%), and more likely to have multiple partners (25.5% vs. 9.0%).^{viii} Condom use remains below 70%. Adolescent boys who know their status and are on treatment are also far less likely to be virally suppressed than their female counterparts (65.3% vs. 95.8%).^{ix} Data show that boys and girls are equally vulnerable to sexual abuse,^x yet boys are often stigmatized as potential perpetrators, limiting their access to post-violence care. This fuels a cycle of violence and harmful masculinity.^{xi}

Age-disaggregated prevalence data suggests a need for intensified programming aimed at young key populations. Among FSW, HIV prevalence increases with age, however, the 2018 South Africa Health Monitoring Study revealed that young FSW aged 16-24 years in Durban already have a prevalence of 65.4%.^{xii} Among MSM, HIV prevalence is highest in Cape Town among those aged 25-34 years, at 30.2%.^{xiii}

3.3.Objectives of the AYP programme

The Global Fund AYP Programme offers a comprehensive package of services that aims to improve the health, psychosocial and socio-economic wellbeing of Adolescent Girls and Young Women (AGYW) and Adolescent Boy and Young Men (ABYM) collectively known as Adolescents and Young People (AYP). The programme targets AYP, in and out of school, age 15-24 years, with the aim to effect risk reduction, behaviour change and empowerment.

Objectives of the AYP programme aim to;

- Decrease HIV incidence
- Decrease teenage pregnancy
- Increase retention in school
- Increase economic opportunities
- Reduce gender-based violence (GBV)

This call for applications seeks to identify organisations that are efficient and effective implementers of the scope of work listed below. Applicants need to have implemented similar programmes before, and preferably in the target sub-districts, districts or province. The specific scope of work includes interventions described below.

3.4. Programme Description

Programme coverage

Geographic coverage:

PROVINCE	DISTRICT	SUB-DISTRICT
KwaZulu-Natal	Zululand	AbaQulusi
	King Cetshwayo	uMhlathuze
Mpumalanga	Ehlanzeni	Mbombela
	Gert Sibande	Govan Mbeki
North West	Bojanala Platinum	Rustenburg

The programme is aimed at:

- Adolescents and young people aged 10 – 24 years, all sexes, but with an emphasis on supporting young women.
- Men, with an emphasis on age group: 25 – 34 years.

Key programme implementation sites include:

- Quintile 1-4 primary /secondary/combined schools
- Safe spaces and satellite sites (with a focus on out-of-school youth, but also reaching in-school youth during weekends, holidays, no-school days and after school).
- Communities: any community space accessed by community members for their needs -community halls, sports fields, social grant pay points, and others.
- Tertiary institutions, universities and TVETs: This intervention will be led by NACOSA and implemented by Higher Health in close collaboration with other AYP SRs.
- Workplaces: to reach men. Mainly informal workplaces /under-insured workforce.

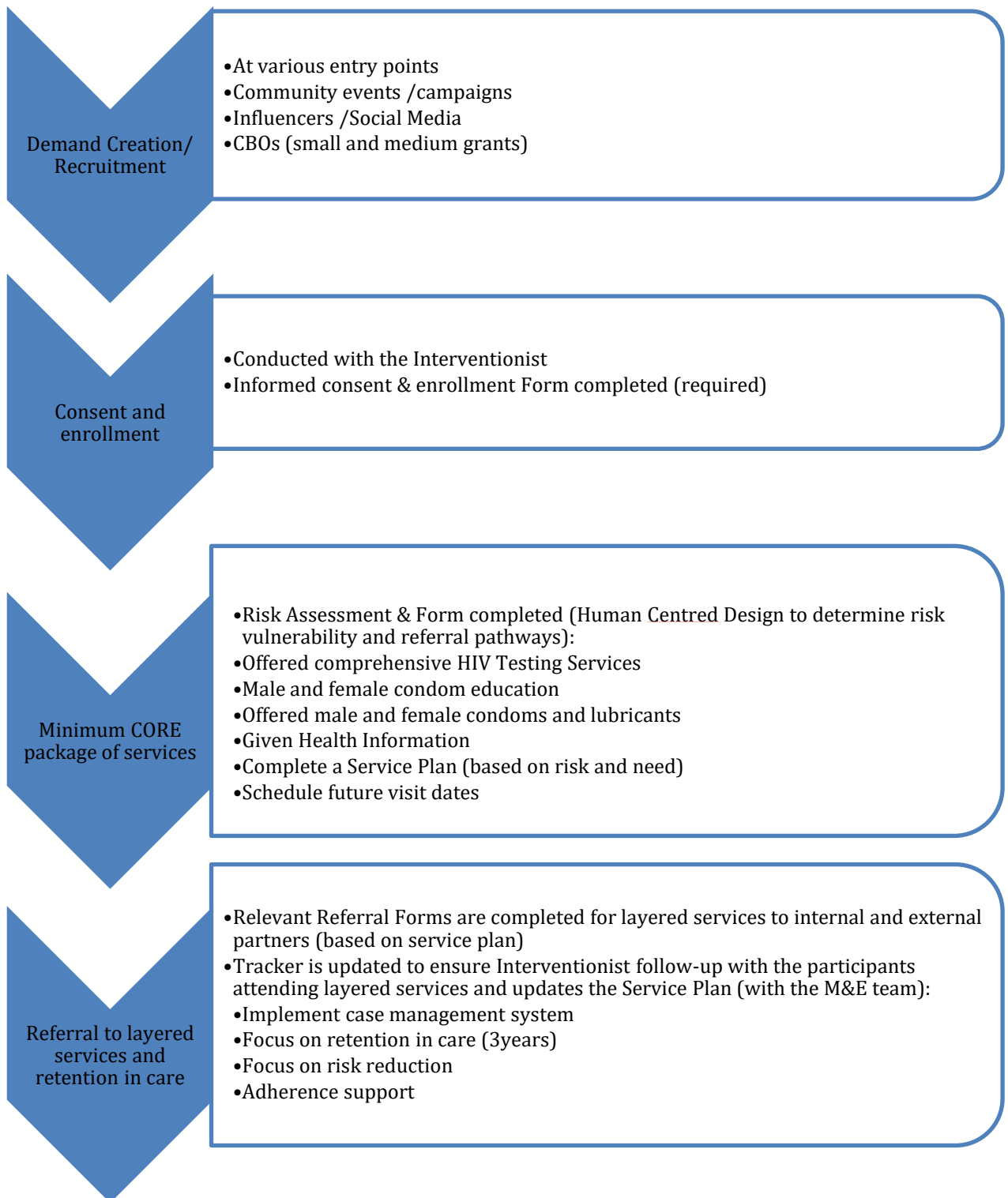
Interventions are structured, age-appropriate and evidence based to account for the evolving, unique emotional and physical developmental needs of beneficiaries. The AYP can enter the programme from a number of service entry points (schools, Safe Spaces and elsewhere in community) where they will receive a core package, inclusive of individual risk screening, and where they will be offered HIV testing, condoms and IEC materials.

Based on the AYP personal risk profile, the AYP will be directed to a range of layered health, behavioural and structural interventions and if required, they will also be supported to successfully access services offered via referral links.

When an AYP enters the programme, they will register via a biometric system (with their fingerprint), which will serve as their unique identifier. Thereafter the biometric system will track all future services that the AYP may receive. There will also be additional activities targeting and impacting the broader community and school contexts, male sex partners of AGYW as well as activities to strengthen youth.

All beneficiaries entering the programme need to receive the core intervention and be reassessed every 6 months. The following outcomes are anticipated from the core intervention:

- For programme staff to build immediate rapport with the beneficiary as trusted persons who can be called on.
- To extract the beneficiary risk and vulnerability profile of the beneficiary and flag them as high, medium or low risk
- To know the HIV status of the beneficiary (HIV positive, HIV negative, Status not known)
- To agree on a journey plan and motivate for the beneficiaries' engagement in the programme
- To register the beneficiary on the biometric system



Participant and service flow

Risk avoidance and age-stratified interventions to be provided to AYPs

Components	10 – 14 years	15 – 19 years	20 – 24 years
1. School-based interventions	Soul Buddyz Grassroots Soccer Kidz Alive adherence programme ISHP/ CSE	MTV Shuga Peer Education; Grassroots soccer; Career Jamborees ; Homework Support; Dignity packs; ECD Vouchers; Home visits; Psycho-social Support (PSS) Vutshilo 3 (HIV Pos AGYW and ABYM – age 18)	MTV Shuga Peer Education; Grassroots soccer; Career Jamborees ; Homework Support; Dignity packs; ECD Vouchers; Home visits; Psycho-social Support (PSS)
2. Higher Education-based interventions: TVETs & CET	N/A	Biomedical services including PrEP initiation and HPV screening Commodities via Vending Machines MTV Shuga. Mobile clinics	Biomedical services including PrEP initiation and HPV screening Commodities via Vending Machines MTV Shuga Mobile clinics where they don't exist
3. Community-based interventions		Access to the community adolescent-friendly safe spaces (CASS) to implement a range of programmes (e.g.) Teen Parenting programme	ESL light and Biz AIDS. Access to the community adolescent-friendly safe spaces (CASS) to implement a range of programmes Families Matter!; Traditional Authorities and Religious Leaders
4. Biomedical interventions	Biomedical services in line with ISHP, including HPV Vaccination ART referral, VL monitoring; Food vouchers; Adherence clubs	HTS/ HIVSS/ PrEP, SRHS: contraception, EC, STI, TB, condoms, lubricants Referrals for ANC and ToP HPV Vaccination and referrals ART initiation (NimART RNs), VL monitoring; Food vouchers; Adherence clubs	HTS/ HIVSS/ PrEP, SRHS: contraception, EC, STI, TB, condoms, lubricants Referrals for ANC and ToP HPV Vaccination and referrals ART initiation (NimART RNs), VL monitoring; Adherence clubs. Food vouchers; Cervical cancer and breast cancer awareness and education.
5. Male Sexual Partners-based interventions	N/A	Biomedical service and referrals Men's dialogues	Biomedical services and referrals Men's dialogues
6. Gender Based Violence	Provide longer term PSS support to survivors of violence; Trauma focused /trauma informed CBT; Stepping Stones.		

3.5. Biomedical Services

Biomedical /clinical services will form part of Safe Spaces and Community Based Service Delivery. The health services on offer for in-school and out-of-school adolescents will very similar. The programme will review and build on current community HIV testing services (HTS) practices to explore avenues including HIV self-screening for male sex partners, door to door home-based counselling and testing, “seek, test and treat” through outreach services and network referrals. Service provision will also take place through specialised health mobiles as part of out-reach services. In areas where specialised mobiles are not operating, beneficiaries will receive services at fixed facilities including PHC clinics, community health centres. The programme will integrate important symptom screens into the pre-test information session (for example, TB, STI and pregnancy screening).

Layered clinical services on offer

- HIV Testing services (including HIV self-screening)
- Condoms
- STI Screening
- Pregnancy Testing
- TB screening

TB services to be provided in the community

- Educate and raise TB awareness
- TB symptomatic screening, testing and linkage to care to be integrated in HTS services offered to AYPs.
- SR to collect sputum for TB testing from all AYPs presenting with TB symptoms.
 - Refer TB symptomatic clients to nearby health facilities where sputum cannot be successfully collected.
 - SRs to link with local facilities for referral
 - Provide adherence support & link defaulters back to treatment
- SR teams with nurses to initiate clients that tests TB positive on TB treatment and link to care in cases where the teams are unable to initiate clients on treatment.
 - SRs to use the TB register and report back to health facilities.
- Digital chest x-rays (DCXR)

- AYP SRs to partner with TB SRs where available for outreach activities for access to DCXR.
- TB confirmed clients to be initiated on treatment and referred to health facilities where there are no nurses on site to initiate clients on treatment.
- Monitoring and reporting
 - Report TB services using standardized DoH reporting system.
- TPT
 - Provide TPT for PLHIV after excluding TB.
- SRs to ensure MOUs with the districts include a clear referral pathway

3.6. Quintile 1-4 School based Interventions

- Programme coverage will include quintiles 1-4 schools.
- Both primary and secondary schools will be supported.
- Core package of services, Homework support, Career Jamborees, early childhood development (ECD) vouchers, home visits, referrals to community-based and biomedical services, psychosocial support;
- Delivered through support to DBE, building the capacity of school leadership structures to implement the:
 - comprehensive sexuality education (CSE) program,
 - DBE HIV/TB/STI Policy,
 - Integrated School Health Policy (ISHP).
- School health teams will include this staff:
 - Technical specialists, Programme officers, provincial technical coordinators, and 50 Learner Support Agents (per sub-district).
 - Learner support agents (LSAs) will be deployed to primary schools for the first time in this new grant, as well as high schools.
 - Professional nurses and enrolled nurses to the schools (4 nurses per sub-district), to ensure that the clinical teams visit the schools more regularly.
 - School governing bodies and school management teams will receive an intensive training in the beginning of the grant, and then annual refresher trainings thereafter.
 - Conduct separate trainings for parents, to sensitize them on the CSE, the DBE policy, and ISHP policy and its objectives.

- Support the DBE peer education programs, including roll out of MTV Shuga. Messaging will be tailored to emphasize the location-specific AYP issues (e.g. *ukhuthwala* in KwaZulu-Natal, gangsterism in the Western Cape).
- Renewed emphasis must be placed on engaging parents, Sexual Orientation, Gender, Identity and Expression (SOGIE), GBV, and mental health.
- Support to DBE will also fund implementation of the Common Elements Treatment Approach (CETA) for addressing trauma, depression, anxiety, reducing violence and alcohol abuse. This will be done by strengthening (training and supporting) the task-shifting of Learner Support Agents and Peer Educators.
- The “Breaking the Silence” approach is included in the programme design and may be introduced, pending results of ongoing pilots in two provinces, to make comprehensive sexuality education even more accessible.

3.7. Community-based services

Following a situational analysis, health (SRH interventions), psychosocial (life skills and psychosocial support) and structural interventions will be packaged in line with district specific needs and services available. A number of AYP, whether in or out of school, will be able to access these more specialized services / interventions unique to their risk profiles as part of “layered: services” e.g. a parenting skill programme an AYP has child rearing responsibilities or PrEP if they are a suitable candidate, adherence support group if they’re on ART.

These services can be offered at schools, safe spaces or through outreach.

- *Boys and Men’s GBV and Substance Use Dialogues*: Targeted tailored messaging for high-risk HIV groups including taxi drivers, township bar owners and mine workers.
- *Mobile / outreach services*: Outreach service sites will as far as possible deliver the same kinds of interventions as done at the safe spaces, with mobile teams bringing the services to the AYP, if the locales are far from the safe spaces.
- *Schools*: Some services will be provided as school-based after school programmes – for learners in school.

- Sessions with Local Formal and Informal Leadership Structures: Raise awareness and buy-in for school health policies
- Community Education and Engagement: Parents (e.g. Families Matter! approach), Traditional authorities (e.g. on *Ukhuthwala*), Religious leaders.
- Cervical cancer and breast cancer awareness and education

3.8. Safe spaces

Each district will have several safe spaces from where a range of health, psychosocial and structural services (“layers”) are routinely delivered to 15-24-year-old youth in/after school and out of school youth, with multiple outreach sites based at schools and in communities. Once a youth accesses the safe space and is assessed, these layered health, psychosocial and socio-economic services will be on offer. A Safe Space will support satellite / outreach sites based at schools and in the community. The Safe Space will be youth friendly and will attract AYP through fun, recreational programmes and interactive media. Once a youth accesses the Safe Space and is assessed, core and layered health, psychosocial, socio-economic and recreational services will be on offer. Youth will also be linked to relevant services offered in the community.

3.9. Satellite Sites

Teams will be deployed to satellite sites that provide decentralized services to ensure greater access by programme beneficiaries. Satellite sites could include schools, churches, community halls, community-based internet wifi hotspots and other suitable community spaces to deliver interventions to AYP. As far as possible, the outreach teams will provide the same level of service as those rendered via a safe space. Once an AYP accesses the outreach site and is assessed, core and layered health, psychosocial, socio-economic and recreational services will be on offer.

3.10. Digital and online health

The Programme must provide online services through telemedicine and e-pharmacy. Must be implemented for all key and vulnerable populations. This includes building on lessons learned during COVID-19 adaptations (e.g. online outreach to clients). Services must include virtual consultations, reporting poor services, service unavailability, human rights violations, psychosocial support. Must also introduce online ordering and dispensing of commodities and medication (“e-pharmacy”), combined with telemedicine. Through the e-pharmacy, the following must be available: PrEP, PEP, ART, HIV self-screening, lubricants, condoms and HPV and STI self-screening kits.

3.11. Linkage to services /layers

To improve linkage to care, the programme will advocate implementing the following set of strategies:

- Immediate referral to HIV care and ART following an HIV diagnosis;
- Use of broad-spectrum of the cadre of counsellors, patient navigators
- Proactive engagement and tracking of patients who miss clinic appointments and/or are lost to follow-up, including intensive outreach for those not engaged in care within 1 month of a new HIV diagnosis, to retain person living with HIV in care and to locate and re-engage patients lost to follow-up.

Layered clinical services on offer;

- PrEP
- ART and viral load monitoring
- STI Treatment
- Termination of Pregnancy and Post-abortion care
- TB prevention therapy and treatment
- Mental Health Services

The following layered services will also form part of the AYP programme:

1. Peer education, through MTV Shuga series and content on HIV, GBV, Substance Abuse
2. Individual and group psychosocial therapeutic interventions
3. Risk reduction programmes like PrEP and IPV counselling
4. Structured support groups, e.g. Teen parenting, Vhutshilo 2.2, adherence and grief support.
5. Economic strengthening programmes. This programme will focus on skills development, income generation activities, livelihoods support and mentorship. The primary target for this “GLO light” Programme is the NEETS, aged 20-24 years. To strengthen engagement with the private sector and for sustainability purposes, a sub-set of girls who complete the GLO light Programme must be offered BizAIDS’s entrepreneurship program. This will complement the entrepreneurship and mentorship arm of “GLO light”.
7. Access to internet-based programmes
8. Health service provision, including HTS, STI and TB screening, contraceptives and condom distribution, pregnancy testing and emergency contraceptives, PrEP will be provided
9. Programmes for parents / caregivers of AYP to establish nurturing relationships and reduce the risk of violence against teens in and outside the home and creating a nurturing and supportive home environment

3.12. Referral and linkage to external services

If services are not available at the schools and safe spaces, the beneficiary will be referred and linked to services offered by other stakeholders in reasonable proximity to the school, safe space or outreach site. To this end there will be an updated resource directory at every safe space and at every outreach site. In addition, the implementation teams will also engage stakeholders to ensure greater mobilization of stakeholder services rendering.

3.13. Outputs and Targets

There are three coverage indicators for the AYP Program, the indicators and targets are featured in the tables below, categorized by sex (AGYW or ABYM). Each indicator is further differentiated by age category (10-14 years), (15-19 years) or (20-24 years), but this age split is not shown in this document -refer to performance framework for details. These are draft targets and are subject to change before programme initiation and revision during implementation stage.

YP-Other 2: Percentage of adolescents and young people aged 10-24 years reached with HIV prevention programs- defined package of services - AGYW

Subdistricts	Year 1 (60%)	Year 2 (70%)	Year 3 (80%)
mp City of Mbombela Local Municipality	60231	70269	80308
mp Govan Mbeki Local Municipality	25494	29743	33992
kz City of uMhlathuze Local Municipality	39548	46139	52731
kz Abaqulusi Local Municipality	22118	25804	29491
nw Rustenburg	53864	62842	71819
Total	201255	234798	268340

HTS-Other: Number of adolescents and young people age 15-24 who were tested for HIV and received their results during the reporting period - AGYW

Subdistricts	Year 1 (60%)	Year 2 (70%)	Year 3 (85%)
mp City of Mbombela Local Municipality	34930	40752	49484
mp Govan Mbeki Local Municipality	15183	17713	21509
kz City of uMhlathuze Local Municipality	23789	27753	33700
kz Abaqulusi Local Municipality	12018	14021	17025
nw Rustenburg	30961	36121	43861
Total	116880	136360	165580

YP-Other 3: Percentage of eligible adolescents and young people who initiated oral antiretroviral PrEP during the reporting period - AGYW

Subdistricts	Year 1 (10%)	Year 2 (15%)	Year 3 (18%)
mp City of Mbombela Local Municipality	4852	7277	8733
mp Govan Mbeki Local Municipality	2108	3162	3794
kz City of uMhlathuze Local Municipality	3307	4960	5952
kz Abaqulusi Local Municipality	1673	2509	3011
nw Rustenburg	4326	6489	7787
Total	16265	24397	29276

YP-Other 2: Percentage of adolescents and young people aged 10-24 years reached with HIV prevention programs- defined package of services - ABYM

Subdistricts	Year 1 (25%)	Year 2 (30%)	Year 3 (40%)
mp City of Mbombela Local Municipality	24545	29454	39272
mp Govan Mbeki Local Municipality	11625	13950	18600
kz City of uMhlathuze Local Municipality	15837	19004	25339
kz Abaqulusi Local Municipality	9423	11308	15077
nw Rustenburg	24138	28966	38621
Total	85569	102682	136910

HTS-Other: Number of adolescents and young people age 10-24 who were tested for HIV and received their results during the reporting period - ABYM

Subdistricts	Year 1 (15%)	Year 2 (20%)	Year 3 (30%)
mp City of Mbombela Local Municipality	9012	12016	18024
mp Govan Mbeki Local Municipality	4570	6093	9139
kz City of uMhlathuze Local Municipality	5966	7954	11932
kz Abaqulusi Local Municipality	3246	4328	6493
nw Rustenburg	9085	12113	18170
Total	31879	42505	63757

YP-Other 3: Percentage of eligible adolescents and young people who initiated oral antiretroviral PrEP during the reporting period - ABYM

Subdistricts	Year 1 (10%)	Year 2 (15%)	Year 3 (18%)
mp City of Mbombela Local Municipality	2385	3578	4293
mp Govan Mbeki Local Municipality	1209	1814	2177
kz City of uMhlathuze Local Municipality	1579	2369	2842
kz Abaqulusi Local Municipality	859	1289	1547
nw Rustenburg	2410	3615	4339
Total	8443	12665	15198

3.14. SR team training

Components	Training to be done
1. School-based interventions	Soul Buddyz; Grassroots Soccer; Kidz Alive; ISHP, SOGIE and CETA policies
2. Higher Education interventions	MTV Shuga; PrEP; RTCQI; HPV Screening
3. Community-based interventions	Vutshilo 3; ABYM programme; Positive parenting programme; ESL Income generation; Biz AIDS; Youth Leadership programme Families Matter!; Social and behavior change communication (SBCC) Programmes at a community level.
4. Biomedical interventions	Adherence clubs model. Dapivirine Vaginal Ring, HCWs – PrEP provision Cervical cancer and breast cancer: Awareness and Education, HPV Vaccination promotion; HPV: screening (self-sampling), DNA testing for HIV positive clients; Referrals and Treatment using LLETZ Injectable PrEP (based on approval)
6. Gender-based violence interventions	Trauma focused/ trauma informed CBT. Stepping stones.

3.15. Estimated budget envelope

Estimate below may be subject to review and change. Final budget per SR will be confirmed during contracting stage. It will depend on targets allocation, number of SRs implementing same module /programme per district and final budget allocation per module. Each district /sub-district may have 1-3 SRs depending on the targets and size of the sub-district /district. AYP programme budget envelope estimate: R43,000,000 per annum, per district.

4. SR PREQUALIFICATION CRITERIA

All applicants must have a broad-based black economic empowerment (B-BBEE) level one (1) or two (2) only. Applicants that do not meet the above requirement will be disqualified from further evaluation.

Administrative requirements for acceptance of SR application

The administrative requirements include the following:

- Use of the prescribed application form and adherence to length of submission limits (number of pages).
- Submission of the following documents (in addition to any other evidence submitted by an applicant): Proof of legal entity (NPC, Trust, Voluntary Association, Close Corporation, Pty (Ltd)).
- NPO registration status.
- List of board members and management, their current job titles and certified copies of IDs.
- Valid SARS tax clearance certificate together with tax compliance status pin.
- Valid B-BBEE certificate or sworn affidavit deposed by a director/board member of the applicant confirming B-BBEE level. Organisations who don't have a B-BBEE Verification Certificate by an independent verification agency must complete a sworn affidavit using the required templates for specialised entities on the Department of Trade and Industry website as follows: B-BBEE Qualifying Small Enterprise - Specialised Entity template. This is for qualifying organisations with an annual income between R10 million and R50 million.
- B-BBEE Exempted Micro Enterprise - Specialised Entity template. This is for exempted organisations with an annual income below R10 million.
- Last audited Annual Financial Statements signed by Board chairperson. Management accounts, signed by the preparer of such accounts and the Board Chairperson, may be accepted if the audited annual financial statements are older than 2 years or the financial statements have never been audited.
- Organogram for all management and administrative positions (Human resources, finance, PSM, M&E, project management).
- Policies and procedures documents addressing financial management, procurement, travel, and human resources.
- Letter confirming participation in the district coordination structure e.g. the District Aids Council (DAC), if it exists. If not, a letter issued by the PCA should suffice.

5. LIST OF ANNEXES /SUPPORTING DOCUMENTS REQUIRED

Annex 1: Board resolution authorising submission of application.
Annex 2: Proof of legal entity (NPC, Trust, NPO, Close Corporation, Pty Ltd).
Annex 3: NPO registration status and confirmation of compliance with Department of Social Development requirements.
Annex 4: Profile of the organisation, including history and work experience relevant to this application.
Annex 5: List board members and certified ID
Annex 6: Valid SARS tax clearance certificate with tax compliance status pin.
Annex 7: VAT Registration document
Annex 8: Valid BBBEE certificate or sworn affidavit deposited by director/board member (for eligible entities) not older than three months from closing date. No beneficiary recognition certificates will be accepted.
Annex 9: Latest employment equity report submitted to the Department of Labour.
Annex 10: Last two audited Annual Financial Statements signed by Board chairperson. If your last audited annual financial statement is older than 2 years then supply the most recent management accounts pack signed by the preparer.
Annex 11: Audit management letter for the last audit.
Annex 12: Organogram for all management and administrative positions (Human resources, finance, PSM, M&E, project management).
Annex 13: Policies + procedures documents addressing financial management, procurement, travel, human resources, inventory management; occ health safety.
Annex 14: An executive summary of a recent report to a donor for any of the high-level areas that this grant will focus on.
Annex 15: Letter confirming participation in district coordination structures.
Annex 16: Letter of recommendation from government department/s, for supporting related programmes.
Annex 17: MOU or SLA from a government department, for supporting related programmes.
Annex 18: Most recent risk register
Annex 19: Appropriate evidence to support your geographical coverage (e.g. office lease, utility /rates statement, organisation-owned vehicle registration document).

6. EVALUATION PROCESS AND CRITERIA

The evaluation of submissions will be managed by an SR Selection Panel (SSP) which will prepare a shortlist of applicants that meet the threshold for appointment as an SR. The PR will use the shortlist drawn by the SSP to recommend applicants to be appointed as SRs by the GF CCM. The GF CCM will make the final decision taking into account the recommendations by the PR.

The evaluation process will be conducted according to the following stages:

The first stage of the evaluation process assesses for compliance with pre-qualification criteria. Applications that do not comply will not be evaluated further.

The second stage of the evaluation process assesses compliance with administrative requirements (*see relevant section above*). Applications that do not comply will not be evaluated further.

The third stage of the evaluation process assesses technical competency focusing on the ability to fulfil the requirements of an SR, experience and expertise of implementing similar interventions and presence in the selected district. Applicants need to achieve a specified minimum score of the technical competency requirements in order to progress further.

The fourth stage, which is optional and at the discretion of the SSP, may involve an on-site visit to clarify details about the applicant. No points are awarded for this stage.

6.1. Scoring applications

For applicants that satisfy the pre-qualification criteria and the administrative requirements, the weighting of the overall score is as follows:

- Technical evaluation score 80%
- B-BBEE points 20%
- Total **100%**

6.2.RFA scoring template.

How points will be awarded:

0 =not submitted /does not comply /invalid, 1 = Poor – grossly out of line with best practices, 2 = Weak – may have a small component that is positive, 3 = Good – some positive attributes, 4 = Very good – close to best practices, 5 = Excellent – meet best practices.

CRITERIA	MEASURE	Weight	Points (0-5)	Final score
PREQUALIFICATION CRITERIA -if not provided or invalid, do not proceed with evaluation				
Valid B-BBEE status	Annex 1: B-BBEE certificate /affidavit Level 1 =5 points. Level 2 =3 points.	4		
Administrative requirements (All annexures listed in this section must be submitted and valid, to proceed with evaluation)	Application form completed in full.	Not scored		
	Annex 2: Letter confirming participation in the district coordination structure e.g., the District Aids Council (DAC). If not available, a letter issued by the PCA is acceptable. Priority will be given to district-based, followed by provincial-based organisations. If no suitable district/provincial-based applicant is found, applicants from other provinces will be considered.			
	Annex 3: Board resolution authorising submission of application			
	Annex 4: Proof of legal entity ((NPC, Trust, NPO, Close Corporation, Pty (Ltd)).			
	Annex 5: NPO registration status and confirmation of compliance with Department of Social Development requirements.			
	Annex 6: Valid SARS tax clearance certificate together with tax compliance status pin.			
	Annex 7: Last two audited Annual Financial Statements signed by Board chairperson. Or financials prepared by a SAIPA or SAICA accredited accountant. These records must within the last two years (2020 - 2021).			
	Annex 8: Audit management letter for the last audit. If not available, state reason.			
Technical competency (Minimum score of 48 points (60%) on technical points required to proceed)				
Scope of Work Experience of implementing similar programme focus areas	Annex 9: Profile of the organisation, including history and work experience relevant to this application.	6		
	Annex 10: Letter of recommendation from government department/s, for supporting related programmes.			
	Annex 11: MOU /SLA from a government department, for supporting related programmes.			
	Annex 12: SARS VAT Registration document			

Ability to function as an SR and meet GF and GF CCM requirements throughout the life of the grant. GOVERNANCE. Board members & staff: suitably qualified & represent community served by the proposed GF programme.	Annex 13: Latest employment equity report submitted to the Department of Labour -if eligible.			
	Annex 7: Last two audited Annual Financial Statements signed by Board chairperson. Or financials prepared by a SAIPA or SAICA accredited accountant. These records must within the last two years (2020 - 2021).			
	Annex 8: Audit management letter for the last audit. If not available, state reason.			
	Annex 15: List of board members and certified copies of IDs.			
	Annex 16: Organogram for all management and administrative positions (Human resources, finance, PSM, M&E, project management).			
	Annex 17: Senior management staff: job titles, CVs and certified copies of IDs. Key positions to include: CEO /executive director, programme manager, finance manager, monitoring & evaluation manager /coordinator /officer.			
Application form	Review responses to the application form. Form completed properly, in full and signed /dated. Experience provided matches project applied for. Experience supported by adequate supporting documents: recommendation letters, MOUs /SLAs, etc.	10		
			Grand total	100

The SSP will present its evaluation outcome to the PR for consideration and recommendation to the GF CCM for a decision on the final list of SRs. Aggrieved applicants can lodge an appeal with the CEO /Executive Director within seven working days of receiving official communication of the SR selection decision, clearly stating the grounds for appeal, and providing the necessary evidence.

7. APPLICATION INSTRUCTIONS

Clearly mark applications with the bid number as shown on the application form.

Applicants must submit the following documents:

- Motivation letter, with key contact details (name, email address, cellphone number, physical address), Programme and district applying for.
- Completed application form
- Annexes as shown below

7.1. How to submit your application:

If applying for more than one district /sub-district /programme, you are required to submit one separate application for each district /sub-district /programme you are applying for.

All supporting documents must be labelled accordingly, using annexes listed in this document.

Ensure completeness of the application (including the attachment of all necessary supporting documentation) and not exceed recommended length of sections.

Confirm in writing that the information and statements made in the application submission are true and accept that any misrepresentation contained in it may lead to disqualification;

Ensure timely submission of all documents and reports if requested as part of the assessment of the organisation's ability to continuously fulfil the role of an SR;

Submitting by email:

Attach all documents required.

Huge files may transmit slower. Thus, allow sufficient time to submit all supporting documents before cut-off time. A grace period of 15minutes maximum will be allowed, after which applications will be deemed late. The last attachment must be submitted within this cut-off time.

Applications submitted electronically should use the same bid number in the email subject line.

Email application to: quotes@aims.org.za

Submitting by hand delivery:

Deposit 6 copies of the application package with all supporting documentation into the tender box located at AFSA offices: 135 Musgrave Road, Musgrave, Durban, 4001.

Should COVID-19 restrictions prohibit travel to AFSA offices /or offices closed due to unforeseen circumstances, email submissions will be to only acceptable submission procedures, and email cut-off times apply. Visit AFSA website regularly for updates.

7.2.Key dates

8. Bid submission & evaluation timelines:

Stage	Date (2022)
Email enquiries to: quotes@aims.org.za Use bid number as subject heading.	16 May
Questions received on email and during briefings posted on AFSA website as questions & answers: https://www.aims.org.za/	20 May
Deadline for submitting applications with all supporting documents	25 May, 16h00
Evaluation period (indicative) during which additional details may be requested and an on-site visit may be done to evaluate SR capacity.	26 – 31 May
Due diligence visit /assessment. Ensure appropriate staff is available on site when required.	26 – 31 May
Final SR selection decision (Followed by feedback to applicants)	31 May
Contracting, induction & project implementation start	Jun

8.1.RFA ToR advertising and dissemination

Once approved by the GF CCM Management Committee, the RFP shall be circulated widely including: PR website, PR mailing list, SANAC website, SANAC mailing list and at least one provincial/district newspaper with wide circulation. The RFP shall also be shared with the relevant PCAs, DACs, LACs, local municipalities and civil society networks for circulation.

9. REFERENCES

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- ⁱ Online at <http://aidsinfo.unaids.org/>
- ⁱⁱ HSRC (2018) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017 – Full Report. Page xl. Online at <https://bit.ly/31vxNqX>
- ⁱⁱⁱ UNDP's 2019 Gender Inequality Index (GII). Online at <http://hdr.undp.org/en/content/gender-inequality-index-gii>
- ^{iv} UNAIDS & UN Women (2021) Gender Assessment of the HIV Response South Africa – A Strategic Discussion Paper on HIV and GBV Intersectionality and Integration. Page 27. Online at <https://bit.ly/3foe9VZ>
- ^v HSRC (2018) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017 – Full Report. Page 134. Online at <https://bit.ly/31vxNqX>
- ^{vi} HSRC (2018) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017 – Full Report. Page 133. Online at <https://bit.ly/31vxNqX>
- ^{vii} HSRC (2021) HIV Status of Adolescent Boys and Young Men (ABYM) in South Africa - the 2017 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey. Slide 7. Online at <https://bit.ly/3yzoZyT>
- ^{viii} HSRC (2021) HIV Status of Adolescent Boys and Young Men (ABYM) in South Africa - the 2017 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey. Slide 13-14. Online at <https://bit.ly/3yzoZyT>
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- ^x USB Optimus Foundation (2016). Optimus Study South Africa: Technical Report Sexual victimisation of children in South Africa Final report of the Optimus Foundation Study: South Africa. Page 10. Online at http://www.knowviolenceinchildhood.org/newsletter3/images/08_cjcp_report_2016_d.pdf
- ^{xi} UNAIDS & UN Women (2021) Gender Assessment of the HIV Response South Africa – A Strategic Discussion Paper on HIV and GBV Intersectionality and Integration. Page 27. Online at <https://bit.ly/3foe9VZ>
- ^{xii} Aurum, Anova & UCSF (2020) Summary Sheet – South African Health Monitoring Survey – A Biological And Behavioural Survey Among Female Sex Workers In South Africa (SAHMS 2018). Page 3. Online at <https://bit.ly/3sAAy6v>
- ^{xiii} Aurum, Anova & UCSF (2020) Summary Sheet – South African Men's Health Monitoring Survey - A Bio-Behavioural Survey Among Men Who Have Sex With Men In South Africa (SAMHMS 2019). Page 2. Online at <https://bit.ly/2P9YQWt>