Terms of Reference

Appointment of a Service Provider to provide TB training for AFSA and its AYP and SWP Sub-Recipients

REFERENCE: _GLO03REQ08948

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Application deadline: 24 May 2023 at 12:00

AFSA reserves the right to amend this document or to cancel this call, for any reason

Note: Please direct any queries to procurement@aids.org.za

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Abbreviations

ADV	Advocacy
AFSA	AIDS Foundation of South Africa
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CAO	Community Advice Office
CBM	Community-Based Monitoring
CCM	Country Coordinating Mechanism
CDA	Central Drug Authority
CSS	Community Systems and Responses
CSE	Comprehensive Sexuality Education
CSS	Civil Society Sector
DCA	District Council on AIDS
DoH	Department of Health
DoJ	Department of Justice
GBV	Gender Based Violence
GF	The Global Fund
HIV	Human Immunodeficiency Virus
HR	Human Rights
HRWG	Human Rights Working Group
IBBS	Integrated Biological and Behavioural Surveillance
IEC	Information, Education, Communication
IPO	Implementing Partner Organisation
KP	Key Population(s)
KVPs	Key and Vulnerable Population(s)
LASA	Legal Aid South Africa
LEA	Law Enforcement Agents
LFA	Local Fund Agent
LGBTQIA+	Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual, + all people who have non-normative gender identity or sexual orientation
M&E	Monitoring and Evaluation

MDIP	Multi District Implementation Plan
MSM	Men who have sex with Men
NDoH	National Department of Health
NSP	National Strategic Plan
OST	Opioid Substitution Treatment
PAs	Programme Area(s)
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PCA	Provincial Council for AIDS
PIP	Provincial Implementation Plan
PLHIV	People Living with HIV
PR	Principal Recipient
PTB	People infected with TB (TB Survivors)
PWID	People who inject drugs
PWUD	People who use drugs
QA	Quality Assurance
REAct	Rights-Evidence-Action
RFF	Request for Funding
SANAC	South African National AIDS Council
SANAC CSF	South African National AIDS Council Civil Society Forum
SAPS	South African Police Services
SR	Sub-Recipient
SSR	Sub-sub-recipient
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TG	Transgender
TCC	Thuthuzela Care Centre
UNAIDS	The Joint United Nations Programme on HIV/AIDS

1. Introduction and Background

The AIDS Foundation of South Africa (AFSA) is a Durban-based NGO that acts as an interface between Donors and Community Based Organisations (CBO's) working in the HIV/AIDS sector, by placing donor funds with strategically selected CBOs in South Africa, and providing them with ongoing, technical support & capacity building.

The South Africa Global Fund Country Coordinating Mechanism (GF CCM) is responsible for leading 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 selected the AIDS Foundation of South Africa (AFSA) to be appointed by the GF as one of the four Principal Recipients (PRs) that will implement programmes funded by the grant, during Apr 2022 – Mar 2025.

Serving as a grant manager, the PR coordinates grants' execution through sub-recipients (SRs), service providers and consultants as the main implementers of the GF programmes. AFSA's programmes under the current Global Fund grant are implemented in 20 districts, across all nine South Africa's provinces. Four core programmes are assigned to AFSA:

1) Adolescents and Young People (AYP) programme
2) Sex Workers programme
3) Human Rights & Advocacy programme
4) Community Systems Strengthening programme.

AFSA is responsible for procurement of specific technical services from consultants for implementation of clinical/ biomedical interventions by SRs in order to support these organizations in the fight against HIV/Aids and other conditions. It is upon this background that AFSA seeks to appoint a reputable service provider that will provide high standard, up to date TB Training both at PR as well as SR level.

The TB Training will help improve TB awareness, prevention, case finding and treatment thereof. It will also improve accurate documentation and reporting of all TB cases.

2. The objectives of training consultancy

The service provider will:

- Provide a 2-day face-to-face TB training to AFSA and all its SRs for the AYP, SWP and HRA programs.
- Provide mentorship to AFSA and all its SRs at the PR request, maximum of 3 mentorship sessions per SR.

Groups	Number of participants
Group 1 (Mpumalanga - Badplaas)	80 (Split into further two groups)
Group 2 (North West - Rustenburg)	62 (Split into further two groups)
Group 3 (KZN – R/Bay or Empangeni)	66 (Split into further two groups)
Group 4 (KZN – Vryheid)	28
Group 5 (Limpopo- Polokwane)	27

Group 6 (Free State – Welkom)	22
Group 7 (Eastern Cape – Port Alfred)	26
Group 8 (KZN – Kokstad)	20
Group 9 (Gauteng)	22

Costing tool:

ITEM	Unit price (Excl VAT)	QUANTITY	TOTAL (Excl VAT)
1. Content review (pre- & post training assessments, agenda, attendance register, training slides)	Rate per day	Two (2) days	
2.Training reports per group - Full package (pre- & post training assessments, agenda, attendance register)	Rate per day rate	One (1) day	
3. Printing of training material	Rate per paper	Align to training manual	
4. Printing of certificates	Rate per certificate	Align to participants	
5. 2-day face to face training per facilitator.	Rate per day per group	Align to number of groups	
6. Mentorship	Rate per session	Three (3) sessions	

3. Scope of the work

This must be a comprehensive NDoH Human Rights aligned TB training that covers the following:

3.1 TRAINING TOPICS

- TB epidemiology (Globally and in South Africa) incl. MDR & XDR TB.
- TB etiology and risk factors (children, adolescents and adults)
- TB transmission, Infection prevention and control
- TB signs and symptoms
- TB strains and/ or types
- TB/ HIV comorbidity
- TB diagnosis (including effective screening)
- Specimen (sputum) collection - demonstration and strategies
- Effective referral and follow-up of TB suspects/ cases
- Treatment and adherence support strategies
- TB data collection and data management tools (M&E) – TB Case Identification register, TB screening tool and NHLS lab forms.
- Patients' Rights to TB and quality health services:

- ✓ What does the right to comprehensive health care and TB services mean?
- ✓ Provision of Health care service including TB as a fundamental huma rights principle; why is right-based approach an important element in TB treatment and for the general population?

- Key components of TB patients' right to health
  - ✓ Mechanism to prevent violation of patients' rights to access health care services.
  - ✓ Core components of human rights violations against TB patients
  - ✓ Mechanisms to report and address human rights violations.

3.2 CERTIFICATION

- Provide participants with certificates of attendance after completion of the training (full attendance)

3.3 TRAINING MANUALS, GUIDELINES AND SOPs

- Revised training manuals aligned to the NDoH TB guidelines.
- AFSA Human Rights Violation Toolkit Manual
- Issue participant's manuals to each participant

3.4 TRAINING REPORTS

- Conduct pre- and post-training assessments.
- Compile and submit a full training report.

Deliverables

Under the guidance by AFSA Global Fund teams, the service provider undertakes the following:

1. Content review (pre- & post training assessments, agenda, training slides, pre- and post-training reports)
2. Provide mentorship to AFSA CHPM team on ad hoc basis (On quarterly basis as requested by the PR).

Contracting Period

The service provider will be contracted to develop/update the TB Training manual (both trainers' and participants' manual and roll-out the training to AFSA and all its SRs. The contract period will be determined in the Service Level Agreement after appointment of the service provider.

IMPORTANT NOTE:

Materials developed during this consultancy become property of AFSA /Global Fund and can be used in future similar activities -for non-commercial purposes. Trainings provided to AFSA and it's partners must be in a format of training the trainer and AFSA staff and partners will further roll out the training to additional trainees if needed.

4. Requirements: Educational & Experience

Qualifications, experience, skills, and knowledge assessed

- Degree or diploma in Nursing or Equivalent health related qualification
- 5-year experience developing training materials within health of key and vulnerable populations environment using rights-based approaches.
- Understanding SA Constitution and application of Human Rights principles in the health sector
- Proven track record in conducting TB Training or similar/ related trainings in the last 5 years in the health sector.
- Suitably qualified personnel with relevant qualifications and understanding of TB programs
- Training materials aligned to the NDoH and/or WHO TB guidelines.

Other important criteria to be assessed

- Proven track record to providing similar or related trainings (proof of references)

5. Mandatory documents to be submitted.

IMPORTANT: Documents listed in the table below must be submitted as one pdf file and, in the order shown. Insert a blank page, with appropriate label & mark it "NOT SUBMITTED" to indicate documents not submitted. AFSA will not be held responsible for documents delayed or misplaced during file transmission.

DOCUMENT NUMBER	DESCRIPTION REFERENCE:
*DOC-01	Motivation /cover letter, with full contact details: indicate reference number. Attach this page onto the motivation letter.
*DOC-02	A declaration confirming the absence of any conflict of interest; or alternatively a declaration stating existing relationship with AFSA employees or Directors. Document provided on page 12.
*DOC-03	Detailed proposal of how the service provider will conduct the training across all 29 SRs within a space of 30 days, giving full details of the project, implementation, training as well as the mentorship of AFSA CHPM
*DOC-04	CV, of personnel to be involved in the project including 2-3 contactable references.
*DOC-05	Proof of registration as a legal entity (NPC, Trust, Close Corporation, Pty (LTD). Sole Proprietor: Certified copy of identity document
*DOC-06	Qualification documents (Degree certificates etc.) for all the personnel to be involved in the project
*DOC-07	A valid tax clearance certificate issued by the South African Revenue Service (SARS).
*DOC-08	VAT vendor registration
*DOC-09	Table listing relevant current and completed assignments /projects, in the last 5 years.
*DOC-10	Two examples of relevant recent written work (last 5 years): report/ proposal /article /etc.
*DOC-11	B-BBEE status level verification certificate. Attach affidavit if trading below the prescribed threshold.
*DOC-12	Costing: Proposed rate (per day) At contracting and payment stage, payments will be linked to Milestones and not time worked.

Documents marked with asterisk are mandatory. Applications missing these documents will be disqualified. Documents are valid only if certified within 6 months of the closing date. Only short-listed candidates will be contacted.

NB: Upon successful shortlisting, you will be requested to submit the draft training material.

6. Evaluation Criteria -stages

Stage 1: Administrative compliance: If some mandatory documents are missing, application may be disqualified.

Stage 2: Minimum qualifications: If minimum qualifications were not met, application will be unsuccessful, and no further evaluation will be conducted.

Stage 3: Technical qualifications /experience: proposal and supporting documents will be assessed and scored accordingly. Minimum score of 50% is required to be eligible for oral presentation and to move to next evaluation stage.

Stage 4: Costing: AFSA is not obligated to prioritise costing over technical integrity of the applicant, and as such will not automatically select the lowest application. Both technical score and costing will be considered in the final selection.

Technical evaluation criteria and score

ELEMENT	Maximum Score
Submission compliant with documents listed in the table above: Submitted documents as 1 pdf file. Documents clearly labelled. Clearly marked placeholders for documents not submitted.	15
Detailed proposal of how the service provider will conduct training of AFSA and its SRs, giving full details of the project, implementation, training as well as mentorship to AFSA. Clear, detailed, demonstrate understanding of assignment. An indication of the approach to carrying out the assignment, including any inputs that may be required from AFSA. Indicate how your qualifications and experience make you suitable for the assignment. If assignment/s will be undertaken by more than one person, include your team structure: indicate names and qualifications and attach their CVs. **DOC-03**	10
Tertiary qualifications –all persons who will be involved in undertaking any part of this assignment. **DOC-06**	10
Experience working on related issues /projects. Specify your role in these assignments. Track record of similar work assessed through table listing of prior assignments or CV or sample work submitted. **DOC-04 /09 /10.**	10
Highly developed written and communication skills (sample submitted). If no prior work submitted, this assessment will be based on the proposal submitted **(DOC-03 /10).**	05
Presentation: knowledge on the subject & responding to questions (15), implementation methodology & proposed team structure (10), presentation /slides /communication skills (5).	30
Cost. Provide rate per head, inclusive of all training/ administration /coordination fees, etc. Provide breakdown of what constitutes your per head rate, with notes /justification. *Exclude VAT & travel logistics /accommodation because AFSA makes these arrangements where applicable. Preferential Procurement Policy Framework Act, and 80/20 rule, may be applied when scoring B-BBEE and quoted price.* **DOC-12**	20
Total (80% technical score and 20% price score)	**100**

*Proposals must achieve at least 60% on the technical evaluation to be considered further.

7. Deliverables, remuneration and institutional arrangements

- The service provider should provide rates which will be applied for the duration of this contract.
- AFSA will pay directly for travel logistics to activities, using standard AFSA procurement policies; so, these are to be excluded from quote.
- Service provider is expected to provide their own work tools (laptop, cell phone, airtime /data, and other basic work tools related to the consultancy).
- Payment will be based on review and acceptance of the completed deliverables presented with required contractor paperwork /supporting documents.
- This service provider will work under the supervision of an AFSA Manager and will also interact with project staff and stakeholders in various districts.
- Important: project /assignment will be considered successfully completed after submission and approval of final product /deliverable /milestone. Some deliverables require final approval /sign-off by multiple stakeholders. If several revisions are required to produce acceptable quality, costs of these revisions are to be borne by the service provider.
- Before any work can start, AFSA will issue a contract and purchase order. Before each activity /assignment starts, AFSA will request a quotation, and confirm assignment by issuing a written confirmation /acceptance of quotation before the assignment is undertaken. Failure to comply to this requirement invalidates any claims made against the contract.

8. Submission Instructions

- Suitably qualified service providers /consultants are required to apply to quotes@aids.org.za with this reference: "*GLO03REQ08948*" on the subject line, by 24 May 2023 at 12:00.
- All enquiries are to be submitted in writing *only* to procurement@aids.org.za with subject line clearly marked "*GLO03REQ08948-Enquiry*".
- *If you are not contacted within 45 days of closing date, please consider your submission unsuccessful.*

DOC 02

DECLARATION OF INTEREST FORM

Please respond to the following questions, by placing an "X" on your response.
If you require additional space to complete a response, please continue your response on a separate page and sign and date that page.

1) **Do you or any of your immediate family members have any financial interest in the work of the AIDS Foundation of South Africa?**

   Yes: _____No: _____
   If you have responded "yes", please give details in the box below sufficient for AFSA to evaluate the situation, including, but not limited to, the following:
   - If the financial interest relates to a role held at an organization, please list the name of the organization, the role held at the organization (such as employee, consultant, or board member), the work performed in the role, and the dates during which the role was held.
   - If the financial interest relates to an ownership interest, please describe the nature and amount of the interest owned, the duration for which the interest has been held, and any other relevant information.

2) Have you or an immediate family member had a professional relationship with an organization subject to a diagnostic review, audit, investigation, or similar activity by AFSA, or been personally subject to an investigation by AFSA? Has there ever been an investigation by any other authority against you, your immediate family members, or an organization to which you have a professional relationship?

Yes: _____No: _____

If you have responded "yes", please describe relevant information in the box below, including, as applicable:

- The organization involved.
- The role and tile held (such as employee, consultant, or Board member), whether the role was held by you or by an immediate family member, and the dates when the role was held.
- The work performed, and whether the role involved working on, managing, or overseeing matters involving AFSA.
- The investigating authority
- The focus of the investigation or other action
- The outcome or resolution of the investigation or other action (such as findings of fraud or misuse of funds).

3) Have you or any of your immediate family members been involved in a legal dispute with AFSA or its grant recipients, or are you currently involved in any other legal dispute that could have a real or perceived effect on your duties at AFSA?

Yes: ____No: _____

If you have responded "yes", please give details in the box below on the nature of the dispute, the parties involved, and, as applicable, the status of the dispute or how and when the dispute was resolved.

Note: This question is intended to only address legal disputes that could have a real or perceived effect on your ability to work with the best interests of AFSA in mind. Therefore, any legal issues you may have experienced relating to your gender, sexual orientation, political beliefs, disease status, activities as a sex worker or drug user, or activities associated with advocacy for social, political or human rights issues do not need to be disclosed here. For the legal disputes disclosed here, you may provide any background you deem relevant.

4) Do you or any of your immediate family members or business associates have any relations with AFSA Sub-recipients, Donors, Partners, Suppliers or Contractors?

Yes: _____No: _____

If you have responded "yes", please give details in the box below sufficient for AFSA to evaluate the situation:

5) Do you or any of your immediate family members or business associates have any relations with AFSA?

Yes: _____No: _____

If you have responded "yes", please give details in the box below sufficient for AFSA to evaluate the situation:

6) Is there anything else not captured in the questions above that could affect your objectivity or independence in the performance of your duties for AFSA, or in your opinion, the perception by others of your objectivity and independence?

Yes: ____No: ____
If you have responded "yes", please give details in the box below sufficient for AFSA to evaluate the situation.

In signing this Form, I, the undersigned, _____ hereby confirm:

i. That the information which I disclose in this Declaration of Interest Form is correct and complete.

ii. That in the event of a material change to the information provided, I shall advise the AFSA Chairperson and/or CEO immediately of the situation consisting of a conflict of interest or that which could give rise to a conflict of interest and undertake to update the information in this Declaration Form in the event of these circumstances and, in any event, at least annually.

iii. That I have not made, and will not make, any offer of any type whatsoever from which a personal advantage can be derived from my involvement or employment with AFSA.

iv. That I understand that AFSA reserves the right to verify this information and that I am aware of the consequences which may derive from any false declaration in respect of the information required by AFSA

Signature: Date:

_____ _____

Name (please print): Title (please print):

_____ _____

9. Annexure 1: Description of AFSA's Global Fund Programme to be supported by this consultancy

9.1. Key and Vulnerable Populations (KVPs)

While South Africa has a generalised HIV epidemic, it is also characterised by distinct sub-epidemics among key and vulnerable populations (KVPs). The National Strategic Plan (NSP) defines key and vulnerable populations for HIV and Tuberculosis (TB) as:

Table 1: Definition of Key and Vulnerable populations

Key populations for HIV and STIs	Vulnerable populations for HIV and STIs	Key populations for TB
• Gay men and other men who have sex with men. • Inmates. • People living with HIV. • People who use or inject drugs. • Sex workers. • Transgender persons.	• Adolescent girls and young women. • Children, including orphans and vulnerable children. • Mobile and migrant populations (including undocumented migrants). • Other LGBTI+ people. • People living in informal settlements. • People with disabilities.	• Children under 5 years old. • Health care workers. • Household contacts of TB index patients. • Inmates. • Migrants and undocumented foreigners. • Miners and peri-mining communities. • People living in informal settlements. • People living with HIV. • People with diabetes. • Pregnant women.

9.2. Adolescents & Young People (AYP) in high prevalence settings

HIV prevention for adolescents and young people (AYP) remains the top priority for the GF programme for the NFM3 grant cycle. A comprehensive package of social, structural, and biomedical services will be offered to AYP in selected sub-districts. The main is to achieve 80% saturation amongst adolescent girls and young women (AGYW) and 25% saturation amongst adolescent boys and young men (ABYM) aged 10-24 years. AFSA has been assigned responsibility for the management and overseeing the implementation of the AYP programme in 5 sub-districts as follows:

KwaZulu-Natal

1) City of uMhlathuze, in the King Cetshwayo District
2) AbaQulusi, in the Zululand District

Mpumalanga

3) City of Mbombela, in the Ehlanzeni district
4) Govan Mbeki, in the Gert Sibande district

North West Province

5) Rustenburg, in Bojanala Platinum district

The package of services and interventions to be implemented in the 5 sub-districts targeting AYP are comprised as follows:

9.2.1. Adolescent Girls and Young Women (AGYW)

Core Package: All AGYW will receive a core package of services, this comprises of:

Risk Assessment to determine the risk profile and needs of each AGYW reached through the programme. The risk assessment shall determine the needs and referral pathways for each AGYW to access layered services and interventions through the programme.

- Offered a HIV test
- Provided with male and female condom education and offered condoms and lubricants
- TB Screening,
- STI and pregnancy screening services
- Additional health information and a Service Plan

Following risk assessment, a service plan shall be developed for each AGYW recruited into the programme.

Layered Services

The layered services are structured according to biomedical, behavioural, and structural services and interventions.

- Biomedical: HIV self-screening (HIV SS); TB testing and treatment; pregnancy testing; contraception; syndromic STI screening and testing, investigation, and treatment; PrEP; PEP; cervical cancer and breast cancer awareness and education (new addition to the programme); ART initiation or referral, viral load monitoring, PMTCT, termination of pregnancy and post-abortion care; TB treatment; and TPT.

- Behavioural: Peer-led education; comprehensive sexuality education (CSE); psychosocial support (to beneficiaries and to interventionist staff; PrEP and SRH knowledge and demand creation; mental health support; physical activity; substance use programmes; parenting programmes; adherence support through KidzAlive approach for 10-14-year-olds; post-violence care (TCCs & DFs); GBV prevention and response, social and behaviour change communication (SBCC) programmes at a community level.

- Structural*:* Referral for social support services including child and disability grants; birth certificate or ID registration; menstrual health information and packs; homework support and career guidance; return to school programmes/keeping girls in school; childcare (ECD) vouchers for young mothers; parenting programmes for teen mothers and positive parenting skills for all caregivers(parents, guardians); economic strengthening with a focus on skills, income generation and livelihood support including food security, youth leadership, GBV and IPV awareness and post violence care services.

9.2.2 Modified Package for Adolescent Boys and Young Men (ABYM)

ABYM will receive a modified package: during the 3rd year of the 2019-2022 grant, HIV prevention services were introduced to boys, and this is to be continued and expanded for the NFM3 grant. The package of services and interventions to be provided to boys includes the following:

- Enrolment, consent, and core services

- Biomedical HTS/HIVSS, PrEP, linkage to care, medical male circumcision referrals, condom education and offered condoms and lubricants, TB screening and testing, STI screening, rapid test, and treatment.

- Structural: Referral for social support services and assistance with applying for identity documents.

- Behavioural: standardized peer education programme; men's community dialogues (with referral to MSP programme); psychosocial support services; sports-based HIV prevention programming using the Grassroot Soccer approach will also be introduced (also open to girls), by engaging the ongoing support of an experienced service provider.

The package will be age-tailored to 10-14-year-olds, 15-19-year-olds, and 20-24-year-olds. Important to note, the 10-14-year-olds package will be aimed at risk avoidance with a focus on vulnerability identification through a modified risk assessment tool. The primary entry point will be through schools, strengthening the Integrated School Health Programme and offering the evidence-based Soul Buddyz curriculum (delivered with the ongoing support of an experienced service provider).

In terms of reaching AYP, the focus will be on reaching the target groups in-school and in communities. For the age group 10- to 14-year-olds the focus will be on reaching this group 100% in-school. For the age group 15–24-year-olds the focus will be on reaching 40% in school and 60% out-of-school in particular the NEETs (not employed nor in education or training).

The in-school programme will be delivered through support from the Department of Basic Education (DBE). It will also focus on building the capacity of school leadership structures to implement the CSE programme, the DBE HIV/TB/STI policy and the Integrated School Health Policy (ISHP). This will include technical specialists, programme officers, provincial technical coordinators, and learner support agents.

The programme will continue to support DBE peer education programmes, including roll out of MTV Shuga, messaging will be tailored to emphasize the location specific AYP issues, and renewed emphasis on Renewed emphasis will be placed on engaging parents, sexual orientation, gender identity and expression (SOGIE), GBV, and mental health.
The in-school programme shall be extended to Quintile 4 schools, this is to increase saturation and based on implementation lessons that many girls from vulnerable community's travel to attend these schools.

Out of school – community-based programming will be delivered as follows:
Safe Space Model: the safe space model to deliver youth friendly services will be expanded, and the number of safe spaces in the 5 AFSA target sub-districts will be increased to 40. The operating hours of safe spaces will be extended to include weekends and flexible hours.
Scale-up the use of digital/social platforms: to increase reach to more out-of-school youth, the use of digital/social media will be scaled-up as part of peer-led communication and awareness raising on HIV prevention and sexual and reproductive health.
Expanding adolescent and youth access to health services: the number of mobile clinic teams in the 5 AFSA target sub-districts will be increased to 10 to strengthen differentiated service delivery by extending clinic hours, expanding non-facility-based services (e.g., schools, libraries) and strengthening AYP-friendly services. The mobile clinics will serve both in- and out-of-school girls, roving the sub-district on a predictable schedule and route. Services will be offered as close to school grounds and safe spaces as communities permit.
Community education and engagement: interventions will be conducted to strength community engagement; this will include the Families Matter! Programme with parents, and engaging with traditional authorities, and religious leaders.

Economic Strengthening: The primary target group will be youth "Not in Education, Employment, or Training" (NEET) aged 20 to 24 years and focus on this intervention will be skills development, income generation activities, livelihoods support and mentorship. A sub-set of the young women that successfully complete the ESLP programme will be offered the opportunity to participate in the BizAIDS's entrepreneurship programme.

9.2.2. Technical and Vocational Education and Training (TVET) and Community Education and Training (CET) Colleges

Ongoing support will be provided to Technical and Vocational Education and Training (TVET) and Community Education and Training (CET) colleges to provide comprehensive services including peer education (MTV Suga), commodity vending machines, PrEP initiation on campus, and other clinical services through mobile units where they don't exist. NACOSA will continue to lead contracting and coordination of the TVET SR (Higher Health (HH)). HH will contribute towards AFSA's community-based services and targets.

9.3. Male Sexual Partner programme

The male sexual partners programme (MSP) will be strengthened in all the AYP target sub-districts. The purpose of the programme is to identify MSPs living with HIV and to initiate them on treatment and link men testing negative for HIV, to HIV prevention services (PrEP and VMMC). The programme will offer comprehensive health screening (HIV, STIs and NCDs) to men aged 25-34 years in the 14 AGYW sub-districts and along transport routes that feed in and out of these locations.

The approach will target AGYW referrals, taxi ranks, and workplaces, as evidence from the current grant shows this is where the highest positivity is. Partnerships with general practitioners and specialized men's health service providers will continue and partnerships will be explored with private pharmacies to expand HIVSS access, pharmacy-initiated ART, and SMS reminders for medicine pick-up. The programme will continue to employ Nurse Initiated Management of ART (NIMART) nurses to assist with clinical management and linkage to care. NIMART nurses can do ART initiation, PrEP initiation, and offer other clinical services at community level.
This programme will continue to be implemented and co-financed by the private sector sub-recipient. AFSA will coordinate the MSP co-funding component of the MSP programme in **all** 14 sub-districts (including AYP districts managed by the other 2 PRs: Beyond Zero & NACOSA), through engaging a lead private sector partner to incorporate the co-funding element.

9.4. Thuthuzela Care Centre Programme

Despite South Africa's commendable Human Rights framework and legislation, promoting gender equality, as well as a range of civil society and government interventions; the rights of women, girls and other vulnerable populations continue to be compromised by high levels of GBV. The terms "violence against women" and "gender-based violence" are often used interchangeably as women and girls are the most at risk and most affected by GBV. However, boys and men can also experience GBV, as can sexual and gender minorities.

Regardless of the target, GBV is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control[3]. Sexual violence is a component of GBV. The WHO defines sexual violence as: "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work." [3]

It is estimated that 20–25% of new HIV infections in young women in South Africa are attributable to GBV. Given the substantial relationship between GBV and HIV, as well as other sexual and reproductive health (SRH) outcomes, there has been an in increasing trend of combining GBV intervention efforts with HIV prevention programmes[3]. This is particularly important for the prevention of new HIV infections among vulnerable, high-risk populations.

Although the South African National Strategic Plan for HIV, TB and STIs 2017 – 2022 (NSP) is primarily focused on HIV, TB and STIs, its most recent iterations have incorporated structural and social drivers of HIV, TB and STIs, such as GBV. This has been guided by research showing that social, economic, and environmental factors affect the HIV risk and prevalence.

Gender and GBV are seen as contributing factors in HIV risk and prevalence. Within Goals 3 and 4, sub-Goals related to GBV include:

- Increase access to and provision of services for all survivors of sexual and gender-based violence in the priority districts.
- Increase access to provision of services for all survivors of sexual and gender-based violence.
- Provide support for survivors of sexual assault.
- Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts.

Beyond the NSP, the South African government has taken various measures to address GBV including:

- Ratifying various international treaties and conventions e.g., the Convention on the Elimination of All Forms of Violence Against Women
- Introducing a strong legislative framework including the Criminal Law (Sexual Offence and Related Matters) Amendment Act (SORMA) (Act No. 32 of 2007)

SORMA's unique incorporation of HIV, as it relates to the protection and reduction of harm of survivors, includes the prescription that all survivors of sexual assault have the right to receive information on potentially negative health outcomes and should receive related medical assistance with these potential outcomes, such as PEP within 72 hours of the alleged offence. Compulsory HIV testing of the alleged offender within a set time period is also prescribed in the Act, providing survivors with the means to make informed medical and lifestyle decisions.

The TCC concept was developed by the NPA in collaboration with numerous government departments to provide comprehensive services to sexual assault survivors across South Africa. TCCs are intended to function as multi-sectoral one-stop facilities, which provide a broad range of essential services to survivors in one location. They aim to reduce secondary trauma for the victim, improve conviction rates and reduce the cycle time for finalising cases. Patients do not have to move from one place to another to get help; they are offered the necessary services at one place with all the required resources.

Due to the need of ensuring a positive yield for PEP and ART, PRs are ensuring that SRs facilitate that survivors are assisted and linked to Care. Education on adherence to treatment starts at the beginning of the treatment cascade. Adherence includes taking treatment as prescribed, keeping to appointments for test results, referrals, and further investigation. The survivor motivation to continue engaging with care regardless of eligibility for ART is influenced by their experience and attitudes of others.

Adherence requires ongoing assessment and monitoring, which should be part of each visit, as factors that influence adherence are dynamic and require different approaches as they change over time. The Services for Rape Survivors module of the AYP programme is implemented in conjunction with the Community Systems Strengthening (CSS) programme which seeks to capacitate SRs implementing Global Fund programmes as well as create coordination and alignment across programmes in provinces of South Africa.

9.5. Sex Worker Programme

A comprehensive package of social, structural, and biomedical services (aligned to the National Sex Worker Plan 2019-2022) will be offered to male, female, and transgender sex workers at fixed and mobile sites, aiming for 95% saturation in 16 non-PEPFAR districts. The districts include in original 14 districts of Amathole, Alfred Nzo, Buffalo City, Bojanala Platinum, Capricorn, Greater Sekhukhune, King Cetshwayo, Mopani, Nelson Mandela Bay, Sedibeng, Thabo Mofutsanyane, Ugu, West Rand and Zululand, and two new districts have been added to the programme: Lejweleputswa and Francis Baard due to the high numbers of sex workers and service inequalities in these two districts. The programme aims to reach and provide services of 45,584 sex workers.

9.5.1. Core Package & Layers

The minimum (core) package for sex workers is comprised of a risk assessment, peer education (HIV-negative sex workers) and peer navigation (HIV-positive sex workers), offer of male and female condoms and lubricants, offer of HIV testing services, TB and STI screening, risk reduction counselling, social mobilization, offer of psychosocial support (to beneficiaries and to interventionist staff – new addition), PrEP demand creation (HIV-negative sex workers) and GBV screening and awareness (based on WHO LIVES). Then, layers are added based on the risk assessment.

Layers:

- Biomedical: HIVSS, pregnancy testing, annual pap smear, cervical cancer awareness, screening, and referrals (new addition in this funding request), emergency contraception, PrEP, PEP, ART initiation or linkage, viral load monitoring, PMTCT, termination of pregnancy, PPT for STIs, TPT, TB treatment, Hep B screening and immunization, mental health services, hormone therapy (for trans sex workers) and rectal care (for male and trans sex workers).
- Behavioural: PrEP use support, peer-led adherence support, parenting support, harm reduction (for sex workers who use drugs), substance use support.
- Structural: Community empowerment, dignity packs, gender-transformative condom negotiation, economic empowerment, reporting human rights violations, sensitizing healthcare workers and HTA, legal services, post-violence care, interventions for young people who sell sex, HIV service uptake for clients and partners, referrals to Sisonke.
- The programme aims to enhance the tailoring of packages for transgender sex workers, male sex workers, young sex workers, and sex workers who are parents. Outreach will be led by 288 peer educators/navigators (ratio of 1 peer educator to 150 sex workers), 32 of whom are young sex workers, 32 of whom are peer mothers, and 48 of whom are specially trained linkage officers who will link sex workers to services. The proportion of male and transgender peer educators will be determined based on the demographics of the specific site.

9.5.2. Children of Sex Workers

The programme will continue to prioritize special programming aimed at **children of sex workers**. Support groups for sex workers who are parents will be established to share information on perinatal health (including mental health), SRHR, child health, child development, and parenting skills. The "Mothers 4 the Future" four-week curriculum will be updated and modified. A cohort of specialized peer educators shall be trained to conduct outreach work to sex workers who are pregnant or have

children. Family health days for sex workers' children will be hosted to conduct health checks, vaccinations, nutritional assessment and support, and school readiness assessment.
Provision has been made for SRs to employ social workers (1 per site), and auxiliary social workers (2 per site) to assist sex workers in obtaining childcare grants, birth certificates, nutritional support, and other social protection and to provide legal and social support for sex workers on matters relating to child custody. As appropriate, linkages will be made to the Global Fund AGYW programme, DREAMS, DBE's Learner Support Agent programme, and other OVC programming.

9.5.3. Clients of Sex Workers

The programme will include a new component specifically targeting the clients of sex workers, this has been included at the request of the sex workers. The initial focus will be on engaging with the owners, managers, staff and other 'gatekeepers' at sex worker venues (e.g., bars, shebeens, brothels, truck stops, hostels) to ensure that occupational health and safety standards for sex workers are developed and maintained, and to be able to engage with clients of sex workers around their sexual health. This will be done performed by outreach peer education teams in each of the districts. Outreach teams will be led by the by venue gatekeepers to facilitate individual or small group discussions with clients around promoting the sexual health of both clients and sex workers, creating demand for HIV and STI services, particularly HIV testing and treatment initiation and adherence support for those who are positive, navigation to where they can access discreet HIV and STI services, PrEP promotion, awareness of support services, challenging harmful gender norms which perpetuate violence against sex workers, raising awareness of sex workers rights, among other relevant topics. Occupational health and safety will be promoted through a zero tolerance of violence policy in workplaces, and availability of condoms, lubricants and HIV SS at sex work venues will be ensured. Existing materials developed by Sonke Gender Justice will be adapted, including a workshop curriculum, and IEC materials will be made available to clients. Collaboration with the private sector will be explored for example with the road freight industry, mining industry, the beverage industry among others.

9.5.4. Develop and Pilot a Strategy for Minors (<18 years) Who Sell Sex

Another new component to the Sex Worker programme is the plan to develop and pilot for minors (<18 years) who sell sex. During the first year of the NFM3 programme cycle consultations will young people who sell sex in the co-creation of appropriate, relevant programmes which meet their needs. A multi-sectoral national working group will also be established in year 1 (sustained in years 2 and 3), which will develop a strategy to address the HIV-related needs of minors selling sex. The working group will include representation of young people who sell sex.

Additionally, the programme will conduct a programmatic mapping to assess current services for minors selling sex and analyze gaps. The research and the mapping will explore minors who sell sex in their diversity (male, female, and transgender) as well as a variety of venues, including online. Importantly, this will include representatives of young people who sell sex in the national working group. From year 2 onwards, funding will support the piloting of a targeted programme to address the HIV-related needs of minors who sell sex.

9.5.5. Economic Empowerment

The **economic empowerment** programme piloted during 2019-2022 will be scaled up to all districts (reaching 40 sex workers per district per year), integrating lessons learnt from the evaluation (2021/2). Core elements of the programme are training in financial literacy, work readiness or entrepreneurship, savings clubs, and mentorship. Microenterprise training that involves food security will be added to address effects of COVID-19. New tailored educational support opportunities for young sex workers will be integrated.

9.5.6. Cross Cutting Key and Vulnerable Population Prevention Intervention

A key priority is to address the intersectional, diverse, and individual nature of key populations, one of the ways in which this will be done is to pilot and evaluate a new model for a one-stop-shop key population centre. The pilot KP Centre will be a space where all key populations in their diversity can access services in a safe, stigma-free space. Practically speaking, the programme will cluster several SRs, each providing services to different KPs, under one roof, while encouraging linking, collaboration, and referral. The centre will work to ensure that diversity and vulnerability within key population groups are addressed, including key populations who have multiple vulnerabilities for example transgender sex workers, MSM who use drugs, key populations who are migrants, and key populations with disabilities.

9.6. Programmes to Reduce Human Rights- Related Barriers to HIV & TB Services

9.6.1. The Global Fund

The Global Fund Strategy's (2017-2022) Strategic Objective 3(c) commits the GF to support all countries that apply for grants to include and scale up programmes to remove human rights-related barriers to health service[2]. The GF has recognized access to affordable and quality treatment for HIV, STIs, and TB that is free of stigma and discrimination for Key Vulnerable Populations (KVPs) as a priority in its current funding period, 2022 to 2025. It has introduced **Programmes to Reduce Human Rights Related Barriers to HIV Services** as a new module in this funding period. This module "…provides additionality to government and PEPFAR service delivery by improving access and quality".

In addition, South Africa is one of the twenty countries which is a focus of Global Funds' **Breaking Down Barriers Programme**. This intensive programme aims to support the scale up of quality human rights programmes in these countries, recognizing that human rights programmes are 'critical enablers' which boost the effectiveness of Global Fund grants. As part of the Breaking Down Barriers Programme, a baseline assessment was conducted of the human rights barriers which limit access to, uptake of and retention in HIV and TB services in South Africa, particularly for KVPs.

South Africa's NSP for HIV, TB, and STIs: 2017–2022 recognizes that, despite South Africa being recognized globally for its positioning and response to human rights, significant gaps remain before we realize the full implementation of the human rights agenda. These gaps remain significant for KVPs. It is critical to translate key policies into implementation and to ensure that all people know their rights and how to seek redress when those rights are violated.

9.6.2. The National Strategic Plan

South Africa's NSP 2017-2022, **Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches** informed the development of a Three-Year National Implementation Plan for A Comprehensive Response to Human Rights-Related Barriers to HIV and TB Services and Gender Inequality (hereafter referred to as the National Human Rights Plan).

Figure 1: Key Programmes to reduce stigma and discrimination and increase access to justice in national HIV responses (UNAIDS)

The National Human Rights Plan sets out a comprehensive response to human rights and gender-related barriers to HIV and TB services in South Africa for people living with HIV, people living with TB, key and vulnerable populations. This Human Rights module of the current Global Fund grant, therefore, has as its foundation these three key documents: the NSP, the baseline assessment, and the National Human Rights Plan. This module is the outcome of these three processes. Implementation of the Human Rights programme builds on existing research, tools, trainings, reporting mechanisms and legal support from the GF and aligns to the seven key programmes recommended by UNAIDS, as shown below.

Implementation by AFSA will focus on five out of the seven programme areas listed above. Programme Areas (PAs) 2: *Training of Healthcare Workers on Human Rights and Medical Ethics* will be directly implemented by the National Department of Health (NDoH), while PA7: *Reducing Discrimination against Women (including Adolescent Girls and Young Women) in the context of HIV* will mainly be implemented through the Adolescent Girls and Young Women (AYP) programme and the *Thuthuzela Care Centre (TCC) interventions* aimed at providing care and support to survivors of Gender-Based Violence (GBV).

Furthermore, these seven programme areas are implemented across different districts and provinces alongside the Advocacy and Community-Based Monitoring programmes – which are distinct yet complimentary programmes – under the Global Fund grant and which are also implemented by AFSA.

9.6.3. The National Implementation Plan

On June 11, 2019, South Africa launched a Three-Year National Implementation Plan for A Comprehensive Response to Human Rights-Related Barriers to HIV and TB Services and Gender Inequality in South Africa. Interventions under the Human Rights programme and aspects of the Advocacy and Community-Based Monitoring Interventions will contribute toward the realization of the targets set in this plan.

Table 2 outlines specific interventions by each one of the Sub Recipients (SRs) and other service providers coordinated by AFSA. In addition to the efforts coordinated by AFSA, efforts by other PRs and stakeholders may also appear in the table below. Each Programme Area will also highlight opportunities for collaboration across all Global Fund supported programmes and cross-cutting nature of interventions. This will strengthen linkages across all programmes.

Successful implementation of the Human Rights programme depends on strengthened collaboration by different stakeholders. These include the South African National Aids Council (SANAC), Primary Recipients (PRs), SRs from across all GF funded modules, the civil society sector, government departments, community leaders and, most importantly, KVPs directly affected by gaps in recognizing human rights for all.

AFSA has appointed SRs to undertake direct implementation across five out of the seven Programme Areas listed earlier. These programme areas are PA: 1, 3, 4, 5, 6 (See Figure 1). While AFSA – through its SRs – will contribute towards implementation of Programme Area 2 (Training of Healthcare Workers on Human Rights and Medical Ethics), whilst the National Department of Health will lead implementation under this PA. Scaling up of all Human Rights programme related interventions through increased awareness and referral of KVPs to services will be facilitated through the Advocacy and Community-Based Monitoring interventions.

It should also be emphasised that, in practice, there is overlap between the different programme areas. Activities implemented under one programme area may have outcomes under multiple programme areas. For example, the REAct model, while primarily a tool to document human rights violations, can be used as a platform to increase legal literacy, track access to justice, and to reduce stigma and discrimination, as well as hold health care workers and law enforcement accountable for non-stigmatising service delivery.

Table 2: National Implementation Plan for Comprehensive Response

PROBLEM	ACTIVITY	OUTPT	OUTCOME	DESIRED STATE
HIV, TB, SW Key & Vulnerable populations continue to experience challenges or barriers in accessing services essential for their health and social wellbeing.	Reach communities with KVPs-specific anti-stigma & discrimination messages	SRs appointed to coordinate anti-stigma & discrimination interventions at district level	Community level coordination & monitoring of anti-Stigma and Discrimination interventions through steering committees	Communities can identify and resolve challenges and barriers experienced by KVPs
	Develop Standardized anti-stigma and discrimination sensitization material	Update the Human Rights Toolkit developed under NFM2.	Community workers across all SRs, SSRs and IPOs trained on Human Rights for KVPs	Discourse on HIV-TB KVP is normalized across communities. Increased awareness on the needs and experiences of KVPs
	Document human rights violations for KVPs	Improve roll-out of REAct across all districts. Develop web-based national platform for consolidating Human rights violations (HRV) reports. Produce analysis & reports on HRV.	Analytical reports on KVPs human rights violations	Analysis on the state of human rights for KVPs
	Facilitate legal support services for KVPs	Number of paralegals, lawyers attending to human rights violation cases for KVPs. IPO appointed to provide legal support services to KVPs.	Efficient Legal recourse to violations of human rights violations for KVPs and number of cases taken up	Increased access to legal services for KVPs
	Sensitize and train Law enforcement agents (LEA) on the rights and experiences of KVPs	Roll-out the Diversity Dignity and Policing training for LEA (SAPS and correctional services personnel, etc).	5000 LEA sensitized across the country	Acceptable and supportive LEA protection services esp. for SWs, PWID /PWUD & LGBTQI

Furthermore, the human rights module of the current grant is planned in such a way as to scale up human rights programmes that work in combination with each other, and which mutually support each other, for optimal impact. Efforts under the Human Rights programme will yield several deliverables. However, the core deliverables that AFSA will focus on include but are not limited to the following:

- Training of law enforcement agents in: Dignity, Diversity and Policing.
- A National Web-based platform or mechanism for the documentation and reporting on human rights violations experienced by KVPs in the context of HIV & TB.
- Capacity building support to People Living with HIV (PLHIV), TB and key population-led CSOs to provide district-level sensitisation, training, and mentorship.
- Support for PLHIV, TB and KP-led CSOs to expand and evaluate, through collaboration with health facilities, existing training, and clinical mentorship at district level.
- Support for participatory action, operational science, and pilot programmes to improve policy to include new approaches to TB care, that empower patients and respect their privacy and confidentiality.
- Conduct Stigma Index 2.0

AFSA has appointed Sub-Recipients to implement programmes and interventions to ***reduce human rights-related barriers to HIV and TB services*** across 18 districts implementing AFSA's KVP programmes. Sub-Recipients are direct implementers of programme interventions. SANAC SR is the implementer of human rights & advocacy intervention spanning across national level. The other SRs have a district-focus in their implementation.

9.7. Advocacy Programme

The advocacy grants will be for district- and province-specific work led by KVP networks. The grant will enable these networks to develop district-specific advocacy plans and lead advocacy activities aligned to the realisation of the programme modules for the Global Fund 2022 – 2025 grant. Civil Society leadership is committed to realising the goals of the NSP and its advocacy priorities are anchored in the NSP, with which all modules of the grant are aligned.

9.7.1. Advocacy Strategy goal

Overall, the goal of the advocacy strategy is to *strengthen the capacity of community-based organisation* communities to advocate for improved effectiveness of health, social and justice services for AYP, KP, PLHIV and PTB, through addressing the barriers to access to services. This includes advocating for improvement in the following areas;

a) Advocacy for greater participation and involvement of the key and vulnerable population in planning, implementation, and monitoring of global fund grant programme modules at the district level. Policy implementers need to ensure meaningful participation of the key and vulnerable population in the District AIDS Councils and in the implementation of the district implementation plan (DIP's) and provincial implementation plan (PIP) and sectorial plans.
b) Advocacy for improved access to comprehensive health services for key and vulnerable populations by addressing bottlenecks and advocacy issues identified by communities.
c) Advocacy for greater resource allocation for capacity building of the key and vulnerable population. Key and vulnerable populations should meaningfully participate and monitor the budgetary processes particularly on commitments that are made for them.
d) Addressing gender inequality and stigma and discrimination as a cross cutting issue through all advocacies.

9.7.2. Advocacy Strategy Objectives

a) Strengthened Organizing by Civil Society

Community level mobilization and organizing by civil society will facilitate for a structured and active participation of HIV-TB key and vulnerable populations on issues that directly affect the. This will further ensure meaningful constituency engagement amongst the sectors and at multi-levels of the leadership of civil society. Civil Society organizing will ensure that organisations receiving small advocacy and community monitoring grants are supported in their advocacy efforts through clear identification of advocacy issues and regular advocacy engagements.

b) Evidence-based advocacy

The Advocacy interventions will be based on the collection of systematic evidence on the ***availability, accessibility, acceptability, quality of services*** including issues related to gender inequality and stigma and discrimination of key and vulnerable populations. Implementing organisations will collaborate with SRs documenting violations of human rights.

The depth and breadth of relevant research needs to be understood to empower the key and vulnerable population so that they lead on issues relating to their communities, including playing a central role in developing policy briefs; building long term relationships with key stakeholder at all levels; forming coalitions

and networks; building the capacity of all partners including government to understand and utilise evidence in decision-making related to delivery of services in line with objectives of this strategy and to develop sustainable community programmes.

c) Synergy and partnerships

The implementation of this strategy relies on collaboration between communities, PRs, SRs, CSF, and all other relevant stakeholders, including DoH, DCAs and PCAs. Strengthening of partnerships and formalisation of existing ones will be pursued at all levels. In addition, synergic relationships amongst key and vulnerable population sectors will be maximised.

d) GIPA/MIPA Principle

The GIPA/MIPA Principle or the 'Greater/Meaningful Involvement of People living with HIV' is a principle that aims to realise the rights and responsibilities of people living with HIV, including their right to participation in decision-making processes that affect their lives This is the principle of 'Nothing about us, without us'.

The active and meaningful participation and leadership of the strategy's core constituency - people living with HIV, people affected by TB and key and vulnerable populations, will be central in the implementation of this strategy.

Top Tips for Successful Constituency led Advocacy Interventions

- Clearly defined problems that directly affect the target constituency/networks.
- Agree on measurable impact – quantitative and qualitative.
- Develop strategic activities aligned to achieving impact.
- Clear and strong messages
- Develop a power map to identify allies and target audience to influence.
- Remain flexible to catalyse on key opportunities!
- Regular review and reflection on plan

9.7.3. Advocacy Strategy Activities

To ensure community needs and realities inform the planning, coordination and implementation of the HIV and TB response, the SRs will undertake the following:

a) Identify actionable advocacy issues

SRs will identify actionable advocacy issues which relate to the *availability, accessibility, acceptability, quality and responsiveness of services.*

- Participatory consultative processes, with AGW, KP, PLHIV and PTB as per SR target population/s, that identify advocacy issues.
- Participatory processes that prioritize key advocacy issues per semester.

b) Develop advocacy plans to address issues identified

- Undertake campaigns, activations, and other forms of strategies to address issues identified.

- Develop a Power and Stakeholder analysis to *identify allies, target groups to mobilize support, target groups to lobby.*
- Clearly define timeframe for advocacy interventions – align strategic interventions for short-, medium- and long-term outcomes.

c) Implement and document advocacy interventions

- Implement advocacy intervention/s with key and vulnerable populations (KVPs)
- Document activities which form part of the advocacy intervention
- Develop case studies (problem statement, planned advocacy, what happened, result, learning)

d) Strengthen coordination and accountability through structured mechanisms

- Participate and engage Community Systems Strengthening (CSS) across all eight provinces, including the District Consultative Forum Meetings[1]
- Direct engagement with local service providers, decision makers and partners
  - -Participation in clinic committees
  - -Participation in community forums
- Participate in district, provincial and national committees (District AIDS Councils, Civil Society Sector Forums).
- Engage and collaborate with fellow Advocacy Strategy SRs – across KVP groups, and across districts.
- Engage and collaborate with Human Rights Programme Sub-Recipients – across KVP groups, and across at district and provincial level.
- *Strengthen referral mechanisms* across all Global Fund supported service provision interventions-*AYP, PWID, Sex Workers, TG, MSM and TB programmes*

e) Contribute towards Multi Sectorial Implementation Plans (MDIPs)

- All Sub-recipients (SRs) will *implement, monitor, and report on activities aligned to the Multi-District Implementation Plans (MDIPs)* according to their assigned key and vulnerable population.
- Assessment and reporting on contributions towards MDIPs is facilitated through the SCR programme. Advocacy Implementing Partner Organizations will participate in CSS coordinated meeting to report on their contributions.

f) Support and participate in coordinated media engagement opportunities

- Through AFSA-facilitated media engagement, SRs should catalyse the role of the media (mainstream, community, and social media) to disseminate information, increase knowledge and enhance sensitization on AYP, KP, PLHIV and PTB issues

g) Use the above steps to identify advocacy issues to be escalated to higher decision-making platforms.

- Under certain circumstances, advocacy issues cannot be resolved with short-term interventions at local level and will need to be escalated. These circumstances could include local stakeholders are resistant to engagement on the identified advocacy issue; the advocacy issue is experienced more widely than in just one location; the advocacy issue is affected by policies, plans or other barriers at a higher level.
- Under these circumstances, SRs should advocate for the issue to be escalated to a higher level, including inclusion in future MDIP, PIP and NSP development processes.

h) Mark key calendar dates to amplify advocacy messages aligned to KVPs

- SRs can use key dates to organise advocacy campaigns. They can use both national and international dates to mobilise communities and raise awareness around issues. Key dates also provide opportunities to strengthen partnerships.
- The Department of Health has an annual health calendar which highlights a different health issue every month.
- All key and vulnerable populations included in the Advocacy Strategy have key dates for their constituencies.

i) Community-led monitoring

Key and vulnerable population organizations and networks will conduct community-led monitoring (CLM) to track the availability, accessibility, acceptability, and quality of HIV, TB, and broader sexual and reproductive health services provided in Global Fund districts where key and vulnerable population programming is being delivered, both in health facilities and in communities (e.g. mobile units). As a first step, the programme will conduct rapid evaluation of current systems and digital innovations for CLM, including those done by civil society (e.g. 'Community Matters' App, ITPC's 'Citizen Science'), PLHIV networks (e.g. Ritshidze) and key populations (REAct, Mystery Clients).i KVPs will be involved in context analysis and tools development to ensure they are customized and appropriate for use. Based on the evaluation, CLM tools and approaches will be finalized for the grant.

One organization per Global Fund district will be chosen to do CLM. To do the CLM, seven national networks will be contracted by SANAC: one PLHIV network, one TB network, one sex worker network, one LGBTI network, one women's network, one PWUD network, and one youth network. These national networks will work with sub-partners at province or district level to implement the CLM. The networks will be trained in the specific CLM tools and methodology. For the TB CLM, the country will explore using the OneImpact approach. They will be funded to hire data collectors and purchase tools required for data collection (e.g. bicycles, tablets). They will collect data monthly from the health facilities and community service delivery points. Then the KVP groups will analyze the data, and develop advocacy materials. The networks will present their CLM data and analysis on a quarterly basis, in relevant technical working groups,

LAC/DAC/PCA meetings, CSF forum meetings, Programme Review Committee meetings, among other consultative forums.

j) Stakeholders to be engaged:

- Community Based Organizations – Aligned to key populations
- Civil Society Organizations – Aligned to key populations
- SANAC Civil Society Forum
- South African National AIDS Council
- Provincial Aids Councils
- District Aids Councils
- Ward based Councils
- National Government Departments – Aligned to key populations
- National Assembly – and members of relevant committees
- Department of Health
- Department of Social Development
- Department of Basic Education
- National Prosecution Authority

9.8. Community Systems Strengthening (CSS) Programme

South Africa's NSP emphasizes that an agile, well-resourced civil society is better positioned to contribute to stronger community systems and to ensure a seamless continuum of care from the health to the community system.ii As such, the current grant will prioritize community systems strengthening. Priorities are to build capacity and sustainability of civil society and community groups and support their meaningful engagement in multi-stakeholder leadership and accountability mechanisms.

Institutional capacity building, planning and leadership development

The major drive in this intervention is to expand the capacity building and small grants programme to community-based organizations (CBOs), both in scale and in scope. About 129 small community-based organizations will receive capacity building support, and about half of these will subsequently be awarded small grants to implement community-based activities in support of the Global Fund programme. The types of CBOs supported will be strategically selected to contribute to NSP and Global Fund implementation of TB and HIV programming for key and vulnerable populations.

In the previous grant, capacity was built primarily among PLHIV/TB CBOs and AGYW CBOs, as well as some sex workers CBOs, LGBTI CBOs, and PWID CBOs, PLHIV-led, WLHIV-led, GBV survivor-led, TB survivor-led, youth-led, sex worker-led, drug user-led, LGBTI-led, disabled people's organizations (DPOs), women-led, and human rights-focused organizations, especially those working in remote and rural areas of priority districts.

An additional 16 CBOs who previously completed the capacity building programme, will be awarded medium-sized grants to complement the programme objectives. The 18 Civil Society Sector host organizations will be prioritized for medium-sized grants, as they have had their capacity built in the previous Global Fund grant. Both the small and medium grants will be used to strengthen community-led service delivery in HIV and TB in Global Fund-supported districts at the community level.

Social mobilization, building community linkages, collaboration, and coordination

The second priority activity in this module is to sustain and strengthen existing support to South Africa's multi-stakeholder leadership and accountability mechanisms. This includes improving the capacity of AIDS Councils, at all levels, to effectively coordinate the multisector responses. These are the main mechanisms for community engagement in national HIV, TB and COVID-19 responses. Programme will strengthen and maintain the Provincial and District Framework for AIDS Councils implementation, as well as strengthen and maintain the implementation of the District Development Model for local government HIV, TB and STI responses. This includes the human rights capacity building for PCAs and DACs, contained in the human rights module. To achieve this, programme will develop induction and orientation tools that will target political heads of the response including Premiers, MECs, Mayors and Local Councillors and civil society leadership. The programme will also continue support for monitoring and evaluation (M&E) systems for AIDS Councils at Provincial and District level. It will also support SANAC to strengthen and maintain a web-based automated AIDS Councils Functionality Dashboard at all respective levels.

As part of strengthening the AIDS Councils, the programme will increase civil society capacity to effectively participate and meaningfully contribute to the multisector response by providing support for civil society coordination structures at provincial level. The programme will continue to support KP-led model that was used for consulting key populations for developing the current Global Fund programme. This will be done to

ensure ongoing meaningful engagement of communities throughout grant implementation. Key population networks will receive sub-grants through the relevant PRs to hold focus group discussions with their communities (quarterly), documenting recommendations from service users, and feeding this information back to PRs and SRs for continuous improvements. This will be closely linked with the CLM activities in the prevention module.