TERMS OF REFERENCE

Process Evaluation of the My Journey Vending Machine Pilot Programme

REQUEST FOR PROPOSALS | DECEMBER 2021

REFERENCE: **CFP-06-AGY-12-2021**

SUMMARY	
Title	Process Evaluation of the My Journey Vending Machine Pilot Programme
Reference	CFP-06-AGY-12-2021
Description *(Summary for website - 100 words max)*	NACOSA is seeking the services of a suitably qualified and experienced service provider to undertake a rapid evaluation of the My Journey Vending Machine Pilot Programme. The evaluation will assess the utility and benefit of the pilot programme among AGYW in accessing sexual and reproductive health commodities.
Questions to	queries@nacosa.org.za
Submission to	proposals@nacosa.org.za
Submission must include	1. Comprehensive proposal 2. CVs of evaluation team members 3. Detailed budget 4. Company profile 5. PIN for Tax clearance certificate verification 6. Valid B-BBEE Certification 7. Signed Code of Conduct for Suppliers of services related to Global Fund financing (sign each page): https://www.nacosa.org.za/2017/03/14/code-of-conduct-for-suppliers 8. Completed and Signed Declaration of Interest: https://www.nacosa.org.za/wp-content/uploads/2019/10/DECLARATION-OF-INTEREST.pdf 9. Confirmation of Banking Details not older than 3 months, by means of a stamped letter from the bank, bank statement or cancelled cheque. **Applicable for Company or CC** 10. Company documents detailed below **Applicable for Sole Proprietorship** 11. Owner documents detailed below
Deadline for questions	**17h00 on Friday 7th January 2022**
Briefing meeting	**Tuesday 11th January 2022**
Deadline for submission	**17h00 on Friday 21st January 2022**

CONTENTS

ACRONYMS

Acquired Immune Deficiency Syndrome	AIDS
Adolescent Boys and Young Men	ABYM
Adolescent Girls and Young Women	AGYW
AIDS Foundation South Africa	AFSA
Antiretroviral Therapy	ART
Beyond Zero	BZ
Department of Labour	DOL
Early Childhood Development	ECD
Expanded Public Works Programme	EPWP
Further Education and Training	FET
Gender-Based Violence	GBV
Grow Learn Own	GLO
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Intimate Partner Violence	IPV
Low-Middle Income Countries	LIMC
National Department of Health	NDOH
National Youth Development Agency	NYDA
Networking HIV & AIDS Community of Southern Africa	NACOSA
Not in Employment, Education, or Training	NEET
Peer Group Trainer	PGT
People Living with HIV	PLHIV
Principal Recipient	PR
Service Provider	SP
Services Sector Education and Training Authority	SETA
Sexual and Reproductive Health	SRH
Sexually Transmitted Infection	STI
Small Enterprise Development Agency	SEDA
Small, Medium and Micro-Enterprise	SMME
Standard Operating Procedure	SOP
Sub-Recipient	SR
Technical and Vocational Educational Training	TVET
Tuberculosis	TB

1. BACKGROUND

Overview of HIV and AGYW in South Africa

South Africa is home to the largest human immunodeficiency virus (HIV) epidemic in the world, modelled at 7.7 million people living with HIV (PLHIV) (all ages) in 2019[1]. However, over the years South Africa has made significant progress in turning the tide in the fight against HIV. According to THEMBISA model version 4.3, the number of newly infected adults has declined by 49% from 2010 to 2019[2]. It is estimated that the total number of new HIV infections for the year 2019 sits at 186 641, with Gauteng and KwaZulu-Natal provinces having the highest number of adults with new HIV infection[3]. South Africa's overall HIV prevalence is currently estimated at 13% among people of all ages which is an increase from the 12.2% in 2012. The HIV prevalence among those aged 15-49 years has also increase marginally from 18.8% in 2012 to present-day 19%[4] [5].

Women continue to be disproportionately affected by the HIV burden throughout their life, particularly those in Low-Middle Income Countries (LIMC). According to various studies, the HIV prevalence of adolescent girls and young women (AGYW) aged 15-24 years in LIMC is three times higher than that of their male counterparts of similar sexual behaviour[6] [7]. Similar sex disparities were pronounced in a South African study among adolescent girls and young women aged 15-24 years, whose HIV prevalence is 2.7 times greater than that of their male peers (9.9% compared to 3.7%)[8]. A further comparable perspective is shared by a study conducted in South Africa where a probable 27.6% of adolescent girls aged 15 years will be infected by HIV before the age of 60 years. This is in comparison to a probable 14.8% for adolescent boys aged 15 years[9]. Whilst this is a rather dejected outlook for adolescent girls, it is not improbable due to the fact most adolescent girls are often subjected to multiple factors that disempowers them such as intergenerational marriages at a young age.

[1] Johnson, L. & Dorrington R., E. (2020). THEMBISA version4.3: Modelling the impact of HIV in South Africa's provinces: 2020 update. Centre for Infectious Disease Epidemiology and Research working paper. Centre for Infectious Disease Epidemiology and Research, University of Cape Town; 2014. http://www.thembisa.org/content/downloadPage/WPversion1

[2] Eaton. J. (2020). Naomi: District-level estimates for HIV programme planning in South Africa. MRC Centre for Global Infectious Disease Analysis School of Public Health, Imperial College London. http://www.hivdata.org.za/

[3] UNAIDS, (2020). UNAIDS DATA 2020. https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf

[4] UNAIDS, (2020). UNAIDS DATA 2020. https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf

[5] Statss, (2019), Mid-year population estimates 2020. http://www.statssa.gov.za/publications/P0302/P03022020.pdf.

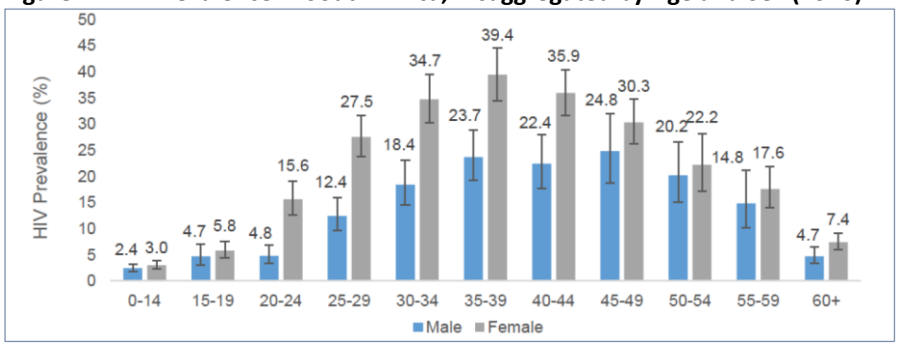
[6] Magadi, M., A. (2011). Understanding the gender disparity in HIV infection across countries in sub-Saharan Africa: evidence from the Demographic and Health Surveys. Social Health Illn. 33(4):522-39. doi: 10.1111/j.1467-9566.2010.01304.x. PMID: 21545443; PMCID: PMC3412216

[7] Klass, N., E. (2018). Thupayagale- Tshweneagae G, Makua TP. The role of gender in the spread of HIV and AIDS among farmworkers in South Africa. Afr J Prm Health Care Fam Med. 10(1), a1668. https://doi.org/ 10.4102/phcfm.v10i1.1668.

[8] Simbayi, L., C. Zuma K. Zungu N. Moyo S. Marinda E. Jooste S. Mabaso M. Ramlagan S. North A. van Zyl J. Mohlabane, N. and the SABSSMV Team, (2018). South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press. Page 52. Key Reference Document.

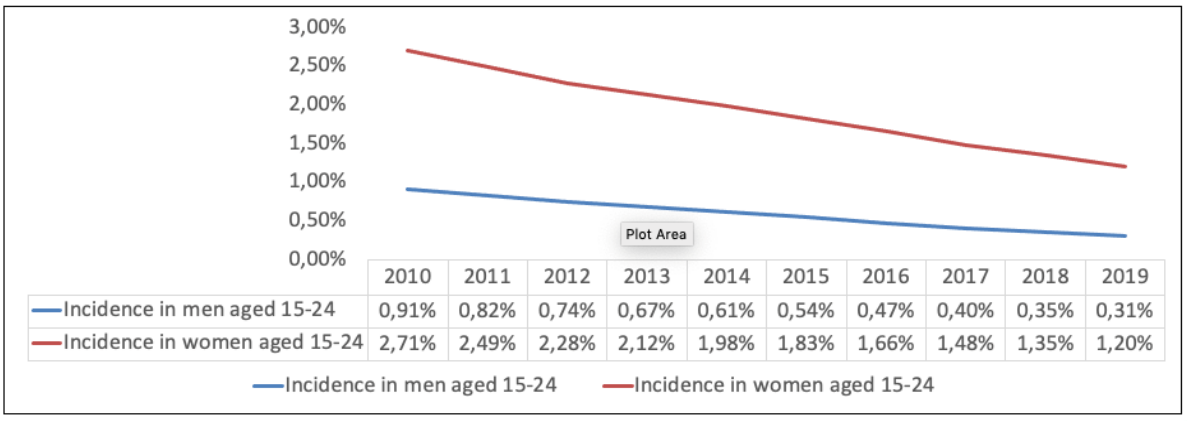
[9] Ibid

Figure 1. HIV Prevalence in South Africa, Disaggregated by Age and Sex (2016)[10]



Although there are gaps that South Africa still needs to address, the notable progress that it has made thus far towards achieving the 90-90-90 targets is commendable[11]. AGYW are one of the key groups susceptible to South Africa's epidemic and are thus identified as a vulnerable population in the country's National Strategic Plan. It is estimated that a third of all new HIV infections in the country occur in AGYW aged 15-24 years[12], totaling 1,674 new infections each week[13]. Modelling suggests that HIV incidence peaks among AGYW when they are 19 years old, at 2.74%[14]. However, the age and gender disparities in new infections are most significant among 17-year-olds, when girls are 8.7 times more likely to acquire HIV than their male peers[15]. This data suggests that tailored interventions focusing on older adolescent girls are needed.

Figure 2. HIV Incidence among Adolescents and Young People aged 15-24 (2019)[16]



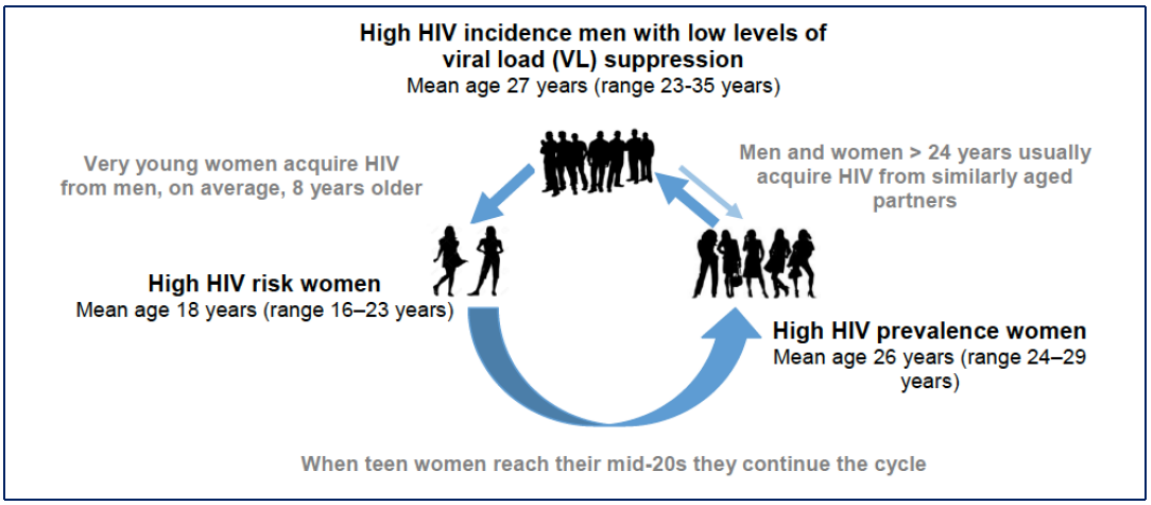
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Incidence in men aged 15-24	0,91%	0,82%	0,74%	0,67%	0,61%	0,54%	0,47%	0,40%	0,35%	0,31%
Incidence in women aged 15-24	2,71%	2,49%	2,28%	2,12%	1,98%	1,83%	1,66%	1,48%	1,35%	1,20%

A host of social and structural factors drive age and gender disparities in HIV incidence. Approximately 20 – 25% of new infections in young women in South Africa are attributable to gender-based violence (GBV)[17]. Age disparate relationships are common for AGYW – a phenomenon not observed to the same degree among adolescent boys[18]. In 2017, 35.8% of adolescent girls (age 15-19 years) had a male

[10] DHIS, (2016) Maps generated using South Africa's Focus for Impact Platform.
[11] UNIADS, (2016) Country Factsheet South Africa. Available online at http://aidsinfo.unaids.org.
[12] Simbayi, L., C. Zuma K. Zungu N. Moyo,S. Marinda, E. Jooste, S. Mabaso, M.Ramlagan, S. North, A. van Zyl, J. Mohlabane, N. and the SABSSMV Team, (2018). South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press. Page 52. Key Reference Document.
[13] Scorgie, F. Vearey, J.Oliff, M. Stadler, J. Venables, E. Chersich, M., F. and Delany-Moretlwe S. (2017). 'Leaving no one behind': Reflections on the design of community-based HIV prevention for migrants in Johannesburg's inner-city hostels and informal settlements. BMC Public Health, 17(3), 482. Page 81. Available online at https://www.ncbi.nlm.nih.gov/pubmed/28527472.
[14] UNAIDS, (2017). HIV Prevention 2020 Roadmap. Available online at http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-roadmap_en.pdf.
[15] Ibid
[16] NDOH, (2016). Standard Operating Procedures for Linkage, Adherence and Retention in Care. Key Reference Document.
[17] South African Global Aids Response Progress Report (GARPR) 2015. Page 51. Online at http://sanac.org.za/wpcontent/uploads/2016/06/GARPR_report-high-res-for-print-June-15-2016.pdf
[18] Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mohlabane N and the SABSSMV Team (2018) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press. Page 156. Key Reference Document.

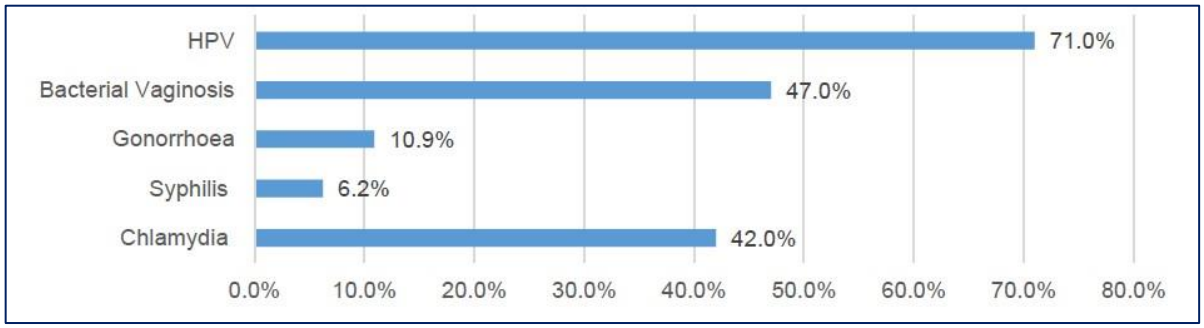
sexual partner who was 5 or more years older than them, up from 33.6% in 2012[19]. Genotyping shows that such relationships fuel the cycle of HIV transmission in South Africa[20].

Figure 3. The Cycle of HIV Transmission in South Africa[21]



The ability of AGYW to negotiate condom use increases with age, but nearly half (48.6%) of adolescent girls (aged 18-19 years) in KwaZulu-Natal report never using a condom with male sexual partners. Transactional sex is common, with 37.0% of young women (aged 20-24 years) receiving money or gifts for sex. The prevalence of sexually transmitted infections (STI) in AGYW is also alarmingly high. As a result, this drives HIV incidence and signals a need for improved, integrated and comprehensive sexual and reproductive health (SRH) services. In a recent assessment, STI prevalence rates of 17% - 42% for chlamydia, 71% for human papillomavirus (HPV), 6.2% for syphilis, 10.9% for gonorrhea and 42% - 47% for bacterial vaginosis were found among AGYW[22]. South Africa is working towards a 70% reduction of new STIs and a 90% HPV vaccination rate for Grade 4 girls[23].

Figure 4. STI Prevalence among AGYW in Cape Town and Johannesburg



[19] Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mohlabane N and the SABSSMV Team (2018) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press. Page 97. Key Reference Document.
[20] Dellar, R., Tansfer, F., Abdool Karim, Q. et al. (2016). Transmission networks and risk of HIV infection. Caprisa & UNAIDS. As cited in South Africa's NSP. Page
[21] Dellar, R., Tansfer, F., Abdool Karim, Q. et al. (2016). Transmission networks and risk of HIV infection. Caprisa & UNAIDS. As cited in South Africa's NSP. Page 14
[22] SANAC, (2017). Let our Actions Count: South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022. Page 8. Available online at: http://sanac.org.za/wp-content/uploads/2017/05/NSP_FullDocument_FINAL.pdf.
[23] Ibid

The Global Fund My Journey Programme (2019 – 2022)

The Global Fund (GF) to Fight AIDS, Tuberculosis and Malaria is an international partnership designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics. The Global Fund works in partnership with governments, civil society, technical agencies, the private sector and people affected by the diseases. NACOSA is a Principal Recipient (PR) of the Global Fund ZAF-C grant, entitled "Investing for Impact against Tuberculosis and HIV" which intends to strengthen South Africa's national response to HIV and TB.

Programme Outcomes

The My Journey Programme, expected to run from 1 April 2019 until 31 March 2022, offers an age-tailored combination prevention package for AGYW aged 15-24. The programme targets AGYW in and out of school and aims to reduce the risk of AGYW contracting HIV, promote positive sexual behaviour change and personal empowerment. Specifically, the programme has the following five key objectives:

1. Increase retention in school
2. Decrease HIV incidence
3. Decrease teenage pregnancy
4. Decrease gender-based violence
5. Increase economic opportunities

Structure, Oversight and Geographical Coverage

The implementation of the programme is the responsibility of three PRs: AFSA, BZ, and NACOSA. The PRs sub-contract sub-recipients (SRs) to implement intervention components.

Table 1. Geographic and Structural Breakdown of the My Journey Programme

PR	PROVINCE	DISTRICT	SUB-DISTRICT	SUB-RECIPIENT(S)
AFSA	KwaZulu Natal	Zululand	AbaQulusi	• MIET Africa • Higher Health (TVETs)
		King Cetshwayo	uMhlathuze	• Consortium for Strategic Analytics (Strategic Analytics & Management) • Higher Health (TVETs)
	Mpumalanga	Ehlanzeni	Mbombela	• Institute of Health Programmes and Systems (IHPS) • Higher Health (TVETs)
		Gert Sibande	Govan Mbeki	• Phidisa • Higher Health (TVETs)
BZ	Eastern Cape	Nelson Mandela Bay	Nelson Mandela C	• MIET Africa • Higher Health (TVETs)
		OR Tambo	Nyandeni	• Social Change • Higher Health (TVETs)
	Free State	Thabo Mofutsanyana	Dihlabeng Setsoto	• Institute of Health Programmes and Systems (IHPS) • Higher Health (TVETs)
	Limpopo	Greater Sekhukhune	Fetakgomo-Greater Tubatse	• Institute of Health Programmes and Systems (IHPS) • Higher Health (TVETs)
NACOSA	Gauteng	Tshwane Metropolitan	Tshwane 1	• Zakheni Training & Development Centre (Biomedical + Schools)

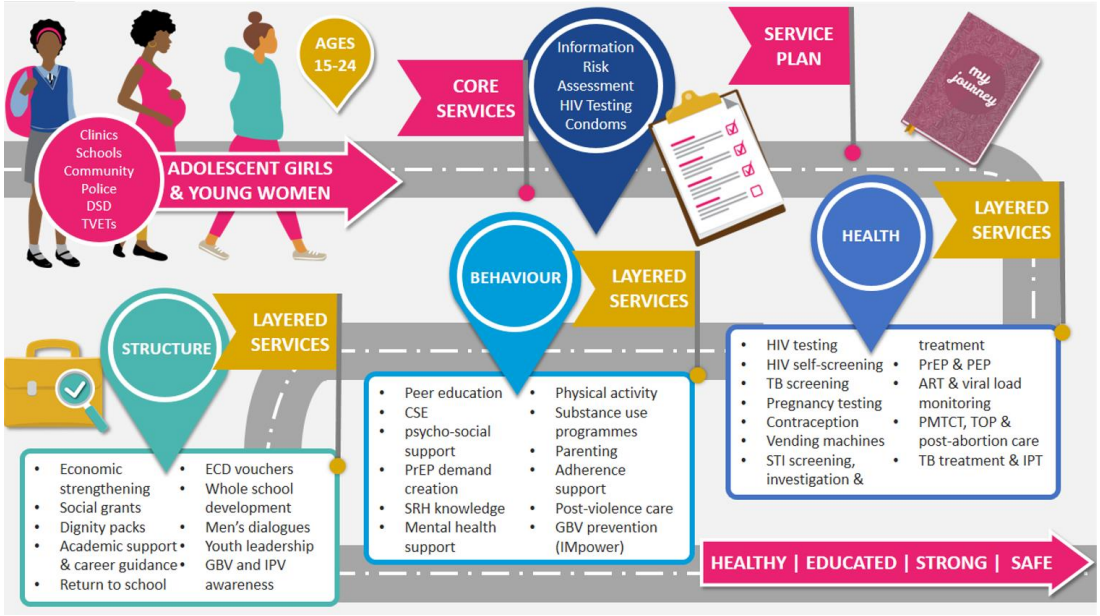
				• MIET Africa (Biomedical) • Childline Gauteng (Community) • Higher Health (TVETs)
	North West	Bojanala	Rustenberg	• Lifeline Rustenburg (Biomedical) • Show me your Number (Schools) • Childline SA for Childline North West (Community) • Higher Health (TVETs)
	Western Cape	City of Cape Town	Klipfontein Mitchells Plain	• TBHIV Care (Biomedical) • Partners in Sexual Health (Schools) • Amandla Community Education Development (Community) • HOPE Africa (Community) • Higher Health (TVETs)

Core and Layered Services

Adolescent girls and young women are introduced to the programme through a number of entry points and are channelled to two main service components called the Core Service and Layered Services. Core Services are delivered and AGYW then follow a programmatic path receiving additional services layered over time as required. The layered services are not necessarily provided in specific order and are dependent on the needs of the AGYW.

Both core and layered services are delivered by funded sub-recipients (SRs) in three tailored and targeted settings namely schools, TVETs and dedicated safe spaces in communities. A fourth "setting" or entry point is the mobile clinic that delivers clinical HIV and SRH related services at different points in the community within or nearby schools, TVETs and safe spaces. Layered services are categorised into health (which includes vending machines), behavioural and structural services and can also be delivered by unfunded external service providers (SPs) in their own settings via referrals from funded SRs. Figure 4 presents an overview of the Core and Layered Service Components that are currently being offered across the various implementation settings described in this document.

Figure 5. An AGYW's Path through The My Journey Programme



The **Core Service** consists of three main activities namely demand creation, a risk assessment and follow-up of journey plans for each AGYW over time. The risk assessment consists of the following five actions which take place during a private and confidential conversation between an interventionist and an AGYW:

1. Facilitated HIV risk and vulnerability assessment; TB, STI, and GBV screening
2. Offer of HIV testing
3. Offer of male and female condoms
4. HIV, TB, STI, and GBV information
5. Service Plan

The assessment and screenings result in a **Service Plan** which forms part of an agreed journey that each AGYW plans for her future. The service plan provides the overall guide for the integrated and layered services tailored and responsive to the needs of the girl/young woman.

The **Layered Services** are categorised into three services types:

1. Comprehensive **Health Services** to AGYW and ABYM delivered from mobile or fixed clinics in/near schools and in communities.
2. **Behavioural Services** delivered to AGYW and ABYM at safe spaces and other settings in communities.
3. **Structural Services** delivered to AGYW and ABYM at safe spaces and other settings in communities focused on AGYW but also on changing norms and raising awareness of GBV among men, boys, parents and caregivers.

Referrals are achieved by issuing a referral letter/slip to the beneficiary following the risk assessment or testing service. The beneficiary takes the letter to the allocated service provider. If possible, the SR provides for the AGYW, or accompanies her to the referral services (referred to as the handshake approach). Linkage officers are responsible for linkage to care and tracking successful referrals by making regular telephonic contacts with the AGYW or checking routine public health service registers such as Tier.Net.

AGYW are retained in the intervention through strategies such as incentives, service/activity reminders through WhatsApp groups, constant invitations to programme events, linkage to care and follow-ups, home visits/face-to-face visits, and youth events.

Vending Machine Pilot

As part of the health services within the layered service offering, the My Journey Programme is piloting the placement of 36 commodity vending machines for the provision of free SRH commodities to AGYW enrolled in the My Journey programme. The vending machines are stocked with pregnancy tests, male and female condoms, dental dams, finger cots, sanitary towels and lubricant at TVET campuses in 11 sub-districts. The pilot aims to provide a novel solution to promoting access to SRH commodities among young people.

In addition to other activities run at TVETs, demand creation for vending machine commodities and SRH services is actioned through the implementation of campus-based awareness campaigns and dialogues run by peer group trainers (PGTs). PGTs are responsible for the Peer education and demand creation through dialogues, IEC material distribution and the FTF programme (assisted by Peer Mentors)

- Enrolment in the AGYW programme through a biometric system
- Core package of services to individual AGYW
- Linkage to services, treatment, care & support
- Access to SRH commodities from vending machines

Pilot Outputs

The following indicators are monitored through the operation of the vending machines:

- Number of AGYW accessing the vending machine
- Number of male condoms dispensed
- Number of female condoms dispensed
- Number of lubricants dispensed
- Number of dental dams dispensed
- Number of finger cots dispensed
- Number of pregnancy tests dispensed
- Number of sanitary pads dispensed

Structure and Oversight

The implementation of the pilot programme is the responsibility of three PRs namely AIDS Foundation of South Africa (AFSA), Beyond Zero (BZ), and Networking HIV & AIDS Community of Southern Africa (NACOSA). PRs are responsible for the monitoring and evaluation (M&E), coordination, design and oversight of programme implementation with Higher Health, the SR responsible for Higher Education-Based Services at Technical Vocational Education and Training (TVETs) institutions within the My Journey Programme. The responsibility for programme management and contracting with service providers is held by NACOSA.

Geographical Coverage

The distribution vending machines geographically is illustrated in the table below.

Table 2. Geographic Breakdown of SRH Commodity Vending Machines

PR	PROVINCE	DISTRICT	SUBDISTRICT	TVET	CAMPUS	VENDING MACHINES
BZ	Eastern Cape	Nelson Mandela Bay	NMB Health C	Eastcape Midlands	Heath Park	2
				Port Elizabeth	Dower	2
					Iqhayiya	1
					Russell Road	1
		OR Tambo	Nyandeni	KSD	Libode	2
	Free State	Thabo Mofutsanyana	Dihlabeng	Maluti	Bethlehem	2

	Limpopo	Sekhukhune	Greater Fetakgomo Tubatse	Sekhukhune	CN Phatudi	3
NACOSA	Gauteng	City of Tshwane	Tshwane 1	Tshwane North	Pretoria	2
					Soshanguve North	1
				Tshwane South	Pretoria West	2
	North West	Bojanala	Rustenburg	Orbit	Rustenburg	2
	Western Cape	City of Cape Town	Klipfontein	College of Cape Town	Crawford	2
					Athlone	1
					Guguletu	1
AFSA	KwaZulu Natal	King Cetshwayo	uMhlathuze	Umfolozi	Esikaweni	2
					Richards Bay	2
		Zululand	Abaqulusi	Mthashana	Vryheid	2
	Mpumalanga	Ehlanzeni	City of Mbombela	Ehlanzeni	Barberton	2
					Nelspruit	2
		Gert Sibande	Govan Mbeki	Gert Sibande	Evander	2
					TOTAL	**36**

2. SCOPE OF WORK

An independent evaluation of the My Journey Vending Machine Pilot is part of the Global Fund ZAF-C Grant agreements signed with PRs. The primary objective of this rapid evaluation is to understand how AGYW have used and benefitted from the vending machine pilot programme. A secondary objective of the evaluation will be to assess the quality of the pilot programme.

Drawing on the above, lessons should be formulated that can be used to improve on current implementation and inform future grants, and other programmes.

Evaluation Objectives

There are three key evaluation objectives and provisional evaluation questions have been developed for each objective, however, the successful service provider is expected to workshop and refine these questions together with evaluation stakeholders. The evaluation objectives and accompanying evaluation questions are:

1. **Assess the factors which contribute to the implementation of the pilot.**
    a. To what extent is the pilot being implemented as intended?
        - Is the pilot being implemented at a suitable level of quality[24]?
    b. What are the contextual factors influencing the implementation of the pilot?
        - How are campus-based awareness campaigns and dialogues working to create demand for vending machine use?
        - What are the barriers and enablers of effective implementation?
            - How can barriers be reduced?
    c. What are the strengths and weaknesses of the pilot thus far?

[24] NACOSA has developed indicators used to assess the degree of quality with which the programme is implemented. These will be shared with the successful service provider during the inception phase of the evaluation.

d. What are recommendations for improving the use of vending machines for distribution of SRH commodities?
e. How has COVID-19 impacted the demand creation and uptake of services?
f. What were PGTs experiences in:
   - Maintaining and restocking machines; and
   - Managing and tracking access to machines?

2. To determine whether and how the vending machines have been used by AGYW.

a. Have the vending machines been used by AGYW to access SRH commodities?
   - What commodities did AGYW access from the machines?
     - Disaggregated by age, risk profile, campus, sub-district, district[25].
b. What are AGYW's perceptions around access to the vending machines based on where they are located?
   - Are machines easy to access?
   - Are machines located in areas which are safe for AGYW to access them?
   - What are AGYW's perceptions on privacy when accessing vending machines?
c. Do AGYW use these commodities themselves?
   - If yes, what were their experiences in using these commodities?
d. Have AGYW's use of the vending machines changed over time?
e. Was there a demand for or service uptake by ABYM?
   - If yes, how was this different and/or did it yield different lessons compared to AGYW?

3. To determine whether there are benefits to accessing commodities from vending machines.

a. What are AGYWs experiences with the vending machines?
b. What are the benefits of accessing commodities from vending machines?
c. What are the challenges in access in commodities from vending machines?
   - Were there any unintended risks AGYW experienced in accessing commodities from machines?
d. What are AGYW and PGT perceptions about whether:
   - Access to commodities through vending machines was useful in reinforcing or creating demand for participation in the My Journey programme?
   - Vending machines are able to improve the uptake of SRH commodities.
e. What lessons can be learned as a result of product choice, vending machine customisation, monitoring and evaluation, and management that might inform future work in this area?

Evaluation Stakeholders and Users

It is intended that the users of the evaluation will include the Global Fund, SANAC, NACOSA, AFSA, BZ, Higher Health and other recipients of My Journey Programme funding in South Africa and across the region. The evaluation will also be disseminated and shared with SRs and AGYW that participated in the evaluation as well as SRs and AGYW who are part of the programme.

[25] Further disaggregations to be discussed with NACOSA in the inception phase of the evaluation.

3. EVALUATION METHODOLOGY

Evaluation Approach

The evaluation should adopt a mixed methods approach, utilising both qualitative and quantitative methods to ensure the validity and triangulation of evaluation findings. The applicant should propose a suitable, robust evaluation design that effectively addresses the evaluation objectives and questions. Secondary quantitative data, collected in the form of routine monitoring data, is available at an individual level for AGYW. Qualitative data collection methods should include interviews and/or focus group discussions (FGDs).

The chosen approach should be well suited to allow for reflection on what is working well, for whom, why, under what circumstances and how to address challenges. In their proposals, service providers must clearly outline the strengths of the approach and motivate for why the chosen approach is best suited to meet the objectives of this evaluation.

Sampling Strategy

The applicant should consider the most appropriate sample size and sampling approach. NACOSA will support with sampling, but the sample should be sufficiently representative along the following dimensions:

- Geographical context
  - All provinces, PRs and districts must be represented in the sample
- Machine distribution/weighting
- Representatives from each of the following stakeholder groups:
  - All campus AGYW enrolled on core at TVETs
  - SR staff
    - This should include programme managers, Peer Group Trainers, activity coordinators, and social workers involved in recruitment/selection of AGYW.
  - PR staff
    - This should include programme specialists, M&E specialists, and finance personnel.
- Cost-effectiveness.

Recruiting AGYW for the sample can be done via the AGYW database which contains detail on each AGYW reached by the programme. Collaboration with the SR will be required to obtain the contact details of each AGYW.

Final decisions regarding sampling will be made together with the Steering Committee.

Data Collection Methods

The applicant is expected to propose the most appropriate data collection methods in their proposal. Data collection could include, but is not limited to: site visits, focus group discussions, semi-structured interviews, and surveys. The evaluation must include a document review and analysis of programmatic data, programme reports and relevant literature from the field to address relevant evaluation questions. Programmatic data is available at an individual level for AGYW. Programme data will be

provided to the service provider without identifying information in compliance with the POPI Act. Data regarding the AGYW who will participate in any data collection efforts will be handled by NACOSA.

The proposal should address the impact of COVID-19 on data collection and should describe:

1. Steps that will be taken in terms of standard protocols for reducing risk of transmission during fieldwork; and
2. Demonstrable alternative/innovative methods that could be used for data collection (should travel restrictions be imposed) together with cost implications of these methods.

4. ETHICAL CONSIDERATIONS

The service provider must have demonstrable experience in conducting field work with vulnerable AGYW. The service provider must further demonstrate a sensitised approach to working with AGYW and should address the ethical considerations that go along with this and ensure proposed methods do not risk and harm to evaluation participants. Ethically sensitive approaches will need to be employed and described in proposals together with an overview of how ethical approval of the evaluation protocol will be sought.

5. TIMEFRAMES AND DELIVERABLES

The evaluation is expected to be undertaken between February 2022 and March 2022. The table below sets out the key deliverables and proposed deadlines for the evaluation. While there is some flexibility for the applicant to propose alternative deadlines in their Gantt Chart annexed to the proposal, the minimum deliverables for the evaluation are set out in the table below.

Table 3. Timeframes and Deliverables

PHASE 1: APPOINTMENT AND PLANNING			
	2 weeks	• Queries on ToR submitted: 7th January 2022 • Virtual briefing session: 11th January 2022 • Queries on ToR addressed on NACOSA website: 12th January 2022 • Submission of proposals deadline: 21st January 2022	• ToR queries submitted • Virtual briefing session • ToR queries addressed • Proposals submitted
	5 weeks	• Review of proposals and shortlisting of applicants: 4th February 2022 • Presentations by short-listed candidates: 9th February 2022 • Appointment of service provider and contracting: 11th February 2022	• Contract awarded and signed
		• Evaluation planning workshop: Date no later than 18th February 2022 • Literature review, develop evaluation protocol including work plan and data collection tools: 4th March 2022	• **Key deliverable 1:** Inception report which includes evaluation protocol, sample, final work plan, literature review and draft data

		• Approval of data collection instruments: 11th March	collection tools (11th March 2022)
	4 weeks	• Ethics approval obtained: 8th April 2022	• **Key deliverable 2:** Ethical approval obtained (8th April 2022)
PHASE 2: DATA COLLECTION			
	1 week	• Fieldwork planning and set up • Fieldwork plan submitted: 14th April 2022	• Fieldwork set up • **Key deliverable 3:** Fieldwork plan (14th April 2022)
	1 week	• Pilot data collection instruments at selected sites and revise accordingly	• Finalise data collection instruments and fieldwork process based on pilot
	3 weeks	• Training of fieldwork team	• Fieldwork team trained • **Key deliverable 4:** Pilot and training report (19th April 2022)
		• Desktop review and review of monitoring data	• Monitoring data and relevant documents reviewed
		• Data collection and transcription	• **Key deliverable 5:** Fieldwork report (6th May 2022)
PHASE 3: ANALYSIS AND REPORTING			
	2 weeks	• Data analysis	• **Key deliverable 6:** Report structure overview (13th May 2022)
	1 week	• Draft report submitted: 20th May 2022	• **Key deliverable 7:** First draft report (20th May 2022)
	2 weeks	• Draft report reviewed by Steering Committee, comments gathered and incorporated into second draft of report: 3rd June 2022	• **Key deliverable 8:** Second draft report (3rd June 2022)
	1 day	• A stakeholder workshop presentation on draft report	• **Key deliverable 9:** Presentation and workshop on evaluation findings and recommendations (6th June 2022)
	2 weeks	• Submit final report and appendices incorporating feedback from second draft and stakeholder workshop: 17th June 2022	• **Key deliverable 10:** Final evaluation report and related products including executive summary, all tools and final presentation (17th June 2022) • **Key deliverable 11:** Dataset with codebook (17th June 2022)

6. REQUIRED COMPETENCIES OF THE EVALUATION TEAM

The appointed applicant(s)/organisation/firm is required to possess the following skills and experience, which should be clearly reflected in the proposal:

- Extensive evaluation experience, particularly in South Africa and in undertaking similar evaluations;
- Evaluation design and research skills;
- Programmatic or evaluation experience with AGYW or HIV/AIDS (e.g. HIV prevention programmes with specific experience in economic strengthening an advantage);
- Experience in employing both qualitative and quantitative data collection methods, including participatory evaluation techniques with vulnerable populations. Noting the sensitivities in conducting research with AGYW, applicants should demonstrate appropriate experience and skills within the team or how they will consider/prepare to minimise harm and maximise benefits to respondents;
- Good project and people management skills and the ability to deliver within time frames as reflected in the work plan; and
- Excellent writing skills in English.

7. EVALUATION OF PROPOSALS

Only submissions that meet the technical specifications in all aspects as stipulated in this terms of reference will be considered. Evaluation will be split into 2 stages:

Evaluation Stage 1: Correctness and Completeness

Bidders must provide the documentation as specified in Section 9. Please note: The absence of the following documentation automatically disqualifies the bid:

1. A valid tax clearance certificate;
2. A valid B-BBEE certificate or Affidavit; and
3. Completed and Signed Declaration of Interest.

Evaluation Stage 2: Technical Evaluation

Once the proposals have been evaluated on Correctness and Completeness, an evaluation panel will allocate points according to the criteria set out in the quality assessment guide below.

Table 4. Quality Assessment Guide

<table>
<tr><th>FUNCTION</th><th>RATING</th><th>POINTS</th></tr>
<tr><td>Comprehensive Proposal</td><td>
<table>
<tr><th>Comprehensive Proposal</th><th>Points</th></tr>
<tr><td>Proposal does not:
• Demonstrate understanding of the brief
• Demonstrate an understanding of the sector
• Use specified submission template
• Address sections specified in Appendix 1</td><td>0</td></tr>
</table>
</td><td>15</td></tr>
</table>

<table>
<tr>
<td></td>
<td>
<table>
<tr><td>• Demonstrate coherence between proposed methodology and budget</td><td></td></tr>
<tr><td>Proposal shows minimal:
• Understanding of the brief
• Understanding of the sector
• Use of specified submission template
• Ability to address sections specified in Appendix 1
• Coherence between proposed methodology and budget</td><td>5</td></tr>
<tr><td>Proposal shows good:
• Understanding of the brief
• Understanding of the sector
• Use of specified submission template
• Ability to address sections specified in Appendix 1
• Coherence between proposed methodology and budget</td><td>10</td></tr>
<tr><td>Proposal shows exceptional:
• Understanding of the brief
• Understanding of the sector
• Use of specified submission template
• Ability to address sections specified in Appendix 1
• Coherence between proposed methodology and budget</td><td>15</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>Evaluation Methodology</td>
<td>Assessment of bidder’s ability to align evaluation design, sampling strategy and data collection methods.
<table>
<tr><th>Evaluation Methodology</th><th>Points</th></tr>
<tr><td>Not aligned</td><td>0</td></tr>
<tr><td>Partially aligned</td><td>10</td></tr>
<tr><td>Adequately aligned</td><td>15</td></tr>
<tr><td>Fully aligned with methodology that will add value beyond the originally intended purpose and objectives of the evaluation</td><td>25</td></tr>
</table>
</td>
<td>25</td>
</tr>
<tr>
<td>Past Performance and Experience of Company</td>
<td>
<table>
<tr><th>Past Performance and Experience of Company
(max 20 points)</th><th>Points</th></tr>
<tr><td colspan="2">Company’s previous evaluation experience in HIV prevention programmes with AGYW (Assessed via submission of previous examples of work; Bidders must submit all previous examples of work to achieve scoring below [i.e. 6 examples for 5 points])
(max 10 points)</td></tr>
<tr><td>No experience</td><td>0</td></tr>
<tr><td>Limited experience, 1-2 evaluations</td><td>3</td></tr>
<tr><td>Adequate experience, 3-4 evaluations</td><td>5</td></tr>
<tr><td>Considerable experience, 5-6 evaluations</td><td>7</td></tr>
<tr><td>Extensive experience, 6+ evaluations</td><td>10</td></tr>
<tr><td colspan="2">Relevant and contactable company references (Assessed via submission of written reference letters signed-off by contactable referee not older than 5 years; Bidders must submit all written reference letters to achieve scoring below [i.e. 4 letters for 5 points])
(max 10 points)</td></tr>
<tr><td>No contactable references</td><td>0</td></tr>
<tr><td>1 relevant, contactable reference</td><td>3</td></tr>
<tr><td>2 relevant, contactable references</td><td>5</td></tr>
<tr><td>3 relevant, contactable references</td><td>7</td></tr>
<tr><td>4 relevant, contactable references</td><td>10</td></tr>
</table>
</td>
<td>20</td>
</tr>
</table>

Team Composition and Competence	<table><tr><th>Team Composition and Competence</th><th>Points</th></tr><tr><td colspan="2">Team Leader (max 10 points)</td></tr><tr><td colspan="2">Qualification</td></tr><tr><td>Masters in health research, evaluation, HIV prevention, or similar</td><td>5</td></tr><tr><td>Non-Masters qualification</td><td>0</td></tr><tr><td colspan="2">Experience conducting research/evaluation projects</td></tr><tr><td>10+ years' experience</td><td>5</td></tr><tr><td>7-9 years' experience</td><td>4</td></tr><tr><td>4-6 years' experience</td><td>3</td></tr><tr><td>1-3 years' experience</td><td>2</td></tr><tr><td colspan="2">Mid to Senior Level (max 10 points)</td></tr><tr><td colspan="2">Qualification</td></tr><tr><td>Honours in health research, evaluation, HIV prevention or similar</td><td>5</td></tr><tr><td>Post-Graduate in health research, evaluation, HIV prevention or similar</td><td>3</td></tr><tr><td colspan="2">Experience conducting research/evaluation projects</td></tr><tr><td>5+ years' experience</td><td>5</td></tr><tr><td>2-4 years' experience</td><td>4</td></tr><tr><td>1-2 years' experience</td><td>3</td></tr><tr><td><1 years' experience</td><td>2</td></tr><tr><td colspan="2">Low to Mid-Level (max 10 points)</td></tr><tr><td colspan="2">Qualification</td></tr><tr><td>Bachelors in health research, evaluation, HIV prevention or similar</td><td>5</td></tr><tr><td>Diploma in health research, evaluation, HIV prevention or similar</td><td>3</td></tr><tr><td colspan="2">Experience conducting research/evaluation projects</td></tr><tr><td>5+ years' experience</td><td>5</td></tr><tr><td>2-4 years' experience</td><td>4</td></tr><tr><td>1-2 years' experience</td><td>3</td></tr><tr><td><1 years' experience</td><td>2</td></tr></table>	30

<table>
<tr>
<td>Evaluation Workplan</td>
<td>
<table>
<tr><th>Evaluation Workplan</th><th>Points</th></tr>
<tr><td>• Proposal does not include workplan</td><td>0</td></tr>
<tr><td>• Workplan does not address all deliverables
• Workplan does not provide an indication of the number of days each team member will spend on each task
• Workplan does not indicate completion of the project within the required timeframes
• Workplan does not provide reasonable assumptions in terms of time and effort</td><td>3</td></tr>
<tr><td>• Workplan addresses all deliverables
• Workplan does not provide an indication of the number of days each team member will spend on each task
• Workplan indicates completion of the project within the required timeframes
• Workplan does not provide reasonable assumptions in terms of time and effort</td><td>5</td></tr>
<tr><td>• Workplan addresses all deliverables
• Workplan provides an indication of the number of days each team member will spend on each task
• Workplan indicates completion of the project within the required timeframes
• Workplan provides reasonable assumptions in terms of time and effort</td><td>7</td></tr>
<tr><td>• Workplan addresses all deliverables
• Workplan provides an indication of the number of days each team member will spend on each task
• Workplan indicates completion of the project within the required timeframes or sooner via innovative solutions
• Workplan provides insightful assumptions in terms of time and effort</td><td>10</td></tr>
</table>
</td>
<td>10</td>
</tr>
<tr><td colspan="2">TOTAL</td><td>100</td></tr>
</table>

Evaluation Stage 3: Price and B-BBEE

Bidders whose bids achieve a minimum of 75 points on the above technical evaluation will continue to be evaluated on price. Bids that do not meet the 75 points threshold will be excluded from the process. The Preference Point System (PPS) applicable to this bid is 80/20. A maximum of 80 points is allocated for price on the following basis:

CRITERIA	NUMBER OF POINTS
Price	80
B-BBEE	20
Total Points	**100**

Price points calculation formula as follows:

The calculation for price points will be conducted as follows:

$$PS = P\left[(1 - \frac{(Pt - Pmin)}{Pmin})\right]$$

Where:
PS = Points scored for comparative price of tender/offer under consideration
P = Maximum points
Pt = Comparative price of tender/offer under consideration
Pmin = Comparative price of lowest acceptable tender/offer. Points scored will be rounded-off to the nearest 2 decimal places

Example
P = Maximum points to be obtained is 90.
Pt = Comparative price of tender/offer under consideration, for example John Smith Inc. quoted R520 000.00.
Pmin = Comparative price of lowest acceptable tender/offer, for example Jane Wesson Inc. quoted R430 000.

$$PS = 80\left[\left(1 - \frac{(520\,000 - 430\,000)}{430\,000}\right)\right.$$

PS = 63.26 scored out of 80 for John Smith Inc.

Pricing

Prices proposed should be exclusive of Value Added Tax (VAT). It is an expressed requirement of this Call for Proposals tender that Bidders provide transparency in respect of their pricing approach. In this regard, Bidders must indicate the basis upon which they have calculated their pricing by giving a detailed quotation. There must be no hidden costs.

B-BBEE points calculation as follows:

B-BBEE STATUS LEVEL OF CONTRIBUTOR	NUMBER OF POINTS
1	20
2	18
3	14
4	12
5	8
6	6
7	4
8	2
Non-compliant contributor	0

8. MANAGEMENT ARRANGEMENTS AND WORK PLAN

The evaluation will be managed by the Global Fund Evaluations Steering Committee, which will include, but not be limited to, representatives from SANAC, NACOSA, BZ, and AFSA. The Steering Committee will hold regular meetings at key points in the cycle of the evaluation. For example – they will meet at the following intervals:

1. Evaluation planning meeting;
2. Review of evaluation protocol;
3. Review of data collection tools;

4. Monitoring and review of evaluation progress;
5. Review of all drafts of the evaluation report; and
6. Feedback and recommendations workshop.

It is expected that the successful Service Provider be available to attend any required virtual or in-person meetings (in Cape Town or Pretoria) with the Steering Committee. NACOSA will provide operational support to the evaluation with the provincial staff of the identified districts providing support with the implementation arrangements of this evaluation. The table below provides a description of the roles and responsibilities for the evaluation members, stakeholders and partners.

Table 5. Roles and Responsibilities

STAKEHOLDER	MAIN ROLE
Evaluation Service Provider	Deliverables in Table 4 above and: • Logistical and travel arrangements for field work. • Undertake the evaluation data collection process. • Developing a data analysis strategy. • Prepare data and undertake comprehensive data analysis. • Formulate the key findings and recommendations. • Prepare reports; identify major findings, develop recommendations.
NACOSA, AFSA, and BZ Programme Managers, Programme Staff, M&E Team, Sub-Recipient Staff, and Administrative staff	• Work with the Evaluation Service Provider in facilitating access to required information and resources. • Management of the Evaluation Service Provider's contract. • Monitoring the implementation and deliverables of the evaluation. • Provide input and sign off the report structure, evaluation design, sampling, data collection tools and processes by the Evaluation Service Provider. • Support with coordinating and providing logistical support for field visits and meetings with key stakeholders during data collection. • Support in the process to dissemination evaluation findings and recommendations.

9. SUBMISSION OF PROPOSALS

A non-mandatory virtual briefing meeting will be held on **Tuesday 11th January 2022 from 10h00 to 11h00**. Please register for the briefing meeting using the following link: https://tinyurl.com/mrx5bkyn. Questions of clarity on the ToR can be submitted via email to queries@nacosa.org.za **by no later than 17h00 on Friday 7th January 2022**. PLEASE NOTE: No telephonic queries will be entertained by any NACOSA staff member. Queries must include the tender reference (CFP-06-AGY-12-2021) in the subject line. *(The system automatically allocates questions to the relevant person based on the reference number, without the reference number your question might not be answered)*. All questions submitted will be addressed in the briefing meeting and a recording of the session will be placed on the NACOSA website (https://www.nacosa.org.za/latest/) by **Wednesday 12th January 2022**.

Proposals are due to proposals@nacosa.org.za by **17h00 on Friday 21st January 2022**. Please use reference number CFP-06-AGY-12-2021 in the email subject line. Only bids submitted by email to proposals@nacosa.org.za will be accepted and reviewed – no late bids will be reviewed.

IMPORTANT: No telephonic or direct email queries (apart from those addressed to queries@nacosa.org.za) will be entertained by any NACOSA staff member.

The proposal should not be more than 20 pages in length (excluding appendices) and should follow the format and structure of the template provided in **Appendix 1**.

Short-listed candidates must be available to provide a presentation on the proposal in Cape Town on approximately the following dates: **Wednesday 9th February 2022**.

10. AWARDING OF CONTRACT

The contract will be awarded by **11th of February 2022**.

- A NACOSA-constituted Selection Committee will select the service provider. The selection committee reserves the right to request any, or all, of the bidders to meet to clarify their proposal.
- The Committee is not bound to accept the lowest or any proposal.
- The proposal will be evaluated against the review matrix provided above.
- The Committee may, entirely at its discretion, decide to:
    - Award contracts to different bidders for different sections of the scope of work.
    - Award contracts for particular sections of the scope of work, but invite new proposals for other sections of the work.
    - Delay the award contracts for certain sections of the scope of work (considering, inter alia, timing of funding availability).
    - Make award of contracts subject to such conditions as NACOSA may determine at the stage of awarding the contracts.
    - Commission the work in two phases should it become evident that this is necessary.
    - Review and modify the evaluation criteria.
    - Not award contracts.
- The Service Provider may be required to sign the Global Fund's Code of Conduct for Service Providers should they be contracted.

11. EVALUATION BUDGET

A maximum budget of R350 000.00 may be awarded for the evaluation.

12. PAYMENT TERMS

1. The successful bidder will be required to sign a contract to deliver in terms of this terms of reference requirements.
2. Our following Terms and Conditions of Delivery and Payment shall be applicable to all commercial transactions of the contract as noted in 1.

3. Our Terms and Conditions of Delivery and Payment shall apply exclusively. We shall not accept terms and conditions of the successful bidder that conflict with or deviate from our Terms and Conditions of Delivery and Payment unless we have given our express written consent to their application.
4. Collateral agreements, amendments to these terms and conditions as well as deviations from these terms and conditions must be agreed upon in writing.
5. All payments under the contract shall be made to the winning bidders banking details as supplied and stipulated in the bidding process.
6. The contract as stipulated in 1 above shall be denominated in ZAR and all payments will also be made in ZAR.
7. Vendor payments will be based on each of the project phases as agreed between NACOSA and the vendor. Payments are to be linked to clearly specified outputs (deliverables) of each project phase.
8. For each Milestone Payment, the Vendor shall provide a request for payment to NACOSA at least 10 working days before the payment due date.
9. Notwithstanding anything else in this Agreement, the percentage (specified in contract) of the value of each invoice rendered by the Vendor and approved for payment by NACOSA (net of the VAT) shall be retained by NACOSA until the accumulated retention corresponds to the cap of the Phase Fees as specified contract. The same shall be retained by NACOSA until all of the Vendor 's responsibilities under this Agreement have been completed to the reasonable satisfaction of NACOSA and a "contract closure certificate" has been prepared by the Vendor and accepted in writing by NACOSA.

These terms of reference are issued by:

NETWORKING HIV & AIDS COMMUNITY OF SOUTHERN AFRICA NPC

NACOSA

3rd Floor, East Tower | Century Boulevard | Century City | Cape Town
t. 021 552 0804 | **f.** 021 552 7742 | **e.** info@nacosa.org.za

Non Profit Organisation: NPO 190-030 | Public Benefit Organisation: PBO 930056308
Non Profit Company: 2015/448924/08 | VAT Number: 473 0273 234 | Section 18A Tax Exempt
Accredited by the Health & Welfare SETA | Level 1 B-BBEE Entity (135% recognition)

Nacosa.org.za