health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Terms of Reference

Process Evaluation

of the NRASD Global Fund ART Adherence Programme

3 February 2016

NRASD
National Religious Association
for Social Development

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TABLES AND FIGURES

ACRONYMS

ART	Antiretroviral Therapy
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based Organsation
DoH	Department of Health
GF	Global Fund to Fight AIDS, TB and Malaria
HCBC	Home Community Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NRASD	National Religious Association for Social Development
NSP	National Strategic Plan
SANAC	South African National AIDS Council
STI	Sexually Transmitted Infection
PR	Principal Recipient
TB	Tuberculosis

1. THE SOUTH AFRICAN ART SITUATION

South Africa has the biggest and most high profile HIV epidemic in the world, with an estimated 6.3 million people living with HIV in 2013. In the same year, there were 330,000 new infections while 200,000 South Africans died from AIDS-related illnesses.[1]

South Africa has the largest antiretroviral treatment programme globally and these efforts have been largely financed from its own domestic resources. The country now invests more than $1 billion annually to run its HIV and AIDS programmes.[2]

However, HIV prevalence remains high (19.1%) among the general population, although it varies markedly between regions.1 For example, HIV prevalence is almost 40% Kwa-Zulu Natal compared with 18% in Northern Cape and Western Cape.[3]

ANTIRETROVIRAL TREATMENT (ART) IN SOUTH AFRICA

South Africa has the largest antiretroviral treatment (ART) rollout programme in the world, achieving a 75% increase in HIV treatment access between 2009 and 2011.26 28 In three provinces, the life expectancy of people receiving ART is now about 80% of normal life expectancy provided they do not start treatment late.[4]

By October 2012, over two million people were receiving ART, surpassing the country's universal access target (80%) in accordance with the 2010 World Health Organisation treatment guidelines (offering

[1] UNAIDS (2014) 'The Gap Report 2014'

[2] Maurice, J. (2014) 'South Africa's battle against HIV/AIDS gains momentum' The Lancet 383(9928):1535-1536

[3] South African National AIDS Council (SANAC) and National Department of Health (DoH) (2012) 'Global AIDS Response Progress Report: Republic of South Africa'

[4] UNAIDS (2013) 'Global Update on HIV Treatment 2013: Results, Impact and Opportunities'

treatment to people with a CD4 count under 350).[5] However, the new 2013 WHO treatment guidelines (treatment for those with CD4 counts under 500) have since made many more people eligible for ART and coverage has fallen to 42%.[6]

In order to achieve higher levels of ART coverage, the South African government employed task shifting. Task shifting refers to the reallocation of tasks among available staff. In this case, nurses (rather than doctors) initiate ART; lay counsellors (rather than nurses) carry out HIV tests; and pharmacy assistants (rather than pharmacists) prescribe ARVs. This increases the number access points to treatment and care by reducing the 'bottlenecks' in the healthcare system created by a shortage of staff able to provide vital HIV services.[7]

Though treatment programmes have expanded rapidly, many South Africans still begin treatment with a very low CD4 count. In 2009, it was reported that the average CD4 count at which patients started treatment in South Africa was just 87.31. One study based in two Durban clinics found that 60% of patients were tested when their CD4 counts were below 200. Of these patients, just 42% had begun treatment within 12 months. Of those who were eligible for treatment, more than a fifth died, mostly before beginning treatment.[8]

In other cases, individuals simply refuse treatment despite being eligible. A study in Soweto found that of 743 newly diagnosed HIV-positive adults eligible to begin treatment immediately, 20% refused. More than a third gave "feeling healthy" as the reason for refusing treatment despite having a low CD4 count, with many also co-infected with tuberculosis.[9]

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[5] IRIN (2012, 9 October) 'SOUTH AFRICA: Revamped AIDS council makes its debut'

[6] UNAIDS (2014) 'The Gap Report 2014'

[7] UNAIDS (2007) 'HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011'

[8] Bassett, I.V. et al (2010) 'Who starts antiretroviral therapy in Durban, South Africa?

[9] Katz, I.T. et al (2011) 'Antiretroviral therapy refusal among newly diagnosed HIV-infected adults' AIDS 25(17):2177-2181

2. BACKGROUND AND INTRODUCTION TO THE GLOBAL FUND PHASE II ART ADHERENCE PROGRAMME

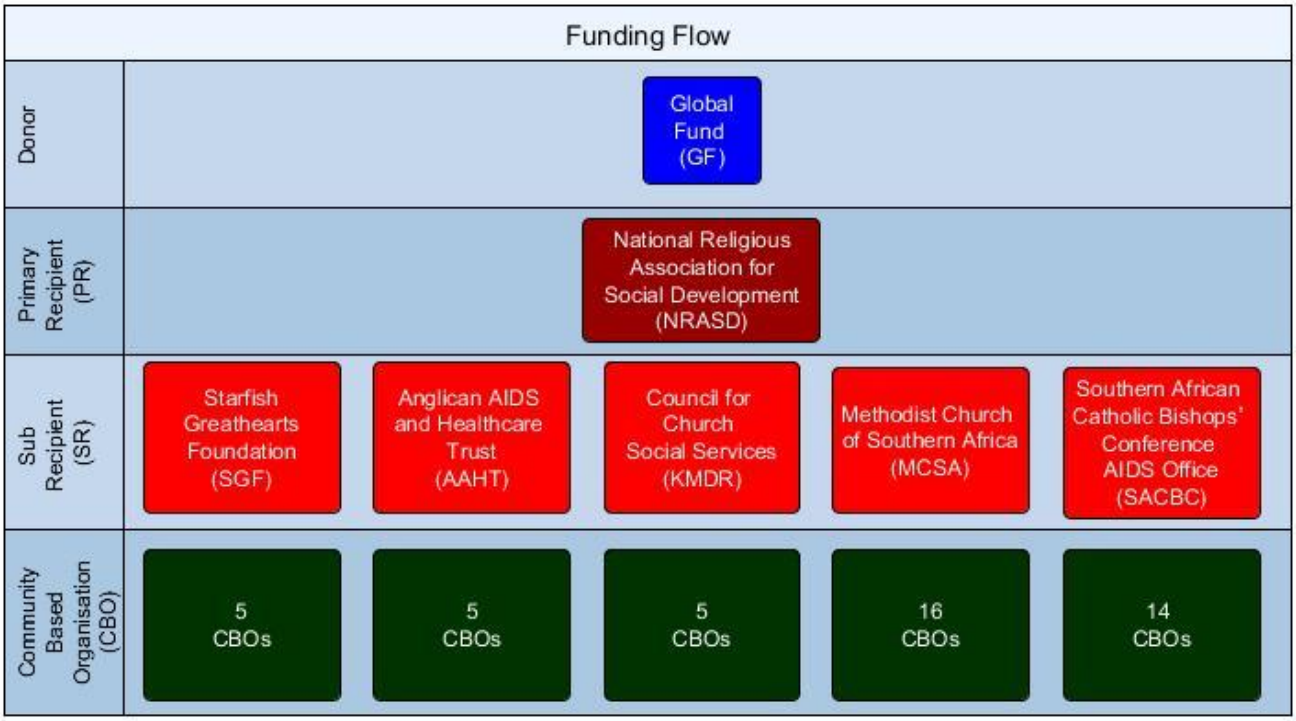
NRASD is a network of religious groups with the aim of fostering the role of religious organisations in social development. The basic approach of the NRASD is to strengthen the capacity and programmes of existing networks to enable them to play an even bigger role in this field.

NRASD is one of the current six Principal Recipients (PRs) in the Global Fund Phase II Grant. NRASD was also a PR under the Phase I grant which was implemented from October 2010 – September 2013. The second implementation period is from 1 October 2013 to 31 March 2016.

A PR's responsibility is to manage the Global Fund (GF) grant and ensure that the grant objectives are achieved. This includes the disbursement to implementation partners who are part of the service delivery team as well as monitoring and evaluation of the achievement of grant objectives. Money thus flows through the NRASD to a number of national organisations as well as provincial Non-Governmental Organisations (NGOs) and Community-based Organisations (CBOs) in South Africa, who then deliver services to patients. They are known as sub-recipients (SRs) and sub-sub-recipients (SSRs).

SRs and SSRs are the direct implementers of the ART Adherence programme. NRASD funds five sub-recipients, who provide further funding to 45 CBOs (sub-sub-recipients). Figure 1 below shows the relationships between different stakeholders in the grant.

Figure 1: Structure of the GF ART Adherence programme Sub-Granting Relationships



This Terms of References sets out the requirements for the process evaluation for the ART Adherence programme. The timeframe for the evaluation is February 2016 – March 2017.

ART ADHERENCE PROGRAMME DESCRIPTION

The ART Adherence programme is a subsection of the overall SANAC Country Coordinating Mechanism Global Fund Grant and both PRs contribute to the ART Adherence programme. The Global Fund Grant has three programme goals:

- Goal 1: Reducing the incidence of TB by 50%
- Goal 2: Reduce new HIV infections by at least 50% using combination prevention approaches
- Goal 3: Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation

The ART Adherence programme mainly contributes to Goal 3 through the establishment of ART Adherence clubs.

Nurses would be deployed at site level in communities to provide supervision, quality control and care to Care Workers. Nurses would be provided with a financial contribution in terms of per diems and for travel costs between sites.

In addition, Coordinators would be deployed at site level in the communities to coordinate the work of Care Workers. Sites would be provided with a financial contribution to overheads costs.

Nutritional support would be provided to patients through food distribution schemes, food parcels or allowances for food gardens. The provision of limited nutrition is a critical enabler for treatment, care and support. Nutrition assistance is intended to improve adherence to medication and retention in care. Based upon the detailed activities described above, it is anticipated that this intervention will result in:

- Expanded adherence and care support to PLWHA and their households.
- Improved quality of services and to PLWHA and their households.
- Retention of PLWHA in the health care system and improved patient outcomes.
- A contribution to universal access to treatment, services and address of stigma.
- Recordkeeping on HIV and TB status and treatment to improve referral and linkages with health facilities and reduce loss to follow-up.
- Strengthening the Care Workers with increased knowledge in subject area.

The intervention offers pre-treatment education and treatment adherence, as well as care and support services to PLWHA which is extremely important in terms of preventing drug resistance and delays in transfer to second line regimens and mortality.

The intervention will function as the link between the household and the health/ treatment facility and will decrease the large number of PLWHA whom are lost to follow-up due to lack of follow-up capacity of health facilities, as the retention of patients in care is highly important.

In terms of programming, the NRASD is proposing a main activity that allows for the rendering of essential services to a key population in underserved communities, as the activity is brought to the home of the PLWHA in an area where other sectors find it challenging to provide services. In terms of calculations, the NRASD considered the requirement to provide quality service and not merely achieving quantities. The same PLWHA's would be visited more than once per quarter by a trained Care Worker, coordinated by a Coordinator, under the supervision of a Nurse.

The NRASD ART Adherence program focuses on providing adherence support to patients via various mechanisms:

- Home visits
- ART Support groups
- ART Adherence clubs

The ART Adherence programme has the following output indicators in the Global Fund performance framework:

- Number of ART patients receiving adherence support

Further details of the output, outcomes, and impact indicators of the overall grant is provided in Annex 1.

The ART Adherence programme focuses on providing direct services to patients as well as strengthening community structures to create an enabling environment for patient adherence support. The implementation of the ART Adherence programme funded under the Global Fund Grant is implemented by the NRASD through Home Based Care organisations.

OVERVIEW OF THE SCOPE AND REACH OF THE GF ART ADHERENCE PROGRAMME

The NRASD programme is implemented by five SRs who manage the work of 45 CBOs based in Gauteng, North West, Free State, Limpopo and Mpumalanga. The five Sub Recipients are:

1. Anglican AIDS and Healthcare Trust
2. Council for Church Social Services
3. Methodist Church of Southern Africa
4. Southern African Catholic Bishops' Conference AIDS Office
5. Starfish Greaterhearts Foundation.

A total of 5,760 patients will be reached by the end of the grant. NRASD implement the programme in the 5 inland provinces as shown in Table 2 below.

Table 1: SR CBOs per province and district

Count of SUB SITE NAME	Column Labels					
Row Labels	AAHT	KMDR	MCSA	STARFISH	SACBC	Grand Total
FREE STATE	2	1	3	3		9
Lejweleputswa	1		1	1		3
Thabo Mofutsanyana	1	1	2	2		6
GAUTENG	2	1	1		1	5
Sedibeng	2	1	1		1	5
LIMPOPO			4	2	3	9
Mopani			1	2	3	6
Sekhukhune			3			3
MPUMALANGA		1	7	5	1	14
Ehlanzeni		1	3	5	1	10
Gert Sibande			4			4
NORTH WEST	1	2		3		6
Dr Kenneth Kaunda	1	2		3		6
NORTH WEST			1			1
Dr Kenneth Kaunde			1			1
GAUTENG				1		1
Sedibeng				1		1
Grand Total	**5**	**5**	**16**	**14**	**5**	**45**

ART COMMUNITY ADHERENCE CLUBS

NRASD got the buy-in to implement community adherence clubs in 4 out of 5 Provinces supported. Clinics are very excited about the model as it is decongesting their facilities and also optimizes their capacity to initiate and manage unstable patients. NRASD at present, is the only partner implementing community adherence clubs in the supported Provinces. Other partners are facilitating clinic based clubs.

Patients are also excited as they view clubs as a quick service option.

For quality assurance purposes, NRASD clubs are started at facilities for few sessions then moved to the community venues.

Below is the summary per province:

1. **Gauteng Province (Sedibeng District)**

Table 2: Gauteng Clubs

Community Based Organisation	Clinics Allocated	No of adherence clubs
1. Reach out (Starfish Greathearts Foundation)	Dr Helga Kuhn	3
2. Thy Kingdom (Starfish Greathearts Foundation)	Market Avenue Boipatong Clinic	5
3. Ahanang Parish (SACBC)	Zone 17	1
4. Four Steps (AAHT)	Zone 12 Zone 3 Evaton Main	2
5. Emaneng Nokeng (KMDR)	Kookrus Clinic	1
TOTAL	**8**	**12**

2. **North West Province (Dr Kenneth Kaunda District- Wolmaransstad sub-district)**

- 6 Clinics in Wolmaransstad sub-district were trained on adherence club model. Two clinics will pilot the clubs (The Programme officer will verify with the Department of Health on the names of piloting clinics).
- 20 Caregivers under Starfish Great Hearts were also trained, 8 of them will be club facilitators.
- Recruitment for clubs will commence in November with the support from NRASD Nurse.
- Collaboration with CCMDD

3. Free State Province (Thabo Mofutsanyane District)

Table 3: Free State Clubs

Community Based Organisation	Clinic Allocated	Expected clubs to be launched in November
1. Golden Gate Hospice(Starfish Greathearts Foundation)	Mphohadi	5
2. Dihlabeng Development Initiative (Starfish Greathearts Foundation)	Bakenpark	3
3. Thusanang Community Development(AAHT)	Fouriesburg Clarens	2
4. People of Hope (MCSA)	Itumeleng	2
TOTAL	**5**	**12**

4. Limpopo Province (Mopane District)

- NRASD was finally given the go ahead to implement clubs in the Province. Training of the department of health clinics and officials from the District will provided by NRASD. Dates for training will be discussed with Limpopo Department of Health and will be shared with the Programme Manager.

Table 4: Limpopo Clubs

Name of CBO	Clinics linked to CBOs	Number of Caregivers
Good Sherpered (Homolani)	Homolani Clinic Maphutha malatjie Hospital	**9**
Valoyi Trust(Nwamitwa)	Nwamitwa Zimgodeni Dr Hugo	**5**
Ntsuxekani HBC	Maphalle Clinic Labaka Clinic	**5**
Mokgolobotho	Lenyenye Clinic Lephepang Clinic Nyeleti Clinic	**8**
Motupa	Motupa Clinic	**8**
TOTAL	**11**	**35**

5. Mpumalanga Province

No progress has been made so far in the Province on the implementation of clubs. However, the Programme officer is trying to get a contact person from the National Department of Health. Progress will be updated.

Note:

- NRASD clubs are contributing towards the 90-90-90 strategy (Third 90 - By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression).
- NRASD is still in discussion with the National department of Health on how we can align our model to the National Department of Health's Adherence Guidelines for HIV, TB and Non-Communicable diseases.

1. EVALUATION SCOPE OF WORK

EVALUATION PURPOSE AND OBJECTIVES

The purpose of the evaluation is to assess the functioning of the NRASD ART Adherence programme as a whole. The key evaluation objectives are:

1. To evaluate whether the NRASD ART Adherence Programme is aligned with the national adherence policies, guidelines and programmes;
2. To capitalize the experience aiming at extracting lessons learned, good practices and recommendations for the future.
3. The evaluation process is also expected to provide an insight of key stakeholders and beneficiaries – their perception and acceptance of different project components.

The scope of the evaluation will be on the direct services provided to patients and impact on them and the evaluation includes all SRs and SSRs implementing direct services to patients.

1. **Evaluating alignment with the national policies, guidelines and programmes**

The evaluation will assess whether the ART Adherence programme being implemented by the NRASD is in line with the DoH guidelines. This should be done at both a documentation and implementation level.

Gaps need to be clearly identified and recommendations for programme alignment.

Source data: DoH documents, MSF documents, PR documents, DoH key informants, PR key informants, SSR key informants

2. **Document the NRASD experience**

The whole NRASD ART Adherence programme experience needs to be analysed and systematized in order to transform the gained institutional experience and knowledge into capital that can be used in future, specifically, to support further decisions concerning the project itself, and/or to benefit other ART Adherence projects.

This would specifically focus on defining the process for rollout at a provincial, district and clinic level by extracting lessons learned, good practices and recommendations for the future.

Source data: PR documents, PR key informants, SR key informants, SSR key informants

3. Insights from key stakeholders

The NRASD ART Adherence programme was a transition programme to take traditional HBC organisations and realign their services to the greater need of ART Adherence programmes. The evaluation should provide an insight the perception and acceptance of different project components of key stakeholders and beneficiaries.

Elements that could be analysed:

- Effectiveness/ or the role of community adherence caregivers in improving adherence amongst patients on ART in remote settings
- Effectiveness of community led adherence support groups in addressing barriers to adherence
- Examining the effectiveness of provision of psychosocial support in adherence support groups (Does psychosocial support improve adherence and retain to care?)
- Community based support groups linkages with facilities/Medicine distribution

Source data: DoH key informants (national, provincial, district & clinic), SANAC key informants, PR key informants, SR key informants, SSR key informants, Beneficiaries

4. EVALUATION METHODOLOGY

EVALUATION DESIGN AND METHODOLOGY

The evaluators should propose a range of suitable methodologies through which the evaluation questions can be answered, including, but not limited to; questionnaires, focus groups and key informant interviews. Participants of the evaluation, at community level, could include; patients, community caregivers and managers of HBC organisations. Further sampling could include interviews with the NRASD, MSF, SANAC and DoH. Review of programmatic data (from reports) and review of other studies/researches should also be included.

SAMPLING

The rollout of ART Adherence Clubs is relatively recent and does not cover all CBOs, accordingly a statistical sampling does not seem relevant as we would like to ensure that at least one CBO per district where Clubs are being implemented are part of the evaluation.

The final sample design for the evaluation will be further developed by the evaluator with input from Technical Advisory Committee.

Evaluators must provide a detailed explanation of measures that will be undertaken to ensure that all participants' identity remains anonymous and that they are protected from harm at each stage of the evaluation. Applicants must illustrate the ethical procedures and principles that will be implemented as part of the evaluation processes, for example, consent and assent from patients should obtained.

4. EVALUATION DELIVERABLES

Note, the final report will provide findings on the key evaluation questions.

DELIVERABLES

The main outputs of the evaluation are:

- Deliverable 1. Evaluation workplan & protocol
- Deliverable 2. Draft evaluation report (released per objective)
- Deliverable 3. Stakeholder workshop to review initial findings
- Deliverable 4. Final evaluation report with executive summary

REPORT FORMAT

The following report format will be the minimum requirement for this detailed report:

Table 5: Report Format

SECTION	TO INCLUDE
Report Cover	• Title of report, date, NRASD, DoH and Global Fund required logos, contract number
Title Page	• Title of project • Authors of report • DoH, NRASD and Global Funds' name and logos according to marketing guidelines • Date of report
Executive Summary	• Summary of objectives, when data was collected, target groups, description of data collection tools and methods • Summary of key findings – evaluation • Summary of lessons learnt, best practices and recommendations in bullet format
Table of Contents	• Including page numbers • Glossary of key terms (incl. indicator, result, output, outcome, impact, impact evaluation and performance evaluation) • List of tables and / or figures and page numbers
Background	• Include a brief program description • Describe the role of the evaluation in project implementation, relationship to other data collection methods being used, concisely describe the context in which the evaluation took place • Include map of the relevant geographic area(s)
Evaluation purpose and key questions	• Describe the purpose of the evaluation • Outline the key evaluation questions and related sub questions

Methods	• **Briefly describe the evaluation approach and design** • **Describe the sampling methods applied** • **Describe the data collection methods employed (include a description of where and how data were collected, quality assurance measures, length of data collection process and problems encountered in conducting research)** • **Describe the ethical considerations and provisions made to ensure participant protection and adhere to established ethical standards** • **Present demographics of participants/respondents** • **Describe what methods were used to analyse the data** • **Describe the study limitations**
Research Findings; Discussion and Interpretation	• Present data organised around main objectives and main ideas in the surveys/interviews and combine qualitative with Quantitative data (with descriptive summaries, use quotations where necessary) • For each evaluation question, describe findings and their meanings in the context of the project, with highlights of unexpected findings, discuss potential problems with the data
Recommendations, best practices and lessons learnt	• Provide a detailed list of recommendations (with explanations) for programme implementation, policy implications, possible redesign etc. • Provide a detailed list of best practices identified • Provide a detailed list of lessons learnt.
Annexes	• Detailed sampling strategy • Data collection tools and tools used to address ethical data collection • Extracts of tables from statistical data analysis process • The final survey dataset with value and variable labels and / or a data dictionary • The finalised tools (surveys) • Baseline dataset and code book

QUALITY ASSESSMENT OF EVALUATION

The evaluation should assist the NRASD in their objective to ensure evidence based programming and accordingly take the following quality assessment questions into account in the final presentation of the report:

1. Addressed a Clearly Focused Issue

   Was there adequate information on:

   - Purpose of the review and/or rationale of the study
   - Research question to be answered
   - Previous data or theory on study population, context or issue of study
2. Methodology
   - Search of review materials was taken from multiple sources
   - Specified inclusion and exclusion criteria to reduce biased sampling
   - Methodology was carried out systematically
   - Included published and unpublished literature
   - Appears to represent an exhaustive collection of materials
3. Analysis
   - Review examines multiple aspects of the issue across body of literature
   - Described analytical process and tools including framework for analysis
   - Thorough reporting of the results and key findings
   - Takes into account the strength of the evidence in information collected
4. Review
   - Reported findings are well substantiated by information presented
   - Discussion of study implications for policy or programming
   - Discussion of study limitations or biases, including contradictory findings
   - Identified areas for further research or review

5. MANAGEMENT ARRANGEMENT AND WORK PLAN

Overall the evaluation will be monitored by the National Department of Health. The evaluation will be managed by the NRASD who will hold regular meetings at key points in the life of the evaluation. For example;

1. Selection of Service Provider
2. Contract negotiation with the Service Provider
3. Briefing of the Service Provider
4. Review of evaluation protocol
5. Monitoring and review of evaluation progress
6. Review of all drafts of the evaluation report.

The contractual arrangements will be the NRASD's responsibility.

Table 6 below provides a description of the roles and responsibilities for evaluation team members, evaluation stakeholders and partners.

Table 6: Roles and Responsibilities

Stakeholder	Main Role
External Evaluators	• Develop the evaluation design and key measures for each evaluation question. • Develop the data collection and sampling strategy. • Develop the qualitative data collection instruments. • Developing data analysis strategy. • Logistical and travel arrangements for field work to sampled organisations • Undertake the evaluation data collection process. • Prepare data and undertake comprehensive data analysis. • Formulate the key findings and recommendation. • Prepare reports; identify major findings, develop recommendations.
NRASD and organisations' Programme Managers Programme staff, M&E team,	• Work with the External Evaluator in facilitating access to required information and resources. • Management of the External Evaluators contract.

Organisations' staff Administrative staff	• Monitoring the implementation and deliverables of the evaluation. • Preparation of evaluation management documents- TOR, SOW, Contract • Provide input in finalising the evaluation design, sampling, data collection tools and processes by the External Evaluator. • Assist with coordinating and providing logistical support for field visits and meetings with key stakeholders during data collection. • Plan for and undertake dissemination of findings.
National Department of Health	• Monitoring of the solicitation process for identifying suitable External Evaluator. • Provide input in finalizing the evaluation design, sampling, data collection tools and processes. • Monitoring the implementation of the evaluation. • Review and sign off of draft and final reports.
Global Fund	▪ Evaluation budget ▪ Final evaluation report

TIMEFRAMES

The evaluation activities are expected to be undertaken between February 2016 and March 2016.

Table 7: Timeframes and Tasks

ESTIMATED TIMEFRAMES	PHASE	KEY DELIVERABLES
Feb 2016	Appoint evaluator(s). Initial meetings.	Contract awarded. Briefing meetings.
	Develop evaluation Protocol.	Final evaluation protocol.
	Desktop review and review of secondary data.	
Feb 2016-March 2016	Quantitative data collection and capturing.	Quantitative data collected.
	Data capture and analysis of dataset.	Dataset and Codebook.
	Draft report written and submitted.	Draft 1 of the evaluation report.
	Technical Advisory Committee review and comment on the draft report.	Draft 1 with comments by Technical Advisory Committee.
	Feedback from the Technical Advisory Committee incorporated into draft report.	Second draft of the report.
	Technical Advisory Committee review and comment on the draft report.	Draft 2 with comments by Technical Advisory Committee.
	Comments received by evaluation team and incorporated into final report.	Final report and related products including the PPT presentation and dataset.

7. REQUIRED COMPETENCIES OF EVALUATION TEAM

The appointed applicant(s) is required to possess the following skills and experience:

- Evaluation experience particularly in South Africa; demonstrated experience in undertaking similar evaluations.
- Evaluation design and research skills.
- Experience in ART Adherence programmes as well as HIV and AIDS including experience with community-based programmes. (Please ensure that you have this skill within your team)
- Experience in employing qualitative data collection methods including participatory evaluation techniques.
- Good project and people management skills and the ability to deliver within time frames as reflected in the Work Plan.
- Excellent writing skills in English.
- To indicate the level of involvement of the principle investigators and all relevant staff using a matrix.

8. SUBMISSION OF PROPOSALS

Please submit questions and final proposal via email to adherence@cddc.co.za by 22h00 on 10 February 2016. Late submissions will not be considered. Please ensure the subject line states: "Application – NRASD Global Fund ART Adherence Evaluation."

The outline of the proposals should include the following:

1. Proposed Evaluation Approach and Design
2. Motivation as to why you/organisation should be selected
3. Evaluation Team, a summary of the role and responsibility of each staff person/consultant and estimated time to be spent by each staff person/consultant;
4. Evaluation work plan reflecting proposed time frames and outputs/deliverables (including Gantt chart)
5. Budget - detailed budget including hourly/daily fees for each staff person/consultant and breakdown of all other costs to be charged to the contract. The prospective service provider must submit a budget range (min to max) for the project – the contract will be paid on a time and material basis and detailed time sheets will be required.
6. Addendum: Detailed CVs must include the names and contact numbers of the staff/consultants assigned to the project.

Please note short-listed candidates must be available to provide a presentation on the proposal on the following dates:

- 11 February 2016 afternoon in Johannesburg or
- 12 February 2016 in Stellenbosch

ANNEX 1 – OUTCOME AND IMPACT INDICATORS

SANAC CCM GF PROGRAMME OBJECTIVES AND INDICATORS

The SANAC CCM renewal application is linked to the following objectives and indicators in the performance framework:

Table 6: Programme Goals

1	Reducing the incidence of TB by 50%.
2	Reduce new HIV infections by at least 50% using combination prevention approaches
3	Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation

Table 7: Programme Impact Indicators

Linked to goal(s) #	Impact indicator	Baseline Value	Target Year 5 2016
Goal 2	HIV incidence (CSW)	Baseline results expected July 2014	TBD
Goal 2	HIV incidence in general population	1.7%	50% reduction
Goal 3	HIV Prevalence rate	12.2%	50% reduction
Goal 3	AIDS related Mortality	33.5%	50% reduction
Goal 3	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	92.35%	94%
Goal 3	Mother to child transmission rate at 6 weeks	2.4%	<2%
Goal 1	TB case registration rate (proxy TB incidence)	681/100,000 pop	422/100,000 pop
Goal 1	TB mortality rate	10.7%	50% reduction

Table 8: Programme Objectives

Objectives:	
1	Address Social and Structural Drivers of HIV , STI and TB Prevention, Care and Impact

2	Prevent new HIV, STI & TB Infections
3	Sustain health and wellness among patients and those affected by HIV/AIDS
4	Create an enabling environment for implementation through effective program planning, management and monitoring

Table 9: Programme Outcome Indicators

Linked to objective(s) #	Outcome indicator	Baseline Value	Target Year 5 2016
Obj 2&3	TB Treatment success rate	N/A	84%
Obj 2&3	MDR-TB Treatment success rate	N/A	56.5%
Objs 1-3	Percentage of men and women aged 15-24 reporting the use of a condom with their sexual partner at last sex	58.4%	TBD
Objs 1-3	Percentage of sex workers reporting the use of a condom during penetrative sex with their most recent client	TBD	TBD
Objs 1-3	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	TBD	TBD
Objs 1-3	Percentage of pregnancies during the previous academic year amongst Grade 8-12 learners.	8737	7077

Table 10: Programme Output Targets

Output/ coverage indicator	PR	Target	
Number of ART patients receiving adherence support	NRASD	5,760	Non-cumulative over the grant period