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TERMS OF REFERENCE FOR INSTITUTIONAL CONTRACT

Reference:	LRPS-2024-9189538
Title:	Technical and strategic information support to institutionalise the pregnant AGYW peer mentor model and improve the access, uptake, and quality of care for children and adolescents living with HIV in three districts in Gauteng province (Tshwane, Ekurhuleni, City of Johannesburg, eThekwini (KZN) and Sekhukhune district (Limpopo).
Location:	City of Tshwane, City of Johannesburg, Ekurhuleni **(**Gauteng Province) and Sekhukhune (Limpopo Province)
Duration:	1 year

Background and Justification There have been successes in the commitment to end vertical transmission of HIV in South Africa with 97% of pregnant women living with HIV having received antiretroviral therapy to prevent vertical transmission of HIV in 2020[1]. Mother to child transmission (MTCT) rates at 18 months declined from 30% in 2000 to an estimated 3.29% in 2020[2]. However, the knowledge of HIV positive status before pregnancy was significantly lower among younger women (15–19 years and 20–24 years: 47.6% and 59.4% respectively) compared to older women (35–49 years: 85%). More than half (51.6%) of the pregnancies were unintended and as expected, 76% of Adolescent (15−19 years) and 57% young women (20−24 years) had higher prevalence of unintended pregnancy compared to older women (35−49 years: 45%). The Hey Baby study found that only half (179/364) of the children of adolescent and young mothers living with HIV received ART as either prophylaxis or treatment, falling far short of the global target of 95 per cent . Even for adolescents who do initiate ART, retention in care has been found to decline over time, thereby negatively impacting attaining and sustaining viral suppression (VLS). While deaths from HIV-related causes have declined among people living with HIV (PLHIV) in most age groups, this is not the case for adolescents whose HIV-related mortality levels remain high by comparison (65% in girls 10-14 years and 62% in girls 15-19 years)

One of the largest challenges on the path to controlling the global HIV epidemic is the persistently high vulnerability of adolescent girls and young women (AGYW) to HIV. AGYW ages 15-24 years are disproportionately infected with HIV. The HIV incidence in AGYW (15-24 years) (1.5%) was three times higher compared to the incidence in the general population in 2020 (0,5%). AGYW accounted for nearly half (43%) of the HIV burden in women in the country in 2020.

Teenage pregnancies have increased over the past year. Between October 2020 and September 2021, 13.5% of adolescent girls aged 10-19 years or 139,334 girls have delivered in facilities in South Africa and 14,970 terminations of pregnancies were recorded for AGYW under 20 years, representing an increase of 12% in pregnancies from 2017.

Similarly, access to HIV testing in children poor in many countries, including South Africa, creating a bottleneck for the scale-up of treatment. Many HIV-positive children remain undiagnosed. Children living with HIV are also less likely to receive treatment than adults. Globally, only 53% of children are on treatment compared to 67% of adults. Evidence further suggests that the proportion of children aged 5–14 years who are living with HIV has increased. Of the estimated 840,000 children living with HIV and not on treatment in 2019, 560,000 (66.6%) were between the ages of 5 and 14 years.

[1] Tier.net

[2] Tembisa 4.4, Centre for Infectious Diseases Epidemiology and Research

A large proportion of people enrolled on HIV treatment have family members, including children, whose HIV status is unknown. Index testing of family members that is rights-based and gender-sensitive, can serve as an entry point for the identification of older children living with HIV not identified through PMTCT programme testing. This type of family-based approach to HIV testing and services enables parents and their children to access care as a unit. Index case testing is a potentially high-yield identification strategy that can contribute significantly to efforts to find and treat undiagnosed children living with HIV. In South Africa, only 47 percent of children living with HIV are receiving treatment compared to 71 percent of adults. Moreover, only 79 percent of children know their HIV status and of those that are on treatment only 39.8 percent are virally suppressed.

The 2019 South Africa HIV Guidelines introduced Dolutegravir and ritonavir/lopinavir oral pellets for adolescents and children to improve adherence and viral load suppression. However, one of the factors affecting viral load suppression is the adjustment of dosage in line with the weight and not switching ART regiments when indicated (such as virological failure). The country has not made enough effort in ensuring that children receive the right regimen and right dosing at the right time. Hence, more focus and effort are required from the government and partners to improve testing, access to treatment and viral load suppression.

UNICEF South Africa, in partnership with the National and Provincial Department of Health and the NGOs, mothers2mothers, piloted a Young Peer Mentor Mother Support Project in communities in two clinics (Soshanguve and Dark City), in the City of Tshwane between April 2016 and December 2017. The project targeted adolescent girls and young mothers between 15 and 24 years, in pregnancy and in the postnatal period and their children up to two years of age. The objective was to increase access to and uptake of quality adolescent and youth friendly HIV, prevention of vertical transmission program and MNCH services among young mothers and their babies. The project focused on providing peer-based facility and household linked psychosocial support services and health education along the antenatal care (ANC) and postnatal (PNC) continuum of care to the target group to achieve the said objective. Following the success of the pilot, the program was scaled up in 7 districts in Gauteng, Limpopo, and Kwa Zulu natal provinces.

Since 2019, the program enrolled 31637 pregnant Adolescent Girls and Young Women in 55 facilities in 7 districts in 3 provinces (City of Tshwane, City of Johannesburg, and Ekurhuleni in Gauteng Province; eThekwini, uMgungundlovu and Zululand in Kwa-Zulu Natal and Sekhukhune in Limpopo Province). Among the enrolled Adolescents Girls and Young Women 63% (19878) of the enrolled clients are aged between 20- 24 years; 36% (11353) were aged between 15-19 years, and 1% (406) were aged between 10-14 years. 17 Young mom clubs (4811 participants) and six post-natal clubs have also been established to improve retention in care during the postnatal period.

The Programme has identified gaps in service delivery, institutionalization, data, and scaling towards achieving the sustainability of the programme. Post-natal clubs are an important intervention to address adherence and retention in care in the postpartum period, particularly given growing number of infections postnatally. A related challenge to improve adherence and retention in care is poor post-natal follow up through the end of breastfeeding. Particularly, since a growing number of MTCT now occurs during the breastfeeding period, with 80% of these transmissions happening in the first 6 months after birth. The program has also expanded inyerventions to include HIV negative preagny young women and offer PrEP.

Data collection, analysis and use remain a challenge in facilities and at a district level. The client management tool and tally sheets are not always completed correctly and indicator definitions are not equally well understood. Partners do not consistently implement data quality control checks, impacting the quality and completeness of the data. A lack of tools and data linking mother infant pairs makes it difficult to follow up on clients post-natally. Partners and facilities are not using data to inform decisions and improvements but depend on field reports only.

UNICEF collaborated with National Department of Health (NDOH) and partners in South Africa to review routine programme and national health laboratory (NHLS) data. It was found that nearly 60% of HIV infections in children were from 14 districts (out of 52) and seven (out of the nine) provinces in the country.

These districts have large populations (e.g., Metros such as Tshwane, Ekurhuleni, City of Johannesburg, eThekwini, and City of Cape Town) and/or high levels of vertical transmission of HIV. Some of the issues contributing to the high burden of HIV infections include poor adherence, poor retention in care and frequent interruptions in treatment resulting in inadequate viral load suppression and unsafe breast-feeding practices. The findings of the 2019 joint review of the HIV, STI, TB and PMTCT programmes specifically identified data issues, reporting systems, and weak linkages between communities and facilities as bottlenecks to the performance of the health care systems. The Review emphasized targeting monitoring, implementation, and programme performance in high transmission districts.

Another critical challenge that remains is full support and buy-in from government in all the districts to fully integrate the programme and to provide monitoring and oversight. The pregnant AGYW peer mentor programme is not yet fully integrated with MTCT and MNCWH programmes and few districts has taken over the stipend bill of the peer mentors. To date, only eThekwini district has taken over stipends, we are awaiting the hiring of 120 peer mentors, Tshwane 17 peer mentors and 11 peers for the Ekurhuleni district. In Sekhukhune and eThekwini services are implemented by loveLife and IQVIA respectively with technical support from UNICEF. Additional funding has been provided for the revival of the programme in Tshwane, Ekurhuleni, and City of Johannesburg. However, this program has not taken off due to delays in signing MOU between the identified partners and the provincial government.

The objective of this TOR is to scale up the implementation of the pregnant AGYW peer mentor program in the three districts of Tshwane, Ekurhuleni, and City of Johannesburg in Gauteng province, while advocating for Tshwane model whereby the DoH funds the stipends of the peer mentors and the district partners provide ongoing support and mentoring for sustainability.in addition, the program will expand to improve the quality of care for children and adolescents in order to improve clinical outcomes and in line with the global alliance plan. In addition, the [partner is expected to provide support to loveLife to implement the program in Sekhukhune district.

UNICEF is committed to ending AIDS by 2030, in line with global targets, and to making HIV services easier to access. Preventing new HIV infections and improving access to testing and treatment saves lives and are the pillars of UNICEF's HIV response.

Scope of Work

Project Aim

To provide technical and strategic information support to institutionalise the pregnant AGYW peer mentor model and improve the access, uptake, and quality of care for children and adolescents living with HIV in three districts in Gauteng province (Tshwane, Ekurhuleni, and City of Johannesburg) and Sekhukhune District in Limpopo, with a possibility of expanding to KZN, eThekwini, once the peer mentor are hired.

Objectives

The project objectives include:

- Support other partners to scale up the program- capacity ongoing and ongoing Technical Assistance
- Provide Technical Assistance to implement the full package of the AGYW peer mentor services in the three districts in Gauteng province including male involvement and the provision of PrEP to eligible clients and improving the quality of services, targeting postnatal services (post-natal clubs, young mom clubs and the e-service delivery platform for follow-up)
- Integrate contraception, nutrition, and child health(immunization) and collect the data.
- Support selected district and or health facilities in the high burden metros to provide age specific Paediatric and Adolescent HIV interventions to improve the access and quality of care to achievement of the 95-95-95 targets by building their capacity through training and mentorship.

- To provide technical and strategic information support to strengthen data capturing, quality, and use to identify gaps and improve quality of the service delivered.
- To develop and strengthen linkage and collaboration between health facilities and communities and improve paediatric case finding particularly for children aged 18 months to 18 years.

Approach

The peer mentor model is designed as follows:

A simple package of services and tools were developed for use by the Young Peer Mentor mothers to support pregnant and breastfeeding adolescent girls and young women visiting the clinics or identified within the surrounding communities and households. The package of services included the following interventions:

- Promoting HIV testing among pregnant and postnatal young mothers, including TB pre-screening.
- Skills to support adolescent girls and young women who tested HIV negative to remain negative, including the promotion of PrEP and contraceptive use.
- Support for HIV treatment initiation, adherence education and follow-up to improve retention in care.
- Maternal and child nutrition especially counselling on folic acid supplement during pregnancy, immunization, Nutritional assessment (using MUAC tapes) counselling on feeding, referral, and support.
- Education on and promoting breastfeeding, including safe infant and young child feeding (IYCF) practices to prevent MTCT,
- Referrals and linkages to clinical and non-clinical services for mental health, nutrition, EPI, contraceptives, male partner testing, GBV and return to school.
- One-one education and psychosocial support including scaling up Young Moms and Post-Natal Clubs to improve retention in care until the infant is 18 months and had, had their final test.
- Registration on the e-service delivery platforms such as Mom connect and B-Wise

The technical partner will build the capacity of district support partners to: (i) train identified peer mentors (150) on provision of quality peer-based support to pregnant and breastfeeding AGWY; (ii) mentor and coach the peer mentors to provide adolescent and youth friendly support at facility and community level; (iii) utilise modelling and provide mentorship to sub-district and facility management for quality supportive supervision, (iv) use data for improvement and (v) conduct joint supportive supervision and programme management to project sites. This capacity building strategy should be implemented over period of 12-months in all the program districts. The technical partner will simultaneously support the sustainability of projects by advocating for stipends for the peer mentors to be taken over by DoH and or other existing partners. This support includes attending quarterly. PMTCT and MNCWH review meetings and presenting data from programme sites to advocate for adolescent and youth friendly services throughout districts.

In all project sites, the technical partner will work with the district support partners and the DoH to improve the quality of services, focusing on the implementation of young-mom clubs, post-natal clubs and follow-up of mothers and their infants. The technical partner will work with stakeholders to design and implement age specific HIV services for children and adolescents, strengthen referral systems for GBV and mental ill-health and will explore different modalities to involve male partners to support pregnant and breastfeeding AGYW. Furthermore, the technical partner will support the DoH to scale PrEP to AGYW and provision of adolescent and youth friendly services through the programme implementation.

The technical partner will work with UNICEF, and the Department of Health to use data for improvements. On-site quality assurance /improvement plans will be developed using programme data. To successfully track mother-infant pairs, the technical partner will work with UNICEF to capacitate the peer mentors to collect data for cohort monitoring, conduct a review to assess the process and outcomes of the institutionalisation and capacity building support including service coverage/utilization at facility and community levels at the end of the project term.

The successful service provider will share a proposed approach for the AGYW peer mentor program and methodology to improve the uptake and quality of the paediatric and adolescent HIV program in Tshwane, City of Johannesburg, Ekurhuleni districts and in selected high burden health facilities within those districts by:

- Identifying facilities with high MTCT rates and large number of AGYW for roll-out of the tailored interventions, including selection and training of Peer Mentors, related cadres, and Champions, in alignment with criteria and responsibilities that relate to the tailored intervention package, and suitability in supporting pregnant and breastfeeding AGYW in selected districts.
- Advocating for and getting buy in to implement the program.
- In consultation with the Department of Health training and deploying:
  - Peer Mentors and/ or adolescent and youth friendly services (AYFS) champions
  - Site Supervisors to support monitoring and ongoing supervision.
  - Sub-District Supervisors to support implementation and oversight of activities.
  - District level PMTCT and MNCWH Coordinators who play a key oversight and supportive role for buy-in.
- Delivering key capacity building activities including the following:
  - Capacity assessments will be conducted to determine technical support needs of identified Peer Mentors, Champions, and their supervisors. This will also establish facility baselines for selected sites to be supported through the project. Informed by the assessments, facilitate joint development of Capacity Building Plans with the Districts, Sub-Districts, and sites, outlining training needs, post training site support, supervision mentoring and coaching, site mentoring in selected districts.
  - Training of Peer Mentors and Champions
  - Design and implement age specific HIV services focusing on the following age categories:
    - 1-18months: testing, correct dosage and regimen, viral load monitoring, viral load suppression, nutrition, and early stimulation.
    - 1.5 - 18 years: status disclosure, adherence, psychosocial support, mental health, adolescent friendly sexual reproductive health services, HIX prevention especially condom use.
  - Post training support to be provided for service start-up including joint supportive supervision visits led by the Programme Advisor with district and facility supervisors to ensure appropriate start-up and integration of services at site and community level.
  - data reviews and stock taking meetings at facility, sub district and districts level to track the uptake of the Paediatric and Adolescent HIV Program and to determine the proportion of newly identified children linked to treatment, initiated on treatment and VL suppressed.
  - Routine and targeted site supervision visits, to be conducted jointly with DoH supervisors and include observations on-site of quality and technical soundness, use of robust reporting tools and data quality checks and monitoring, and provision of ongoing coaching, short-term technical assistance, and training.

Expected Deliverables, Payment Schedule and Reporting Requirements

Specific deliverables:

1. Inception report with a work plan on how the project will be implemented – 30%.
2. Indicators to be tracked in the selected districts and health facilities monthly and reported on. - 20%
3. Quality improvement plans that are SMART, tracked monitored and /interventions improvements reported. - 20%
4. Quarterly reports which entail: - 20%
   a. Capacity building reports for District partners and peer mentors
   b. Indicator performance tracking report
   c. Data quality meetings reports, improvement plans, quarterly data reports from all implementing districts and health facilities. lessons learned and challenges as well as a plan for the next quarter.
   d. Report on expansion of post-natal clubs among other services
5. Final report after 12 months - 10%

Specific indicators to report on to achieve the said objectives:

Outcome indicators

- Percentage of enrolled AGYW with known HIV status
- Percentage of enrolled AGYW living with HIV who received antiretroviral medicines to reduce the risk of vertical transmission of HIV.
- VL suppression among pregnant AGYW lining with HIV.
- PrEP uptake among pregnant AGYW and their partners
- Partner testing, contraceptive uptake, and nutrition
- Percentage of infants born to women living with HIV receiving a virological test for HIV within 2 months of birth (early infant diagnosis)
- Percentage of infants born to women living with HIV receiving a virological test for HIV at 18 months.
- Percentage of mothers virally suppressed at 6 months.
- Percentage of children and adolescents aged 1.5 -18 years who are virally suppressed.
- Proportion of HIV+ AGYW mothers exclusively breast feeding their baby
- Proportion of HIV+ AGYW mothers using any form of contraceptive

Proposed indicators to be tracked:

a) *95-95-95 paediatric HIV cascades at national, provincial and district level for ages 0-4yrs; 5-9 yrs;10-14 years; 15-19 yrs.*
b) *Number of provinces, districts, and selected health facilities with plans to improve paediatric HIV case finding and care.*
c) *Number of districts with clinical forums to discuss paediatric HIV cases.*
d) *Number of districts and facilities achieving the 95-95-95 targets for children living with HV.*

Output indicators

- *Number of district partners trained and capacitated to implement the AGYW peer mentor programme.*
- *Number of project sites fully supported by the DoH (including stipends) and District partners.*
- *Number of AGYW enrolled (antenatally and postnatally)*
- *Number of people including partners, department of health and peer mentors capacitated to implement the program.*
- *Number of children loss to follow up who are returned/linked back to care/treatment.*
- *Proportion of children who have completed age-appropriate immunization dosage.*

Process indicators

- *Number of AGYWs educated on, screened, and referred for STIs, SRHR, GBV, COVID-19 and HIV/AIDS*
- *Number of postnatal clubs established (disaggregated by type of support group either virtual or in person)*
- *Number of young mom clubs established (disaggregated by type of support group either virtual or in person)*
- *Number of AGYW clients attending young moms*
- *Number of AGYW clients attending postnatal clubs*
- *Number of AGYW enrolled on PrEP.*
- *Number of AGYW with partners supporting them in pregnancy and during breastfeeding*
- *Number of improvements plans using data.*
- *Number of breastfeeding AGYW mothers counselled on folic acid supplement and IYCF.*
- *Number of children who have nutrition status monitored using MUAC.*
- *Number of children immunized.*
- *Number of AGYW on contraceptives*

Reports due by the service provider.

- Monthly meeting minutes (between UNICEF and service provider's focal person)
- Training reports (who was trained, how, what was distributed etc)
- Quarterly progress reports (due middle of the following month)
- Inception and Final report (due after project approved and one month after project implementation has ended)

Desired competencies, technical background, and experience

The Service Provider requires the following experience and skills:

- Understanding the landscape and paediatric HIV program challenges in South Africa
- In depth experience in supporting government departments such as the working with the department health, education, and social development as well as community partners.
- Experience in public health and adequate capacity to oversee implementation of similar projects Experience in clinical management of HIV in children.
- Experience working in implementing peer mentoring programs, training and supporting the peer mentor project on various platforms (or similar)
- Experience in development of training materials and facilitating training.
- Experience in monitoring and evaluation including using data to improve program implementation.
- Engaging in high level discussions with the department of health and other stakeholders
- Experience and knowledge in data systems such as the DHIS and Tier.net
- The organisation should be based in South Africa, having an active MOU with provincial governments, especially Gauteng. is an added advantage.

The expertise required from the institution (key staff competencies, academic qualifications, specialized skills and/or training needed, years of experience in the technical area relevant to consultancy) to be included in the application.

Administrative issues

Informal weekly updates on the project, formal monthly meeting to provide updates and data provided monthly. Quarterly reports will be submitted outlining current progress, challenges, best practices and unexpected outcomes, and areas requiring additional support. A project report will be submitted one month after the project has concluded.

Conditions

As per UNICEF DFAM policy, payment is made against approved deliverables. No advance payment is allowed unless in exceptional circumstances against bank guarantee, subject to a maximum of 30 per cent of the total contract value in cases where advance purchases, for example for supplies or travel, may be necessary.

The contract will be governed by and subject to UNICEF's General Terms and Conditions for institutional contracts.

Technical Evaluation Criteria and Relative Points

Technical Criteria	Description of Technical Sub-criteria	Maximum Points %
Overall Response	Completeness of response	15
	Overall concord between RFP requirements and proposal	15
	Maximum Points	30
Institution & Key Personnel	Range and depth of experience with similar projects	5
	Number of customers, size of projects, number of staff per project	N/A
	Client references	N/A
	Key personnel to be assigned: relevant qualifications & experience	5
	Maximum Points	10
Proposed Methodology and Approach	Proposed Methodology for this project	30
	Proposed Work Plan to accomplish the Project	30
	Maximum Points	60
	Total Score for Technical Proposal	100
	Minimum Acceptable Score for Technical Proposal	70

Weights: Indicate 70 % Technical vs. 30% Financial Offer