PHYSICAL ADDRESS:
2nd Floor, Building 2
Walker Creek Building
90 Florence Ribeiro Avenue
Mucklenuek
Pretoria
0181

Request for Applications (RFA)
Terms of Reference (ToR)

Appointment of Service Provider for the Development of an Electronic Monitoring, Evaluation, Research & Learning (M&ERL) System for the Implementation of Prevention Programmes for Sex Workers (SWP), their Clients and Other Sexual Partners.

Global Fund Grant Cycle 7: 1 October 2025 – 31 March 2028

Closing date: 16th of November 2025, 16h00: SAST

BID REFERENCE: CCI_GF_0411_01

Note:

- Only email applications will be considered. All applicants must follow the instructions laid out below and submit applications to RFA@ccisa.org.za **before the closing date and time indicated above.**
- Any relevant queries and or questions to be submitted to TORenquiries@ccisa.org.za not later than the 13th of November 2025 (16h00), and answers to frequently asked questions will be posted on the CCI website www.ccisa.org.za
- **All applications and or enquiries must contain the BID REFERENCE in the subject line.**
- Any changes to this RFA and any related documents or information will be published on the CCI website. Please check the CCI website regularly.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
B-BBEE	Broad- Based Black Economic Empowerment
CCI	Centre for Community Impact
CCM	Country Coordinating Mechanism
DOH	Department of Health
DSD	Department of Social Development
FSW	Female Sex Worker
GBV	Gender Based Violence
GF	Global Fund
GF CT	Global Fund Country Team
HIV	Human Immunodeficiency Virus
HIVSS	HIV Self Screening
HTS	HIV Testing Services
I ACT	Integrated Access to Care and Treatment
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
NSP	National Strategic Plan
NSWP	National Sex Work Plan
PCA	Provincial Council for AIDS
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
RFA	Request for Application
SA	South Africa
SANAC	South African National Aids Council
SQL	Structured Query Language
SSL	Secure Sockets Layer
SR	Sub Recipient
SSR	Sub-sub Recipient
STI	Sexually Transmitted Infection
SW	Sex Worker
SWP	Sex Worker Program
TB	Tuberculosis
TCC	Thuthuzela Care Centres
TUTT	Targeted Universal Testing for TB

INTRODUCTION AND BACKGROUND

The South African Global Fund Country Coordinating Mechanism (GF CCM) is responsible for overseeing the implementation of Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) programmes funded by the Global Fund to fight Acquired Immune Deficiency Syndrome (AIDS), TB, and Malaria in the country. The GF CCM determines the content of the programming guided by the submitted South Africa's (SA) Request For Funding (RFF), the National HIV, TB and STI Strategic Plan (2023 – 2028), the modular framework, the budget envelope, and the output and outcome indicators and targets. The GF CCM has selected the Centre for Community Impact (CCI) as one of the Principal Recipients (PRs) that will implement programmes to be funded by the grant in SA from the 1st of October 2025, until 31st of March 2028, a 30-month programme implementation period. The GF CCM decided that a PR should serve as a grants manager, while sub-recipients (SRs) will be the main implementers of the programmes. CCI therefore, invites service providers or other qualifying providers experienced in the development and implementation of information management systems to apply to develop and implement an electronic Monitoring, Evaluation, Research & Learning (M&ERL) System for the Implementation of Prevention Programmes for Sex Workers (SWP), their Clients and Other Sexual Partners

NB: Applicants are required to submit detailed implementation plans and budgets as part of this call for applications.

SEX WORKER PROGRAMME OVERVIEW

This call for applications seeks to identify service providers who are efficient and effective implementers of the scope of work listed below. Applicants need to have implemented similar projects in the past. The specific scope of work is detailed within this document.

BACKGROUND

HIV Prevalence and Burden

Sex workers (SWs) in SA remain a key population in the national HIV response, as outlined in the National Strategic Plan (NSP) 2023 - 2028. Recent estimates suggest that the number of female, male, and transgender SWs ranges from 132,000 to 182,000, with an intermediate estimate of 153,000. Adolescent SWs (aged 15–19) are estimated at nearly 5,000, with over 1,300 in Global Fund priority districts. In 2025, HIV prevalence among FSWs is projected to be 56.0%, with 96.1% of FSWs Living with HIV and diagnosed. ART coverage is estimated at 72.8%, and 19.2% PrEP coverage among FSWs (Thembisa 4.8 model, 2025). In addition to HIV, FSWs in South Africa experience high rates of other STIs. The high prevalence of STIs among SWs in South Africa underscores the need for comprehensive sexual and reproductive health services tailored to this population.

Mental Health, Substance Use, and Drug Use Among Sex Workers

Mental health challenges are highly prevalent among sex workers (SWs), with depression and post-traumatic stress disorder (PTSD) being among the most common conditions. A national study in South Africa found that **52.7% of female sex workers (FSWs) had depression** and **53.6% had PTSD**, underscoring the significant burden of psychological distress within this population (Coetzee et al., 2018, *MDPI*). Contributing factors to poor mental health outcomes among SWs include **childhood trauma**, living with HIV, food insecurity, high exposure to gender-based violence (GBV), substance use, and pervasive stigma and discrimination (Coetzee et al., 2018). These overlapping vulnerabilities create a cycle in which poor mental health and substance use reinforce each other, further undermining health and well-being. Substance use is a major concern within SW communities. Alcohol misuse is particularly widespread, with studies reporting **prevalence rates ranging from 43% to 81.5%** among SWs (Coetzee et al., 2018). The **National Sex Worker Programme (NSWP)** has therefore

identified the integration of mental health and substance use support as a critical component of comprehensive SW services. Localised studies provide further insight into specific patterns of substance use. For example, research in **Soweto and Klerksdorp** found that **56.2% of FSWs engaged in binge drinking** and **29.4% reported drug use in the past year** (Bekker et al., 2015, *PubMed*). Such high rates of harmful alcohol consumption and drug use highlight the urgent need for tailored harm reduction and psychosocial support services within SW programmes.

Gender-Based Violence and Human Rights Violations
SWs experience high levels of violence and human rights violations. A study in Soweto found that 53.8% of SWs were exposed to physical or sexual violence by intimate partners in the past year, with 46.8% perpetrated by clients and 18.5% by police. The National Sex Worker HIV, TB, and STIs Plan emphasizes the need to address these issues through human rights- based approaches and legal reforms. (nacosa.org.za)

Cervical Cancer Risk and Screening
FSWs, particularly those living with HIV, are at increased risk of cervical cancer. A study found that 42% of HIV-positive female SWs had high-risk pap smear tests indicating precancerous cervical lesions. However, screening uptake remains low, with only 4% of SWs having ever been screened. The National Sex Worker Programme aims to integrate cervical cancer awareness, screening, and treatment into services for SWs, aligning with WHO's 2021 recommendation to use HPV DNA testing as the primary screening method. (aidsmap.com)

Tuberculosis (TB) and Co-Infection
South Africa has one of the highest TB burdens globally, with an estimated 154,348 undiagnosed TB cases, 68% of whom are people living with HIV (PLHIV). SWs, along with men who have sex with men (MSM) and transgender individuals, have higher TB rates than the national average. Integrating TB services into SW programmes is essential for effective TB control.

Integration and Linkage to Care:
Integrating TB screening and treatment services into SW programmes is essential to reduce morbidity and mortality. SW programmes provide routine TB symptom screening during outreach and clinical visits, and those with suspected or confirmed TB are linked immediately to district health facilities for diagnostic testing, initiation of TB treatment, and adherence support. Co-management of TB and HIV is prioritized through coordinated care plans, referral follow-ups, and support for treatment adherence. Such integration ensures that SWs receive holistic, client-centered care, improving health outcomes and reducing the risk of ongoing transmission in key populations.

Programme Response and Strategic Direction
The Global Fund-supported Sex Worker Programme in South Africa has evolved to provide a comprehensive package of services, including HIV testing, ART, PrEP, TB and STI screening, mental health support, and gender-based violence services. By 2019–2022, a solid foundation had been laid through the district saturation model in 14 GF supported districts. The GC6 grant 2022–2025 grant cycle expanded coverage to 16 districts and the current GC7 grant (2025–2028) will scale up the programme to 18 districts by including the City of Johannesburg and City of Cape Town respectively. The programme aims to achieve 95% saturation in 18 districts, reaching an estimated 193,537 SWs with CORE and LAYERED peer-led services. Peer- led interventions, community-based microplanning, and integration of non-communicable diseases (NCDs) are key strategies. The programme also focuses on addressing the needs of SWs who are parents, including child health services and parenting support. Additionally, guidelines for supporting minors who sell sex were developed and will be piloted. (aids.org.za).

While significant progress has been made in addressing the health and rights of SWs in South Africa,

challenges remain, particularly in mental health, violence prevention, and access to screening services. Continued investment in comprehensive, human rights-based programmes is essential to reduce HIV transmission and improve the well-being of SWs.

PROGRAMME DESIGN

The Sex Work Programme aims to improve the health and wellness of SWs in SA and the envisaged outcomes are:

1. Prevent new infections of HIV, STIs and TB amongst SWs.
2. Improved 95- 95- 95 health outcomes for SWs, clients, and sexual partners through combination prevention approaches.
3. Reduced human rights, social and structural barriers to HIV, STI and TB prevention, care, and impact among SWs.
4. A strengthened health system for the implementation of the National Sex Work Plan (NSWP).

Programme delivery is grounded in community-based, peer-led microplanning and a cohort management approach. Services are provided through fixed sites, satellite and mobile clinics, safe spaces, and virtual platforms. The SW programme will enhance the tailoring of packages for transgender SWs, male SWs, young SWs, and SWs who are parents and, their sexual partners and where appropriate, linkages will be made to the relevant stakeholders.

- For **transgender SWs**, interventions will integrate psychosocial support, and targeted HIV/STI prevention and treatment services, while addressing barriers such as stigma, discrimination, and legal challenges.
- For **male SWs**, the programme will incorporate tailored HIV prevention messaging, mental health support, and harm-reduction interventions, recognising the intersection of sex work, sexual orientation, and masculinity-related stigma.
- For **young SWs**, services will emphasise age-appropriate sexual and reproductive health education, access to contraception, life skills development, and pathways to alternative livelihoods, ensuring protection from violence and exploitation.
- For **SWs who are parents**, the programme will integrate parenting support, child health services, and linkages to social protection programmes, recognising their dual role in sustaining their livelihoods and caring for dependents.

The programme will also target **sexual partners of SWs**, offering HIV testing, prevention, and treatment services to reduce reinfection risks and promote shared responsibility for health.

Where appropriate, strong **linkages will be made to relevant stakeholders**—including legal aid providers, social services, mental health professionals, and economic empowerment programmes—to address the broader determinants of health and well-being for SWs and their families.

PROGRAMME INTERVENTIONS

The programme is comprised of three categories of interventions, namely biomedical, behavioural, and structural as depicted in **Table 1** below. Each intervention category is divided into 'core' and 'layered' services and activities. Core services will be provided by the selected programme implementers to all SWs enrolled in the programme. Furthermore, core services may be supplemented with the additional services known as layers. Layered services will be offered and provided to SWs based on their risk assessment profile and their individual needs. These services will be provided by SRs or through referrals to other service providers, such as the Department of Health, Department of Social Development, other NGOs, etc.

Table 1: SWP interventions

BIOMEDICAL	BEHAVIOURAL	STRUCTURAL
CORE • Offer of male and female condoms and lubricants, • Offer of HTS for HIV negative SW and those with unknown HIV status, • Risk assessments, • TB screening and STI screening	**CORE** • Small groups activities – (PSS, counselling, parenting skills, PrEP./ART, TB adherence, Youth support groups, substance use programs and support) • Harm reduction for SW who inject drugs	**CORE** • GBV screening and awareness in line with WHO Lives Framework.
LAYERS • HIV self-screening, pregnancy testing, annual pap smear, emergency contraception • PrEP, ART, monitoring, PMTCT, periodic presumptive treatment for STIs[21], TB treatment, PEP, hepatitis B screening, mental health services, rectal care cervical cancer and HPV awareness, screening and referrals. • NCD screening and referral	**LAYERS** • Support for effective PrEP use • Emotional & psychosocial support • Peer-led adherence support • Parenting programmes for SWs who have children. • Teen parenting programme for young women who sell sex • Substance use programmes and support	**LAYERS** • Dignity packs with menstrual health • Mechanism to report and record human right violations. • Improve SRH service delivery by sensitizing health care workers and strengthening the HTA programme. • Legal services to enhance access to justice. • Violence prevention support • Post-violence care • Interventions for young people who sell sex • Increasing HIV service uptake among clients and non-commercial sex partners

GEOGRAPHICAL COVERAGE

The Sex Worker Programme (SWP**)**, implemented under GC7, strategically targets 18 priority districts across eight provinces in South Africa. These districts were selected based on their high HIV burden**,** significant sex work activity**,** and alignment with national and provincial HIV prevention priorities**.**

Five Sub-Recipients (SRs), each in charge of providing services across several provinces and districts, coordinate the program's decentralized implementation model. In order to maintain high-quality service delivery while guaranteeing efficiency, cost-effectiveness, and value for money, this structure is made to correspond with population size estimates (PSE).

A 'satellite office' arrangement is used to provide services in districts with extremely low PSE. Instead of a full Programme Management Unit (PMU), a satellite office is a smaller, strategically placed operational base for outreach personnel. It can accommodate clinical teams, outreach workers, and peer educators, allowing them to swiftly mobilize into nearby communities. These offices offer a local hub for stakeholder coordination, planning and reporting space, and secure commodity storage.

This approach allows for targeted, context-specific interventions, ensuring that both urban and rural

areas receive appropriate and sustained HIV prevention, care, and treatment services tailored to the needs of sex workers.

Below is a breakdown of the SWP's geographic reach, showing the assigned Sub-Recipients (SRs), districts and provinces covered, and the targeted number of sex workers to be reached during the GC7 period:

Table 2: SWP Implementation Arrangements and Reach Targets.

Province	Sub Recipient	District	Reach Target
Gauteng	**Sub Recipient 1**	City of Johannesburg	**14591**
		Sedibeng	**4355**
		West Rand	**4328**
North-West		Bojanala - Satellite	**3181**
Limpopo	**Sub Recipient 2**	Capricorn	**3183**
		Mopani	**4247**
		Sekhukhune	**8076**
Free State	**Sub Recipient 3**	Lejweleputswa - Satellite	**1700**
		Thabo Mofutsanyane- Satellite	**1822**
Northern Cape		Frances Baard – Satellite	**2124**
Western Cape		City of Cape Town	**14273**
Eastern Cape	**Sub Recipient 4**	Alfred Nzo	**4154**
		Amathole	**2560**
		Buffalo City	**4796**
		Nelson Mandela Bay Metro	**7958**
KwaZulu Natal	**Sub Recipient 5**	King Cetshwayo	**3671**
		Ugu	**4222**
		Zululand	**2857**

NB: A total of four Districts are defined as Satellite for GC7.

PROGRAMME ACTIVITIES

1. Differentiated Service Delivery

CCI's SRs will be following a differentiated service delivery (DSD) model. This means that the service delivery will be dependent on:

- The Key Population (KP) context within a district, i.e., whether there are friendly and accessible public services available to KPs in the district.
- The development level of the SR, i.e., how many years of experience does the SR have in implementing programmes and the established systems for service delivery.
- The outcome of negotiations with the provincial Department of Health (DOH) and the agreements with the district and local health facilities.

Furthermore, in all contexts, peer educators will follow a micro-planning approach, which will identify the needs of specific SW in a district or identified high burden areas within a district. This method links with the fast-tracking approach, especially in cities, where SRs will pinpoint their focus on locations and interventions that deliver the greatest impact. The micro-planning has been enhanced to ensure value for money without compromising the quality of services for the SWs. Service frequency, intensity and location will differ based on the individual needs and risk of SWs.

Examples of service delivery elements that will differ are outlined below:

- **Service frequency:** – will depend on risk:
    - Newly enrolled SWs will receive a full-service package at REACH, followed by comprehensive assessments every six months and shorter quarterly micro-assessments. This approach ensures continuous, responsive, and tailored support while enabling early identification of emerging needs or risks.
    - SW newly initiated on ART or TB treatment will be seen monthly to assess adherence
    - Stable SWs on ART will be seen biannually for baseline bloods repeat and new prescriptions
    - HIV negative SW will be tested once a quarter
    - SW on PrEP will be seen monthly during the first 6 months and thereafter every 2 months but this may change with injectable LEN PrEP introduction **Lenacapavir (LEN)** is a long-acting injectable antiretroviral medication
- **Service Intensity:** - Core, layered and linkage services based on need, and also provided during the several outreach campaigns and community dialogues:
    - Offer clinical services (HTS, SRH) through mobile and outreach services.
    - Work in partnership with a clinic facility or in an independent SR clinic/drop-in centre.
    - Working with Ward-Based Outreach Teams (WBOTS) where they exist.
- **Service location:** - SRs may:
    - deliver a fully accredited 1-stop shop HTS, PrEP and ART service themselves at the district safe spaces, or
    - offer clinical services (HTS, SRH – incl PrEP) through mobile services and link SW to the local health facility for ART initiation
    - arrange with the DOH nurse to come to the hotspot/outreach site on a needs basis to provide specialized services

Peer educators are the first point of contact for SWs; peer educators are responsible for approaching SWs and introducing them to the programme and explaining what services are available to SWs through the programme. Relationship building is key for the peer educators to gain the trust, confidence, and friendship of the SWs. SWs recruited into the programme, by the peer educators, will also be offered services from a clinical nurse, linkage officers, a social auxiliary worker or other specialized practitioners in the health and wellness field.

2. Comprehensive Outreach Package of Peer-Led Behavioral Services

2.1 HIV Education and Support through Outreach

Strategies for outreach work shall be adapted according to the type of site to be targeted, e.g., taverns versus the street, and the local context where the SWs do business. Micro- planning tools shall be completed to ensure that the largest range of SWs e.g., internet, street, clubs, and brothels can be reached, and their needs met. CCI will adopt the safety guidelines for programme personnel that shall be responsible for providing outreach services to SWs, to ensure their safety.

Peer educators to work on the SWP shall be former or current SWs, experienced in sex work and with the ability to access and conduct outreach work in SW hotspots such as brothels, taverns and

on the street. Using the micro planning methodology, the peer educators will be tasked with reaching SWs with a core package of services which include:

- Provide HIV and TB information and education to SW and facilitate their introduction to the SWP.
- TB messages/ IEC material including material with the use of National TB Health Check self-screening application will be made available.
- Provide condoms and lubricant, and demonstrate correct condom use
- Conduct an enrolment risk assessment per SW.
- Conduct applicable screenings such as TB, STI, emotional wellness and GBV/violence screening.
- Offering or refer for a HIV test if the SW does not know their HIV status. SWs who self-report being HIV positive, will be navigated for ART initiation. ART adherence support to SWs on ART will be provided routinely.
- If applicable, mobilize the SW for group work, biomedical, legal, or psycho-social support services.

2.2 Human Rights and Gender Based Violence Education and Awareness

All peer educators will be trained as Human Rights and Gender (HRG) reactors to identify and report on human rights violations perpetrated against SWs. They will support SWs subjected to human rights violations with referral and linkage to paralegal services and ensuring response mechanisms are activated when needed. The SRs working in the SWP districts shall also be able to take up SW human rights violations and refer cases to public interest law centres.

2.3 Group Work

Based on the risk assessments, peers will mobilise SW to attend group activities such as parenting skills groups, Integrated Access to Care and Treatment (I ACT), PrEP and GBV groups as well as risk reduction workshops.

2.3.1 Risk Reduction Workshops

Risk Reduction workshops cover topics which are identified by SW and range from health, sexual and reproductive health, risk reduction, human rights, and other topical issues. These workshops serve as a social mobilisation mechanism where SWs build relationships with each other in a safe environment free of stigma and discrimination.

2.3.2 Small Groups

Sex workers (SWs) will be mobilised into small groups based on individual risk assessments to address their specific psychosocial and health-related needs. These groups offer a safe, supportive environment for SWs to engage with peers, build resilience, and access accurate information and services.

3. Comprehensive Package of Biomedical Services

The biomedical component of the Sex Worker Programme is not intended to create parallel clinical services to those offered by the DOH. Rather, it is designed to complement and enhance access to primary health care for sex workers (SWs) through the provision of targeted services delivered by trained and certified NIMART nurses and HTS/Linkage counsellors. A key focus is on strengthening linkages to, as well as integration with existing public health facilities, ensuring continuity of care and sustainability. All biomedical team members will be key to ensure earliest possible linkage to care.

Biomedical services offered through the programme will include HIV testing services, STI screening

and treatment, TB screening, PrEP and ART initiation support, and referral for additional care where necessary. These services will be provided alongside consistent condom distribution and demonstration. Information and education on condom use will be tailored to context-specific dynamics, with particular attention given to the uptake of female condoms. Efforts will focus on addressing gender-related barriers to condom use and promoting informed choice through culturally appropriate education and engagement strategies.

3.1 HIV Testing Services (HTS)

HIV testing serves is a critical entry point to HIV prevention and treatment services. As such, Sub-Recipients (SRs) will be supported to intensify efforts to scale up a robust "test and treat" approach. Under the HTS umbrella, SRs will deliver a comprehensive package of health services aimed at maximizing reach and impact, particularly among new entrants and underserved sub-populations of sex workers (SWs). HTS services will be provided by the HTS/Linkage Counsellor and in Year 2 of programme implementation, it is anticipated that trained Peer Coordinators will also support HTS during outreaches and themed dialogues.

3.2 Integration of TB services

HIV Testing Services (HTS) will serve as a critical entry point for TB screening within the Sex Worker Programme as TB/HIV collaboration is central to managing these two epidemics. All symptomatic clients will undergo screening, with sputum samples collected for GeneXpert testing. SRs will be responsible for monitoring results via the Lab Track system to ensure timely follow-up and linkage to care. SRs will also support implementation of the Targeted Universal Testing for TB (TUTT) approach, which screens high-risk groups, regardless of the presence of symptoms. These include people living with HIV, individuals with recent close contact with a TB patient, and those with a history of TB within the past two years. As this intervention is being rolled out in phases by the DOH, SRs will collaborate with local DOH facilities to implement TUTT only in districts where it is already operational.

3.3 Pre-exposure Prophylaxis (PrEP)

While all HIV-negative sex workers (SWs) are at risk of HIV acquisition, SRs will be required to identify and prioritize those at highest risk for targeted promotion of Pre-Exposure Prophylaxis (PrEP). Risk profiling will be based on standardised risk assessments conducted for every SW enrolled in the programme, using a uniform screening tool to ensure consistency and quality. IEC materials developed by the NDOH will be used and SRs will be encouraged to launch their own local PrEP campaigns and actively monitor and analyse what works for SW in this regard. Offering of PrEP will be staggered across sites and grant period as health facilities become ready to provide it and the appropriate referral/navigation procedures have been established within SRs.

3.4 Anti-Retroviral Treatment (ART)

To strengthen coordination and ensure seamless referral pathways between Sub-Recipients (SRs) and public health services, CCI will establish Memorandum of Understanding (MoUs) with the Provincial Departments of Health (DOH) in all eight provinces where the Sex Worker Programme (SWP) will be implemented. These agreements will formalize collaboration and facilitate timely access to ART for sex workers (SWs) diagnosed with HIV.

3.5 Sexual Reproductive Health Services (SRH)

Sex workers will be provided with a comprehensive package of sexual and reproductive health (SRH) services. This includes STI screening, pregnancy testing, annual Pap smears, access to emergency and modern contraceptives, as well as cervical cancer and HPV screening. Breast cancer screening will also be offered, with appropriate referrals for further care as needed.

4. Structural Interventions

The structural interventions and services include the core service of awareness of GBV, screening for cases of GBV as well as the provision of client-specific layered services as required.

4.1 Gender-based and Human-rights Violence Awareness, Screening and Support

GBV awareness will be integrated into the programme through one-on-one peer educator sessions, group activities, risk reduction workshops, and the distribution of IEC materials. All sex workers (SWs) will be screened for GBV using the WHO LIVES framework during the initial risk assessment at enrolment and annually thereafter. Additional screening may also occur during individual sessions with peer educators.

SWs who disclose current or past experiences of HRV and/or GBV will be supported through a range of layered services, which may include:

- Assisted referrals to Thuthuzela Care Centres (TCCs) or Designated Centres (DCs) for post violence care within 72 hours. These centres offer integrated services, including trauma counselling and long-term psychosocial support.
- Counselling provided by SR social workers and auxiliary social workers, with referrals to the Department of Social Development (DSD) and South African Social Security Agency (SASSA) for social assistance where needed.
- Support for reporting HRV and GBV cases to the South African Police Services (SAPS) and assistance in applying for protection orders.
- Access to legal services, including paralegals and public interest law organisations, as well as court accompaniment.
- Referrals to human rights defenders and temporary shelters for safe accommodation and support.
- Mechanisms for reporting and documenting human rights violations.

Beyond individual support, the programme will offer structural HRV/GBV-related services, including assistance for the children of SWs, community-based violence prevention efforts, and broader structural interventions.

4.2 Children of Sex Workers

The programme will prioritise tailored interventions for the children of sex workers (SWs), recognizing their specific needs and vulnerabilities. Support groups will be established for SWs who are parents, providing a platform to share knowledge and strengthen skills in perinatal and mental health, sexual and reproductive health and rights (SRHR), child health, development, and parenting.

The updated Mothers 4 the Future curriculum will be implemented in GC7. This curriculum covers key topics such as counselling and confidence-building, maternal and child wellness, SRHR, postnatal care, nutrition, and financial literacy. Sessions will be facilitated by trained Teen Mother Peer Educators, specialist peer educators who conduct outreach to pregnant SWs and those raising children. To address the health and development needs of children, quarterly Family Health Days will be organised in each district. These events will provide routine child health services including health screenings, immunizations, nutrition assessments, and school readiness evaluations. In addition, baby packs containing essential items will be distributed to eligible mothers with children aged three years and below, during the family health days.

4.3 Vouchers

Value Vouchers

Sex workers (SWs) on ART, TB often face food insecurity, which undermines treatment adherence, drug absorption, and overall health outcomes. The SWP will include value vouchers, distributed per quarter, which allows recipients the flexibility to purchase essential food items that suit their

personal and family needs, thereby offering a more dignified and tailored approach to nutrition support. They support treatment adherence and improve the overall well-being of beneficiaries through nutritional support. The value voucher fits well within the differentiated service delivery model by offering tailored, responsive support that recognises the complex realities of SWs, including mobility, violence, and economic precarity.

Emergency Vouchers

SWP will provide an emergency voucher to SWs who would have suffered any kind of human rights violation and would need financial support for various purposes, e.g. transport cost, accommodation, food while a long-term solution is being sought.

4.4 Violence Prevention for Sex Workers

The following interventions shall be implemented to prevent and reduce violence against sex workers:

- Safety and security training to be conducted for SRs, peer educators, and other interventionists
- Each SR to establish violence prevention and response teams comprised of a social worker or registered counsellor, a paralegal, and peer human rights defenders. These teams will be required to periodically analyze data on violence and identify issues for follow up, quality improvement, or for local or national advocacy.
- SRs to be equipped to dispense PEP and emergency contraception.
- SRs to dispense emergency relief (grocery parcels or emergency funds), when needed, based on rapid vulnerability assessments by social workers (including emergency relief for victims of violence and children/relatives of murdered sex workers).
- SRs to establish a sensitised network of local resources for violence response, including TCCs, health facilities, police, magistrate courts (e.g, for protection orders), social services, NGOs, services for suspected victims of trafficking, shelters, community leaders.
- SRs to establish a crisis response team and protocol, including designated crisis responders that are adequately equipped with cell phones, data, and transport to respond.

4.5 Clients of Sex Workers

This client-focused approach strengthens the overall impact of the programme by promoting shared responsibility, reducing transmission risk, and fostering a safer and more supportive environment for sex workers. The programme will maintain a strong focus on engaging gatekeepers, including owners, managers, and staff of establishments such as bars, shebeens, brothels, truck stops, and hostels. Their involvement is essential in ensuring that occupational health and safety standards for sex workers are upheld and that access is granted to engage clients around their sexual health.

4.6 Young People Who Sell Sex (Aged 18–24)

The programme will pilot a targeted strategy for young people aged 18–24 who engage in sex work, recognising their unique vulnerabilities and HIV-related needs. Under the leadership of CCI as the Principal Recipient for the Sex Work Programme, and with technical guidance from the SANAC Technical Support Unit, the Young Key Populations (YKP) Programme Implementation Guidelines will be disseminated and stakeholder sensitization conducted in all implementing districts. Stakeholders and sub-recipients (SRs) in implementing districts will be trained to adopt and integrate these guidelines into district-level programming.

SCOPE OF WORK

SYSTEM ARCHITECTURE

The proposed M&ERL system for CCI's Key Population (Sex Workers) program must be designed to provide a secure, scalable, and interoperable platform that ensures real-time data capture, high-quality reporting, and program oversight. The system should likely be built around DHIS2 as the core Tracker platform, integrated with a robust SQL database backend and hosted on the cloud locally (within South Africa). All system components must be secured with SSL encryption, and access controlled to maintain strict POPIA compliance.

CORE COMPONENTS OF THE MERL SYSTEM:

- The MERL system must likely be built around DHIS2.
- The MERL system must effectively collect, store, and manage data, ensuring data accuracy, security, and compliance.
- The MERL system must enable efficient tracking of individual beneficiaries and cohorts, supporting targeted interventions and follow-ups.
- The MERL system must provide real-time monitoring of service delivery, enabling proactive issue resolution and performance tracking.
- The MERL system must seamlessly integrate with other relevant systems to ensure a holistic approach to service delivery.
- The MERL system must be able to allow for offline capturing and be compatible with mobile device data collection such as smart phones, tables, biometric devices and others.
- The MERL system must offer robust reporting and analytics capabilities to track indicator performance in measuring the effectiveness of the programme and inform data-driven decision-making.
- The MERL system must be capable of providing real time reports to track programme performance and performance dashboards.
- The MERL system must have built in quality check mechanisms.
- The MERL system must encompass data warehousing that is capable to securely store all clients, programs, and analytical data to enable tailored access and reporting.
- The MERL system must be hosted on local cloud hosting dedicated servers (within South Africa) offering automated daily backups, disaster recovery, SLA-backed uptime, and full compliance with POPIA and international data protection regulations.
- The MERL system must have built in strict access controls.
- The MERL system must uniquely identify beneficiaries to prevent duplication and ensure accurate service delivery. The system must also have built in quality checks in data validation and deduplications mechanisms.
- The MERL system must allow encryption in transit and at rest, periodic penetration testing, and role reviews to maintain high levels of security and compliance.

PROJECT MANAGEMENT AND IMPLEMENTATION REQUIREMENTS:

- Testing and Training – conduct User Acceptance Testing (UAT) and provide initial and refresher trainings to M&E and outreach teams on system use.
- Hosting and infrastructure (including licenses where applicable).
- Helpdesk support

- Development of user guides and manuals (video tutorials, SOPs, data dictionary, reference guides etc.)
- Maintenance and system updates/enhancements
- Continuous improvements and enhancements

TIMELINE:

The project will follow defined phases: planning, core development, testing and training, deployment and post-implementation support. Each phase should have detailed timelines with milestones specifically focused on the integration and deployment of the MERL system.

DELIVERABLES:

Phase	Deliverables
Planning	Inception Report detailing system requirements, stakeholder engagements, project plan including timelines
Core Development	Configured DHIS2 tracker module, data collection forms, user access controls, mapped workflows. Demo system.
Testing and Training	UAT report, attendance registers, completion records and reports.
Pilot Deployment	Pilot testing conducted at identified site, pilot data collected including feedback report. Modified workflows and dashboards.
Reports and Dashboards	Test reports and data dashboards
Post Implementation Support	Support and maintenance logs/reports, helpdesk reports. Issues and resolution logs, SOPs, user guides and manuals.

All applicants must submit a detailed proposal highlighting the requirements as described in the scope of work above, including examples and proof of similar work conducted. Applications must be submitted together with a detailed costing. The costing of the proposal must follow the structure below:

Phase	Activity Description	Y1 Cost	Y2 Cost	Y3 Cost	Total Cost
Planning					
Core Development					
Testing and Training					
Pilot Deployment					
Reports and Dashboards					
Post Implementation Support					

PREQUALIFICATION CRITERIA

All applicants must have a broad-based black economic empowerment (BBBEE) level one (1) or two (2) or a sworn affidavit for eligible applicants.

EVALUATION PROCESS AND CRITERIA

- The evaluation of submissions will be managed by CCI and the appointment of the successful service provider by CCI. Preference will be given to organisations that have women, KP, disability, PLHIV, and youth-led

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

STAGES	EVALUATION PROCESS
FIRST STAGE	• This stage assesses for compliance with **pre-qualification criteria**. • Applicants must have a broad based black economic empowerment (B-BBEE) level one (1) or two (2) only. A valid B-BBEE certificate, or applicable Sworn Affidavit is required. • Applications that do not comply will not be evaluated further.
SECOND STAGE	This stage assesses compliance with **administrative requirements.** **All applicants MUST submit all the documents below and all LABELLED as indicated below:** • **Annexure 1: Proof of CIPC Legal Entity** • **Annexure 2: Valid SARS Tax clearance certificate** • **Annexure 3: VAT Registration Certificate** • **Annexure 4: Certified Solutions Architect accreditation** • **Annexure 5: Proof of 5 years or more of Public Health System design and development experience** • **Annexure 6: Profile of the organisation and relevant experience** • **Annexure 7: Detailed quotation** • **Annexture 8: Detailed proposal** **Applicants that fail to submit the administrative requirements will not be evaluated further.**
THIRD STAGE	• This stage of the evaluation process assesses **Technical Competency** focusing on the ability to fulfil the requirements based on the scope of work, experience and expertise of developing and implementing a MERL system. • Applicants need to achieve a score of at least 45 points of the technical competency requirements in order to progress further. The detailed scoring criteria shall be posted on the CCI website.

TECHNICAL EVALUATION SCORING MATRIX:

Criteria for Technical Evaluation	Total Score to account for 70%
Meets or Exceeds the requirements of the TOR	5
Partially meets the requirements of the TOR	3
Poorly meets the requirements of the TOR	1
Does not meet the requirements of the TOR	0
(TECHNICAL EVALUATION) System Design and Architecture	**Score (Max 50)**
The MERL system is built around DHIS2.	0 - 5
The MERL system effectively collects, stores, and manages data, ensuring data accuracy, security, and compliance.	0 - 5
The MERL system enables efficient tracking of individual beneficiaries and cohorts, supporting targeted interventions and follow-ups.	0 - 5
The MERL system provides real-time monitoring of service delivery, enabling proactive issue resolution and performance tracking.	0 - 5
The MERL system seamlessly integrates with other relevant systems to ensure a holistic approach to service delivery.	0 - 5
The MERL system allows for offline capturing and is compatible with mobile device data collection such as smart phones, tables, biometric devices and others.	0 - 5
The MERL system has built in quality check mechanisms.	0 - 5
The MERL system has built in strict access controls.	0 - 5
The MERL system uniquely identifies beneficiaries to prevent duplication and ensure accurate service delivery. The system also has built in quality checks in data validation and deduplications mechanisms.	0 - 5
The MERL system allows encryption in transit and at rest, periodic penetration testing, and role reviews to maintain high levels of security and compliance.	0 - 5
(TECHNICAL EVALUATION) Data analysis, Dashboards and Reports	**Score (Max 20)**
The MERL system must offer robust reporting and analytics capabilities to track indicator performance in measuring the effectiveness of the programme and inform data-driven decision-making.	0 - 10
The MERL system must be capable of providing real time reports to track programme performance and performance dashboards.	0- 10
(TECHNICAL EVALUATION) Hosting, Maintenance and User Support	**Score (Max 25)**
The MERL system encompasses data warehousing that is capable to securely store all clients, programs, and analytical data to enable tailored access and reporting.	0 - 5
The MERL system is hosted on local cloud hosting dedicated servers (within South Africa) offering automated daily backups, disaster recovery, SLA-backed uptime, and full compliance with POPIA and international data protection regulations.	0 - 5
Provides Helpdesk support and User training.	0 - 5
System has user guides and manuals (video tutorials, SOPs, data dictionary, reference guides etc.).	0 - 5
Maintenance and system updates/enhancements and has factored continuous improvements and enhancements	0 - 5
TOTAL TECHNICAL EVALUATION TO BE AVERAGED OUT OF 70%	

BBBEE or Eligible Affidavit	Score (Out of 20%)
Level 1 or Affidavit = 20%	20%
Level 2 = 10%	10%
PRICE	**Score (Out of 10%)**
Within 10% out of range of the budget (over or under) = 10%/10 points	10%
Within 11 - 20% out of range of the budget (over or under) = 5%/5 points	5%
Within 21% out of range of the budget (over or under) = 2%/2 points	2%

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

Technical Evaluation Score	70%
BBBEE	20%
Price	10%
Total	**100%**

- **The CCI Bid Evaluation Committee will present its evaluation outcome to CCI's BAC for consideration and recommendation on the selected service provider.**

APPLICATION INSTRUCTIONS

All applicants are required to:

- Only email-submitted applications will be considered.
- Mark their applications with **"Application - MERL System Development – Name of Organisation – BID Reference Number"** in the email subject line.
- Should the application submission be too big for one email, applicants must submit batches as detailed below until all batches are submitted:
  - **"Batch 1 - Application - MERL System Development – Name of Provider – BID Reference Number"**
  - **"Batch 2 - Application - MERL System Development – Name of Provider – BID Reference Number"**

KEY DATES

The deadline for the submission of a fully completed application, including all relevant attachments, is the **16th of November 2025 (16h00: SAST)**. The key dates for the application process are shown in the table below.

STAGE	DATE / PERIOD
1. Publication of the Request for Applications	**5th of November 2025**
2. Deadline for questions and request for information. Such must be directed to TORenquiries@ccisa.org.za	**13th of November 2025 (14h00: SAST)**
3. Deadline for submitting applications. No late applications will be accepted.	**16th of November 2025 (16h00: SAST)**
4. Evaluation period (indicative) during which additional details may be requested.	**17th – 19th of November 2025**
5. Appointment of Service provider (Indicative)	**20th – 21st of November 2025**