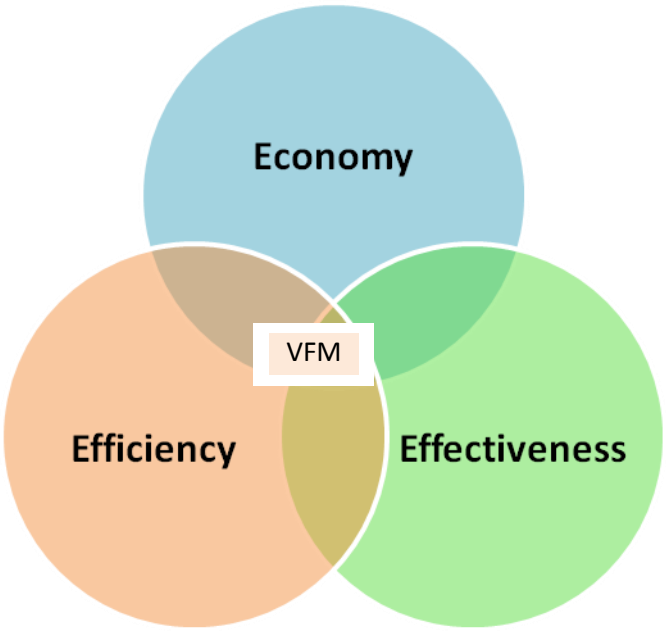
Planning and Implementation Guidelines of HIV&AIDS Component in Road Contracts



"Ascertaining and Promoting VFM in the Road Sector"

First Edition

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Preface

It is a well-known fact that Roads are the arteries of development. As the Country embarks on a very ambitious programme of developing the road network through projects such as Link Zambia 8000, L400, C400 and Pave Zambia 2000, it is important to ensure that externalities and in the context of these guidelines, HIV&AIDS are addressed for development to be meaningful.

Road construction like any other capital project is labour intensive. The labour particularly the skilled one is often very mobile. A number of studies including the Mode of Transmission Study (MOT) conducted in 2009 shows that mobility is one of the key drivers of the HIV epidemic. The Roads Sector recognised the need to ensure that each road project has a component of mitigating HIV&AIDS impacts since 2002 through the Road Sector Investment Programme (ROADSIP).

However, a review of the HIV&AIDS Component in road contracts conducted by the National Road Fund Agency (NFRA) and the National HIV/AIDS STI/TB Council (NAC) in 20014/15 indicates that although a lot of effort has been made, a lot more needs to be done for **Value for Money** (VFM) to be attained and to halt and begin to reverse the trends of HIV infections.

As such, these guidelines have been produced to improve HIV&ADS Programming in the roads sector at each of the following stages:

1. Initiation
2. Planning
3. Selection of Project Team
4. Implementation
5. Monitoring and Reporting
6. Project Closure Phase

These guidelines are to be used by supervisors, consultants, contractors, service providers and other stakeholders in the sector.

These guidelines have further attempted to strengthen oversight and good governance by encouraging joint monitoring visits as well as the use of local structures and evidence in the AIDS response.

It is my hope that when a review is done in a few years' time, the situation on the ground would have changed for the better. It is hoped that the skilled labour that has been trained at a huge cost will be protected and that vulnerable communities in which the road projects traverse will also be protected. This is the only way that the road projects will contribute to sustainable development.

Lastly, these guidelines are not cast in concrete. They will be reviewed and updated periodically to incorporate any emerging issues.

Acknowledgement

These guidelines have developed with technical input and support from the following organisations and individuals:

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Road Development Agency

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Special thanks also go to the Director General at the National AIDS Council for making his staff available whenever need arose.

It is my hope that the officers can continue making themselves available particularly during the dissemination phase of these guidelines so that they explain the thinking and concepts included in these guidelines.

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BOQ	Bill of Quantities
CBO	Community Based Organisation
DACA	District AIDS Coordination Advisor
DATF	District AIDS Task Force
DCMO	District Community Medical Office
DHID	Department of Housing and Infrastructure Development
eMTCT	elimination of Mother To Child Transmission of HIV
EPB	Environmental Project Brief
ESIA	Environmental and Social Impact Assessment
ESMP	Environmental and Social Impact Management Plan
GBV	Gender Based Violence
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IEC	Information Education Communication
ILO	International Labour Organisation
KYE	Know Your Epidemic
MLGH	Ministry of Local Government and Housing
MOT	Mode of Transmission
NAC	National HIV/AIDS/STI/TB Council
NCC	National Council for Construction
NGO	Non-Governmental Organisation
NRFA	National Road Fund Agency
NZP+	Network of Zambia People Living With HIV
PACA	Provincial AIDS Coordination Advisor
PBE	Provincial Buildings Engineer

RDA	Road Development Agency
R-NASF	Revised-National AIDS Strategic Framework
ROADSIP	Road Sector Investment Programme
SBCC	Social Behavioural Change Communication
STI	Sexually Transmitted Infection
UN	United Nations
VFM	Value For Money
VMMC	Voluntary Medical Male Circumcision
ZDHS	Zambia Demographic and Health Survey
ZEMA	Zambia Environmental Management Agency

1.0 Background

The prevalence of HIV in Zambia, though declining still remains high at 13.3 % (ZDHS, 2014). The incidence is equally high with 56,000 new infections recorded in 2014 (estimates and Projections, 2015). There are many drivers for this, but one such relates particularly to the influx of migrant and mobile workers associated with construction and **subsequent operation of large capital projects**. The impact on households, institutions, society and the economy is reflected in the rising cost of health care, changes in the population structure, and increased dependency ratios. The growing appreciation of these implications has created greater political support for efforts to deal with HIV and gender-related issues, but at the same time, placing increasing strain on limited government resources.

Many studies have identified construction workers as a risk group along with miners and transport workers (ILO, 2007). This is partly because many of the workers are mobile, with poor living conditions and often separated from their families. Many construction firms however, try to source as much labour as possible from local communities, but inevitably there are few skilled or semi-skilled workers present especially in rural areas and skilled human resources need to be sourced from elsewhere.

1.1 Why focus on the road sector?

- The sector often imports large male migrant workforce;
- Migrant and mobile workers are away from home and their spouses and have disposable incomes to spend ;
- Local rural populations in most of these project sites are poorer and young women tend to be vulnerable to promises of money and are unable to negotiate for safer sex;
- Most of the migrant and mobile skilled personnel come from cities and urban areas which have with higher HIV prevalence rates
- Road construction usually opens up previously isolated communities
- HIV and AIDS activities in construction sites start too late and end early.

The Zambian Government through the Modes of Transmission (MOT) studies has highlighted mobility as one of the six key drivers of the HIV epidemic in the country. In response, it has established a national campaign to initiate, revitalize and scale up innovative HIV prevention programmes for mobile populations.

The Road Sector Investment Programme (ROADSIP) in 2002 enshrined an HIV component in major Road Contracts to prevent the spread and mitigate HIV&AIDS amongst workers and communties in which road projects are located.

However, implementation of the HIV and health component has been a challenge as reflected in the Rapid Assessment conducted by the National Road Fund Agency (NRFA) and National AIDS Council (NAC) in 2014/15.

Some of the key findings were;

a. All projects visited did not have the Environmental Assessment Reports

b. There was a systematic lack of information sharing. The district official did not know what was in the final ESIA or report as a copy was not available at district level

c. There was no objective and systematic planning for HIV&AIDS and gender issues in the project document and the allocation for HIV&AIDS was not based on any evidence documents at all

d. In most cases it was very difficult to ascertain the amounts of funds spent on HIV&AIDS activities as there were no records showing planned activities, allocated funds, requests and expenditure

e. The contractors in most cases hired individuals or organisations to conduct sensitisation talks on HIV&AIDS to workers on pay days. The talks were however not well planned and were haphazard and did not relate to any local situation analysis

f. Condoms were distributed to workers as a prevention intervention. However, the distribution was neither systematic nor adequate as this was done once per month or was kept in an office and staff had to request or demand for them

g. There was no evidence that the contracted organisations or individuals bought any condoms from the HIV&AIDS funds allocated in the project document as most of the condoms found on site were public condoms from the GRZ or UN systems

h. There was a general lack of appropriate HIV prevention messages in the communities surrounding the road projects as the sensitisation was confined to workers

i. Involvement of local stakeholders such the Ministry of Health, Ministry of Community Development Mother and Child health, the Councils and DATFs in planning and execution of HIV&AIDS activities was very limited and uncoordinated

As such, these guidelines have been developed by key stakeholders in the sector responding to these key findings to ensure that sustainable development and **value for money** is achieved.

1.2 Purpose of the Guidelines

The purpose of these guidelines is to help all stakeholders to have an evidence based approach to planning for HIV and AIDS activities in the road sector. Furthermore the guidelines are meant to ensure that the investment is smart and result oriented in the management of the HIV and health component in road contracts.

1.3 Who should use these guidelines?

These guidelines are designed to be used by a range of stakeholders including but not limited to the following:

- Line ministries such as the Ministry of Transport, Works, Supply and Communication as well as the Ministry of Local Government and Housing (MLGH)
- Funding agencies such as the National Road Fund Agency (NRFA)
- Implementing Agencies such as the Roads Development Agency (RDA), Ministry of Local Government and Housing and the National Council for Construction (NCC)
- Local Road Authorities
- Project Supervisors and Consultants
- Contractors

1.4 Structure and Orientation of the Guidelines

The results of the assessment done in 2014/15 by the National AIDS Council on the HIV Component showed that most of the challenges encountered relate to inadequacies in planning and implementation. As such, the guidelines have been framed to integrate HIV and Health in the project design stages of;

- Initiation phase
- Planning
- Selection of project team
- Implementation phase
- Monitoring and reporting
- Project closing phase

2.0 HIV Investment Framework, anchor for Basic HIV Programing in the Road sector

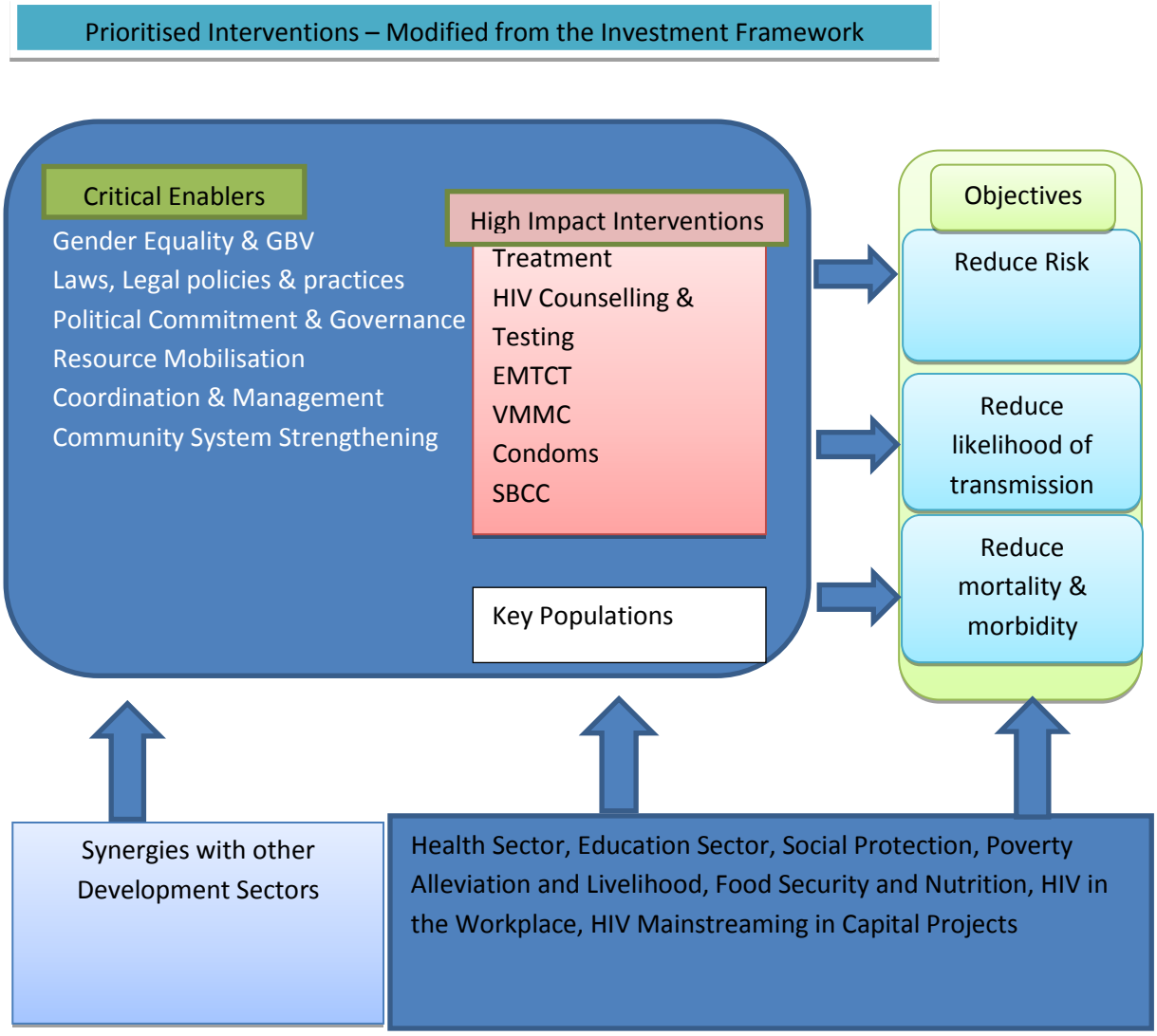
The response to HIV and AIDS has evolved over the last thirty years. With the evidence that has been gathered over years, it is now clear that for the response to be effective, focus and investment should be in the high impact interventions as shown in figure one (1). These high impact interventions are:

- Treatment (ART)
- HIV Counselling and Testing (HCT)
- Elimination of Mother to Child Transmission (eMTCT)
- Voluntary Medical Male Circumcision (VMMC)
- Condom Programming
- Social and Behavioural Change Communication (SBCC)

Investing in these high impact interventions will result in;

- Reduced risk of infection
- Reduced likelihood of transmission of the virus and
- Reduced HIV&AIDS related deaths

Figure 1:



Furthermore, the investment approach promotes synergies with other sectors, partners and stakeholders in order to leverage resources and promotes efficiency. The investment approach also takes on board critical enablers. Critical Enablers are factors that can affect the basic HIV programming if they are not factored in. For example, Gender Based Violence can easily affect the uptake of services such as eMTCT or condoms.

3.0 Integration of HIV programming in the Road Project planning and implementation Phases

3.1 INITIATION PHASE

The initiation phase is a very critical stage of a project because this is when a lot of information that will influence the design of the project is gathered. With reference to HIV Programming, this is the stage when evidence is gathered around the local context of the epidemic. The requirement for Environmental and Social Impact Assessments (ESIA) to be done for most road contracts is an opportunity to integrate health and gender issues. However, not all projects require an ESIA to be done. Small project require an Environmental Project Brief (EPB).

3.1.1 Proponent

- Ensure that the Environmental and Social Impact Assessment is done
- Ensure that the team conducting the ESIA has competent officers to tackle health, HIV dynamics and gender issues
- For smaller projects, ensure that an EPB is done
- Ensure that evidence from other documents such as District Situation Analysis, District HIV and AIDS Strategic Investment Plans are utilised as part of the Know Your Epidemic (KYE)
- Ensure that the key stakeholders such as Local Authorities, Traditional Leadership, Civil Society and other Civic Leaders are consulted
- Use appropriate media platforms to inform communities to participate in the process of developing the ESIA.

3.2 PLANNING STAGE

The planning stage is when designs and the associated Bills of Quantities (BoQs) are prepared. It is at this stage that the evidence gathered should be packaged in a matter that is;

- Economically sound
- Legally compliant
- Socially acceptable
- No net loss to the environment
- Not injurious to the health and wellbeing of the workforce and surrounding communities

In as far as HIV programming at this stage is concerned; the following should be done at planning stage:

3.2.1 Proponents

- Ensure that the Environmental Management Plans are incorporated into the tender documents.
- Adjudicate the tenders using a range of criteria, including those relating to HIV and management of social issues.
- Check that the contractor's budget for health (HIV) management and social issues are separate line items and are sufficient to cover all the required measures or activities.
- Check that the contractor has identified specific personnel to manage the health and social programmes (internal staff, NGOs, CBOs, consultants).

3.2.2 Contractors

- Ensure that the cost reflected in the bidding documents is as reflected in the EMP
- If the cost in the EMP is not comprehensive or the project has no EMP at all, use population, duration of the project, urban or rural considerations and apply the costing index attached as Annex 3.
- Cost Social and Behavioural Change Communication (SBCC) and condom promotion activities and identify areas of synergies for the other high impact interventions
- Always integrate the provision of health services for the workers and communities
- When planning for accommodation, consider the gender dimensions as well as water and sanitation

3.3 SELECTION OF PROJECT TEAM

The selection of a project team in as far as HIV Programming is concerned relates to the selection of a service provider. The Service Provider focuses on the provision of general health services on behalf of the contractor. However, attention should also be given to gender issues. Gender dimensions are a critical enabler for demand creation of HIV related programming to be successful.

Community Based Organisations have proved to be critical players in the response to AIDS. Since they are often domiciled in the affected area, they have a better contextual understanding of the epidemic. Since they are locally based, trasactional costs are low hence more resources are made available for interventions. An example is Chishima Support Group in Nchelenge which benefitted from the NAC sub granting mechanism. With an investment of only K35, 000.00, the group was able to:
Reach 3383 pregnant women with PMTCT
Reach 1351 men with VMMC
Reache out to 1,486 community members with HCT
Distribute 13,069 pieces of condoms

It is very common for national and international organisations to be selected as service providers. It must be noted that Local Community Based Organisations are equally capable of delivering such services at a lower cost but effective because of understanding the local context. The proximity to the projects sites transalates into lower administration costs.

As such, service providers should meet the following creteria;

- Good understanding of the local context of the HIV epidemic
- Preferably locally based unless where such organisations are not available
- Known and endorsed by the DATF, Local Authority and District Administration. As such, service providers bidding to be engaged should obtain reference letters from the DATF or Local Authority.
- Be in a position to mobilize before the contractor moves to site.
- Be in a position to establish baselines before implementation of activities and measure outcomes and impacts at the end of the project.
- An agreement between the contractor and service provider should be signed as evidence of the service provider being engaged.

3.4 IMPLEMENTATION PHASE

3.4.1 PROPONENT

During implementation phase of road projects, the proponent should ensure that the following is done:

- Ensure that the contractor implements the provisions of the ESIA and ESMP
- In the absence of ESIA and ESMP, the proponent should ensure that the contractor has a comprehensive evidence based HIV implementation plan
- Ensure that the HIV implementation is approved by the DATF
- Ensure that during site meetings, progress on the implementation is reported
- Detailed monthly reports are submitted to the client and funding agency as basis for payment of the HIV&AIDS component. Refer to annex 2.
- The close out phase should include conducting an HIV impact assessment to determine the impact of investment to assess the impact of the HIV intervention on the health of the community

3.4.2 CONTRACTORS GUIDELINES

1. Contractor should appoint HIV Focal Person on site who will be responsible for the development of a work Plan and overall coordination of HIV&AIDS activities in collaboration with DATF.

2. The Contractor should prepare a work plan that will form the basis of all planning, implementation, monitoring and reporting activities. The work plan will define all key areas of intervention that will be designed by taking into account the local context. Broad work areas of the work plan may include as a standard practice: condom distribution; HTC, STIs and ART and sensitization programmes at specified intervals in line with R-NASF priorities.

3. Planning for HIV&AIDS should commence at the project mobilization phase. During this phase, key activities such as community sensitization about the upcoming project and engagement with local leaders, service providers and other stakeholders may be initiated.

4. The contractor is expected to facilitate the provision of mobile HTC services for the workers (financial/transport costs and allowances for health providers) in line with the work plan.

5. The contractor should allocate time for workers to access treatment, attend sensitization meetings and visit the service centres.

3.4.3 SERVICE PROVIDERS

To facilitate HIV integration during the implementation stage,

1. The service provider should undertake a stakeholder mapping of organizations that offer HIV and other health services in the catchment area. It is expected that the HIV and health service providers will collaborate with the local leadership and other service providers for support e.g. District Administration (DA), Local Authority (LA), DATF, DCMO, Area Councillor and traditional leadership.

2. The service provider will work with the local health centres to provide an integrated package of health services as they provide the HIV&AIDS related services.

3. The service provider should extend services to local community

4. The service provider should explore the possibility of supporting mobile HTC services for the workers (financial/transport costs and allowances for health providers) through a clearly articulated budget line.

3.4.3.1 HIV TESTING AND COUNSELING GUIDELINES

The following considerations must be made:

1. Engage local leadership and local service provider/for support e.g. District Administration(DA), Council, DATF, MCDMCH , Area Councillor
2. Possibility of supporting mobile HTC services for the workers (financial/transport costs and allowances for health providers) through a clearly articulated budget line.
3. Decide how often HIV Testing and Counselling services will be offered in consultation with the contractor.
4. Employees who go for HTC should not lose part of their salary
5. The service provider must provide support for employees who test HIV positive and protect them from stigma and discrimination
6. Establish a referral network to link clients to relevant health facilities
7. Lobby service providers for relevant I.E.C materials for workers.

3.4.3.2 PROMOTING ADHERENCE TO TREATMENT

1. The service provider should ensure that the workers are fully informed about integrated HIV and other health service provision and sensitization days.
2. The service provider must ensure that cost effective referral system for trans-in and trans-out workers on treatment is established and supported.
3. The service provider must ensure confidentiality and protect employees who are on treatment from stigma and discrimination.
4. The service provider must identify and train peer to peer promoters to enhance treatment adherence.
5. The service providers should provide relevant I.E.C materials on adherence

3.4.3.2 EFFECTIVE CONDOM PROGRAMMING

1. Condoms must be stored in a cool and safe place.
2. Condoms must be placed in locations that are easy to access by all workers.
3. The HIV&AIDS focal person must ensure constant supply and availability of condoms on site.
4. Workers should be trained in the correct use of condoms
5. The HIV Focal Person should always check expiry dates for stocked condoms and when receiving new consignments

3.4.3.4 HOW TO CONDUCT BEHAVIOUR CHANGE COMMUNICATION

1. The service provider must take into account the local context based on available evidence and develop appropriate messages.
2. The DATF and other relevant stakeholders should be engaged when developing messages to be in line with the local context.
3. As much as possible, and as appropriate, local resources such as community radio stations and drama groups should be used to convey the HIV&AIDS messages.
4. Best practices and any achievements should be documented for future replication to other project sites
5. Identify and engage local leaders who will serve as champions for behavioural change within the communities.

4.0 Monitoring

Monitoring is the mirror image of planning. Monitoring is critical in ensuring that the planned activities are on course and on schedule in meeting the objectives and performance targets. As such, it is important to have key indicators that show progress being made in the implementation of the HIV component of road contracts As such, during site meetings, apart from discussing physical, technical and financial progress of the project, adequate time should be allocated to discussing HIV and other health and gender issues.

A monitoring/inspection tool has been developed to guide the supervisors, contractors and service providers in terms of areas of investment (Refer to Annex 1). The monitoring/inspection

tool has been developed in a format that is able to measure performance. As such, it is able to guide decision markers whether to clear a payment certificate or not.

The monitoring framework below gives a guide as to what indicators should be used to track the key interventions.

Monitoring Framework

Key interventions	**Key indicators**
Sensitization and Prevention Activities	• Number of workers reached though sensitization meetings • Number of community members reached though sensitization meetings • Number of male & female condoms distributed to workers • Number of male & female condoms distributed to community members
Sensitization and Promotion Activities (IEC Materials)	• Number of posters distributed • Number of flyers distributed • Number of bill boards set up • Number of community radio programmes aired • Number of drama performances conducted • Number of brochures distributed • Number of T-shirts produced
Facilitation of HTC for workers and the community	• Number of people male and female counseled • Number of HIV testing conducted • Number of males and females tested
Referral and Treatment	• Number of workers tested for HIV • Number referred for ART • Number commenced on ART • Number referred for STI treatment • Other ailments (wellness)
Utilization of funds within the budget	• Expenditure against planned allocation in the BOQ and activities in the work plan

4.1 General indicators

- Availability of Monitoring plan – targets and resources
- Availability of HIV work plans- Activities and the intervals
- Availability of reports
- # of District HIV&AIDS plans
- Social expert in HIV&AIDS and should be sourced locally

4.2 Joint Monitoring Teams

4.2.1 District Level

- NAC
- MLGH/Council
- RDA
- Community Development
- Traditional Leadership
- NZP+ (Network People living with HIV positively)
- Any other relevant stakeholder or organization

4.2.2 Provincial Level

- RDA
- MLGH/DHID
- Provincial Heath Office
- Works And Supply –PBE
- NAC –PACA
- NZP+ (people living with HIV positively

4.2.3 NATIONAL LEVEL

- NAC
- RDA
- MLGH
- NCC
- MTWSC
- NZP+ (people living with HIV positively)
- NRFA

4.3 CLOSE OUT PROCEDURE

During project closeout, it is imperative that attention is given to the softer issues of HIV, General health and gender issues. The following should be considered;

- Preparation of completion certificates/ reports
- Final inspection reports by ZEMA, NRFA, MLGH and RDA
- Fulfilment of commitments with the community
- Rehabilitation of material extraction sites
- Handover meetings with the clients
- Gender and Health issues during defects liability period to be discussed in plenary
- Impact assessment of planned interventions before final closure of the project
- Entrepreneurship activities for the workers after the project

5.0 Annexes

Annex 1. MONITORING/INSPECTION TOOL

CONTRACT REFERENCE DATA

Project Name:				**Implementing Agency**	
Contractor:			**Supervisor**		
Province:		**District:**		**Location**	
Road Name:				**Funding Source**	
Funding:		**HIV&AIDS Contract Amount**		**Disbursed Amount**	
Start Date:		**End date**		**Contract Period**	
General HIV&AIDS Scope of Works:					

1. INSPECTION DATA

Inspection Date		**Inspection No.**	
Inspector(s) Name(s):			
People met during the inspection (name and function):			
Project Notes: Brief background/History/Significance relating to HIV&AIDS:			

1. GENERAL OBSERVATIONS CHECKLIST

No.	Item	Tick	Remark
1	No. of Workers on site (M/F)		
2	On site health facility		
3	Workers quarters (Living conditions)		
4	Water and sanitation facilities		
6	HIV&AIDS Service provider (s)		
6.1	Service provider sourced from within the district or external		
7	EIA and EMP available		
8	Reference to plan		

2. PROGRESS CHECKLIST

S/N	Activity	Planned		Actual		Planned	Actual	%	Remarks
		Male	Female	Male	Female				
1.0	HIV sensitisation meetings								
2.0	Number of workers reached though sensitisation meetings								
3.0	Number of community members reached though sensitisation meetings								
4.0	Number of condoms distributed to workers								
4.1	Number of								

	condoms distributed to community members								
5.0	Information Education Communication (IEC) medium used								
5.1	Number of local posters distributed								
5.2	Number of flyers distributed								
5.3	Number of bill boards set up								
5.4	Number of community radio programmes aired								
5.5	Number of drama performances conducted								
5.6	Number of brochures distributed								
5.7	Number of T-shirts produced								
6.0	Are the IEC material used cleared by the IEC Technical Working Group at National, provincial or district level						Yes	No	
7.0	Number of workers tested for HIV								
8.0	Number referred for ART								
	Average percentage								

3. PERFORMANCE MEASUREMENTS

Performance rating	Grading	Percentage achievement of target	rating
Exceeding expectation	Excellent	>95%	
Meets expectation	Very Good	90-95%	
Adequate	Good	60-89%	
Inadequate but potential demonstrated	Fair	30-59%	
Unacceptable	Poor	<30%	

4. VALIDATION OF INFORMATION (Community members, workers, head teachers, health staff)

Key questions	Yes	No	Comment
Were there any HIV&AIDS activities carried out by the contractor?			
Were they adequate and specific to this area?			
Was the language and medium used appropriate?			
Are you seeing any change as a result of the interventions?			

5. GENERAL COMMENTS

6. DETAILS OF RESPONDENTS

No	Name	Signature	Date

Annex 2. Reporting Template

1. CONTRACT REFERENCE DATA

Project Name:				**Implementing Agency**	
Contractor:			**Supervisor**		
Province:		**District:**		**Location**	
Road Name:				**Class**	
Funding:		**HIV&AIDS Contract Amount**		**Disbursed Amount**	
Start Date:		**End date**		**Contract Period**	
Reporting Period					
General HIV&AIDS Scope of Works implemented during period under review					

2. CURRENT STATUS

No.	Item	Male	Female	Tick/cross	Remark
1	No. of Workers on site				
2	On site health facility				
3	Provision of workers quarters (Living conditions)				
4	Water and sanitation facilities				
6	Availability of HIV&AIDS Service provider (s)				
6.1	Service provider sourced from within the district or external				
7	EIA and EMP available				
8	Reference to district plan				

3. ACTIVITIES IMPLEMENTED DURING PERIOD UNDER REVIEW

S/N	Activity	Planned Male	 Female	Actual Male	 Female	Planned	Actual	%	Remarks
1.0	HIV sensitisation meetings								
2.0	Number of workers reached though sensitisation meetings								
3.0	Number of community members reached though sensitisation								

	meetings								
4.0	Number of condoms distributed to workers								
4.1	Number of condoms distributed to community members								
5.0	Information Education Communication (IEC) medium used								
5.1	Number of local posters distributed								
5.2	Number of flyers distributed								
5.3	Number of bill boards set up								
5.4	Number of community radio programmes aired								
5.5	Number of drama performances conducted								
5.6	Number of brochures distributed								
5.7	Number of T-shirts produced								
6.0	Are the IEC material used cleared by the IEC Technical Working Group at National, provincial or district level							Yes	No
7.0	Number of workers tested for HIV								
8.0	Number referred for ART								
	Average percentage								

4. PERFORMANCE MEASUREMENTS

Performance rating	Grading	Percentage achievement of target	rating
Exceeding expectation	Excellent	>95%	
Meets expectation	Very Good	90-95%	
Adequate	Good	60-89%	
Inadequate but potential demonstrated	Fair	30-59%	
Unacceptable	Poor	<30%	

GENERAL COMMENTS

Attendance List

Compiled by (Service Provider)

Name:.....

Designation.....

Date.....

Verified by (DATF)

Name:.....

Designation:.....

Date:.....

Approved by (Contractor)

Name:.....

Designation:.....

Date:.....

Annex 3. Costing Template

Cost of Service for SBCC

Activity	Unit Cost	Frequency	Population	Total Cost
Male Condom				
Female Condom				
Combo Pack				
Billboard Production & Installation /design				
National Radio Adverts/advertisement				
Cost of airing 60” TV spot ad (ZNBC)/time aired				
Cost of airing 60min radio call in show/time aired				
Leaflet cost				
Poster Large				
Poster Small				
Wall branding				