DEPARTMENT OF PERFORMANCE MONITORING AND EVALUATION

THE PRESIDENCY

Terms of Reference for Diagnostic/Implementation Evaluation of Nutrition Interventions for Children from Conception to age 5

RFP / Bid number: 12/0287

Compulsory briefing session
Date: 27 August 2012
Time: 11.00-13.00
Venue: Room 222, East Wing, Union Buildings

Please note that security procedures at the Union Buildings can take up to 30 minutes.

Bid closing date:
16.00 19 September 2012 with provision of an electronic and 6 hard copies.

1 Background information and rationale

1.1 Background to the intervention being evaluated

South Africa is in a nutrition transition which includes the coexistence of under- and over-nutrition which is evident between and within populations and across age groups. Under-nutrition has stayed roughly constant in South Africa since the early 1990s. Despite our relatively high per capita income, the country has rates of child stunting comparable to other lower-income countries in its region, and higher rates of stunting than lower-income countries in other regions. While some indicators show improvement, several conditions seem to have worsened over the past decade. In addition, children's nutritional status varies considerably among the nine provinces and possibly within each province. This has bearing on targeting and prioritization for interventions and resource allocation. Malnutrition undermines progress towards the Millennium Development Goals (MDGs) directly to those goals related to poverty, maternal health, child mortality and education, and indirectly to the remaining MDGs. Nutrition is critical for, inter alia, the improvement of maternal and child health, as underscored in the Negotiated Service Delivery Agreement

Since the democratisation of South Africa, the Government has remained consistently committed to reducing malnutrition in children and mothers. The appointment of the Nutrition Committee by the Minister of Health in August 1994 to investigate an Integrated Nutrition Strategy for South Africa was the beginning of a new chapter in nutrition in South Africa. In considering the sectoral and multi-faceted causes of malnutrition, the Committee recommended an Integrated Nutrition Strategy (INS) with three components, namely health facility-based services, community-based nutrition programmes and nutrition promotion. Instead of the fragmented and mostly food-based approaches of the past, the INS was to implement complementing strategies and follow an integrated approach to address nutrition problems. The INS was adopted in the Department of Health's White Paper for the Transformation of the Health System in South Africa (1997) and served as the basis for the Integrated Nutrition Programme (INP) for South Africa.

Priority interventions for the Integrated Nutrition Programme for children under five are as follows:

- Infant and young child feeding, which include promotion of safe infant feeding practices;
- Micronutrient malnutrition control-supplements, fortification and food diversification;

- Facility-based nutrition interventions including management of severe malnutrition;
- Growth monitoring and promotion;
- Disease-specific interventions such as nutrition interventions for children living with TB, HIV&AIDS and other debilitating conditions;
- Maternal nutrition which includes provision of micronutrients.

The beneficiaries of nutrition-related interventions and the coverage are as follows:

- Vitamin A provided to post-partum women = 760 000 (current coverage is 94%);
- Vitamin A provided to children from 6 to 59 months – 3 673 584 (current coverage 6-12 months = 90%, and 12-59 months = 41%;
- Nutritional interventions provided to people infected with TB, HIV and AIDS – 640 281;
- Malnourished children (including moderate and severely malnourished) – 134 832;
- School going children through the school nutrition programme – 7 125 273;
- Exclusive breastfeeding promoted to all children under six months old – current coverage of 25% of children from zero to six months.

The health sector is leading and harnessing the efforts to achieve Outcome 2: "A long and healthy life for all South Africans". The Strategic Plan of the National Department of Health (NDOH) provides a framework of the implementation of the 10 Point Plan of the health sector for 2009-2014, which is aimed at creating a well-functioning health system capable of producing improved health outcomes. The outcome-based approach adopted by government to accelerate the implementation of the NDOH Strategic plan guides the development of specific strategies in the sector. The four key outputs that the health sector should produce to achieve Outcome 2 are: increasing life expectancy; decreasing maternal and child mortality; combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis; and strengthening health systems effectiveness.

Improving the nutritional status of the population should benefit the health system and reduce the economic burden of medical treatment and care in a number of ways. It can reduce the demand for curative treatment, and thus the number of patients, shorten the duration of hospital stays and improve recovery rates. Reduced patient loads at primary health care facilities can facilitate improved delivery of nutrition and other preventive and promotive services. Therefore, implementing proven nutrition interventions at scale will contribute in achieving Outcome 2 of the health sector.

The expected outcome of nutrition-related interventions is improving the nutritional status of the South African population, with specific reference to the most vulnerable groups, namely; pregnant women and children under the age of five. The desired outcomes are mainly:

- Reduction of stunting in children;
- Reduction of underweight in children;
- Reduction of case fatality rate due to severe acute malnutrition;
- Reduction of micronutrient deficiencies especially Vitamin A, iron, zinc and iodine;
- Promoting healthy eating amongst the children and adults to combat chronic diseases of lifestyles such as diabetes, cancers and cardiovascular diseases;
- Improving nutritional status of individuals living with chronic and other debilitating conditions.

Recent reports from government, notably the diagnostic report from the National Planning Commission also reflected the need to address the problem of child malnutrition in South Africa. The 2008 input paper from the Development Bank of Southern Africa on "Combating Malnutrition" also highlighted the need to act with speed in tackling malnutrition. The contribution of malnutrition as an underlying cause and major contributor to infant mortality in South Africa has been highlighted through various reports. This has prompted the Minister of Health to urge government to scale-up key child survival interventions such as breastfeeding to contribute in reducing infant mortality rate.

The economic costs of under-nutrition are substantial: productivity losses to individuals are estimated at more than 10 percent of lifetime earnings, and losses to gross domestic product may be as high as 2–3%. The estimated budget allocation for nutrition related interventions in provinces under the health budget vote is R320 million. Therefore the evaluation is important because of the investment that government is making on nutrition related interventions for under-five children. Identifying bottlenecks in scaling up nutrition related interventions targeting children under five will contribute better programme planning and resource allocation.

In order to understand problems of malnutrition and resources and systems needed at different levels, the "UNICEF Conceptual Framework (1990) should be used as a guide. The conceptual framework outlines in diagrammatic form the multiple causes of malnutrition operating at various levels in society. The framework also focuses on the processes, programmes and policies that need to happen at the higher level to ensure that reductions in maternal and child under-nutrition will not only be achieved in the short term, but will be maintained in the long term, will be sustainable, and will be transmitted from one generation to another. Public and private sector interventions need to influence household decision-making to influence nutrition.

The multi-sectoral nature of nutrition requires various government departments, donor agencies and the industry to work together. The following stakeholders within and outside government are critical in the successful implementation of various nutrition related interventions: Departments of Basic Education, Social Development, Agriculture, Trade and Industry, Treasury, Water Affairs, Rural Development and Land Reform, United Nations agencies, food industry, NGOs and other development partners. The Integrated Nutrition Programme became operational in 1994.

Various nutrition interventions are currently being implemented. Table 1 shows a list of the interventions to include in this evaluation.

Table 1: Nutrition interventions to be covered by this evaluation (*= high impact interventions drawn from Copenhagen Consensus of 2012 and the Lancet Series 2008)

Interventions to cover	Department responsible
Breast-feeding support*	Health
Complementary feeding*	Health
Food fortification (Vitamin A, Iron and Iodine)*	Health
Micronutrient inc Vitamin A supplementation*	Health
ORS and Zinc*	Health
Management of severe malnutrition*	Health
Management of moderate malnutrition inc targeted supplementary feeding*	Health
Deworming	Health
Growth monitoring and promotion including the use of MUAC	Health
Nutrition education and counselling (part of all of these)	Health
Improving hygiene practice (including in relation to water and sanitation) – should be in all	Health
BANC (Basic ante-natal care) – education and supplements, timing	Health
IMCI (integrated management of childhood illnesses)	Health
Household food production and preservation (home gardening)	DAFF
Access to (nutritious) food, food prices	DAFF
Food security (output 2 of outcome 7)	DRDLR/DAFF
Food access (eg food parcels, soup kitchens) (DSD)	DSD
ECD (food in ECD centres) (DSD)	DSD

The evaluation should feed into other government priorities that are geared towards the reduction of infant mortality in South Africa, especially policy initiatives such as re-engineering of Primary Health care

that are pioneered by the Department of Health. The recent review of the ECD interventions also provides an opportunity to address issues of nutrition comprehensively, focus on the most vulnerable members of the society. Malnutrition is an underlying cause of the death of children in one-third of the total of children's deaths in South Africa. Malnutrition undermines economic growth and reduces the productivity of people trying to work their way out of poverty. It is estimated that 2-3% of the national income of a country can be lost to malnutrition. Therefore it is imperative that South Africa act now to address problems of malnutrition, since we have been identified as one of the 36 countries where 90% of the world's stunted children resides.

1.2 Purpose of the evaluation

The evaluation will focus on identifying the critical system and implementation issues inhibiting or enabling people's access to nutrition-related interventions targeting children from conception to below the age of five, how these should be addressed and scaled up where appropriate.

The evaluation will provide the opportunity to re-focus interventions targeting children under five.

2 The focus of the evaluation

2.1 Evaluation questions

The key evaluation questions that this evaluation will address include:

- Do relevant **policies** exist for these interventions (those in table 1), have they been adopted by appropriate departments/levels of government, are they funded, and are they coherent across sectors?[1] Are there policy gaps?
- Does government have the appropriate policy and **regulations** to avoid inappropriate marketing of products affecting child nutrition? What are the gaps in monitoring and enforcement? How consistent is this across government? Why are some regulations not being applied effectively, or not enforced? Is there sufficient capacity in regulatory agencies? What type of partnership with industry is appropriate to promote child nutrition and development?[2]
- To what extent are nutrition interventions from different agencies (government and non-government) influencing household decisions and **reaching under 5 children** across the country (from secondary data and facility monitoring) and which are being carried by government and which by non-government agencies?
- Are **high impact interventions** being prioritised in practice? See Table 1 for a list of high impact interventions.
- What interventions are being **implemented effectively**, what aren't?
- **Why** are some interventions not being implemented effectively and efficiently and what is needed to strengthen, upscale and sustain them? Sub-questions include:
    - How far is nutrition **mainstreamed** into the work of relevant services which impact directly on children? These services should be defined in the inception report.
    - Are there appropriate **plans** to implement these nutrition interventions, are they included in departmental strategic plans, APPs and operational plans?
    - Is there appropriate **leadership** for nutrition at the respective levels and are they empowered to play that role?
    - Are there **relevant workers** (not necessarily professional dieticians or nutritionists) to address nutrition-related interventions?
    - Do key staff (government and non-government) at different levels have the **skills** to play the roles they need to play and deliver the services needed?

[1] A list will be provided

[2] Note some work has been happening in terms of food control agencies

- Do the PHC and other service facilities have the necessary **equipment, guidelines, protocols** and supplies to deal with nutrition in under-five children?
- Do service **standards/norms** exist for relevant interventions?
- Are **resources** allocated appropriately and sufficiently (this would draw on international evidence of cost-benefits)
- In terms of the **service delivery model** operating in practice, do we have appropriate systems and structures operating at **community level** to have effective outreach to communities (eg community-based services such as nutrition advisors, and platforms for community involvement). How extensive are these?

➢ What **institutional arrangements** are currently in place within and across departments and agencies (government, private sector, community actors) to address child nutrition and what is needed to improve the effectiveness of nutrition interventions?

➢ What **monitoring and evaluation systems** are in place and needed to monitor and improve the evidence base for and implementation of nutrition-related interventions?

2.2 Intended users and stakeholders of the evaluation

The key potential users of the evaluation results and how they may use it are shown in Table 2.

Table 2: Users and their use of the evaluation results

User	Key question	How they may use the evaluation results
Political leadership at national and provincial levels	• What do we need to do to ensure that our children are well nourished and able to use their full potential? • What institutional arrangements and M&E is needed across departments and agencies (government, private sector, community actors) to improve the effectiveness of nutrition interventions for children?	• Reprioritise resources • To strengthen intergovernmental cooperation (and with civil society) around child nutrition and development?
All departments and provinces	• What interventions are being implemented effectively, what aren't and where are the gaps? • Why are some interventions not being implemented effectively and efficiently and how can we strengthen, upscale and sustain them? • How does each department's role need to be strengthened to address this?	• Overcoming blockages and improving implementation • Reprioritise resources • Collaborate more effectively with other agencies
Development partners and NGOs	As above plus: • Where are the key gaps where our support can make a difference?	• Prioritise funding and support to programmes
Staff at facility or community level	• What skills and support do we need to ensure we can deliver services appropriately	• Recognising their shortcomings • Motivate for the support they need Allocating their time differently • Motivating and mobilising the community more appropriately
Industry	• How can industry's products and services be more appropriate in addressing child	• Refocusing products and services

User	Key question	How they may use the evaluation results
	nutrition • What type of partnership with government is appropriate to promote child nutrition?	• Appropriate partnerships established

2.3 Scope of the evaluation

Table 3 shows the issues which are to be covered, and those to be excluded.

Table 3: Scope of the nutrition evaluation

To be included	To be excluded
System issues include policy, the design of programmes, budgets, how processes work in practice	
Period from conception to age 5 Women pregnant/caring for children under 5	Exclude children >5 Women of child-bearing age who are not pregnant, and are not caring for children under 5
Link with HIV	
Main intervention programmes targeting under 5s across government	Indirect issues such as Child Support Grant. Build on existing CSG evaluation.
Underweight and overweight	
ECD	Don't cover what already covered by ECD Diagnostic Review
Public health interventions including at community level	Exclude tertiary and district hospitals except for management of severe acute malnutrition (SAM). Main focus not on clinical interventions
Budget for wider nutrition interventions beyond the Integrated Nutrition Programme, but will also look at previous INP budget for infant formula.	
Role of industry and how government engages with industry	
Relate to international experience eg in middle income countries	

3 Evaluation design

The key elements of the design include:

1. Good literature review to draw together existing research and evaluation (a set of core documents will be provided at the bidders briefing).
2. Review of existing national and provincial policies, regulations and interventions to show how these cohere or not and govern provision (bearing in mind that most nutrition action is taken at household level).
3. Some comparison with other middle-income countries, especially where data is limited. The countries should be suggested in the inception report.
4. Overview of all the interventions and the progress/not and challenges using secondary data.
5. Four provinces selected for detailed case studies to explain what is occurring and why (including those working well, those working less well). This should include KwaZulu Natal where there is

extensive community-based nutrition work happening, Western Cape, Free State/North West and Eastern Cape. These should cover urban to remote rural communities and facilities, perhaps 6 per province, covering a relatively well performing district and a poorly performing. See Annex 2.

6. Some high impact interventions selected for detailed case studies (probably breast-feeding support, targeted meal supplementation, management of severe malnutrition and possibly Vitamin A supplementation) as well as household food production and preservation (home gardening). These should show the linkages and value chain between household and the decisions made, community, facility, district, province and national level including the private sector. This should explain and illustrate implementation challenges and proposals to strengthen.
7. Thorough institutional analysis to understand how within and across departmental systems, structures, capacity, organisational culture and leadership is facilitating or limiting impacts. This will build on the landscape analysis.
8. Recommendations should take a short/medium/long term perspective.

4 Evaluation plan

4.1 Products/deliverables expected from the evaluation

The deliverables expected include:

- Inception Report by the service provider as a follow-up to the proposal with a revised evaluation plan, overall evaluation design and detailed methodology and content structure for the final report.
- Literature review;
- Final data collection instruments and other tools;
- Analysis plan;
- Individual provincial reports on field work;
- Draft evaluation report for review, full and in 1/3/25 format;
- A workshop with stakeholders to discuss the draft report;
- The final evaluation report, both full and in 1/3/25 format, in hard copy and electronic;
- Provision of all datasets, metadata and survey documentation (including interviews) when data is collected.
- A Powerpoint or audiovisual presentation of the results.

4.2 Activities

The evaluation design suggests the type of activities required. In addition to this it is expected that:

1. There would be inception meetings and then regular meetings with the Steering Committee, and these stakeholders would also be interviewed as part of the field work.
2. The evaluator is expected to provide opportunities for participating departments to be involved in the activities where this will not prejudice the information received from respondents.

4.3 Time frame for the project

Table 4 sets out the expected duration and milestones assuming the project is commissioned by 3 September 2012.

Table 4: Outline project plan and payment schedule (check against deliverables, those in bold will be present in all evaluations)

Deliverable	Expected milestones	% payment
Inception Report	16 October	10%
Literature review		10%
Final data collection instruments and other tools		
Analysis plan		
Other technical or process reports, eg field work report		
Provincial reports		20%
Draft evaluation report for review, full and in 1/3/25 page format (see Action Points)	15 March 2013	30%
Workshop with stakeholders to discuss the draft report	26 March 2013	
The final evaluation report (incorporating comments)	1 May 2013	20%
Provision of all datasets, metadata and survey documentation (including interviews) when data is collected (see Annex 2)	8 May 2013	
Powerpoint or audiovisual presentation of the results	8 May 2013	10%

5 Budget and payment schedule

The funding will be provided by DPME who will commission the evaluation. The proposed payment schedule is in Table 4.

6 Management Arrangements

6.1 Role of steering committee

A steering committee has been established comprising the main departments and agencies involved in the intervention in question. This includes Health, DPME, DSD, DRDLR, DAFF, WCPD, Treasury, UNICEF. The co-chairs of the steering committee are Department of Health and DPME.

6.2 Reporting arrangements

The commissioning department is DPME and the evaluation project manager to whom the service provider will report is Dr Ian Goldman, DDG Evaluation and Research.

7 The proposal to be submitted

7.1 Structure of proposal

The structure of the proposal required is shown in Box 4.

Box 4: Structure of a proposal
The tenderer must provide the following. Failure to provide this will lead to disqualification.

1 Understanding of the intervention and the TORs
2 Approach, design and methodology for the evaluation (eg literature and documentation review, data collection, tools, sample, suggestions for elaboration or changes to scope and methodology as outlined in the TORs, examples of evaluation questions suggested, process elements)
3 Activity-based evaluation plan (including effort for different researchers per activity and time frame linked to activities)

4	Activity-based budget (in South African Rand, including VAT)
5	Competence (include list of related projects undertaken of main contractor and subcontractors, making clear who did what, and contact people for references)
6	Team (team members, roles and level of effort, and key competence related to this evaluation)
7	Capacity development elements (building capacity of partner departments and PDI/young evaluators)
8	Quality assurance plan (to ensure that the process and products are of good quality)

Attachments
Example of a related evaluation report undertaken
CVs of key personnel
Completed supply chain forms, tax clearance etc

7.2 Evaluation team

The team must cover the competencies outlined in section 7.5, and must be enough people to undertake the work in the time available (ie undertake provincial case studies in parallel). The service provider also needs to demonstrate how it will ensure skills transfer of stakeholders and PDI evaluators.

Key contacts in related departments:

Lynn Moeng, Nutrition, Dept of Health	Co-Chair of Steering Committee	moengl@health.gov.za
Nolwazi Gasa, Health Outcome, DPME	Co-Chair of Steering Committee	Nolwazi@po.gov.za
To be confirmed	Dept of Rural Development and Land Reform	
Steve Mohlabi, Food security	Department of Agriculture, Fisheries and Forestry	DFS@nda.agric.za
Mondli Mbhele, Sustainable Livelihoods	Department of Social Development	
Chantelle Witten, Nutrition	UNICEF	cwitten@unicef.org
To be confirmed	Women, Children and People with Disability	
Mark Blecher	National Treasury	Mark.Blecher@treasury.gov.za
Dr Ian Goldman, Evaluation, DPME	Secretary of Steering Committee	ian@po.gov.za

7.3 Competencies and skills-set required

The following is a list of generic competencies expected for this assignment:

- Strong understanding and knowledge of the nutrition sector in South Africa, covering from conception to age 5;
- Good knowledge of government policies, systems and practical implementation issues at national and provincial level, particularly in relation to nutrition;
- Strong understanding of the use of logical frameworks, results chains, and theories of change for planning and M&E;
- A good knowledge of evaluation methodologies, and experience in applying them. This would be required in relation to:
    - Qualitative research;
    - Conducting of research synthesis;
    - Policy analysis and policy evaluation.
- Cultural competence – the ability to deal effectively with the different stakeholders involved in the evaluation, including appropriate language skills;
- Demonstrated experience of building ownership of evaluations and evaluation results, working in ways which build capacity and commitment amongst stakeholders;

- Ability to write short reports (using a 1/3/25 page rule) and to communicate effectively to different audiences;
- Strong project management skills, including field coordination and implementation where needed;
- Knowledge of and exposure to international good practice would be an advantage, particularly in middle-income and African countries.

8 Information for service providers

A bidders briefing will be held on 27 August 2012 at the Presidency. Tenders should be submitted by 16.00 on 19 September 2012 with an electronic and 6 hard copies.

The short-listed candidates will be asked to come and present their proposal on 26 September at DPME as part of the selection process.

Annex 1 provides an outline of existing research conducted around the interventions under review.

8.1 Key background documents

A list of key documents will be provided at the bidders briefing meeting.

8.2 Pricing requirements

All prices must be inclusive of VAT. All quoted prices should be valid for at least three months from the closing date indicated above. Price escalations and the conditions of escalation should be clearly indicated. No variation of contract price or scope creep will be permitted. Price proposals should be fully inclusive to deliver the outputs indicated in this terms of reference.

8.3 Evaluation of proposals

8.3.1 Administrative compliance

Only proposals and quotations that comply with all administrative requirements will be considered acceptable for further evaluation. Incomplete and late bids / quotes will not be considered. The following documentation must be submitted for each quote/bid:

- Documents specified in the tender documents (distributed separately from this ToR)
- Any other requirement specified in the ToR

8.3.2 Functional Evaluation

Only bids/quotes that comply with all administrative requirements (acceptable bids) will be considered during the functional evaluation phase. All bids/quotes will be scored as follows against the function criteria indicated below:

1 – Does not comply with the requirements
2 – Partial compliance with requirements
3 – Full compliance with requirements
4 – Exceeds requirements

Table 5 below outlines the functional evaluation criteria as applied to the competences outlined in section 7.3 which will be used in assessing the proposals.

Table 5: Functional evaluation criteria

Functional Evaluation Criteria	**Weight**	**Score**	**Weight X Score**	***Minimum***
Understanding of the nutrition and food security sector and the TORs	2			*6*
Approach, design and methodology	2			*6*
Quality of activity-based plan (including effort for different consultants per activity and time frame linked to activities)	2			*6*
Demonstrated high quality experience in at least 5 related projects undertaken in last 5 years by main contractor and subcontractors	5			*15*
Team demonstrate the following key competences related to this assignment:				
• Good knowledge of government policies, systems and practical implementation issues at national, provincial and local level;	1			*3*
• Strong understanding of the use of logical frameworks, results chains, and theories of change for planning and M&E;	1			*2*
• A good knowledge of evaluation methodologies, and experience in applying them. This would be required in relation to:				
• Qualitative research;	3			*9*
• Policy analysis and policy evaluation.	1			*2*
• Cultural competence – the ability to deal effectively with the different stakeholders involved in evaluations, including appropriate language skills;	1			*2*
• Demonstrated experience of building ownership of evaluations and evaluation results, working in ways which build capacity and commitment amongst stakeholders;	1			*3*
• Ability to write short reports (using a 1/3/25 page rule) and to communicate effectively to different audiences;	1			*3*
• Strong project management skills, including field coordination and implementation where needed;	2			*6*
• Knowledge of and exposure to international good practice, particularly in middle-income countries.	1			*2*
Capacity development elements (building capacity of partner departments)	1			*3*
Quality assurance plan (to ensure that the process and products are of good quality)	1			*2*
TOTAL	**25**	**-------**		

Minimum requirement: Service providers that submitted acceptable bids and that scored at least the minimum for each element as well as an overall minimum score of 75 based on the average of scores awarded by the evaluation panel members.

Proposals should clearly address the project description and the functional evaluation criteria mentioned above.

8.3.3 Price evaluation: The PPPFA

Only proposals/quotes that meet the minimum required indicated under functional evaluation above will be evaluated in terms of the Preferential Procurement Framework Act and related regulations. The 90/10 evaluation method will be used for propoals from R1 million and the 80/20 method will be used for bids/quotes below R1 million. Points will be awarded to a bidder for attaining the B-BBEE status level of contribution in accordance with the table contained in SBD 6.1 (see attached bid documents)

In the application of the 80/20 preference point system, if all bids received exceed R1 000 000, the bid will be cancelled. If one or more of the acceptable bid(s) received are within the R1 000 000 threshold, all bids received will be evaluated on the 80/20 preference point system.

In the application of the 90/10 preference point system, if all bids received are equal to or below R1 000 000, the bid will be cancelled. If one or more of the acceptable bid(s) received are above the R1 000 000 threshold, all bids received will be evaluated on the 90/10 preference point system.

9 General and special conditions of contract

Awarding of the final contract will be subject to the conclusion of a service level agreement between the Department and the successful service provider.

10 Enquiries

For content enquiries please contact Lynn Moeng of the Department of Health MoengL@health.gov.za , or for enquiries about the commissioning or evaluation process contact Dr Ian Goldman, DPME ian@po.gov.za.