

HIV MONITORING AND EVALUATION FRAMEWORK FOR HIGHER EDUCATION



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Higher Education HIV/AIDS Programme (HEAIDS)

The Higher Education HIV/AIDS Programme (HEAIDS) is a dedicated national facility to develop and support the HIV mitigation programmes at South Africa's public Higher Education Institutions (HEIs).

HEAIDS is an initiative of the Department of Higher Education and Training that is undertaken by Higher Education South Africa (HESA), the representative body of South Africa's 23 public Higher Education Institutions.

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CONTACT

Higher Education HIV/AIDS Programme (HEAIDS)

UNISA Sunnyside Campus

Building 3

corner Rissik and Steve Biko (Mears) Streets,

Sunnyside, Pretoria

Tel: 012 4841134

Fax: 012 4841147

E-mail: heidsa@hesa.org.za

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FOREWORD BY PROFESSOR BRIAN O' CONNELL CHAIRPERSON, HESA-HEAIDS STRATEGY GROUP

On 29 November 2012, the higher education sector launched a revised *Policy and Strategic Framework on HIV and AIDS for Higher Education*. The revision of our previously adopted Policy Framework was motivated by a number of considerations, including the need for HEAIDS to be in alignment with the country's formal national HIV response strategy and to define objectives that facilitate effective Monitoring and Evaluation (M&E).

Our M&E provides a basis for critical reflection and is essential for informing programme priorities and enhancing efficacy. As the 2012 HEAIDS conference, "Applying the Research / Researching the Applied", motivated, there is an on-going need for HEAIDS to develop a strategic focus which will strengthen, deepen and expand institutional responses to the HIV and AIDS challenge. The M&E will also assist HEAIDS to provide an effective and comprehensive response to many national challenges, including HIV and AIDS. What is now required is that our interventions be driven by the best evidence and informed understandings, and that they can be monitored, evaluated and interrogated as we strive for ever higher levels of efficacy.

Our M&E framework, which we regard primarily as a tool for local action with respect to local challenges which in sum aggregate to a national response, promotes this and is likely to impact on the further development of M&E capacity across all the sectors in our society. In fact, The National Strategic Plan for HIV, STIs and TB (NSP) requires all sectors of society to own our challenges, commit to engage with them, and develop the competences to do so successfully. Our entire nation must act in concert if we are to contest with the HIV and TB epidemics and other national



threats. As a sector, Higher Education has a definite role to fulfill, not least because of its demographic make-up. The M&E Framework will allow our contribution to the goals of the national strategy to be accounted for. It also provides a standard on the sourcing and use of M&E data across our rich diversity of higher education settings, and is also part of the development of a unified sector response that must enhance the scale of our impact.

I end by commending all our institutions for confronting the challenge of the need for a sector-wide M&E Framework, and for successfully negotiating and achieving what is a significant milestone in the development of the Higher Education HIV/AIDS Programme.

Brian O'Connell

ACRONYMS

ARV	Antiretroviral Treatment
BCC	Behaviour Change Communication
DOH	Department of Health
DOTS	Directly Observed Therapy Shortcourse
HCT	HIV Counseling and Testing
HICC	HIV Institutional Coordinating Committee
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
HE	Higher Education
HEAIDS	Higher Education HIV/AIDS Programme
HEIs	Higher Education Institutions
KABP	Knowledge, Attitude, Behaviour and Practice
M&E	Monitoring and Evaluation
MSM	Men having Sex with Men
NSP	National Strategic Plan
PCU	Programme Coordinating Unit
PLWHIV	People Living With HIV
PWG	Programme Working Group
QSCR	Quarterly Service Coverage Report
SANAC	South African National AIDS Council

SECTION 1 INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The Higher Education HIV/AIDS Programme (HEAIDS) is a national facility originated to develop and support the HIV mitigation programmes at South Africa's public higher education institutions. HEAIDS is an initiative of the Department of Higher Education and Training that is undertaken by Higher Education South Africa (HESA).

HEAIDS supports higher education institutions to respond to HIV and AIDS through their core functions of learning and teaching, research and innovation, and community engagement. The programme is rooted in a concept of the responsibility of HEIs to address the HIV/AIDS pandemic on a human rights basis on at least five fronts:

- Developing HIV prevention programmes for students and staff, and facilities for the treatment, care and support of students and staff living with HIV.
- Providing a comprehensive workplace HIV/AIDS programme that caters to the needs of staff.
- Educating and equipping students to make a contribution to the national HIV/AIDS response in their future career fields.
- Conducting research that will strengthen society's ability to resist and ultimately overcome the pandemic.
- Providing HIV/AIDS services to related communities through outreach projects and practical training programmes.

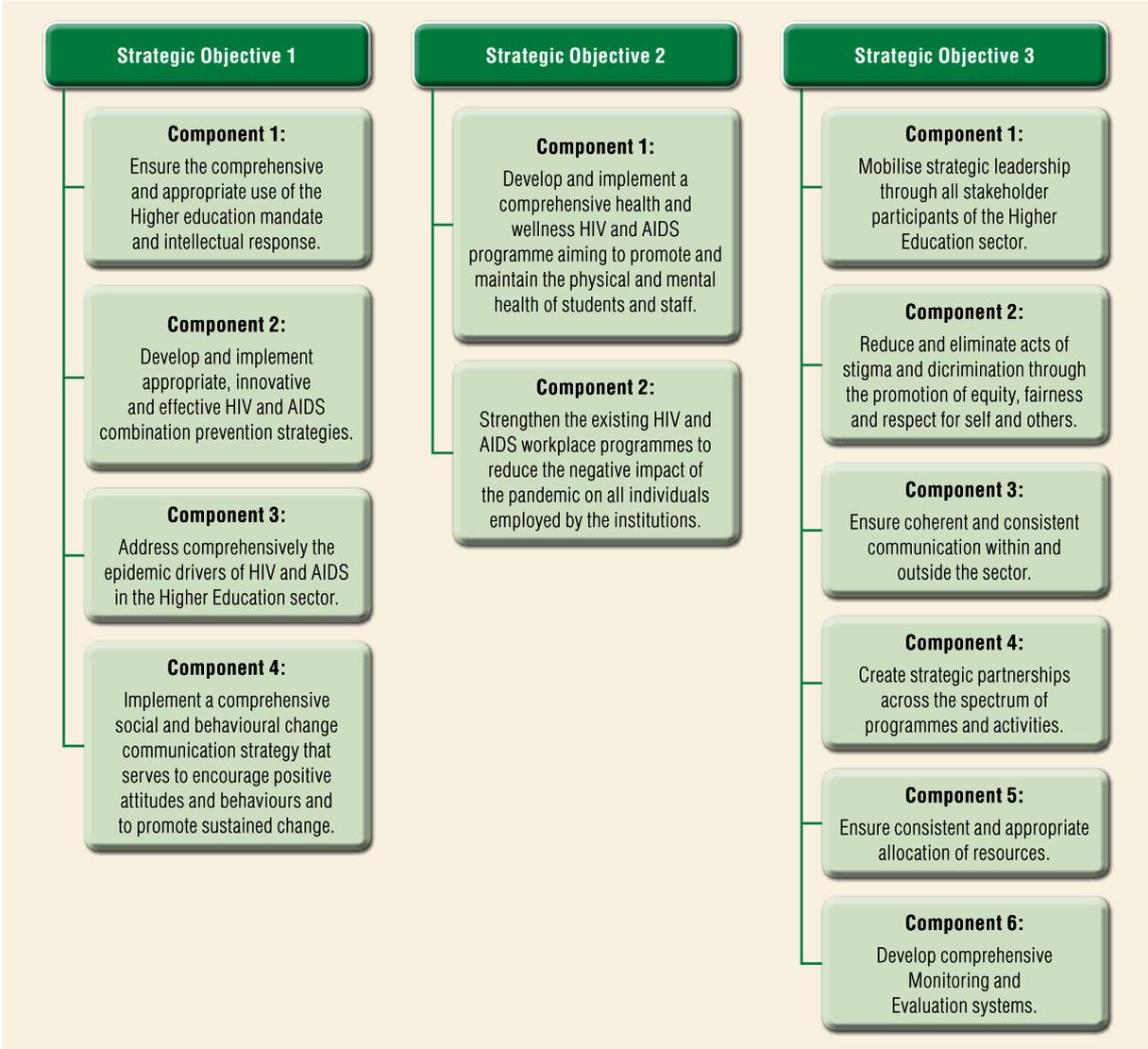
On 29 November 2012, the higher education sector launched a revised Policy and Strategic Framework on HIV and AIDS for Higher Education. The previously adopted Policy Framework on HIV and AIDS was revised among other reasons to align with the 2012-2016 National Strategic Plan on HIV, STIs and TB and specifically to define objectives in a way that facilitated effective Monitoring and Evaluation (M&E).

The Objectives of the Policy and Strategic Framework on HIV and AIDS for Higher Education

- To ensure the comprehensive and appropriate use of the Higher Education mandate of teaching and learning; research, innovation and knowledge generation; and community engagement to effectively respond to the epidemic drivers.
- To promote the health and well-being of the higher education community at individual, group and institutional levels through strengthening existing capacity, systems and structures responding to the pandemic
- To create an enabling environment to ensure a comprehensive and effective response to HIV and AIDS within the higher education sector, free of stigma and discrimination.

Figure 1 on page 5 shows the components of each objective of the *Policy and Strategic Framework on HIV and AIDS for Higher Education*.

Figure 1. Key components of the Policy and Strategic Framework



1.2 EPIDEMIOLOGY

In 2010, findings from South Africa’s first national HIV prevalence survey of higher-education institutions and an associated study on knowledge, attitudes, perceptions and behaviour (KAPB) relevant to HIV and AIDS (HEAIDS 2010)¹

were released. The key findings reported for this study were as follows²:

- HIV prevalence of students was 3.4%, academic staff at 1.5%, administrative staff at 4.4%, and service staff at 12.2%.

1 HIV prevalence and Related factors Higher Education Sector Study South Africa, 2008–2009

2 Ibid

- Concurrent sexual partnership was measured as people who had more than one partner in the past month. 19% of male students and 6% of female students reported that this applied to them.
- Condom use at last sex was high among students compared with other groups: 65% among males aged 18–24 and 60% among those aged 25 and older.
- The majority (54%) of students never tested for HIV. This result must be considered against reported sexual behavior where the majority (65%) have never had sex before. Additionally, only 2.3% of those never tested was HIV positive. Among academic and administrative staff, around a third of respondents never had a test, and HIV prevalence was 1.0% and 4.1% respectively. However, among the 48% of service staff who had never tested HIV prevalence was 10.7%.
- Knowledge was measured through a battery of simple questions, and at this stage of the epidemic correct responses may be expected to be ubiquitous. Questions related to the transmission of HIV through breastfeeding, the availability of drugs for post-exposure prophylaxis in the case of rape, and the legality of sex with partners younger than 16. All questions attained overall inadequate correct responses.
- Both students and staff exhibited affirming attitudes towards people with HIV and AIDS, but there was a distinct contrast between these professed values and, perceptions of how accepting their friends at the institution would be if they were to reveal to them that they were HIV positive. Only 38% of students for example thought that they would be supported by their friends.

Qualitative data emphasised how students, both male and female, residing away from home for the first time, had been required in the first months at university to manage freedoms they had not previously had. It was widely reported that during this period first-year students lack the

experience to make good, risk-aware decisions, especially regarding sexual liaisons and the use of alcohol.

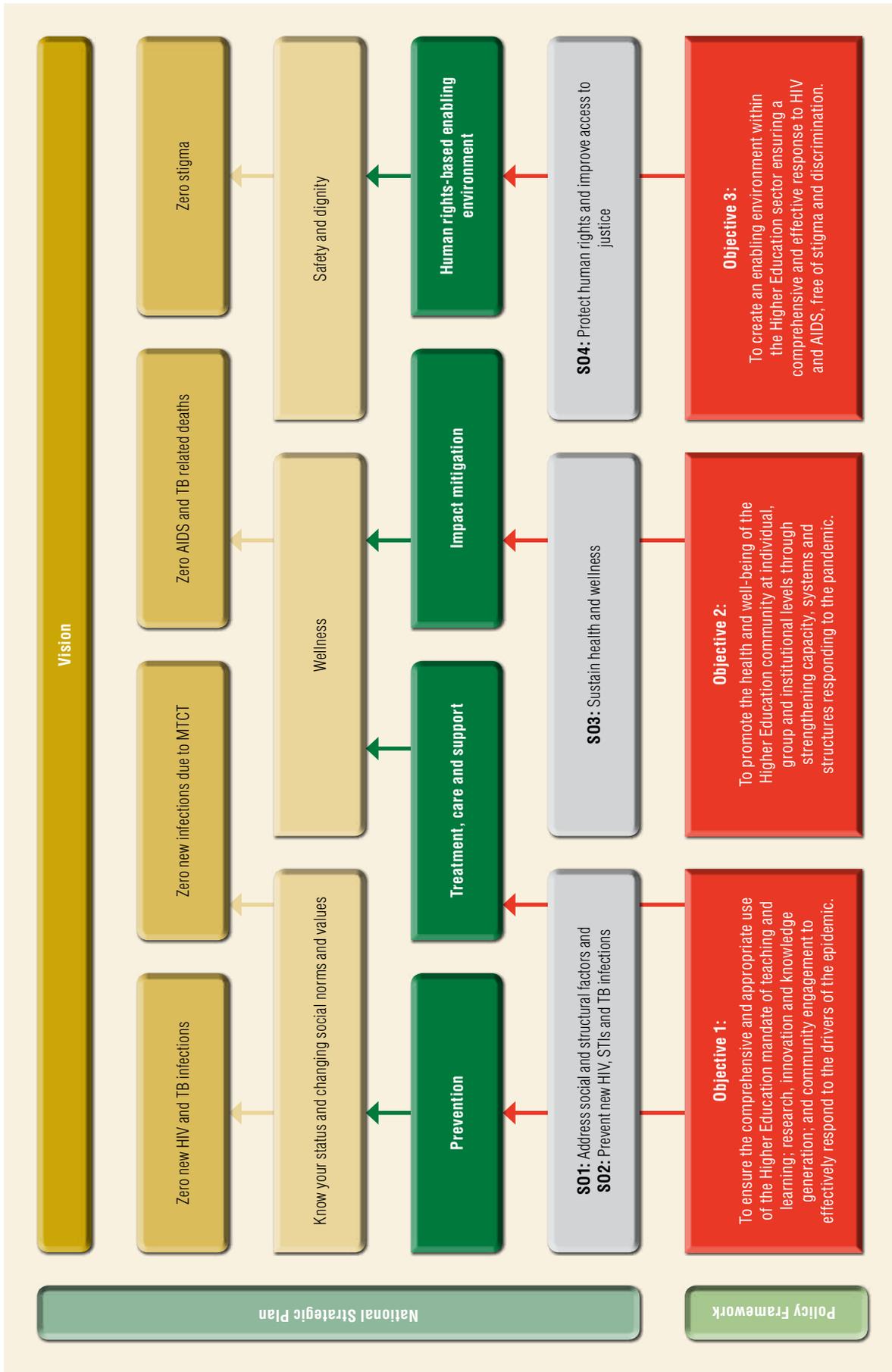
Most studies with data on the association between education level and HIV prevalence, report that HIV is modestly lower among people with a tertiary education. Again, this is likely to be confounded by factors of race but this study found that those with no tertiary degree were 3.3 times more likely to be HIV positive when compared to those with a degree. In summary, the HIV prevalence results in the higher education sector are lower than in the general community but the patterns of infection are consistent with what has previously been reported.

1.3 ALIGNMENT TO THE NATIONAL STRATEGIC PLAN (NSP)

Higher Education, as a key sector and SANAC constituent, plays an important role in contributing to the goals of the 2012–2016 National Strategic Plan for HIV, STIs and TB (NSP). Its *Policy and Strategic Framework on HIV and AIDS for Higher Education* is explicitly aligned to the NSP, based on an appreciation of the relationship between Higher Education Institutions (HEIs) and society.

The NSP calls on all of members of society to assist with reversing the HIV and TB epidemics. Among the key populations that it identifies as most likely to be exposed to or transmit HIV and/or TB are young women between the ages of 15 and 24 years. This positions a clear role for the higher education sector in the national strategy given its demographic make-up – as does the Key Populations of people who abuse alcohol and illegal substances; un-circumcised men, Men who have Sex with Men; and young people who engage in transactional sex. HIV risk is also compounded by factors of poverty and other social and structural drivers of the epidemic.

Figure 2: Alignment to the NSP 2012–2016



SECTION 2 MONITORING AND EVALUATION FRAMEWORK

2.1 OVERVIEW

The HEAIDS M&E Framework is designed to measure progress towards the objectives of the *Policy and Strategic Framework on HIV and AIDS for Higher Education*, which are linked to the National Strategic Plan 2012 – 2016. Therefore, the aim of the M&E Framework is to collect and provide information to track progress on implementation of provisions of the Policy and Strategic Framework.

The M&E framework will help HEAIDS and HEIs to monitor and evaluate the programmes which are aligned to the Policy and Strategy Framework. The M&E Framework will also assist HEAIDS and HEIs in reporting periodically and meaningfully on the sector's contribution towards meeting its NSP obligations.

The higher education sector's M&E Framework is aligned to the SANAC *National M&E Framework for HIV* through the following indicators:

2.1.1 Development of M & E Framework

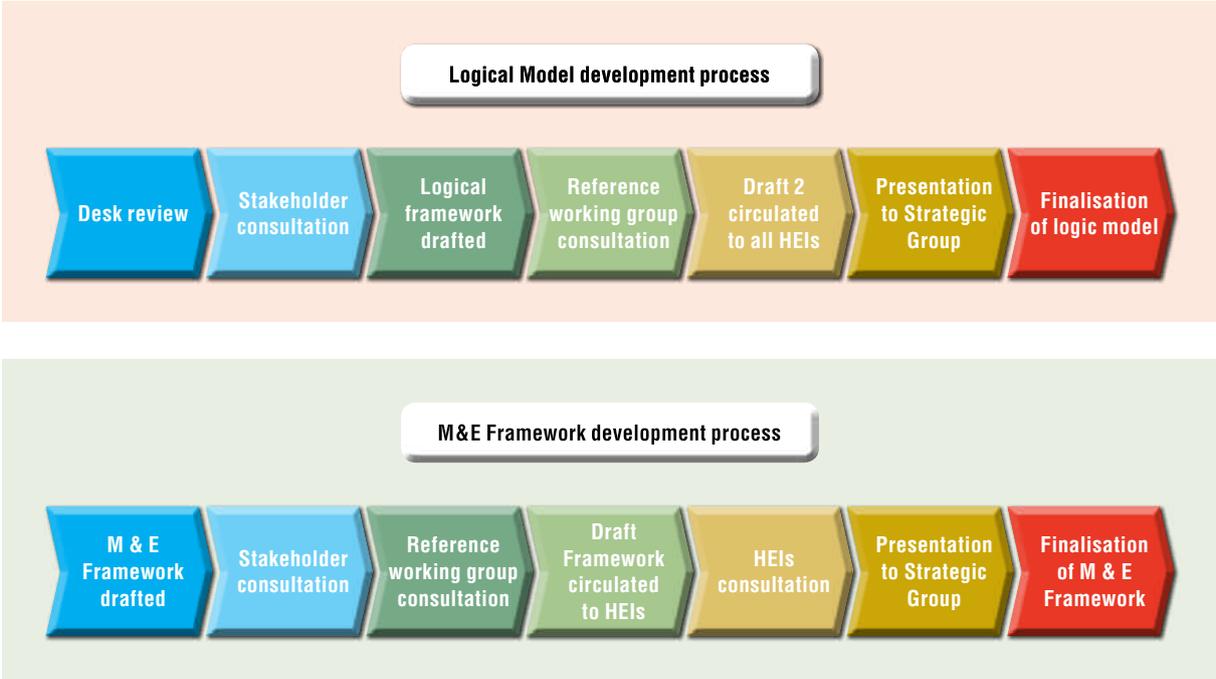
The first process undertaken in the development of the M&E Framework was the development of the Logic Model, followed by the M&E Framework. The process of development involved thorough consultation with all key stakeholders (see figure 3).

2.2 CURRENT APPROACH TO HIV AND AIDS MONITORING AND EVALUATION IN THE HIGHER EDUCATION SECTOR

Shortly after the establishment of HEAIDS the platform for Monitoring and Evaluation was established through a number of published instruments, including primarily the development of policy frameworks, the *Framework for Workplace Programmes*, and the *Norms and Standards for HIV and AIDS Prevention, Treatment, Care and Support for*

SANAC National M & E Indicators	Higher Education Indicators
1. HIV prevalence among women and men aged 15–24	1. HIV prevalence among staff and students in HEIs
2. HIV prevalence in key populations	2. Percentage of staff and students screened for TB
3. Percentage of people screened for TB	3. Percentage of staff and students who used condoms with their sexual partner at last sex
4. Percentage of men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex	4. Percentage of students and staff who used condoms consistently with one regular partner over the past 12 months
5. Percentage of young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)	5. Percentage of staff and students who have had sexual intercourse with more than 1 partner in the last 12 months
6. Percentage of women and men aged 15–49 years who have had sexual intercourse with more than 1 partner in the last 12 months	6. Percentage of staff and students who received an HIV test in the last 12 months and who know their results
7. Number and percentage of men and women 15–49 counselled and tested for HIV	7. Number of stigma cases reported
8. Stigma Index	8. Number of HEIs implementing programmes on stigma and discrimination
9. Male condom distribution	9. Number of male condoms distributed in HEIs
10. Female condom distribution	10. Number of female condoms distributed in HEIs
11. Number of men medically circumcised	11. Number of men medically circumcised
12. Number of people reached by prevention communication at least twice a year	12. Number of people reached by prevention communication at least twice a year

Figure 3. Development of HEAIDS M & E Framework



Higher Education Institutions in South Africa to name a few. The *Report on the Development of an HIV and AIDS Policy Framework for Higher Education in South Africa* (December 2009) made reference to the parameters and guiding principles for Monitoring and Evaluation. A key objective of this report was to establish a common understanding and agreement for the development of HIV and AIDS Policy and M&E Frameworks for the sector.³

A second study that set the basis for M&E was the adoption and Implementation of the Policy and Strategic Framework. *The Policy and Strategic Framework on HIV and AIDS for Higher Education* guided institutions in the development and implementation of institutional policies in

order to mitigate the impact of HIV and AIDS.⁴ The sector *Framework for Workplace Programmes* aimed to enhance the capacity of institutions to develop and implement comprehensive workplace programmes responsive to the needs of individual HEIs. This intervention was identified in the prevalence report as a critical one. The *Norms and Standards for HIV and AIDS Prevention, Treatment, Care and Support for Higher Education Institutions in South Africa* provided a basis for identifying key indicators that is aligned to the *Policy and Strategic Framework on HIV and AIDS for Higher Education in South Africa*. In addition, the norms and standards directed the key programmatic areas to be monitored and evaluated.⁵

3 Development of an HIV and AIDS Policy Framework for Higher Education in South Africa December 2009

4 Development of the Policy Framework on HIV and AIDS for Higher Education in South Africa: Study Report 2009

5 Norms and standards for HIV and AIDS prevention, treatment, care and support for Higher Education institutions in South Africa

The *Sero-prevalence and Related Factors Report* (2009) provided a cohesive set of baseline data for many of the indicators detailed in Annexure A. The purpose of this study was to determine the institutional and sector level prevalence and distribution of HIV and associated risk factors among staff and students. Another study that provided an understanding of a key pillar of higher education was the *Rapid Assessment of Curricular Responses in South African Higher Education Institutions*. This report offers a series of recommendations based on the recognition that the curricula of Higher Education forms a knowledge area and that teaching in the age of AIDS is an important area of investigation.

It is against this background that the current M&E Framework has been developed for improved tracking of Policy and Strategic Framework implementation.

2.3 RATIONALE

With the national and global momentum to scale up responses to HIV and AIDS, it is becoming increasingly important for HEAIDS as the entity mandated with coordinating the higher education sector response to accurately and timeously report comparable data to national stakeholders, development partners, and communities. Such information is useful to understand the scale and outcome of implementation and may be used to enhance and scale-up HIV programmes across all HEIs.

The HIV Monitoring and Evaluation Framework for Higher Education is *interalia* motivated:

- for more effective implementation of HIV mitigating programmes and projects;
- to strengthen programme Monitoring and Evaluation capacity;
- in response to national reporting requirements;
- to provide a basis for exchange and collaboration between national-level and HEI stakeholders in monitoring and evaluating the sector's response.

2.4 PURPOSE OF THE M&E FRAMEWORK

The purpose of the M&E Framework is to:

- define a list of core indicators that will enable tracking of the response in the higher education sector.
- provide guidance and a standard on the utilization of M&E data across the variety of higher education settings.
- develop clear M&E processes that will enable systematic collection, collation, processing, analysis, and interpretation of data.
- standardise the data sources to be collected.
- support resource mobilisation through result based management in reporting.
- enable the higher education sector to document and share best practises and disseminate results.

2.5 GUIDING PRINCIPLES FOR MONITORING AND EVALUATION

In order to develop appropriate monitoring and evaluation processes and mechanisms that meet the overall results, it is necessary to generate principles against which the system and the measurement items (metrics) and processes can be screened. Such principles include the following:

- Consistency** – where possible a consistent approach should be adopted to ensure economies of scale, share services and encourage benchmarking. This does not necessarily mean that the nature of the measures will be identical, but that a baseline set of measures are applied consistently.
- Transparency** – information disclosure regarding the results, process, substantive measures when developing the system, and realignment following monitoring and evaluation, is critical. The degree of transparency in the process heightens buy-in from institutions and has the potential of limiting the potential for downstream manipulation.

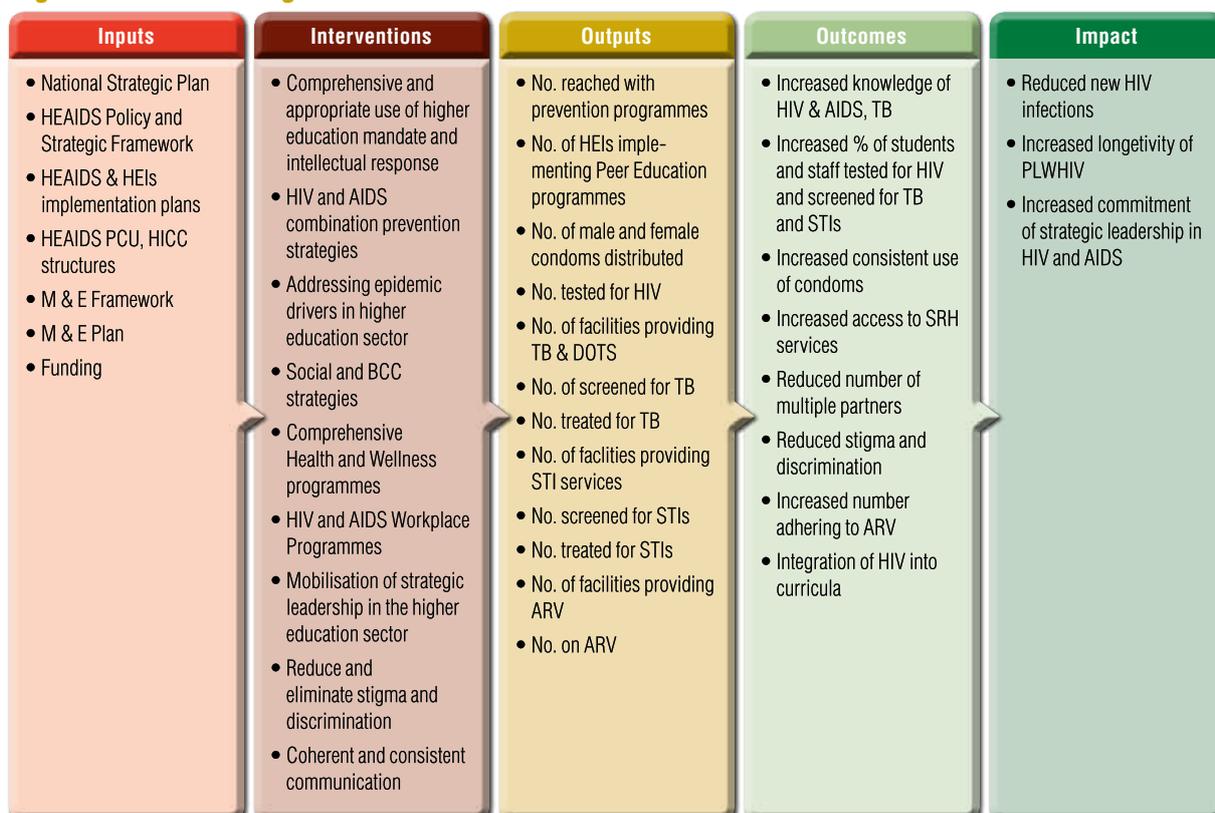
- iii. **Relevance** – any number of measurement processes can be established, however, measurement and evaluation should bear direct relevance to the overall strategic objectives and priorities (i.e. there must be a good reason and this reason should be easily understood).
- iv. **Flexibility** – Appropriate mechanisms to ensure matching forms of measurement should be sought in order to ensure that like comparisons are made and that the organisational context is adequately recognized.
- v. **Manageability** – monitoring and evaluation processes have the potential to be overly complicated. A sequenced and practical approach should be adopted that aligns organisational resources and needs.
- vi. **Timeous** – data should be collected timeously in order to ensure that it bears relevance to the prevailing context. However, periodic data, in addition to continuous data, should be defined in order to reduce the complexity of the system.

M&E should be seen as a means of promoting accountability, good governance and transparency. It increases broad-based participation and promotes critical reflection and learning. M&E is about providing appropriate information that is essential in tracking implementation progress (monitoring) and assessing the impacts (evaluation) of programmes and/or projects. This means that M&E processes assist in providing evidence for public resource allocations and identifying how challenges should be addressed and successes replicated.

2.6 HEAIDS LOGIC MODEL

The logic model provides the basic framework for Monitoring and Evaluation. Figure 4 is a graphic representation that describes logical linkages across the different levels of results. It illustrates a programme's theory of change; how day-to-day activities connect to the outcomes the programme is trying to achieve.

Figure 4: HEAIDS Logic Model



The logic model is simply a schematic representation of the logical sequence and causal relationships among:

- The results and the changes to achieve;
- The activities planned; and
- The resources to operate the programme.

The Logic Model is divided into six levels: inputs, activities, outputs, direct outcomes, intermediate outcomes, and ultimate outcome. Each of these represents a distinct step in the causal logic of a policy, strategy, program, or project.

The bottom three levels (inputs, activities, and outputs) address the how of a plan, whereas the top three levels (the various outcomes) constitute the actual changes that take place: the development results.

In some ways the Logic Model is a road map enabling managers to determine how their day-to-day activities and outputs logically link to the outcomes and impacts. The indicators are used to measure performance against the different level of results in the logic model as also indicated on table 1.

Table 1: Logical Framework

Result	Indicator	Disaggregation	Baseline	Target for 2017	Source	Frequency	Responsible
IMPACT LEVEL							
1. Reduced new HIV, TB & STI infections by 50%	HIV prevalence	Students	3.4% (HEAIDS Survey 2010)	1.7%	KAP Survey/ Behavioural Surveillance Survey	4 years	SANAC/ NATIONAL
		Staff: • Academic • Administration • Service	1.5% 4.4% 12.2% (HEAIDS Survey 2010)	0.8% 2.2% 6.1%			
	HIV incidence	Students	TBD	50% reduction			
	TB incidence	Students and Staff	TBD	50% reduction			
	STI incidence	Students and Staff	TBD	50% reduction			
2. Increased longevity of PLWHIV	Reduced number of deaths	Students and Staff	TBD	50% reduction	KAP Survey/ Behavioural Surveillance Survey	4 years	HEAIDS/ HESA/ DHET
OUTCOMES LEVEL							
3. Increased knowledge of HIV & AIDS, TB	% who correctly identify ways of preventing transmission of HIV	Students	TBD	TBD	KAP Survey/ Behavioural Surveillance Survey	4 years	HEAIDS/ HESA/ DHET
		Staff: • Academic • Administrative • Service					
4. Increased consistent use of condoms	% who used condoms consistently with one non-regular partner over the past 12 months	Students	60% (HEAIDS Survey 2010)	80%	KAP Survey/ Behavioural Surveillance Survey	4 years	HEAIDS/ HESA/ DHET
		Staff Academic	20%	50%			
		Administrative staff	28%	50%			
		Service staff	39%	60%			

Result	Indicator	Disaggregation	Baseline	Target for 2017	Source	Frequency	Responsible
5. Reduced number of multiple partners	% having sexual intercourse with more than one partner in the last 12 months	Students	36%	15%	KAP Survey/ Behavioural Surveillance Survey	4 years	HEAIDS/ HESA/ DHET
		Academic staff	11%	6%			
		Administrative staff	17%	9%			
		Service staff	24%	12%			
6. Increased number adhering to ARV	% who continue to be on treatment 12 months after initiation of antiretroviral therapy	Staff and students	TB	TB	Programme Reports	Quarterly	HEIs
7. Reduced stigma and discrimination	% accepting attitudes towards people with HIV	Students	90%	TBD	Programme Report/Surveys	4 years	HEIs HEAIDS/ HESA/ DHET
		Academic staff	90%	TBD			
		Administrative staff	90%	TBD			
		Service staff	80%	TBD			
OUTPUTS LEVEL							
8. Increased percentage of students and staff tested for HIV and screened for TB and STIs	% that take HIV test in the last 12 months and know their results	Students	65%	80%	Routine/ Behavioural Surveillance Survey	4 years	HEAIDS/ HESA/ DHET
		Academic Staff	41%	80%			
		Administrative	47%	80%			
		Service	55% (HEAIDS Survey 2010)	80%			
	% reporting unsafe sex screened for STIs	Students	1.2% (Campus Health Data 2010)	80%	Routine/Sero prevalence Survey	4 years	HEAIDS/ HESA/ DHET
% testing for HIV screened for TB	Staff Students	64% (FTF 2012) not disaggregated	80%	Programme Reports	Quarterly	HEIs	
9. Increased number reached with HIV, AIDS, STI, and TB prevention campaigns	Number reached with HIV, AIDS, STI, and TB prevention campaigns	Students	TBD	80%	Programme Reports	Quarterly	HEIs
		Academic staff					
		Administrative staff					
		Service staff					
10. Increased number tested for HIV	Number tested for HIV	Students	66 496 (not disaggregated by students and staff)	80%	Programme Reports	Quarterly	HEIs
		Staff					
11. No of HEIs implementing Peer Education programmes	Number of HEIs implementing Peer Education activities	Staff and students	TBD	TBD	Programme Reports	Annual	HEIs

Result	Indicator	Disaggregation	Baseline	Target for 2017	Source	Frequency	Responsible
12. No Male and female condoms distributed	Number of male condoms distributed	Staff and students	TBD	TBD	Programme Reports	Quarterly	HEIs
	Number of female condoms distributed	Staff and students	TBD	TBD	Programme Reports	Quarterly	HEIs
13. No of facilities providing TB & DOTS	Number of campus health clinics accredited to provide TB treatment and supervision of DOTS	HEIs	TBD	TBD	Programme Reports	Annual	HEIs
14. No TB screening and treatment	Number screened for TB	Staff and Students	42 744 (64%) (FTF data, 2012)	80%	Programme Reports	Quarterly	HEIs
	Number on TB treatment	Staff and students	TBD	TBD	Programme Reports	Quarterly	HEIs
15. No of facilities providing treatment for STIs	Number of campus health clinics providing treatment for STIs	HEIs	23	TBD	Programme Reports	Annual	HEIs
16. No STI screening and treatment for STI	Number screened for STIs	Staff and Students	TBD	TBD	Programme Reports	Quarterly	HEIs
	Number on STI treatment	Students	1.2% (Campus Health Data 2010)	80%	Programme Reports	Quarterly	HEIs
17. No of facilities providing ARV	Number of campus facilities accredited to provide ARVs	HEIs	2	21	Programme Reports	Quarterly	HEIs
	Number of HEIs distributing ARV treatment	HEIs	2	21	Programme Reports	Quarterly	HEIs
18. No on ARVs	Number on ARV	Staff and students	TBD	TBD	Programme Reports	Quarterly	HEIs
19. Increase access to SRH services	Number of Medical Male Circumcision done	HEIs	TBD	40000	Programme Reports	Quarterly	HEIs
	Number of students given Morning after pill	Students	TBD	TBD	Programme Reports	Quarterly	HEIs
	Number received PEP on campus	Students and staff	TBD	TBD	Programme Reports	Quarterly	HEIs
	Number referred for PEP to public health facilities	Students and staff	TBD	TBD	Programme Reports	Quarterly	HEIs
20. HEIs implementing stigma and discrimination	% of HEIs implementing programmes on stigma and discrimination	HEIs	TBD	100%	Programme Reports	Annual	HEIs

Result	Indicator	Disaggregation	Baseline	Target for 2017	Source	Frequency	Responsible
21. Integration of HIV into curricula	% HEIs with an integrated HIV and AIDS Curriculum within the faculty of education teacher's training	HEIs	87%	100%	Programme Reports	Annual	HEIs
	% of faculties (e.g. health sciences, social sciences, engineering, humanities and business schools) mainstreaming HIV into curricula	HEIs/Faculties	TBD	TBD	Programme Reports	Annual	HEIs

SECTION 3 ROUTINE MONITORING

3.1 INDICATORS

Core to the development of an M&E Framework is the development of the indicators to measure the performance of the results detailed in table 1. An indicator seeks to measure a result, to provide evidence that a result has been achieved or to provide a signal that progress is being made towards the achievement of a result. An indicator is a means of measuring actual results against planned or expected results in terms of quality, quantity and timeliness. Indicators must be directly related to the result they are measuring. Suitable indicators need to be specified to measure performance in relation to outputs, outcomes and impacts. It is important to specify indicators that measure things that are useful from a management and accountability perspective. Defining a good performance indicator requires careful analysis of what is to be measured and why. One needs to have a thorough understanding of the nature of the output, the desired outcomes and impacts, and all relevant definitions and standards used in the field.

Table 1 on page 12 of the M&E Framework details the level of indicators. These are:

- **Impact indicators** – indicators that show to what extent the project has contributed towards its goals
- **Outcome indicators** – indicators that show to what extent the project has achieved its planned outcomes
- **Output indicators** – indicators that show the specific outputs that have been delivered as a result of the activities

The criteria used in the selection of indicators were as follows:

- **Reliable:** the indicator should be accurate enough for its intended use and respond to changes in the level of performance.

- **Well-defined:** the indicator needs to have a clear, unambiguous definition so that data will be collected consistently, and be easy to understand and use.
- **Verifiable:** it must be possible to validate the processes and systems that produce the indicator.
- **Appropriate:** the indicator must avoid unintended consequences and encourage service delivery improvements, and not give managers incentives to carry out activities simply to meet a particular target.
- **Relevant:** the indicator must relate logically and directly to an aspect of the institution's mandate, and the realisation of strategic goals and objectives.

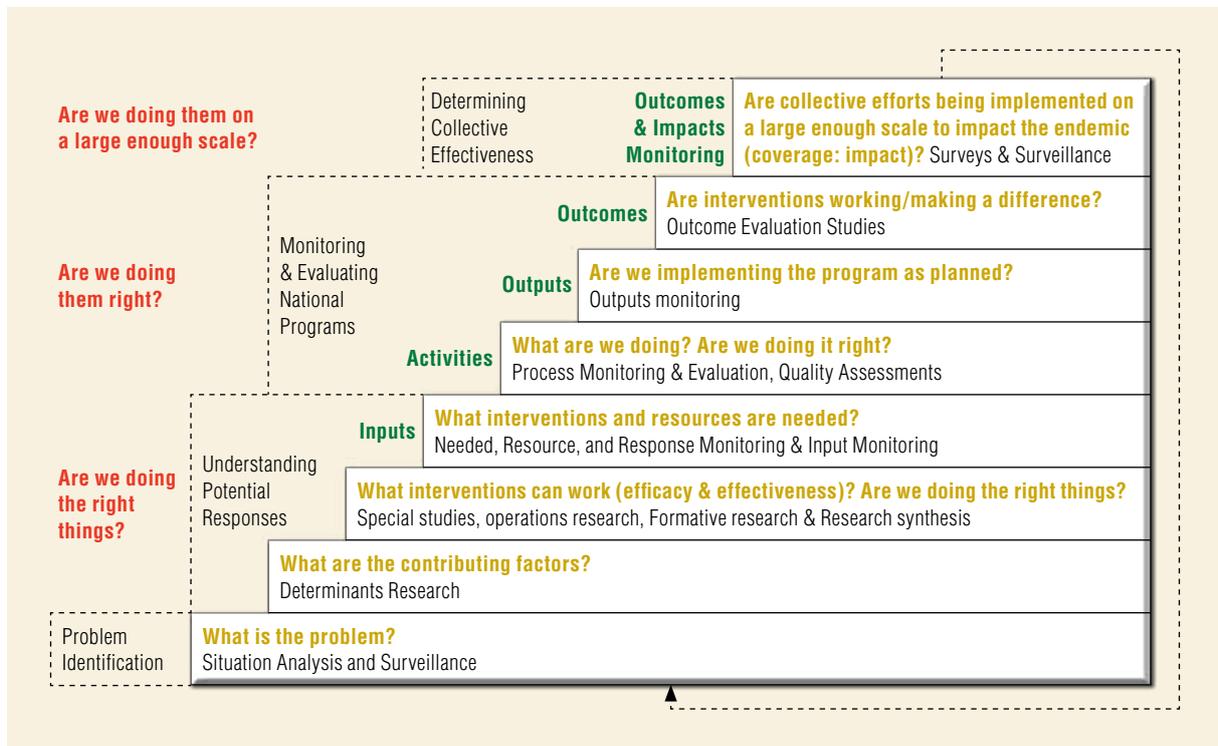
3.2 ROUTINE REPORTING AND SURVEYS

Routine monitoring is the *routine* tracking of the key elements of program/project performance (usually inputs and outputs) through record-keeping, regular reporting and surveillance systems, as well as surveys. Monitoring helps program or project managers determine which areas require greater effort and identify areas which might contribute to an improved response. In a well-designed M&E system, monitoring contributes greatly towards evaluation. Indicators selected for monitoring will be different, depending on the reporting level within the system. Routine monitoring is used for measuring trends over time, thus the methods used need to be consistent and rigorous to ensure an appropriate comparison.

There are two major sources of data for the core indicators – routine and periodic:

- (a) data sources for indicators that will be measured by surveys (outcome and impact indicators and outcome/impact data sources) are periodic; and

Figure 5: An approach to HIV and AIDS Programmes Monitoring and Evaluation



Source: Rugg et al. (2004). Global advances in HIV/AIDS monitoring and evaluation. New Directions for Evaluation. Hoboken, NJ, Wiley Periodicals, Inc.

(b) data sources for indicators that will be measured continuously – monitor programme outputs (output indicators and output data sources) are routine.

Input and output monitoring data are important, as these answer questions about the resources and interventions needed and provided, and whether planned programmes have been implemented. Input and output monitoring data are *collected through routine monitoring systems*, and are addressed by this component

Two questions arise in respect of routine data:

- Is it really necessary to collect data on issues other than whether or not interventions are making a difference and whether they are being implemented as planned?

- Is it really necessary to use routine monitoring systems to collect data about available funding (input data) and whether programmes have been implemented as planned (output data).

This framework motivates that routine data is important for a number of reasons:

- Routine monitoring data provides data to explain the changes at the outcome and impact level. This project intervention is needed to bring about higher-order changes. Therefore the implementation of such interventions and the inputs supplied to deliver these, need to be monitored. The data helps to interpret positive and negative changes (or lack thereof) at the higher order level.
- Routine monitoring provides real-time data that can be used for day-to-day monitoring, coordination and

planning for the project, unlike surveys and evaluation which simply provide a snapshot in time.

- Routine monitoring data can be used to validate service coverage data generated through the baseline and the training needs assessment.

3.2.1 Performance Tracking Tools and Forms

These are the key tools and forms that HEAIDS could use to track performance against targets at various stages in the implementation of the Policy and Strategic Framework. The Performance Framework contains a summary of key indicators and targets measuring output and coverage on a routine basis (quarterly or six-monthly depending on reporting frequency). The performance tracking tools and forms assist with progress reporting for the reporting period. It serves as an indication of progress with respect to the interventions implemented. It includes a periodic report (quarterly or six-monthly depending on reporting frequency) on the following:

- programmatic progress/results in relation to the targets
- achievements recorded
- challenges recorded
- deviations recorded against the targets
- the reasons for the deviations
- plan of action for the next reporting period

3.2.2 Student or Staff Based Data Collection Tools

Student and staff-level data collection involves the gathering of data about each individual client and maintaining that information in a database. Student and staff data can then be retrieved, sorted, grouped, and analyzed across different variables of interest. In contrast, aggregate data collection combines information about all students and staff served by an intervention and does not retain client-specific data in a database. Student and staff-level

data can be pooled to yield aggregate data, however information collected in aggregate form cannot be converted to client-level data.

HEIs will want to collect student and staff-level data and for the different interventions implemented on the campus site. However, in contrast, HEAIDS will use an aggregate data collection tool that combines information about all staff and students served by an intervention and not retain specific data in a database. The benefits of using student and staff-level data for the HEIs is that it facilitates the reporting of several process monitoring data elements required by the Logic Model. In the absence of client-level data, HEIs may not be able to report this information accurately. This data also may be useful for HEI based evaluation and planning purposes.

3.2.3 HEI Quarterly and Annual Service Coverage Activity Forms

At an HEI there are many sources of data. All routine data should go through to the focal point at the HEI where they will be captured, analysed and compiled into a quarterly and annual service coverage report.

The Quarterly and Annual Service Coverage Reporting Form should be used to capture data on all activities being implemented in the HEI. Each HEI will be requested to monitor the coverage of HIV interventions at its institution and share this information with HEAIDS on a quarterly basis through the Quarterly Service Coverage report (QSCR). For the HEIs to compile the QSCR, all implementing partners at the HEI will be required to report their activities to the focal point on a monthly basis by completing the Quarterly and Annual Service Coverage Reporting Form.

The focal person at each HEI will collate the information from the completed forms. Quality checks of data will be done by the HEI before the data is sent to HEAIDS for capturing into the HEAIDS database.

3.2.4 Data Quality Assessment

Data quality refers to the “fitness for use” of the collected data and ensuring that the process of data collection, collation and analysis enables the reported data to be fit to be used and can withstand an internal and external data quality audit. If data management is flawed there is a risk that the data will be of poor value. As programme practitioners it is prudent to make plans to ensure that data collected will be of good quality.

Data quality reflects the value and accuracy of data and is a measure of how well an information system represents the real world – the real world in this instance being programme activities and their results. Data quality therefore is a measure of how well the data collection tools being used reflect or mirror the activities or services being implemented. Good data quality is when our information system accurately collects, processes and disseminates information on needs, interventions and the results of these activities.

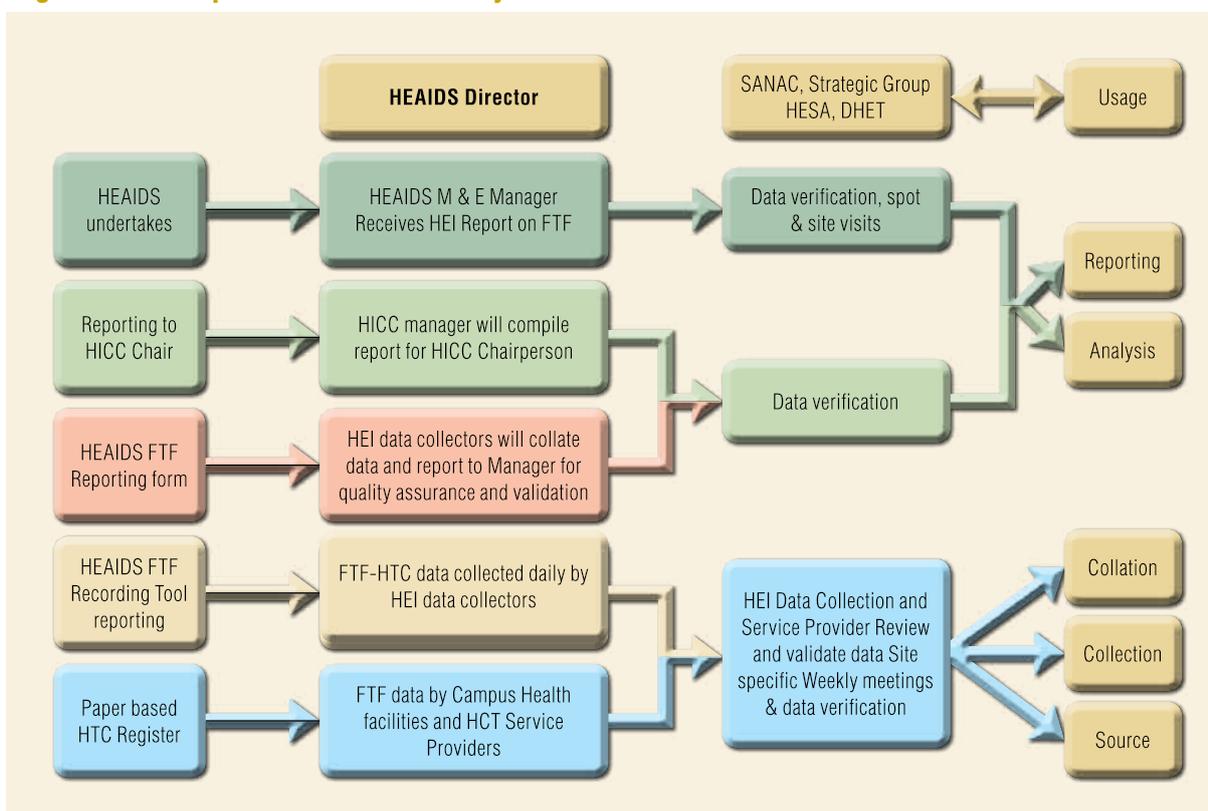
Data Quality Assessment is the process of verifying the completeness and accuracy of a selection of HIV output/ program monitoring forms through:

- field visits to the HEIs that submitted the forms;
- checking the quality of raw data kept by the reporting HEIs by examining the daily records used to complete the output monitoring form for a specific reporting period;
- comparing the output monitoring form data against the raw data; and
- checking for internal consistency.

Data assessment is useful because:

- it helps improve the credibility of the M&E data by improving HIV stakeholders’ confidence that the data presented to them presents a true picture of the services delivered.
- it build HEI capacity in routine data collection and capture, and the way in which they can use data to improve their own programmes.

Figure 6: Example of the Data Quality Assessment Process



- it helps improve the use of information for decision making, as more HIV implementers collect and capture better quality data, and learn how to use this data.

Data quality assessment involves both verifying that appropriate data management systems are in place and the quality of reported data for key indicators at selected HEIs. This implies that data-quality processes

need to assess the design of the data management and reporting systems; check system implementation for design compliance at selected service delivery and intermediary reporting sites; trace and verify historical reporting on a limited number of indicators at a few sites; and communicate the audit findings and suggested improvements in a formal audit report. As an example, figure 12 refers to ways and paths for improved data with reference to the First Things First HCT campaign data.

Table 2: Routine Indicators

Indicator	Definition	Disaggregation	Baseline Values	Target 2017	Data Source	Frequency	Responsibility
OBJECTIVE ONE: TO ENSURE THE COMPREHENSIVE AND APPROPRIATE USE OF THE HIGHER EDUCATION MANDATE OF TEACHING AND LEARNING, RESEARCH, INNOVATION AND KNOWLEDGE GENERATION; AND COMMUNITY ENGAGEMENT TO EFFECTIVELY RESPOND TO THE EPIDEMIC DRIVERS OF THE PANDEMIC							
1. Number of HEIs with an integrated HIV and AIDS Curriculum within the faculty of education teachers' training	Track progress with respect to all relevant, appropriate and essential HIV/AIDS curriculum across all faculties in HEIs	HEIs	20 HEIs	23	Programme Reports	Annual	HEIs
2. Number of faculties (e.g. health sciences, social sciences, engineering, humanities and business schools) mainstreaming HIV into curricula		Faculties	TBD	TBD	Programme Reports	Annual	HEIs
3. Number of HEIs contributing in national HIV research 3.1 Number of HEIs disseminating their research work 3.2 Number of HEIs attending/participating at both national and international conferences.	Track HEIs contribution and participation in national and international HIV/AIDS research work and agendas	HEIs	TBD	23	Programme Reports	Annual	HEIs
4. Number of campaigns run by HEIs	Review of programme campaigns on prevention	HEIs	TBD	TBD	Programme Reports	Quarterly	HEIs
5. Number of estimated staff and students reached with HIV, AIDS, STI and TB awareness campaigns	Reach of staff with HIV, AIDS, STI and TB awareness campaigns (First Thing First campaign). Awareness programmes are an effective methodology that raises awareness about HIV related issues including multiple sexual partners, high risk sexual behaviour, alcohol abuse and prevention messages	Staff Students	TBD	80%	Programme reports	Quarterly	HEIs
6. Number of HEIs implementing Peer Education activities	Peer Education has been developed to enable staff members and students or trainers who are interested in HIV/AIDS to spearhead the growth of awareness within their respective organizations. Peer educators are trained not only to be compassionate in their implementation of HIV/AIDS projects, but also effective in terms of skills and methodologies. Peer education often involves training in interactive methodologies and taught to manage colleagues in a sensitive, professional and appropriate manner. Workbooks are provided and contain questionnaires, simulations, and problem solving sessions and group activities that ensure maximum participation.	HEIs	TBD	TBD	Programme reports	Annual	HEIs

Indicator	Definition	Disaggregation	Baseline Values	Target 2017	Data Source	Frequency	Responsibility
7. Number of male condoms distributed in HEIs	This indicator measures the distribution of male condoms. Condoms are used to reduce the likelihood of pregnancy and to prevent the transmission of sexually transmitted infections, including HIV. The male condom is a thin rubber cover that fits over a man's erect penis.	HEIs	TBD	TBD	Programme reports	Quarterly	HEIs
8. Number of female condoms distributed in HEIs	This indicator measures the distribution of female condoms. The female condom is a polyurethane pouch that fits inside the vagina.	HEIs	TBD	TBD	Programme reports	Quarterly	HEIs
OBJECTIVE TWO: TO PROMOTE THE HEALTH AND WELL-BEING OF THE HIGHER EDUCATION COMMUNITY AT INDIVIDUAL, GROUP AND INSTITUTIONAL LEVELS THROUGH STRENGTHENING EXISTING CAPACITY, SYSTEMS AND STRUCTURES RESPONDING TO THE PANDEMIC							
9. Percentage of HE staff and students who received an HIV test in the last 12 months and who know their results ⁶	This indicators measure the number of staff and students who took the test and received their results in the last 12 months. The objective of counseling in the context of an HIV diagnosis is to encourage the client to explore important personal issues, identify ways of coping with anxiety and stress, and plan for the future (keeping healthy, adhering to treatment, and preventing transmission). When counseling in the context of a negative HIV test result, the focus is exploring the client's motivation, options and skills to stay HIV-negative.	Students Staff • Academic • Admin. • Service	65% 41% 47% 55%	80% 80% 80% 80%	KAP Survey/ Behavioural Surveillance Survey	4 years	HEIs/HEADS
10. Number and percentage of HEI staff and students screened for STIs ⁷	A screening test for STIs. Transmission of HIV, or other sexually transmitted infection, from one individual to another as the result of sexual contact.	Staff Students	1.2% (students only)	80%	Programme reports	Quarterly	HEIs
11. Number and percentage of HEI staff and students screened for TB ⁸	This refers to screening for symptoms of TB only i.e. assessing if a person is a TB suspect, hence it does not refer to screening for TB disease through X-ray, microscopy or other diagnostics. This refers to persons who do not already know their TB status.	Staff Students	42744 (64% (FTF, 2012)	80%	Programme reports	Quarterly	HEIs

6 Baseline values from HIV prevalence and related factors Higher Education Sector Study South Africa, 2008–2009

7 Campus Health Clinic Data, 2010

8 FTF Data, 2012

Indicator	Definition	Disaggregation	Baseline Values	Target 2017	Data Source	Frequency	Responsibility
12. Number of campus health clinics accredited to provide TB treatment and supervision of DOTS	DOTS coverage is an indicator that is particularly useful in the early stages of DOTS implementation. But it is also somewhat simplistic, as it only measures the presence or absence of DOTS services within universities	HEIs	TBD	TBD	Programme reports	Annual	HEIs
13. Number of HEI health facilities providing treatment for STIs	This indicators measures the number of HEI health facilities providing treatment for STIs	HEIs	TB	TBD	Programme reports	Annual	HEIs
14. Number of Medical Male Circumcision 14.1 Number of Medical Male Circumcision done on campus 14.2 Number of Medical Male Circumcision done at a public or other partner health facility	Measures medical circumcision done either on campus or off campus at public health and other partner facilities.	HEIs	TBD	40000	Programme reports	Quarterly	HEIs
15. Number of students given "morning after pill"	This indicators measures HEI health facilities providing Morning after pill	Students	TBD	TBD	Programme reports	Quarterly	HEIs
16. Number of PEP distributed 16.1 Number of staff and students who received PEP on campus 16.2 Number of staff and students referred for PEP to public health facilities	Measures the number of students and staff on PEP. Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a partner with HIV infection.	HEIs	TBD	TBD	Programme reports	Quarterly	HEIs
17. Number of campus facilities accredited to provide ARVs	To assess progress towards providing antiretroviral combination therapy to staff and students with	HEIs	2	21	Programme reports	Annual	HEIs
18. Number of HEIs distributing ARV treatment	advanced HIV infection	HEIs	2	21	Programme reports	Annual	HEIs
19. Number of HEI health workers trained in NIMART and TB diagnosis ⁹	Nurse Initiated Antiretroviral Therapy Training	HEIs	65	TBD	Programme reports	Annual	HEIs

9 2012 Trained nurses by NDOH

Indicator	Definition	Disaggregation	Baseline Values	Target 2017	Data Source	Frequency	Responsibility
OBJECTIVE THREE: TO CREATE AN ENABLING ENVIRONMENT TO ENSURE A COMPREHENSIVE AND EFFECTIVE RESPONSE TO HIV AND AIDS WITHIN THE HIGHER EDUCATION SECTOR FREE OF STIGMA AND DISCRIMINATION.							
20. Number of HEIs with operational plans aligned with the HIV Policy and Strategic Framework and minimum standards	To assess progress in the development and implementation of HEI level HIV and AIDS policies and strategies	HEIs	TBD	23	Programme reports	Annual	HEIs
21. Number of HEIs implementing programmes on stigma and discrimination	Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions. Discrimination refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures.	HEIs	TBD	100%	Programme reports	Annual	HEIs
22. Number of HEIs with a functional M&E system	Report on 80% of the indicators that are relevant to your institution. Across the national sector – the report must have 80% indication	HEIs	TBD	100%	Programme reports	Annual	HEIs
23. Number of HEIs trained in M&E system development and functionality	Track progress on the functionality of the M&E system	HEIs	TBD	TBD	Programme reports	Annual	HEIs
24. Amount of funding spent by HEIs on the HIV and AIDS programme	This measures progress in terms of institutionalising and funding the planning instruments	HEIs	TBD	TBD	Programme reports	Annual	HEIs/HEAIDS

SECTION 4 PERIODIC EVALUATION

4.1 EVALUATIONS

Deciding precisely why and when to conduct an outcome evaluation is a process that begins early in the programming cycle. Evaluation plans are made on the basis of a certain (and varying) number of outcomes that are required to evaluate in a given programme cycle. A variety of outcome evaluations – each with different purposes, scopes and timing – will be determined during the programme cycle. HEAIDS should strive to identify, at least generally, the purpose and timing of evaluations in a comprehensive and coherent manner – and as early as possible.

The timing of an outcome evaluation should be directly linked to its purpose. If, for example, the outcome evaluation is expected to contribute to learning and a change in the type of outputs or the partnership strategy, it should be conducted early enough to allow this change in programming. This means that if a project began working towards an outcome in year one of the programme cycle, an evaluation of that outcome might be most strategically placed at the end of year three because enough time would have lapsed to have something to evaluate and enough time would remain to apply lessons learned from the evaluation. On the other hand, an evaluation might be most strategically placed at the beginning of year five to extract lessons regarding the quality of outputs and partnership strategy employed towards an outcome and how each did or did not contribute to its achievement. The same principle holds true for programme evaluations: the purpose of an evaluation should dictate its timing and scope.

The scope of an outcome evaluation will be larger than that of a process evaluation in most cases. The HEAIDS M&E Manager, the HEIs, key partners and, if possible, the

evaluation team leader, should all participate in defining the scope of the outcome evaluation.

At a minimum, the scope of an outcome evaluation should incorporate the following four categories of analysis, either fully or in part.

- **Outcome status:** Whether or not the outcome has been achieved and, if not, whether there has been progress made towards its achievement;
- **Underlying factors:** An analysis of the underlying factors beyond HEADS and HEIs control that influence the outcome;
- **HEI and HEAIDS:** Whether or not outputs and other interventions can be credibly linked to achievement of the outcome, including the outputs, programmes, projects and soft and hard assistance that contributed to the outcome.

4.1.1 Process Evaluations

Process evaluations focus on gaining a good understanding of how a programme works. An outcome evaluation assesses whether a programme works (i.e. whether it is attaining its intended results). It looks at what is being done by a programme, for whom, and in what way in an effort to gain an in-depth understanding of the functioning of a programme. Process evaluations are used to identify where improvements might be made to programme design and delivery, and can also support decisions about whether a programme should be replicated or expanded. While they don't necessarily address the question of the effects of the programme, process evaluations will include an assessment of whether a programme is meeting its objectives. Most early or mid-term evaluations will be process evaluations.

4.1.2 Outcome and Impact Evaluations

These are sometimes referred to as final evaluations or summative evaluations. These types of evaluations deliver an assessment of the contributions the programme has made towards immediate changes and/or broader long-term effects, and help explain why a particular intervention has or has not been successful. Outcome and impact evaluations range in rigour from those that attempt to build a strong case for attributing change(s) to a programme to those that simply measure changes *ex-anti* and speculate on links between the changes and the programme. Outcome and impact evaluations tend to use experimental or quasi-experimental designs.

4.1.3 HIV Prevalence, Knowledge, Attitude, Behaviour and Practice (KABP)

The purpose of this study is to enable the higher education sector to understand the threat posed by the epidemic to its core mandate. This is done through determining, at the institutional and sector level, the prevalence and distribution

of HIV and associated risk factors among the staff and students at public, Higher Education Institutions (HEIs) in South Africa. This study comprises a cross-sectional HIV prevalence, knowledge, attitudes, behaviour and practice (KABP) survey and qualitative study among staff and contact students at HEIs across South Africa. The study comprises of an “unlinked, anonymous HIV survey with informed consent” and the HIV results of the study cannot be linked to individual participants.

Participation in the study is voluntary. It is conducted anonymously and no identifying information such as individual identity numbers for students, academic staff, administrative or service staff is obtained from any participant. For statistical analysis purposes, the KABP survey data is linked to the HIV test data via a unique barcode. Participation in qualitative focus group discussions and interviews is also voluntary and no individual identifying information is reported. The data collection tools are tailored to the different target groups, student, academic staff and administrative/service staff. These tools are administered and completed by the respective individual.

Table 3: Periodic Indicators

Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Responsibility
OBJECTIVE ONE: TO ENSURE THE COMPREHENSIVE AND APPROPRIATE USE OF THE HIGHER EDUCATION MANDATE OF TEACHING AND LEARNING, RESEARCH, INNOVATION AND KNOWLEDGE GENERATION; AND COMMUNITY ENGAGEMENT TO EFFECTIVELY RESPOND TO THE EPIDEMIC DRIVERS OF THE PANDEMIC							
25. Percentage of HEI staff and students who correctly identify ways of preventing transmission of HIV	To assess progress towards universal knowledge of the essential facts about HIV transmission	Staff <ul style="list-style-type: none"> • Academic • Administrative • Service Students	TBD	TBD	KAP Survey/ Behavioural Surveillance Survey	4 years	HEAIDS/HESA/ DHET
26. Percentage of HEI staff and students who have had sexual intercourse with more than one partner in the last 12 months ¹⁰	Measure of multiple partners	Students <ul style="list-style-type: none"> • Academic • Administrative • Service Staff	36% 11% 17% 24%	15% 6% 9% 12%	KAP Survey/ Behavioural Surveillance Survey	4 years	HEAIDS/HESA/ DHET
27. Percentage of HEI staff and students who used condoms consistently with one <u>non-</u> regular partner over the past 12 months ¹¹	Success of prevention – Student and staff programmes in achieving a high number of protected sex acts	Students <ul style="list-style-type: none"> • Academic • Administrative • Service Staff	60% 20% 28% 39%	80% 50% 50% 60%	KAP Survey/ Behavioural Surveillance Survey	4 years	HEAIDS/HESA/ DHET
OBJECTIVE TWO: TO PROMOTE THE HEALTH AND WELL-BEING OF THE HIGHER EDUCATION COMMUNITY AT INDIVIDUAL, GROUP AND INSTITUTIONAL LEVELS THROUGH STRENGTHENING EXISTING CAPACITY, SYSTEMS AND STRUCTURES RESPONDING TO THE PANDEMIC							
28. HIV prevalence among staff and students in HEIs ¹²	Monitor trends in HIV prevalence in staff and students to assess progress in reducing new infections. Prevalence is the number or proportion of people with HIV in a given population and at a specific time.	Students <ul style="list-style-type: none"> • Academic • Administrative • Service Staff	3.4% 1.5% 4.4% 12.2%	1.7% 0.8% 2.2% 6.1%	HIV sentinel surveillance	4-5 years	HEAIDS/HESA/ DHET
29. Percentage of staff and students who continue to be on treatment 12 months after initiation of antiretroviral therapy	Measurement of adherence	Staff <ul style="list-style-type: none"> • Academic • Administrative • Service Students	TBD	TBD	Programme reports	Quarterly	HEIs

¹⁰ Baseline values from HIV prevalence and Related factors Higher Education Sector Study South Africa, 2008–2009

¹¹ Ibid

¹² Ibid

Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Responsibility
30. Number of HEIs with functioning Workplace Programmes.	Track progress with respect to and level of functionality of the Workplace Programme in HEIs;	HEIs	TBD	23	Programme reports	Annual	HEADS/HESA/DHET
OBJECTIVE THREE: TO CREATE AN ENABLING ENVIRONMENT TO ENSURE A COMPREHENSIVE AND EFFECTIVE RESPONSE TO HIV AND AIDS WITHIN THE HIGHER EDUCATION SECTOR FREE OF STIGMA AND DISCRIMINATION.							
31. Percentage of staff and students expressing accepting attitudes towards people with HIV.	Assesses staff and students expressing accepting attitudes towards people living with HIV.	Students Staff • Academic • Administrative • Service	90% 90% 90% 80%	TBD	Report/Surveys	4 years	HEIs
32. Number of stigma cases reported ¹³	Trends of stigma and discrimination experienced by people living with HIV	HEIs	TBD	TBD	Programme reports	Annual	HEIs
33. Number of HEIs with functional HIV Institutional Coordinating Committees	Track progress in respect of functional HIV Institutional Coordinating Committees	HEIs	23	23	Programme reports	Annual	HEIs
34. Number of HEIs with operational plans that include a communication component aligned to HEADS communication strategy	Track progress in respect of communication across HEIs	HEIs	TBD	23	Programme reports	Annual	HEIs

13 See Stigma Mitigation Framework: A guideline for the design and implementation of stigma reduction interventions for Chronic Infectious Diseases including HIV and AIDS & TB, July 2010

SECTION 5 DATA MANAGEMENT

5.1 OVERVIEW

The purpose of data management is to manage and supply data either for decision-making or monitoring and evaluation purposes so that data can be put to best possible use. Data management is the cornerstone of the monitoring pillar of performance management. Relevant data must be stored in such a way that it is secure but also easily retrievable. Data management comprises a number of activities that should be conducted. These include:

- Data collection
- Records management
- Data security

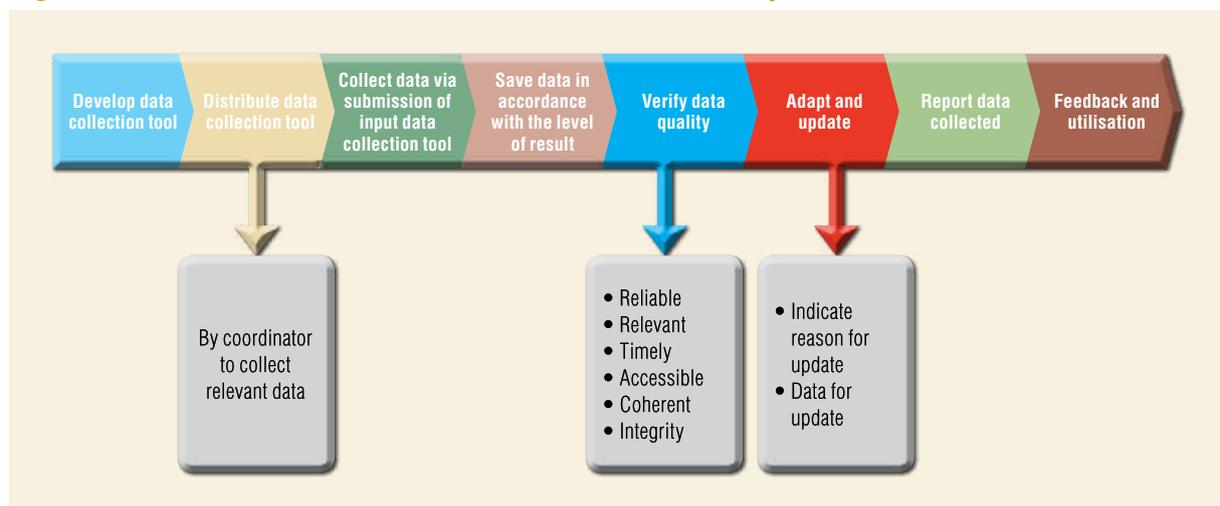
Data can only be monitored and used to determine performance if it is collected accurately and well. Effective data management requires that data be collected and captured according to prescribed processes. Data collection should also be monitored to ensure the integrity of the data. Verification of data is therefore an integral part of the data collection activity. The data collection activity encompasses the following as shown on Figure 7:

A common pitfall in data collection is the misunderstanding of the data to be collected. This is often the result of the way that the data is recorded. Effective data collection requires consistency during the creation of data. Scorecards cascading may assure that data related to similar outcomes, outputs and indicators are collected, which in turn will ensure that data on similar programmes and projects are captured at various levels on an integrated automated system.

5.2 DATA COLLECTION TOOLS

The indicators detailed above will be collected routinely or periodically. A number of tools can be developed for collecting routine data. Examples of such tools include the performance tracking forms, HEI Quarterly and Annual Service Coverage Activity Forms and a Service Coverage Form that HEADS will use to aggregate the data from HEIs. Both HEAIDS and HEIs would need to develop tools to evaluate the components and sub-components of the Policy and Strategic Framework. The focus of the evaluation will be on short, medium and long term indicators.

Figure 7: Schematic Framework of Data Collection Activity



HEIs use various data collection tools to collect and report process monitoring data including simple tally sheets for documenting aggregate data about clients served. Data collection tools may be the same for all HEIs or they may vary from one HEI to another, even when the same type of intervention is being implemented. HEAIDS and HEIs can collaborate to harmonise and standardize process monitoring data collection tools. Tools can be designed to collect data needed to meet the reporting requirements as it relates to the specific results and indicators, as well as to gather other information of interest.

Using the same data collection tools facilitates collecting uniform data across the HEIs and enables comparisons across interventions and HEIs. These tools should be developed as a collaborative effort between HEIs and HEAIDS as this increases understanding of the requirements of the tools and willingness to utilise the tool as required.

Examples of data collection tools for routine monitoring and periodic evaluation are:

Routine (Monitoring)	Registers – HTC, Treatment, TB, STI
	HEI Quarterly Service Coverage Activity Forms – student and staff
	HEI Annual Service Coverage Activity Forms
	HEAIDS Activity Service Coverage Activity Forms
Periodic (Evaluation)	National KAP Survey
	National Population-based surveys (Demographic Health Survey etc)
	Programme Evaluations (First Things First campaign)

5.3 INFORMATION PRODUCTS AT NATIONAL LEVEL

For effective monitoring and evaluation of the Higher Education response to HIV/AIDS, HEAIDS will need to develop information products, from the data sources mentioned above, that will be disseminated to HEIs. The information products that need to be developed include the following:

- Quarterly Service Coverage Report:** This report provides information on coverage statistics per HIV programme area, and is essentially based on the main interventions as envisaged in the Policy and Strategic Framework and the NSP 2012-2016. The report from the HEIs to HEAIDS should conform to the terms of minimum reporting standards, as well as the HEAIDS reporting format.
- Bi-annual Report:** This report provides the semi-annual activities on the Higher Education response to HIV/AIDS, and is based on the quarterly reports which have been submitted by the HEIs to HEAIDS. The content of the report includes issues to do with coordination, implementation (results being achieved), M&E, emerging issues, including challenges, and any special study report which has been submitted.
- HIV/AIDS M&E Annual Report:** This report provides a comprehensive overview of the higher education sector’s response to HIV in a year period. The report is done by reporting on a selected list of indicators as contained in this M&E Framework. It also provides key observations and guidance for future implementation. All the relevant indicators from survey and research findings conducted in the course of the year are also reported.

SECTION 6 STRUCTURE AND FUNCTIONS

6.1 HUMAN CAPACITY FOR THE M&E SYSTEM

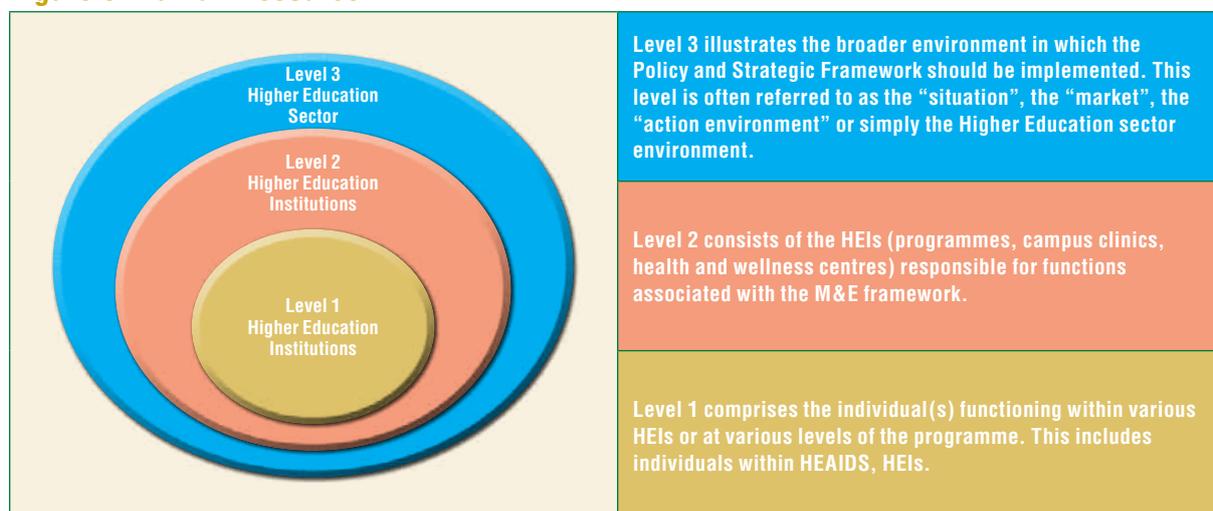
- HEAIDS to coordinate, capacity build and monitor all M&E focal points
- Appointment of personnel from within the HEI through the HICC Chairperson. HEAIDS will capacitate HEI staff on this M&E Framework
- Staff selected from the following operating units will be capacitated by HEAIDS and be responsible for collection and reporting on unit based information: Staff of campus clinics, employees of Health and Wellness centres, staff responsible for implementing HIV programmes, HR staff responsible for HIV and AIDS at institutional level, and staff involved with the academic curriculum in HIV and AIDS.
- Training and Development – capacity building sessions will be conducted for M&E focal persons at HEIs.
- Development of capacity building material to assist in on-going skills building and training, including in data collection, analysis, and utilisation of data planning and program implementation.

- Development of reporting strategies which will facilitate the timely submission of data and the development of mechanisms for the return of data to HEAIDS.
- Development of self assessment tools to improve data utilization at HEAIDS and at HEIs.
- HEAIDS will collect and consolidate the data into a quarterly report to be submitted on a quarterly basis or annually.

Capacity building or capacity development is focused on three levels, including the individual, organisational and systems. This component focuses on individuals at different levels in the organisations focusing on the different areas of HIV.

HEAIDS together with the HEIs are responsible for monitoring and evaluation of the implementation of the Policy and Strategic Framework. It has been acknowledged that M&E capacity is varied across HEIs. For most HEIs capacity is limited to effectively and efficiently implement the M&E Framework. HEAIDS is committed to strengthening M&E capacity in both the immediate short-term and in the long term at HEIs. The diagram below illustrates the three-fold focus of capacity and Capacity Development.

Figure 8: Human Resource



The capacity building requirements for the implementation of the Policy and Strategy Framework should focus on providing technical assistance to individuals involved in monitoring and evaluation as part of on-the-job training. The capacity building should focus on building institutional memory within the programme by ensuring that all individuals trained are in a position to train others. The training strategy and plan should be relevant to the programme.

Capacity Building should focus on some of the following elements:

- Context of M&E
- Planning – Results Based Management
- M&E Models
- Developing Logic Models
- Developing Indicators

- Developing data collection tools
- Data management and analysis
- Reporting

6.2 MONITORING AND EVALUATION FUNCTIONS

All HEIs are responsible for performing all M&E functions at institutional level. The HEI coordinating units will collate the implementation reports on a monthly, quarterly, biannual, and annual or any other time frame as may be prescribed by the respective indicators. It should be noted that the execution of M&E functions is an overarching responsibility that is to be shared by all HEIs. However, M&E in HEAIDS has a leading role and will be accountable for the performance thereof. The core functions for M&E are as follows:

Table 4: Functions required for better implementation of M & E

FUNCTIONS	DESCRIPTION OF FUNCTIONS
FUNCTION ONE: Planning, Monitoring, Evaluation and Reporting	<p>Planning</p> <ul style="list-style-type: none"> • Development and implementation of the M&E Plan • Devise and build an integrated M&E system that links verified inputs, outputs, outcomes and impacts. <p>Monitoring</p> <ul style="list-style-type: none"> • Maintain the comprehensive tracking system to collect, capture, verify and analyze information • Monitor the achievement of targets • Coordinate monitoring process between relevant stakeholders • Produce manuals on data quality, flow and feedback, reporting and tools <p>Evaluation</p> <ul style="list-style-type: none"> • Coordinate the collection of baseline data • Conduct assessment of process (mid-term review, outcome (end term review and impact of the programme interventions) <p>Reporting</p> <ul style="list-style-type: none"> • Provide feedback to relevant stakeholders on achievements and areas of weaknesses • Prepare programme reports as prescribed in the Indicator protocol reference sheets
FUNCTION TWO: Coordination and leadership	<ul style="list-style-type: none"> • HEAIDS will provide system leadership and ensure overall coordination in all monitoring and evaluation activities. • HEAIDS would ensure that reporting schedules are aligned and prevent duplication and overlaps.
FUNCTION THREE: Leading system development and design	<ul style="list-style-type: none"> • This entails developing and constantly reviewing the M&E processes to ensure relevance and coherence in a changing environment. • This may involve clarifying objectives, developing new indicators, identifying and developing new M&E tools for specific programmes • HEAIDS must create and maintain a definitive reference source on indicators and develop and enhance an integrated monitoring system for the project
FUNCTION FOUR: Providing implementation support to the M&E system	<ul style="list-style-type: none"> • HEAIDS must support the implementation of the M&E system at HEI level • Where necessary it should provide technical support to all HEIs on the implementation of the M&E Framework.
FUNCTION FIVE: Reporting, dissemination and utilization.	<ul style="list-style-type: none"> • Ensuring reliable and quality data is available. • HEAIDS would develop and produce reports based on the core indicators for submission to various stakeholders • HEAIDS would work closely with HEIs to finalize and verify reports. HEAIDS will work closely with the HEIs to access data. • Disseminating knowledge gathered through M&E processes is another important responsibility. • In keeping with the drive to ensure M&E is utilization oriented, HEAIDS would maintain and use a system for recording recommendations in M&E reports and would monitor whether or not they are implemented.

6.3 ROLES AND RESPONSIBILITIES OF IMPLEMENTERS

An M&E partnership refers to a cooperative relationship between people or groups of people who agree to share responsibility for achieving the M&E Framework performance objectives. Such partnerships are characterised by commitment to cooperation, shared responsibility and the achievement of common goals. Partnerships are both internal (within HEAIDS) and external (HEIs)

Almost any plan will have multiple audiences (stakeholders). This M&E framework has divided the audience into internal and external audiences. For the purpose of this plan the internal audience are the primary custodians or programme implementers, whilst the external audience performs a support role.

6.3.1 Coordination of the M&E Partnership

To ensure the effectiveness of the M&E partnerships an M&E Programme Working Group (PWG) will be formed to play a coordinating role. The M&E PWG will consist of M&E Focal Persons from the 23 HEIs as well as HEAIDS and external experts. The M&E PWG will be mandated to

fulfil specific objectives related to M&E, including technical M&E developments and challenges in the sector. The aim of the PWG will be to lead and guide the successful implementation of the M&E Framework. The work of the PWG will be based on agreed Terms of Reference.

6.3.2 Advocacy and Communication Plan

It is critically important to develop advocacy and communication strategies to help communicate and popularise monitoring and evaluation as an effective tool for managing performance. The objective is to obtain buy in for the implementation of the M&E Framework. The performance goal is to ensure knowledge of, commitment to M&E among HEIs. The following will be the critical means of institutionalising M&E:

- **Advocacy** – the intention here is to educate, sensitise, influence and change opinion or motivate by creating and implementing favourable policy
- **Communication** – good communication always has clear purpose, content, reliable sources, effective transmission and is effectively delivered to intended recipients
- **M&E Culture**- shared set of values, conventions or social practices associated with M&E

Table 5: Roles and Responsibilities of Implementers

WHO	RESPONSIBILITIES
HEAIDS LEVEL RESPONSIBILITIES	
HEAIDS M&E Manager	The HEAIDS M&E Manager will be responsible for facilitating technical support and capacity building, develop standardised reporting tools, coordinate implementation of the M&E Framework, collate and verify HEI data and draft routine periodic reports
HEI LEVEL RESPONSIBILITIES	
M&E Focal Person/ HIV and AIDS Unit Director/Manger/Coordinator	Each HEI needs to identify the M&E Focal Person/HIV and AIDS Unit Director/Manager/Coordinator to perform the day to day M&E activities especially compiling data for reporting and using information towards performance and enhancement.
Data Collectors (HIV Implementers)	Staff of campus clinics, HIV and AIDS Unit, employee wellness centres, HIV/AIDS curriculum implementers and HR personnel responsible for HIV/AIDS programmes will be responsible for documenting information gathered at primary source

SECTION 7

CONCLUSION AND IMPLEMENTATION OF THE MONITORING AND EVALUATION FRAMEWORK

In line with the HEAIDS mandate to coordinate the Higher Education response to HIV/AIDS and having a coordinated M&E System, the execution of the M&E framework requires commitment and partnership, guided by the principles articulated previously in the document. The following will be necessary for the successful execution of the M&E system:

- **Developing and building consensus on an M&E work plan** (operation plan) for data collection and reporting;
- **Building and strengthening a functional M&E system**, with a database linked to SANAC and other sub-systems;
- **Strengthen M&E units at HEIs** through capacity development workshops to strengthen the capacity of HEIs on data analysis, estimates and projections.
- **Execution of the M&E Framework** will require human, financial and physical resources. There is need, therefore, to build consensus on the investment strategy for M&E. The coordination of various activities in this plan by HEAIDS and support from HEIs and other stakeholders like the Department of Higher Education and Training will be critical.
- **Institutional Strengthening:** The intervention targets making the M&E systems at HEAIDS and the HEIs functional and effective. Specific activities include:
 - Creation of a functional database at HEAIDS
 - Supporting HEIs to develop data management systems;
 - Carrying out supervision and data audits;
 - Establishing a functioning resource center, including a virtual library;
 - Organizing workshops and seminars to establish and enhance the culture of M&E, e.g. targeting advocacy and sensitisation.
- **Strengthening Data Collection, Analysis and Reporting:** This component targets more efficient and timely data collection, analysis and reporting, which enhances the quality of data and makes it available for decision making and programming. The specific areas of interventions include:
 - Develop national HIV M&E operational guide (user's guide)
 - Develop HEI level M&E annual data collection plan, with clear activities and timeframes;
 - Establishing a baseline for core HIV/AIDS indicators where none are available;
 - Develop and build consensus on standardised, user friendly data collection instruments and reporting formats;
 - Establish Data Quality Assessment Protocols.
- **Strengthening coordination of HIV/AIDS research and surveys** – This component aims at enhancing the coordination of HIV/AIDS research. Specific activities include the following:
 - Development of HIV/AIDS research protocol / norms;
 - Finalising the development of a higher education HIV/AIDS research strategy;
 - Identifying and coordinating the carrying out of strategic research;
 - Enhancing the reporting and dissemination of research results to national and provincial forums, including through publication of research articles.

- **Coordinating regional and national consultative meetings and reviews of the HEAIDS M&E plan –**

This component of intervention targets the dissemination of information products by HEAIDS to relevant stakeholders and implementers. The dissemination of information products has to be coordinated to reach various stakeholders in time and in an effective manner. Specific activities in this component include the following:

- Organise the annual national stakeholders meeting on the HIV/AIDS response;
- Organise workshops for the dissemination and discussion of results with HEIs and Provincial AIDS Councils;

- Organise dissemination workshops for sharing good practice and lessons learned.

Annexure one of this M&E framework details the activities that need to be considered by HEAIDS and HEIs over the next two years. The activities target the strengthening of the M&E system for the higher education sector. It should be noted that the specific operational budget for M&E annual work-plans at decentralized levels will have to be developed and agreed upon.

ANNEX 1 REPORTING TOOL



SECTION A	Reporting Institution:								
	Reporting Period:	From:	Day	Month	Year	To:	Day	Month	Year
	Quarter reporting on:	From:	Day	Month	Year	To:	Day	Month	Year

SECTION B	Annual Reporting							
	Institutional Demographic information							
	List and name of campuses across the institution:			Name:			Name:	
	Number of registered students for current year:		Full-time students	Part-time students/ Distance Learning	Number of students living in residences	Sub-total	Total	
	Male							
	Female							
	Staff	Academic	Administrative	Service	Full-time	Part-time	Sub-total	Total
	Male							
	Female							
	Number of campus health clinics							
Number of health care professionals		Nurses	Doctors	Auxiliary	Sub-total	Total		
Male								
Female								
Accredited site	TB	ARV	Family Planning	Basic Primary Health Care Services				
Yes								
No								

SECTION C	Institutional HIV Policy and Plans	Yes	No	If yes, please attach
	HEI HIV Policy in place			
	HEI Strategic Plan and Operational Plan for current year			
	M & E plan available for current year			

SECTION D	QUARTERLY REPORTING				
	Objective 1: To ensure the comprehensive and appropriate use of the higher education mandate of teaching and learning, research, innovation and knowledge generation and community engagement to effectively respond to the drivers of the epidemic				
	Curriculum and Research				
	List of faculties integrating HIV into teaching and learning curricula				
			Yes	No	
	HIV and AIDS Curriculum integrated within the faculty of education teachers training				
	Number of HIV research projects undertaken in the current year			Number	
	Clinical Research				
	Biomedical Research				
	Social/Behavioral Research				
	Other (specify)				
	Prevention Activities				
	Interventions	Campus sites reached	Estimated Students reached	Estimated Staff reached	Comment
	HCT				
Health and Wellness					
STI					
MMC					
TB					
Stigma and discrimination					
Gender based violence					
Total reached by activities					

Peer Education

	Yes	No		
Peer Education programme in place				
Number of peer educators	Male	Female	Newly enrolled Peer Educators	
			Male	Female
Students				
Staff				
Total of peer educators				

Number of peer education activities/programme

Objective 2: To promote the health and well being of the higher education community at individual, group and institutional levels through strengthening existing capacity, systems and structures responding to the pandemic

Prevention and Treatment Services

Condom distribution

Number of male condoms distributed during this quarter	
Number of female condoms distributed during this quarter	
Number of campuses distributing condoms	

HIV Counselling & Testing (HCT) – including campaigns and campus health clinic testing	Number pre-test counselled for HIV		Number tested for HIV		Number who tested HIV positive		Number of HIV positive referrals	
	Male	Female	Male	Female	Male	Female	Male	Female
Students								
15–24 years								
25+ years								
Sub-total								
Staff								
15–24 years								
25+ years								
Sub-total								
Total								

Number pre-test counselled for HIV			TB Confirmed		Number of TB referrals		Number confirmed TB positive	
Students	Male	Female	Students		Male	Female	Male	Female
15–24 years			15–24 years					
25+ years			25+ years					
Sub-total			Sub-total					
Total			Total					
Staff	Male	Female	Staff		Male	Female	Male	Female
15–24 years			15–24 years					
25+ years			25+ years					
Sub-total			Sub-total					
Total			Total					

SECTION D

Number of medical male circumcisions performed	Students	Staff	Onsite	Referred/Offsite*
15–24 years				
25+ years				
Total				

PEP for HIV distributed/received (unprotected sex or needle injury or other)	Students	Staff	Onsite	Referred/Offsite*
15–24 years				
25+ years				
Total				

Morning after Pill	Students	Staff	Comment:
15–24 years			
25+ years			
Total			

Treatment

TB	Students	Staff	Comment:
Number newly initiated on TB treatment during the quarter			
Number currently on TB treatment (excluding newly initiated)			
Total number currently on TB treatment			
Total number adhering to TB treatment			

ARVs	Students	Staff	Comment:
Number newly initiated on ARV treatment during the quarter			
Number currently on ARV (excluding newly initiated)			
Total number currently on ARV treatment			

Training

Number of health care professional trained in NIMART	Number	Number of health care professionals trained in post operative complications	Number
Nurses		Nurses	
Doctors		Doctors	
Auxiliary		Auxiliary	
Total trained		Total trained	

Number of health care professional enrolled in mentorship	Number	Peer educators trained in MMC	Number
Nurses		Students	
Doctors		Staff	
Auxiliary			
Total trained			

Number of students and staff trained on Basic HCT	Number	Number of staff trained on M & E	
Students			
Staff			
Total trained			

General Comments:

For HEI Use

Report compiled by:		Date:	
Contact details:	Telephone no.:	Email:	
Report verified by:		Date:	
Contact details:	Telephone no.:	Email:	
Report submitted by:		Date:	
Contact details:	Telephone no.:	Email:	

For HEAIDS Use

Report received by:			
Date Received:			
Date Reviewed:			
	Yes	No	
Comments	Received on time:		
	Completeness of all information:		
	Accuracy – verified:		
	Date captured:		

ANNEX 2 GLOSSARY OF KEY TERMS

Baseline Information	Information (usually consisting of facts and figures collected at the initial stages of a project) that provides a basis for measuring progress in achieving project outcomes. Historical performance.
Behaviour change communication (BCC)	Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership. Behaviour change communication is developed through an interactive process, with its messages and approaches using a mix of communication channels in order to encourage and sustain positive, healthy behaviours.
Combination HIV prevention	The combination prevention approach seeks to achieve maximum impact on HIV prevention by combining behavioural, biomedical and structural strategies that are human rights-based and evidence-informed, in the context of a well-researched and understood local epidemic.
Comprehensive HIV Prevention, Treatment, Care, And Support	Comprehensive HIV prevention, treatment, care, and support includes tailored HIV prevention strategies, clinical care, adequate nutrition, psychological support, social and daily living support, involvement of people living with HIV and their families, and respect for human rights and legal needs.
Efficiency	Assesses the outputs in relation to inputs, looking at costs, implementing time and economic and financial results.
Effectiveness	Measures the extent to which an objective has been achieved or how likely it is to be achieved.
Evaluation	Systematic and independent assessments of ongoing or completed projects or programs, their design, implementation and results with the aim of determining the relevance of objectives, development efficiency, effectiveness, impact and sustainability.
Gender Equality	Gender equality between men and women means that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles and prejudices. Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services
Human Immunodeficiency Virus (HIV)	HIV is the virus that weakens the immune system, ultimately leading to AIDS. Since HIV means human immunodeficiency virus, it is redundant to refer to the 'HIV virus'.

Impacts	The positive and negative, foreseen and unforeseen, changes to and effects caused by the projects or programs under evaluation.
Indicators	A measure used to gauge the extent to which an output and outcome has been achieved (policy developed, presentation delivered, service rendered). Quantitative or qualitative statements that can be used to describe situations which exist and measure changes or trends over a period of time. (In the context of the Logic Model approach, an indicator defines the performance standard to be reached in order to achieve an objective.) Cost, Quality, Quantity, Time or Compliance.
Inputs	The funds, personnel, materials, etc., necessary to produce the intended outputs.
Monitoring	The continuous or periodic process of collecting and tracking implementation (process) and outcomes over time to measure the performance of a program, project, or activity. (As an integral and continuing part of project/program management, it provides managers and stakeholders with regular feedback on implementation and progress towards the attainment of global environmental objectives).
Monitoring and Evaluation (M&E)	The combination of monitoring and evaluation which together provide the knowledge required for: a) adaptive project management, b) reporting and accountability responsibilities, c) learning and d) empowering the primary stakeholders.
M&E System	The set of planning, information gathering and synthesis, and reflection and reporting processes, along with the necessary supporting conditions and capacities required for the M&E outputs to make a valuable contribution to project decision making and learning.
Strategic Objectives / Goals	The ultimate and long-term development impact that is expected to be attained after the project purpose is achieved. (Objectives or goals define a project's success).
Output	The planned results that can be guaranteed with high probability as a consequence of project activities.
People Living With HIV	people living with HIV (PLHIV), since this reflects the fact that an infected person may continue to live well and productively for many years.
Post-exposure prophylaxis (PEP)	PEP refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a person living with HIV.

Performance	Human performance involves (1) people's behaviour or actions, and (2) the outcomes or effects of those actions. Performance is a process in which resources are used in an effective, efficient and productive way to produce results that satisfy requirements of time, quality and quantity, and which are the effect or outcome of the actions or behaviour of a performer in the work process.
Programmes	A programme consists of managed, organised activities that provide services/benefits that are intended to improve people's circumstances OR managed, organised activities that provide services/benefits that are intended to improve people's circumstances
Seroprevalence	As related to HIV infection, sero-prevalence is the percentage of persons who have serologic evidence of HIV infection, i.e. antibodies to HIV, at any given time.
Sexually transmitted infection (STI)	STIs are spread by the transfer of organisms from person to person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhoea), the spectrum of STIs also includes: HIV, which causes AIDS; Chlamydia Trachomatis; Human Papilloma Virus (HPV), which can cause cervical, penile or anal cancer; genital herpes; and Chancroid. More than 20 disease-causing organisms and syndromes are now recognised as belonging in this category.

Stakeholders	People, groups, organisations or other bodies with a "stake" or interest in the area or field where interventions and assistance are directed.
Stigma and Discrimination	'Stigma' is derived from the Greek meaning a mark or a stain. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions. Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures.
Tuberculosis (TB)	Tuberculosis (TB) is the leading HIV-associated opportunistic infection in low- and middle income countries and is a leading cause of death among people living with HIV globally.
Validity	The extent to which the information measures what it is intended to measure.

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Contact
Higher Education HIV/AIDS Programme (HEAIDS)
UNISA Sunnyside Campus
Building 3
corner Rissik and Steve Biko (Mears) Streets,
Sunnyside, Pretoria
Tel: 012 484 1134
Fax: 012 484 1147

E-mail: heaida@hesa.org.za



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