



“DRAFT”

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HIV MONITORING and EVALUATION FRAMEWORK FOR THE HIGHER EDUCATION SECTOR



higher education
& training

Department:
Higher Education and Training
REPUBLIC OF SOUTH AFRICA



acronyms

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, and 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 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 analysing data to measure the performance of a program, project, or activity. (As an integral and continuing part of

GLOSSARY OF KEY TERMS

	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) empower 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. An output is used synonymously with the terms outcome at more senior levels and result of an activity at the lower levels of an organisation.
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 group of related projects or services directed toward the attainment of specific (usually similar or related) objectives, as per Treasury definition.
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.
Vulnerability	

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SECTION ONE: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

In South Africa, the AIDS epidemic is changing the landscape of sustainable development across all social and economic sectors.¹ Higher Education plays an important role in the economic and social well being of South Africa. The sector contributes to the overall economy through human development, knowledge production through research and in many instances through services to communities.

In tandem with these roles, the Higher Education sector in South Africa plays a fundamental role in developing leaders who will shape the country's future economy, its communities, government, and global role². HEIs are confronted with the impact of HIV and AIDS, not only on their staff and registered students, but also through external factors such as a reduction in the number of successful school-leavers, in labour supply and in general economic development. Katahoire³, and Katjavivi and Otaala⁴, in their observations on the most noticeable impacts of HIV and AIDS on the Higher Education sector, mention the decline in student intake, the rise in unpaid student debts due to students leaving the institutions as a result of AIDS-related illnesses, the increased general institutional and specific labour costs due to an increased loss and replacement of staff, the increase in frequency of payment of staff members' end-of-contract benefits, as well as the indirect costs represented by low staff morale. A general increase in absenteeism among staff members and students is also likely to compromise the quality of the teaching and research outputs. At times, HEIs may not directly notice the impact of students' deaths due to AIDS-related illnesses as students often complete their studies long before they are terminally ill⁵.

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)⁶ were released. The key findings reported for this study were as follows⁷:

- HIV prevalence of students was 3,4%, academic staff at 1,5%, administrative staff at 4,4%, and service staff at 12,2%.

¹ Development of the Policy Framework on HIV and AIDS for Higher Education in South Africa: Study Report 2009

² HESA. 2005. HEAIDS: Strategic Framework 2006–2009 and Beyond.

³ Katahoire. P.H. 2004. Review of Themes and Issues Emerging from Literature on Higher Education in Africa and Uganda in Particular. UNESCO.

⁴ Katjavivi, P.H. and B. Otaala. 2003. *African Higher Education Institutions Responding to the HIV/AIDS Pandemic*. Paper presented at the AAU Conference of Rectors, Vice-Chancellors and Presidents of African Universities (COREVIP), Mauritius, 17–21 March 2003.

⁵ International Institute for Educational Planning/UNESCO. 2008. *The impact of HIV and AIDS on Higher Education Institutions in Uganda*. UNESCO.

⁶ HIV prevalence and Related factors *Higher Education Sector Study South Africa, 2008–2009*

- Concurrent sexual partnership was measured in the present survey as people who had more than one partner in the past month and 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.
- While among students never testing was highest at 54%, it must be taken into account that only 65% have ever had sex before. Additionally, only 2, 3% of those never tested was HIV positive. Among academic staff and administrative staff never having had a test applied to around a third of respondents, 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 should be ubiquitous. Questions related to 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 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 values and perceptions of acceptance by friends at the institution if it was revealed that they were HIV positive. Only 38% of students, for example, thought they would be supported by 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 from 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 as 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.

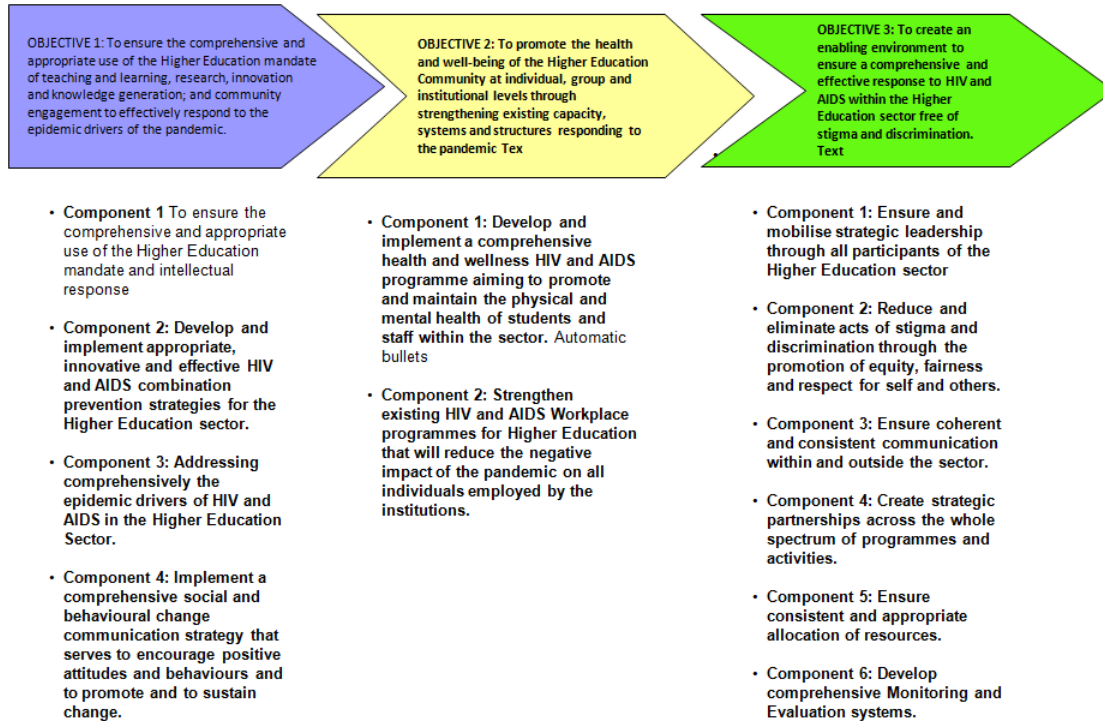
1.2 THE RESPONSE BY THE HIGHER EDUCATION SECTOR TO HIV

On December 1, 2011, the President of South Africa launched the 2012-2016 National Strategic Plan for HIV, STIs and TB (NSP). The NSP focuses on the investment approach to reversing the epidemic in terms of a 20 year vision to attain zero targets. The NSP focuses on four strategic objectives which will bring about reduced incidence of HIV, STIs and TB, promote wellness through universal health care, and address issues related to stigma and discrimination, particularly for vulnerable groups. The Higher Education sector has aligned its response to the new NSP and on the 29th November 2012 formally launched its Policy and Strategic Framework on HIV and AIDS for Higher Education.¹⁶ The age demographic of the sector, its strategic place in society, as well as its vulnerability to the pandemic, positions it as an important contributor to the national strategy.

The Policy and Strategic Framework builds on the policy framework that was adopted by the sector in November 2008. In addition to forming part of the country's multi-sector response, it accounts for the impact studies undertaken by HEAIDS in 2009/2010. The Policy and Strategic Framework reaffirms the sector's policy commitment to respond to HIV and AIDS on a comprehensive, effective and human rights basis and practically guides institutional HIV programmes in this through the declared mission of higher education institutions: teaching and learning; research and innovation; and community engagement.

Figure 1 on page 9 shows the objectives of the HIV and AIDS Policy and Strategic Framework with its components.

Figure 1: The key components of the Policy Framework are as follows:

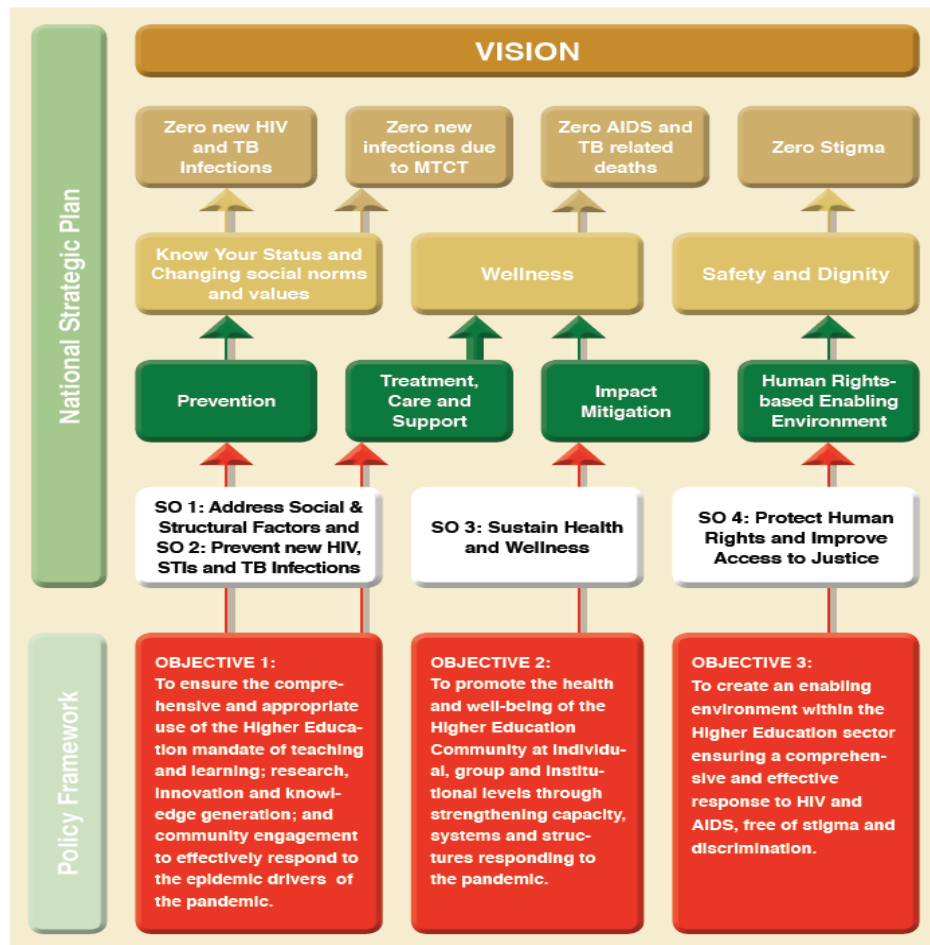


1.3 ALIGNMENT TO THE NATIONAL M&E FRAMEWORK

Higher Education as a key sector and SANAC constituent plays an important role in contributing to the achievement of the NSP objectives. The NSP identifies as key populations young women between the ages of 18-24 who are four times more likely to have HIV than men of the same age; un-circumsised men, MSM; those who use illegal substances, abuse alcohol and engage in transactional sex. All these groups are key populations in the higher education sector, compounded by the factor of many being from poor socio-economic backgrounds, a social and structural driver of the epidemic.

The Department of Higher Education and Training will contribute to the four NSP objectives as depicted on figure 2.

Figure 2: Alignment to the NSP 2-12-2016



Reporting performance of the HEAIDS 2012 Policy and Framework as aligned to SANAC National M&E Framework for HIV through the following indicators:

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

It is envisaged that the HEAIDS M&E Unit and the Higher Education Institutions will utilise the standardised tools developed for the collection, collation, analysis and reporting.

1.4 CURRENT APPROACH TO MONITORING AND EVALUATING HIV AND AIDS IN THE HIGHER EDUCATION SECTOR

⁸ TB screening questionnaire used according to DOH guidelines.

Shortly after the establishment of HEAIDS the platform for monitoring and evaluation was established. This platform was established primarily through the development of Policy Frameworks, the Framework for the Workplace Programmes, the norms and standards 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 establishing a common understanding and agreement for the development of HIV and AIDS Policy and Monitoring and Evaluation (M&E) Frameworks for the sector.⁹

A second study that set the basis for monitoring and evaluation 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 these policies the upgrading and implementation of institutional policies in order to mitigate the impact of HIV and AIDS within the sector¹⁰. The **Sector Framework for Workplace Programmes**: aimed to enhance the capacity of institutions to develop and implement comprehensive effective workplace programmes responsive to the needs of the individual HEI. This intervention was identified in the prevalence report as a critical area for intervention. 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 provided direction in respect of the key programmatic areas to be monitored and evaluated.¹¹

Routine monitoring data was collected from HEIs through annual reports and programme based reports. These reports were based on the indicators that HEIs were tracking. The **Sero-prevalence and Related Factors Report (2009)** provided a coherent and 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 the staff and students at public, Higher Education Institutions in South Africa. Another study that provided an understanding of one of the key pillars of higher education was the **Rapid Assessment of Curricular Responses in South African Higher Education Institutions**. This report offers a series of recommendations recognizing that the curricula of Higher Education form a knowledge area and that the teaching in the age of AIDS in Higher Education Institutions as well as in schools is critical area of investigation.

It is in this context and background that the current M & E Framework is being developed to guide the sector for improved tracking of the Policy and Strategic Framework implementation.

⁹ Development of an HIV and AIDS Policy Framework for Higher Education in South Africa December 2009

¹⁰ Development of the Policy Framework on HIV and AIDS for Higher Education in South Africa: Study Report 2009

¹¹ Norms and standards for HIV and AIDS prevention, treatment, care and support for Higher Education institutions in South Africa

SECTION TWO: MONITORING AND EVALUATION FRAMEWORK

2.1 RATIONALE

With the national and global momentum to scale up responses to HIV and AIDS, it is becoming increasingly important for HESA/HEAIDS as the entity body mandated with coordinating the Higher Education Sector response in particular, to be able to report accurate, timely, and comparable data to national stakeholders, development partners, and communities. Such information is useful to understand the scale and outcome of implementation and can be used to enhance and scale-up HIV programmes across all HEIs.

The following reasons justify the necessity of having the Higher Education HIV and AIDS M&E Framework:

- (i) To assist the HEIs and HEAIDS for more effective implementation of projects and programmes in mitigating HIV/AIDS
- (ii) It provides an opportunity to strengthen the programme to monitor and evaluate the response of the higher education sector
- (iii) It contributes in responding to the national reporting requirements;
- (iv) It provides the platform for partnership for sharing, networking, and collaboration in the sector between national-level and HEI stakeholders in monitoring and evaluating the higher education's responses to HIV and AIDS.

2.2 PURPOSE OF THE MONITORING & EVALUATION FRAMEWORK

The purpose of the Monitoring and Evaluation 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 different Higher Education stakeholders
- Develop clear M&E processes that will enable systematic collection, collation, processing, analysis, and interpretation of data
- Standardising the data sources to be collected in the framework.
- Support resource mobilisation through result based management in reporting.
- Enable the higher education sector to document, share best practises and disseminate results.

2.3 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 should include the following:

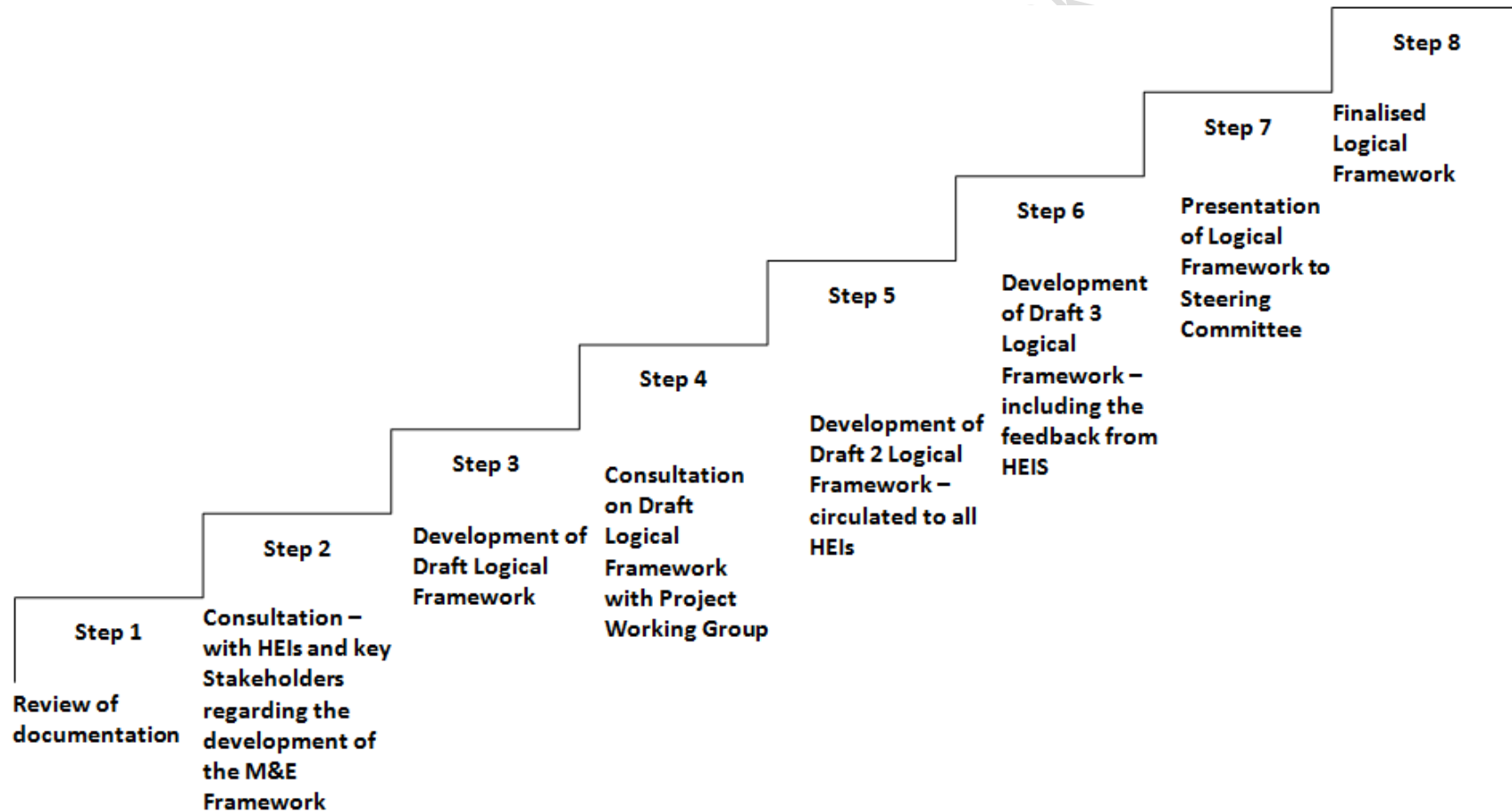
- i. **Consistency*** – where possible a consistent approach should be adopted to ensure economies of scale, share services and encourage benchmarking. This does not necessarily mean that the nature of the measures will be identical, but rather that a baseline set of measures are applied consistently.
- ii. **Transparency*** – information disclosure regarding the results, process, substantive measures when developing the system and realignment following monitoring and evaluation will be critical. The degree of transparency in the process will heighten the buy-in from HEIs 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 of (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 organizational resources and needs.
- vi. **Timeous*** – data should be collected timeously in order to ensure that it bears relevance to the current context. However, periodic, in addition to continuous, data should be defined in order to reduce the complexity of the system.

Monitoring and Evaluation 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 monitoring and evaluation processes assisted in providing evidence for deciding public resource allocations and helping to identify how challenges should be addressed, and successes replicated.

2.4 PROCESS OF DEVELOPMENT OF THE FRAMEWORK

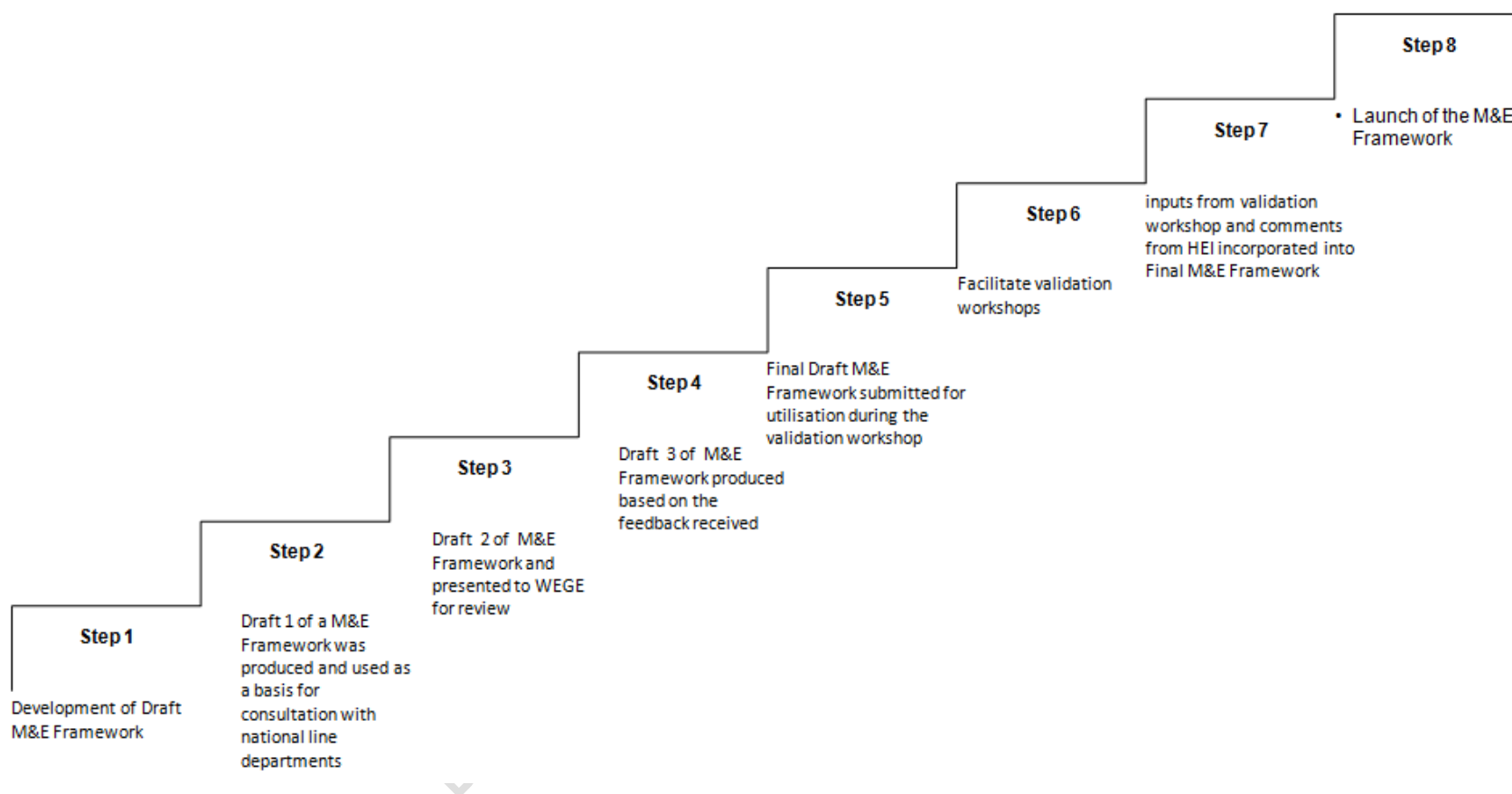
The process for developing the Logic Model was as follows:

Figure 3: *Process for the Development of the Logic Model*



The process for developing the M&E Framework was as follows:

Figure 4: *Process for the Development of the M&E Framework*



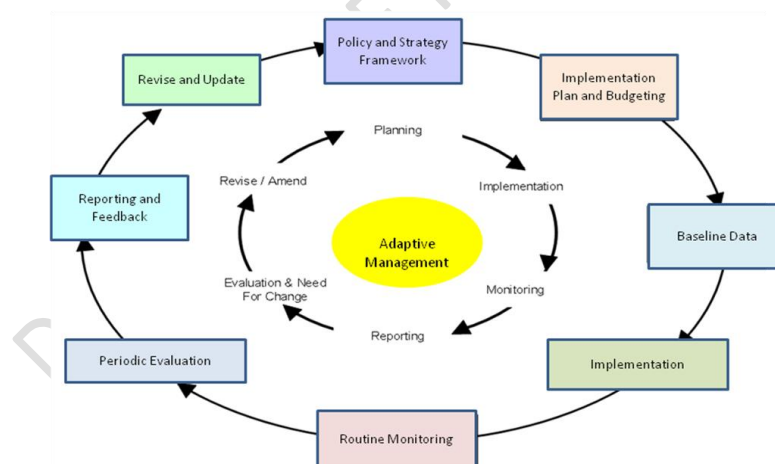
SECTION THREE: METHODOLOGY FOR THE DEVELOPMENT OF THE MONITORING AND EVALUATION FRAMEWORK

3.1 CONCEPTUAL FRAMEWORK FOR RESULTS BASED MANAGEMENT

Results-based management (RBM) is a lifecycle approach to management that integrates strategy, people, resources, processes, and measurements to improve decision making, transparency, and accountability. The approach focuses on achieving outcomes, implementing performance measurement, learning, and adapting, as well as reporting performance.

RBM is a management philosophy and approach that emphasizes development results in planning, implementation, learning and reporting. As reflected in the figure below, the development of the logic model and the M&E is dependent upon sound planning (including budgeting) and implementation as its base. In fact planning and M&E are viewed as two sides of the same coin – one can only be as good as the other. To quote the adage: “if you can measure it, you can manage it”.

Figure 5: Conceptual Framework



The above conceptual framework also answers the critical question: “what do we seek to measure through the HEAIDS Monitoring and Evaluation system?” In short, we measure:

- **Outcomes:** Incrementally in 5 year chunks within the Policy and Strategic Framework
- **Outputs:** Mostly quarterly and annually as defined in the implementation plan

On the basis of the above, HEAIDS adopted the Results-based management (RBM) for monitoring, evaluation and reporting across HEAIDS and the HEIs. RBM is a life-cycle approach to management that integrates strategy, people, resources, processes, and measurements to improve decision making, transparency, and accountability. The approach focuses on achieving outcomes, implementing performance measurement, learning, and adapting, as well as reporting performance.

The key elements of the RBM methodology used were:

- Defining **realistic expected results** based on **appropriate analysis**;
- **clearly identifying programme beneficiaries** and designing programmes to meet their needs;
- **monitoring progress toward results and resources consumed** with the use of appropriate indicators;
- **Identifying and managing risk** while bearing in mind the expected results and necessary resources;
- Increasing knowledge by **learning lessons and integrating them into decisions**; and
- **Reporting** on the results achieved and resources involved.

3.1.1 THE LOGIC MODEL

The logic model provides the basic framework for monitoring and evaluation. Figure 5 is a graphic representation that describes logical linkages across the different levels of results. It illustrates a program's theory of change, showing how day-to-day activities connect to the results or outcomes the programme is trying to achieve. Similar to a flowchart, it lays out programme activities and outcomes using boxes, and using arrows to connect the boxes, shows how the activities and outcomes connect with one another.

- 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 plan to do; and
 - The resources to operate 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*.

Figure 6: Results-Based Management Cycle

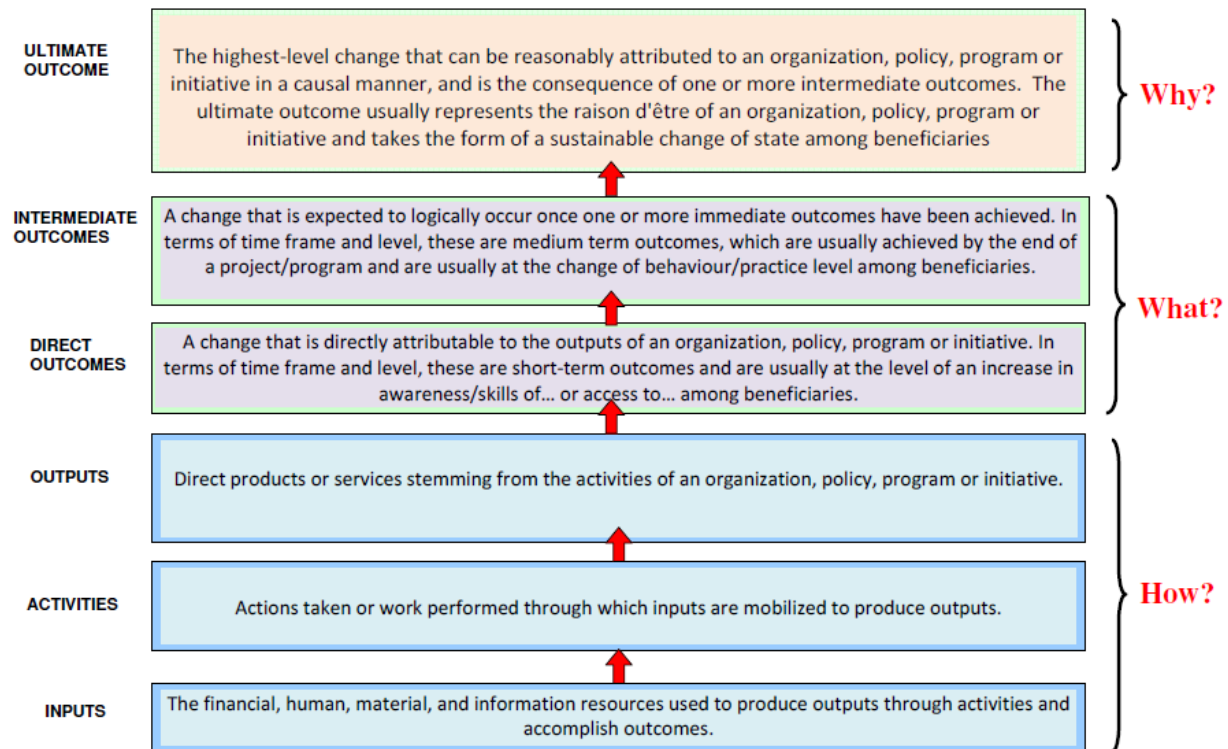
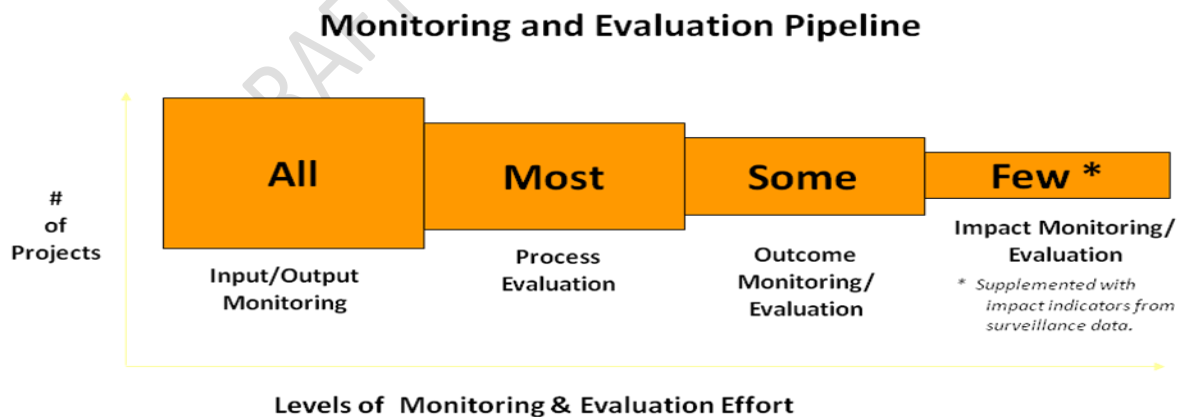


Figure 7: Results Pipeline



The Logic Model schematically represents the causal or logical relationship between activities and outputs and the outcomes of a given policy, strategy, programme or initiative that they are intended to produce. The Logic Model is an illustration of the results chain or how the activities of a policy, strategy, programme or initiative are expected to lead to the achievement of the final outcomes and impacts and is usually displayed as a flow chart. 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.

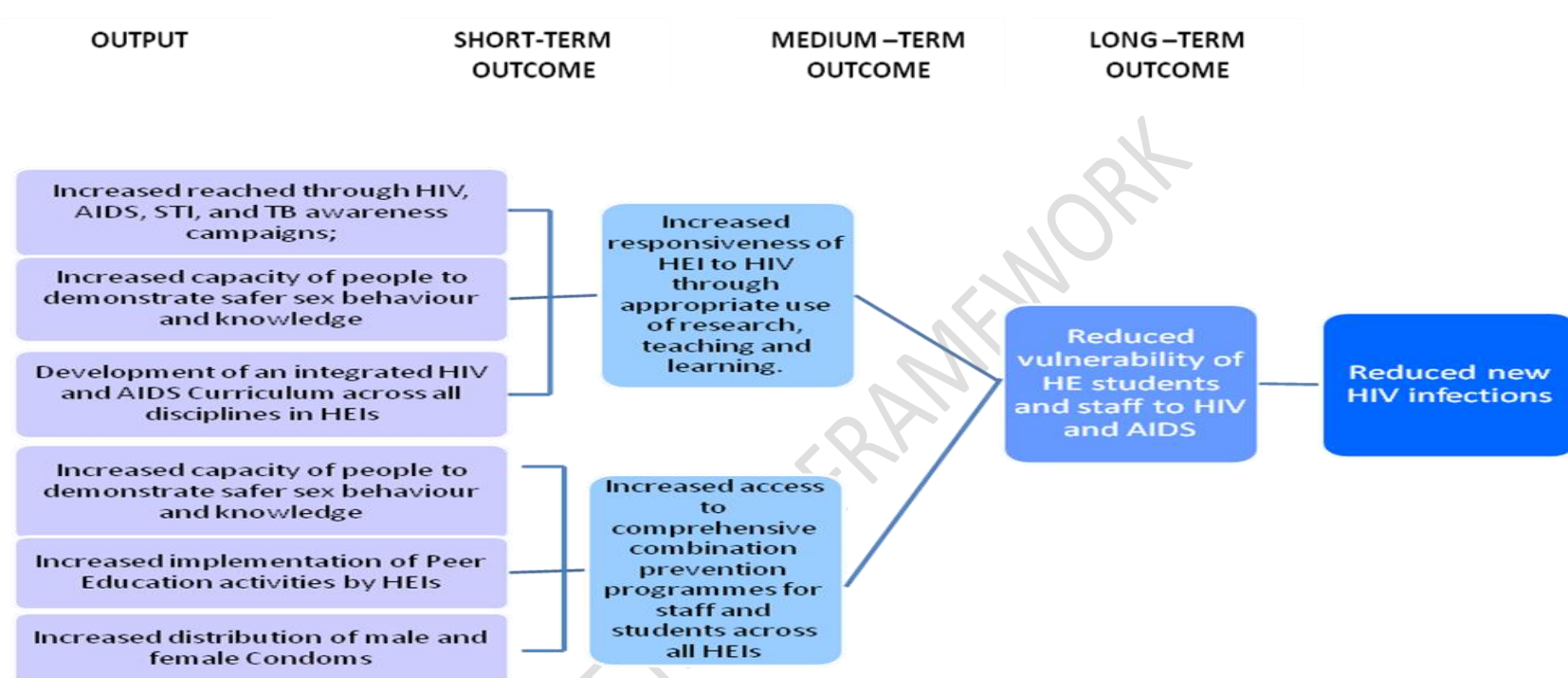
3.1.2 OBJECTIVE ONE

This objective focuses on prevention. HIV, TB and STIs have a profound impact on the individual living with these diseases, as well as their families and communities. Social and structural approaches address the social, environmental, political, cultural and environmental factors that lead to increased vulnerability. Practices that put people at HIV risk are ingrained in social norms which need to be critically examined and addressed in order to introduce positive behavioural changes that promote safe practices. The structural approach addresses issues deeply entrenched in society and require long-term strategies and interventions that are outside the sole domain of health and HIV. For this reason, HIV management must be mainstreamed into core strategy.

Targeted, evidence-informed combination prevention interventions are needed to achieve the long-term goal of zero new HIV and TB infections. Combination prevention interventions recognise that no single prevention intervention can adequately address the HIV and TB epidemics, but must consider the combination of structural, biomedical and behavioural approaches that together are likely to have the greatest impact on reducing the likelihood of transmission, and mitigating individuals' susceptibility and vulnerability to acquiring new infection. Different combinations of interventions need to be designed for different key populations.¹²

¹² Policy and Strategic Framework on HIV and AIDS for Higher Education, 2012

Figure 8: *Logic Model for 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*

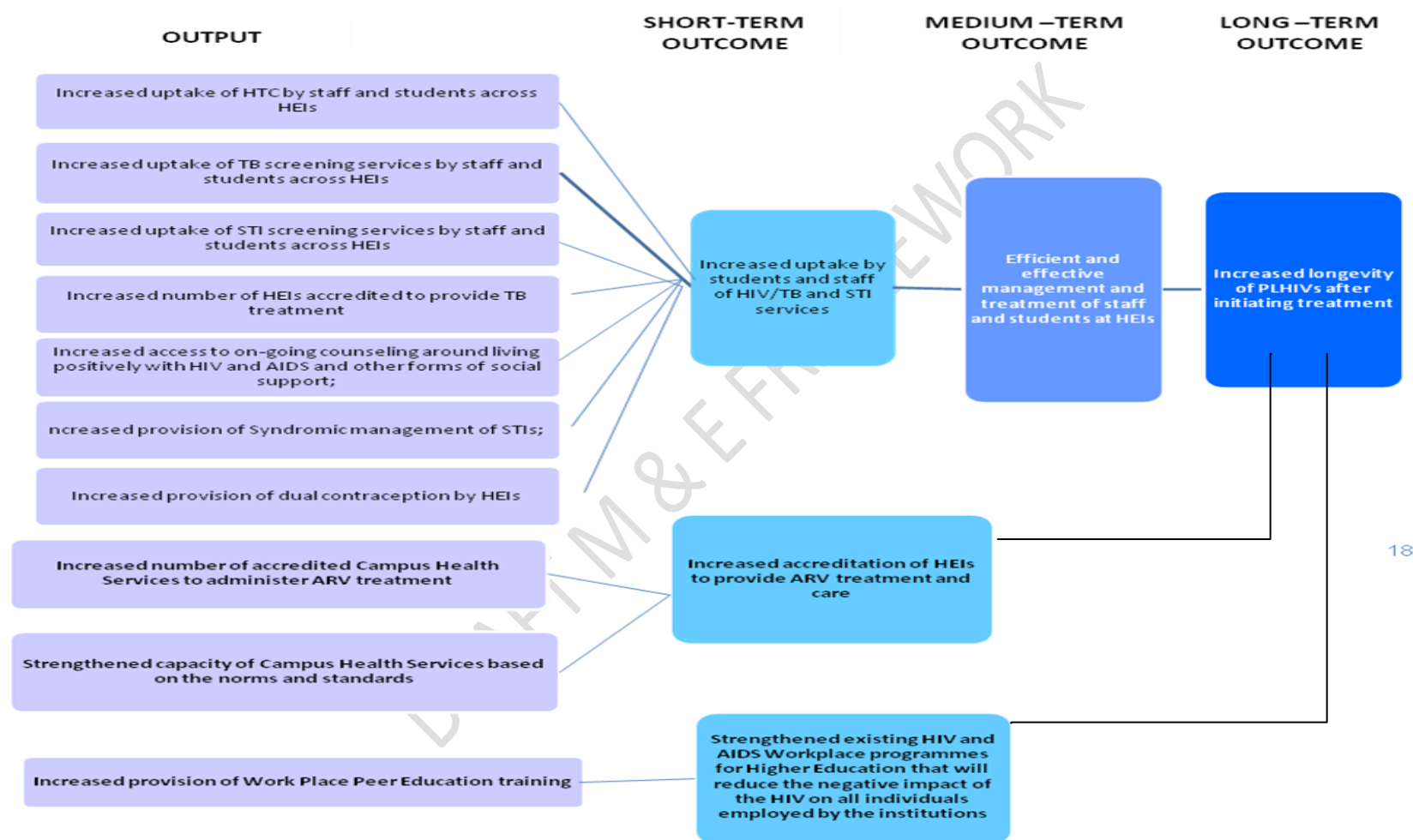


3.1.3 OBJECTIVE TWO

This objective focuses on achieving a significant reduction in deaths and disability as a result of HIV and TB by facilitating access to early and improved diagnosis, improved access to speedy, appropriate and user-friendly treatment services and retention in treatment and care. The focus of wellness is rapidly becoming part of any corporate landscape and institutions of Higher Education are an integral part of this landscape. Significant gains have been made in the implementation of creative and innovative HIV and AIDS workplace programmes in South Africa's Higher Education Institutions at the individual, group, family, and at local community level.¹³

¹³ Policy and Strategic Framework on HIV and AIDS for Higher Education, 2012

Figure 9: Logic Model for 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

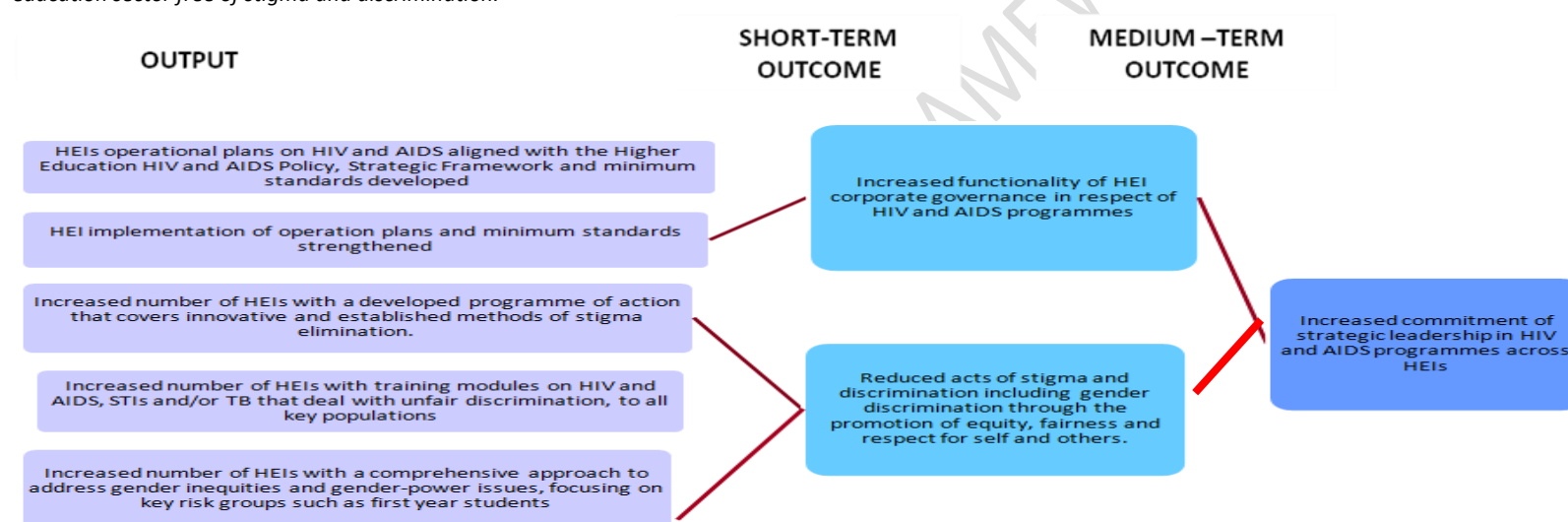


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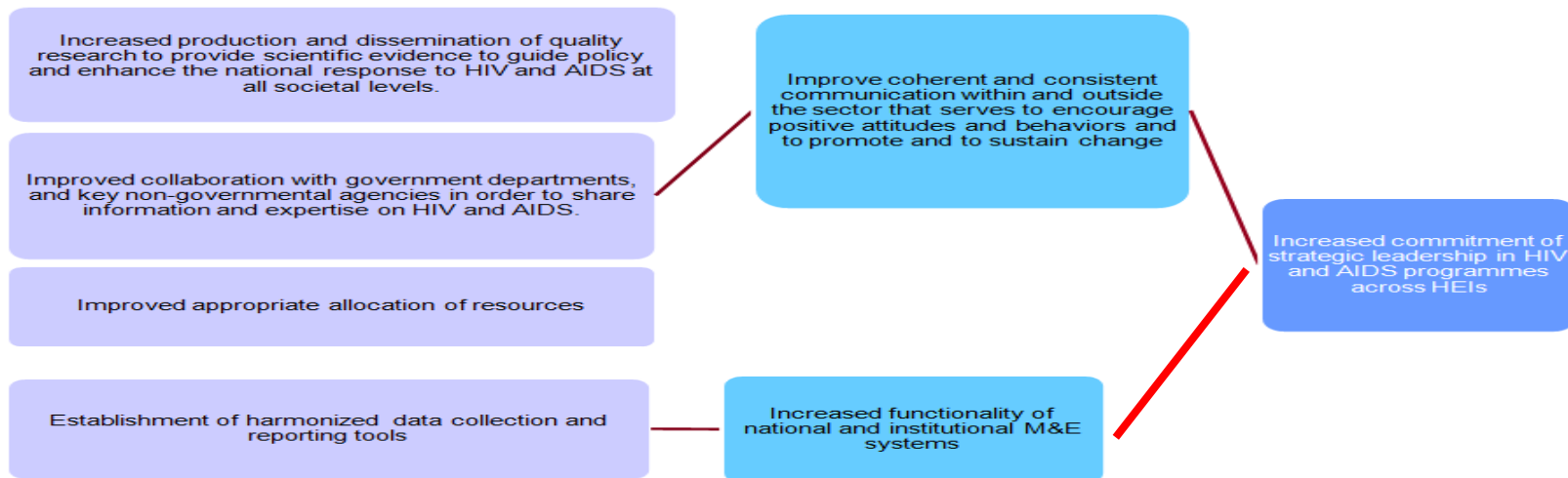
3.1.4 OBJECTIVE THREE

Leaders at all levels of society play a vital role in entrenching and sustaining socio-cultural norms. It is also known that risk tolerance can be driven by lack of social cohesion and perceptions of lack of choice, and a vision for the future. Providing effective leadership is one way social cohesion may be attained and sustained. This will further promote adherence to human rights practices and improved access to justice. The objective is further aimed at creating the enabling environment to promote the efficient and effective implementation of the Policy and Strategic Framework at both a sector and institutional level.¹⁴

Figure 10: *Logic Model for 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.*



¹⁴ Policy and Strategic Framework on HIV and AIDS for Higher Education, 2012



3.1.5 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 Annexure A. 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.

Annexure A 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 detailed in Annexure A 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.

SECTION FOUR: ROUTINE MONITORING

4.1 OVERVIEW

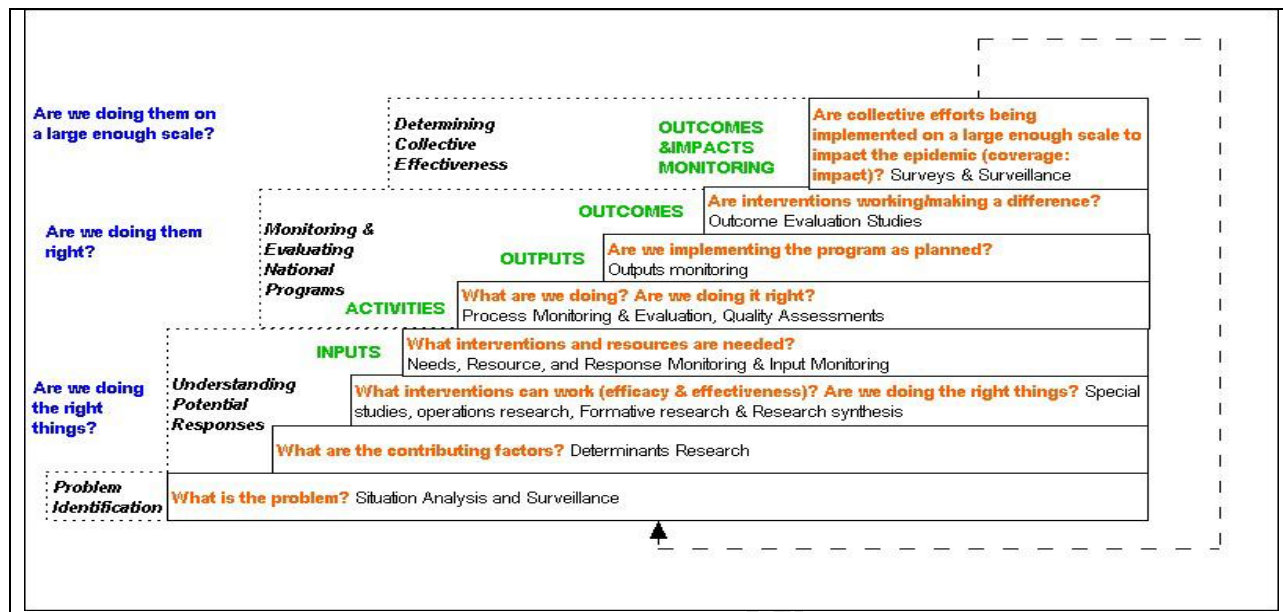
Not everything that can be counted counts, and not everything that counts can be counted."

Albert Einstein (1879-1955)

For HIV results at all levels to be measured, the entire spectrum of input, output, outcome and impact data are needed. Figure 10 illustrates the different types of data required. 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. Routine monitoring refers to the frequency of data collection and the type of data collected.

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 monitoring and evaluation 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.

Figure 11: *An approach to Monitoring and Evaluation HIV and AIDS Programmes*



There are two major sources of data for the core indicators – periodic and routine: (a) data sources for indicators that will be measured by surveys (outcome and impact indicators and outcome/impact data sources) are periodic; and (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 purports 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.

4.2 ROUTINE DATA COLLECTION TOOLS

4.2.1 PERFORMANCE TRACKING TOOLS AND FORMS

These are the key tools and forms that the 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 assists with progress reporting for the reporting period. It serves as an indication of how 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

4.2.2 STUDENT OR STAFF BASED DATA COLLECTION TOOLS

Student and Staff-level data collection involves gathering 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 at for the HEIs is that it facilitates reporting 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. These data also may be useful for HEI based evaluation and planning purposes.

4.2.3 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 required 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 check of data will be done by the HEI before the data is sent to HEAIDS for capturing into the HEAIDS database.

4.2.4 DATA QUALITY ASSESSMENT

Data quality refers to the “fitness for use” of the collected data and focuses on ensuring that the process of data collection, collation and analysis enables the data reported is 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 planners/implementers it is prudent to make plans to ensure that data collected will be of good quality.

Data quality reflects the value / accuracy of data and is a measure of how well an information system represents the real world - the real world in this instance, being HEADS 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 HEADS needs, interventions and the results of these activities.

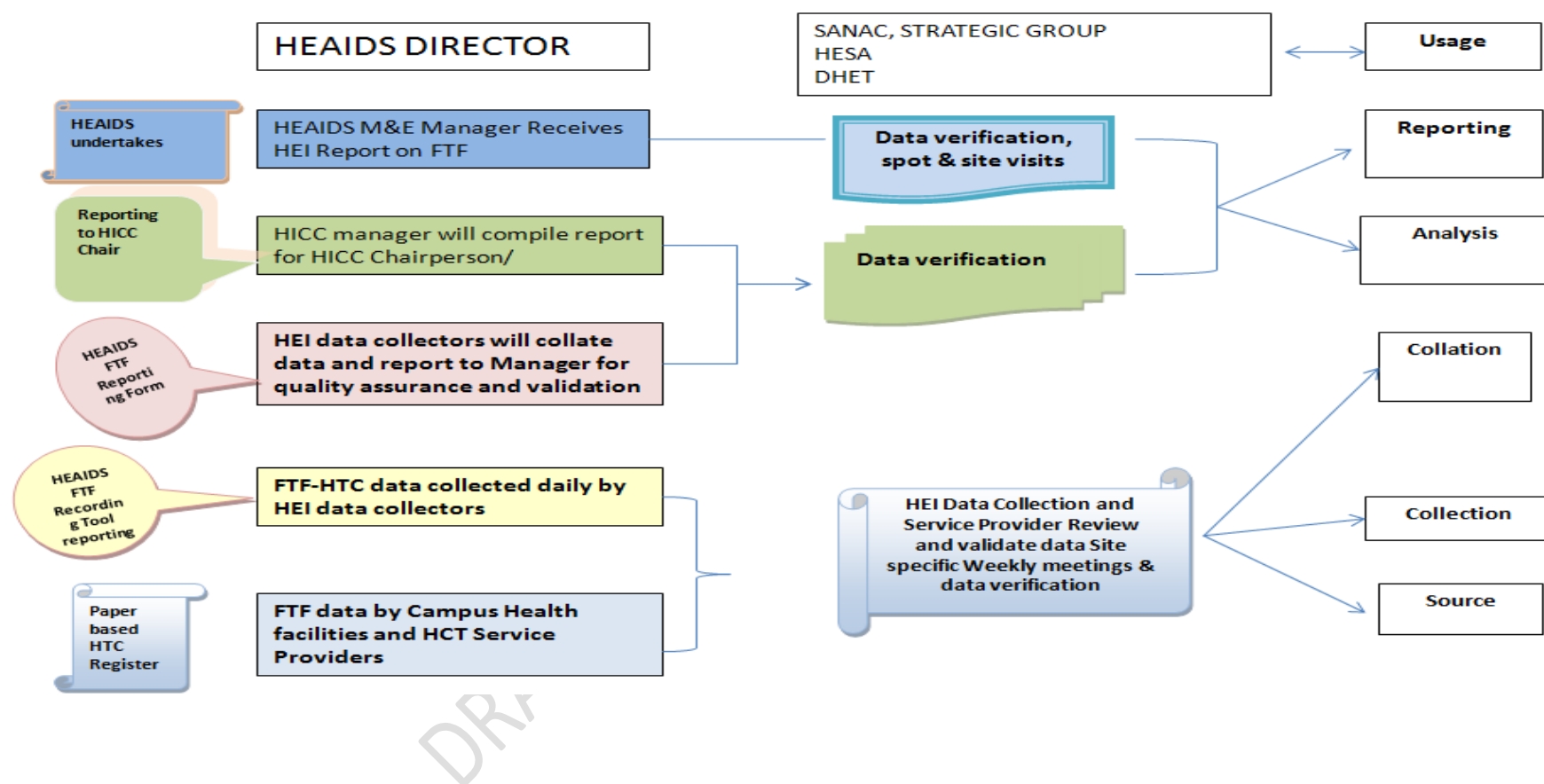
Data Quality Assessment is the process of verifying the completeness and accuracy of a selection of HIV output/program monitoring forms through, a) field visits to the HEIs that submitted the forms; b) checking the quality of raw data kept by the reporting HEIs by examining the daily records used to complete the output monitoring form for a specific reporting period; c) comparing the output monitoring form data against the raw data; and d) checking for internal consistency.

Data assessment is useful because:

1. The data assessment processes help 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 HIV Services delivered.
2. These processes help build HEI's capacity in routine data collection and capture, and the way in which they can use data to improve their own programmes.
3. These processes help to 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. For example, figure 12 makes reference to ways and paths for improved data with reference to the FTF HCT data.

Figure 12: Example of the Data Quality Assessment Process



Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Accountability
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	Track progress with respect to all relevant, appropriate and essential HIV/AIDS curriculum across all faculties in HEIs;	• HEIs	20 HEIs	23	Curriculum Reports	Annual	HEI
2. Number of faculties (e.g. health sciences, social sciences, engineering, humanities and business schools) mainstreaming HIV into curricula		• Faculties	To be determined	To be determined	Annual reports	Annual	HEI
3. Number of HEIs contributing in national HIV research 3.1 Number of HEIs dissemination 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	To be determined	23	Annual reports	Annual	HEI
4. Number of campaigns run by HEIs	Review of programme campaigns on prevention	• HEIs	To be determined	To be determined	Operational plans	Annual	HEI
5. Number of 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	62475	To be determined	Annual programme Reports	Annual	HEI
6. Number of HEIs implementing Peer Education activities	Peer Education has been developed to enable staff members 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.	• HEIs	To be determined		Annual programme Reports	Annual	HEIs

Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Accountability
	Workbooks are provided and contain questionnaires, simulations, problem solving sessions and group activities that ensure maximum participation.						
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.	<ul style="list-style-type: none"> HEIs 	To be determined		Annual programme Reports	Annual	HEI
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.	<ul style="list-style-type: none"> HEIs 	To be determined		Annual programme Reports	Annual	HEI
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	This indicators measure the number of staff and students who took the test and received their results in the last 12 months. Counseling in the context of an HIV diagnosis, the objective 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.	<ul style="list-style-type: none"> Staff <ul style="list-style-type: none"> ✓ Academic ✓ Administrative ✓ Service Students 	41% 47% 55% 65%		KAP Survey/ Behavioural Surveillance Survey	2 years	HEI/National
10. Percentage of HEI staff and students screened for STIs	A screening test for STIs. Transmission of HIV, or other sexually transmitted infection, from one individual to another as the result of sexual contact.	<ul style="list-style-type: none"> Staff Students 	1.2% (students only)		Annual programme Reports	Annual	HEI
11. Number and percentage of HEI staff and students screened for TB	A screening test for tuberculosis (TB). Purified protein derivative (PPD) extracted from the bacterium that causes tuberculosis is injected just below the skin (intra-dermal). After 48 to 72 hours, a health care professional checks the site of injection for a reaction that indicates that the	<ul style="list-style-type: none"> Staff Students 	38,416 (3.2%)		Annual programme Reports	Annual	HEI

Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Accountability
	person has been exposed to TB. Following a positive TB skin test, additional tests are necessary to determine whether a person actually has active TB (TB disease).						
12. Number of facilities 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 a given administrative area	<ul style="list-style-type: none"> HEIs 	23	23	Annual programme Reports	Annual	HEI
13. Number of HEI health facilities providing treatment for STIs	This indicators measures the number of HEI health facilities providing treatment for STIs	<ul style="list-style-type: none"> HEIs 	23		Annual programme Reports	Annual	HEI
14. Number of students given Morning after pill	This indicators measures HEI health facilities providing Morning after pill	<ul style="list-style-type: none"> Students 	To be determined		Annual programme Reports	Annual	HEI
15. Number of PEP distributed 14.1 Number of staff and students who received PEP	Measures the number of students 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.	<ul style="list-style-type: none"> HEIs 	To be determined		Annual programme Reports	Annual	HEI
16. Number of campus facilities accredited to provide ARVs 17. Number of HEIs distributing ARV treatment	To assess progress towards providing antiretroviral combination therapy to staff and students with advanced HIV infection	<ul style="list-style-type: none"> HEIs 	2	23	Annual Report	Annual	HEI
18. Number of HEI health workers trained in NIMART and TB diagnosis		<ul style="list-style-type: none"> HEIs 	74	All nurses	Annual programme Reports	Annual	HEI
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.							
19. Number of HEIs with operational plans aligned with the HIV policy, strategic framework and minimum standards	To assess progress in the development and implementation of HEI level HIV and AIDS policies, strategies	<ul style="list-style-type: none"> HEIs 	To be determined	23	Institutional Assessment Reports/ Operational plans	Annual	HEI
20. Number of HEIs implementing	Stigma can be described as a dynamic process of	<ul style="list-style-type: none"> HEIs 	To be	23			

Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Accountability
programmes on stigma and discrimination	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.		determined				
		<ul style="list-style-type: none"> HEIs 	To be determined	23	Institutional Assessment Report	Annual	HEIs
21. Number of HEIs with a functional M&E system	HEIs reporting on 80% or minimum routine indicators	<ul style="list-style-type: none"> HEIs 	To be determined	23	Institutional Assessment Report	Annual	HEI
22. Number of HEIs trained in M&E system development and functionality	Track progress on the functionality of the M&E system	<ul style="list-style-type: none"> HEIs 	To be determined		Institutional Assessment Report	Annual	HEI
23. Amount of funding spent by HEIs on the HIV and AIDS programme	This indicators measures progress in terms of institutionalizing and funding the planning instruments	<ul style="list-style-type: none"> HEIs 	To be determined		Annual reports	Annual	HEIs/HEAIDS

SECTION FIVE: PERIODIC EVALUATION

5.1 OVERVIEW

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 each province is 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 M&E should strive to identify, at least generally, the purpose and timing of their evaluations in a comprehensive and coherent manner—and do so 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 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 has elapsed to have something to evaluate, yet enough time remains to apply lessons learned from the evaluation. On the other hand, an evaluation of might be most strategically placed at the beginning of year five if the Provincial Departments wants to extract lessons learned 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 project evaluation in most cases. 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. Categories of analysis:

- **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

5.2 EVALUATIONS

5.1.1 PROCESS EVALUATIONS

Process evaluations focus on gaining a good understanding of how a programme works. They look 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.

Example of questions raised in a process evaluation includes:

Coverage
1. List the activities implemented by the HEI?
2. Who were the Primary beneficiaries of the activities?
3. What were the stated deliverables?
Relevance
4. To what extent are the objectives of the programme still relevant? What changes have taken place?
5. Are the activities and outputs of the project consistent with the overall goal and the attainment of objectives
6. Are the activities addressing the problems and challenges?
7. Are the activities and outputs of the programme consistent with the intended impacts and effects
8. Are the approaches used for addressing the problems responsive to the needs of the groups targeted? How do you know?
Efficiency
9. What forms/methods were used to deliver the activities? How did your HEI implement the activities? How did you implement lessons from the capacity building training on HIV/AIDS? What new knowledge and skills are you using?
10. Were the activities delivered as per the schedule (timeliness, duration)
11. Were the "right" people targeted for the activities? Who attends the capacity building training?
12. Were activities cost-efficient?
13. Were objectives achieved in a timely manner and at the least cost?
14. Was the programme or project implemented in the most efficient way compared to alternative ways?
15. How is the programme organized and managed? Who is managing the programme? Where are women in relation to men in the programme hierarchy? (formal decision-making positions and informal practice)

5.1.2 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 at one end of the spectrum to those who simply measure changes ex-anti and speculate on links between the changes and the programme at the other. Outcome and impact evaluations tend to use experimental or quasi-experimental designs.

Questions for consideration are:

Effectiveness
16. To what extent were the activities achieved? Or are likely to be achieved? What do you think is realistic in terms of short, medium and longer term goals?
17. What are the major factors influencing the achievement or non-achievement of the objectives? Can you tell us anything about shifts in stigma, discrimination, gender based violence?
18. What problems have been addressed as a result of the implementation of the project?
19. What new practices did you implement as a result of the grant received?
Impact
20. What has happened as a result of the activities implemented? What are the signs of shifts in attitudes, behavior and practice?
21. What real difference has the activity made to the beneficiaries? What are the concepts that you are using to measure?
22. How many have been affected? (sex disaggregated data)
Sustainability
23. What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?

5.1.3 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 23 HEIs across South Africa. The study design is 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 will be 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 groups discussions and interviews is also voluntary and no individual identifying information is reported. The data collection tools were tailored to the different target groups, student, academic staff and administrative/service staff. These tools were administered and completed by the respective individual.

DRAFT M & E FRAMEWORK

Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Accountability
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							
24. Percentage of HEIs 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	<ul style="list-style-type: none"> • Staff <ul style="list-style-type: none"> ✓ Academic ✓ Administrative ✓ Service • Students 			KAP Survey/ Behavioural Surveillance Survey	2 years	National
25. Percentage HEIs staff and students who have had sexual intercourse with more than one partner in the last 12 months	Measure of multiple partners	<ul style="list-style-type: none"> • Staff <ul style="list-style-type: none"> ✓ Academic ✓ Administrative ✓ Service • Students 	11% 17% 24% 36%		KAP Survey/ Behavioural Surveillance Survey	2 years	National
26. Percentage of HEIs staff and students who used condoms consistently with one <u>non-regular</u> partner over the past 12 months	Success of prevention – Student and staff programmes in achieving a high number of protected sex acts	<ul style="list-style-type: none"> • Staff <ul style="list-style-type: none"> ✓ Academic ✓ Administrative ✓ Service • Students 	20% 28% 39% 60%		KAP Survey/ Behavioural Surveillance Survey	2 years	National
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							
27. HIV prevalence among staff and students in HEIs	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 a HIV in a given population and at a specific time.	<ul style="list-style-type: none"> • Staff <ul style="list-style-type: none"> ✓ Academic ✓ Administrative ✓ Service • Students 	1.5% 4.4% 12.2% 3.4%		HIV sentinel surveillance	4-5 years	National
28. Percentage of staff and students who continue to be on treatment 12 months after initiation of antiretroviral therapy	Measurement of adherence	<ul style="list-style-type: none"> • Staff <ul style="list-style-type: none"> ✓ Academic ✓ Administrative ✓ Service • Students 	To be determined		Annual Programme Report	Annual	HEI

Indicator	Definition	Disaggregation	Baseline Values	Target 2016	Data Source	Frequency	Accountability
29. Number of HEIs with functioning workplace programmes.	Track progress with respect an level of functionality of the workplace programme in HEIs;	<ul style="list-style-type: none"> HEIs 	To be determined	23	Workplace Evaluation report	Annual	National
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.							
30. Percentage of staff and students expressing accepting attitudes towards people with HIV.	Assesses staff and students expressing accepting attitudes towards people living with HIV.	<ul style="list-style-type: none"> HEIs 	To be determined	23	Institutional Assessment Report/Surveys	2-3 years	HEI
31. Number of stigma cases reported	Trends of stigma and discrimination experienced by people living with HIV	<ul style="list-style-type: none"> HEIs 	To be determined	23	Institutional Assessment Report	Annual	HEI
32. Number of HEI with functional HIV Institutional Coordinating Committees	Track progress in respect of functional HIV Institutional Coordinating Committees	<ul style="list-style-type: none"> HEIs 	23	23	Institutional Assessment Report HEI Annual Report	Annual	HEI
33. Number of HEIs with operational plans that include a communication component aligned to HEAIDS communication strategy	Track progress in respect of communication across HEIs	<ul style="list-style-type: none"> HEIs 	To be determined	23	Institutional Assessment Report	Annual	HEI

SECTION SIX: DATA MANAGEMENT

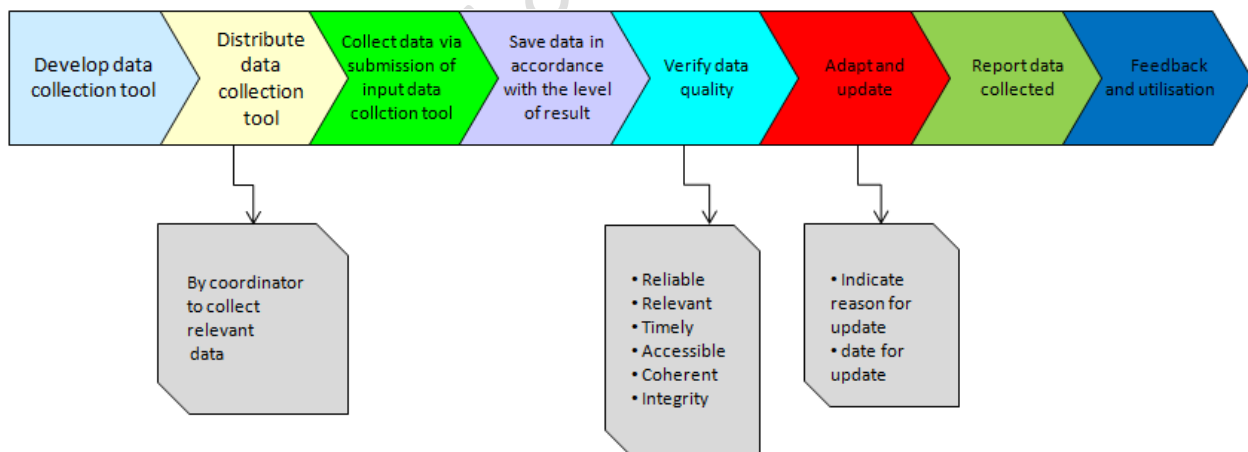
6.1 OVERVIEW

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 of a number of activities that should be conducted. These include:

- (i) Data collection
- (ii) Records management
- (iii) 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:

Figure 13: Schematic Framework of Data Collection Activity



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.

6.2 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 HEADIS will use to aggregate the data from the HEIs. Both HEIADS and the 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 the short, medium and long term indicators.

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 the 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 in the HEI.

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 the HEIs and HEAIDS as this increased 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)

6.3 INFORMATION PRODUCTS AT NATIONAL LEVEL

For effective monitoring and evaluation of the higher education response to HIV/AIDS, the 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:

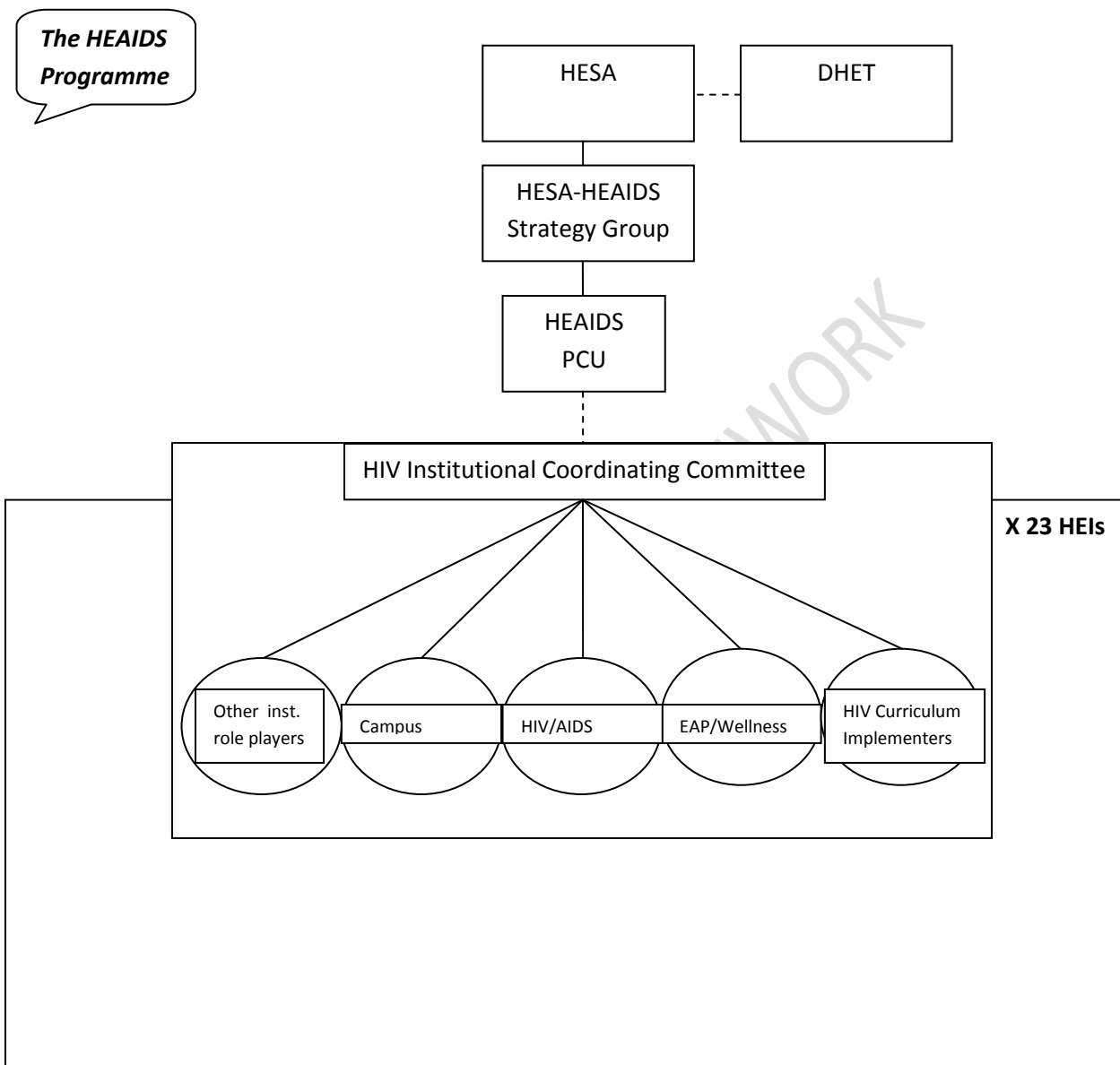
- **Quarterly Service Coverage Report:** This report provides information on coverage statistics per HIV programme area, and is essentially based on the main interventions as envisaged in the Policy and Strategic Framework and the NSP 2012-2016. The report from the HEIs to HEAIDS should conform to the terms of minimum reporting standards, as well as HEAIDS reporting format.
- **Bi-annual Report:** This report provides the semiannual 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 include 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's response to HIV in a year period. The report is done by reporting on 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 SEVEN: STRUCTURE AND MANDATE

7.1 HUMAN CAPACITY FOR THE M&E SYSTEM

- HEAIDS structure to coordinate, capacity building and monitoring of all M & E focal points
- Appointment of personnel from within the HEI through the HICC Chairperson. HEADIS will be capacitate HEI staff on this M&E Framework
- Staff of campus clinics, employees of health and wellness centres, staff responsible for implementing the HIV programmes, HR staff responsible for HIV and AIDS at institutional level and staff involved with the academic curriculum in HIV and AIDS. Staff selected from these operating units will be capacitated by HEAIDS and will be responsible for collection and reporting on unit based information.
- Training and Development - capacity building sessions will be conducted for M&E focal persons in HEI.
- Development of capacity building material to assist in on-going skills building and training in areas including 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 HEIs
- HEAIDS will collect and consolidate the data into a quarterly report to be submitted on a quarterly basis or annually.

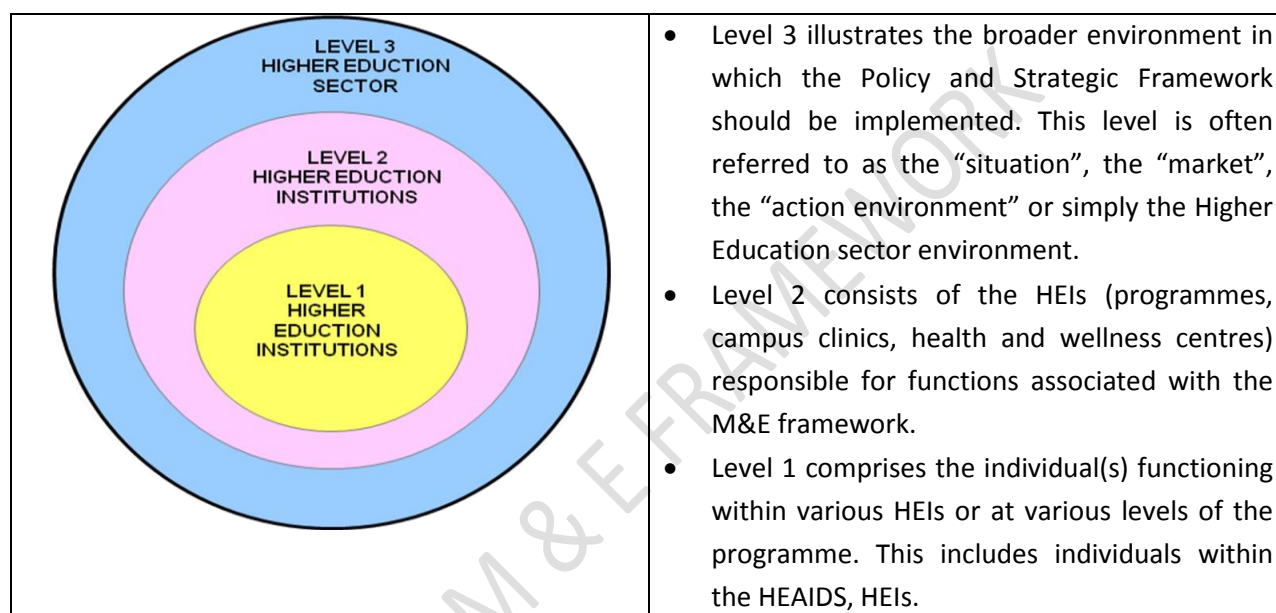
Figure 14: HEAIDS Organogram



Capacity building or capacity development is focused on three levels, including the individual, organizational 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 the capacity is limited to effectively and efficiently implement the proposed M & E Framework. HEAIDS is committed to strengthening M & E capacity in both the immediate short-term and in the Long term at the HEIs. The diagram below illustrates the three-fold focus of Capacity and Capacity Development.

Figure 15: Human Resource



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

The training strategy and plan should be relevant to the programme.

The Capacity building should focus on some of the following elements:

- Context of Monitoring and Evaluation
- Planning – Results Based Management
- Monitoring and Evaluation Models
- Developing Logic Models
- Developing Indicators

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

7.2 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 the M&E are as follows:

Table 1: Functions required for better implementation of M & E

FUNCTIONS	DESCRIPTION OF FUNCTIONS
FUNCTION ONE: Planning, Monitoring, Evaluation and Reporting	<ul style="list-style-type: none"> • Planning <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. • Monitoring <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 • Evaluation <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) • Reporting <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.

FUNCTIONS	DESCRIPTION OF FUNCTIONS
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 • The 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.

7.3 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 goal. 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 perform a support role.

Table 2: Role 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 data collection tools, coordinate implementation of the M&E Framework, collate and verify HEI data and draft routine periodic reports
HEI LEVEL RESPONSIBILITIES	
HICC Chairperson/Director	The HICC Chairperson/Director will be responsible for mentoring and oversight of HEI performance and for ensuring that desired outcomes and impacts are achieved. Also provide the bodies to which they are accountable with detailed regular reports on the performance against its Mandate.
HICC Manager	The HICC Manager /Coordinator will be responsible for mentoring and assisting the M&E Focal person on an ongoing basis. The HICC Manager /Coordinator will assist with data verification and validation.
M&E Focal Person/ HIV and AIDS Unit Coordinator	Each HEI needs to identify the M&E Focal Person/HIV and AIDS Unit Coordinator to perform the day to day M&E activities especially collecting, capturing, verifying and using data and information towards performance accountability 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 responsibility for documenting information gathered at primary source

7.3.1 COORDINATION OF THE M&E PARTNERSHIP

To ensure the effectiveness of the M&E partnerships an M&E Reference Group (RG) will be formed to play a coordinative role. The M&E Reference Group 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 to M & E, ideally to discuss technical M&E developments and challenges in the sector. The aim of the Reference Group will be to lead and guide the successful implementation of the M&E Framework for the implementation of the Policy and Strategic Framework. The work of the Reference Group will be based on Terms of Reference which will guide the constitution of the Forum and other institutional arrangements.

7.3.2 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 overarching objective is to obtain buy in to 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 source, effective transmission and is effectively delivered to intended recipients
- **M&E Culture**- shared set of values, conventions, or social practices associated with M&E

DRAFT M & E FRAMEWORK

SECTION EIGHT: CONCLUSION - IMPLEMENTATION OF THE M&E FRAMEWORK

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

- **Developing and building consensus on a 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 the M&E units at the HEIs** through the capacity strengthening workshops to strengthen the capacity of HEIs on data analysis, estimates and projections.
- **The execution of this 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 the various activities in this plan by HEAIDS and the support from HEIs and other stakeholders like the Department 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 the HEIs to develop a data management systems;
 - Carrying out supervision and data audit;
 - Establishing a functioning resource center including virtual library;
 - Organizing workshops / seminars to establish and enhance the culture of M&E, e.g. targeting advocacy and sensitization.
- **Strengthening Data Collection, Analysis and Reporting** This component targets making data collection, analysis, and reporting more efficient and timely. Besides, it is to enhance the quality of data and make it available for decision making and programming for the HIV/AIDS activities. The specific areas of interventions include:
 - Develop national HIV M&E operational guide (User's guide)
 - Develop the HEI level M&E annual data collection plan – with clear activities and timeframe;
 - Establishing a baseline for core HIV/AIDS indicators, where there are not available;
 - Developing and building consensus on a standardized, user friendly data collection instrument (s) and reporting formats;
 - Establish Data Quality Assessment Protocols.
- **Strengthening coordination of HIV/AIDS Research and Surveys** - This component aims at enhancing the coordination of the HIV/AIDS research. Specific activities include the following:

- Development of the HIV/AIDS research protocol / norms;
 - Finalizing the development of higher education HIV/AIDS research strategy;
 - Identifying and coordinating the carrying out of strategic research
 - Enhancing reporting and dissemination of research results to, national and provincial forums including publication of research articles.
- **Coordinating Regional and National Consultative Meetings and Reviews of the HEAIDS M&E Plan -**
 This component of intervention targets 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:
 - Organize the annual national stakeholders meeting on the HIV/AIDS response;
 - Organize workshops for the dissemination and discussion of results with HEIs and Provincial AIDS Councils;
 - Organize dissemination workshops for sharing good practice and lessons learned in the HIV/AIDS programme activity monitoring and HEI responses;

Annexure one of this M&E framework details the activities that need to be considered by HEAIDS and the HEIs over the next two years. The activities target the strengthening the monitoring and evaluation 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.

ANNEXURE ONE: DATA COLLECTION TOOLS

DRAFT M & E FRAMEWORK

ANNEXURE TWO: LOGIC MODEL

Components	Result Statement		Sector indicators	Institutional indicators
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 epidemic drivers of the pandemic				
impact	Reduced new HIV infections		HIV prevalence among staff in HEIs	
			HIV prevalence among students in HEIs	
Medium – term Outcome	Reduced vulnerability of HE students and staff to HIV and AIDS			Number of HEIs students vulnerable to HIV
				Number of HEIs staff vulnerable to HIV
To ensure the comprehensive and appropriate use of the Higher Education mandate and intellectual response	Short-term Outcome	Increased capacity of people to demonstrate safer sex behaviour and knowledge	Percentage of HEIs students who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Percentage of HEIs students who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
			Percentage of HEIs staff who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Percentage of HEIs staff who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
			Percentage HEIs Students who have had sexual intercourse with more than one partner in the last 12 months	Percentage HEIs Students who have had sexual intercourse with more than one partner in the last 12 months
			Percentage HEIs Staff who have had sexual intercourse with more than one partner in the last 12 months	Percentage HEIs Staff who have had sexual intercourse with more than one partner in the last 12 months
	Short-term Outcome	Increased capacity of people to demonstrate safer sex behaviour and knowledge	Percentage of HEIs Students who used condoms consistently with one non-regular partner over the past 12 months	Percentage of HEIs Students who used condoms consistently with one non-regular partner over the past 12 months
			Percentage of HEIs Staff who used condoms consistently with one non-regular partner over the past 12 months	Percentage of HEIs Staff who used condoms consistently with one non-regular partner over the past 12 months
	Short-term Outcome	Development of an integrated HIV and AIDS Curriculum across all disciplines in HEIs		Number of HEIs with an integrated HIV and AIDS Curriculum across all appropriate disciplines
	Develop and implement appropriate, innovative and effective HIV and AIDS combination prevention strategies for the	Short-term Outcome	Increased access to comprehensive combination prevention programmes for staff and students across all HEIs	Percentage of HEIs students reached with HIV prevention programs
Percentage of HEIs staff reached with HIV prevention programs				
Short-term Outcome		Increased reached through HIV, AIDS, STI, and TB awareness		Number of staff reached with HIV, AIDS, STI, and TB awareness campaigns

Components	Result Statement		Sector indicators	Institutional indicators	
Higher Education sector.		campaigns;		Number of students reached with HIV, AIDS, STI, and TB awareness campaigns	
	Short-term Outcome	Increased implementation of Peer Education activities by HEIs		Number of HEIs implementing Peer Education activities	
	Short-term Outcome	Increased distribution of male and female Condoms		Number of male condoms distributed in HEIs	
				Number of female condoms distributed in HEIs	
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.					
Develop and implement a comprehensive health and wellness HIV and AIDS programme aiming to promote and maintain the physical and mental health of students and staff within the sector.	Impact	Increased longevity of PLHIVs after initiating treatment	Percentage of students on treatment 12 months after initiation of antiretroviral therapy	Percentage of students on treatment 12 months after initiation of antiretroviral therapy	
			Percentage of staff on treatment 12 months after initiation of antiretroviral therapy	Percentage of staff on treatment 12 months after initiation of antiretroviral therapy	
	Medium – term Outcome	Efficient and effective management and treatment of staff and students at HEIs	Number of HEIs with referral systems managing treatment and care of staff	Number of HEIs with referral systems managing treatment and care of staff	
			Number of HEIs with referral systems managing treatment and care of students	Number of HEIs with referral systems managing treatment and care of students	
	Short-term Outcome	Increased uptake of HTC by staff and students across HEIs	Percentage of HEI Students who received an HIV test in the last 12 months and who know their results	Percentage of HEI Students who received an HIV test in the last 12 months and who know their results	
	Short-term Outcome		Percentage of HEI Staff who received an HIV test in the last 12 months and who know their results	Percentage of HEI Staff who received an HIV test in the last 12 months and who know their results	
	Develop and implement a comprehensive health and wellness HIV and AIDS programme aiming to promote and maintain the physical and mental health of students and staff within the sector.	Short-term Outcome	Increased uptake of TB screening services by staff and students across HEIs		Percentage of HEI staff screened for TB
					Percentage of HEI students screened for TB
Increased uptake of STI screening services by staff and students across HEIs				Percentage of HEI staff screened for STIs	
				Percentage of HEI students screened for STIs	
Increased access to on-going counseling around living positively with HIV and AIDS and other forms of social support;			Number of HEIs providing social support to PLWHIV	Number of HEIs providing social support to PLWHIV	
Increased number of HEIs accredited to provide TB treatment			Number of HEI health facilities accredited to provide TB treatment and supervision of DOTS	Number of HEI health facilities accredited to provide TB treatment and supervision of DOTS	
Increased provision of Syndromic management of STIs;			Number of HEI health facilities providing treatment for STIs	Number of HEI health facilities providing treatment for STIs	
	Increased provision of dual		Number of students given Morning after		

Components	Result Statement		Sector indicators	Institutional indicators
		contraception by HEIs		pill
				Number of students on PEP
		Increased accreditation of HEIs to provide ARV treatment and care	Number of HEIs providing ARV treatment	Number of HEIs providing ARV treatment
		Increased number of accredited Campus Health Services to administer ARV treatment.	Number of facilities accredited to provide ARVs	Number of facilities accredited to provide ARVs
		Strengthened capacity of Campus Health Services based on the norms and standards	Number of HEI health workers trained in NIMART and TB diagnosis	Number of HEI health workers trained in NIMART and TB diagnosis
Strengthen existing HIV and AIDS Workplace programmes for Higher Education institutions	Short-term Outcome	Strengthened existing HIV and AIDS Workplace programmes for Higher Education that will reduce the negative impact of the HIV on all individuals employed by the institutions	Number of HEIs with an workplace plan to operationalise the national HIV workplace strategy Number of HEIs with functioning workplace programme	Number of HEIs with an workplace plan to operationalise the national HIV workplace strategy Number of HEIs with functioning workplace programmes.
		Increased provision of Work Place Peer Education training		Number of HEIs who have conducted Workplace Programme on Peer Education training

Component	Result Statement		Sector indicators	Institutional Indicators
OBJECTIVE 3: 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.				
Impact	Increased commitment of strategic leadership in HIV and AIDS programmes across HEIs		Number of HICC chaired by executive management	Number of HICC chaired by executive management
			Number of HEIs with corporate governance strategies that address HIV	Number of HEIs with corporate governance strategies that address HIV
Ensure and mobilize strategic leadership through all participants of the Higher Education sector	Increased functionality of HEI corporate governance in respect of HIV and AIDS programmes		Number of HEI with functional HIV Institutional Coordinating Committees	Number of HEI with functional HIV Institutional Coordinating Committees
			Number of HEI with representative HIV Institutional Coordinating Committees	Number of HEI with representative HIV Institutional Coordinating Committees
	Short-term Outcome	HEIs operational plans on HIV and AIDS aligned with the Higher Education HIV and AIDS Policy, Strategic Framework and minimum standards developed	Number of HE institutions with operational plans aligned with the HIV policy, strategic framework and minimum standards	Number of HE institutions with operational plans aligned with the HIV policy, strategic framework and minimum standards
		HEI implementation of operation plans and minimum standards strengthened		No of universities implementing HIV operational plans and minimum standards

Component	Result Statement		Sector indicators	Institutional Indicators
OBJECTIVE 3: 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.				
Reduce and eliminate acts of stigma and discrimination through the promotion of equity, fairness and respect for self and others.	Short-term Outcome	Reduced acts of stigma and discrimination including gender discrimination through the promotion of equity, fairness and respect for self and others.	HEI rating in accordance with the Stigma Index	Number of stigma cases reported
	Short-term Outcome	Increased number of HEIs with a developed programme of action that covers innovative and established methods of stigma elimination.	Number of HEIs implementing programmes on stigma and discrimination	Number of HEIs implementing programmes on stigma and discrimination
	Short-term Outcome	Increased number of HEIs with training modules on HIV and AIDS, STIs and/or TB that deal with unfair discrimination, to all key populations		Number of targeted HIV and TB interventions for all key populations
		Increased number of HEIs with a comprehensive approach to address gender inequities and gender-power issues, focusing on key risk groups such as first year students.	Number of HEIs with a comprehensive approach to address gender inequities and gender-power issues	Number of HEIs with a comprehensive approach to address inequities and power issues, focusing on first year students.
Ensure coherent and consistent communication within and outside the sector.	Short-term Outcome	Improve coherent and consistent communication within and outside the sector that serves to encourage positive attitudes and behaviors and to promote and to sustain change	Number of HEIs with operational plans that include a communication component aligned to HEAIDS communication strategy	
			Number of HEIs implementing the targeted HEAIDS communication activities	
		Increased production and dissemination of quality research to provide scientific evidence to guide policy and enhance the national response to HIV and AIDS at all societal levels.		Number of HEIs with a HIV research and evaluation agenda
				Number of HEIs undertaking HIV-related research and evaluation studies
				Number of HEIs which utilize research and evaluation findings to inform programmes and decision making (dissemination, annual information sharing)
		Improved collaboration with government departments, and key non-governmental agencies in order to share information and expertise on	Number of HEAIDS partners collaborating in the implementation of the HIV and AIDS programme for HEIs sector	

Component	Result Statement	Sector indicators	Institutional Indicators
OBJECTIVE 3: 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.			
		HIV and AIDS.	
		Improved appropriate allocation of resources	Amount of funding allocated to the HEIs components of operational plans
Develop comprehensive Monitoring and Evaluation systems.	Short-term Outcome	Increased functionality of national and institutional M&E systems	Number of HEIs with a functional M&E system
			Number of HEIs trained in M&E system development and functionality
			Number of HEIs that provide reports using harmonized data collection tools
			Number of HEIs participating in the Data Quality Audits