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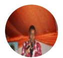
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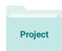

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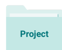

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# Challenges of HIV/AIDS education in a South African rural-based university

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**Abstract**

Whilst it can be confidently assumed that institutions of higher education are attempting to mainstream HIV/AIDS into the curriculum, the impact of doing this as far as reducing HIV infections is concerned is simply not visible. This can be seen by the continued increase in HIV infections and the persistence of behaviour that increases the risk of infection among university students. The purpose of the study was to explore and describe approaches used in a South African, rural-based university for HIV/AIDS education. A qualitative design using descriptive, contextual and exploratory approach was undertaken. In-depth, face-to-face interviews and focus group discussion were conducted with key informants such as students, HIV/AIDS coordinators, campus health personnel and health promoters. The data were analysed according to the guidelines suggested by Tesch. Although the institution had several approaches to HIV/AIDS education, the findings suggest that these approaches failed to yield positive results. The study found evidence of stigma and discrimination on campus, limited access to HIV/AIDS programmes by academics, and high-risk sexual behaviour. The HIV/AIDS education is also negatively affected due to inadequate financial, infrastructural and, human resources. It was concluded that HIV/AIDS education approaches should take into consideration the rural-based university community and the context of the risk of HIV infection for this community

**Keywords:** HIV/AIDS education, South Africa, rural-based University, sexual behaviour.

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## Introduction

Universities are considered to be high-risk areas for HIV infection (Ochanda, Njima & Schneegans, 2006). Otaala (2007) reported that universities in Africa have a high transmission rate owing to the prevalence of high-risk sexual behaviours. These behaviours include “Sugar-daddy” practices, sexual experimentation, prostitution on campus, unprotected casual sex, concurrent sexual partners, and gender violence. This was confirmed by the Higher Education HIV/AIDS Programme (HEAIDS) (2010a) which reported that universities are considered to be high-risk areas for HIV infections simply because students who are away from home tend to engage in high-risk sexual

behaviour. The HEAIDS report further revealed that there was a significant problem of a high HIV infection rate amongst university non-academic staff. HIV/AIDS obviously has a detrimental effect on universities because it increases a university's operating costs, reduces productivity, diverts resources and poses a threat to a university's source of income (Katjavivi & Otaala, 2003; Kelly, 2001). The findings of this report were confirmed by Katahoire and Kirumira (2008), who stated that the HIV/AIDS epidemic negatively affects universities in terms of both their functions and operations.

Higher Education South Africa (HESA) established the HEAIDS programme to ensure that higher educational institutions mitigate the spread of HIV (HESA, 2008). The emphasis has been on the development and implementation of curriculum innovation strategies with regards to HIV/AIDS education programmes, including curriculum integration and professional development. HEAIDS recommended that higher education ensures that students are educated about HIV/AIDS for reasons relating to their own personal protection (HEAIDS, 2010b). Despite several recommendations from different organisations and authors for the integration of HIV/AIDS into the curriculum, studies show that most lecturers teach HIV/AIDS purely on the basis of their personal interest in the subject, and that there are no measures in place to monitor or measure the impact of such education on the university community (Auerbach, Byram & Kandathil, 2005). HEAIDS (2004) report indicated that a South African rural-based university in Limpopo Province has been involved in HIV/AIDS education since 2003.

The purpose of the HIV/AIDS education was to mitigate the spread of HIV through promoting safe sexual behaviour. Despite the statistics of university HIV/AIDS unit statistics reflects that students still engage in risky sexual behaviours as shown by: an increase in the demand for emergency contraceptives (48 in 2004; 277 in 2011), in those who test positive (12 in 2004; 52 in 2011), and in the number of students treated for STIs (154 in 2005; 279 in 2011) while the university enrolment has declined. These statistics imply that people still engage in risky sexual behaviours despite the availability of HIV/AIDS education programmes in universities. Therefore, the purpose of the study was to explore and describe approaches used by the University for HIV/AIDS education.

## Methodology

A qualitative design using descriptive, contextual and exploratory approach was undertaken to explore and describe approaches used by the University for HIV/AIDS education. Two different data collection methods were used, i.e. In-depth, face-to-face interviews and focus group discussion.

*Study setting*

The study was conducted at a South African rural-based university in the Limpopo province. Historically, South Africa's rural-based universities are predominantly black universities established during the apartheid era in the former homelands.

*Sampling and sample size*

A non-probability purposive sampling method was used to select informants for the face to face interviews. The researcher used their own judgement to decide who would have relevant information about HIV/AIDS education on campus. Informants were selected if they were involved in HIV/AIDS programmes and policy-making at various levels in the university, if they participated in any HIV/AIDS education activity organised by the university, they were recipient of HIV/AIDS education provided by HIV/AIDS unit or campus health centre, and they were students at the university in any school and enrolled in any degree programme. A maximum sample variation was preferred, because this allowed various voices to give input (Patton, 1990). Eighteen in-depth face-to-face interviews with selected informants were subsequently undertaken.

Focus groups informants were purposively selected from among the university students who attended an HIV/AIDS information workshop (these students were enrolled in different departments within the university). Two focus group discussions were conducted and each consisted of four males and four females. The groups were composed of students of various ethnic groups at different programme levels in the University.

*Data collection*

Data were collected between January and March 2012 using in-depth individual interviews, focus group interviews and documentary reviews. A core question, i.e. "What do you think of the HIV/AIDS education at this university?" was posed to the 18 informants for individual interviews as well as the focus group discussion to elicit in-depth responses. Interviews were audio-recorded with participants' consent.

*Measures to ensure trustworthiness of data*

Strategies described in the literature to ensure trustworthiness were applied (Polit & Beck, 2008). Credibility was ensured through prolonged engagement, reflexibility and triangulation of data, using independent coding, peer evaluation and through the researcher's experience in the field of HIV/AIDS. To ensure dependability, raw data were given to an independent coder. The coding process

was evaluated at different phases by two independent coders. Neutrality was ensured through the strategy of conformability (Krefting, 1990) by keeping appropriate distance between the researcher and informants to avoid influencing the findings. Data were coded and recoded several times and compared with the themes and categories identified by the independent coder. Inconsistencies were discussed to reach consensus.

*Ethical considerations*

Ethical clearance was granted by the Health, Safety and Research Ethics Committee of the University. The informants were fully informed about the purpose of the research and voluntary consented to participate in the study. The informants' right to confidentiality was maintained by the use of pseudonyms. Permission was also granted to review the documents from the HIV/AIDS unit.

The audio-recorded information was reviewed and transcribed by the first author so that it was available for the independent coder. The responses of different informants were discussed without revealing their identities or positions on campus. Throughout the focus group interviews, emphasis was on mutual respect and respect for each individual's viewpoint and inputs.

## Results and Discussion

The data collected from the interviews were subjected to analysis following the guidelines of Tesch in Creswell, 2009) and Lacey and Luff (2007). These guidelines include familiarisation with data, transcribing and organising data, and coding data (which involves open coding, conceptual coding, categorising data and identifying themes and relevant categories).

The documents reviewed offered descriptive information, verified emerging hypotheses, advanced new categories, offered historical understandings, and helped to track change and development about HIV/AIDS education at the university, thereby facilitating triangulation of data.

Shown in Table 1 are the themes and categories which emerged from the interviews and focus group discussions.

**Table 1:** Themes and related categories

| Themes | Categories |
| --- | --- |
| Approaches used for HIV/AIDS education and curriculum integration | Workshops on HIV/AIDS information<br>Health promotion<br>Peer education<br>Support group meetings for people living with HIV and AIDS<br>HIV/AIDS awareness campaigns<br>Community outreach<br>Integration of HIV/AIDS into the curriculum |
| The impact of HIV/AIDS education and curriculum integration | Persistence of stigma and discrimination on campus<br>HIV/AIDS education programmes not reaching university staff members<br>Sending of negative messages that promote high-risk sexual behaviour<br>Health promoters HIV/AIDS education biased towards specific groups<br>Persistence of high-risk sexual behaviour |

## Theme 1: Approaches used for HIV/AIDS education and curriculum integration

The informants seemed eager to talk about the approaches and indicated the need for more to be done to promote accessibility to all the students. Results showed that the university used the following in its approach to HIV/AIDS education: workshops, health promotion, peer education, awareness campaigns, community outreach and gradual integration of HIV/AIDS into the curriculum.

*Category 1.1 Workshops on HIV/AIDS information*

HIV/AIDS unit staff were involved in facilitating workshops to students and staff on HIV/AIDS, as can be seen in the following remarks captured during an interview:

*"When we did the budget for campus health unit, there are items which we know that this items are done by HIV/AIDS unit like training, what else, especially training and workshops. Workshops are often done by HIV/AIDS unit."*

The university offers HIV/AIDS training workshops to students and staff in line with literature (Thom & Cullinan, 2003). Consistent with other findings (Hall, 2006), the majority of staff members trained were service workers. The fact that university is offering the training to its staff and students indicates the seriousness of the institution in mitigating the impact of HIV/AIDS.

*Category 1.2 Health promotion*

Health promotion was identified as another approach to HIV/AIDS education. Health promotion is championed by health promoters who are people living with HIV and AIDS (PLWHA) employed by the university to live openly with HIV and AIDS. The responsibilities of health promoters were indicated by the following remarks:

*"I coordinate the peer educators which helps me with all the campaigns which are run at the campus which are either awareness campaign or even, events or outreach programmes. When people come for voluntary counselling and testing, we have to counsel them before they can be tested. The most important thing for me is to promote positive living so that people can be encouraged to know their HIV status so that they can know what to do whether they are positive or negative."*

The utilisation of health promoters in the HIV/AIDS programmes is in accordance with recommendations in the literature (HEAIDS, 2010c). The involvements of PLWHA in the HIV/AIDS programme make people realise the reality of HIV which by itself can be a preventative strategy.

*Category 1.3 Peer education*

The findings revealed that the university had a peer education programme for both staff and students. This was confirmed by the following statement from one of the participants:

*"Peer educators ... they are doing condom distribution and they did on the condom and STI month, and they do door to door campaign and in recess, and they do word of mouth outside during their free time. I mean their spare time and their lunch time."*

These results are in accordance with the findings of HEAIDS (2004), and Thom and Cullinan (2003) that universities train students to be peer educators who spread the message of safer sex to other students. Involvement of students is a positive move for the university as students understand their peers better than adults or other people who are not in their age category.

*Category 1.4 Support group meetings for people living with HIV and AIDS*

The findings also revealed that the university had a support group that held regular meetings. In these meetings, PLWHA share information and their experiences. One participant had this to say about support group:

*"So for those whom we find that they are already infected with HIV, what we do is we provide them with on-going counselling and support whereby we have our special meetings once a month and even during the month we have mini support groups where we support each other by sharing information."*

The findings concerning support groups and mini support groups differ from those of several studies which do not mention the presence of support groups as part of their programmes on university campus (Ambe-Uva, 2007; Auerbach et al., 2005; Hall, 2006). Aspects of support group where PLWHA share their own challenges and experiences is the most important teaching and support strategy. It also strengthens those who are still newly diagnosed especially when they see people other people who are healthy though living with HIV. For students it is also a motivational factor when the first year students meet with other students who are at honours or master's level who were also diagnosed with HIV during their first year at the university.

*Category 1.5 HIV/AIDS awareness campaigns*

Several awareness campaigns were held in the university often in partnership with other organisations like Love Life, as can be confirmed in the following statement:

*"I don't know if I should say this. There is also One Love which is initiated by Soul City but, they want us as students to be involved in talks, marches, campaigns or whatever we can do to help students to understand that having one love is important."*

HIV/AIDS awareness campaigns are a means of reaching many people with HIV/AIDS information at once. Though it is not easy to evaluate the impact there of regarding HIV prevention. These findings concur with results of other studies which indicated that HIV/AIDS awareness campaigns are one of the programmes offered by institutions of higher education (Dube & Ocholla, 2004; Ambe-Uva, 2007).

*Category 1.6 Community outreach*

The university is also involved in community outreach programmes to different organisations including schools and churches. One of the participants confirmed that:

*"With our outreach, we normally go to local schools or wherever we got invited. We go to churches, we go to community centre, anywhere where we can find a group of people that we can address and given a platform, we always go, we never refuse any invitation."*

Conducting community outreach is part of the university mandate to empower its immediate community. It is also a good approach to reduce the spread of HIV as the university community belongs to the university neighbourhood and some of their sexual partners are in the community. Addressing the learners at local schools is a good strategy to ensure that the future university students are knowledgeable about HIV prevention strategy which can save them from unnecessary HIV infection which usually occurs among the first entering students during the registration and orientation period. This finding concerning community outreach by university members is consistent with is reported in the literature about other universities (HEAIDS, 2004; Thom & Cullinan, 2003; USAID Health, 2003).

*Category 1.7 Integration of HIV/AIDS into the curriculum*

The results showed that the university was to a certain extent, in the process of integrating HIV/AIDS into the curriculum. The following remarks indicate the extent of this integration in the different departments:

*"In the school of social work, we deal with these things. ...when we go for the field work we start working there, we deal with almost all this things related to HIV/AIDS, maybe of counselling client and patients with HIV/AIDS."*

The lack of uniformity in HIV/AIDS education means that while some students graduate being well equipped with HIV/AIDS information, which can be a good strategy to also rollout the information to wherever the graduate may be in other disciplines, a student may even graduate without any relevant information regarding HIV. This may have a negative impact in the workplace. This lack of uniformity in the strategies that faculties use to address HIV/AIDS education only in those modules which they regard as appropriate has also been highlighted in previous studies (Auerbach et al., 2005; Clarke, 2008).It is apparent from the findings that the university is using different approaches to HIV/AIDS education. The use of different HIV/AIDS education approaches has also been previously reported (Ambe-Uva, 2007).

**Theme 2: The impact of HIV/AIDS education and curriculum infusion**

HIV/AIDS education and curriculum infusion if strategically implemented may hugely impact the lives of students and employees. With regards to the effectiveness of HIV/AIDS education, the results indicate minimum impact of the different educational methods. This is evidenced by the persistence of stigma and discrimination; limited response by staff members; promotion of negative messages, bias towards a specific group or ethnic group, presence of the myths related to HIV/AIDS, persistence of high risk behaviour, and reluctance of students to seek information.

*Category 2.1 Persistence of stigma and discrimination on campus*

Heath promoters play a role in addressing the stigma and discrimination targeted towards PLWHAs, as indicated in the following statement:

*"I try to make HIV as normal as it can be so that people would not be afraid of me. Not that they are afraid, people are getting used to it and when I stand up, they just see me as a normal person, and whatever I do, they see it as normal. They even forget that I have HIV unless I get sick."*

However, other informants feel that stigma and discrimination against PLWHA still exist at the university. One participant claimed that the persistence of stigma is due to the rural nature of the university and its patriarchal orientation:

*"The stigma of HIV has to be killed around campus because ... I think this university is in such a rural area where the people are still very cultural about everything where a man is very empowered than a woman and as young stars we have grown up with that tendency of saying a man is more powerful than a woman which is all wrong if that can be sorted out first, and we can be able to deal with the stigma."*

Although the university had established a health promoters' programme to reduce stigma and discrimination, in compliance with the policy of the South African National AIDS Council (SANAC, 2007), the evidence indicated that stigma and discrimination are still rife on campus. The presence of stigma can fuel the spread of HIV on campus as some people will be reluctant to undergo HIV test, and those who are HIV positive may not seek support or disclose the status to their partners.

*Category 2.2 HIV/AIDS education programmes not reaching university staff members*

Results indicated that health promoters and peer educators fail to reach staff members as indicated in the following statement:

*"I have seen a couple come, but is not even majority but minority of the staff coming to test and usually come to test when there are free beads to be given out."*

The limited focus on university staff members may be related to staff attitudes towards health promoters, as can be seen in the following informant's response:
*"The response from staff members is so bad; they never attend most of our events even when we do go to their offices. You can even see with their attitude that people are not interested in a way. Our staff members the way they are*

*acting or behaving, I don't know whether is because of little knowledge or ignorant, they will make you feel that you are just wasting your time."*

The limited focus of HIV/AIDS education programmes on staff members exemplifies the findings of the HEAIDS (2004; 2010a) audit report. Majority of staff members were between the ages of 24 -49 years, a group with typically very high incidence of HIV as they are in stable relationships and of child bearing age, which makes condom usage a challenge. If they are not given proper information related HIV prevention, the importance of testing and positive living, the output of the university may be negatively affected due to absenteeism related to opportunistic infection, with resultant early retirement and even death.

*Category 2.3 Negative messages that promote high-risk sexual behavior*

Results indicate the portrayal of behaviours by health promoters which may promote messages contributing to the spread of HIV. This may be related to the age of the health promoters who are employed while they are too young and still need to explore issues related to their sex life. This view is supported by the following statement:

*"Since is my first pregnancy here, I don't know about the management except that I'm getting complaints coming from them through my supervisors but ... with the students, I think I am empowering students with HIV who are living positively with HIV who want kids, who have got rights to have babies and, I'm like their role model. And to those who are not positive, they see that I am still human though they still want to understand how can one who is positive have a child, so I have to do some explaining."*

This aspect of promoting negative message may be related to the age of Health Promoters who are employed being at young age where they also need to explore their sexual life. The challenge with such practice is that it may encourage more students who are HIV positive to also fall pregnant which may affect their academic progress and even their health status. Results further indicate that students were reluctant to obtain information from peer educators since some peer-educators' lifestyles did not portray positive sexual behaviour:

*"I went to the class having that thing written Peer Educator, they said to me, how can you counsel us because you are already having a boyfriend. What are you going to tell me? What are you going to teach me?"*

Apart from health promoters and peer educators, there are allusions to the fact that some lecturers actually encourage behaviour that promote the risk of contracting HIV. This is illustrated in the following statements:

*"Because if they are failing, they will teach you different things, they will tell you about "monate". Most of the things that are encouraged here is monate. Monate is having good time, fresher's ball, drinking, bashes whatever. They will encourage those things. Some of the lecturer even tell you to have at least a boyfriend ... They teach such type of things."*

These findings are unique to this study. Aspects of promoting life which increase the risk of HIV infection may be related to limited HIV/AIDS information given by the lecturers who may have graduated without relevant HIV information. Such practices if not curbed may contribute to further spread of HIV as students may consider it as a normal way of life at tertiary institutions.

*Category 2.4 HIV/AIDS education biased towards specific groups*

Health promoters spend more time with their close friends and people of their own ethnic groups rather than doing what they should, which is concentrating on the entire university community. For example, one of the informants made the following statement:

*"Since I was a student here, I focus on my friends, and a whole lot of Shangaan speaking people. Those are the people I frequently communicate with regarding HIV/AIDS information.*

The findings above indicate that although the HIV/AIDS education programme in place at the university's HIV/AIDS awareness has improved generally, but the programme suffers from certain short comings. These include not reaching staff, focusing mainly on friends and people of the same ethnic group, and the unintentional promotion of contradictory messages which, in fact, end up defeating the whole purpose of the HIV/AIDS education programme at the institution.

There is also evidence of ignorance among students with disabilities as far as HIV/AIDS programmes are concerned. The following report by one of the informants gives an indication of some of the most common reactions by students with disabilities towards HIV/AIDS prevention messages:

*"Oh, we need to do away with the thought of our disabled students who said the AIDS won't affect us or we won't be infected because we are disabled and so forth, and so forth."*

The findings related to myths about disabled students in which it is erroneously believed that they are immune to HIV, has also been reported in the literature, i.e. that there is increased vulnerability of disabled children to sexual abuse due

to their inability to protect themselves and the myth that deaf people cannot be infected and which makes them targets for 'cleansing purposes' (Coombe, 2000).

*Category 2.5 Persistence of high-risk sexual behaviour*

Results also indicated that the HIV/AIDS education programme in place had, in fact, a limited positive effect on the reduction of high-risk sexual behaviour for instance, a participant stated as follows:

*"The pregnancy around the campus really shows that people are sleeping around without using the condom. You find that they are being impregnated by another guy who was dating another one. And you find another guy even impregnating two ladies at the same time. These shows that people are ignorant."*

These findings are also consistent with previous reports (Chetty, 2001; HEAIDS, 2004) as non-condom use contributes to large numbers of unplanned pregnancies, abortions, STIs, as well as HIV/AIDS (Parker, Makhubele, Ntlabati & Connolly, 2007; Stevens, 2008). Lack of behaviour change is also confirmed by Otaala (2007) who indicated that, while awareness campaigns improve knowledge, they do not improve behaviour.

## Conclusion

In this study the rural-based university had several approaches to HIV/AIDS education. These approaches included workshops, health promotion, peer education, support group meetings, awareness campaigns, community outreach and the gradual integration of HIV/AIDS into the curriculum. However, the findings of this study suggest that these approaches have failed to yield positive results, as evidenced by the persistence of stigma and discrimination on campus, limited access to HIV/AIDS programmes by university staff members, the promotion of negative messages, programmes biased towards specific ethnic groups, the persistence of certain HIV/AIDS myths, and unabated high-risk sexual behaviour. All challenges concerning ineffective HIV/AIDS education are related to specific organisational challenges like inadequate infrastructure human resources and funding for HIV/AIDS education programmes and policy issues. Therefore, the HIV/AIDS education approaches used in the university do not address the contextual challenges that predispose the rural-based university community to the risk of HIV infection.

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