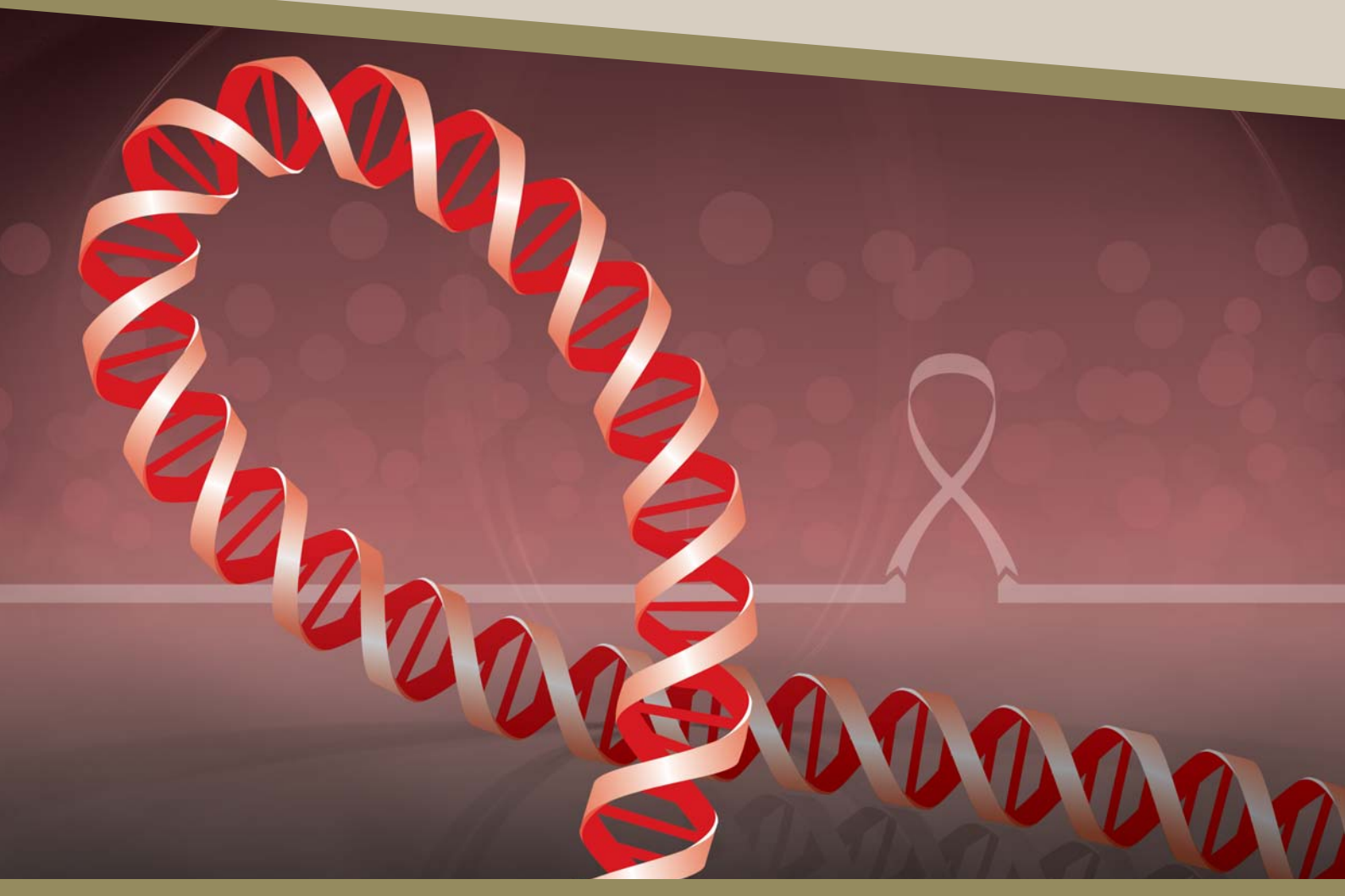
# HIV/AIDS prevention good practice– Strategies for public higher education institutions (HEIs) in South Africa

*A Report*



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# Contents

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# Abbreviations & Acronyms

| | |
|---|---|
| CDC | Centre for Disease Control, Atlanta |
| CPUT | Cape Peninsula University of Technology |
| DCI | Development Co-operation Ireland |
| DFID | Department for International Development (UK) |
| DUT | Durban University of Technology |
| DoE | Department of Education |
| FTE | Full time equivalent |
| HEIs | Higher Education Institutions |
| HEAIDS | Higher Education HIV/AIDS Programme |
| HSRC | Human Science Research Council |
| IEC | Information, Education and Communication |
| KABP | Knowledge, Attitude, Behaviour and Practice |
| KYE | Know your epidemic |
| NMMU | Nelson Mandela Metropolitan University |
| PE | Peer education |
| SAUVCA | South African Universities Vice Chancellor Association |
| SU | Stellenbosch University |
| TUT | Tshwane University of Technology |
| UCT | University of Cape Town |
| UFS | University of the Free State |
| UJ | University of Johannesburg |
| UKZN | University of Kwa-Zulu Natal |
| UNIVEN | University of Venda |
| UWC | University of Western Cape |
| VCT | Voluntary counselling and testing |
| WITS | University of the Witwatersrand |

# Executive Summary

The HIV epidemic in South Africa is very severe and constitutes a serious threat to society. The multi-sectoral *National HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP)* [7] prioritizes prevention and specifically targets youth. The students at HEIs constitute a potentially important group – the future leaders of the country. To tackle the HIV epidemic, SAUVCA took the initiative of a national HIV control programme in 2000, the HEAIDS Programme, which has been supported by the EC since 2004, through a grant of EUR 20m. The project has now been completed.

HEAIDS is South Africa's nationally co-ordinated, comprehensive and large-scale HIV prevention effort. The programme is designed to develop and strengthen the capacity, the systems, and the structures of all HEIs. HEAIDS has developed the HEAIDS Strategic Framework: 2006 – 2009 and beyond, and the Policy Framework on HIV and AIDS for Higher Education in South Africa for the higher education sector. This includes HEIs' dual mission to inform and protect the student population and "to provide leadership to the government and to the community by addressing the whole range of political, social, legal and management implications of HIV and AIDS". HEAIDS is implemented as part of the multi-sectoral response to the epidemic, in accordance with the national strategic plan (NSP).

This study was undertaken to identify the HIV prevention programmes and practices that have been implemented at HEIs and the extent to which they cohere with good practice as described in the literature. The research team began by identifying "international and local good practice with regards to HIV/AIDS prevention". The outcome of this process informed the development of an HIV/AIDS Prevention framework with clear indicators to guide the design, development and implementation of effective HIV/AIDS Prevention interventions/programmes appropriate for students in the higher education sub-sector. Next, the study team applied this instrument to a selected number of HEIs to identify and review good practices that had been adopted. Findings from this research project would be used to "inform the development and implementation of appropriate, innovative and effective HIV/AIDS Prevention strategies for the sub-sector". By identifying and documenting good practices at some universities and disseminating those practices to, or sharing them with, other universities, the overall quality of prevention efforts across HEIs could be improved. In addition, the study helps to highlight the wider role of HEIs in national control efforts.

Nine HEIs were selected for a case study analysis. The research instruments were based on the "good practices" framework and indicators. For these 9 sites, the research team described the context in which prevention activities are conducted. The team later added another three HEIs and identified their good practices, with only limited details of the context. The initial selection was made, primarily on the basis of previously

outlined institutional reports. That is to say, our research team selected HEIs that previously have had comprehensive HIV/AIDS Programmes, as we assumed that these HEIs were the most likely to have HIV prevention programmes with "good practices".

The research team defined two types of good practice: (1) good practices for individual components, such as peer education (PE) programmes or voluntary counselling and testing (VCT), and (2) Good Practices in Operations, implying that a systemic approach was used.

By applying the framework indicators, including a small number of quantitative indicators, and describing the context, the researchers were able to obtain both a qualitative and a quantitative picture of current practices at the nine initially-selected HEIs as well as good practices at the other three institutions.

In general, the team found that the HEIs implemented good practices. Furthermore, the study indicates that there might be a rather uniform approach to HIV prevention, at least among resourceful HEIs in South Africa. Prevention activities in 7 out of 8 selected HEIs are dominated by PE and VCT; and in all 8 HEIs, VCT is prominent. These programmes all demonstrated good practices according to the framework indicators. There is larger-scale, professionally-lead counselling/life skills training only at one HEI, but these efforts are still mainly carried out on a one-to-one basis and even here the magnitude is not clear. Curriculum integration occurs in several HEIs, but mostly on a limited scale.

Despite the uniformity of the ongoing programmes, we found a large range in the proportion of students who are tested annually, varying between 8% and 27%. Similarly, the number of condoms distributed per student varies widely, between 3.4 and 21.3.

The team assessed good practices for programme components in Peer Education and VCT at Campus Health Centres at a number of HEIs. Several Good Practices in Operations at a smaller number of HEIs were also identified. Monitoring and community outreach activities could benefit from improvements.

We also appraised the special case of the Centre for the Study of AIDS (CSA) at the University of Pretoria and recognised its important role in problematising current control efforts. Other significant programmes and programme components that our team identified were:

- the model-based approach at UCT and the use of external evaluation to improve the programme
- the community outreach programme at UZL, including the importance given to underlying societal factors for understanding the HIV problem in the student population
- the community-based project among farm workers undertaken by UFS.

In conclusion, the study indicates that many programme components and operations exhibit good practices. Furthermore, the study identified examples of excellent programmes conducted by qualified and enthusiastic staff at several HEIs. A key conclusion is that these efforts have led to increased awareness and have contributed to behaviour change among student participants at least.

The study findings demonstrate a similar approach to HIV prevention across the selected HEIs where Peer Education and VCT are important components and curriculum integration is gradually being introduced. This uniformity may be attributed to the strong and positive influence of the Rutanang model of Peer Education. Also, the relatively limited resources at all HEIs do not allow for a variety of choices. Another reason could be the relatively frequent contact and exchanges of ideas between the managers of the different programmes.

Prevention interventions, such as these listed above, can contribute to behaviour change: a reduction in risky sexual behaviour or the continuation of risk-free behaviour such as abstinence. Efforts at counselling to promote behaviour change and the development of life skills and resiliency are important and necessary components of a prevention programme. By applying international standards of good practice, it has been shown that interventions are most effective when guided by theory, including both individual-focused models and socio-cultural theories, and implemented by professionals with a background and experience in

behaviour change interventions. VCT counsellors and peer educators, however, must be provided with opportunities to learn the theories and how they apply to their work. They must also be offered opportunities to practice these skills so that they can become competent in helping students to change their behaviour. On-going and systematic supervisory support is also required.

Our research found that peer educators are often first- or second-year students with limited life experience and no training in behaviour change theory or techniques. Realistic, specific and appropriate targets have to be set for their interventions with individual students. For example, PEs could be required to demonstrate their understanding of behaviour change theory by using techniques they learned to raise students' awareness of present behaviour to initiate the behaviour change process. Behaviour change among the peer educators themselves may be possible. According to the limited information that we were able to collect, it does also take place through training and monitoring. However, we suspect that this might not take place in the general student population, despite the excellent work of the peer education programmes at many HEIs.

In line with the of thinking of some of the HEIs visited, we recommend that psychologists working at student counselling units play a stronger role in life skills training and in counselling. Psychologists have experience and skills in behaviour change techniques and use psycho-social theory for groups and the community. To accomplish this, student counselling units would have to be considerably strengthened; alternatively some HEIs would employ additional psychologists/social scientists on the HIV programmes to implement professional development and model techniques of behaviour change practice. A lack of resources prevented the effective and consistent monitoring and evaluation of programme components at most HEIs. We recommend that additional resources be made available to assist programme staff and volunteers to use evidence-based practices and theoretical approaches in their prevention activities, and include monitoring and evaluation as on-going activities to help ensure the effectiveness of the programmes.

The research also found a lack of a systems approach to HIV prevention programming – primarily due to the shortage of resources. Thus little effort was expended on defining the problems of the student population, such as by conducting a thorough situation analysis, including assessing the social context of students' lives on and off campus. Limited formal attempts were made to define the underlying determinants of HIV incidence for the student population and for the community.

Southern Africa has the largest HIV epidemic in the world. The reasons for this are not fully clear. These will vary between different settings in the country. Understanding the local underlying determinants is important in order effectively to address the epidemic. HEIs have an important role to play in defining these determinants, disseminating them, and using them to evaluate the policies and strategies already outlined to increase involvement in prevention efforts in the local communities. Although this is well in line with the HEI Strategic and Policy Framework for 2006–2009 and beyond, as well as the Policy Framework on HIV and AIDS for Higher Education in South Africa, HEIs have not yet fully taken on this task. There is a critical need to:

- establish additional research programmes
- further strengthen social science research, and
- conduct more research about behaviour change: i.e. how to develop appropriate messages for specific populations; which is the most effective type of media for disseminating the messages; etc.

In the final analysis, the research team identified the need to increase advocacy for a larger share of the overall resources allocated to HIV prevention and the DoE as part of national control efforts. The DoE currently receives a limited proportion of the overall funding for HIV control. HEIs can begin to play a more central role in these efforts.

HEIs also need to inform and protect the student population. As indicated above, we observed that this is well done at many of the selected HEIs through programmes to raise awareness, increased condom

use reported among young people as well as increased VCT at HEIs. Similar efforts need to be extended to other HEIs that were not included in this study and have yet to be identified. This could be accomplished using the same framework and research instruments once they have been reviewed and improved.

In addition, HIV prevention efforts can be enhanced and improved at the initially selected HEIs. The research uncovered certain weaknesses in current approaches. These mainly reside in: a) the definition of the problem among the student population; b) monitoring and evaluation; and c) the involvement of professionals. Such changes demand that additional resources be made available. An end to earmarked EC funding constitutes a threat to maintaining on-going efforts. This threat has to be countered by substantial additional funding from the DoE. Such funding could be used effectively by the human resources already available at many HEIs who know how to enhance and expand their HIV prevention programming.

## RECOMMENDATIONS

- The existing reference group that oversees the implementation of HIV prevention at HEIs should be further supported and given additional resources.
- Increased advocacy work should be undertaken to secure a larger share of the national HIV control budget for prevention, including an increased share for the DoE.
- Control efforts at HEIs need to be strengthened through a systematic approach using psychological and socio-cultural theory to inform the development and implementation of the programmes and the monitoring and evaluation thereof. More behaviour change professionals (both those who know how to implement theory-driven programmes and those who know how to develop research and evaluation studies) should be involved in the offerings at HEIs. This implies the need to apply a theoretical framework to HIV prevention programming. A new focus will result in clearer problem definition and the fine-tuning of the goals and objectives of the HIV prevention approach at HEIs. Theory-driven programming, a system-wide approach, and well-trained staff will result in improvements, enhancements, and expanded programmes. Skilled evaluators and capacity builders can develop or fine-tune data collection protocols to collect information through situational analyses. Stronger monitoring and evaluation systems will follow from a more theory based approach and also need to be instituted.
- Student counselling units, if strengthened, could take on a more important role in HIV prevention through more HIV/AIDS Prevention counselling and life skills training.
- Community involvement with HEIs should increase. The community can play a more important role in the institution's programmes. HEI also needs to engage with the community as well. For instance, in some communities where traditional healers are influential, staff have endeavoured to involve them in the HIV/AIDS Prevention programmes. Other problems such as the presence of "sugar daddies" on campus, older men from the local community, have not been addressed. Furthermore, PEs and staff could introduce significant interventions at local schools. The PE can help to prepare students entering HEIs to deal with the problems that arise due to the shift from living under the family's watchful eye to independent dormitory living. The issue of circumcision might be addressed.
- Non-selected HEIs need to be assessed using improved versions of the research instruments used for this study. Identified weaknesses at non-selected HEIs need to be addressed. Improvements could be achieved through study visits to some of the HEIs mentioned in this report with excellent operations.
- A National HEI monitoring system needs to be established. Computerised information systems need to be set up at all HEIs. They must be asked to submit biannual reports of quantitative data analysis to HESA, as well as narrative reports with qualitative indicators that could be forwarded every second year.
- Considering the availability of high-quality human resources, and the large experience gained South African HEIs ought to take on an even more

important role in HIV control both nationally and internationally. They would do this by first of all by contributing to the implementation of effective HIV/AIDS Prevention programmes at HEIs and in communities all over South Africa. Secondly by assuming leadership roles first in Southern and sub-Saharan Africa through exchange of experience and ideas and then thirdly internationally both by contributing to a more important role for the Education sector in HIV prevention and by sharing experiences through scientific presentations and papers.

SECTION 1

# Introduction

The HIV pandemic is striking the middle income countries of Southern Africa particularly hard. A population corresponding to 4% of the world population harbours nearly half of the entire world's HIV-infected people. These countries also recorded 35% of all new HIV infections and 38% of all AIDS deaths in 2007. Africa thus continues to bear a disproportionate share of the global burden. Of the total 33 million infected, approximately 2/3 (67%) live in sub-Saharan Africa. Of these, approximately 5 million live in South Africa, which has the world's most severe HIV epidemic (UNAIDS, 2008)[1] . For additional details on the epidemiological situation see Annex 1.

The reason for the concentration of the epidemic in Southern Africa is still not clear. It has been suggested that it is related to a low level of social cohesion (Barnett, Whiteside, Decosas 2000)[2]. It is also likely to be related to dense sexual networks caused by several underlying factors, including cultural patterns with sexual relations that occur within a context of power relations and patriarchy. Often husband and wife live separately. Furthermore, multiple and concurrent sexual partnerships and transactional or cross-generational sex are common. Alcohol and drug use often lower inhibitions and lead to unsafe sexual behaviour (SADC, Maseru 2006)[3]. How to tackle these determinants effectively is still not clear. Although the epidemic seems to have levelled off lately (HSRC 2008)[4], its prevalence is still very high – between 15% and 25% of the adult population in many areas, but with large regional variations (Annex 1). It is therefore possible that we are just at the beginning of the struggle against the epidemic in South Africa. Considering the intricate nature of the epidemic's determinants, it might take generations of social change efforts to control it, if there is no breakthrough in medical research into a vaccine or cure.

To increase the effectiveness of HIV control, there is a need for a better understanding of local epidemics. The combination of direct and underlying factors that determine the epidemic has to be defined (Wilson, Halperin)[5]. The so-called "know your epidemic" (KYE) analyses have been conducted in several countries in Southern Africa, recently including South Africa. These analyses point out the complex and varied nature of the different local epidemics. To be effective in addressing them, a combination of interventions needs to be directed both at structural, underlying and direct factors. These include underlying socio-cultural and economic determinants, as well as direct factors, such as condom use and circumcision status. Piot et al. (Piot 2008)[6] stress that no single intervention will be sufficient to control the epidemic. To a large extent, there is a need to move away more markedly from previous simplistic approaches and, instead, underline the need for what is called "*combination prevention*." This approach has to be based on a thorough analysis of "the immediate risks and the underlying drivers of the epidemic." It addresses "not only the individual dimensions of HIV prevention, but also the legal, cultural and social environment".

HIV/AIDS Prevention strategies specifically targeting youth are critical. Research by UNAIDS and the WHO emphasize that young people (10-24 years) are at the centre of the global HIV/AIDS epidemic. In many countries, a significant proportion of young people become sexually active before the age of 15 (WHO, 2004). They may not be aware of their vulnerability to contracting the virus or of ways to prevent infection. They may also lack access to the means to protect themselves.

It is against this background that South Africa, in the multi-sectoral *National HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP)*[7], prioritizes prevention and specifically targets young people in its suggested prevention efforts. It proposes a number of strategies, including:

- reducing vulnerability to HIV infection
- strengthening behaviour change programmes , interventions and curricula for preventing the sexual transmission of HIV, customised for different groups
- focusing on vulnerable populations and populations at risk, including young people and especially young women; creating an enabling environment for HIV testing, and
- increasing the uptake and quality of VCT services.

University students make up part of the youth population. Moreover, they constitute a segment of the youth population that is potentially very important both for the development of society and for the determination of future norms. Addressing university students effectively is therefore particularly important.

## THE HIGHER EDUCATION AND HEAIDS CONTEXT

To address the epidemic, HIV control programmes were established in the 1990s by many individual HEIs. In 2000, the South African Universities Vice Chancellor Association (SAUVCA) took the initiative for a national response to the HIV/AIDS epidemic at Higher Education Institutions (HEIs) in the country. With the support of the Department for International Development (DFID) (UK), Development Co-operation Ireland (DCI), and Centres for Disease Prevention and Control (CDC) (Atlanta, Georgia, USA), the first national programme on HIV/AIDS in higher education (HEAIDS) was outlined. The first phase of the project resulted in a number of valuable products, including the Rutanang model for peer education (PE). At the launch of a second phase of the programme in June 2004, the European Commission (EC) allocated a grant of 20 million Euros to the programme through the Department of Education (DoE). Answering a Grant Call for Proposals from the EC, HEIs submitted proposals for funding. Higher Education South Africa (HESA), the representative body of the Vice Chancellors of South African public universities, was contracted by the DoE to implement the programme, and a Programme Co-ordination Unit (PCU) was formed to co-ordinate activities.

Although implementing prevention programme efforts at HEIs directly reaches only a small proportion of the total adult South African population, i.e. approximately 700,000 students (HEIs), its importance should not be underestimated. The students represent a population of great potential importance, given that they are likely to become the country's future leaders and potentially opinion-makers and policy shapers. The potential risks to students at Higher Education Institutions (HEIs) are also heightened by the liberal atmosphere characteristic of HEI campus cultures, open to activities and life-styles that facilitate HIV transmission. The HEIs are not only teaching institutions. To a large extent, the role of the universities is also in research and the dissemination of findings. Therefore, HEIs have the dual role of protecting the health of the students and carrying out research that increases the understanding of the epidemic and how it can be controlled within and outside the universities.

HEAIDS is South Africa's nationally co-ordinated, comprehensive and large-scale effort aimed at developing and strengthening the capacity, the systems, and the structures of all HEIs. To reduce new infections and mitigate the impacts of the HIV/AIDS epidemic on the sector HEAIDS has developed HEAIDS – Strategic

Framework 2006-2009 and beyond (HEAIDS)[8]; and the Policy Framework on HIV/AIDS for the higher education sector (HEAIDS)[9]. This includes the dual role of HEIs both to inform and protect the student population and "to provide leadership to the government and to the community by addressing the whole range of political, social, legal and management implications of HIV and AIDS". HEAIDS is implemented as part of the multi-sectoral response to the epidemic in accordance with the national strategic plan – the NSP.

The public higher education sub-sector in South Africa comprises 23 Higher Education Institutions (HEIs) divided into Universities and Technical Universities. Each institution has its own, often diverse, characteristics regarding location and mode of teaching (distance – contact), mixture of ethnic groups, language and culture. The sector still suffers from the historical imbalance between the different universities/technikons; both human and financial resources vary considerably. Each institution also has a high level of independence. The HIV programmes at the different HEIs are therefore not uniform.

EC support for HEAIDS is now coming to end. HESA has to sum up the results of the support and create a firm base for the future. To do so, HESA commissioned eight studies to be conducted under the guidance of the PCU. These include:

- Development of a sub-sectoral policy and monitoring and evaluation framework
- Development of norms and standards for a comprehensive HIV/AIDS service package
- Development of a sustainable funding model
- Support for the development of teacher education curricula
- Undertaking an HIV sero-prevalence and KAPB survey at HEIs
- Development of a workplace programme
- Grants to public HEIs to facilitate the development of comprehensive responses to HIV/AIDS.

However, the need to research and understand current practices at the HEIs, and learn the extent to which these meet accepted good practice, has not yet been met. It constitutes the subject of this study, which aims: firstly, to identify "international and local good practice with regards to HIV/AIDS prevention"; secondly, to develop a HIV/AIDS Prevention framework including indicators "to guide the design, development and implementation of effective HIV/AIDS Prevention interventions/programmes appropriate for the population (students and staff) of the higher education sub-sector"; and thirdly, to apply this instrument to a selected number of HEIs in order to identify and review good practices undertaken at HEIs. Findings from this research would be used to "inform the development and implementation of appropriate, innovative and effective HIV/AIDS Prevention strategies for the sub-sector". By identifying and documenting good practices at some universities and disseminating findings to other universities, the overall quality level of prevention efforts at HEIs could be increased. This is the main purpose of this study. The study could also help to identify the wider role of HEIs in national control efforts.

## OBJECTIVES

The objective of this study is to strengthen HIV/AIDS Prevention in the public higher education sub-sector in South Africa, by identifying and disseminating good-practice HIV/AIDS Prevention models and interventions.

### Specific objectives

- Conduct desktop research to understand behaviour and behaviour change in the context of HIV/AIDS Prevention activities and programmes. It should include the identification of international and local good practice with regards HIV/AIDS Prevention based on relevant norms and standards.
- Develop a HIV/AIDS Prevention framework, including indicators, to guide the design, development and implementation of effective HIV/AIDS Prevention interventions/programmes appropriate for the population (students and staff) of the higher education sub-sector.
- Identify existing HIV/AIDS Prevention interventions/programmes in the higher education sub-sector

and rate them against the HIV/AIDS Prevention framework and indicators, and identify and document good practice.
- Disseminate research findings to HEIs through two national consultations, one obligatorily being a capacity development workshop on HIV/AIDS Prevention good practices.

## Definitions

To clarify how we used the different concepts, and in order to be able to undertake the study, we introduced the following definitions.

### *Good Practices*

Good practices are well-documented and assessed programming practices that provide evidence for success/impact and which are valuable for replication, up-scaling and further study. These practices are generally based on similar experiences in different countries and contexts. Good practices mostly lack very clear scientific evidence that is often difficult to come by. However, general agreement exists regarding about their usefulness (see Annex 2).

In this report, two types of good practice are considered. One is programme component good practice, such as Peer Education, including what the programme component should contain, how peer educators are selected, trained, supervised, etc. *Good Practice in Programme Components* is the subject of a Desktop Review of internationally accepted good practices. The researchers also introduced another type of good practice concept; the good practice in operating a comprehensive, well-balanced programme, here called *Good Practice in Operations* (see 2.4 below). We think that what is considered as Good Practice has to be seen in light of the existing resources and what is feasible in a specific context.

### *Innovative Practices*

Innovative practices are actions that invent, or begin to apply, techniques, methods, processes, initiatives, etc., that are new or novel. In this report, this term means new solutions to a particular programme aspect that we judge interesting and potentially effective.

### *Peer education*

Peer education is a health promotion and intervention strategy. It refers to unleashing the potential of individuals to transform their lives and those of the members of their communities[11]. This involves empowering individuals so that they are able to make informed decisions about the challenges they face. It is also about identifying and equipping individuals to influence their peers through positive peer pressure or the modelling of socially acceptable behaviours.

Peer education is, according to the Rutanang approach[12] a process in which "trained supervisors assist a group of suitable learners to:

- educate their peers in a structured manner
- informally role model healthy behaviour
- recognise youth in need of additional help and refer them for assistance
- advocate for resources and services for themselves and their peers"[1,]
- We have adopted the above definition for the report.

### *Counselling*

Counselling is a process that enables a person to sort out issues and reach decisions affecting his/her life.[13] The process involves having a trained individual talk with a client in a way that helps that client solve a problem.[14] The client could also be assisted to create conditions that will help him/her understand or improve his/her behaviour, character, values or life situation. Counselling may cover several areas, such as counselling for behaviour change, pre- and post-test counselling as part of VCT, or supportive counselling for HIV-positive individuals. In the case of prevention at HEIs, as in this report, it mainly implies pre- and post-test VCT counselling (see below). However, it also implies counselling activities aimed at behaviour change. Many variables influence the effectiveness of the counselling process for behaviour change. These variables include the degree to which the counsellors'

work is grounded in theories of change and their application to practice, their level of knowledge and skills, and their ability to adjust their counselling approach to the needs and decisions of their clients. Counselling that has been demonstrated to be effective tends to be longer than the usual length of time allotted to, for example, VCT. Most HIV/AIDS counselling tends to be brief, even though the problems are often complicated. In this report, counselling was mostly considered to equal VCT.

### *VCT*

VCT is a confidential dialogue between a counsellor and a client[14]. This dialogue aims to support clients in making informed, responsible and effective decisions regarding future behaviours concerning HIV and AIDS. Counselling and Testing – key operational guidelines of the UNAIDS Programme). VCT comprises of pre-test counselling, a rapid HIV test and post-test counselling.[14]

### *Behaviour change communication*

Behaviour Change Communication (BCC) is an interactive process with individuals, communities and/or societies[15]. The focus is to develop tailored messages and approaches, using a variety of communication channels. The strategy is used to encourage positive attitudes and behaviours and to promote and to sustain individual, community, and societal change. Implementing these strategies will enable individuals to initiate and sustain possible and desirable behavioural outcomes[16]. In this report, it is seen as closely related to IEC combined with services.

### *Life skills*

Life skills consist of the abilities individuals need in order to acquire and use adaptive and positive behaviours. These behaviours enable individuals to deal effectively with the social demands and challenges of everyday living and the rapidly changing environment[17]. Life Skills assists students to improve their communication skills, analyze and clarify their values, and to develop decision-making and stress management techniques.[18]

Since the approach is interactive and participatory, Life Skills incorporates group work and discussions, as well as brainstorming, role-play, educational games, and debates. Facilitators provide consistent opportunities for students to practice and hence reinforce the skills they are learning.

## SECTION 2

# Background

To understand the task at hand, it is important to be familiar with the Ministry of Education's Policy and Strategic Framework, within which the HEAIDS programme is implemented. Furthermore, it is essential to have information on the content of the Rutanang model for peer education, as this constituted the basis for much of the work to establish peer education at HEIs in South Africa. Finally, it is necessary to have an overview of on-going activities at the HEIs.

## POLICY AND STRATEGIC FRAMEWORK ON HIV/AIDS FOR HEIs

Within the context of institutional autonomy and the role of higher education at national level, the Ministry of Education has developed a **Strategic Framework** for phase 2 of HEAIDS[8] (HEAIDS-Strategic Framework 2006-2009 and beyond[8]).

The framework has two main strategies to:

- maintain institutional capacity
- grow and empower teaching, training, research, community engagement and service functions.

This will be done by:

- formulating institutional policies
- setting norms and standards for funding models and human and material resources
- curriculum integration
- standardised interventions – best practice in prevention, care and support and curriculum integration
- improved monitoring and quality control
- establishing workplace programmes.

Many of the strategic activities have already been undertaken. This study is part of those efforts. On the basis of the **Strategic Framework a Policy Framework on HIV and AIDS** (Policy Framework on HIV/AIDS for the higher education sector[9)] framed within the South African Constitution, the HIV and AIDS and STI National Strategic Plan for South Africa 2007-2011 and related legislation, has also been outlined. The policy aims to contribute to the main objective of the national plan: reducing the number of new infections in South Africa by 50% by 2011. The framework highlights the role of the higher education sector, which aims to:

- support democracy and human rights
- meet national development needs through teaching, learning, research and community outreach
- promote equal access to higher education.

The Guiding Principles of the framework include:

- supportive and committed leadership
- the promotion of human rights
- a comprehensive response
- a consolidated national response and effective partnerships

- effective advocacy and communication.

Formulated in line with these three objectives are:

- the provision of strong, committed internal as well as external (societal) leadership
  - educating future leaders to deal with the HIV problem in society
  - producing research that influences the national response
  - contributing to the national and international debate
- the creation of a healthy and safe environment within institutions
  - to ensure the wellbeing of staff and students
- the establishment of a co-ordinated, comprehensive and integrated response
  - an environment that fosters collaboration between the HE sector, its communities and other sectors.

Some pillars were defined for reaching these objectives:

- coherent communication within and outside the sector
- appropriate resource allocation
- a comprehensive Monitoring and Evaluation system
  - identification of SMART core indicators
  - systems to monitor and evaluate the impact of the institutions' responses to HIV and AIDS.

## THE RUTANANG APPROACH – A RESULT OF HEAIDS PHASE 1

One of the main outcomes of the first phase of HEAIDS was a model for the establishment of Peer Education programmes. It has been used extensively by HEIs either in its original or in a modified form. Rutanang (Sotho for *learning from one another*) was developed in an articulate 18-month process, which involved a large number of experts and provincial authorities. It is based on a thorough review and analysis of peer education internationally, and on the experience of several experienced practitioners. It has two main objectives:

- to strengthen Peer Education on HIV, other STIs and Life Skills
- to introduce a process that involves self-assessment, evaluation and improvement of PE.

It consists of Part One, which outlines the standards of the practice of PE, and Part Two which comprises guidelines on how to establish, implement and evaluate PE.

Part One ends with a description of the 11 essential elements of PE. These steps are the following:

- Planning
- Mobilisation
- The supervisory structure
- Linkages
- Learning programme
- Peer Educator infrastructure
- Management
- Recognition and Credentials
- Monitoring and Evaluation
- Sustainability
- Gender

All elements are divided into three levels of comprehensiveness: "Must have", Should have", and "Could have". In Part Two the implementation of these elements is outlined in detail. The process is precise and stresses the need for strong structures to establish an effective PE programme.

The same steps also constitute the **evaluation checklist** that deals with the three levels of comprehensiveness. This list has much in common with the Framework Indicators that take up similar issues for Peer Education, albeit in a different order (see 4.1.2 Framework with Indicators for Good Practices – our main research instrument). These include programme elements, professional competence and linkages. The two documents, the Framework Indicator document and the Rutanang document, also share references and have a similar basis.

## GOOD PRACTICE IN OPERATIONS – OVERVIEW OF HIV CONTROL ACTIVITIES AT HEIs

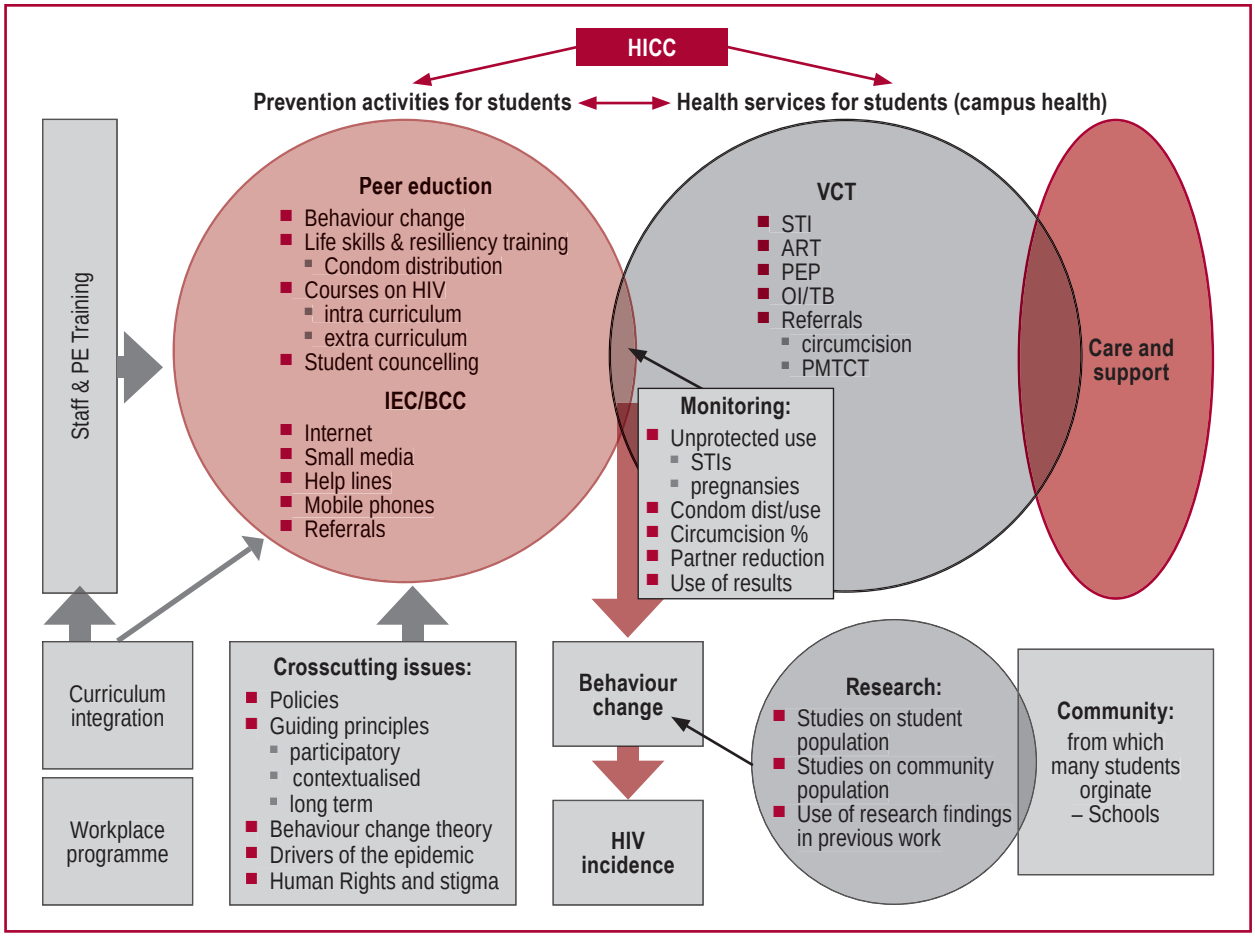
HIV control activities have similar content at most of the HEIs in this study. They include the same main components: *Prevention activities*, *Activities at Campus Health (Wellness Clinic), and Care and Support* (see Fig. 1). These activities are supported by capacity building activities, including training for staff and peer educators as

well as curriculum integration to make education on HIV/AIDS part of regular teaching activities. Activities also include monitoring, research and community outreach.

In a well functioning system it could be imagined that results from monitoring of implementation and research conducted on the student population and at the community level (indicated by the circle and square at the bottom right) should be fed back into prevention activities (indicated by the black arrows from Monitoring and Research). In a resourceful system it should also be fed back to the community and to the student population in order to encourage discussion and action both among the students and among members of the community. This would constitute examples of what we have called *Good Practice in Operations.*

Prevention is built, to a large extent, on peer education. Much of this has been developed on the basis of the Rutanang model (see above). The subjects of this report are prevention activities including VCT, and Peer Education with aspects of behaviour change counselling and life skills training as well as IEC/Behaviour Change Communication. They do not exist in isolation, but are highly dependent both on each other and on other activities. Thus, VCT depends on IEC and advocacy work by peer educators, which encourages peers to undertake VCT, which is then carried out with pre- and post-test counselling at Campus Health. Monitoring is mainly undertaken at Campus Health and for PE activities. In some HEIs, the results are already fed into a computerised system for easy and rapid access. Such systems are under development in other HEIs. All activities in a well-operated system should be permeated with the Cross-Cutting Issues – such as policies, guiding principles, behaviour change theory, drivers of the epidemic, human rights and stigma (fig.1).

**Figure. 1** Overview of HIV control activities at HEIs



SECTION 3

# Methods

## METHODS

The study included several steps. It began with a desktop review of the literature on Good Practice in HIV prevention that informed the development of a Good Practices Framework including indicators, through which prevention activities can be appraised. Following this the research team conducted study visits to selected HEIs, where activities were examined through the application of the principals and other cross-cutting issues identified in the desktop review and by the indicators developed as part of the Framework. To this were added case descriptions to give a contextual background. On the basis of the findings, good practices for both individual components and for operations were identified.

### Review of the literature

Thus, in a *first* step, Good Practices in HIV prevention were identified through a review of international literature (see further 4.1.1) that involved the following activities:

- locating and describing available studies, interventions and curricula that demonstrate positive effects of HIV/AIDS behavioural prevention interventions for participants
- undertaking a critical review of these studies, and
- synthesizing identified good prevention practices for reducing HIV risk.

**Types of Study.** Studies were included that had in some way either evaluated or demonstrated the positive effects of behavioural interventions on an outcome measure related to HIV transmission. These included randomised controlled trials and studies that used comparison groups and the prevention curricula of evaluated programmes. Other innovative programmes were also included that may not have had a formal evaluation, but demonstrated potential to help participants make behaviour changes that could reduce HIV transmission. The review focused primarily on literature from Southern Africa, including materials produced by HEAIDS. Beyond this studies from American Centres for Disease Control and Prevention, UNAIDS and similar organisations that have been deemed effective through systematic research were also included.

**Types of Intervention.** Interventions aiming to change individual behaviours without efforts to target or mobilize a community or larger population were included, particularly those based on Behavioural Change Theory, Counselling, Comprehensive Health Services including Voluntary Counselling and Testing, Peer Education, Behaviour Change Communication, and Curriculum Integration for use in university classes.

**Types of Outcome Measures.** The team searched in particular for studies and reports that had at least one outcome measure related to HIV transmission. This measure could be knowledge, attitudes, intentions,

self-reported risky behaviour, biological outcomes, or increased use of VCT, reproductive health, HIV, or STI services. Reports of innovative or unique programmes that did not have a demonstrable outcome, but had potential to comply, were also included.

**Review Methodology.** The consultant team reviewed the literature for relevance, based on types of participants, interventions, and outcome measures. Literature was abstracted onto a data form. The review could not be as systematic or comprehensive as desired, because of severe time constraints. However, the consultant team members are all experienced in the field of HIV/AIDS prevention so, to conduct the review, the team was able to rely upon individual and combined knowledge of the literature, as well as adopting standard literature review practice.

## Development of Framework and Framework Indicators

In a *second* step a Framework for HIV Prevention was developed (see 4.1.2). This included indicators to guide the design, development, implementation and evaluation of effective HIV/AIDS Prevention interventions/programmes suitable for the higher education sub-sector.

The development of the framework drew on a number of information sources including the following:

- Primary research to inform the development of national guidelines for the development and implementation of programmes and services.
- Exploration of professional associations on the web, such as the British Association for Counselling & Psychotherapy, that provides a list of good practices for their professionals.
- Articles and other materials from the above review of the literature that describes good practices for HIV/AIDS Prevention programmes and activities, internationally, in sub-Saharan Africa, and particularly in South Africa.
- Good practices identified by the experts on the team from their years of experience in the field of HIV/AIDS Prevention.

On the basis of the identified Framework, Indicators, data collection instruments consisting of questionnaires/focus groups and interview instruments were then developed for the key prevention areas of programme management, VCT, Counselling and Life Skills Training as well as Peer Education. The data collection instruments included questions for managers, supervisors, volunteers, and students.

### *Refining of the data collection instruments*

The instruments used for data collection were developed directly from the "good practices" defined in the initial Framework (see 4.1.2 and Annex 4) with its indicators. After pre-testing the questionnaires at 2 HEIs, the team revised and added probes to the 7 questionnaires, including one for the interview with the Institutional Officer/HIV/AIDS Co-ordinator, two for Peer Education, two for Counselling and Life Skills, and two for VCT. Information collected through the questionnaires as well as from the draft Institutional Reports was used to outline the *case descriptions.* These served to give a contextual background. The above "Overview of HIV control activities at HEIs" (Fig. 1) served as an outline for the *Case descriptions* (Annex 5). These were thus divided into:

- general aspect of
  - cross-cutting issues
  - prevention activities
  - health services at campus health
  - care and support
- description of the main prevention programmes
  - PE
  - VCT
  - IEC/BCC
- summary

Training and workplace programmes that appear in the overview were, however, not included, as the focus was maintained on prevention activities.

We also shortened the *Framework Indicators instrument* to make it feasible to apply within a limited time. The Shortened Framework Indicator instrument

(Annex 4) was then sent out to all the selected HEIs. As part of the indicators we asked about the *experience of the Rutanang model.*

We also developed a form for *selected resources and outputs* – quantitative data on the number of students, number of PE activities, VCTs undertaken and condoms distributed etc.

## Selection of HEIs to assess

In a *third* step, the team utilised the instruments to examine HIV prevention practices at selected HEIs.

We defined two types of Good Practice: Good Practices for Programme Components as defined in the Desktop Review and reflected by the Framework Indicators and Good Practices in Operations (see 1.2 Definitions and 2.4).

In order to identify Good and Innovative prevention practices at HEIs, as defined above, the team utilised a case study approach. Initially, we *assumed that HIV programmes at HEIs* that were recently identified *to be comprehensive and of a good standard were also likely to harbour good and innovative practices.* These institutional programmes were therefore intentionally selected for study. Time limitations prevented the team from selecting more than 8-10 programmes for the research. – We identified and selected potential Good Practice programmes (the selection included both types of Good Practice) in the following way:

First, we stratified the 23 HEIs into Universities and Technical Universities. UNISA was excluded because it is a distance-learning university to which our research instruments could not be applied. We then purposefully selected 9 potential Good Practice institutions (6 Universities and 3 Technical Universities). The institutional selection was based on the findings of the desktop review applied to several sources. These included draft Institutional Reports on HIV activities, (which were outlined in a previous study and which we assumed will not change much when finalised), including a gap analysis in relation to standards; interviews with representatives of the programmes who attended HESA financing workshops; a previous gap analysis (Turning the Tide); the study of web sites; telephone calls and personal knowledge of some of the programmes by two members of the team. One of the selected universities, University of Pretoria, however, undertakes activities for which our instruments were not suitable. Ultimately, we therefore ended up with 8+1 cases (8 HEIs for which we could apply our instrument and analyse jointly and UP, which was described as a special case). Two rural universities were purposefully included. Logistical challenges resulted in our team visiting only one rural HEI. It is included among the 8 HEIs.

The *selected* HEIs included 6 universities: Stellenbosch University (SU), University of Johannesburg (UJ), University of Venda (UNIVEN), University of the Western Cape (UWC) and University of Witwatersrand (WITS), plus University of Pretoria (UP), which was described separately; and 3 Universities of Technology: Cape Peninsula University of Technology (CPUT), Durban University of Technology (DUT) and Tswane University of Technology (TUT).

Later, after additional information had been collected, we visited/contacted 5 additional HEIs with potentially good and innovative practices (see Fig. 2) to obtain a more complete picture of on-going good practices at HEIs. These included UCT, RU, NMMU, UFS and UZL. (See *4.6 Good Practices at other HEIs* below*).* Team members visited UCT and UZL and had e-mail/telephone contact with NMMU and RU. UFS was also contacted to elicit information on its outreach programme. However, due to resource limitations and limitations in ability to visit the HEIs, we have only accounted for good practices at UCT, UZL and UFS.

## The data collection processes

We described the activities at the 8 visited "case" universities using our initial data collection instruments and probing questions to uncover the context in which the programmes were offered and arrive at *Case descriptions.* All cases were described in the same way and divided into the same sub-sections (see above under **Refining of the data collection instruments**).

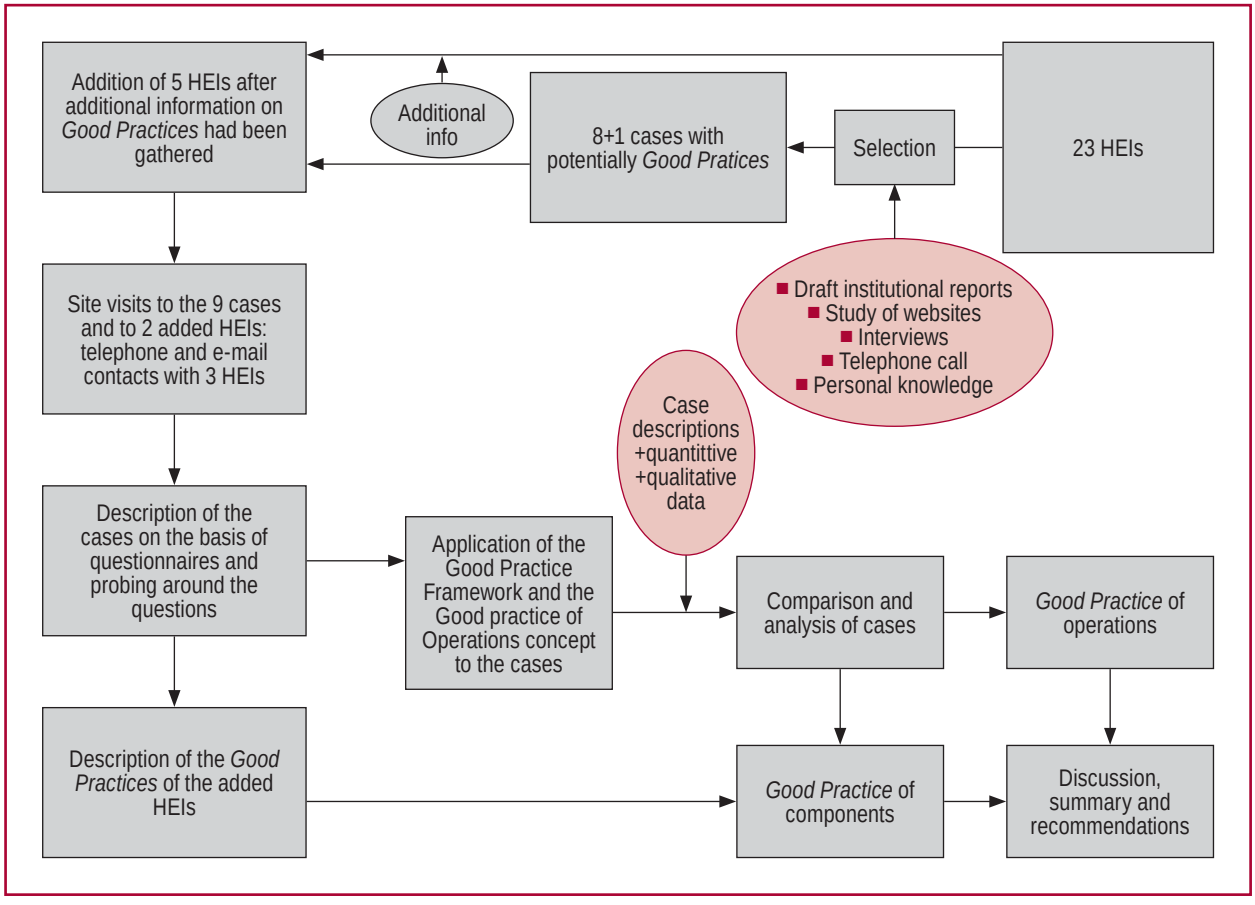
Draft case descriptions were distributed to the HEIs for correction and approval before the final draft was written. The simplified version of the *Framework Indicator form* was also sent to the selected HEIs together with the form for quantitative data on *Selected resources and outputs.* This form was filled by all selected and some not initially selected HEIs.

## Data Analysis

In a *fourth step* the data were analysed. The analysis of the collected data was mainly done through a compilation of the findings of the form for quantitative *Selected resources and outputs* data and the *Framework Indicator Form.* The data were summarized and presented in two tables. E.g. the proportion of VCTs per student and year as well as the condoms distributed per student was calculated from the quantitative data. The framework indicators were divided into its main groups: Cross-Cutting Issues, VCT, Counselling, PE , Life Skills, IEC/BCC, and finally Monitoring and Evaluation In each group the questions were given scores. Score 1 if the indicator was in accordance with Good Practices, 0.5 if they were partly in accordance with Good Practice and finally 0 if they did not follow Good Practice as defined by the Framework : Yes=1, Intermediary=0.5 and No=0. The scores for each HEI were then summarised.

In an attempt to improve the balance between the indicators, which are dominated by the many indicators for PE, we also added a weighted measurement. We divided the activities into 5 groups, as we judged that VCT and Counselling are linked as are PE and Life Skills training. The five groups, therefore, were: Cross-Cutting Issues, VCT and Counselling, PE and Life Skills, IEC/BCC, and finally Monitoring and Evaluation The main activities of VCT and Counselling, PE and Life Skills and IEC/BCC were given a double weight of Cross-Cutting Issues and Monitoring and Evaluation, and within each group Programme Elements, Professional Competence

**Figure. 2** The study process



and Linkages were given the same weights. Two types of data – raw scores and weighted scores – were presented.

### Feedback to Participants

In a *fifth* step, the final drafts were presented at a workshop to which all HEIs were invited. Suggestions and conclusions from the workshop were added to the final assessment.

### Ethical Procedures

The initially developed instruments, the framework indicators and questionnaires were reviewed and approved by HSRC. Informed consent was requested and received from all those interviewed.

### Assessment of HIV prevention practices at HEI's

We applied the simplified version of the framework and the Good Practice in Operations concept to the case descriptions and after analysis and a summary identified good practices both for all main **programme components** and for **operations**.

The findings were also discussed in light of existing HEI policies and the role of HEIs in national and international efforts to control HIV. Furthermore, we described the mix of interventions in relation to international findings on cost-effectiveness and methods to assist changes in individual behaviour.

In addition to the Desktop Review, the Framework instrument and the Good Practice in Operations Model, the team also considered the "Policy Framework on HIV/AIDS for HEIs" as well as findings from international research when scrutinizing the Good Practices.

Finally, we summarised the findings, discussed them, and outlined recommendations.

## LIMITATIONS OF THE STUDY

The final parts of the project were constrained by an extremely limited time frame. This meant that the specific objective of the ToR of scrutinizing HIV prevention activities at all 23 HEIs had to be abandoned. As the main objective was the identification of Good Practices and the dissemination of findings to all HEIs, it was decided to identify HEIs with potentially Good and Innovative Practices and to study only these. Initially, a selection of 9 HEIs to visit and comprehensively examine (an average of three per researcher) was considered feasible for the case studies. Later, 5 additional HEIs were added for a limited description of Good Practices only. The initial selection was, to a large extent, based on previous draft institutional reports. If these are incorrect, or if they undergo major changes when finalised, there is a risk that we have missed some HEIs that do have good practices. Furthermore, probably not all good practices are undertaken at HEIs with comprehensive programmes. It is likely that good practices exist at less resourceful HEIs with more limited programmes.

Furthermore, the study was conducted during the examination period, when students could often be unavailable for interview. Students were only interviewed at one university. Data collection could not, therefore, be triangulated through the use of several sources. The short implementation period also meant that the study had the character of a rapid appraisal. The findings, to a large extent, are based on reports written by programme directors, PEs and VCT supervisors themselves; they are therefore dependant on their judgment, frankness and openness.

The research team could not go into detail regarding the indicators and their precise levels. Indicators were therefore simplified and not presented as percentages (as in the original framework). Instead, they were more generally classified as *yes*, *no* or *intermediary*. This makes it impossible to determine the exact scale on which the various indicators were implemented, and difficult to differentiate with certainty between the levels of good practice at the various universities. This approach mainly gives an indication of whether good practices are undertaken or not, not to what extent. In addition to using the indicators to identify Good Practices, they were also used to confirm that

the selected universities were offering Good Practice interventions.

During the course of the study, we found that almost all counselling activities are those undertaken by VCT counsellors. Other counselling services, such as professional counselling for students, normally do not cover HIV. They are mostly undertaken on a one-to-one basis on a limited scale. Similarly, there is little or no life skills or resiliency training carried out by professional staff. This is part of peer education. This meant that the questionnaires for Counselling and Life Skills and Resiliency training were not fully relevant, but findings had to be corrected/clarified through additional interviews after the draft reports had been sent out.

Considering the limited time available to finalise the study, the team was not able to go into detail about the Rutanang process and the Your Moves CD. However, the initial Framework Indicators (as well as the simplified version) and the Rutanang indicators overlap to a very large extent. We used the Framework Indicators that are very similar to those of Rutanang. It is our perspective, therefore, that a more detailed study of Rutanang would not have made a substantial contribution to the study.

Finally, ideas about what constitutes "good practice" change with time, experience, and on the basis of additional evidence-based research. Thus, what is considered as good practice in behaviour change theory may now have shifted more to the use of **community level** models rather than previous models for **individual behaviour change**. There is, therefore, much recent interest in, and substantial rational to, the *promising practices* concept.

SECTION 4

# Results

## DESKTOP REVIEW OF GOOD PRACTICES IN HIV PREVENTION AND THE FRAMEWORK AND INDICATORS FOR GOOD PRACTICES

The initial phase of the study resulted in a well-referenced Desktop Review as well as in a Framework with Indicators plus 7 questionnaires derived from the Framework.

### Desktop Review of Good Practices

The desktop review of good practices (Desktop Review)[20] was based on an extensive search through the literature. The review examined HIV interventions in South Africa, sub-Saharan Africa, and at an international level, and included interventions that focused on:

- Cultural Forms, Stigma, and Gender Inequalities
- Behaviour Change Theory
- Behaviour Change Communication
- HIV/AIDS Prevention Interventions including Counselling, Life Skills, Resiliency Strengthening
- Peer Education
- Comprehensive Health Services and HIV/AIDS Prevention
- Curriculum Integration.

The first points (cultural forms, stigma and gender) are cross-cutting issues. The others are programme components. Rather than prescribe detailed programme content, the Desktop Review suggests that *Good Practices* in Prevention implies that certain core elements are included in the programmes and that certain guiding principles are applied. The core elements and guiding principles mean that programmes should:

- be *participatory*:
  - opportunities for people to critically analyse the determinants of HIV transmission and to be involved in designing and implementing interventions (creating their own knowledge) – participating rather than importing solutions from external professionals
- b*e empathetic*, involvement *of peers and/or caring adults*
- b*e long-term* – long intervention period
- continuously promote *professional development* for implementers
- encourage intensive discussions on main underlying factors including *gender inequality* and *normative cultural practices*
- be *contextualised* – dealing with *locally important problems*
- provide *expanded networks* and *social supports*
- include *operations research* that informs programmes.

Furthermore, it was concluded that good practice programmes should be grounded in a *behaviour change theory* (see Annex 3) and that implementers need to be:

- trained to apply this theory
- trained to strengthen *resiliency and decision-making skills*, such as harm/risk reduction and condom negotiation.

Prevention activities need to be linked to *comprehensive health services*, including HIV and STI treatment.

## Framework with Indicators for Good Practices – the main research instrument

The abovementioned overriding Guiding Principles are reflected in a detailed Framework with Indicators [19] for each subject area. The Framework is divided into three columns. The first column lists good practices, the second qualitative indicators and the third output indicators. What is considered *Good Practice* for each subject area is divided into programme elements, professional competence and linkages. The Framework was outlined to serve as the document for the development of the data collection instruments. It covers the following areas:

### *Cross-cutting issues*

- Behaviour change theory
- Cultural norms
- Gender inequality
- Stigma and discrimination
- Sufficient resources, financial and human

### *Counselling*

- Programme elements
  - Confidentiality assured
  - Counsellors knowledgeable
  - Sufficient number of sessions offered
- Professional competence
  - Trained in Behaviour Change Theory
  - Knowledgeable about HIV, cultural issues, stigma
  - Follows professional practice
  - Records kept, results followed-up
- Linkages
  - Good internal and external linkages

### *Life Skills Resiliency Strengthening*

- Programme elements
  - Integral part of HIV prevention
- Professional competence
  - Facilitators taught problem-solving skills and use multiple methods
  - Facilitators trained to develop resiliency in clients
  - Recipients involved in design
  - Activities monitored and followed up
- Linkages
  - Good internal and external linkages

### *Peer Education*

- Programme elements
  - Activities are theory driven
  - Clear rules for PEs
  - Rigorous selection
- Professional competence
  - Comprehensive training and retraining
  - PEs satisfied with involvement
  - PEs routinely followed-up
  - PEs feed back to supervisors
- Linkages
  - Good internal and external linkages

### *Campus Health*

- Programme elements
  - Confidentiality maintained
  - Comprehensive services
- Professional competence
  - Competent staff – high standards for staff development
  - Practice according to quality standards
- Linkages
  - Good relationships with community-based and campus-based services

### *IEC*

- Programme elements
  - BCC used to recruit students to prevention and health services

  - BCC messages consistent with those of NGOs and other prevention programmes
  - BCC use behavioural theory to tailor to specific audiences
- Professional Competence
  - Targeted participants involved in design
  - Promote gender equality, include stigma reduction
  - Use a variety of media; messages tailored
  - Duration of messages sufficient

*Monitoring and Evaluation*

- Evaluation plan for each prevention programme
- Both quantitative and qualitative data collected
- Computerised system with easy access to data

The indicators also include quantitative indicators. For the purpose of data collection, a simplified shortened version of the original Framework was developed (see Annex 4). The shortened version was directly derived from the initial Framework, but the number of indicators was reduced to 68.

## CASE DESCRIPTIONS – THE CONTEXT OF HIV PREVENTION AT SELECTED HEIs

Case studies were undertaken at 8 selected HEIs (for detailed case descriptions see Annex 5). These aimed at giving a description of prevention activities at the HEIs in the context of overall HIV control activities. The descriptions followed Fig. 1 "Overview of HIV control activities at HEIs", but particularly focused on prevention activities.

They consist of an overview, including problem definition, structures and management, policies and plans to address the problems, human and financial resources, cross-cutting issues of planning and implementation, as well as monitoring and evaluation and research. Furthermore, they contain an overview of all prevention activities, including peer education, condom distribution, counselling, life skills training, IEC/BCC and VCT at Campus Health, as well as curriculum integration and community outreach activities.

Finally, the *Good Practice* Framework Indicators and the *Good Practice in Operations* concept were applied. The Case Description, the Good Practice Framework Indicators and the Good Practice in Operations were then combined to identify Good Practice in Components and Good Practice in Operations for each of the selected HEIs.

In line with our definition of Good Practice, the team looked both at good practice in *individual components* and in *operational aspects of running comprehensive programmes.* The research aimed to answer the following questions:

- Are the programme components being implemented according to international good practice?
- Is the programme comprehensive and well-adapted to the HIV situation on campuses?
- Is it well operated?

Tackling a problem through a systematic approach, such as a logic framework approach, demands a definition of the problem. This also has to be reflected in the policy and in plans. All of this is facilitated and clarified by the use of a conceptual framework. Related to this is the use of models and psychosocial theories to address the HIV problem at the university. Ideally the problem should be described in detail and thoroughly analysed prior to the initiation of planning.

### Defining the problem

Although a clear definition of the problem in the student population is essential and the problem is likely to be different at the various HEIs, the study found that not much effort is put into this issue. We found that problem definition, situation analysis and needs assessment are focused upon only in two of eight HEIs. Very little social science research about the student population has been undertaken in order to understand and define the determinants of HIV incidence in this population, even though many universities have strong psychology, anthropology and sociology departments. Needs assessments for PE are also often limited, but reportedly conducted, at least to some extent, in 4 out

**Table 1** Funding for HIV/AIDS 2007/2008 in Rand (000's)

| Name of HEI | Own funding | DoE funding | Donor funding | TOTAL | % own funding |
|---|---|---|---|---|---|
| CPUT | 212 | 250 | 1 912 | 2 374 | 9 |
| DUT | 0 | 250 | 2 621 | 2 871 | 0 |
| SU | 858 | 250 | 3 500 | 4 608 | 18 |
| TUT | 1 530 | 250 | 2 945 | 4 725 | 32 |
| UJ | 666 | 250 | 2 837 | 3 754 | 18 |
| UNIVEN | 332 | 250 | 1 932 | 2 505 | 13 |
| UWC | 437 | 250 | 3 310 | 4 000 | 11 |
| WITS | 1 043 | 250 | 2 831 | 4 125 | 25 |
| **TOTAL** | **5 078** | **2 000** | **21 888** | **28 962** | **18** |

of 7 HEIs. One reason this is not given more attention could be the emphasis on student participation in planning PE activities. Student opinions about PE activities could be assumed to address issues the students find important, thus providing some idea of the problem, and could be seen as indirectly constituting a

**Table 2** Selected resources and outputs at initially selected and later added HEIs in 2009

| HEI | No of students in 2007** | No of PEs | No of PE super-visors | No of psycho-logists involved in behaviour change/life skills training | No of PE recipients/ year (students who attend PE sessions) | | | Total no of students undergoing VCT/year (2009)/ no HIV pos. | | Total no of male condoms distribu-ted/ year | No of reported STIs /year | No of reported pregnan-cies and/or emergency contracep-tion pills given out/year |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | One-to-one | Small group | Large group | Through Campus Health | Through VCT campaigns | | | |
| UWC | 14 900 | 70 | 3 | 3 | 607 | 545 | 1 870 | 943/16*** | 2 147/12 | 324.000 | 334*** | 152/?*** |
| CPUT | 29 400 | 25 | 2 | 0 | - | - | - | - | 2 547 | 167 840 | _ | |
| SU | 23 300 | 61 | 1 | 1 | | | 10 080 | 704**** | 1 756 | 198.000 | 36 | ?/75**** |
| UCT* | 21 100 | 35 | 1 | 1 | 243 | 460 | >3 500 | 2 182 | 3 588 | 434.400 | 198 | 50/129 |
| WITS | 25 900 | _ | _ | _ | _ | _ | _ | 2 462 | | _ | 119 | 48 |
| TUT | 51 000 | 200 | 13 | 6 | 700 | 1800 | 21 050 | 1 984 | 2 800/16 | | 219 | 156 |
| UJ | 49 000 | 106 | 3 | 2 | No data | No data | 3 965*** | 3 082 | 1 990 | 165 000 | _ | |
| UNI-VEN | 11 000 | 50 | 3 | 0 | 392 | | 17435/41 grps | 1 257/19 | 1 345/22 | 143 158 | 285 | 280/374 |
| DUT | 22 782 | 100 | 2 | 0 | _ | _ | 5 000 | 3 863/111 | | 600.000 | 1 016 | 235 |
| NMMU* | 25 481 | 60 | 12 | 10 | _ | | | 2 082 | | 126 000 | 565 | 148 |

**Source** *Not one of the initially selected HEIs **Source: Draft Institutional Reports ***Jan-Nov**** Jan- Sept *** Based on 2009 LINK activities

needs assessment. However, the impressions obtained through such an approach risk being biased.

## Resources – human and financial

Resources for a key intervention, such as peer education, were reported to be limited in 5 out of 8 HEIs, while it was considered to be insufficient for Campus Health only in 2 out of the 8 selected HEIs. Financial resources are limiting activities in most of the HEIs, particularly regarding monitoring and evaluation activities. As current budget figures were not readily available for all HEIs, we used 2007/2008 figures, already available, to compare the different HEIs. We assumed that funding has retained the same magnitude since that time. As Table 1 shows, funding is often low. Overall, only 18% of the funds came from the HEIs' own resources, placing HIV control activities in a very vulnerable, unsustainable situation.

## Cross-cutting issues

All HEIs had policies for HIV and 7/8 had a functioning HIV/AIDS Committee, mostly called a HICC. 7/8 had an umbrella or strategic plan for HIV control. UWC had not appointed a HICC and had no umbrella plan for HIV control activities, but the HIV & AIDS Programme has been tasked with implementing the HIV & AIDS Policy HIV control was not mainstreamed in many HEIs, as many sectors opposed this, and (among other reasons) many thought it would contribute to AIDS fatigue.

The use of **Behaviour Change Theory** (see Annex 3) varied between the HEIs, but all programmes that reported indicated the use of theory for some components (7 out of 7 HEIs). One HEI also reported a shift in the view on the importance of current behaviour change theories away from individual models to those that can be applied to groups or to the community as well as to other social theories.

All programmes reported addressing gender inequality, cultural practices and stigma. All reported that students participate in the design and implementation of programmes (Table 4, Annex 4).

## Main prevention activities – VCT, PE, life skills training and condom distribution

As can be seen from the case descriptions, a distinct pattern of prevention activities can be distinguished.

**Table 3** Estimated number of VCT and condoms per student in 2009

| Name of HEI | Student population in 2007 | Total no of VCT, extrapolated for whole of 2009 | Proportion VCT per student and year %* | Condoms distributed per student |
|---|---|---|---|---|
| UWC | 14 900 | 3 175 | 21 | 21.3 |
| CPUT | 29 400 | 2 547** | 8 | 5.7 |
| SU | 23 300 | 2 694 | 12 | 8.5 |
| UCT | 21 100 | 5 770 | 27 | 20.6 |
| WITS | 25 900 | 2 462 | 10 | - |
| TUT | 51 000 | 4 784 | 9 | - |
| UJ | 49 000 | 5 072 | 10 | 3.4 |
| UNIVEN | 11 000 | 2 602 | 24 | 13.0 |
| DUT | 22 782 | 3 863 | 17 | 26.3 |
| NMMU | 25 481 | 2 082 | 8 | 4.9 |
| **TOTAL** | **218 963*** ** | **30 042** | **14** | **7.8** |

**Source** *Number of students tested > 1 is not reported ** Only VCT campaigns *** 8 HEIs with complete reports

In all the selected HEIs, except one, the foundation of HIV prevention was PE and VCT. In WITS, PE plays a less prominent role; it is used mainly to create awareness and in advocacy for VCT. It was also found that there is no directly professionally-led, large-scale behaviour change counselling programme at any HEI; and Life Skills and Resiliency Training are mostly basic, limited, and undertaken by peer educators. VCT, undoubtedly, is of high quality and the Campus Health Centres are very well equipped. Still, VCT counselling sessions, as elsewhere in Africa, remain limited and brief with an average of 20-30 minutes per session. However, a substantial portion of the student population does get tested. This varies between 8% and 24% in the selected HEIs and is 27% at UCT (Table 3). This percentage is much lower for male students than for females. The VCT campaigns that are carried out at most HEIs seem particularly effective in attracting students. Thus the majority of VCT are undertaken during campaign periods. PE is also of very high quality at many of the selected HEIs, but also limited in time allotment. It mainly consists in activities during the so-called "Orientation Week" at the beginning of term and in follow-up sessions during the semester. Although this leads to increased awareness as identified by KABP studies, it may not

**Table 4** Selected examples of Framework Indictors for the different issues at the initially selected HEIs (complete framework Annex 4)

| Indicator | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
|---|---|---|---|---|---|---|---|---|---|
| **Cross-cutting issues** | | | | | | | | | |
| Programme is strictly theory based | | | | | | | | | 0/7 |
| Parts of the programme are theory based | I | I | - | I | I | I | I | I | 7/7 |
| Programme is not theory based | | | | | | | | | 0/7 |
| Staff, Supervisors, PEs include **main drivers** of the epidemic in dialogue and thinking | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| Counselling | | | | | | | | | |
| Is there professionally-led, large-scale, behaviour change counselling at the HEI? | N | N | I | N | Y | N | N | N | 1.5/8 |
| **Life skills training** | | | | | | | | | |
| Facilitators, PEs, counsellors etc. are taught critical thinking and problem solving skills | Y | Y | Y | I | Y | Y | N | Y | 6.5/8 |
| Clients taught to increase self knowledge and self discipline | Y | Y | Y | Y | I | N | N | Y | 5.5/8 |
| **Peer education** | | | | | | | | | |
| Strict selection criteria are used | Y | Y | I | Y | Y | Y | Y | Y | 7.5/8 |
| PEs trained in Behaviour Change Theory | N | Y | Y | I | I | I | Y | Y | 5.5/8 |
| PEs develop strong linkages with referral institutions outside campus | N | Y | Y | Y | I | N | I | N | 4/8 |
| **IEC/BCC** | | | | | | | | | |
| Pre-testing of messages | Y | Y | I | Y | N | Y | I | I | 5.5/8 |
| Target populations participate in or are consulted on development and implementation | Y | I | Y | I | N | Y | N | Y | 5/8 |
| **Monitoring & evaluation** | | | | | | | | | |
| Evaluation plan for each HIV prevention programme | Y | I | Y | Y | I | Y | I | N | 5.5/8 |
| Computerised data collection system established | Y | I | Y | Y | Y | Y | Y | N | 6.5/8 |

lead to major change in behaviour. It certainly gives the impression of changing the behaviour of the PEs themselves. Incidentally, it was reported that more condoms are being distributed. The proportion of condoms varied from 3.4 per student to 26.3 (Table 3).

### Monitoring & Evaluation

Most HEIs report that there are too few resources available for monitoring. Monitoring primarily consists in recording attendance at VCT, condom distribution, STIs, pregnancies and emergency contraceptives as well as recording some PE activities. There is no readily available record of outcome measures (such as the number of partners and actual condom use). Nor do HEIs report HIV incidence/prevalence in the student population, although a recent HEAIDS study measured this. A number of HEIs do, however, carry out KAPB studies. But the validity of these KAPB studies may not always be assured. Few thorough external evaluations have been conducted. A thorough external evaluation of an HIV workshop was carried out at UCT with the use of EU funding (see UCT 4.7 and Annex 8.6).

### Research

Very little social science research into prevention activities, the student population, or the population in the surrounding community, was reported.

### Community Outreach Activities

Community activities are undertaken at some universities, but they generally constitute minor components. These are in-school activities, such as the UWC's school programme and other types of linkages, e.g. those established by the Link project at UJ.

## APPLICATION OF THE FRAMEWORK INDICATORS TO THE DIFFERENT PREVENTION COMPONENTS

As can be seen from Table 3, indicators show that the HEIs perform well on most programme components. The overall scores are high, indicating that the selected HEIs, in general, have Good Practices. Around 83% of the raw indicators show good practices. The weighted figure was 86% (complete figures for one university are missing). Thus, it seems to matter little whether it is the raw scores or the weighted scores that are used (see methods). PE and IEC/BCC score particularly well, while monitoring is lower. Almost all PE activities follow good practice, as do activities at Campus Health.

In other programmes, scores are lower (see Tables 4 and 5).

A summary of the indicators divided into components, programme elements, professional competence, and linkages is to be found below (Table 5).

## APPLICATION OF THE GOOD PRACTICE IN OPERATIONS CONCEPT TO HIV PREVENTION AT THE SELECTED HEIs

As can be seen from applying Good Practices in Operations to case descriptions and from the case descriptions themselves, there are a number of Good Practices in Operations at the various selected HEIs. These include good internal and external linkages, for example, good linkages between the VCT at Campus Health and PE in many institutions. However, in others, this co-operation is not as good, and for at least one or two HEIs it is very poor. In at least two HEIs, there are also very good external linkages, such as collaboration with DramAidE at TUT and the Link Programme at UJ. It appears that there is very good internal co-operation at UWC. Linkages to the communities surrounding the universities are limited and mainly consist in school programmes at a few universities. In one or two HEIs, the HIV programme strictly follows a conceptual framework, which implies advantages may be mainly in terms of monitoring and evaluation. In most others, the approaches are more practically oriented.

## EXPERIENCE OF RUTANANG

It seems clear that all HEIs used the Rutanang approach when initiating PE activities. Many, after

**Table 5** Summary of the simplified version of Good Practice Framework Indicators

| Good Practice Area/ HEI | CPUT | DUT | SU | TUT | UJ | UNIVEN | UWC | WITS* | Total Score | Maximum score |
|---|---|---|---|---|---|---|---|---|---|---|
| **Cross-cutting issues** | **2.5 (83%)** | **3 (100%)** | **3 (100%)** | **3 (100%)** | **2.5 (83%)** | **3 (100%)** | **3 (100%)** | **3 (100%)** | **23 (96%)*** | **8x3=24** |
| **Weighted Score Cross-cutting** | **10.4** | **12.5** | **12.5** | **12.5** | **10.4** | **12.5** | **12.5** | **12.5** | **95.8 (96%)*** | **8x12.5=100** |
| **VCT Counselling** | **11.5 (88%)** | **10 (77%)** | **11 (85%)** | **12.5 (89%)** | **10 (77%)** | **10 (71%)** | **11 (85%)** | **12 (86%)** | **88 (85%)** | **8x13=104** |
| Programme support | 0.5 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 3.5 | 8x1=8 |
| Programme elements | 3.5 | 4 | 4 | 4 | 3.5 | 3.5 | 4 | 4 | 30.5 | 8x4=32 |
| Prof. competence | 5.5 | 4 | 5 | 5.5 | 4.5 | 4.5 | 6 | 5 | 40 | 8x6=48 |
| Linkages | 2 | 2 | 2 | 2 | 2 | 2 | 1.5 | 2 | 15.5 | 8x2=16 |
| **Campus Health Services** | **12 (86%)** | **10 (71%)** | **13 (93%)** | **12 (86%)** | **11 (79%)** | **10 (71%)** | **11 (79%)** | **—** | **—** | **8x14=112** |
| Programme support | 1 | 0 | 1 | 1 | 1 | 0 | 1 | — | — | 8x1=8 |
| Programme elements | 8 | 8 | 9 | 8 | 8 | 7 | 8 | — | — | 8x10=80 |
| Linkages | 3 | 2 | 3 | 3 | 2 | 3 | 2 | — | — | 8x3=24 |
| **Weighted Score VCT+Campus Health** | **21.8** | **18.5** | **22.2** | **22.7** | **19.4** | **18.5** | **20.3** | — | **—** | **8x25=200** |
| **Life skills, Resiliency strengthening** | **8 (89%)** | **3 (33%)** | **8 (89%)** | **7 (78%)** | **6.5 (72%)** | **8.5 (92%)** | **9 (100%)** | **6.5 (72%)** | **56.5 (78%)** | **8x9=72** |
| Programme elements | 2 | 1.5 | 2 | 2 | 1.5 | 2 | 2 | 2 | 15 | 8x2=16 |
| Prof. competence | 6 | 1.5 | 6 | 5 | 5 | 6.5 | 7 | 4.5 | 41.5 | 8x7=56 |
| **Peer Education** | **24 (89%)** | **23.5 (87%)** | **21.5 (80%)** | **22 (81%)** | **24.5 (91%)** | **21 (78%)** | **25 (93%)** | **20 (74%)** | **181.5 (84%)*** | **8x27=216** |
| Programme support | 0 | 0 | 0 | 0.5 | 1 | 0 | 1 | 0 | 2.5 | 8x1=8 |
| Programme elements | 3.5 | 3.5 | 3 | 3.5 | 3.5 | 3.5 | 4 | 3.5 | 28 | 8x4=32 |
| Prof. competence | 18.5 | 19 | 16.5 | 16 | 19 | 16.5 | 19 | 15 | 139.5 | 8x20=160 |
| Linkages | 2 | 1 | 2 | 2 | 1 | 1 | 1 | 1.5 | 11.5 | 8x2=16 |
| **Weighted score Life skills+PE** | **22.2** | **18.4** | **20.5** | **20.1** | **21.5** | **20.5** | **23.6** | **18.4** | **165.2 (83%)*** | **8x25=200** |
| **IEC/BCC** | **5.5 (92%)** | **6 (92%)** | **5.5 (92%)** | **5.5 (92%)** | **6 (100%)** | **5 (83%)** | **6 (100%)** | **3.5 (58%)** | **43 (90%)*** | **8x6=48** |
| **Weighted score IEC/BCC** | **22.9** | **25** | **22.9** | **22.9** | **25** | **20.8** | **25** | **14.6** | **179.1 (90%)*** | **8x25=200** |
| **Monitoring and evaluation** | **9.5 (68%)** | **10 (71%)** | **12.5 (89%)** | **11.5 (82%)** | **9 (64%)** | **7.5 (54%)** | **10.5 (75%)** | **9 (64%)** | **79.5* (71%)** | **8x14=112** |
| **Weighted score M&E** | **8.5** | **8.9** | **11.2** | **10.3** | **8** | **6.7** | **9.4** | **8** | **71 (71%)*** | **8x12.5** |
| **TOTAL SCORE** | **75 (87%)** | **65.5 (76%)** | **71.5 (83%)** | **73.5 85%)** | **73 (85%)** | **65 (76%)** | **75.5 (89%)** | **—** | **(83%)*** | **8x86=688** |
| **Weighted score Total** | **86** | **83** | **89** | **89** | **84** | **79** | **91** | **—** | **(85%)*** | **8x100=800** |

**Source** * the scores have different basis; only the percentages can be compared

**Table 6** The Rutanang Approach

| HEI | | CPUT | DUT | SU | TUT | UJ | UNIVEN | UWC | WITS | Score |
|---|---|---|---|---|---|---|---|---|---|---|
| Does your PE programme build on the Rutanang approach | Yes, fully | | Y | Y | | | | | | 2/8 |
| | Yes, to some extent | Y | | | Y | Y | | Y | Y | 5/8 |
| | No, not at all or very little | | | | | | N | | | 1/8 |
| Did you find this approach useful? | | Y | Y | Y | Y | Y | | Y | Y | 7/8 |

gaining experience, have developed their own models. All HEIs that have used the model found the Rutanang approach useful.

# THE SPECIAL CASE OF THE UNIVERSITY OF PRETORIA

## UNIVERSITY OF PRETORIA

"One of the best papers we have written is one that argues against the idea of 'best practices'," stated the Director of the University of Pretoria-based Centre for the Study of AIDS (CSA). In many ways, this statement sums up the ideological position of the CSA regarding the conceptualisation and implementation of interventions for the prevention and management of HIV/AIDS. From this point of view, the UP case study differs from the standard pattern that emerges from the other HEIs.

The field visit to CSA primarily focused on clarifying CSA's position as a university-based research and intervention institution. The bulk of the information on CSA included in this report was sourced from the website. However, information from the website was used to substantiate some of the points that were raised during the field visit. It is important to delve into the ethos that influences the work that CSA does for the following reasons:

- CSA is one of those SA HIV/AIDS institutions that are the face of HIV/AIDS work in SA
- CSA is 10 years old. It is a source of invaluable experience that needs to be considered in the study of HIV/AIDS in SA
- CSA has taken a non-conventional route in the framing and management of HIV/AIDS in SA (and in general).
- CSA is thus a potential generator of innovative practices and ideas
- CSA has evolved into a major player in the global HIV/AIDS community. This is due to the fact that their work and focus remains rooted in SA.

### *CSA Partnerships*

Five leading international universities have joined forces to create 5-CHARI (the Five Centre HIV/AIDS Research Initiative).

This major new international collaboration brings together the combined resources of:

- The National Centre in HIV Social Research, University of New South Wales, Australia
- The HIV Social, Behavioural and Epidemiological Studies Unit, University of Toronto, Canada
- The Centre for the Study of AIDS, University of Pretoria, South Africa
- The Thomas Coram Research Unit, Institute of Education, University of London, United Kingdom
- The University of Sao Paulo, Brazil.

Drawing upon a common set of understandings, work within the five units is generating a better understanding of the epidemic, and contributing to

improvements in HIV/AIDS prevention, impact mitigation and care.

Consultatively and collaboratively, 5-CHARI is promoting:

- Innovative thinking about the epidemic, its course and development
- Development of new research paradigms and perspectives
- Greater recognition of culture, social structure and human relationships in the context of the epidemic
- New thinking about gender and sexuality as they relate to HIV/AIDS
- Development of new explanations of relevance to HIV/AIDS prevention and care
- Innovation and integration within the fields of sexual and reproductive health.

The above partnerships represent Good Practice because:

- They are global in nature and thus combine diverse experiences and expertise
- They represent a strategic sharing of resources
- They emphasize innovation and experimentation, which constitutes a chance for robust and dynamic paradigms and perspectives

As a university-based institution, CSA is well-placed to diffuse the lessons learned from this partnership to students, who are not only future leaders, but are members of communities facing the challenges of the HIV/AIDS epidemic.

CSA guiding principles at a glance:

- **Question the status quo.**
  CSA immediately attracts interest as it positions itself outside the dominant paradigms and perspectives in HIV/AIDS discourse. This is not a good thing in itself. The strength of such a position is derived from recognition of the continued need to problematise notions that are taken for granted. This has potential to foster critical thinking and engagement, leading to more effective innovations.
  CSA has positioned itself as a contributor to robust debate and discussion on HIV/AIDS. This is essential, given the continued need to grapple with HIV/AIDS in complex ways. To this end, CSA publishes a yearly journal: "AIDS Review".

- CSA, by virtue of its guiding ethos, does not do conventional HIV/AIDS work:
  "*We need to examine how we can work with this in a way that is practical, useful, and sustainable. There is the opportunity to do something about HIV for students that is more than just about information, more than the two weeks in your first year that touches on HIV. Every first year student goes through an amazing two week course, so that the university can tick the numbers off, but so what? People come from communities that are complex and informed by different values and structures. We need to think about how to inspire and motivate students beyond the AIDS 101 approach"* (Pierre Brouard, Deputy Director, keynote address AIDS Review Conference 2008)

- Recognize and acknowledge the complexity of HIV/AIDS:
  "*The CSA further promotes a holistic understanding of HIV/AIDS, where it is not simply seen as a pure medical issue, but as a social, medical, developmental and legal one. It is also a social epidemic, dominated by doctors and epidemiologists and biomedical people, but the roots of HIV are about beliefs, social practices, and inequality. If we only approach HIV from the perspective of rolling out VCT and ARVs, we are missing the root causes and consequences of HIV, which are in the social fabric of societies. It has the potential to disrupt social society, and while we need biomedical interventions, we also need to locate HIV in a social frame. Given that we are from universities, we need to look at HIV through different lenses – the lenses of sociology, anthropology, psychology, geography, history, law etc. Unless we take a holistic perspective, our interventions will be critical and narrow. We need to use those lenses to understand the epidemic.*" (Pierre Brouard, keynote address AIDS Review Conference 2008)

- No checklists.
  From this point of view, CSA is fundamentally opposed to the idea of checklists. It was highlighted during the field visit that the strength of CSA lies in its ability to adapt to the changing needs of the student population. More than that, recognition of the complexity of the HIV/AIDS epidemic necessarily goes against the practice of filling in checklists. The position against filling in checklists corroborates the need for a holistic, but nuanced, understanding of HIV/AIDS.

- Beyond the individual.
  Promoting VCT and ARV roll-out is but one aspect of HIV/AIDS prevention and management. However, experience has shown that individualistic, technical interventions do not lead to sustained, widespread changes in the HIV/AIDS epidemic. As Pierre Brouard notes: *"… but the roots of HIV are about beliefs, and social practices, and inequality. If we only approach HIV from the perspective of rolling out VCT and ARVs, we are missing the root causes and consequences of HIV, which are in the social fabric of societies. It has the potential to disrupt social society, and while we need biomedical interventions, we also need to locate HIV in a social frame". From this point of view, focus on preventing and managing HIV from an individual's point of view needs to be coupled with addressing the endemic socio-economic, structural and environmental drivers of HIV/AIDS. In other words, individual level interventions can only be sustained in an enabling environment."*

- Foster critical thinking – what is possible in the new SA?
  Another important CSA ideological viewpoint is to foster critical thinking in the student population. According to the briefing during the site visit, this means that students who engage with CSA one way or another are challenged to begin to adopt a critical view of fashionable, taken-for-granted notions, perspectives and practices. More than that, the CSA ethos encourages students to situate the epidemiology of HIV/AIDS in the unique SA context by asking what is realistically possible for which sector of society in the new SA. In other words, be cognizant of constraints against the wholesale ABC HIV prevention strategy. This is in line with the view of tailoring strategies to the needs of the recipients.

- Imagined futures.
  *"An important perspective taken by CSA is to enjoin students to begin to imagine a positive future for themselves, their communities and the broader SA community. This also applies to students who are living with HIV/AIDS. The aim is to build social capital and to work towards affirming young people, and making them positive about the future."* (Pierre Brouard)

- Respect the knowledge base of the student population.
  CSA also emphasizes the leadership role of students. It recognizes the vast knowledge base that students have and for this reason is against some of the standard information that constitutes HIV/AIDS education. The perspective of CSA is that some of the IEC material infantilizes and thus disempowers students who, in some instances, shoulder important responsibilities in their own right, such as heading households and caring for PLWHAs. CSA argues that some of the standard IEC material engenders AIDS fatigue. CSA argues that students are an adult community and should be treated as such.

- Inculcate a sense of personal and social responsibility.
  *"Universities are also places to get young people to start thinking about what it means to be an engaged citizen. I would argue that this means that it is important to look around, and to feel that one has a responsibility to do something, that it is about participatory democracy, and not just about having services, but about me being actively involved, about voting, and looking for ways to contribute to better governance."* (Pierre Brouard, keynote address AIDS Review Conference 2008).

- Experimentation, relevance and flexibility.
  CSA also advocates a tailored approach to HIV services at HEIs. CSA emphasizes that it is an organically evolved institution that is responsive to the needs of the University of Pretoria. CSA thus advocates experimentation and flexibility; continued relevance at the respective HEI.

- Positive attitude to sex.
  The opening phrase in their much-acclaimed booklet is: "Sex is ok" (and so is abstinence).

- The overall position of CSA is:
  - Students are privileged and awareness of this can be empowering
  - PE cannot change behaviour more than this. CSA calls their PE equivalents "befrienders", thus underlining the equal nature of the relationship
  - VCT is not a prevention strategy
  - Best practice is a fallacy
  - Broader view of HIV – need to improve QOL of the most vulnerable sectors of society
  - Building ramps – there is a need to strengthen enabling socio-cultural factors
  - Imagined futures and resilience – thinking beyond immediate circumstances/concerns.

## SUMMARY

The CSA approach is a Good Practice on many levels. It offers the most radical way of framing HIV as its prevention and management tackle the socio-economic roots. More than anything, the CSA's approach can serve as a check and balance, cautioning against clichéd, narrow and, ultimately, non-productive initiatives. The CSA approach to HIV framing and management is emblematic of the core business of universities: creative thinking.

## GOOD PRACTICES AT OTHER HEIs (SEE ANNEX 8.6)

After the initial selection of HEIs, we understood that Good Practices were also carried out at other HEIs. On the one hand, we knew that the report would be richer if these practices were also mentioned. On the other, we were aware that good practices were also carried out at universities that we would not be able to visit/contact. This being said, we nevertheless chose to make a description of individual good practices at additional universities, although we were neither able to make full case descriptions nor to assess Good Practices in Operations at these HEIs.

At the *University of Cape Town (UCT)*, like many of the initially selected universities, the PE programme is the backbone of prevention (see Annex 8.6). This is closely connected to health services at Campus Health. There are also Care and Support services. The PE activities here take place within a clearly defined theoretical framework. As its framework, UCT's HIV/AIDS programme has adopted the social theory of "an AIDS-competent community" of Catherine Campbell, London School of Economics. This serves as the theoretical framework for PE activities and aims to build the AIDS-competent community through:

- sexual behaviour change
- reduction of stigma
- support for people living with HIV
- access to services.

Achieving this involves:

- building knowledge and skills
- creating social space for dialogue
- promoting ownership and responsibility
- confidence in local strength and the agency to mobilize it
- building solidarity in the form of bonding relationships
- building partnerships in the form of bridging relationships.

Although these activities are similar to much PE work at other HEIs, the fact that it takes place within a theoretical framework has several advantages, particularly when it comes to monitoring and evaluation. For this approach, however, the theory must be good and reflect realities on the ground. This calls for a thorough situation analysis.

Closely linked to the PE programme is the "Me and AIDS" workshop. This is central to HIV information activities. UCT is one of only a few institutions to have allocated funds to evaluate the project. The "Me and AIDS' workshop at the Health Science Faculty has been subject to thorough external evaluation. The evaluation concluded that the workshop had been effective and was well appreciated by the students. It was found that the workshop was low-cost and showed good results regarding awareness. However, it was also noted that contact with PEs mainly takes place during Orientation Week, which limits what the PE programme can potentially offer. Moreover, the observation period was short and the observed changes in knowledge and attitudes were small. It was recommended that increased professional involvement of behaviour change researchers should be sought. Despite these limitations, carrying out an evaluation and using a theoretical framework for PE are important steps that constitute Good Practice. Monitoring and evaluation are facilitated as they fall within the same framework.

The *University of Zululand (UNIZL)* puts great emphasis on community outreach activities. The HIV programme recognises the great importance of the social norms of the community from which the students come. The students arrive with these norms as an integral part of their thinking and after a few years of study they return to the same community. Understanding the HIV determinants in the community is therefore crucial. "One of the drivers of the epidemic is that the student population, as well as the staff, come from a rural area with strong ties to the tribe. The norms and social imperatives promote gender inequality, unprotected sex, etc. There are taboos around discussing sex except in instances where the issues are discussed among peers. Because the university has a rural based constituency as well as staff, cultural issues are difficult to address, such as those that have to do with sexuality, taboos, male-female relationships. Staff are moving slowly on these issues."

The HIV programme has been conducting HIV prevention activities at schools and is now planning to expand that. A large proportion of the student population is from the Zulu ethnic group that does not practice circumcision. Discussions have been initiated by the Zulu king to address this issue.

At the *University of The Free State (UFS)* Community Focused Support is one of six key components of its HIV/AIDS strategy. It consists in an intervention in the farming community.

## Community Focused Support

UFS considers that prevention, treatment, care and support initiatives must be extended in the form of community outreach. Community service is an integral part of UFS core activities. Co-operative partnerships have been developed with the communities in the form of 'flagship' programmes.

### *Community flagships*

One of the flagships of UFS is the Free State Rural Development Partnership Programme (FSRDPP). Using this as a basis, community outreach programmes for prevention, treatment, care and support have been implemented in the communities of Philippolis, Trompsburg and Springfontein as part of the Free State Rural Development Partnership Programme (FSRDPP). What follows is a description and analysis of an intervention that has taken place over a period of 10 months in the abovementioned towns and surrounding farms. It should be noted that this is an ongoing programme.

**HIV/AIDS vulnerability among farm workers in the Southern Freestate** – *Education for Behavioural and Attitude Change in the Context of Living with HIV/AIDS: An Interdisciplinary Approach to Community Development amongst Farm Workers in the Southern Free State of South Africa.*

The farming industry in South Africa is experiencing serious economic threats due to the death rate among farm workers caused by HIV/AIDS-related illnesses. The above mentioned study analyzed an educational intervention, focusing on HIV/AIDS prevention and understanding, involving 8 farms and 90 workers. Interactive and didactic methods included self-reflection, storytelling and group work. Data were collected

through questionnaires and interviews. The workers learned the importance of knowing their HIV status. Their knowledge about HIV/AIDS increased and they developed skills to better manage their health. They became more positive towards people living with AIDS, about condom use, and status disclosure.

Farmers in the Southern Free State and specifically those in and around Springfontein have been trying for years to engage in some kind of discussion in order to assist their employees to better deal with the impact of HIV/AIDS on their families. In the past, mobile clinics visited the farms to minister Primary Health Care, including HIV-related services. But as relationships with Government deteriorated over the years, the services were terminated. As a result, farm workers in this area became a neglected and forgotten group as far as AIDS awareness programmes were concerned. The low literacy levels of most of the workers disadvantaged them further, as most of the printed awareness material passed them by.

This study provides an opportunity to investigate the impact of a specifically designed HIV/AIDS awareness programme on the knowledge, attitudes and behaviour of farm workers in the Springfontein region. The programme will be evaluated continuously in order to improve the methodology and content of the programme. The ultimate aim is to design an HIV/AIDS awareness programme that will assist farmers and farm workers to better deal with the impact of HIV/AIDS.

### Conclusion

While awareness of HIV/AIDS and basic prevention knowledge is quite widespread amongst populations in South Africa, it has been confirmed that there are still sub-populations, such as commercial farm workers, who still lack access to information and among whom HIV myths are still very much alive. The HIV epidemic cannot be removed from issues like sexuality, substance abuse, poverty and grief. The programme was well accepted because it covered all theses aspects, was taken to the farming community, had no political involvement or agenda, and built on some of the strengths in families.

This project can pave the way for other intervention programmes. It can point out the types of knowledge needed to bring about attitude change regarding matters of HIV/AIDS. It can also highlight the shortcomings of such programmes. Based on the above, the development of a programme for people with low literacy levels, as well as the training of peer educators to form a support network, becomes very important.

According to Whiteside, prevention campaigns must be maintained: as new generations become sexually active, they have to be reached and educated. HIV prevention is not something that can be “done” and ticked off a list. That is why it will be very important for close co-operation between stakeholders – including Government Departments, the University of the Free State, local NGOs, CBOs, farmers’ associations and others – to form the basis of these interventions and ensure long-term sustainability.

## IDENTIFIED GOOD AND INNOVATIVE PRACTICES AT HEIS OVERALL

### Good practices in specific components (PE, counselling, VCT, etc.) and in operations

Good Practice Framework Indicators confirm that the initially selected HEIs score high, indicating that they have good practices. Good Practice components in VCT and PE are found in many HEIs and are excellent in a few.

On the basis of the combined information from the Simplified Framework Indicators and the case descriptions, we identified Good Practices at several HEIs. These also relate to Good Practices in Operations.

#### *Good Practice in Programme Components*

##### *Voluntary Counselling and Testing (VCT)*

SA universities have an impressive VCT infrastructure. The VCT culture is well-entrenched, i.e. the infrastructure for rapid HIV testing is in place and there is increased awareness of VCT among students and the

university community. Recognition that VCT is the entry point for HIV care may encourage testing. The expanding antiretroviral (ARV) programme in the country may have contributed to this. VCT is generally undertaken within Campus Health. Housing VCT within Campus Health may pose challenges, such as supporting the previous mistrust of health care professionals who have been traditionally resistant to offering reproductive health care to young people. However, interviewees cited a number of advantages to accessing VCT on campus. These include accessibility, a convenient location, shorter queues, enhanced chances of follow-up, as well as continuity of care and the respect accorded to students as the core clientele of the service. Pre- and post-test counselling is either provided by a professional counsellor (in many instances a psychologist) or by a lay counsellor.

In general, VCT programmes boast the following characteristics in South African HEIs:

- VCT approach/procedure is fairly standard across SA HEIs.
- VCT is generally undertaken in Campus Health and Wellness Centres, which are, in turn, housed in Student Life buildings. These buildings also house SRC offices, canteens, campus radio (where applicable) and other amenities that are specifically geared to the non-academic service of students.
- Testing is generally done by a nursing sister who is either dedicated to VCT or also has other duties in the clinic.
- Rapid HIV testing toolkits supplied by the Department of Health (DoH) are generally used in VCT.
- Confirmation testing is also carried out on site, using a different toolkit also sponsored by the DoH.
- Pre- and post-test counselling is dispensed either by lay counsellors, who are supported by a professional counsellor, or by professional counsellors, who, in addition to holding psychology/social work degrees, have HIV counselling certificates.
- The whole VCT process takes about an hour.
- VCT is walk-in and client-initiated.
- Generally, follow-up sessions are built in for students testing HIV-positive.
- VCT is not anonymous, owing to follow-up sessions.
- VCT is linked to basic reproductive health care, such as STI management.
- Many HEIs are establishing networks with community-based organisations (CBOs) to facilitate continued care for those students who test HIV-positive in particular.
- VCT is closely linked to other HIV prevention initiatives, e.g. peer education and life skills.
- Campus Health usually collects VCT statistics.
- Regular, often once a term, campus/university-wide testing drives, sometimes in conjunction with external partners with more capacity to handle increased numbers of potential VCT clients.
- Follow the national HIV awareness calendar.
- Occasionally put together VCT-specific IEC.
- VCT is generally not viewed as a vehicle for behaviour change due to its short-term nature. Counsellors are usually untrained in behaviour change communication/practice.
- Following a DoH directive, VCT is not offered on Fridays. This allows for immediate follow-up where applicable, without the disruption of a weekend.

The above points to good VCT activity practices undertaken at all visited HEIs. However, the proportion of students tested annually varied from 8 to 24% of the student population, with high figures at UNIVEN and UCT.

### *Counselling for Behaviour Change*

At HEIs this has to be seen as part of VCT and as limited to the short pre- and post-test sessions. Professionally-led behaviour change counselling only occurs on a one-to-one basis in specific cases. As far as was reported, there is large-scale, professionally-led group counselling.

### *Peer education programme*

Peer Education (PE) is another well-entrenched HIV prevention initiative in SA HEIs. It is maybe fair to say that peer education is second in scope and focus to VCT in the HIV prevention package offered in SA HEIs.

In general, “main activities” take place on campus. These relate to the main functions of PEs and include information, awareness raising, advocacy for VCT,

and PEs as role models. The intensive activity during Orientation Week for first year students is crucial and constitutes the major activity. After initial orientation, PEs conduct a number of activities. These include:

- "Digital Storytelling Project". PEs conduct story-telling workshops to allow survivors of gender-based violence, witnesses of abuse, and individuals who have been subjected to HIV and AIDS-related stigma, to write and record first-person narratives about their lives. The goal of the storytelling circle is to provide these individuals with the support, skills and equipment they need to create original multi-media pieces (using still images, video clips, photos and music) to illustrate the impact these events had on their lives.
- "AIDS Act". An educational theatre project, aiming to relay the message of HIV prevention in a creative and fun way. The students who form AIDS Act are HIV and AIDS peer educators and other students interested in drama.
- "Gender-Based Peer Education Project". The aim of this project is to address gender power issues, masculinity issues, issues of sexual consent, sexual and reproductive health, gender-based violence, gender-based barriers to testing for HIV, other STIs, and to look at safer sexual behaviour within a gender context. Peer educators receive annual training to conduct a series of 10 workshops with first year students in the evenings in student residences.

Awareness raising takes place through a variety of media. Much information is through small group meetings with students, but also through discussions about student-selected subjects in larger groups. HIV-positive health promoters often participate in these discussions. They discuss pertinent questions that are formulated by the students, such as rape, gender inequality, homosexuality, gender-based violence and issues related to relationships and sexuality.

It also includes the use of a number of other media including drama and music. Innovation takes the form of designing posters and cards. The interventions, to a large extent, build on interaction with the student population, which plays a very active role.

Remuneration of PEs varies between HEIs. Most are offered a small sum of money for their services. At some HEIs, the PEs' work is entirely voluntary. Some (e.g. CPUT) provide PEs with certificates at a special Peer Education certificate ceremony.

Good practice PE programmes are offered by many HEIs, such as UWC, TUT and UJ, to name but these.

### *Condom distribution*

Condom distribution is an integral part of HIV prevention in SA HEIs. Condom dispensers are routinely placed in strategic locations, such as toilets and health care centres. Procurement of condoms from the Department of Health facilitates universal and uninterrupted condom availability on campuses. Although statistics tracing the distribution of condoms are generally kept, it is virtually impossible to ascertain the actual use to which such condoms are put. The likelihood of government-sponsored condoms being put to waste and not to use in a sexual encounter cannot be neglected due to a common lack of trust of the quality of these condoms. This mistrust is, at least, partly related to the recall of such condoms, as they sometimes do not meet acceptable quality standards. Various models for condom distribution exist. At some HEIs, the cleaning staff is responsible for condom distribution. But it is usually the responsibility of PEs. The numbers of condoms reported to be distributed to students vary from 3 to 26 per student per year, with high figures at DUT and UCT.

### *Life Skills & Resiliency Training*

Incorporating life skills into the repertoire of HIV prevention strategies is to recognise that everyday life poses challenges that call for informed decision-making. Teaching life skills also underscores the premise that making life-enhancing choices is a learned skill. The focus of life skills should be all-encompassing, responding to all facets of an individual's life. Life skills should not only respond to immediate concerns, but should also be prospective, anticipating future challenges.

Life skills for students at university level include academic skills, career counselling, dealing with

sexual harassment, gender dynamics, adjusting to university and campus life, and learning for life. HIV/AIDS knowledge and awareness are but a part of a savvy, independent, empowered and forward-looking student population. Life skilling should be an ongoing process. Learning a particular life skill should be an explicit process that takes the individual through possible scenarios towards mastering a particular skill.

Our research reveals a mixed picture regarding life skills support at HEIs. The shortage of professional counsellors dedicated to general life skills counselling may account for the lack of emphasis on life skills support. Again, providing training to individuals that will enable them to make life-/health-enhancing decisions is insufficient if it is not accompanied by the deliberate fostering of an enabling environment that supports an individual's chances to thrive.

In practice, Life Skills training is limited at most HEIs. It is mostly undertaken as part of Peer Education. At some HEIs such as WITS, it is more prominent and falls under the remit of professionals at Student Counselling.

*Community involvement*

It is neither desirable nor effective for Higher Education Institutions to function in isolation from surrounding communities. The university community is a microcosm of broader society and, therefore, the challenges that plague surrounding communities are reflected in the university community. Moreover, local communities are an important source of data for research, which is the lifeblood of the core goals of HEIs. To this end, HEIs are called to generate socially relevant and useful knowledge. Direct involvement of the skill base found in HEIs has the ability to mitigate some of the social ills that plague surrounding communities. This presents a win-win situation for both entities as students and staff at these universities benefit from the gains made by the communities from which they come. It complements and reinforces efforts undertaken within the institutions of higher learning. Good practices in community outreach are found at UFS and UZL as described above.

*Good Practice in Operations*

Many HEIs demonstrate Good Practices in Operations. Examples include the strictly theory-based approach of UCT that aims at an AIDS-competent society; the good internal linkages and excellent PE programme at UWC (including links with local schools); the good-practice external linkages with DramAidE at TUT; the link programme at UJ; and UP CSA's problematising approach. (See Annex 5 and Good Practices at other HEIs).

## FINDINGS OF THE WORKSHOP

After all of the data had been collected, the reports were finalised and approved by the HEIs. Representatives from all HEIs participated in a workshop to discuss the findings. At the workshop, the following subjects were presented:

- Behaviour change theory
- Research Instruments, including the Desktop Review, the Framework and the Good Practice in Operations concept
- Methods
- Findings
- Conclusions and Recommendations.

Discussions took place between each of the topical presentations. A number of issues emerged for the research team to address and include in the final report, notably:

- Motion to characterize practices as "promising practices" rather than "good or best practices". A concern that the notion of "good practices" within HEIs assumes a concerted approach across autonomous units whose only common denominator is dealing, at some level, with HIV. Sometimes units may have conflicting values.
- Appropriateness of using behaviour change models/theories in HIV management – these do not factor in underlying structural drivers of the epidemic. It was proposed instead that far-reaching theories such as "prospect theory" be considered.

Can Lewin's theories be used at group level, as individuals in the group may be at different levels of change?

- Need to talk about combination prevention that operates at individual, community and structural levels.
- Importance of going beyond "indicators" – need to factor in the context or make contextual inferences – tendency to reduce everything to categories and numbers.
- The student population is a transient population – that affects time frames for research/interventions.
- Limitation of any research: social desirability effect that leads to over and under reporting – this should be reflected in the report.
- A lot of changes in practices and the rationale that underpins them for example: VCT has evolved into a screening/referral tool. From this point of view, how is VCT assessed to be a "promising practice"?
- Counselling was framed as VCT in this study: counselling was not explored fully by the study and so conclusions cannot be made to this effect.
- There needs to be a paradigm change – what evidence supports VCT and PE as efficacious interventions? Need to question this and, if need be, go beyond these.
- There is a need to operationalise key concepts e.g. peer education as a concept may play out differently depending on how peer educators implement it.
- On what basis are we able to pronounce that this study is valid in light of the many limitations that have been highlighted?
- Need to comment on the internal validity of the study. Comment on the extraneous variables that may have confounded the findings.
- Recommendations should be more than programmatic – they should also be technical and strategic.

SECTION 5

# Discussion

This report described the study's limitations – chiefly that the research relied on interviews with stakeholders who may have favoured their own work, i.e., self-reports. Although certainly possible, we do not think this tendency should be exaggerated. The research team assessed that the replies given during the personal interviews were truthful. We could not validate the responses through triangulation because the students could not be interviewed, as the research was conducted during the examination period at the HEIs. However, we do not think that validity is a major problem as we are convinced the interviewees are responsible persons with considerable integrity.

Thus, we found that the study provides an indication there might be a rather uniform approach to HIV prevention, at least among resourceful HEIs in South Africa. Prevention activities in 7 out of 8 selected HEIs are dominated by PE and VCT; and in all 8 HEIs, VCT is prominent. These programmes all demonstrated good practices according to the simplified framework indicators. There is a larger scale, professionally-led, counselling/life skills training programme only at one HEI (WITS). Yet these efforts are still mainly carried out on a one-to-one basis and the magnitude is not clear. Curriculum integration is present at several HEIs, but still mostly on a limited scale.

This raises two fundamental questions which this study will try to answer: *Are the right things being done in the context of HIV prevention? And secondly, are the things that are being done, done in the right way?*

To answer these questions we first scrutinized the main interventions.

## PEER EDUCATION

There could be many reasons for the prominence given to PE at the HEIs. One could be that intuitively PE has been found to lead to results. Another could be that PE is the only option the HEIs can afford at any scale because of limited budgets. Or it could be that the introduction of the Rutanang approach has had a strong effect on the choice of PE as the main approach to HIV prevention, along with VCT.

Rutanang undoubtedly is a very valuable tool, as demonstrated by the finding that all selected HEIs found it useful (Table 6) and that all but one had used it, at least partially.

Yet PE activities are not uniformly seen as cost effective. This was demonstrated by a recent meta- analysis that concludes that peer education programmes are moderately effective "at improving behavioural outcomes, but show no significant impact on biological outcomes" (Medley, Sweat 2009)[21].

However, globally, peer education is one of the most widely used HIV prevention strategies (Population Council/Horizons 2000)[22]. Both the benefits and challenges of HIV/AIDS peer education programmes have been extensively described (Campbell and MacPhail 2002[23]; HEAIDS 2007[24]; Population Council/Horizons 2000[22]). According to Turner and Shepherd 1999[25], some of the most frequently cited benefits of peer education are:

- cost effectiveness
- peers as credible sources of information
- empowerment of those involved
- use of an already established means of sharing information
- greater success by peers compared to professionals in passing on information because people identify with peers
- the emergence of peer educators as positive role models
- positive benefits for the peer educators themselves.

Trained and supported peer educators are described as being capable of effecting change in the knowledge, attitudes, beliefs and behaviours of individuals and of the groups of which they are members. Optimistically, it is thought that peer educators may also be able to engender changes in norms in the wider community. Evidence that peer education programmes have been effective in different settings has been accumulating. For example, a study of workers in Zimbabwe (Katzenstein et al. 1998)[26] demonstrated that HIV incidence was 34% lower than in a control group; and a meta-analysis found that believing that friends used condoms had a strong correlation with actual condom use (Sheeran et al. 1999)[27].

Others have been more critical. Campbell and MacPhail[23] describe it as "a method in search of a theory". In other words, the popularity of PE in HIV prevention is not informed by theoretical soundness. In schools where the PE programmes were studied, the authors state that "*our research highlights a number of features of the programme itself, as well as the broader context within which it was implemented, which are likely to undermine the development of the critical thinking and empowerment, which we argue are key pre-conditions for programme success. In relation to the programme itself, these include peer educators' preference for didactic methods and biomedical frameworks, unequal gender dynamics amongst the peer educators, the highly regulated and teacher-driven nature of the school environment and negative learner attitudes to the programme. In relation to the broader context of the programme, we point to factors such as limited opportunities for communication about sex outside of the peer educational setting, poor adult role models of sexual relationships, poverty and unemployment, low levels of social capital and poor community facilities.*"

Pervasive gender inequalities can serve to undercut the potential of peer education programmes making them inadequate to meet the needs of young women. Fisher and Fisher (1992)[28] identified weaknesses in the sustainability of peer education programmes. Some peer educators identified strongly with the participants rather than with being a role model; they engaged in risky behaviours themselves. Others left school, decreasing the numbers remaining to continue the programme. Of course, limited human and financial resources may prevent implementation of the core elements of peer programmes that have been shown to produce good outcomes in a variety of cultural, social, and economic contexts worldwide. As pointed out in Rutanang, to be successful, PE programmes must be well structured and the PEs very closely guided and supported. Outcomes are related to the strength and rigour of the training, supervision and mentoring, receipt of compensation as recognition of their work, and the ability to support and meet the needs of peers who are living with HIV or AIDS.

Good practices in peer education programmes exist in the areas of: theory-based interventions, peer selection, training and supervision, content of training, methods, activities, delivery, community linkages and other partnerships, and monitoring and evaluation. The good practices are mostly self-explanatory. For example, regarding the delivery of peer education programmes , the literature reports that those of several months' duration have the greatest likelihood of producing desired outcomes. A major issue that

hinders optimal outcomes for participants in peer education programmes is, however, the need to address the gender-specific needs of women and men and to promote equity and human rights.

It would be unrealistic to think that peer education programmes alone, in any context, can influence power and control based on structural and cultural hierarchies and inequality. The role of a good peer educator, however, is to assist young women and men in assessing their current beliefs, perceptions, and intentions, re-conceptualising these beliefs and attitudes, recognising steps needed to change their relationships with partners (for example), and planning and trying out new actions. A rigorous recruitment policy is required to select peers who understand how to help their peers to improve their feelings of self-efficacy and decide to practice safe sex, free of coercion or violence.

Monitoring and evaluating ensure that peers are equipped to take on this complex leadership role of assisting participants to improve their capabilities and desire to conceptualise the possibility of establishing relationships that are equal, constructive and healthy.

We have found that many of the PE programmes we visited at HEIs in South Africa have most of these characteristics.

### *Remuneration of PEs*

Offering stipends to peer educators can increase their retention and motivation and enhance their self-esteem about making a social contribution. Paying trained male and female peer educators may act as an equalizing factor in how they and programme participants perceive men and women as educators.

In almost all of the visited HEIs, the PEs received remuneration and in one, CPUT, there was a prize-giving ceremony.

## VCT & Campus Health

Expanding access to VCT for HIV is an important first step in the development of a comprehensive package of HIV services. HIV counselling and testing seem to constitute a more effective means of secondary prevention for HIV-positive individuals and not an effective primary prevention strategy for those who test HIV negative (Weinhardt 1999)[29]. The HIV prevention potential of VCT is enhanced if VCT is part of an appropriate and proven mix of HIV prevention interventions. Utilisation of VCT services is positively associated with age, education, socio-economic status, proximity to clinics, availability of rapid testing, outreach services and lower levels of HIV-related stigma. The above considerations appear to influence women, whereas men are more influenced by the characteristics of VCT services themselves.

Global VCT best practice involves explicit risk and harm reduction counselling, which often includes systematic and explicit personal HIV risk assessment i.e. making the client aware of his or her specific behaviours and the associated risks, problem-solving and accessing help, stress management and behavioural skills training such as a practical demonstration of using a condom and negotiating use of condoms. While VCT practice in SA is not framed as following risk and harm reduction principles *per se*, Pronyk argues that because VCT is not just an information session, the very nature of the encounter between a counsellor and a client necessarily entails some form of risk reduction counselling (Pronyk)[30] (Hutchinson)[31]

We found that VCT at Campus Health constitutes good practice at all the visited HEIs. A substantial portion, varying between 8% and 27% (Table 3), particularly of female students, gets tested every year. Although, this percent of the student population could be increased further, particularly for male students, substantial efforts are made in many HEIs.

## Counselling for Behaviour Change

According to international standards, counselling for behaviour change should be guided by a behaviour change model, such as Prochaska's Stages of Change model. This has to be undertaken by professionals. However, such models are mainly used for individual approaches. They do not include the underlying and

structural factors, as discussed in the workshop, and therefore have to be combined with socio-cultural theories to be effective. However, we found that in the South African HEI context, very little professionally-led large-scale counselling for behaviour change takes place at all.

## Life Skills & Resiliency training

Life skills approach is a skills development approach that also embraces behaviour change as the major goal of health education. In the HEI context, it is mainly carried out by peer educators and is very basic in character. It is conducted on an individual basis by Student Counselling units at the HEIs, but these do not focus on HIV. We conclude that life skills training can only be effectively accomplished by professional staff. Peer educators can contribute, however, if well-trained and closely supervised.

## IEC/BCC

Information, education and communication (IEC) are an important part of overall HIV prevention strategy and access to treatment, care and support. IEC must be combined with other HIV prevention strategies to be effective. The focus may range from reducing stigma to encouraging VCT uptake. These can encourage the adoption of positive behaviours. Effective use of IEC involves an integrated communication strategy that includes a variety of communication activities that are coherently focused to reinforce each other. IEC can either be generalised, or specific to a defined group for an identified behavioural result. IEC can be as wide-ranging as using theatre, running advisory hotlines, using new media to exchange information, social networking and knowledge management and advertising.

Much of the above is effectively undertaken at the HEIs.

## Community Outreach

Although community outreach is one of the activities implemented many HEIs, we found that, with a few exceptions (such as the project among farm workers at UFS), it is on a very limited scale. Increasing community involvement would be a step towards increased focus on the local character of the HIV epidemic(s). We think such a focus is important and would, for example, lead to identifying the need to address the circumcision issue in the severe epidemic in Zululand and the "sugar daddy" issue at most HEIs.

## Monitoring & Evaluation

Although substantial monitoring of quantitative and qualitative indicators does take place, the research found that monitoring and evaluation were one of the weakest points among current activities. Cost is an important impediment to monitoring and evaluation, as disclosed by the Framework Indicators.

## Research

### *Research on the student population*

We found there are very limited efforts at clearly defining the HIV problem in the student population.

### *Research in the community*

Apart from the study among farm workers at UFS, we found that no or very little research is being conducted among the communities surrounding the HEIs.

## Good Practice in Operations

In answering the questions *"Are the right things being done?"* and *"Are the things being done, being done in the right way?"*, we conclude that what is being done regarding the main interventions of Peer Education and VCT is often of high quality, but that both Life Skills Training and Counselling could be strengthened by additional professional input, if additional resources are allocated. Furthermore, we think that additional efforts at a systematic approach could be made: the problem in the student population could be more clearly defined, the monitoring system further strengthened and results from this could be more effectively fed into prevention activities. Thus, we

think things are mostly done *in the right way* at the visited HEIs, but a more systematic approach could be applied.

Regarding whether *the right things are being done*, we think that, considering the magnitude of the HIV problem, HEIs need to play a more prominent role in national control efforts. This means stronger research efforts at community level and scaled-up community outreach efforts.

There is also an obvious need to set up a monitoring system for HEAIDS that also includes the HEIs that have so far not been appraised.

## Current HIV Prevention at HEIs and the Strategic and Policy Framework

According to the Strategic and Policy Framework, HEIs have a dual role both to inform and protect the student population and "to provide leadership to the government and to the community by addressing the whole range of political, social, legal and management implications of HIV and AIDS". HEAIDS is implemented as part of the multi-sectoral response to the epidemic in accordance with the national strategic plan – the NSP. These efforts need to be strengthened and more resources allocated to the HEIs, or as Prof. Malegapuru Makgoba, Vice Chancellor, University of KwaZulu Natal, expressed it: *"We need a higher education system that is anchored and understands its identity, one that drives its intellectual inspiration from the challenges we as South African society face – poverty, racism, HIV/AIDS, housing, infrastructure and transport."* [32]

If given sufficient resources, we are convinced HEIs in South Africa can fulfil this role.

SECTION 6

# Conclusion & Recommendations

The study indicates that many programme components and operations exhibit good practices. The research team found examples of excellent programmes conducted by qualified and enthusiastic staff at several HEIs. We are convinced these efforts have led to increased awareness and, at least, contributed to additional behaviour change.

The research has shown a relatively uniform approach to HIV prevention at the selected HEIs in which peer education and VCT are important components and where curriculum integration is gradually being introduced. The reasons for this uniformity could be the strong and positive influence of the Rutanang approach to peer education, the relatively limited resources, which do not allow for a variety of choices, and frequent contact and exchanges of ideas between the programme managers of the different programmes.

We also think that prevention, by definition, implies behaviour change such as reducing risky sexual behaviour or continuing non-risky behaviours such as abstinence. Efforts at counselling for behaviour change, and life skills and resiliency training, are important and necessary components of a prevention programme. By applying international good practices, it has been shown that such interventions are most effectively undertaken if guided by theory, including both individual-focused models and socio-cultural theories, and carried out by professionals with backgrounds and experiences in behaviour change interventions. We do not think this can be done effectively as part of VCT or peer education alone, if the counsellors or peer educators are not given specific tools and strong support, including the possibility of referring students, who have already entered a change process or are about to do so.

Peer educators are often first or second year students with limited life experience and without training in behaviour change theory or techniques. We think realistic, specific and appropriate targets have to be set for their activities. Such a target could be to address the stage of contemplation, using techniques to raise the students' awareness of their present behaviours, thus initiating the behaviour change process. We think behaviour change among the peer educators themselves may be possible. According to the relatively limited information we were able to collect, it does also take place among peer educators through training, support and monitoring. However, we also suspect that this might not take place in the general student population despite the excellent work of the peer education programmes at many HEIs.

We also suggest, in line with the thinking at some visited HEIs, that student counselling units staffed by psychologists could play a stronger role both in life skills training and in counselling for behaviour change through the use of psycho-social theory for groups and communities. The units would, of course, have to be considerably strengthened. Another approach would

be to employ additional psychologists/social scientists for the HIV programmes to strengthen the counselling activities.

Because of lack of resources, monitoring and evaluation was not undertaken to the extent that was desired at most HEIs. If more resources were made available and prevention activities were more based on theory, this would implicitly include a monitoring and evaluation approach.

We also found the lack of a systematic approach, to a large extent due to shortage of resources. Thus, few efforts were expended on defining the problem of the student population, for example by conducting a thorough situation analysis, including assessing the situation of students in their social context both on and off campus. Limited formal attempts were made to define the underlying determinants of HIV incidence both for the student population and for their community. Southern Africa has the largest HIV epidemic in the world. The reasons for this are not entirely clear. These will vary between different settings in the country. Understanding the local underlying determinants is important for effectively tackling the epidemic. HEIs have an important role to play in defining these and disseminating the findings in line with policies and strategies already outlined on increased involvement in control efforts in local communities. Although this is well in line with the HEI Strategic and Policy Framework 2006-2009 and beyond, HEIs have not yet fully taken on this task. It implies setting up additional research programmes and further strengthening social science research in particular, including a need to research more into behaviour change, i.e. how to outline messages, which media to use etc. It also means a larger share of overall resources allocated to HIV control and the DoE as part of national control efforts. The DoE currently receives a limited proportion of the overall funding for HIV control. HEIs ought to play a more central role in these efforts.

HEIs need to inform and protect the student population. As indicated above, we have observed that this is well done at many of the selected HEIs through increased awareness raising programmes , increased reported condom use among students, as well as increased VCT at HEIs. Similar efforts need to be expanded to other HEIs that were not researched. These have to be identified. This could be done using the same instruments after they have been reviewed and modified or similar ones.

But prevention efforts can also be improved at the good-practice HEIs. We have identified certain weaknesses in current approaches. These mainly reside in the definition of the problem in the student population, in monitoring and evaluation, and in the involvement of professionals. Such changes demand that additional resources be made available. The end to earmarked EC funding constitutes a threat to maintaining ongoing efforts. This threat has to be countered by substantial additional funding from the DoE. Such funding would be used effectively, as the human resources are already available in many places and capable of absorbing such funding.

## RECOMMENDATIONS

- The existing reference group that oversees the implementation of HIV prevention at HEIs should be further supported, to further improve the already impressive programmes at many HEIs.
- Increased advocacy work should be undertaken to secure a larger share of the national HIV control budget for prevention, including an increased share for the DoE.
- Control efforts at HEIs need to be strengthened through a systematic approach using psychological and socio-cultural theory to inform the development and implementation of the programmes and the monitoring and evaluation thereof. More behaviour change professionals (both those who know how to implement theory-driven programmes and those who know how to develop research and evaluation studies) should be involved in the offerings at HEIs. This implies the need to apply a theoretical framework to HIV prevention programming. A new focus will result in clearer problem definition and the fine-tuning of the goals and objectives of the HIV prevention approach

at HEIs. Theory-driven programming, a system-wide approach, and well-trained staff will result in improvements, enhancements, and expanded programmes. Skilled evaluators and capacity builders can develop or fine-tune data collection protocols to collect information through situational analyses. Stronger monitoring and evaluation systems will follow from a more theory based approach and also need to be instituted.

- Student counselling units, if strengthened, could take on a more important role in HIV prevention through more HIV/AIDS Prevention counselling and life skills training.
- Community involvement with HEIs should increase. The community can play a more important role in the institution's programmes. HEI also needs to engage with the community as well. For instance, in some communities where traditional healers are influential, staff has endeavoured to involve them in the HIV/AIDS Prevention programmes. Other problems such as the presence of "sugar daddies" on campus, older men from the local community, have not been addressed. Furthermore, PEs and staff could introduce significant interventions at local schools. The PE can help to prepare students entering HEIs to deal with the problems that arise due to the shift from living under the family's watchful eye to independent dormitory living. The issue of circumcision might be addressed.
- Non-selected HEIs need to be examined using improved versions of the research instruments used for this study. Identified weaknesses at non-selected HEIs need to be addressed. Improvements could be achieved through study visits to some of the HEIs mentioned in this report with excellent operations.
- A National HEI monitoring system needs to be established. Computerised information systems need to be set up at all HEIs. They must be asked to submit biannual reports of quantitative data analysis to HESA, as well as narrative reports with qualitative indicators that could be forwarded every second year.
- Considering the availability of high-quality human resources, and the large experience gained South African HEIs ought to take on an even more important role in HIV control both nationally and internationally. They would do this by first of all by contributing to the implementation of effective HIV/AIDS Prevention programmes at HEIs and in communities all over South Africa. Secondly by assuming leadership roles first in Southern and sub-Saharan Africa through exchange of experience and ideas and then thirdly internationally both by contributing to more important role for the Education sector in HIV prevention and by sharing experiences through scientific presentations and papers.

## SECTION 7

# References


1 UNAIDS 2008. 2008 report on the global AIDS epidemic

2 Barnett T, Whiteside A, Decosas J. The Jaipur paradigm – a conceptual framework for understanding social susceptibility and vulnerability to HIV. SAMJ Forum Nov 2000, vol.90:11

3 SADC. Expert think tank meeting on HIV prevention in high-prevalence countries in Southern Africa. Maseru, Lesotho 10-12 May 2006

4 HSRC. South African National HIV prevalence, incidence, behaviour and communication survey. 2008 – a turning tide among teenagers?

5 Wilson D, Halperin. Know your epidemic, know your response: a useful approach if we get it right 2008. Lancet 372: 423-4

6 Piot P, Bartos M, Larson H et al. Coming to terms with complexity: a call to action for HIV prevention. Lancet 372:845-59

7 National HIV & AIDS and STI Strategic Plan for South Africa 2007-2011

8 HEAIDS 2006. HEAIDS-Strategic Framework 2006-2009 and beyond

9 HEAIDS 2006. Policy Framework on HIV and AIDS – for Higher Education in South Africa

10 UNICEF (2007). Evaluation and lessons learned: *Innovations, lessons learned and good practices: Good Practices*, www.unicef.org/evaluation/??q=printm3.

11 FHI AIDSCAP, AIDSCAP Behavior Change Communication Unit (BCC) BCC *Handbooks No, 2* How to Create an Effective Peer Education Project, Arlington Virginia; Family Health International 2007. www.fhi.org.

12 Deutsch C & Swartz, S. (2004) Rutanang: Peer Education. Rutanang Collaborative/ http://www.commit.com/en/node/183654.

13 World Health Organization. (2004), HIV Counseling and Testing. Rapid HIV Tests: Guidelines for the Use of HIV Testing an Counseling Services in Resorce Constrained Settings, Geneva.

14 USAID (2010). HIV Counseling and Testing: Technical Issue Brief.

15 Mishya, V, Granwal, P.A., Alva, S, Gu, Y, & Wong, S. (September 2007). Changes in HIV-Related Knowledge and Behavior in Sub-Saharan Africa, DSH Comparative Repors, USAID, ICF Macro, Calverton, 214 pgs.

16 UNICEF, (n.d.).Life Skills, Fact Sheet, Definition of Terms from Wikipedia, the Free Encyclopedia.

17 WHO (1999), Partners in Life Skills. Geneva, 1999/ www.who/mnh/mhp/99.2,

18 Castle MA. Fisher B, Roos J. 2008. Good Practice HIV/AIDS Prevention Strategies for Public Higher Education Institutions (HEIs) in South Africa. Desktop Review

19 Castle MA. Fisher B, Roos J. 2008. Good Practice HIV/AIDS Prevention Strategies for Public Higher Education Institutions (HEIs) in South Africa. Desktop Review- Framework Indicators

20 Medley A, Kennedy C, O'Reilly K, Sweat M. (2009) Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis. AIDS Education and Prevention 21(3):181-206

21 Population Council/Horizons. *Peer Education and HIV/AIDS: Past Experiences, Future Directions.* Washington, D.C. and New York: The Population Council, 2000. www.popline.org/docs/1356/153885.html

22 Campbell, C. and C. MacPhail. "Peer Education, Gender and the Development of Critical Consciousness: Participatory HIV Prevention by South African Youth. *Social Science and Medicine* 55 (2002), no. 2: 331-345

23 Higher Education HIV/AIDS Programme (HEAIDS). Higher Education South Africa (HESA). *HEAIDS: Peer Education Project Report*. Pretoria: 24 Higher Education HIV/AIDS Programme, Higher Education South Africa, 2007

25 Turner, G. and J. Shepherd. "A Method in Search of a Theory: Peer Education and Health Promotion." *Health Education Research* 14 (April 1999), no. 2: 235-247

26 Katzenstein D, W. McFarland, M. Mbizvo, A. Latiff, R. Machenkano, J. Parsonnet and M. Bassett. "Peer Education among Factory Workers in Zimbabwe: Providing a Sustainable HIV Prevention Intervention." International Conference on AIDS 1998 12: 691 (Abstract no. 540/33514)

27 Sheeran, P., C. Abraham, and S. Orbell. "Psychological Correlates of Heterosexual Condom Use: a Meta-Analysis." Psychological Bulletin 125 (1999), 90-132

28 Fisher J, Fisher W. Changing AIDS Risk Behaviour. Psychological Bulletin 11(1992), no 3:455-474

29 Weinhardt, LS, Carey, MP, Johnson, BT, and Bickham, NL, (1999), Effects of HIV counselling and testing on sexual risk behaviour: Meta-analysis of published research, 1985-1997. American Journal of Public Health, 89, 1397-1405

30 Pronyk P M et al. (2001). The introduction of Voluntary Counselling and Rapid testing for HIV in rural SA – from theory to practice. RADAR, Health Development Systems Unit. School of Public Health. University of the Witwatersrand, SA

31 Hutchinson, PL and X Mahlalela AIDS Care, 2006 July 18 (5) pp 455-66. Utilisation of VCT services in the Eastern Cape, SA

32 Sunday Times (Higher Education Supplement) 3 April 2005

## ANNEX 1

# The Epidemiological Situation

South Africa has by far the most severe HIV epidemic in the world with more than 5 million infected individuals.

### The position of South Africa in the global HIV pandemic

As seen from this chart, the HIV epidemic in South Africa is out of an imagined line from the lower right corner to the upper left, corresponding to a general tendency of having more severe epidemics in poorer countries and less severe in richer. In South Africa, as in the other Southern African countries of Botswana, Swaziland and Namibia, there is a very severe epidemic. This exists in spite of a relatively high average income as these countries are all Middle Income Countries. Although attempts have been made to clarify the reasons for the high HIV prevalence here, there is certainly a need to reach an even more profound understanding of underlying factors and of ways to effectively enhance behaviour change in this context.

Looking more precisely into the occurrence of HIV in South Africa, it is clear that the epidemic is stabilizing.

But there are still large differences in HIV occurrence in the provinces.

What is encouraging, however, is that the incidence among the young seems to have declined

One reason for the decline might be an increase in reported condom use. This has occurred particularly among young people.

The overall task must be to address the severe epidemic in its entirety. Control efforts at HEIs constitute one part of this struggle. Although these HIV control programmes only address a small group of approximately 700,000 students, this population is of great potential importance as many are likely to serve as leaders and policy-makers in the future.

The question of the role of HEIs in overall HIV control efforts therefore also arises. Although efforts in HEIs only directly reach a small proportion of the total adult population, research and the communication of research findings in particular could potentially influence a much larger population – if enough resources are made available and utilised effectively.

It must also be kept in mind that it is likely that we are just at the beginning of the fight against the disease in South Africa. Considering the difficulties of the

**Table 1** Annex 1

| Year | HIV Prevalence (%) | 95% CI |
|---|---|---|
| 2002 | 11.4 | 10.0 – 12.7 |
| 2005 | 10.8 | 9.9 – 11.8 |
| 2008 | 10.9 | 10.0 – 11.9 |

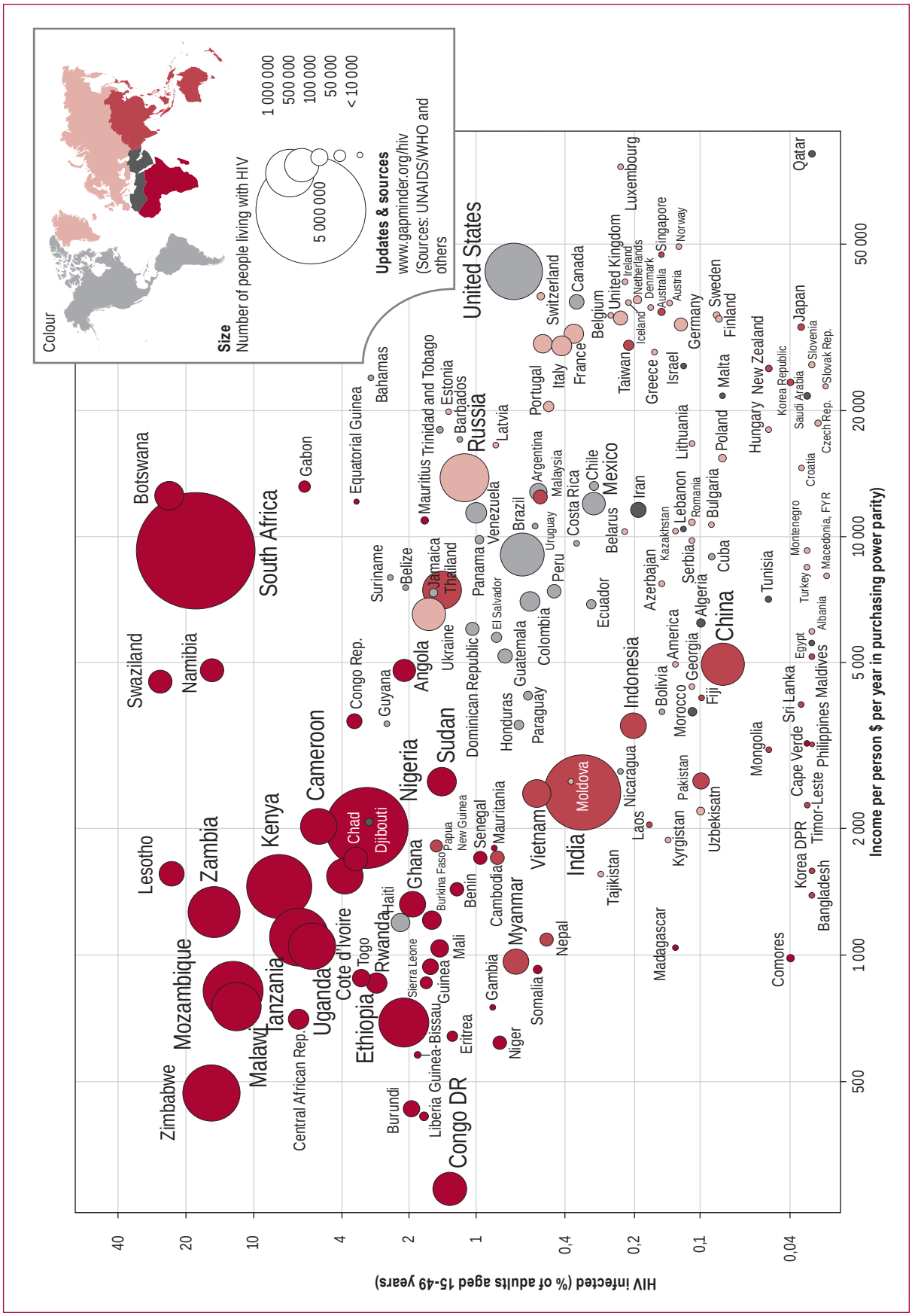



**Figure 3** Gapminder HIV Chart 2009

**Figure 4** HIV prevalence among 15 - 49 year olds by province, South Africa 2008

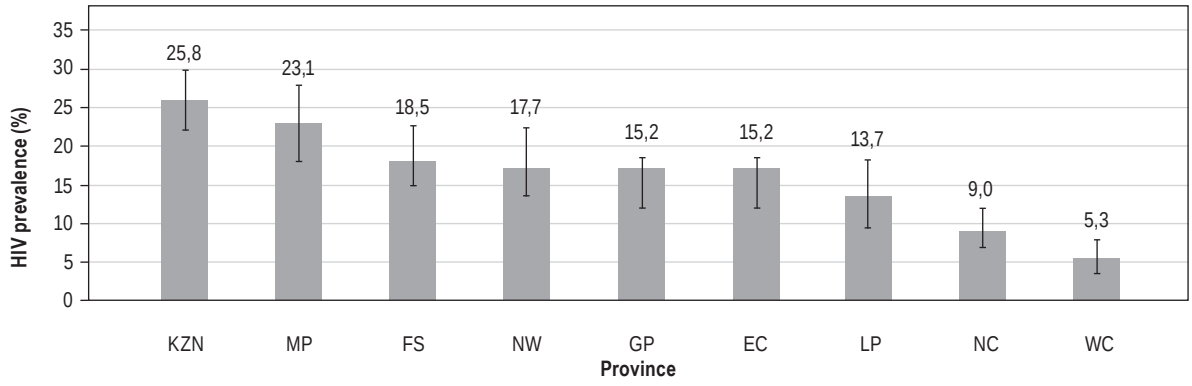



**Figure 5** Comparison of HIV incidence among 15-20 year olds, South Africa 2002, 2005 and 2008

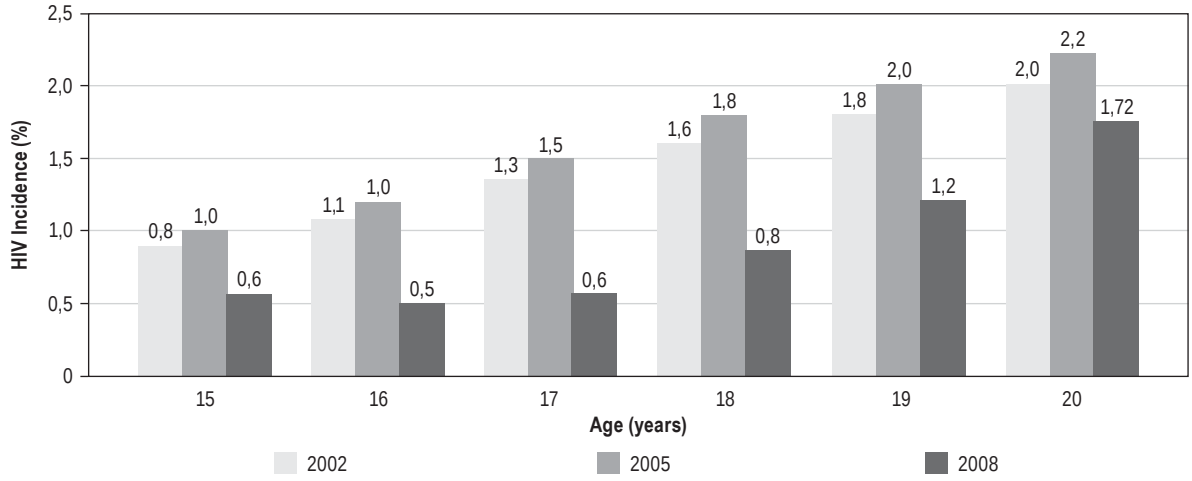



**Figure 6** Condum use by age group and sex, South Africa 2002, 2005 and 2008

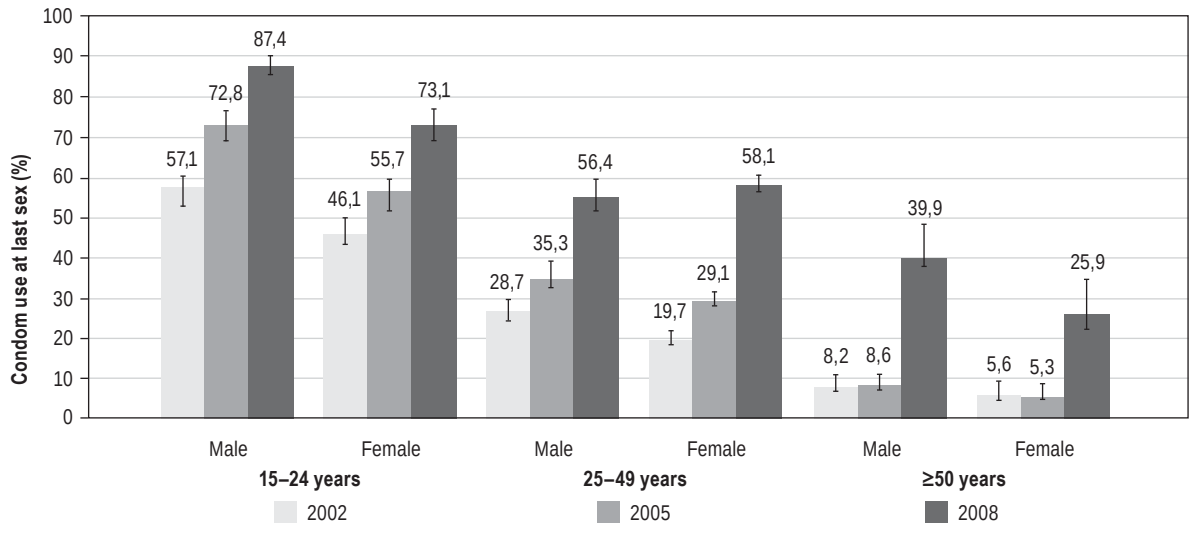


**Figure 7** Condum use at last sex, by province, South Africa 2002, 2005 and 2008

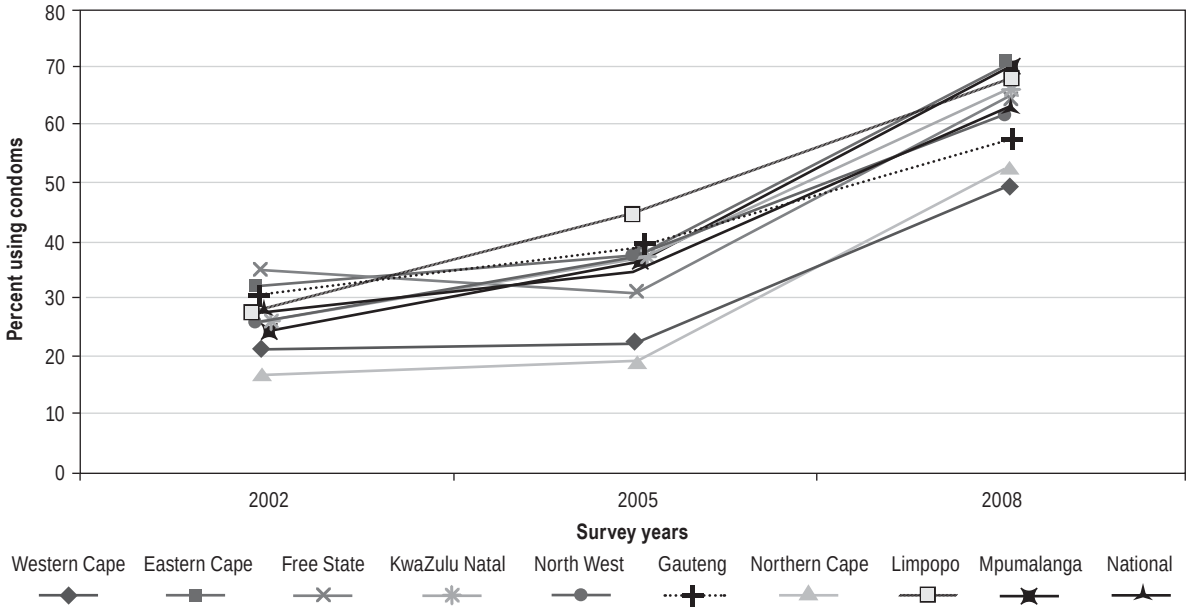
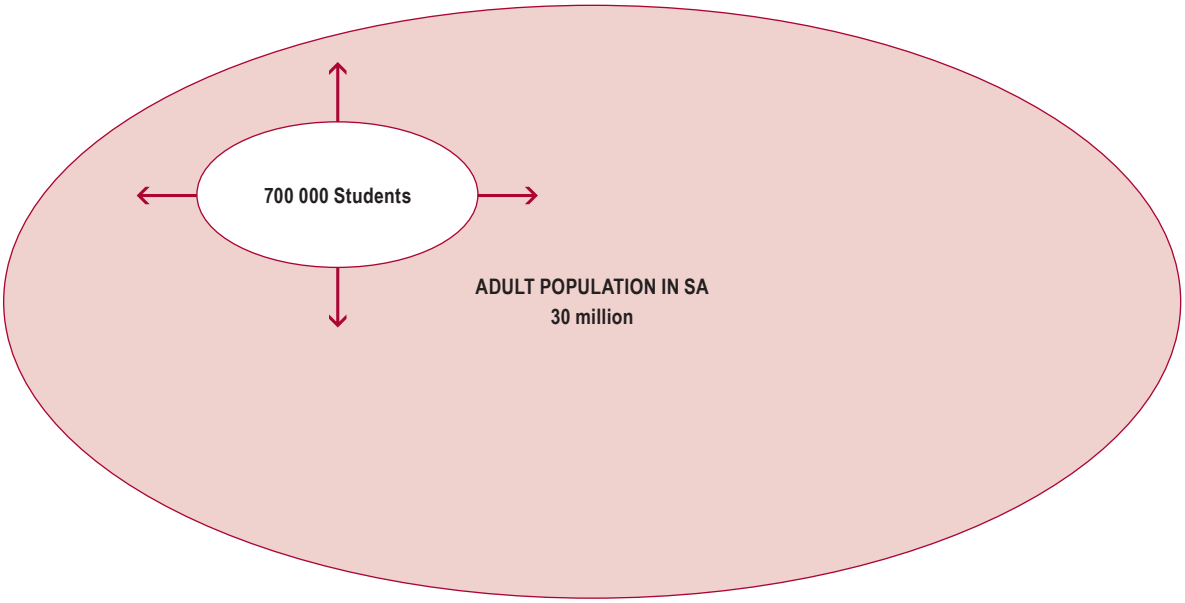



**Figure 8** Adult population in South Africa




struggle, generations of social change may be required before the epidemic is under control, unless there is a breakthrough in medical research into a vaccine or cure.

ANNEX 2

# The Good Practice Concept

## Good vs. Best Practice (Wikipedia)

The need to benchmark a practice using international standards arises from the increasing collaborative work that is being undertaken, the need to disseminate experiences to minimise waste, and the recognition that the world shares similar problems. The need to maximise use of scarce resources further encourages the need to share lessons. The idea of benchmarking a practice against some standard gives a sense of the (international) standing of a particular technique, method or activity with regard to its ability to deliver a particular outcome compared with any other technique, method or process when applied to a particular condition or circumstance. A "Best Practice" is one that has been tested over time and yields similar results with fewer unforeseen complications. The idea is that with proper processes, checks and tests, a desired outcome can be delivered with fewer problems and unforeseen complications. Best practices can also be defined as the most efficient (least amount of effort) and effective (best results) way of accomplishing a task based on repeatable procedures that have proven themselves over time for large numbers of people. A "best practice" denotes finality, authority, obedience and universality; and the matter is closed, decided, set and resolved. A "better practice", on the other hand, is not universal, but depends on the specific situation. Good practices are well-documented and assessed programming practices that provide evidence for success/impact and are valuable for replication, scaling up, and further study. They are generally based on similar experiences from different countries and contexts.

Criticism of the idea of good, better and best practice includes the potential arbitrariness of these concepts. Related to this concern is the unequal ability of institutions/entities to record and put forward a case for their practices, techniques, methods, processes and activities as a potential good or best practice. This relates directly to questions of capacity. It may also stem from an ideological reluctance to buy into global benchmarks that may, in fact, be prejudicial to local conditions and concerns. The latter underscores the salience of recognizing the peculiar, historical, organic evolution of practices and processes that are responsive to local conditions. The question of unequal access to resources is critical here. Finally, the concept of a standardised benchmark is not sensitive to change.

## ANNEX 3

# Behaviour Change Theory

HIV/AIDS Prevention can be broadly defined as any intervention that aims to prevent or reduce the risk of HIV infection. Interventions range from formal strategies, such as information, education and awareness campaigns, to more innovative approaches, such as those associated with behaviour change programmes. A number of strategies have been designed that include reducing the vulnerability to HIV infection and strengthening behaviour

**Table 1—Annex 3** Table of Theories Representing Different Levels of Intervention

| LEVELS | THEORIES | PROCESSES | INTERVENTIONS | OUTCOMES |
|---|---|---|---|---|
| Individual | • AIDS Risk Reduction Model<br>• Behaviour Change Communication<br>• Health Behaviour Model<br>• Personal Empowerment<br>• Theory<br>• Social Cognition (or Learning) Theory<br>• Stages of Change Model | • Participation with others to achieve goals<br>• Efforts to gain<br>• access to resources<br>• Some critical understanding of socio-political environment | • Information, education and communication (IEC):<br>- mass and small group<br>- education<br>- peer education<br>- testing and counselling | • Situation specific, perceived control and resource mobilisation skills |
| Group | • Social Change Communication<br>• Social Network Theory<br>• Theory of Empowerment | • Social/organisational process and structures to enhance member participation to improve organisation's goal achievement | • Theatre, drama, use of internet for education and support<br>• Consciousness-raising guided group discussions | • Development of networks<br>• Growth<br>• Policy leverage |
| Community | • Theory of Social Change or Empowerment Model<br>• Socio-economic factors, Participatory Change Communication | • Collective action to assess government or other community resources<br>• Improvement of quality of life<br>• Connections among community organisations | • Social influence and social network<br>• Outreach interventions<br>• School-based interventions<br>• Condom promotion and social marketing<br>• Community organizing, empowerment, and participatory action research | • Evidence of pluralism\ evidence of organisational coalitions<br>• Assessment of organisational process and structures to enhance member participation to improve organisation's goal achievement<br>• Assessable community resources |
| Structural | | | • Policy Level Interventions | • Increased Access to Services |

**Figure 9** Stages of Change


change programmes The programme framework should include behaviourally-based indicators for the design, development, implementation, monitoring and evaluation of HIV/ AIDS Prevention interventions and programmes. The outcomes of these programmes must be clearly spelled out in advance, that is, the outcomes must be behavioural. The choice of behavioural outcomes must be predicated on sound theoretical underpinnings. Relevant norms and standards must be identified to understand behaviour and behaviour change in the context of HIV/AIDS Prevention activities and programmes. Furthermore, individuals who are responsible for implementing or managing the behaviour change process must have an in-depth knowledge and understanding of human behaviour and of facilitating behaviour change at an individual, community and societal level.

Specific types of theories are available to change behaviour, depending upon how well they match the level of analysis of the change process. At the lowest level of analysis are ***Individual (Psychological) Theories***, next ***Group Theories, Community-focused Theories, Society-focused Theories*** and, finally, at the highest level, ***Policy-focused Theories.*** For a more comprehensive overview of behaviour change theories, see the Desktop Review.

**What is a Theory? What is a Model?** In the social sciences, a theory is an explanation or a testable model of a manner of interaction. It could also be a description of a set of natural phenomena capable of predicting future occurrences or observations of the same kind. A theory can be tested through experiment or falsified through empirical observation, **conjecture, opinion,** or **speculation**. Theories tell us why people do what they do. Models tell us how they do it. In this usage, a theory is not necessarily based on **facts.**

Programmes that stimulated behaviour change also demonstrated good practices and successful and innovative core elements that may vary in scope, content and mode of delivery. They all focus on one or more of the following objectives, that is, they are grounded in specific behaviour change theory and have rigorously trained programme implementers who are knowledgeable about techniques and methods and apply the theory to practice. Their focus includes reducing vulnerability to HIV infection, strengthening behaviour change programmes, customised actions and outcomes for different groups, focusing on vulnerable and at-risk populations including young people, creating an enabling environment for HIV testing and increasing the uptake and quality of VCT services. All of these strategies must be made operational so that the success of the programmes is measured.

Comprehensive Theory and Application of Behavioural Change:

**Several models** of behaviour change theory have been used to study prevention. The training was based on three Behaviour Change theories: The Health Belief Model, the Social Cognitive Model and the Transtheoretical Stages of Change Model. Participants were given campus-based cases and asked to apply the theories to them. Motivational techniques are not

used, so data was not collected on the techniques and methods used and their relationship to the theories.

Two models are presented below to demonstrate the salient issues in applying theory to HIV/AIDS prevention programmes. The first is the trans-theoretical model of behaviour change (Prochaska et al. 1983, 1986) which is one of the stage theories. The second is behaviour change communication.

When used appropriately, theories provide a framework for explaining and predicting individual behaviour change efforts. Programmes that focus on affecting social change in a community require a different process. Participatory communication is used to enable people and communities to define who they are, what they want, and how they can achieve the desired change (INFO Report 2008). The aim is to engage people and communities in making decisions that improve their lives. To accomplish this, programmes must expand opportunities for dialogue and debate and support community leadership. When community members help design and guide a programme, the community gains problem-solving skills and develops a commitment to the programme – both of which are critical to sustaining results (Salem et al. 2008).

### *Readiness to Accept Change*

Because of the complexity of the change process, some nagging questions persist. "How do I get a client to change his or her risky behaviours? What are the reasons why a student doesn't change, despite the dire consequences that seem clear to the change agent?"

When changing behaviour, the individual, community, or institution goes through a series of steps —sometimes moving forward, sometimes back, sometimes skipping steps. Individuals and communities are at different stages of readiness or preparation for change. They can move from having no or very little awareness, to being prepared for a change, to initiating the change, to maintaining change and then expanding it. Appropriate strategies must be developed for each stage of a community's readiness. In both cases, the specific ideas come from the individual or the community.

### *Accepting help occurs when a person is "ready," "willing" and "able" to change (Miller and Brown 1991)*

"Willing" means an individual must perceive the importance of making the change. When a client is "resistant", the counsellor must use interventions that focus on developing a discrepancy between that person's present circumstances and what he/she says that he/she wants for the future. According to self-regulatory theories, the change agent must support an on-going process, addressing the person's core values, many of which can be contradictory (Brown 1998; Kanfer 1986; Miller and Brown 1991).

### *Application of the Theory*

The Motivational Interview Process (MIP), which has been associated with the Stages of Change Theory, can be used in conjunction with other theories as well. The change strategy may differ even though the basic technique may remain the same. For example, in the first phase, the strategy is to raise the participant's social consciousness about the risks associated with his/her sexual behaviours and to facilitate the beginning of a transition to the Contemplation stage related to HIV-related sexual risk behaviours. To accomplish these objectives, the counsellor may use a Force Field Analysis or a Decisional Balance Strategy. Both of these strategies are intended to help the client identify what would make him/her either ready to reduce his/her HIV risk behaviours or not be ready to take those actions. After this strategy, the counsellor uses open-ended questioning to elicit more information about the client's reasons for changing or for maintaining his/her current behaviour. In the third stage, *Preparation/Determination*, the client has the intention to change immediately. The client may have been trying to change but without success. In the fourth stage, *Action*, the client will modify his/her experiences and/or the environment of the problem. In the fifth stage, *Maintenance*, he/she will work with relapse prevention, and the benefits of established changes made during the *Action* stage will be consolidated. In the final stage, *Termination*, the client is completely confident (has a high degree of self-efficacy) that he/she has succeeded in overcoming the problem.

When examining the differences in the psycho-social states of the client at each stage of change, it is clear that the counsellor is required to use a different strategy to move him/her along in the process. Despite all of the other types of interventions available, individual counselling is the most popular intervention strategy although media can provide information to a larger audience. Prevention counselling has to be tailored to the needs of the individual or a particular group. When working with young people, it is important to address their diversity and their needs, to encourage their participation in project design and implementation, and to work with them in a climate of openness that respects their real work. Therefore, a three-pronged approach of media, service delivery such as counselling, and outreach is required to ensure that the message is heard.

Based on a body of literature that supports client-focused counselling, emphasis has been placed on Harm Reduction Strategies and Self-determination Theory rather than on the strict requirement of a goal of abstinence (Brehm and Brehm 1981; Denning 2004;). The counsellor-guided interventions and techniques have been developed to help the client to move through the stages of change. During Motivational Interviewing, the counsellor utilizes specific counselling techniques designed to increase participants' motivation to engage in change. These methods involve strategies for formulating questions and reflective listening techniques.

Effective HIV/AIDS prevention counselling focuses on: 1) increasing clients' readiness to assess and perceive the benefits of changing their risky behaviour (drug and sex-related); 2) making a commitment to modify those behaviours; and 3) developing a plan to facilitate the changes. In their sessions, trained, professional HIV prevention counsellors use specific skill-building exercises, role playing, modelling behaviour, and action planning. They also identify people who will support the behaviour changes. Counselling that takes place over a longer period of time, i.e. more than one or two sessions, has proven to be the most effective for risky behaviours.

Some of these strategies and techniques – either unchanged or modified – are applicable to interventions at a group level. For example, Decisional Balance Strategies can be used with two or more clients. Open-ended questioning skills are useful in all settings and situations. Motivational Interviewing can also be applied in couples counselling (Miller and Rollnick 2002), in group counselling (Walters et al. 2002), and in medical and public health settings (Resnicow et al. 2002).

Motivational Interviewing can help a person to be encouraged by the success of others and by his/her own past successes. By strengthening a client's attitudinal change and helping him/her to master assertiveness or negotiation skills, the counsellor can increase the client's sense of self-efficacy. Once the counsellor and the client believe in the fact that the client can change, the client is encouraged to carry out the change process. Belief in one's own ability to envision and live a healthier life can lead to greater self-efficacy and can also increase resiliency.

Many variables influence the effectiveness of the counselling process. These variables include the degree to which the counsellors' work is grounded in theories of change and their application to practice, their level of knowledge and skills, and their ability to adjust their counselling approach to the needs and decisions of their client. Counselling that has been demonstrated to be effective tends to be longer than the usual length of time allotted to, for example, VCT. Most HIV/AIDS counselling tends to be brief, even though the problems are often are complicated. However, many of the HEIs, such as Wits, refer more complicated cases or those that require more than one or two sessions to their counselling or psychology centres.

## BEHAVIOUR CHANGE COMMUNICATION

A second, widely used approach to change is Behaviour Change Communication (BCC). BCC is an interactive process with individuals and communities to develop tailored messages and approaches. It uses a variety of communication channels to encourage positive attitudes and behaviours and to promote and to sustain individual, community, and societal change. BCC

is grounded in behaviour change theories that have evolved over the past several decades. Some of the most commonly cited theories in the HIV prevention literature that lay the foundation for BCC are: Health Belief, AIDS Risk Reduction, Stages of Change, the Theory of Reasoned Action, Diffusion of Innovation Theory, the Self-Efficacy Model, Empowerment Theory, and the Behaviour Change Continuum. These theories are valuable foundations for developing comprehensive communication strategies and programmes BCC practitioners usually apply a combination of theories and practical steps emerging from the realities of the environment rather than relying on any single theory or model.

In Behaviour Change Communication Theory, the core elements of some commonly used theories are described and the suggested methods are applied to practice. Designers of an HIV prevention campaign can focus on individual behaviour change through strategies such as social marketing of condoms, raising awareness through print and broadcast media, and targeted sensitisation campaigns. Campaigns can also be designed for a higher level of analysis and to focus on social issues, such as human rights, stigma and discrimination, and gender inequality. For example, WITS and TUT follow the National HIV calendar that includes an awareness campaign during the university Orientation Week, the STI awareness/condom week around Valentine's Day, the reproductive health week in August, as well as the HIV/AIDS Commemoration Day on 1 December. Stellenbosch University has e-learning modules for first-year students, peer education and mass media exposure that include articles placed in local papers, radio interviews and public service announcements, poster campaigns and announcements.

In the context of HIV/AIDS, BCC is an essential part of a comprehensive initiative. Effective BCC creates opportunities for dialogue and reassessment of prevailing cultural norms and practices that increase the transmission of the HIV virus. Ideally, BCC raises awareness of the broader socio-economic impacts of the AIDS epidemic and mobilises and advocates for appropriate political, social and economic reforms that are needed to halt the upward trajectory of HIV infections (FHI 2002). For example, the University of the Western Cape uses a variety of media to present behaviour change communication. These include digital story-telling, gender-based peer education programmes, and behaviour-outcome counselling based on a large-scale behaviour change counselling model

An example of the use of drama comes from Tshwane University of Technology (TUT). TUT has a long-standing relationship with DramAidE. This partnership not only provides Peer Educators with innovative ways of presenting messages about HIV/AIDS prevention, but also with tools that expand their skill repertoires to market the concepts. DramAidE uses the arts for social change. The staff of DramAidE use interventions that apply theories of behaviour change and interactive participatory learning methods and techniques, and demonstrate strategies for conducting health communication campaigns. DramAidE staff conceptualizes communication as a dynamic cultural circuit involving complex social interactions whereby meaning is produced, interpreted, negotiated, and exchanged. All the projects have been evaluated by independent evaluators, using participatory action research with the clear objective of disseminating research findings through publications and advocacy aimed at the broader community.

## SYSTEMATIC PROCESS FOR BCC

Successful BCC programmes follow a systematic process that helps programmes work efficiently and to avoid mistakes. For those BCC programmes that focus on individual behaviour change, the process must include: analysis, strategic design, development and pre-testing of messages and materials, implementation and monitoring, and evaluation. Even if resources are limited, BCC programmes can carry out a modified version of these steps, such as: defining the intended audience, defining their objectives, developing the key message points, choosing the communication channels, ensuring good quality materials, and pre-testing materials and revising them based on feedback during the pilot stage (The INFO Project 2008).

To design an effective BCC strategy, it is critical to understand the point in the change process at which a community, individual or a majority of a targeted group, is. Different methods and messages have been shown to be more effective at different stages of the change continuum to achieve different goals. For example, communication through mass media can deliver accurate information to a specific population and can model or promote positive attitudes and behaviours. Appropriate policies must be enacted to support community social change. When audiences are ready to change, the activities, services or products being promoted must be available, accessible and acceptable to them.

All behaviour change programmes must recognize the profoundly complex nature of the social and cultural environments in which young people receive and interpret HIV/AIDS messages. It is equally important to recognize the ways that young people understand, experience and use HIV knowledge in the face of, or while constructing and performing, their sexual identities (Skinner et al. 2003). As LeClerc-Madlala (2002) suggested, young people must engage in a process of self-discovery whereby they achieve an understanding of the construction of themselves and their sexual identities and the ways that HIV/AIDS exacerbates their vulnerability. Health promoters (young people living openly and positively with HIV) are recruited and trained to conduct interactive workshops and campaigns about prevention of HIV and related issues, such as living openly, testing for HIV, and literacy. Health Promoters at TUT work with peer educators to encourage the delay of students' sexual debuts, to inform them of the risk of multiple concurrent partners, and to promote VCT and HIV counselling.

**Traditional gender relations** constitute a key obstacle to condom use among young people. Participatory learning techniques have been successfully used to nurture gender-equitable relationships between men and women. In one study, both male and female participants reported increased condom use, less transactional sex, less substance abuse, and greater communications among couples (Jewkes et al. 2007).

## CHANNELS OF BEHAVIOUR CHANGE COMMUNICATION

In addition to the more traditional communication channels such as radio, TV, CD-ROMs, videos, video conferencing and print media, Information Communication Technology (ICT) can provide enormous support in an effective response to HIV/AIDS. ICT is a cost-effective method of distributing health messages and disease prevention information. The Internet offers many different features that appeal to young people. By crossing borders, the Internet reaches multiple and large populations, thus, offering a low cost per person reach that is typical of broadcast media.

Web-based and other computer-based ICTs offer users more participation in health communication. Users can search for specific information, play educational games and take courses and quizzes. They can seek social support, share feelings and concerns anonymously, and obtain answers to sensitive questions via e-mail messages, interactive internet Web sites, and social media such as e-forums, blogs, and chat rooms. Increasing numbers of Web sites provide health information and messages to general audiences or to specific groups of users. They seek to promote healthy behaviours, enable informed decision-making, and enhance self-efficacy to seek health care services.

The Internet can be an ideal tool for expanding interventions and/or adding boosters. Not limited by time and space, Web-based interventions or components can enhance community or school-based efforts by reaching young people outside normal programming time. For example, through e-mail, bulletin boards, and other electronic forms, the Internet can offer access to information and resources that supplement face-to-face classroom or counselling experiences. Web sites can be easily updated and modified to meet changing needs. Because they provide information interactively and privately, Web sites are popular with young people. For example, numerous Web sites, such as the *LoveLife* site in South Africa, offer reproductive health information to adolescents.

Health communication programmes also use CD-ROMs and computer software. Settings range from primary care facilities to classrooms. These tools avoid problems with Internet access. In two states of India, for example, multi-media computer software in ICT centres informs migrant workers about ways to avoid HIV infection. The CD-ROM, *Your Moves*, could be video streamed and also screened in the waiting rooms of health clinics and classrooms, with content/messages reinforced by peer educators, counsellors, or teachers.

Worldwide, health programmes have used mobile phones to send health messages, remind people to take medicines, and to offer follow-up counselling for people with HIV/AIDS, tuberculosis, diabetes and other illnesses. *SafetyCricket HIV Quiz* was reportedly downloaded over seven million times in 2006.

### *Benefits and Challenges of New Technologies*

The Internet may be a powerful medium for delivering health and risk-reduction information. Expert systems can be created that provide customised feedback options for young people addressing risk and prevention issues. Importantly, sensitive topics may be more easily discussed because of the anonymity offered by many on-line communities (Skinner et al. 2003). Young people can also search for the health-related information that they need and want, but would be reluctant to request directly from a parent, teacher, counsellor, cleric or physician.

The Jordan Health Communication Partnership initiated an Arabic-language health programme called "Ask the Expert" for Internet users to submit questions and receive answers. Durban University of Technology created a similar programme. In order to control the potential problems of the chat room model, DUT established a one-way communication programme where an expert can answer questions about HIV/AIDS raised by students on line. This avoids misinformation or confusing information being given or inappropriate interactions from occurring.

## EVALUATION OF INTERNET HIV/AIDS COMMUNICATION

Only a handful of evaluations have been published on the merits of technology-based HIV programmes. It is therefore difficult to evaluate the effects of Internet prevention activities. Ybarra and Bull (2007) state "results to date suggest the Internet and cell phones are feasible technologies to deliver HIV prevention and intervention programmes for some target populations." Opportunities for future research include: (1) designing programmes for populations other than men who have sex with men who also are at risk for HIV, e.g. for youths, older adults, and the elderly; (2) integrating advances from other fields; (3) examining the potential for using text messaging to affect HIV behaviour change; and (4) applications of Internet-based programmes in developing countries (Ibid.).

## SUMMARY OF BCC INTERVENTIONS

BCC interventions have had mixed results worldwide. BCC interventions that utilize new technologies, such as the Internet, have not yet been adequately evaluated. Nevertheless, even if awareness programmes, by themselves, do not directly lead to behaviour change, they create a platform or prepare the environment for specific interventions (Parker et al. 2007). No single implementation vehicle is sufficient. BCC must be integrated into a multitude of other health promotion and HIV/AIDS prevention interventions. A mix of BCC and other distribution strategies in HIV prevention interventions in health services, NGOs, schools, workplaces, and communities is necessary to improve outcomes in a cost-effective manner.

## OTHER ACTIVITIES AND OPPORTUNITIES

Various types of programme, such as peer education and support groups, use HIV prevention interventions that include counselling for individuals, groups, and couples. It should be noted that peer educators in many HEIs do not do counselling. That is left to

the professional, often a member of the faculty who is a psychologist or a social worker. The peer educator is an educator – a student with expertise in HIV/AIDS prevention knowledge and strategies. Effective counselling and peer education can motivate participants to be tested and further client education about prevention issues can take place during VCT counselling. Counsellors can use their skills to help a client reduce his/her risky behaviours, develop self-esteem, and learn to be assertive and/or avoid peer pressure, and so forth.

Most succinctly put, Life Skills is a developmental approach that has behaviour change as the major goal of health education. Counsellors, teachers, peer educators and mentors use participatory teaching and learning methods to provide a balance of knowledge and skills in a gender-sensitive way. The approach is tailored to the needs of particular students.

The curriculum is designed to improve communication skills, analyse and clarify values, and develop decision-making and stress management techniques. Since the approach is interactive and participatory, Life Skills incorporates group work and discussions, brainstorming, role play, educational games and debates. Facilitators provide consistent opportunities for students to practice and reinforce the skills they are learning. In the area of HIV, a Life Skills approach aims to increase young people's knowledge about HIV/AIDS and the ways that they can protect themselves from contracting the virus. Anticipated behavioural outcomes include participants' postponement of initiating sex, decrease in drug use, increase in drug treatment, decreases in HIV and STI infections, consistent use of condoms, reduction in unwanted pregnancy, decrease in number of sexual partners and in transactional sex, and so forth.

Protective factors include social supports and educational opportunities for students to participate and become meaningfully involved in the classroom and research as well as external environments (e.g. in the community). Examples include encouraging students to become peer educators; involving them in the design of prevention programmes that utilize new technologies, such as Internet blogs; awarding credit for working on a 24-hour abuse/rape/HIV hotline or at a university-owned radio station with weekly or daily question and answer periods about issues of importance to young adults; offering co-operative learning research or other educational experiences, such as filming their own video about a social issue, and so on.

Each of these educational experiences provides students with opportunities to master the knowledge and skills that are required to make a social contribution while they are attending the university and when they enter the workforce. Meaningful participation is related strongly to an improved sense of satisfaction, self-esteem and confidence. These educational activities can increase opportunities for student-constructed learning and prepare them to hone their problem-solving abilities. These activities greatly expand the number of students who act as informal peer models and community change agents. They also expose more students to male peers who have equal relationships with women or who use condoms and to female peers who are confident and have the necessary communication skills to negotiate safe sex.

## AIDS RESEARCH INITIATIVE (ARI)

The ARI is the central data base for all staff and student HIV-related projects. These range in size and scope from postgraduate projects to large-scale community-based projects. The ARI is also instrumental in disseminating funding and conference and related information to the AIDS research community at WITS. ARI also provides resources for PhD student projects, some of whose proposals were presented for HEAIDS funding. ARI also organises seminars for the WITS AIDS research community.

ARI is a Good Practice on the following levels: 1) The central data base is an efficient way to organize research; 2) ARI is very active in disseminating funding and conference information. ARI is thus a gateway to the WITS AIDS research community and a bridge between WITS initiatives and national/international

initiatives; 3) it is actively involved in supporting emerging researchers by sourcing funding support for them; and 4) it facilitates ongoing communication through seminars and symposia between the diverse programmes/projects that are to be found at WITS.

## SUMMARY

Clearly, what has been set out in terms of developing and applying theory to HIV/AIDS Prevention programmes required hard work and challenging applications of the theory in an effort to make changes in student behaviour. While support in the literature exists for the application of theory to practice, the necessary knowledge and skill, as well as support, to do so does not appear to exist. Many of the HEIs have focused on skill-building methods and techniques. Many are associated with behaviour change communication. These techniques and methods include VCT campaigns, the use of technology such as call-in programmes that give students the opportunity to speak anonymously with "the Expert," student focus groups to test literature, posters (i.e. social marketing), etc. What is still limited is evaluation and research that can inform programme mangers as to whether change has occurred because of their efforts; if not, what could be changed to obtain greater outcomes. Behaviour change theory and the research necessary to determine the impact of these types of programmes have not been perceived as a significant component of HEAIDS' agenda. It would be valuable to establish pilot programmes at a sample of HEIs to test the efficacy of a comprehensive behaviour change HIV/AIDS Prevention program, i.e. one that uses theory in the process of designing, implementing, monitoring and evaluating the application of theory to practice.

## ANNEX 4A

# Simplified version of the Framework Indicators for HEI

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| **Cross-cutting issues** | | | | | | | | | | |
| Prevention programmes based on a behaviour change model | Programme is strictly theory based | | | | | | | | | 0/7 |
| | Parts of the programme are theory based | I | I | | I | I | I | I | I | 7/7 |
| | Programme is not theory based | | | | | | | | | 0/7 |
| Discussions/consciousness raising includes the subjects of gender inequality, cultural practices and stigma | Staff, Supervisors, PEs include **main drivers** of the epidemic in dialogue and thinking | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| Recipients/students influence design and implementation of activities | | Y | I | Y | Y | Y | Y | Y | Y | 7.5/8 |
| Programme activities tailored to recipients | | Y | I | Y | Y | Y | Y | Y | Y | 7.5/8 |
| **Counselling (mainly applies to VCT)** | | | | | | | | | | |
| Is there professionally-led, large-scale, behaviour change counselling at the HEI? | | N | N | I | N | Y | N | N | N | 1.5/8 |
| If no, are behaviour change counselling activities part of VCT? | | N | Y | Y | N | N | N | Y | Y | 4/8 |
| Programme support | | | | | | | | | | |
| Counselling (VCT) receives sufficient financial and human resources | | Y | Y | N | Y | Y | N | I | N | 4.5/8 |
| Counsellors maintain privacy and confidentiality | | Y | Y | Y | Y | Y | Y | Y | Y | |
| *Programme elements* | | | | | | | | | | |
| Counsellor clarifies the rights and responsibilities of both the client and the counsellor | Case records are maintained | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| Counsellors updated on latest knowledge in the field of counselling | Counsellors offered regular training opportunities | Y | Y | Y | Y | Y | Y | Y | I | 7.5/8 |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| Counselling is of appropriate duration | Counsellors provide more than one session if possible/necessary | Y | I | Y | Y | Y | I | Y | Y | 7/8 |
| | How many minutes per VCT pre-test session? | NK | 20–30 | 20–30 | >30 | 20–30 | 20–30 | 20–30 | 20–30 | 20–30 |
| *Professional competence* | | | | | | | | | | |
| Counsellor trained in use of appropriate Behaviour Change Theory | | N | Y | Y | Y | Y | I | N | I | 5/8 |
| Counsellors is trained in HIV knowledge, cultural issues, stigma and discrimination | Counsellors knowledgeable in all key areas | Y | Y | Y | Y | Y | I | Y | Y | 7.5/8 |
| Counsellors follow professional practices | Pre- and post-tests, counsellors counsel according to accepted practices | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| Counsellors include condoms in teaching | Counsellors always demonstrate correct ways of condom use to clients | Y | Y | I | Y | I | Y | Y | Y | 7/8 |
| Counselling results in improved knowledge and practices | Are client KABP surveys conducted? | Y | I | I | I | I | I | N | N | 3.5/8 |
| | Do clients have increased knowledge of gender and cultural issues? | N not part of VCT | Y | Y | I | Y | I | N | N | 4/8 |
| Counsellors maintain good quality client records | Periodic quality assurance of client records | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| *Linkages* | | | | | | | | | | |
| Counsellors have good linkages inside and outside campus | Counsellor has good internal linkages with psychologists, health services and care and support functions | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| | Counsellor has good external relations with NGOs | I | Y | Y | Y | Y | Y | Y | Y | 7.5/8 |
| **Life skills, resiliency strengthening (mainly carried out as part of Peer Education in the case of HEIs in SA)** | | | | | | | | | | |
| Life skills established as an integral part of HIV prevention | Life skills curriculum includes problem solving, conflict resolution and confidence building | Y | Y | Y | Y | Y | I | Y | Y | 7.5/8 |
| | Life skills curriculum includes gender inequality, cultural issues, stigma and discrimination | Y | Y | Y | Y | Y | Y | I | Y | 7.5/8 |
| Facilitators, PEs, counsellors etc. are taught critical thinking, problem solving skills | | Y | Y | Y | I | Y | Y | N | Y | 6.5/8 |
| Life skills are taught using multiple methods | Clients receive individual or group counselling, mentoring, coaching etc. | Y | Y | Y | Y | Y | I | N | Y | 6.5/8 |
| Facilitators, PEs, counsellors etc. are trained to develop resiliency in clients | Clients taught to increase self-knowledge and self-discipline | Y | Y | Y | Y | I | N | N | Y | 5.5/8 |
| | Clients taught to increase self-confidence and self-esteem | Y | Y | Y | Y | Y | Y | N | Y | 7/8 |
| Recipients/clients involved in design and implementation of prevention programmes | | Y | I | Y | Y | N | Y | Y | Y | 6.5/8 |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| Life skills & resiliency training followed-up | Are changes in KABP monitored through surveys, reports? | Y | Y | N | I | I | I | N | Y | 4.5/8 |
| Interventions tailored to recipients needs | Is needs assessment undertaken? | Y | I | Y | N | I | Y | I | I | 5/8 |
| **Peer Education Programmes** | | | | | | | | | | |
| *Programme support* | | | | | | | | | | |
| Are there sufficient financial and human resources for PE activities | | Y | N | Y | I | N | Y | N | N | 3.5/8 |
| *Programme elements* | | | | | | | | | | |
| Are activities theory driven? | Programmes use theory to provide comprehensive programmes | Y | I | | I | Y | I | Y | I | 5/7 |
| Rigorous Peer Education selection | Strict selection criteria are used | Y | Y | N | Y | Y | Y | Y | Y | 7/8 |
| | Appropriate balance between male and female PEs | Y | I | I | I | I | Y | Y | I | 5.5/8 |
| Clearly defined rules for PEs | Rules written down | Y | Y | Y | Y | Y | Y | I | Y | 7.5/8 |
| *Professional competence* | | | | | | | | | | |
| Comprehensive training curriculum for PEs | | Y | Y | Y | I | Y | Y | Y | Y | 7.5/8 |
| PEs trained in Behaviour Change Theory | | N | Y | Y | I | I | I | Y | Y | 5.5/8 |
| PEs trained in cultural factors incl. gender inequality, stigma and discrimination | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| PEs trained in multiple delivery methods | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| PEs trained in use of male and female condoms | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| PEs deliver at least 4 sessions per year to recipients | | Y | Y | I | Y | I | Y | Y | Y | 7/8 |
| Evaluation discussions take place after training events and highlights are recorded | | Y | Y | Y | Y | I | Y | Y | I | 7/8 |
| Informal discussions take place after peer-delivered sessions and highlights recorded | | Y | I | Y | Y | I | Y | Y | I | 6.5/8 |
| Feedback obtained from students and recorded | | | Y | I | Y | Y | Y | Y | I | 6/7 |
| Needs assessment undertaken to determine student needs | | | I | I | Y | I | Y | I | N | 4/7 |
| PEs feed back to supervisors | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| PEs satisfied with involvement in the programme | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| PEs benefit from participation | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| PEs have knowledge of how to recruit male and female students to participate in activities | | Y | I | Y | Y | Y | I | Y | Y | 7.5/8 |
| PEs successfully refer recipients to VCT | | Y | Y | Y | Y | N | Y | Y | Y | 8/8 |
| PEs routinely supervised | | Y | Y | I | Y | Y | Y | Y | Y | 7.5/8 |
| Supervisors provide emotional support for PEs | | Y | Y | Y | I | Y | Y | Y | Y | 7.5/8 |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| Supervisors continuously receive training | Supervisors trained in behaviour change theories | Y | Y | Y | N | Y | Y | Y | I | 6.5/8 |
| | Supervisors trained in methods of coaching, mentoring PEs | Y | Y | Y | Y | I | Y | Y | Y | 7.5/8 |
| | Supervisors trained to develop critical consciousness among PEs | Y | Y | Y | I | Y | Y | Y | I | 7/8 |
| *Linkages and Partnership* | | | | | | | | | | |
| Internal and external linkages | PEs develop strong linkages with referral institutions within campus | N done through sup v | Y | Y | Y | Y | Y | I | Y | 6.5/8 |
| | PEs develop strong linkages with referral institutions outside campus | N through sup-ervisor | Y | Y | Y | I | N | I | N | 4/8 |
| **Campus Health Services** | | | | | | | | | | |
| *Programme support* | | | | | | | | | | |
| Are there sufficient financial and human resources for Campus Health Services? | | Y | Y | Y | Y | Y | Y | N | N | 6/8 |
| *Programme elements* | | | | | | | | | | |
| Client privacy is respected | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| Hotline in place | | N | N | Y | Y | N | Y | N | N | 3/8 |
| Adequate services offered | ART | N | N | N | N | N | N | N | N | 0/8 |
| | Post exposure prophylaxis | Y | Y | Y | N | N | Y | Y | Y | 6/8 |
| | Emergency contraception | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| | STI case management | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| | Rape counselling | Y | Y | Y | Y | Y | Y | Y | I | 7.5/8 |
| VCT co-ordinated with PE advocacy activities | | Y | Y | Y | Y | N | Y | N | Y | 6/8 |
| Client services are youth-friendly | | Y | Y | Y | Y | Y | I | Y | Y | 7.5/8 |
| Services are easily accessible | | Y | Y | Y | Y | I | Y | Y | I | 7/8 |
| *Linkages and partnerships* | | | | | | | | | | |
| Good internal and external linkages | Good linkages with PE activities | Y | Y | Y | Y | N | I | Y | Y | 6.5/8 |
| | Good linkages with referral institutions | Y | Y | Y | Y | Y | I | I | Y | 7/8 |
| | Good relations with CBOs and NGOs that are part of the continuum of care | N | Y | Y | Y | I | Y | Y | Y | 6.5/8 |
| **IEC/Behaviour Change Communication (BCC) (at HEIs, mainly seen as IEC in combination with services)** | | | | | | | | | | |
| *Programme support* | | | | | | | | | | |
| BCC used to recruit clients to prevention activities and services | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| Pre-testing of messages | | Y | Y | I | Y | N | Y | I | I | 5.6/8 |
| Designed to meet the needs of target populations | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| *Professional competence* | | | | | | | | | | |
| Target populations participate or are consulted in development and implementation | | Y | I | Y | I | N | Y | N | Y | 5/8 |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| A variety of media used | | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| New media used creatively | | Y | Y | Y | Y | I | Y | N | I | 7/8 |
| BCC used to reinforce messages and strategies of other prevention programmes | | Y | Y | | Y | NK | Y | Y | Y | 6/7 |
| **Monitoring and Evaluation** | | | | | | | | | | |
| Sufficient resources for implementation | | Y | I | Y | I | N | N | N | I | 3.5/8 |
| Evaluation plan for each HIV prevention programme, including staff responsible for data collection, data entry, analysis, reports | | Y | I | Y | Y | I | Y | I | N | 5.5/8 |
| Data collection procedures are established | Qualitative and quantitative data collected | Y | Y | Y | Y | I | Y | Y | I | 7/8 |
| | Data collected for needs assessment | Y | I | | I | I | Y | I | I | 4.5/8 |
| | Client surveys regularly conducted | N | Y | Y | I | I | Y | I | N | 4.5/8 |
| | Behaviour change data collected: delayed initiation of sex, consistent condom use with main partner, decrease in number of partners, decrease in alcohol/drug use, counselling and testing statistics, number and type of clients, demographics of clients, referrals, follow-ups; and type of peer educator activities, etc. | I | I | Y | I | I | I | N | I | 4/8 |
| | Quantitative data on VCT attendance | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| | Quantitative data on number of STI clients | Y | Y | | Y | Y | Y | Y | Y | 7/7 |
| | Quantitative data on pregnancies/ emergency anti-conception | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| | Data on condom distribution | Y | Y | Y | Y | I | Y | Y | Y | 7.5/8 |
| Computerised data collection system established | | Y | I | Y | Y | Y | Y | Y | N | 6.5/8 |
| Quality assurance established | | N | I | Y | Y | Y | Y | I | I | 5.5/8 |
| Quarterly and yearly reports written | | Y | Y | | Y | Y | Y | Y | Y | 7/7 |
| External evaluations conducted at feasible intervals, such as 2-3 years | | N | Y | Y | I | N | I | Y | N | 4/8 |
| **SCORE** | | | | | | | | | | |
| **WEIGHTED SCORE** | | | | | | | | | | |
| **Added Question:** | | | | | | | | | | |
| Does your PE programme build on the Rutanang model | Yes, fully | | | Y | | | | Y | | 2/8 |
| | Yes, to some extent | I | I | | I | I | I | | | 5/8 |
| | No, not at all or very little | | | | | | | | N | 1/8 |
| Did you find this model useful? | | Y | Y | Y | Y | Y | Y | Y | | 7/8 |

## ANNEX 4B

# Questionnaires for Interviews

Questionnaires used for interviews with:

- IO/HIV coordinator
- Peer Education
  - Suppervisors and Peer Educators
  - Focus Group Discussion student participants
- Counselling & Life skills
  - Supervisors/counsellors
  - Focus group Discussion student partcipants
- VCT/Health services
  - Supervisors/counsellors
  - Clients/students
- Consent form for Focus Group Discussions

### IO/HIV COORDINATOR INTERVIEW GUIDE

Institutional Code: _____

Case # _____ Institution Name: _____

Campus # _____

Name/Title of Interviewee: _____

Interviewed by: (Circle one) (1) BFisher (2) Nokathula (3) SHanson Xint: _____

Address: _____

_____

Telephone Number: _____

Date: (yyyy/mm) _____ / _____

For office use only

Circle all HIV Prevention Programs on site (or at different campus) at this institution

0 = None

1 = VCT-Health services

2 = Peer Education Prevention

3 = Curriculum Integration

4 = Counselling/Life skills/

5 = BCC

6 = Other Prevention (list) _____

7 = Monitoring and Evaluation System

8 = Uses behavioral change theories to implement prevention activities

9 = All of the above

Respondent Age: _____

Respondent Gender: _____

Respondent Ethnic/Racial Identification: _____

Position: _____

Attending institution: _____ Yes _____ No

If yes:

Major study: _____

Years at Institution as an employee: _____

Years at Institution as a student: _____

**101a.** I will read to you a list of structures, HIV Prevention programmes and services that are funded by the HEAIDS. Tell me if you have an EU funded programme if you

| | | |
|---|---|---|
| 1. Have a HICC | ☐ yes | ☐ no |
| 2. Have a plan with clear objectives | ☐ yes | ☐ no |
| 3. Have a website | ☐ yes | ☐ no |
| 4. Do you have an organogram of the HEAIDS prog | ☐ yes | ☐ no |

If so could I have a copy. If not could please you draw it for me

**101b.** Which prevention programme components do you have? How many staff are currently employed in each component (within brackets)?

| | | | |
|---|---|---|---|
| ■ Peer Education | ☐ yes | ☐ no | ( ) |
| ■ VCT | ☐ yes | ☐ no | ( ) |
| ■ Behaviour change activities | ☐ yes | ☐ no | ( ) |
| ■ Counselling | ☐ yes | ☐ no | ( ) |
| ■ Life skills/resilience training | ☐ yes | ☐ no | ( ) |
| ■ BCC | ☐ yes | ☐ no | ( ) |

| | | | |
|---|---|---|---|
| ■ Condom distribution | ☐ yes | ☐ no | ( ) |
| ■ Health services | ☐ yes | ☐ no | ( ) |
| ▪ STI | ☐ yes | ☐ no | ( ) |
| ▪ ART | ☐ yes | ☐ no | ( ) |
| ▪ OI/TB | ☐ yes | ☐ no | ( ) |
| ▪ PEP | ☐ yes | ☐ no | ( ) |
| ▪ PMTCT | ☐ yes | ☐ no | ( ) |
| ▪ circumcision | ☐ yes | ☐ no | ( ) |
| ■ Small media | ☐ yes | ☐ no | ( ) |
| ■ Internet | ☐ yes | ☐ no | ( ) |
| ■ Radio | ☐ yes | ☐ no | ( ) |
| ■ Others, specify | ☐ yes | ☐ no | ( ) |
| | ☐ yes | ☐ no | ( ) |

**102a.** To what extent did the funding provided through HEAIDS meet your needs to extend the HIV/AIDS Prevention programmes and services at your institution?

☐ To a great extent ☐ To an extent ☐ So-so ☐ Slightly ☐ Not at all

Explain your rating: _____

_____

_____

_____

_____

**103. CROSS CUTTING ISSUES.**

What considerations did you take into account when you made decisions about the design and implementation of your prevention programme? Can you mention any guiding principles? Explain.

_____

**104a.** Have you or any of the individuals involved in the HIV Prevention Programmes had any exposure (training, group discussions, etc.) to behavioural change theory and/or its application to each programme area?

☐ Yes ☐ No

If yes, describe what has been provided.

_____

**Probes:**

Who has provided that training?

_____

*Note to Interviewer: If training has occurred, ask for the training curricula.*

☐ Available ☐ Not Available

If not available, give the reasons: _____

_____

_____

_____

List the Training Programmes or other events provided:

_____

**104b**. Which staff received training in behavioural change theory?

_____

**104d.** Give examples of how theory is or has been applied to changing the behaviours of participants in HIV prevention interventions.

**Probe:**

1. Do you believe that such theories are needed to develop successful HIV Prevention Programmes?

☐ Yes ☐ No

Give reasons for your answer _____

_____

_____

_____

**105a.** There are certain main drivers/determinants of infection that cut across prevention interventions. Is discussion on *underlying determinants* of infection such as social norms and traditional practices taken up. Are questions of multiple partners and concurrency addressed? Or, which other subjects do you focus on? Please develop further.

_____

**105b.** Is gender inequality part of the subjects taken up. ☐ yes ☐ no

If so how?

_____

**105c**. Is the role of alcohol and other mind-altering substances taken up? ☐ yes ☐ no

If so how?

_____

**105d**. Is the role in HIV transmission of the following *direct determinants* of infection taken up? Do you discuss:

- male circumcision ☐ yes ☐ no
- condom use ☐ yes ☐ no
- STIs. ☐ yes ☐ no

In which programme components are they discussed?

_____

**106.** **PROGRAMME COMPONENTS & SUPPORT SYSTEMS**

DO YOU HAVE ANY PROGRAMME COMPONENT YOU THINK IS ESPECIALLY GOOD OR INNOVATIVE? If so, in what way does it stand out? Is it operated in any special way? Are you following any special principles? Do you think any of the components **listed under point 4** could serve as a model also for other universities? Which component do you think of ? Can you describe what is good with it? Do you have any objective measurement of how effective it is? Kindly explain.

---

**107.** Training: is there some aspect of the training of PEs that you find particularly important to highlight? Any principles in training that are important? Explain.

---

**108.** Monitoring. Do you have a monitoring system? ☐ yes ☐ no

- Are you monitoring the attendance of the different components ☐ yes ☐ no
- Are you monitoring proxies of behavior change such as unsafe sex demonstrated by ☐ yes ☐ no
  - STIs ☐ yes ☐ no
  - pregnancies among students ☐ yes ☐ no
- Are you monitoring condom distribution? ☐ yes ☐ no
- Are you monitoring reported condom use? ☐ yes ☐ no
- Are you following trends in HIV prevalence in the student population? ☐ yes ☐ no

**109.** Research. Have you discussed "know your epidemic" approaches? ☐ yes ☐ no

- Are you doing any research on the student population? ☐ yes ☐ no
- Are you doing any research on the population in the surrounding community? ☐ yes ☐ no
- If so, are you using these research findings in the prevention activities? ☐ yes ☐ no

**110.** **OPERATIONAL ASPECTS**

IS THERE ANYTHING IN THE OPERATIONAL ASPECTS OF YOUR PREVENTION PROGRAMMES THAT WORKS PARTICULARLY WELL? If so why do you think so? Do you think this aspect could be used as a model on a national scale?

---

**111.** Operalisation. Are there meetings between the HIV coordinator and the staff working in the different prevention components? ☐ yes ☐ no

If yes, how often per month?

If no, for what reasons?

- Are there linkages between the components ☐ yes ☐ no
- Are there any external linkages ☐ yes ☐ no

Which? explain. How do they strengthen the programme, if at all?

**112 a**. How are staff and peer educators informed about HIV/AIDS policies and procedures?

---

**112b.** Have students or student organisations participated in the development and implementation of the programmes and services?

☐ yes ☐ no

**Probes:**
Describe the structures or mechanisms that encourage students, staff and/or PLHIV to participate in the design, implementation and evaluation of the programmes.

**113.** In this section, I would like to ask you some specific questions about the capacity of your institution to provide HIV prevention programs

| ACTIVITY | Yes | No | Describe |
|---|---|---|---|
| **113a. Administration**<br><br>1. Are there formalized, clarified, written HIV related policies re: discrimination, gender equity, confidentiality, PLHIV, etc.<br>**8.4.1.1.2 3. Are there functioning Committees for all**<br>**8.4.1.1.3 areas of HIV prevention (quality assurance**<br>**8.4.1.1.4 for VCT, peer**<br>**8.4.1.1.5 education)**<br>4. Is there a structure to evaluate supervisors and staff of these programs? | | | |
| **113b. Community linkages**<br><br>1. Are PLHIV involved in the HIV prevention programmes?<br>2 a Does staff have knowledge of, and access to, prevention programmes and related services in your community?<br>2.b Network developed/expanded Continuum of Care and/or referral relationships with other CBOs and service providers<br>3. Other | | | |

| ACTIVITY | Yes | No | Explain |
|---|---|---|---|
| **113c. PLANNING, EVALUATION and FEEDBACK Do you**<br><br>1. Have a multi-year strategic plan<br>4. Collect client satisfaction data<br>5. Collect client outcomes/behavioural data<br>6. Use available data (surveys, referral rates, focus groups, retention rates) in ongoing planning<br>7. Have an Management Info System (MIS)<br>8. Routinely enter data into the MIS system | | | |
| **113d. STAFF/HR FUNCTIONS. Have you:**<br><br>1. All of the critical positions/functions are filled<br>**8.4.1.1.7 2. Good staff morale/organizational commitment**<br>**8.4.1.1.8 3. Good staff-client rapport**<br>6. Good staff retention<br>8. Client Confidentiality<br>10. Staff and Volunteers are qualified to do their job<br>11. Staff and volunteers are culturally/linguistically appropriate to clients | | | |

**114a.** What aspect of these programs are you most proud of? _____

_____

_____

**114b.** Give your reasons: _____

_____

_____

**114c.** Identify the programmes that you would like to see strengthened. _____

_____

_____

**114d.** Describe how you would like to see them strengthened. _____

_____

_____

Notes: _____

_____

_____

_____

_____

## PEER EDUCATION HIV PREVENTION ACTIVITIES INTERVIEW – SUPERVISOR AND PEER EDUCATORS

**OFFICE USE ONLY**

Institutional Code: _____

Case # _____ Institution Name: _____

Address: _____

_____

Telephone Number: _____

Campus # _____

Name/Title of Interviewee: _____

_____ Supervisor of PEs

_____ Peer Educator

Interviewed by: (Circle one) (1) BFisher (2) Nokathula (3) SHanson Xint: _____

Date: (yyyy/mm) _____ / _____

Circle all HIV Prevention Programs on site (or at different campus) at this institution

0 = None

1 = VCT-Health services

2 = Peer Education Prevention

3 = Curriculum Integration

4—Counselling/Life skills/

5 = BCC

6 = Other Prevention (list) _____

7 = Monitoring and Evaluation System

8 = Uses behavioral change theories to implement prevention activities

9 = All of the above

## Read to Interviewee

As you know, the European Commission funded HEAIDS to assist higher education institutions to strengthen their capacity to initiate, expand or enhance HIV/AIDS prevention activities at their universities.

HEAIDS is interested in learning about good practices in HIV/AIDS prevention activities on higher education institution campuses. I am part of a team that has been hired to document the "good practices" at all 23 higher education institutions in South Africa. Our team is interested in learning about

- The types of HIV/AIDS prevention interventions available at your institution
- Enhancements in your HIV/AIDS prevention activities that may have resulted from the EC's funding
- Barriers or challenges to implementing and/or sustaining these prevention activities.

My name is _____ . I am one of the team members on the HEAIDS good practices project. This interview should take about 45 minutes or an hour. depending upon how many HIV prevention activities are being implemented at this university.

As you know from the telephone conversation with our team member, Dr. Barbara Fisher, I will also be interviewing the staff/volunteers/peers and faculty members who are engaged in the design and implementation of HIV/AIDS prevention programs at this institution. I would also like to speak to some students who have participated in these activities.

Every effort will be made to protect your program and staff's privacy, and no names or personally identifying information will be included in any report – not to HEAIDS nor to the EC. The data will be aggregated across institutions and only summative feedback will be given to HEAIDS to assist in their planning of project enhancements.

Your responses will greatly assist us to learn about practices at your institution that will inform HEAIDS' ability to improve the type and quality of the HIV prevention activities at HEIs that will help other institutions to enhance their service delivery in the area of HIV/AIDS prevention.

We look forward to your candid feedback about what worked this past year and what can been improved and what is needed to accomplish that.

Thank you for taking the time for this interview. If you have any questions about the survey or the project, please do not hesitate to call Zuzelle Pretorias, Programme Manager, HEAIDS, 27 12 484 1145 or zuzelle@hesa.org.za.

Do you have any questions before we begin?

_____

_____

_____

_____

Is your PE progrmma based on the Rutanang approach? ☐ Yes ☐ No

If yes, what do you think of this approach. Is it good or does it have specific limitations. Please explain!

_____

_____

_____

**PEpgm01 __ PEER EDUCATION HIV PREVENTION ACTIVITIES CHART**
**Check = "Yes" for all that** apply
**INSTRUCTIONS:** Review the following list of program offerings that are/can be related to the PE HIV prevention programming.
For each type of services or activity, have the interviewee indicate whether the CBO.....
(A) **already provides** this, AND **(B) Planing to provide (C) Not planning to provide (explain)**

| Peer Education HIV Prevention Activities | Yes we have | Yes we are planning | No not planning (explain briefly why not) |
|---|---|---|---|
| 1. Curriculum based HIV/AIDS Education/Prevention Interventions | | | |
| 2. Individual one-one -Student Social Support by PEs | | | |
| 3. Peer Educators HIV outreach to students | | | |
| 4. Formal Support Groups for Students (Rapp sessions, structured sessions) | | | |
| 5. Referrals for Individual Counseling for students | | | |
| 6. Distribution of Condoms | | | |
| 7. Psycho-educational Groups for students | | | |
| 8. Domestic violence/abuse assistance & referrals | | | |
| 9 Campus wide Education Campaigns | | | |
| 10 Arts/music/theatre HIV prevention programs | | | |
| 11. Peer Educators participate in design and implementing faculty led courses on HIV or infusion into existing courses | | | |
| 12. PLWHA involvement in PE activities | | | |
| **8.4.1.1.9** HEALTH COMMUNICATIONS & PUBLIC INFORMATION: | Yes we have | Yes Planning | No not planning |
| 13. Mass Media/Public Information Campaigns | | | |
| 14. Hotlines | | | |
| 15. Presentations/Lectures (i.e., one-time) | | | |
| 16. Design new health education materials | | | |
| 17. e.g., videos, brochures, manuals | | | |
| 18. Community Mobilization | | | |
| 19. Community-wide Events (health fairs, festivals) | | | |
| 20. Community Planning (focus groups, logistics) | | | |
| 21. Other _____ | | | |
| **8.4.1.1.18**<br>**8.4.1.1.19** 22. Other (specify) _____ | | | |
| **8.4.1.1.20** 24. Monitoring and Evaluation of Peer Ed Activities | | | |

**PEpgm02.** Estimate the total number of **students who Participate in your Peer Education HIV Prevention Programming** in a **Typical Week**

_____

**PEpgm03.** Estimate the number of **students who participate in your Peer Education HIV Prevention Programming/Services/ activities** (unduplicated number of individuals served)** in a **Typical YEAR**

_____

## FOCUS GROUP DISCUSSION – FOR PARTICIPANTS IN PEER EDUCATION ACTIVITIES

THIS WILL BE REFORMATTED INTO A SURVEY IF A FOCUS GROUP IS NOT POSSIBLE TO CONVENE

### Introduction

My name is _____ . As you may know, all public higher education institutions have a mandate to integrate HIV/AIDS prevention interventions – programmes and activities – into the services provided for their students. I am a member of a team from HEAIDS (who oversees the HIV prevention programmes). We are examining Good Practices in HIV Prevention Strategies for Higher Education. As one of the team members, I have been asked to document the "good practices" at all 23 public higher education institutions in South Africa. Our team is interested in your opinions and perspectives on those activities in which you have participated.

This group should take about 45 minutes or an hour to complete.

No names or personal information will be included in any report -- not to your department, the university, or to HEAIDS. We encourage participants to act responsibly with information shared in the group and maintain confidentiality about whatever is said. The information that you provide will be aggregated, that is will be grouped and individual information will not be identifiable. Only summarized information (not individually identified information) will be given to HEAIDS in order to assist them in planning and modifying their projects.

Your responses will help us to learn about good practices at your university and hopefully contribute to improving programmes to help reduce the spread of HIV infections among college students.

We look forward to your candid responses to our questions about what worked this past year, what can be improved and what is needed to accomplish the improvements.

I am passing out a consent form for you to sign, if you agree to participate in the discussion.

Read and follow the instructions in the information sheet and the informed consent.

After the informed consents are signed and collected, begin.

### Focus Group Discussion Guide

For Students Who Participated in Educational Programmes for HIV Prevention Programmes and Activities

Institutional Code: _____

Case # _____ Institution Name: _____

Campus # _____ Telephone Number: _____

Date: (yyyymm) _____ / _____

Total number of students in the Focus Group: _____

**Note to Leader:** With a show of hands, complete the following information on the group's characteristics:
**Number of:**

Females _____

Males _____

First year students _____

Second year students _____

Third year students _____

Fourth year students _____

Graduate students _____

Lead by: (Tick one) ☐ (1)BFisher ☐ (2)Nokathula ☐ (3)SHanson

Do you have any questions before we begin? After answering all questions, begin.

**FGD01.** First, I'd like to find out a little about each of you. I would like to know your name, a little bit about you, what you are studying and the courses that you are taking at this university. Let's begin to my left and go around the room.
**After introductions are completed, say:**

---

**FGD02a.** I'd like to find out what concern you as a university student. I am going to read out a list of concerns that university students might have. If this is an issue that concerns you, please raise your hand.
Any questions?
**Read the list one at a time.** After listing the issue, ask: For how many students, is this problem? Raise your hands." Record the number of students who indicate that this item is a problem and place the number on the right side.

- Crime _____
- Drugs _____
- Pregnancy _____
- Lack of Jobs for College Students _____
- HIV/AIDS _____
- Other health issues (asthma, diabetes, etc). _____
- Gender inequality _____
- Stigma towards people living with HIV/AIDS _____
- Being employed after graduating _____
- Sexual harassment of women students _____
- Cost of education _____
- Guidance about college courses _____
- Family issues _____

What other issues were not on my list but are issues for you? Write them down

_____

_____

_____

_____

_____

**FGD02b.** Which one of these issues that has been mentioned do you believe is of **greatest concern** or a problem for students at this institution?

**FGD02c.** "I am going to ask you to rate the seriousness of the above issues on the following scale." Read the indicators below. Then say: "How many rate the HIV infection as not serious at all. Raise your hand." Put the score next to the appropriate indictor.

☐ Not at all serious ☐ Somewhat serious ☐ Serious ☐ Very serious ☐ Extremely serious

**FGD03a.** What Peer Education HIV prevention activities are offered at the university here?

☐ Informal individual counselling
☐ Referrals to services
☐ Formal prevention interventions (describe)
☐ Other (specify)_____

**FGD03b.** Which Peer Education HIV prevention activities have you participated in?
Select someone to discuss the programme in which they participated.
**Probe:** Tell me one thing that you liked MOST about the Peer Education HIV prevention activities in which you participated?
**Probe:** What did you like LEAST about these activities? How can they be improved?

*Be sure you have a list of positives and negatives about the programme.*
Then ask: 'In what ways could meaningfully improvements be incorporated to improve these activities?
**Probe:** After someone has commented on their participation in a particular programme, ask: "Has anyone else participated in that programme who would like to add to what the previous participant has said or disagree with what has been said?
**Probe:** When the information on the first activity has been exhausted, ask, "Who has comments about another programme that they have participated in?
Ask them to tell you about their experience in the programme.
Continue in the same way as during the first programme.

**FGD0.** Describe how PLHIV participated in the Peer Education activities. If yes, what was their role?

**FGD04b.** Did the Peer educators show non judgmental attitudes towards both participants and PLHIV?

☐ Yes ☐ No Men peers

☐ Yes ☐ No Women peers

☐ Yes ☐ No PLHIV

**FGD04c.** How did they show that?

**FGD05.** Thinking about the Peer Ed activities in which you participated, would you say that both women and men participated equally?

**FGD06b.** If no, what happened? Give an example? How can activities be improved so that everyone feels comfortable to participate and speak during the activities?

**FGD06c.** How did the PEs generate a discussion about dynamics of male-female relationships and how they effect sexual health and give an example?

**FGD06d.** How successful were the PEs in engaging participants in this discussion of The dynamics between male female relationships and its effect on HIV transmission?
**Probe:** Were both males and females equally engaged in these discussions?
Give an example.

**FGD07.** How did the PEs generate a discussion about cultural issues that affect HIV transmission? Give an example.

**FGD108.** Describe the positive cultural ideas and practices were incorporated into the Peer Education activities?

**FGD09.** Describe the methods and techniques they used and how successful or appropriate they were for the topic.

**FGD10.** Describe one thing about HIV/AIDS—the virus, the mode of transmission, etc. – that you learned from participating in the Peer Education activity.

**FGD11a.** Give an example of the knowledge that the Peer Educators showed in referring students for HIV testing?

**FGD11b.** During a PE activity, how many of you learned about a student or students who went for an HIV test? Raise you hand if you did.

_____ No of responses

**FGD12a.** What kinds of methods did the Peer educators use in the activities they conducted? For example, please raise your hand if you participated in.

_____ Role playing
_____ Discussing scenarios
_____ Conflict management
_____ Condom negotiation skills
_____ Use of drama
_____ PLHIV stories and testimonies
_____ Other (specify) _____

**FGD13.** In what other types of HIV prevention activities do you think university students would participate if they were made available?

_____

_____

_____

If no or limited responses are made, say: "Raise you hand, for all or any of the following HIV/AIDS activities in which you think students would be interested in participating if they were made available.
(**Note to leader:** Only include those which presently unavailable on campus.)

___ Research: Conduct research with other students about HIV-related issues that concern them in school and at home?
___ Interactive HIV/AIDS computer games:
___ Taking classes about HIV in their major field of study
___ Condom negotiation skills
___ Painting a mural for students or the community outside
___ Creating computer games for younger students
___ Mentoring programs for younger students (high school, etc.)
___ Internships and jobs for students
___ Safe place to discuss cultural and gender issues that affect HIV
___ Other (specify) _____
___ Other (specify) _____

**FGD14.** By a show of hands, how many of you completed an evaluation form about the PE HIV prevention activities in which you participated?

## Instructions

I am going to hand-out a piece of paper. BUT DO NOT WRITE YOUR NAME

I am asking you to write on that piece of paper – Whether or not your participation in the Peer Education Prevention Activities encouraged you.

This ends the group discussion. Do you have any questions?

It has been a real pleasure talking to you and fun, I really appreciate your responses and will pass them along to HEAIDS for them to think about the kinds of activities that you have reported that you would like to have at this university.

Do not put your name or any identifying information on this paper. Your responses are anonymous.

When you have completed the questionnaire, place it face-down on the corner of the table near the door (or some other designated location away from the interviewer. I will collect the questionnaires when everyone has turned theirs in.

## Peer Education HIV Prevention

**FGD15a.** As a result of your participation in the Peer Education HIV prevention intervention activities did you: **(CHECK ALL THAT APPLY.)**

- ☐ I got an HIV test
- ☐ I am practicing safer sex with my partners
- ☐ I intend to practice safer sex with my partners (use condoms)
- ☐ I am respecting women's rights to determine the use of condoms
- ☐ I am respecting women's rights to say no to sex
- ☐ I have spoken to other students about practicing safer sex
- ☐ I have spoken to other students about condoms
- ☐ I have encouraged other people to get tested
- ☐ I have participated in other HIV prevention activities on campus
- ☐ I got an HIV test
- ☐ I am practicing safer sex
- ☐ I intend to practice safer sex (i.e., use condoms)
- ☐ I am respecting women's rights to determine the use of condoms
- ☐ I am respecting women's rights to say no to sex
- ☐ I have spoken to other students about practicing safer sex
- ☐ I have spoken to other students about condoms
- ☐ I have encouraged other people to get tested
- ☐ I have participated in other HIV prevention activities on campus
- ☐ I have participated in other HIV prevention activities off campus
- ☐ I have reduced my use of drugs/alcohol
- ☐ Other _____
- ☐ None of the above _____

**FGD15b.** List the HIV programmes and activities that you attended.

_____

_____

_____

_____

_____

**FGD15c.** Was there a booster session sometime after the activity in which you participated?

☐ Yes ☐ No ☐ Don't know

**FGD15d.** How many attended a booster session? # _____

**FGD15e.** Percentage of yes there was a booster and attended it _____

**Note to Reader:** This will be modified as a survey. If a focus group discussion cannot be organized, students will be asked to complete a survey covering similar questions.

**PEpgm04a.** # and Gender of Peer Educators: **(Check all that apply)**

☐ Male ☐ Female ☐ PLWHA

**PEpgm04b.** Estimated # and Gender of Student PE Participants: **(Check all that apply)**

☐ Male ☐ Female ☐ PLWHA

**PEpgm05.** Estimated Year in school of PE Participants

☐ First ☐ 2nd ☐ 3-4 year ☐ Graduate School

**PEpgm06.** In **what languages are your HIV/ prevention services/activities** currently offered? **(Check all that apply)**

☐ English Only

☐ One Language – NOT English (write languages )

☐ Multiple Languages (write languages )

**PEpgm07a.** How many Peer educators, staff and volunteers do you have in your Peer Education HIV Prevention programming/services/activities in each of the following categories?

| Categories | Number Full-Time 1 | Number Part-Time 2 |
|---|---|---|
| ■ Supervisors | | |
| ■ Peer Educators | | |
| ■ PLWHAs | | |
| ■ Volunteers | | |
| ■ Clerical/Support | | |

**PEpgm08.** I would like to ask you a few specific questions about the capacity of your institution to provide peer education HIV prevention programs

| Activity | Yes | Not yet but planned | Not planned | Describe |
|---|---|---|---|---|
| **STAFF/HR FUNCTIONS** | | | | |
| ■ Are all Critical positions/functions covered | | | | |
| ■ Is staff/peer ed morale/organizational commitment good | | | | |
| ■ Staff/Peered-client rapport is good | | | | |
| ■ Staff/Peer ed retention is good | | | | |
| ■ Sufficient employee handbook in place | | | | |
| ■ Sufficient PeerED/Staff & Volunteer Training<br>▪ PeerED/Staff &Vol. Training in HIV Prevent.<br>▪ PeerED/Staff/Volunteer Awareness & Commitment to HIV Prevention<br>▪ Client Confidentiality | | | | |
| ■ Performance review process for Staff/Peer Ed and Volunteers | | | | |
| ■ Staff/Peer Ed & Volunteers have qualifications to do their job | | | | |
| ■ PeerEd/Staff/volunteers are culturally and linguistically appropriate to participants | | | | |
| ■ Other | | | | |

**PEpgm08a.** How are Peer Educators recruited? What are the characteristics of good Peer Educators? (non judgmental, representative of demographics of students, leadership qualities, etc.)

**PEpgm08b.** What incentives are provided to recruit and retain Peer Educators?

**PEpgm08d.** How many training sessions are provided for Peer Educators and who does the training?

**PEpgm08d.** Are your Peer Educators adequately trained in the following and would you like assistance to enhance their skills? (CHECK one column for each row)

| Areas of PE Knowledge and Skills | Satisfactory Adequate | A CONCERN And could use assistance to improve | A Concern but NOT our focus now |
|---|---|---|---|
| **About the Peer Educators** | | | |
| ■ PE knowledge about HIV virus, transmission, biology, and of HIV prevention program models (good practices.) | | | |
| ■ PE knowledgeable about behavioral change theories and how to apply them to activities | | | |
| ■ New teaching methods (interactive: role plays, scenarios, negotiation) for PEs to inform students about HIV Prevention Programs | | | |
| ■ Motivational techniques/skills for PEs to engage and retain students in programs and services | | | |
| ■ Training in confidentiality, stigma issues | | | |
| ■ Training in communication and group facilitation skills, and conflict resolution, condom/sexual negotiation skills | | | |
| ■ Training in how to discuss male-female dynamics and gender inequality as it relates to HIV transmission | | | |
| ■ Training in how to engage women and men equally in programs/activities | | | |
| ■ Training in how to start a dialogue about cultural issues (sexual practices) that may affect HIV transmission | | | |
| ■ Training in incorporating cultural forms and ideas into peer ed activities | | | |
| **About SUPERVISORS themselves:** | | | |
| ■ Additional training for supervisors about behavioral change theories and their application to HIV prevention activities (good practices, interactive teaching methods, etc. | | | |
| ■ Overall supervisory/ management skills | | | |
| ■ Communication skills/Team building | | | |
| ■ Monitoring and Evaluation | | | |
| ■ Other (specify) | | | |

**PEpgm09.** Are HIV prevention activities conducted by Peer Educators phased in to allow peers to become competent in each activity? Why or why not—give example.

**PEpgm10.** Are there written procedures for supervisors of Peer Educators (obtain copies)

**PEpgm11.** How often do supervisors meet with peer educators for supervision

- ☐ Weekly
- ☐ Monthly
- ☐ Bi monthly
- ☐ Other (specify) _____

**PEpgm12.** What are supervisors responsibilities towards Peer Educators? (Probe: case conferencing, assessment and evaluation, gradual integration of responsibilities, booster training, mentoring, and coaching.

**PEpgm13.** Which of the Peer Education activities are you most proud? Explain your response.

**PEgm14.** Which of the following Peer Education HIV Prevention program areas/components do you think need to be initiated, enhanced or expanded in your organization? (Check one column for each row)

| Preferred Peer Education HIV Prevention Program Activities and Services | Satisfactory/ Adequate | A Concern and would like assistance to improve | A Concern but NOT our focus at this time |
|---|---|---|---|
| *More comprehensive services*<br>Describe: | | | |
| *Enhanced services (quality)*<br>Describe: | | | |
| *Serve larger number of students*<br>Describe: | | | |
| *Additional Peer educators*<br>Describe: | | | |
| *Incorporation of PLWHAs and community member*<br>Describe: | | | |

**PEpgm15.** **PEgm11a.** How do you document and track the participants in Peer Education HIV Prevention Programs/Services/Activities? (Check all that apply)

- ☐ Provide ID at intake
- ☐ Have a computerized client record system (e.g. Access, Excel)

  Describe: _____
- ☐ Input demographic information into intake form for each client
- ☐ Staff tracks and records each youth's participation in every activity/service

- ☐ Staff consistently inputs all youth data into a computer data base
- ☐ Have a consistent procedure for referrals
- ☐ Have a consistent procedure for follow-up of youth participants
- ☐ Have an adequate data collection system to provide information on unduplicated youth participants and outcomes
- ☐ Routinely share participant information with appropriate staff/supervisors
- ☐ Adequate confidentiality policies and procedures
- ☐ Other _____

**PEgm18.** Regarding HIV prevention and care referral networks for your participants in your Peer Education programs and services:
Check one for each.

■ Do the Peer Educators know about related HIV prevention and care services and activities provided by other organizations that target serve participants or other students)?

☐ Yes ☐ No ☐ Unsure (7)

■ If Yes, Do PEs refer participants to these services at these other organizations?

☐ Yes ☐ No ☐ Unsure (7)

Which organizations?

- ☐ On site VCT services
- ☐ Domestic Violence Counseling
- ☐ Health care services off site
- ☐ Other (specify) _____

**PEpgm19.** What would you say have been the main difficulties or challenges in providing PE activities?

inside university: _____

outside university: _____

**PE20.** Who else should be involved in designing and implementing your Peer Education HIV Prevention Programming. Should we include....
(Check All that Apply)

- ☐ University Administration Management
- ☐ Supervisors
- ☐ Peer Educators
- ☐ PLWHAs
- ☐ Faculty
- ☐ Volunteers
- ☐ University Development Staff
- ☐ Student program participants
- ☐ Local Community Members
- ☐ Other: _____

**PEpgm21.** Are there any particular concerns that we should keep in mind that could limit the progress of your Peer Education HIV Prevention Program activities at your university (e.g., lack of administrative commitment, insufficient funding, communication difficulties between departments):

_____

_____

_____

_____

_____

_____

## COUNSELLING AND LIFE SKILLS
## HIV PREVENTION ACTIVITIES INTERVIEW – SUPERVISOR AND STAFF

**OFFICE USE ONLY**

Institutional Code: _____

Case # _____ Institution Name: _____

Address: _____

_____

Telephone Number: _____

Campus # _____

Name/Title of Interviewee: _____

_____ Supervisor

_____ Staff

Interviewed by: (Circle one) (1) BFisher (2) Nokathula (3) SHanson

Date: (yyyy/mm) _____ / _____

Circle all HIV Prevention Programs on site (or at different campus) at this institution

0 = None

1 = VCT-Health services

2 = Peer Education Prevention

3 = Curriculum Integration

4—Counselling/Life skills/

5---BCC

6 = Other Prevention (list)_____

7 = Monitoring and Evaluation System

8 = Uses behavioural change theories to implement prevention activities

9 = All of the above

### Read to Interviewee

As you know, the European Commission funded HEAIDS to assist higher education institutions to strengthen their capacity to initiate, expand or enhance HIV/AIDS prevention activities at their universities.

HEAIDS is interested in learning about good practices in HIV/AIDS prevention activities on higher education institution campuses. I am part of a team that has been hired to document the "good practices" at 23 higher education institutions in South Africa. Our team is interested in learning about

- The types of HIV/AIDS prevention interventions available at your institution
- Enhancements in your HIV/AIDS prevention activities that may have resulted from the EC's funding

- Barriers or challenges to implementing and/or sustaining these prevention activities.

My name is _____. I am one of the team members on the HEAIDS good practices project.

This interview should take about 45 minutes or an hour. depending upon how many HIV prevention activities are being implemented at this university.

As you know from the telephone conversation with our team member, Dr. Barbara Fisher, I will also be interviewing the staff/volunteers/peers and faculty members who are engaged in the design and implementation of HIV/AIDS prevention programs at this institution. I would also like to speak to some students who have participated in these activities.

Every effort will be made to protect your program and staff's privacy, and no names or personally identifying information will be included in any report – not to HEAIDS nor to the EC. The data will be aggregated across institutions and only summative feedback will be given to HEAIDS to assist in their planning of project enhancements.

Your responses will greatly assist us to learn about practices at your institution that will inform HEAIDS' ability to improve the type and quality of the HIV prevention activities at HEIs that will help other institutions to enhance their service delivery in the area of HIV/AIDS prevention.

We look forward to your candid feedback about what worked this past year and what can been improved and what is needed to accomplish that.

Thank you for taking the time for this interview. If you have any questions about the survey or the project, please do not hesitate to call Gail Andrews, Programme Manager, HEAIDS, 27 12 484 1145 or gail@hesa.org.za.

Do you have any questions before we begin?

_____

_____

_____

_____

_____

**COUN01. COUNSELLING AND LIFE SKILLS HIV PREVENTION ACTIVITIES CHART**
**Check = "Yes" for all that** apply
**INSTRUCTIONS:** Review the following list of program offerings that are/can be related to the PE HIV prevention programming. For each type of services or activity, have the interviewee indicate whether the institution:
A) **Already provides** this; **B) Planning to provide (C) Not planning to provide (explain)**

| Counselling and Life Skills Activities | Yes, we have | No we have not | Comments |
|---|---|---|---|
| 22. Individual Counselling for students/staff | | | |
| 23. Individual Social Support Groups for students and staff | | | |
| 24. Outreach to students or staff to engage in counselling | | | |
| 25. Formal Support Groups for Students or staff (Rapp sessions, structured sessions) | | | |
| 26. Demonstration of effective and consistent use of condoms | | | |
| 27. Distribution of Condoms(male and female condoms) | | | |
| 28. Psycho-educational groups for students/staff | | | |
| 29. Domestic violence/abuse assistance & referrals | | | |
| 30. Life Skills training for students | | | |
| **8.4.1.1.23 10.** Other (specify) | | | |
| **8.4.1.1.24 11.** Monitoring and Evaluation of Counselling/Life Skills Activities | | | |

**COUN02.** Estimate in a month the total number of students(female and male) who Participate in your Counselling and Life Skills Activities related to HIV Prevention Programming

Counselling: _____ females _____ males _____ total

Life Skills: _____ females _____ males _____ total

**COUN04.** How many counsellors do you have who offer counselling or life skills education related to HIV Prevention programming/services/activities in each of the following categories?

| Categories | Number Full-Time 1 | Number Part-Time 2 |
|---|---|---|
| ■ Psychologist | | |
| ■ Social Worker | | |
| ■ Counsellors | | |
| ■ Others (specify) | | |

**COUN05.** I would like to ask you a few specific questions about the capacity of your institution to provide Counselling and Life Skills HIV prevention interventions

| Activity | Yes | No | Comments |
|---|---|---|---|
| **STAFF/HR FUNCTIONS** | | | |
| ■ Are all Critical positions/functions filled? | | | |
| ■ Is staff morale/organizational commitment good | | | |
| ■ Staff-client rapport is good | | | |
| ■ Staff retention is good | | | |
| ■ Sufficient employee handbook in place | | | |
| ■ Sufficient Staff Training<br>▪ Staff Training in HIV Prevent.<br>▪ Staff Awareness & Commitment to HIV Prevention<br>▪ Client Confidentiality | | | |
| ■ Performance review process for Staff | | | |
| ■ Staff have qualifications to do their job | | | |
| ■ Staff act culturally and linguistically appropriate to participants | | | |
| ■ Other _____ | | | |

**COUN06.** How many training sessions are provided for Counselling Staff and who does the training?

Sessions provided _____

Who trains _____

**COUN07.** Are your Counsellors adequately trained in the following and would you like assistance to enhance their skills? (CHECK one column for each row)

| Areas of Knowledge and Skills | Satisfactorily Adequately Trained | A CONCERN And could use assistance to improve. Tick if yes | A Concern but NOT our focus now. Tick if no |
|---|---|---|---|
| **Counselling Staff** | | | |
| ■ Knowledge about HIV virus, transmission, biology, and of HIV prevention program models (good practices.) | | | |
| ■ Knowledge of the local epidemiological situation | | | |
| ■ Knowledge about behavioural change theories and how to apply them to activities | | | |
| ■ Knowledge about life skills/resiliency strengthening using values clarification, problem solving techniques, civic responsibility | | | |
| ■ New teaching methods (interactive: role plays, scenarios, negotiation) to inform students about HIV Prevention Programs | | | |
| ■ Motivational techniques/skills to engage and retain students in programs and services | | | |
| ■ Decisional balance techniques or other harm reduction skills | | | |
| ■ Training in confidentiality, stigma issues | | | |
| ■ Training in communication and group facilitation skills, and conflict resolution, condom/sexual negotiation skills | | | |
| ■ Training in how to discuss male-female dynamics and gender inequality as it relates to HIV transmission | | | |
| ■ Training in how to engage women and men equally in programs/ activities | | | |
| ■ Training in how to start a dialogue about cultural issues (sexual practices) that may affect HIV transmission | | | |
| ■ Training in incorporating cultural forms and ideas into peer ed activities | | | |
| **For SUPERVISORS** | | | |
| ■ Additional training for supervisors about behavioural change theories and their application to HIV prevention activities (good practices, interactive teaching methods, etc. | | | |
| ■ Overall supervisory/ management skills | | | |
| ■ Communication skills/Team building | | | |
| ■ Monitoring and Evaluation | | | |
| ■ Other (specify) | | | |

**COUN08.** Are there written policies and procedures for supervisors of Counsellors (obtain copies)

**COUN09.** How often do supervisors meet with Counselling staff for supervision

- ☐ Weekly
- ☐ Monthly
- ☐ Bi monthly
- ☐ Other (specify) _____

**COUN10.** What are supervisors responsibilities towards Counsellors? E.g. case conferencing, assessment and evaluation, booster training, mentoring, coaching opportunities for new educational advancement experiences, etc.

**COUN11a.** Please describe a typical Life Skills presentation/facilitation? (content, techniques, etc.)

**COUN11b.** Describe the response of students to Life Skills education: Give example.

**COUN12.** Which of the following Counselling/Life Skills HIV Prevention program components do you think need to be initiated, enhanced or expanded in your organization?
(Check one column for each row)

| HIV Prevention Program Activities and Services | Satisfactory/ Adequate | A Concern and would like assistance to improve. Tick if yes | A Concern but NOT our focus at this time. Tick if no |
|---|---|---|---|
| *More comprehensive counselling services*<br>Describe: | | | |
| *Enhanced counselling services (quality)*<br>Describe: | | | |
| More individual counselling services | | | |
| More group counselling or support services for HIV+ students/staff | | | |
| Additional Life Skills opportunities<br>Describe: | | | |

| HIV Prevention Program Activities and Services | Satisfactory/ Adequate | A Concern and would like assistance to improve. Tick if yes | A Concern but NOT our focus at this time. Tick if no |
|---|---|---|---|
| *Serve larger number of students (male, female, overall)*<br>Describe: | | | |
| *Incorporation of PLWHAs and community members in counselling and life skills activities*<br>Describe: | | | |

**COUN13**. How do you document and track the participants in Counselling and Life Skills HIV Prevention Programs/Services/Activities? **(Check all that apply)**

- ☐ Provide ID at intake
- ☐ Have a computerized client record system (e.g. Access, Excel) Describe: _____
- ☐ Input demographic information into intake form for each client
- ☐ Staff tracks and records each participant in every activity/service
- ☐ Staff consistently inputs all participants' data into a computer data base
- ☐ Have a consistent procedure for referrals
- ☐ Have a consistent procedure for follow-up of participants
- ☐ Have an adequate data collection system to provide information on unduplicated participants and outcomes
- ☐ Routinely share participant information with appropriate staff/supervisors
- ☐ Adequate confidentiality policies and procedures
- ☐ Other _____

**COUN14.** Would you like assistance in developing or enhancing a client tracking system and/or planning for implementing a data collection system?

☐ Yes ☐ No ☐ Not sure

**COUN17.** Please describe how you know that participants who are counselled in HIV Prevention benefit from the services, programs and activities? (Probe: did you observe something that showed that your participants have changed—did you hear something. give specific examples, for example: a participant brought a friend to the program, said he/she started to practice safer sex, went to get tested, etc..)

_____

_____

_____

**COUN18.** Regarding HIV prevention and care referral networks for your participants in your Counselling services:
Check one for each

- ■ Does the counselling staff know about related HIV prevention and care services and activities provided by other organizations that target serve participants or other students)?

☐ Yes ☐ No ☐ Unsure (7)

- ■ If Yes, Do staff refer participants to these services at these other organizations?

☐ Yes ☐ No ☐ Unsure (7)

Which organizations?

- ☐ On site VCT services
- ☐ Domestic Violence Counseling

☐ Health care services off site

☐ Other (specify) _____

■ Do you or your counselling staff need assistance to develop and/or enhance a referral network for your participants (e.g., youth friendly health care services)?

☐ Yes ☐ No ☐ Unsure (7)

**COUN19.** What would you say have been the main difficulties or challenges in providing counselling or life skills activities?

inside university: _____

outside university: _____

**COUN20.** Who else should be involved in designing and implementing your Counselling or Life Skills HIV Prevention Programming. Should we include…. (Check All that Apply)

☐ University Administration Management

☐ Supervisors

☐ Peer Educators

☐ PLWHAs

☐ Faculty

☐ Volunteers

☐ University Development Staff

☐ Student/staff program participants

☐ Local Community Members

☐ Other: _____

**COUN21.** Are there any particular concerns that we should keep in mind that could limit the progress of your Counselling or Life Skills HIV Prevention Program activities at your university (e.g., lack of administrative commitment, insufficient funding, communication difficulties between departments):

_____

_____

_____

**COUN22.** Is there anything else you would like to say about the Counselling and Life Skills programming at this institution?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

## FOCUS GROUP DISCUSSION – FOR PARTICIPANTS IN COUNSELLING AND LIFE SKILLS ACTIVITIES

### Introduction

My name is _____. As you may know, all public higher education institutions have a mandate to integrate HIV/AIDS prevention interventions – programmes and activities – into the services provided for their students. I am a member of a team from HEAIDS (who oversees the HIV prevention programmes). We are examining Good Practices in HIV Prevention Strategies for Higher Education. As one of the team members, I have been asked to document the "good practices" at public higher education institutions in South Africa. Our team is interested in your opinions and perspectives on those activities in which you have participated.

This group should take about 45 minutes or an hour to complete.

No names or personal information will be included in any report -- not to your department, the university, or to HEAIDS. We encourage participants to act responsibly with information shared in the group and maintain confidentiality about whatever is said. The information that you provide will be aggregated. , That is it will be grouped and individual information will not be identifiable. Only summarized information (not individually identified information) will be given to HEAIDS in order to assist them in planning and modifying their projects.

Your responses will help us to learn about good practices at your university and hopefully contribute to improving programmes to help reduce the spread of HIV infections among college students.

We look forward to your candid responses to our questions about what worked this past year, what can be improved and what is needed to accomplish the improvements.

I am passing out a consent form for you to sign, if you agree to participate in the discussion.

Read and follow the instructions in the information sheet and the informed consent.

After the informed consents are signed and collected, begin.

### Focus Group Discussion Guide

For Students Who Participated in Counselling or Life Skills Educational Programmes for HIV Prevention Programmes and Activities

Institutional Code: _____

Case # _____ Institution Name: _____

Campus # _____ Telephone Number: _____

Date: (yyyymm) _____ / _____

Total number of students in the Focus Group: _____

**Note to Leader:** With a show of hands, complete the following information on the group's characteristics:
**Number of:**

Females _____

Males _____

First year students _____

Second year students _____

Third year students _____

Fourth year students _____

Graduate students _____

Lead by: (Tick one) ☐ (1)BFisher ☐ (2)Nokathula ☐ (3)SHanson

**NOTE:** The group leader may need a recorder or an assistant to help record the process.

Do you have any questions before we begin? After answering all questions, begin.

**FGD01.** First, I'd like to find out a little about each of you. I would like to know your name, a little bit about you, what you are studying and the courses that you are taking at this university. Let's begin to my left and go around the room.
**After introductions are completed, say:**

_____

**FGD02a.** I'd like to find out what concern you as a university student. I am going to read out a list of concerns that you might have. If this is an issue that concerns you, please raise your hand.
Any questions?
**Read the list one at a time.** After listing the issue, ask: For how many students, is this problem? Raise your hands." Record the number of students who indicate that this item is a problem and place the number on the right side.

- Crime _____
- Drugs _____
- Pregnancy _____
- Lack of Jobs for College Students _____
- HIV/AIDS _____
- Other health issues (asthma, diabetes, etc). _____
- Gender inequality _____
- Stigma towards people living with HIV/AIDS _____
- Being employed after graduating _____
- Sexual harassment of women students _____
- Cost of education _____
- Guidance about college courses _____
- Family issues _____

**FGD02a.** What other issues were not on my list but are issues for you? Write them down

_____

_____

_____

_____

**FGD02b.** Which one of these issues that has been mentioned do you believe is of **greatest concern** or a problem for students at this institution? (You may need to read the list again.)

**FGD02c.** "I am going to ask you to rate the seriousness of the above issues on the following scale." Read the indicators below. Then say: "How many rate the HIV infection as not serious at all. Raise your hand." Put the score next to the appropriate indictor.

☐ Not at all serious ☐ Somewhat serious ☐ Serious ☐ Very serious ☐ Extremely serious

**FGD03a.** What Counselling and Life Skills HIV prevention activities are offered at the university?

- ☐ Informal individual counselling
- ☐ Referrals to services
- ☐ Formal prevention interventions (describe)
- ☐ Other (specify)_____

**FGD03b.** Which Counselling and Life Skills HIV prevention activities have you participated in?
Select someone to discuss the programme in which they participated.
**Probe:** Tell me one thing that you liked MOST about the Counselling and Life Skills HIV prevention activities in which you participated?
**Probe:** What did you like LEAST about these activities?

_____

How can they be improved?
**Be sure you have a list of positives and negatives about the programme**.
Then ask: 'In what ways could meaningful improvements be incorporated to improve these activities?

_____

**FGDO3c.** After someone has commented on their participation in a particular programme, ask: "Has anyone else participated in that programme who would like to add to, or disagree with, what the previous participant has said or disagree with what has been said?

**Probe:** When the information on the first activity has been exhausted, ask, "Who has comments about another programme in which they have participated?
Ask them to tell you about their experience in the programme.
Follow the same procedures used in the previous discussion.

_____

**FGD0.** Describe how PLHIV participate in the Counselling and Life Skills activities. If the participants give examples, say yes: ask:
Describe their role.

_____

**FGD04b.** Did the Counselling Staff demonstrate non judgmental attitudes towards both participants and PLHIV?

☐ Yes ☐ No Men peers
☐ Yes ☐ No Women peers
☐ Yes ☐ No PLHIV

**FGD04c.** Describe their non-judgemental behaviou OR if no, describe their judgemental behaviour.

_____

**FGD05.** Thinking about the Counselling and Life Skills activities in which you participated, would you say that both women and men participated equally?

_____

**FGD06a.** If yes, in what ways (or give an example of how) did the Counselling staff engage both men and women equally in the activities?

_____

**FGD06b.** If no, what happened? Give an example? How can activities be improved so that everyone feels comfortable to participate and speak during the activities?

_____

**FGD06c.** Describe how the staff generated a discussion about dynamics of male-female relationships.
Give an example of how they effected the participants' perception their sexual health.

_____

**FGD06d.** How successful were staff in engaging participants in this discussion of the dynamics of the relationships between males and females and its effect on HIV transmission?
**Probe:** Were both males and females equally engaged in these discussions?
Give an example of the engagements of males and females.

_____

**FGD07.** How did the staff generate a discussion about cultural issues that affect HIV transmission? Give an example.

_____

**FGD108.** Describe the positive cultural ideas and practices that were incorporated into the Counselling and Life Skills activities?

_____

**FGD09.** Describe the methods and techniques the counsellors/peer educators used.
**Probe:** How successful or appropriate they were for the topic. (Probe: Did the counsellor
**Probe:** Discuss how to make decisions about problems, such as using a condom, speaking with your partner about getting an HIV test.
**Probe:** How to notify your partner that a person is HIV+.
**Probe:** Did the counsellor demonstrate how to negotiate using condoms with your partners, etc.)

_____

**FGD10.** Describe one thing about HIV/AIDS – the virus, the mode of transmission, etc. – that you learned from participating in the Counselling and Life Skills activity.

_____

**FGD11a.** Give an example of the knowledge that the Counsellors/Staff showed in referring students for HIV testing?

_____

**FGD11b.** During a counselling session or life skills activity, how many of you learned about a student or students who went for an HIV test? Raise you hand if you did.

_____ No of responses

**FGD12a.** What kinds of methods did the Counselling staff or Life Skills staff use in the activities they conducted? For example, please raise your hand if you participated in:

_____ Role playing
_____ Discussing scenarios
_____ Conflict management
_____ Condom negotiation skills
_____ Use of drama
_____ PLHIV stories and testimonies

_____ Other (specify) _____

**FGD13.** If they were made available iIn what other types of HIV prevention activities do you think university students would participatee?

_____

_____

_____

If no or limited responses are made, say: "Raise you hand, for all or any of the following HIV/AIDS activities in which you think students would be interested in participating if they were made available.
(**Note to leader:** Only include those which presently unavailable on campus.)

___ Research: Conduct research with other students about HIV-related issues that concern them in school and at home?
___ Interactive HIV/AIDS computer games:
___ Taking classes about HIV in their major field of study
___ Condom negotiation skills
___ Painting a mural for students or the community outside
___ Creating computer games for younger students
___ Mentoring younger students (high schoolers, etc.)
___ HIV/AIDS internships and jobs for students
___ Safe place to discuss cultural and gender issues that affect HIV

___ Other (specify) _____

___ Other (specify) _____

**FGD14.** By a show of hands, how many of you completed an evaluation form about the Counselling or Life Skills activities in which you participated?

_____

## COUNSELLING AND LIFE SKILLS HIV PREVENTION

### Instructions

I am going to hand-out a piece of paper. BUT DO NOT WRITE YOUR NAME on it.

I am asking you to write on that piece of paper – Whether or not your participation in the Counselling and Life Skills Activities encouraged you.

This ends the group discussion. Do you have any questions?

It has been a real pleasure talking to you and fun, I really appreciate your responses and will pass them along to HEAIDS for them to think about the kinds of activities that you have reported that you would like to have at this university.

Do not put your name or any identifying information on this paper. Your responses are anonymous.

When you have completed the questionnaire, place it face-down on the corner of the table near the door (or some other designated location away from the interviewer. I will collect the questionnaires when everyone has turned theirs in.

**FGD15a.** As a result of your participation in the Counselling and Life Skills HIV prevention intervention activities did you: **(CHECK ALL THAT APPLY.)**

- ☐ I got an HIV test
- ☐ I am practicing safer sex with my partners
- ☐ I intend to practice safer sex with my partners (use condoms)
- ☐ I am respecting women's rights to determine the use of condoms
- ☐ I am respecting women's rights to say no to sex
- ☐ I have spoken to other students about practicing safer sex
- ☐ I have spoken to other students about condoms
- ☐ I have encouraged other people to get tested
- ☐ I have participated in other HIV prevention activities on campus
- ☐ I got an HIV test
- ☐ I have participated in other HIV prevention activities off campus
- ☐ I have reduced my use of drugs/alcohol
- ☐ Other
- ☐ None of the above mm

**FGD15b.** List the HIV programmes and activities that you attended.

_____

_____

_____

**FGD15c.** Was there a booster session sometime after the activity in which you participated?

☐ Yes ☐ No ☐ Don't know

**FGD15d.** How many attended a booster session? # _____

**FGD15e.** Percentage of yes there was a booster and attended it: _____

Note to Reader: This will be modified as a survey. If a focus group discussion cannot be organized, students will be asked to complete a survey covering similar questions.

## SUPERVISOR/COUNSELLOR HEALTH SERVICES INTERVIEW GUIDE

For OFFICE USE ONLY:

Institutional Code: _____

Case # : _____ Institution Name: _____

Address: _____

Telephone Number: _____

Campus #: _____ Name/Title of Interviewee: _____

Supervisor: _____ Counselor: _____

Interviewed by: (Circle one) (1) B Fisher (2) Nokathula (3) Hanson

Date: (yyyymm) _____ / _____

Circle all HIV Prevention Programs on site (or at different campus) at this institution

0 = None

1 = VCT-Health services

2 = Peer Education Prevention

3 = Curriculum Integration

4—Counselling/Life skills/

5---BCC

6 = Other Prevention (list) _____

7 = Monitoring and Evaluation System

8 = Uses behavioral change theories to implement prevention activities

9= All of the above

### Read to Interviewee:

As you know, the European Commission funded HEAIDS to assist higher education institutions to strengthen their capacity to initiate, expand or enhance HIV/AIDS prevention activities at their universities.

HEAIDS is interested in learning about good practices in HIV/AIDS prevention activities on higher education institution campuses. I am part of a team that has been hired to document the “good practices” at all 23 higher education institutions in South Africa. Our team is interested in learning about

- The types of HIV/AIDS prevention interventions available at your institution
- Enhancements in your HIV/AIDS prevention activities that may have resulted from the EC’s funding
- Barriers or challenges to implementing and/or sustaining these prevention activities

My name is_____ I am one of the team members on the HEAIDS Good Practices Project.

This interview should take about 45 minutes or an hour, depending upon how many HIV prevention activities are being implemented at this university.

As you know from the telephone conversation with our team member, Dr. Barbara Fisher, I will also be interviewing the staff/volunteers/peers and faculty members who are engaged in the design and implementation of HIV/AIDS prevention programs at this institution. I would also like to speak to some students who have participated in these activities.

Every effort will be made to protect your program and staff’s privacy, and no names or personally identifying information will be included in any report – not to HEAIDS, nor to the EC. The data will be aggregated across institutions and only summative feedback will be given to HEAIDS to assist in their planning of project enhancements.

Your responses will greatly assist us to learn about practices at your institution that will inform HEAIDS' ability to improve the type and quality of the HIV prevention activities at HEIs that will help other institutions to enhance their service delivery in the area of HIV/AIDS prevention.

We look forward to your candid feedback about what worked this past year and what can been improved and what is needed to accomplish that.

Thank you for taking the time for this interview. If you have any questions about the survey or the project, please do not hesitate to call Zuzelle Pretorias, Pogramme Manager, HEAIDS, 27 12 484 1145 or zuzelle@hesa.org.za.

Do you have any questions before we begin?

_____

_____

**HS01. Please describe the range of health services offered at this centre. Check all that apply. THIS CAN BE OBTAINED THROUGH BROCHURES OR MATERIALS PROVIDED**

- ☐ Antenatal
- ☐ Contraception
- ☐ Emergency contraception
- ☐ Abortion/referrals
- ☐ STI diagnosis and treatment
- ☐ Partner Notification
- ☐ Pre and post test counselling for HIV
- ☐ Rapid testing for HIV
- ☐ Confirmatory Laboratory Testing for HIV
- ☐ TB testing and treatment
- ☐ Individual counselling
- ☐ Group counselling
- ☐ Couples counselling
- ☐ Emergency care
- ☐ Vaccinations
- ☐ Monitoring HIV+
- ☐ Drug treatment (Harm reduction counselling, needle exchange, methadone, etc.)
- ☐ Drug treatment referrals
- ☐ Post test clubs
- ☐ Support groups
- ☐ Referrals to primary care
- ☐ Referrals to HIV treatment and care
- ☐ Walk in Care
- ☐ Rape Counselling
- ☐ Domestic Violence
- ☐ Nutrition
- ☐ 24 hour hot line for HIV and domestic violence, rape, etc.
- ☐ Other (specify)

_____

_____

**HS02**. Currently, how many individual staff/volunteers (give an estimate) from your institution are involved in implementing HIV/AIDS prevention activities

# of counsellors _____ (list type)

# of supervisory staff_____ (list type)

# laboratory workers _____

# of peer educations _____

# of PLHIV _____

# of Volunteers _____

# of Others _____ (specify)

**HS02b. In a week, about how many students (MALE AND FEMALE)**

Receive pre and post counselling at this facility? _____ TOTAL

Take an HIV test? _____TOTAL

Return for confirmatory test results? _____TOTAL

**HS02c. In a year, about how many students**

Receive pre and post counselling at this facility? _____ TOTAL

Take an HIV test? _____TOTAL

Return for confirmatory test results? _____TOTAL

**HS02d. Are there equal numbers of men and women students who come to this health services? If not, explain**

_____

**HS02e. Are sufficient numbers of students referred to the health services from:**

- ☐ Faculty
- ☐ Peer Educators
- ☐ Other HIV/AIDS Programs (Counselling, Life Skills, etc.)
- ☐ Self referred
- ☐ Other

**Next, we have a few questions about training staff about HIV prevention:**

**HS03. Are ALL staff trained on the following, if not all who receives the training? Check all that apply**

- ☐ Behavioral change theory and how to apply it to counselling
- ☐ Sensitivity and confidentiality issues
- ☐ How to engage clients in risk reduction assessment
- ☐ Harm reduction counselling
- ☐ Providing support for HIV+ individuals
- ☐ Use of questions and listening skills
- ☐ How to focus and tailor counselling to client risk issues
- ☐ Use of motivational interviewing

☐ Use of decisional balance strategies

☐ Partner Notification issues

☐ Other

**HS04. Who provides the training on each of the above topics:**

_____

**HS05. How successful has the training in behavior change theory been in helping staff to apply it to the HIV prevention programs? (Check one ONLY)**

☐ Very successful ☐ Somewhat successful ☐ Needs improvement

Explain response

_____

**HS06. Please give an example of how theory is applied to changing behaviors of VCT clients.**
(*Probe:* What is needed to help the VCT counselors to apply behavior change theory to their programmatic practice? E.g., more training, more funding, more staff)

**NOW, A FEW QUESTIONS ABOUT GENDER DYNAMICS AND CULTURAL ISSUES THAT MAY AFFECT HIV TRANSMISSION**:

**HS07.** What do the VCT staff do to ensure that men and women equally benefit from the counselling about HIV/AIDS prevention?

Describe:

_____

**HS08. What are the major issues in terms of male-female dynamics that affect the program's ability to have good outcomes—i.e., increasing knowledge? Increasing skills? Change in attitudes, beliefs, interpersonal relationships, behaviors?**

What could help to address these issues?

_____

**HS09. Other than taking an HIV/AIDS test, how do supervisors, staff know when they have succeeded in influencing participants'**

- Knowledge
- Awareness
- Skills
- Change in their attitudes, beliefs, interpersonal relationships
- Change in their behaviors?

Give Examples:

_____

**HS10. In what ways has Health Services Centre initiated a dialogue about the role of cultural issues in transmission? (Describe)**

_____

How successful have staff been in starting a dialogue about the role of cultural issues in transmission?

☐ Very successful ☐ Somewhat successful ☐ Not very successful

Please explain the rating (e.g., provide an example of successful programmes or why it has not been successful)

_____

**HS11. How have positive cultural norms and practices been utilized in HIV/AIDS prevention interventions (e.g., theatre, drama, PLWHA stories or testimonies?)**

_____

**HS12. In this section, I would like to ask you some specific questions about the capacity of your institution to provide HIV prevention programs**

| Activity | Yes | Not yet but planned | Not planned | Describe |
|---|---|---|---|---|
| **A. FINANCIAL HEALTH** | | | | |
| 1. Are there multiple sources of funding available for VCT activities | | | | |
| 2. Is there funding available for infrastructure for the VCT services | | | | |
| 3. Is there sufficient funding for commodities (condoms, emergency contraceptives, etc.) | | | | |
| 4. Other (specify) | | | | |
| **B. ADMINISTRATION** | | | | |
| 1. Are there formalized, clarified, written HIV-related policies **re: discrimination, gender equity,** confidentiality, PLHIV etc. | | | | |
| 2. How are staff informed about HIV/AIDS policies and procedures? | | | | |
| 3. Is there a functioning Quality Assurance Committee for VCT and other health services? | | | | |
| 4. Is there a structure to evaluate supervisors and staff of these programs? | | | | |

| Activity | Yes | No but planned improvements | Needs Improvement | Explain |
|---|---|---|---|---|
| **C. CONTINUUM OF CARE** | | | | |
| 1. How are PLHIV involved in the HIV prevention services? | | | | |
| 2. Does staff have knowledge of and access to prevention and related services in your community | | | | |
| 3. Network developed/expanded Continuum of Care and/ or referral relationships with other CBOs and service providers | | | | |
| 4. Other | | | | |
| **D. VCT INFRASTRUCTURE & FACILITIES** | | | | |
| 1. Do you have sufficient private space to discuss sensitive client issues | | | | |
| 2. Do have sufficient meeting space for staff/volunteers | | | | |
| 3. Do you have sufficient meeting space for client group activities | | | | |
| 4. Adequate electrical and phone systems | | | | |
| 5. Other | | | | |

**HS13. Is there a quality assurance committee for HIV prevention/testing services?**

_____

Who sits on this committee?

_____

How often does it meet?

_____

**HS14. How often do supervisors meet with staff for supervision?**

☐ Weekly ☐ Monthly ☐ Bi monthly

☐ Other (specify) _____

**HS15. VCT Session – COMPREHENSIVENESS**

For each row place a check in the column in which you think you have achieved in your VCT counseling work.

This guide should be COPIED AND PROVIDED TO THE RESPONDENT – SO HE/SHE CAN READ ALONG WITH YOUR QUESTIONS

| | Usually Achieved | Sometimes Achieved | Not Achieved |
|---|---|---|---|
| Introductions, explain role/session content | | | |
| Explain confidentiality and anonymous test | | | |
| Review rapid test process – clinic flow | | | |
| Address immediate concerns and questions | | | |
| Assess recent risk pattern (who, where) | | | |
| Identify risk triggers, vulnerabilities, circumstances | | | |
| Assess communication with partners | | | |
| Summarize and reflect back client's story/risk | | | |
| Review previous risk reduction experiences | | | |
| Identify obstacles to risk reduction | | | |
| Assess and enhance condom skills | | | |
| Identify range of options for reducing risk | | | |
| Role-play, skill build, and problem solve | | | |
| Assess client's reason for VCT, previous tests | | | |
| Identify with whom client has shared test decision | | | |
| Discuss understanding of a positive/negative result | | | |
| Determine client's test readiness/decision | | | |
| Discuss benefits of testing/positive living | | | |
| Provide and explain results clearly and simply | | | |
| Explore client's understanding/response to results | | | |
| If positive, provide support, address positive living | | | |
| Develop incremental steps toward behavior change | | | |
| Identify Sources of Support and Referrals | | | |
| Identify to whom client may disclose for support, care, VCT | | | |
| Discuss approach to disclosure/referral–role play | | | |
| Follow-Up with Clients for confirmatory testing and counselling | | | |

**HS16. Which HIV Prevention components do you think need to be initiated, enhanced or expanded in your organization?**

What would you need to do this? (funds, staff, etc.) _____

**HS17. Other than your testing statistics, please describe how you know that your clients benefit from the HIV prevention services, programs and activities?**

_____

**(Probe:** Did you observe something that showed that your participants have changed did you hear something. give specific examples, for example: a participant brought a friend to the program, said he/she started to practice safer sex, went to get tested, etc.)

_____

**HS18. Regarding HIV prevention and care referral networks for clients**

*Check one for each*

Do the counselors know about related HIV prevention and care services and activities provided by other organizations that target serve participants or other students)?

☐ Yes ☐ No ☐ Unsure

If Yes, Do they refer clients to these services at these other organizations?

☐ Yes ☐ No ☐ Unsure

Which organizations? (specify not names but functions, e.g. dv, rape survival, etc.)

_____

Do you or the counselors need assistance to develop and/or enhance a referral network for your participants (e.g., youth friendly health care services)?

☐ Yes ☐ No ☐ Unsure

**HS19. What would you say have been the main difficulties or challenges in providing HIV prevention services at this university?**

inside university: _____

outside university: _____

HS19. Are there any particular concerns that we should keep in mind that could limit the progress of your HIV Prevention Health Services (e.g., lack of administrative commitment, insufficient funding, communication difficulties between divisions):

_____

**HS20. Is there anything else you would like to tell me about the VCT services at this institution?**

_____

## SURVEY FOR CLIENTS ATTENDING VCT OR HEALTH SERVICES

For OFFICE USE ONLY:

Institutional Code: _____

Case # : _____ Institution Name: _____

Address: _____

Telephone Number: _____

Telephone Number: _____

Campus #: _____ Name/Title of Interviewee: _____

Supervisor: _____ Counselor: _____

Interviewed by: (Circle one) (1) BFisher (2) Nokathula (3) Hanson

Date: (yyyymm) _____ / _____

Number of students who responded to the survey:

Male _____ Female _____ PLHIV _____

Circle all HIV Prevention Programs on site (or at different campus) at this institution

0 = None

1 = VCT-Health services

2 = Peer Education Prevention

3 = Curriculum Integration

4 = Counselling/Life skills/

5 = BCC

6 = Other Prevention (list) _____

7 = Monitoring and Evaluation System

8 = Uses behavioral change theories to implement prevention activities

9= All of the above

## Voluntary Counseling and Testing - Student Satisfaction Survey

We are working for the higher education institutions' HIV programme (HEAIDS). They would like to know your opinions and perspectives about your experience with the Voluntary Counseling and Testing services that you just received so that the services can be made more effective and meet students' needs. Your answers will be confidential and anonymous, and therefore, PLEASE DO NOT write your name on this form.

First just some demographic information:

Are you ☐ female ☐ male

Are you a ☐ lst year student ☐ 2nd year student ☐ 3–4th year student graduate student

Other (specify) _____

☐ Are you staff at the University?

**VCT01. Please rate the QUALITY of the HIV COUNSELLING AND TESTING Services you received today.** (Check one column for each line)

| | | Excellent | Satisfactory | Needs Improvement |
|---|---|---|---|---|
| a. | Knowledge about HIV and AIDS | ☐ | ☐ | ☐ |
| b. | Explaining HIV test results | ☐ | ☐ | ☐ |
| c. | Skills negotiate condom use with partners | ☐ | ☐ | ☐ |
| d. | How to use condom effectively | ☐ | ☐ | ☐ |
| e. | Talking with family and friends | ☐ | ☐ | ☐ |
| f. | Providing referrals to other HIV services | ☐ | ☐ | ☐ |

**VCT02. Please rate the IMPORTANCE of the following topics to you. (Check one column for each line)**

| | | Very important | Somewhat important | Not at all important |
|---|---|---|---|---|
| a. | Knowledge about HIV and AIDS | ☐ | ☐ | ☐ |
| b. | Explaining HIV test results | ☐ | ☐ | ☐ |
| **c.** | Skills negotiate condom use with **partners** | ☐ | ☐ | ☐ |
| d. | How to use condom effectively | ☐ | ☐ | ☐ |
| e. | Talking with family and friends | ☐ | ☐ | ☐ |
| f. | Encouraging you to return for follow-up tesst or results | ☐ | ☐ | ☐ |
| g. | Providing referrals to other HIV services | ☐ | ☐ | ☐ |

**VCT03. Did the counselor use any of the following instructional activities when he/she spoke with you today? (Check one column for each line)**

| | | Yes | No | D/K |
|---|---|---|---|---|
| a. | Lecture sessions | ☐ | ☐ | ☐ |
| b. | Small group discussions | ☐ | ☐ | ☐ |
| c. | Participant exercise | ☐ | ☐ | ☐ |
| d. | Role-plays | ☐ | ☐ | ☐ |

**VCT04. How would you rate your counselor's ability to assist you to understand information about HIV/AIDS in the following areas: (Check one column for each line)**

| | | Excellent | Satisfactory | Poor |
|---|---|---|---|---|
| a. | Sensitivity of counselors to HIV concerns | | | |
| b. | Privacy of counseling space | ☐ | ☐ | ☐ |
| c. | Written materials on the HIV test | ☐ | ☐ | ☐ |
| d. | Performing the HIV test | ☐ | ☐ | ☐ |
| e. | Understanding of gender dynamics & how it affects condom use | ☐ | ☐ | ☐ |
| f. | Non judgmental about people living with HIV and/or AIDS | ☐ | ☐ | ☐ |

**VCT05. How were you referred to this Counseling and Testing Service by (Check all that apply)**

a. ☐ Peer educator

b. ☐ Faculty member

c. ☐ Another student

e. ☐ Came on your own

f. ☐ Other (specify) _____

**VCT06. Are you planning or intending to do any of the following: (Check all that apply)**

a. ☐ To return for another HIV test in 3 months

b. ☐ To return for the confirmatory HIV lab test results

c. ☐ To use condoms with all sex partners

d. ☐ To encourage other students/family/friends to take an HIV test

e. ☐ To encourage other students/family/friends to practice safer sex

f. ☐ To respect women's rights to determine the use of condoms

g. ☐ To respect women's rights when they say no to sex

h. ☐ To reduce drug and alcohol use

i. ☐ To speak with other students about practicing safer sex

j. ☐ To speak to other students about condoms

k. ☐ To practice safer sex (i.e., use condoms)

l. ☐ Did you participate in other HIV prevention activities on campus

m. ☐ Other _____

n. ☐ None of the above

**VCT07. In which HIV prevention activities or programmes have you participated (Check all that apply)**

a. ☐ On this campus

b. ☐ In the community

c. ☐ Elsewhere (specify

d. ☐ I have not participated in any HIV prevention activities

**VCT08. In general, how satisfied were you with the HIV/AIDS prevention services (counselling and testing, etc.) at this facility? Check one only**

☐ Very satisfied ☐ Somewhat satisfied ☐ Not satisfied

Please give an example of why you are not satisfied with the services at this facility.

_____

Many thanks for your time and thoughtfulness in completing this survey. It will help improve the services at this counselling and testing site and at other universities.

## Good Practice HIV/AIDS Prevention Strategies for Public Higher Education Institutions (HEIs) in South Africa

*Focus group student participant information sheet and consent form*[1]

Hello, my name is **Barbara Fisher**. I have been hired as a consultant by the Higher Education of South Africa (HESA) through a EuropeAid Contract to conduct research at your university about HIV/AIDS prevention programmes. The research is funded by the European Union under the bilateral partnership with the European Community (EC) and the Republic of South Africa. The contracting authority, IBF International, is the lead agency with Femconsult and Agmin Italy the participating agencies. I am asking students who participate in the HIV/AIDS prevention programmes to answer some questions about your experiences with them or related health services. We hope that your responses will benefit students at this university and possibly other universities in the future by helping them improve their HIV/AIDS prevention programs and health services You are being asked to participate in a field research project entitled **Good Practice HIV/AIDS Prevention Strategies for Public Higher Education Institutions (HEAIDs)** in South Africa

Please understand that you are not being forced to take part in this study; the choice to participate or not is yours alone. However, we would really appreciate it if you would share your thoughts, feelings and experiences

with us. If you choose **NOT** to answer these questions, you will **NOT** be affected in any way. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this, you will not be penalized and you will **NOT** be prejudiced in any way.

### *Goal of the Research:*

The goal or overall purpose of the research is to improve HIV/AIDS Prevention in the public Higher Education sub-sector in South Africa through the identification and dissemination of good practice HIV/AIDS Prevention models and interventions.

I will be asking you to give your opinions, perspectives, and experiences with the design, implementation, or your participation in HIV/AIDS prevention interventions at your institution. The researchers are particularly interested in your perspectives on innovative or good practices in HIV/AIDS prevention interventions, challenges you have faced in implementing or participating in the interventions and your ideas about how to solve these challenges.

I will be recording the session so that I have a way of insuring that my notes from the focus group are complete and accurate. We will keep the information on the tapes confidential and follow the same procedures as we do when securing the confidentiality of all the data that we are collecting.

### *Your Rights*

- Your participation in this project is voluntary
- You are free not to answer any questions that you do not want to answer
- You may decide not to take part in, or to withdraw from, this project at any time without any penalty.
- You can still participate in services and interventions related to HIV/AIDS prevention even if you decide not to participate in this research.

### *Benefits*

Your opinions and perspectives will be documented and used to improve, enhance, and initiate HIV/AIDS Prevention Interventions at your institution, as well as others. Students at this university and other universities may benefit from your responses which HESA will use to improve or create new HIV/AIDS prevention programs or services.

### *Risks*

There are no risks associated with your participation in this research.

### *Confidentiality*

We ask that the members of this focus group discussion treat the information you have shared in the group as confidential, but we cannot guarantee that it will be handled in that way. Your name will not, however, appear on any reports or papers published from the findings of this project. Your name will not be placed on any of the project forms or data bases. Instead, your name will be substituted with a Research ID number and that ID will be placed on the forms and data base. The data files will be saved in password-protected formats. All records, data and tapes will be stored in locked files in the project office. The cross-reference list with your name and code number will also be kept in a locked file marked "Confidential" and the Team Leader, Dr. Castle, will be the only one with access to that information. The focus group discussions will be recorded and the tapes will be stored in a safe place for five years.

### *Focus Group Session*

The focus group interview will last about 45 minutes. When I ask you a question, please be as open and honest as possible in answering them. Some questions may be of a sensitive nature. I will also be asking some questions that you may not have thought about before and which involve your thinking about your past experiences with HIV prevention programmes. We know that you cannot be absolutely certain about the answers to these questions, but we ask that you try to be thoughtful in your responses. There are no right and wrong answers to the questions that you will be asked.

If I ask you a question which makes you feel sad or upset, we can stop and talk about it. If anything upsets you, Dr. Barbara Fisher, a member of the consultant

team, is a psychologist and she will be available to talk with you and, of course, the discussion will be kept confidential. If you wish to do so, I will give you her telephone number. If you need to speak with anyone after I have left, I will give you the contact details of a professional person nearby.

*Project Results*

Project findings will be used in a final report provided to HEAIDS. At the end of project, at a National Consultation with the 23 institutions, we will share new knowledge and skills about the good practices in HIV prevention that can be used to improve existing programs at HEIs and foster the development of new ones. They will also receive the final report.

If you wish to complain or report an ethical infringement that occurred during the research process **OR** if you want to talk to anyone about this project because you have questions, or you think you have not been treated fairly or you believe you can be hurt by joining this project, please contact all or any of the following, Human Sciences Research Council's toll-free ethics hotline 0800 212 123.

The REC Administrator, Ms. Jurina Botha, at the Human Sciences Research Council, on (012) 302 2009. E-mail: JEBotha@hsrc.ac.za.

**OR**

Ms. Zuzelle Pretorius, Programme Manager, Higher Education HIV/AIDS (HEAID) Programme, Higher Education South Africa (HESA).

Telephone number: +27 12 484 -1145/34 Email: www. hesa.org.za. Do you have any questions?

When the questions are answered, say:

If you sign the consent form, you are acknowledging your willingness to participate in the research described to you verbally and on this sheet.

**CONSENT**

I hereby agree to participate in research regarding HIV/AIDS prevention programmes at my university. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point, should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact, should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to any questionnaire or information that I provide during the focus group and that my answers will remain confidential.

I understand that, if at all possible, feedback will be given to students who have provided data that contributes to the results of the research.

_____ _____

**Signature of participant:** **Date**:

I hereby agree to the tape recording of my participation in the study

_____ _____

**Signature of participant:** **Date**:

**NOTE: Signed copies of this consent form will be a retained on file in the participant's case record with the Team Leader of the Research Project, Dr. Mary Ann Castle and a copy given to the participant.**

## ANNEX 4C

# Simplified version of the Framework Indicators for HEI (unfilled form)

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| **Crosscutting issues** | | | | | | | | | | |
| Prevention programmes based on a behaviour change model | Programme is strictly theory based | | | | | | | | | |
| | Parts of the programme are theory based | | | | | | | | | |
| | Programme is not theory based | | | | | | | | | |
| Discussions/consciousness raising includes the subjects of gender inequality, cultural practices and stigma | Staff, Supervisors, PEs include main drivers of the epidemic in dialogue and thinking | | | | | | | | | |
| Recipients/students influence design and implementation of activities | | | | | | | | | | |
| Programme activities tailored to recipients | | | | | | | | | | |
| **Counselling (mainly applies to VCT)** | | | | | | | | | | |
| Are there professionally led large scale behaviour change counseling at the HEI? | | | | | | | | | | |
| If no, are behaviour change counseling activities part of VCT? | | | | | | | | | | |
| *Programme support* | | | | | | | | | | |
| Counselling (VCT) receiving sufficient financial and human resources | | | | | | | | | | |
| Counsellors maintain privacy and confidentiality | | | | | | | | | | |
| *Programme elements* | | | | | | | | | | |
| Counsellor clarifies the rights and responsibilities of both the client and the counselor | Case records are maintained | | | | | | | | | |
| Counsellors updated on latest knowledge in the field of counseling | Counsellors offered training opportunities regularly | | | | | | | | | |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| Counselling is of appropriate duration | Counsellors provide more than one session if possible/necessary | | | | | | | | | |
| | How many minutes is a VCT pretest session? | | | | | | | | | |
| *Professional competence* | | | | | | | | | | |
| Counsellor trained in use of appropriate Behaviour Change Theory | | | | | | | | | | |
| Counsellors is trained in HIV knowledge, cultural issues, stigma and discrimination | Counsellors knowledgeable in all key areas | | | | | | | | | |
| Counsellors follows professional practices | Counsellors pre- and posttest counsel according to accepted practices | | | | | | | | | |
| Counsellors include condoms in teaching | Counsellors always demonstrate correct ways of condom use to clients? | | | | | | | | | |
| Counselling results in improved knowledge and practices | Are client KABP surveys conducted? | | | | | | | | | |
| | Do clients have increased knowledge of gender and cultural issues | | | | | | | | | |
| Counsellors maintain good quality client records | Periodic quality assurance of client records | | | | | | | | | |
| *Linkages* | | | | | | | | | | |
| Counsellor have good linkages inside and outside campus | Counsellor has good internal linkages with psychologists, health services and care and support functions | | | | | | | | | |
| | Counsellor has good external relations with NGOs | | | | | | | | | |
| **Life skills, resiliency strengthening ( in the case of HEIs in SA mainly carried out as part of Peer Education)** | | | | | | | | | | |
| Life skills established as an integral part of HIV prevention | Life skills curriculum includes problem solving, conflict resolution and confidence building | | | | | | | | | |
| | Life skills curriculum includes gender inequality, cultural issues, stigma and discrimination | | | | | | | | | |
| Facilitators, PEs, counselors etc. are taught critical thinking, problem solving skills | | | | | | | | | | |
| Life skills are taught using multiple methods | Clients receive individual or group counseling, mentoring, coaching etc. | | | | | | | | | |
| Facilitators, PEs, counselors etc. are trained to develop resiliency in clients | Clients taught to increase self knowledge and self discipline | | | | | | | | | |
| | Clients taught to increase self confidence and self esteem | | | | | | | | | |
| Recipients clients involved in design and implementation of prevention programmes | | | | | | | | | | |
| Life skills & resiliency training followed-up | Are changes in KABP monitored through surveys, reports | | | | | | | | | |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| Interventions tailored to recipients needs | Is needs assessment undertaken? | | | | | | | | | |
| **Peer Education Programmes** | | | | | | | | | | |
| *Programme support* | | | | | | | | | | |
| Are there sufficient financial and human resources for PE activities | | | | | | | | | | |
| *Programme elementsY* | | | | | | | | | | |
| Are activities theory driven? | Programmes use theory to provide comprehensive programmes | | | | | | | | | |
| Rigorous Peer Education selection | Strict selection criteria are used | | | | | | | | | |
| | Appropriate balance between male and female PEs | | | | | | | | | |
| Clearly defined rules for PEs | Rules written down | | | | | | | | | |
| *Professional competence* | | | | | | | | | | |
| Comprehensive training curriculum for PEs | | | | | | | | | | |
| PEs trained in Behaviour Change Theory | | | | | | | | | | |
| PEs trained in cultural factors incl. gender inequality, stigma and discrimination | | | | | | | | | | |
| PEs trained in multiple delivery methods | | | | | | | | | | |
| PEs trained in use of male and female condoms | | | | | | | | | | |
| PEs deliver at least 4 sessions per year to the recipients | | | | | | | | | | |
| Evaluation discussions take place after training events and highlights recorded | | | | | | | | | | |
| Informal discussions take place after peer delivered sessions and highlights recorded | | | | | | | | | | |
| Feed back from the students is gotten and recorded | | | | | | | | | | |
| Needs assessment undertaken to determine student needs | | | | | | | | | | |
| PEs feed back to supervisors | | | | | | | | | | |
| PEs satisfied with involvement in the programme | | | | | | | | | | |
| PEs benefit from participation | | | | | | | | | | |
| PEs have knowledge of how to recruit male and female students to participate in activities | | | | | | | | | | |
| PEs successfully refer recipients to VCT | | | | | | | | | | |
| PEs routinely supervised | | | | | | | | | | |
| Supervisors provide emotional support for PEs | | | | | | | | | | |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| Supervisor continuously receive training | Supervisors trained on behaviour change theories | | | | | | | | | |
| | Supervisors trained in methods of coaching, mentoring of PEs | | | | | | | | | |
| | Supervisors trained to develop critical consciousness among PEs | | | | | | | | | |
| *Linkages and Partnership* | | | | | | | | | | |
| Internal and external linkages | PEs develop strong linkages with referral institutions within campus | | | | | | | | | |
| | PEs develop strong linkages with referral institutions outside campus | | | | | | | | | |
| **Campus Health Services** | | | | | | | | | | |
| *Programme support* | | | | | | | | | | |
| Are there sufficient financial and human resources for Campus Health Services | | | | | | | | | | |
| *Programme elements* | | | | | | | | | | |
| Clients privacy is respected | | | | | | | | | | |
| Hotline in place | | | | | | | | | | |
| Adequate services offered | ART | | | | | | | | | |
| | Post exposure profylaxis | | | | | | | | | |
| | Emergency contraception | | | | | | | | | |
| | STI case management | | | | | | | | | |
| | Rape counselling | | | | | | | | | |
| VCT coordinated with PE advocacy activities | | | | | | | | | | |
| Client services are youth friendly | | | | | | | | | | |
| Services are easily accessible | | | | | | | | | | |
| *Linkages and partnerships* | | | | | | | | | | |
| Good internal and external linkages | Good linkages with PE activities | | | | | | | | | |
| | Good linkages with referral institutions | | | | | | | | | |
| | Good relations with CBOs and NGOs that are part of the continuum of care | | | | | | | | | |
| **IEC/Behaviour Change Communication (BCC) ( at HEIs mainly seen as IEC in combination with services)** | | | | | | | | | | |
| *Programme support* | | | | | | | | | | |
| BCC used to recruit clients to prevention activities and services | | | | | | | | | | |
| Pretesting of messages | | | | | | | | | | |
| Designed to meet the needs of target populations | | | | | | | | | | |
| *Professional competence* | | | | | | | | | | |
| Target populations participate or are consulted in development and implementation | | | | | | | | | | |
| A variety of media used | | | | | | | | | | |
| New media creatively used | | | | | | | | | | |

| GOOD PRACTICE | INDICATOR | HIGHER EDUCATION INSTITUTIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | UWC | CPUT | SU | TUT | WITS | UJ | DUT | UNIVEN | Score |
| BCC used to reinforce messages and strategies of other prevention programmes | | | | | | | | | | |
| **Monitoring and Evaluation** | | | | | | | | | | |
| Sufficient resources for implementation | | | | | | | | | | |
| Evaluation plan for each HIV prevention programme | | | | | | | | | | |
| Data collection procedures are established | Qualitative and quantitative data collected | | | | | | | | | |
| | Data collected for needs assessment | | | | | | | | | |
| | Client surveys regularly conducted | | | | | | | | | |
| | Behaviour change data collected: delayed initiation of sex, consistent condom use with main partner, decrease in number of partners, decrease in alcohol/drug use, counselling and testing statistics, # and type of clients, demographics of clients, referrals, follow-ups; and type of peer educator activities, etc. | | | | | | | | | |
| | Quantitative data on VCT attendance | | | | | | | | | |
| | Quantitative data on no of STI clients | | | | | | | | | |
| | Quantitative data on pregnancies/ emergency anticonception | | | | | | | | | |
| | Data on condom distribution | | | | | | | | | |
| Computerized data collection system established | | | | | | | | | | |
| Quality assurance established | | | | | | | | | | |
| Quarterly and yearly reports written | | | | | | | | | | |
| External evaluations conducted at feasible intervals, such as 2-3 years | | | | | | | | | | |
| **SCORE** | | | | | | | | | | |
| **WEIGHTED SCORE** | | | | | | | | | | |
| **Added Question:** | | | | | | | | | | |
| Does your PE programme build on the Rutanang model | Yes, fully | | | | | | | | | |
| | Yes, to some extent | | | | | | | | | |
| | No, not at all or vey little | | | | | | | | | |
| Did you find this model useful? | | | | | | | | | | |

ANNEX 5

# Case descriptions of initially selected HEIs

## CASE 1. CAPE PENINSULA UNIVERSITY OF TECHNOLOGY (CPUT) – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

### General aspect

CPUT has five campuses. The University is the largest in the Western Cape and has more than 28,000 students. Slightly over half of the students are female (53%). Nearly half of the students are African and 50% of the staff is coloured.

*Opinions on the HIV-related context at campus – towards a definition of the HIV problem in the student population*

The students do not see HIV as the main sexuality-related problem they face. They identified pregnancy as the main issue.

**Table 1–Annex 5** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own Funding | R212,465 |
| Donor Funding | R1,912,186 |
| DoE | R250,000 |
| **Total** | **R2,374,651** |

**Source:** Draft Institutional Report

*Structure, management and operations*

The office of the HIV/AIDS unit was launched in 2004. It has a HIV/AIDS Committee, HICC.

Additional funds have come from donors, mainly from USAID and the EC.

The total budget has increased since then. It now stands at R2.8m.

## CROSS-CUTTING ISSUES

### HIV policy

The university has a current HIV policy. IT is currently in the process of renewal. The aim of the HIV and AIDS Unit is to prevent, control and manage HIV and AIDS among students and staff at the Cape Peninsula University of Technology and in the community. Peer educators pledge to spread the ABC message and champion VCT.

### Guiding principles

Thinking about *sustainability* features prominently in the University. The Engender Health Model, which follows an "inform – stimulate – ready to go" approach is currently used as the behaviour change model.

### Underlying determinants: "drivers of the epidemic"

The main drivers that are addressed include unprotected sex, gender inequalities, and substance use. Alcohol is an important concern and difficult to tackle.

### Human rights and stigma

Stigma remains a major problem.

### Monitoring

Monitoring activities are still limited. Attendance at VCT is recorded, as is the number of distributed condoms, STIs and pregnancies.

### Research

There is no research conducted on students that would increase knowledge and inform prevention activities. Such activities lack funding.

## PREVENTION ACTIVITIES

### Peer Education

Two trained Peer Education Officers are co-ordinating the peer education project and are involved in all nine programmes at the HIV and AIDS Unit. PEs are also involved in condom distribution.

### Condom Distribution

Both male and female condoms are provided; the provision of female condoms started only recently. The process of condom distribution and record-keeping needs to be refined. At present, this is partly the responsibility of the HIV peer educators and residence managers on a volunteer basis.

The HIV and AIDS Unit ensures regular condom restocking from the DoH. Condoms are available only at a limited number of sites on campus because of human resources constraints. Incidentally, condom use has increased and the number of distributed male condoms has increased. Female condoms are available on request, but not very popular.

### Life Skills training

Life skills training at CPUT is conducted by the peer educators. They are given support by nurses and by the Programme Director. There is no involvement of psychologists.

### Counselling

The main counselling activity is VCT counselling.

## IEC/BCC

### Awareness Campaigns

A number of HIV, AIDS, STIs and TB awareness presentations are made by staff accompanied by Peer Educators within the lecture period during Orientation Week. The students are shown the correct use of condoms and provided with information to enhance their understandings of the impact of HIV and AIDS.

The HIV and AIDS Unit, in collaboration with peer educators and SRC, hosts awareness programmes i.e. drama to promote the VCT Campus Drive. The following days focus on youth and HIV and AIDS: Freedom Day (Bellville), Candlelight Memorial, Valentine's Day. The movie "Confessions of the Gambler" was screened with the director present to respond to viewers' questions.

There are a number of e-learning programmes. These include TABIESA: Interactive HIV/AIDS Classroom YOUR MOVES: 'Virtual Reality'.

### 24-hour helpline

Campus heath services are available during working hours (8.30 – 15.30), but not on a 24-hour basis. However,

the health promoter is available by telephone for HIV-positive students. There is no chat room site. The peer educators meet regularly to exchange experiences with the staff of the HIV and AIDS unit. Those who are positive are able to stay in contact with the Health Promoter, who is herself living openly with HIV.

## HEALTH SERVICES AT CAMPUS HEALTH

The campus health service at CPUT is an accredited VCT provider. The testing procedure and the confidentiality of the procedure are in place. Approximately 1,000 students and staff were tested for HIV (in the 6 months from Dec '07 to May '08). HIV and AIDS staff and peer educators proactively promote VCT using the HIV and AIDS Safe Sex Pledge. There is a health promoter at the two major campuses.

The HIV and AIDS Unit, in collaboration with the Campus Clinic and Counselling Services and an out-sourced NGO, initiated a VCT Campus Drive in March and April 2008 on the main campuses. Such campaigns are now bi-yearly events.

### Post-Exposure Prophylaxis (PEP)

PEP for students and staff is provided. A 3-day survival kit is available at Campus Health clinics for rape and needlestick victims. Staff and students are referred to an off-campus clinic for further ongoing treatment. These services are supported by a central budget

### Opportunistic Infections (OIs)

The drugs for the treatment of opportunistic infections are provided. These drugs are purchased by CPUT.

### Referrals

The Institution is not a registered ARV site. Students who need ARVs are referred to the local ARV site at Tygerberg Hospital or the closest site to the student's geographic location.

There are links between community structures, such as clinics and hospitals, to accommodate HIV-positive students during the recess periods for ARV services. There are no links with NGOs.

## CARE AND SUPPORT

Free treatment services are provided to students. The Bellville clinic has a full-time psychologist whose primary responsibility is HIV counselling. In addition to the VCT service, she provides on-going support to HIV-positive students.

The supplies, other than medication, are provided by CPUT. The care and support services are rendered by CPUT. No evaluation of the care and support services has taken place. The health promoter, on request from an HIV-positive student, also provides care and support. However, if specialised services are required, the staff or student is referred to student counselling services. If a person is still in need of further specialised counselling services, he or she is referred to services off campus.

Student counselling is part of the multi-disciplinary team on campus that works according to the wellness model. Student counselling focuses primarily on the psychological aspect of HIV and AIDS.

#### *Curriculum integration*

Not penetrated.

#### *Extracurricular courses*

The HIV/AIDS Unit has developed a very unique *Beyond HIV/AIDS/STI & TB Awareness Workshop* for students at CPUT as one of its strategies for incorporating HIV/AIDS into the curricula of first year students. These workshops span over a period of 1–5 days (depending on the course that students have registered for). At times, workshops are 'tailor-made' to suit the needs of the course/students and/or requests from the academics. All of these workshops aim to change perceptions, attitudes, beliefs, opinions and practices of

participants. Thus, on completion of these workshops, participants are likely to be better equipped to interact with those infected and affected by HIV/AIDS/STI&TB. Participants will not only be equipped to overcome the stigma and discrimination that are often associated with HIV/AIDS/STI & TB (especially among those who are infected), but also to pro-actively contribute to the various challenges facing communities. More importantly, participants are equipped to contribute positively to the prevention, management and control of HIV/AIDS/STI & TB, towards the mitigation of the negative impact of the epidemic within their respective communities.

The workshops comprise a series of lectures, interactive participation, group work, role play, hypothetical scenarios, case histories, stimulated exercises, demonstrations, as well as computer- generated scenarios prompting participants to make decisions and choices in 'virtual reality' situations with a special focus on a problem-based learning approach in the context of HIV/AIDS/STI & TB. Thus the workshops also provide opportunities for participants to become involved in debates and discussions on contentious issues regarding HIV/AIDS/STI & TB. In the process, students can move towards becoming catalysts and active agents for positive lifestyle change. Students are encouraged to participate actively in all the sessions of the workshop to stimulate them into recognising and expressing their innermost feelings/fears/prejudices. This constitutes an important component of the learning process of these workshops. Furthermore, participants are required creatively to analyse and solve hypothetical scenarios, work on HIV/AIDS/STI & TB-related exercises/case histories, as well review, critique, evaluate and make certain recommendations about topics that are contentious issues on HIV/AIDS/STI & TB in a fun way, both in groups and on an individual level.

This series of workshops is named *Beyond HIV/AIDS/STI & TB Awareness* since it not only aims at empowering participants based at tertiary institutions, but more importantly at equipping participants in the application of their newly acquired knowledge and skills to the various areas of HIV/AIDS/STI & TB, wherever they are based (i.e. their respective communities and/or workplace).

Special 'tailor-made' HIV/AIDS/STI & TB workshops are also designed for CPUT staff as well as allied professional health staff. Staff, especially academics, are also assisted and trained and encouraged to initiate the incorporation of HIV/AIDS/STI & TB into their respective curricula.

### *Community outreach activities*

The community outreach projects (Malmesbury and Wallesdean) were implemented by the HIV and AIDS Unit.

- Ongoing Community Malmesbury Correctional Community Outreach Project
- Walacedeen Community Outreach Project
- Recent Community Outreach in Collaboration with NGO (Mustadafeen): Victims of Xenophobia
- One-off Community Outreach Projects on Invitation

## OPERATIONAL ASPECTS: DESCRIPTION OF THE MAIN PREVENTION PROGRAMMES

### Peer Education

Peer Education is the main prevention activity at CPUT and what drives the programme. Among the activities, the "Men as Partners" programme features prominently. There are currently 25 PEs at the main campuses. This number will be increased as activities are expanded to include satellite campuses. 40% of the PEs are male and 60% female.

Peer Educators carry out the advocacy work for the VCT campaigns. There are two VCT drives per year at the campus that last for two weeks. Approximately 1,250 students are tested per campaign. Parallel to this, there is also regular VCT at the Campus Health.

### Recruitment and selection of PEs

Recruitment at CPUT is based on a set number of criteria including:

- academic transcript

- participant's response during workshops
- panel interview of candidates
- motivation letter.

There are three levels of PEs at CPUT. There are the Peer Facilitators, who are responsible for 2 Peer Educators each, who, in turn, are responsible for two Peer Assistants each. The latter are then candidates to become Peer Educators the following year. One advantage of this system is that the supply of Peer Educators is assured.

### Training

Training of students, especially peer educators, has been ongoing since 2004 with workshops on the basics of HIV and AIDS; Men as partners (MAP); Basic Listening and Counselling skills.

### Peer education activities

PE focuses on five areas:

- Awareness campaigns
- Condom distribution
- Community outreach
- VCT advocacy
- Discussion groups.

PEs are remunerated and there is an annual awards ceremony.

**What programme components are particularly good according to the Programme Director?**

The PE programme is working well.

**What programme components need to be improved?**

- space & staff & titles/designation/capacity bldg
- mobile HIV/AIDS unit/logistics/launch
- joint newsletter/journal club
- increase male uptake in VCT/monitoring risk behaviour change
- harmonisation/restructuring of peer programme and HIV/AIDS unit curricula
- integration/incorporation
- sustainability of funds/programmes
- HIV/AIDS key performance for all staff
- HIV/AIDS needlestick & rape policy
- quality assurance needs review
- staff and student training
- research – generic postgraduate HIV/AIDS course
- strategic plan.

**SUMMARY**

HIV prevention activities at CPUT are dominated by Peer Education activities that constitute a comprehensive programme. It follows an Engender Health behaviour model. The university has a unique recruitment model for PEs, which hopes to assure recruitment of PEs for the following years. Much of the learning is internet-based.

## CASE 2. DURBAN UNIVERSITY OF TECHNOLOGY (DUT) – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

Durban University of Technology (DUT) is a multi-campus University of Technology. It is located in the cities of Durban and Pietermaritzburg. DUT is the result of a merger of two technikons – ML Sultan and Technikon Natal in April 2002. It was named the Durban Institute of Technology and later became Durban University of Technology.

DUT has seven campuses located in Durban and the Midlands (Pietermaritzburg). 75% of the students are African, while 43% of the staff is Indian.

### Opinions on the HIV-related context at campus – towards a definition of the HIV problem in the student population

When the interviewees were asked about problems and issues on campus, they were very vocal about them. They were given a wide range of topics and asked to rate their importance on a scale from a "very

unsatisfactory situation" to a "very satisfactory" one. The following items were satisfactory: crime, pregnancy, guidance about college courses, family issues and alcohol. These were not big problems, but maybe minor annoyances. Thefts were not frequent, although some theft was related to having clothing stolen from the washing line. In terms of drugs, they felt it was mainly dacha that was used, not hard drugs. Their main concerns were about physical fighting, the lack of anger management by some students, the heavy drinking by some of the macho males, and the physical abuse of men towards the women they date.

Many young women had "sugar daddies" who, on Fridays, they would park their expensive cars at the campus car park and wait to pick up their "girl friends." The interviewees said that when young women came to the university for the first time, they often "lost their character". This meant that they wanted clothing, jewellery and cell phones and so attracted an older man who would give them the things that they wanted. In the process, they put themselves at risk of HIV/AIDS. Multiple and concurrent partners was also a problem. Stigmatizing HIV and AIDS was a problem, so they said that students need to talk about these things freely.

## HIV control activities

### *Structures and management*

An HIV/AIDS Committee has been established and comprises stakeholders from all sectors of the University. This committee serves as the major consultative and communication structure. The main task of the committee is to formulate, review and effectively implement the HIV and AIDS policy. The HIV/AIDS Co-ordinator sited the following programmes as part of the structure of the prevention programmes and services provided at DUT: an HICC, a plan with clear objectives; a website; peer education, VCT, behaviour change activities including counselling, life skills/resilience training; BCC and condom distribution. They have an on-line discussion forum for the DUT community. Student counselling provides counselling for students while the health clinic offers primary health care and runs a wellness programme for HIV-positive students.

**Table 2–Annex 5** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own Funding | ? |
| Donor Funding | R2,621,500 |
| DoE | R250,000 |
| **Total** | **R2,871,500** |

In the 2007/2008 financial year the following funding was received (Table):

DUT now provides approximately R1m for all student heath, clinic and counselling services, including HIV services and salaries.

DUT received grants for HIV and AIDS activities from:

- Department of Education (17-month project): R 250 000.00
- Own Funds (17-month project): R 37 150.00
- European Union (HEAIDS) (17-month project): R 2 584,350.00

The HIV and AIDS Centre is in the Student Counselling and Health department. Its operational budget covers the three units, i.e. Student Counselling, Campus Health Clinic and the HIV/AIDS Centre. The Centre employs 6 VCT counsellors, 2 professional nurses, 3 information officers (academic support for curriculum integration) and 3 admin. assistants plus 1 researcher to stimulate HIV research, engage academics on HIV research and to establish a website.

These staff members are all part-time and are funded by the HEAIDS Programme. DUT only funds the HIV and AIDS Specialist/Co-ordinator and the Health Promoter. Additional funding will be required when HEAIDS is depleted. The co-ordinator felt that, to a great extent, the funds provided through HEAIDS supported staffing because previously the HIV/AIDS Centre was staffed by two people only.

FPD (Foundation for Professional Development) provides training in the Administrative Capacity of the Institutions to provide HIV Prevention Programmes.

### *Policy and plans*

There are formalised, written HIV policies regarding discrimination, gender confidentiality and PLWHAs. However, there are no functioning committees for all areas of HIV prevention (quality assurance for VCT, curriculum integration, peer education, etc.).

The DUT HIV and AIDS policy balances the interests of the students, staff and the organisation. The policy which will be monitored by HICC has recently been reviewed using a consultative approach and has been implemented. The new policy has been aligned with the sector's strategic goals and the NSP. The policy also includes procedures that guide implementation. The HIV and AIDS Co-ordinator works together with the HIV and AIDS committee in formulating, reviewing, monitoring and effectively implementing the HIV and AIDS policy.

DUT does not have a corporate social investment policy that makes provision for HIV and AIDS activities. No resolutions have been taken at Senate/Council level to indicate their commitment towards the pandemic. The mission statement does not portray institutional commitment and no evidence exists that reflects operational commitment towards HIV and AIDS. The institutional strategic plan does not embrace HIV and AIDS as a strategic priority. Due to HEAIDS funding, three staff members (Information Officers) were appointed to facilitate the process of mainstreaming HIV into the curriculum. The institution also does not include HIV and AIDS as part of a performance management system or score card. In terms of planning, evaluation and feedback, the institution has a two-year strategic plan.

### *Monitoring*

The programme collects client satisfaction data through a quality survey. Behavioural data is collected as part of the lifestyle section, which is covered during counselling. The counsellors collect data for the clinical records. They use available data such as surveys and referral rates, data from focus groups and retention rates in their on-going planning. They have an MIS system and routinely enter data into the MIS system in terms of staffing and human resources functions.

**Outputs:**

- No. of recipients of PE
- No. of students who have undergone VCT
- No. of condoms distributed.

## Prevention Activities

### *Peer Education*

The Peer Educator interviewed was a second-year student. She was asked to indicate what programmes are offered, what is planned to be offered, and what was not presently being planned or offered. Activities provided are curriculum-based HIV/AIDS Education Prevention interventions; peer educator HIV outreach to students; formal support groups for students; referrals for individual counselling for students; condom distribution; psycho-educational groups for students; domestic violence/abuse assistance and referral; campus-wide educational campaigns; and PLWHA involvement in peer education programmes. In terms of health communication and public information, one-time presentations and lectures were given, new health education materials such as videos, brochures and manuals were designed, and there was community mobilisation. Monitoring and evaluation of peer education activities occurred.

When asked about the capacity of the institution to provide peer education HIV prevention programmes, the respondent said that all the critical functions and positions were covered; that the staff and peer educators' morale was good; and that staff, peer educators and clients had a good rapport. Retention is good and client confidentiality is maintained; a performance review process is available to staff; staff, Peer Educators and volunteers have qualifications to do their job and they are culturally and linguistically appropriate to

participants. Even the peer educators were not culturally adequate at the start of the programme, but training helped them to behave appropriately. Sufficient peer education and staff and volunteer training, specifically in HIV AIDS, enhanced their skills.

### *Selection*

The peer educators were selected on the basis of projects that they had completed. Some had had a course in peer education in high school. They were assessed on their human relations skills and their overall ability to work with other people. The characteristics of a good Peer Educator are that he or she listens, communicates well, is calm and quiet when people are upset. There is nothing but a personal incentive to become a peer educator. No money is given to them. At the end of the year, they receive an award or a certificate. The ratio of females to males is 55 to 45%.

### *Training*

Each year, 50 new students are trained as peer educators. These students are normally in their second year of studies. So, in any given year the University has 100 peer educators. The HIV/AIDS Centre provides training for peer educators. Outside service providers are invited to provide specific training, for instance TAC might be invited to provide training on treatment. The training includes an introduction to Peer Education, facilitation, opportunistic infections, HIV/AIDS and health promotion.

The students are volunteers and not paid. However, they are given certificates confirming their participation in this programme and undergo training.

Peer educators were trained in March 2009. Training was divided into two sessions. The first session provided information while the second one looked at presentation and facilitation skills. This year, the peer education programme was extended to other campuses.

After training, peer educators have conducted 19 workshops in residences. Some of the residences covered were: Hertine Court, Escombe, Stratford, Berea residence, Student Village and Carlo Court. Different methods were used to conduct these workshops. In some instances, a movie was shown and there were discussions around what had been shown in, or understood from, the movie. One movie shown to students warned them about the dangers of sugar daddies and sugar mommies. One of the highlights of the peer education programme this year was when one of the peer educators attended an HIV/AIDS in higher education conference hosted by the University of Zululand, during which he shared the platform with peer educators from other institutions.

The total cost of this programme amounts to R60,000p.a. This includes training, printing brochures and leaflets, and programmes run by the peer educators on campus. The peer educators' programme is controlled by the HIV and AIDS Centre located in Open House on Steve Biko.

The respondents discussed the Rutanang Campaign and said it was very successful. They reported that what they liked most about the programme was that they got to inform people, talk with them, and make them understand.

### *Condom distribution*

Prevention services include the provision of both male and female condoms and are marketed through various "know your status" campaigns. The continuous availability of condoms is ensured with the assistance of peer educators and cleaning services, tasked with filling up the condom dispensers in the toilets. House committees fetch condoms for the residences. Universal precautions are implemented only by the clinic health staff using government policy. However, no provision has been made to ensure the implementation of these provisions within the institution.

DUT reports that there are no costs attached to the distribution of condoms. Condoms are sourced from the DoH at no cost.

### *Behaviour Change Counselling/Life Skills Training*

When asked what counselling and life skills HIV prevention programmes were offered at the university, interviewees reported that informal counselling was provided by the health promoters. Clients are referred to services. For example, if the peer educator can't handle the problem, the client is referred to the HIV Co-ordinator. Career and Peer Counsellors do not work with HIV and AIDS. They address social problems, diversity problems, etc. The Health Promoters travel with peer educators when they are conducting workshops to offer them support. The staff have not received training in behaviour change theory. Health promotion and Drama Aide may be using a theory. The respondent suggested that a theory would provide some guidelines as to what one needs to learn, such as gender-based violence.

## IEC/BCC

The following IEC material has been created by the HIV/AIDS Centre:

- Flyer on on-line forum
- Brochure on multiple concurrent partners
- Quarterly Newsletter (Izwi Lakho)
- Know Your Status poster and brochure.

DUT does not have campus radio, however. The above materials are distributed as print media to the DUT community.

**24-hour helpline:** Not available.

**Health services**

- VCT
- STI

When asked, *What health services are provided?,* the interviewee responded that ART, TB, PMTCT and circumcision were not provided.

### *Curriculum integration*

Curriculum integration is reflected in the HIV and AIDS Policy. However, no other policy addresses the mainstreaming of HIV and AIDS. Curriculum integration is taking place and is faculty-based. In 2008, some departments initiated integration. There are no generic-type courses available for all students.

### *Community outreach*

PEs do outreach services.

### *Application of the Framework Indicators to prevention activities*

The cross-cutting issues are reportedly all in line with good practice. This includes addressing the main drivers of the epidemic and recipients participating in the design and planning of the interventions.

There is no professionally-led, large-scale *counselling,* but this is largely part of the VCT counselling. The human resources for counselling are sufficient. The financing depends on donor financing through HEAIDS. VCT is of good quality and sessions last an average of 20-30 minutes. Behaviour change activities are not implemented by psychologists, but by the nursing staff as part of VCT. No KAPB studies are carried out. The counsellors have good internal linkages with the psychologists and externally with NGOs.

Some *Life Skills and Resiliency Training* is provided, yet it does not follow a curriculum. Facilitators are not trained to develop resiliency and increase self-confidence in recipients. The resources for peer education activities are not sufficient. The programme uses theory for the design of interventions. PEs are selected on the basis of strict criteria. Rules for the activities are written down. PEs are trained in multiple delivery methods and they deliver several sessions per year. Activities are recorded and evaluated. PEs are supervised, but needs assessments are not conducted. Supervisors receive continued training. Both external and internal linkages are limited. Campus Health is not well co-ordinated with PE activities. Staff retention is not a problem, but many leave after one year of service. Thus, thirty-two

of the Peer Educators left this year, but have been replaced by newly recruited PEs.

Monitoring covers the regular quantitative data, including condom distribution, VCT attendance, pregnancies and STIs. But only limited qualitative information is collected. There is a computerised data collection system. External evaluations are reportedly carried out.

### Application of the Good Practice in Operations Model to HIV prevention

In terms of the structure to evaluate the supervisors and staff of these programmes, a new performance management system is to be implemented. In terms of community linkages, PLWHAs are involved in HIV prevention programmes. Staff have knowledge of and access to prevention programmes and related services in the community. HAS are involved in the HIV prevention programmes. The staff has knowledge of and access to prevention programmes and related services in the community, and networks have developed and expanded the Continuum of care and/or referral relationships with other CBOs and service providers. In addition, links have been made with CAPRISA, MRC, and RHRU.

All critical positions/functions are covered. Staff morale and organisational commitments are good. Student retention is a problem. Client confidentiality is maintained. Staff and volunteers have qualifications for their jobs. Staff and volunteers are culturally and linguistically appropriate to the client.

**SUMMARY**

DUT is located both in Durban and in Pietermaritzburg, which leads to certain logistical problems. DUT has comprehensive good-practice prevention activities including VCT at Campus Health and a PE programme. There are no large-scale group counselling activities. Counselling is mainly undertaken through VCT. The PE programme is built on the Rutanang approach and follows good practice. The linkage between VCT at Campus Health and PE activities at the HIV/AIDS Centre is not optimal. Still, a relatively large number of VCTs are undertaken and a high number of condoms is distributed according to reports.

## CASE 3. STELLENBOSCH UNIVERSITY (SU) – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

### General Aspects

Stellenbosch University (SU) is recognised as one of the four top research universities in South Africa. It has one of the country's highest proportions of post-graduate students, of which almost ten percent are international students.

Stellenbosch was founded in 1679. It is the oldest town in South Africa. The University has four campuses. The language of instruction in undergraduate programmes is primarily Afrikaans; students need a working knowledge of Afrikaans. At postgraduate level, the main language of instruction is English.

#### *The HIV-related context at campus – towards a definition of the HIV problem in the student population*

In the last decade, the University has undergone broad transformation. There is now greater representation of women in management positions. Although there has been a significant growth in the number of black students enrolled at the University, they still only constitute a small proportion, particularly at undergraduate level. White students made up about 70% of all students at the end of 2007.

The fact that SU has a large proportion of white students coupled with a very low HIV prevalence creates a peculiar situation for HIV work at SU.

#### *HIV control activities – structure & management*

The Office for Institutional HIV Co-ordination (OIHC) oversees the implementation of institutional HIV programmes and serves as a strategic link with other Higher Education Institutions as well as with national and international HIV organisations and experts. The programme has a lean structure and the staff consists of the Programme Director, the Co-ordinator for Curriculum Development and Training

and the Co-ordinator for HIV Prevention Programmes. The programme has a budget of R4.3m, out of which 3.5 million came from EU funds. Approximately R826,000 was allocated from the university's own funds to sustain the salaries of the OIHC alone for 2010. In addition, funds (+-R570,000) were allocated to Campus Health Services and HR to sustain the post of a professional nurse, administrative officer and wellness co-ordinator.

The following institutional HIV projects are managed by the OIHC:

- Annual Grow Up and Get Tested VCT campaign
- Student Peer Education programme
- HIV Community Outreach initiatives
- Service Learning Programme for International students
- E-learning module for first year students
- Curriculum development
- Condom Distribution.

The OIHC also offers a variety of training and skills development opportunities for staff and students. OIHC's research-based workshops are characterised by the balance between practical health communication skills and theoretical knowledge.

Annual short courses presented by OIHC include:

- Africomnet Health Communication courses
- Leadership in Strategic Health Communication courses
- "HIV in the South African Context" Orientation HIV course presented to international students.

## *Cross-cutting issues*

### *HIV policy*

Stellenbosch University had two HIV and AIDS policies, one for students developed in 2007 and one for staff that was developed in 2006. Both policies were reviewed, merged and aligned with the HEAIDS National Policy Framework and submitted for comments from the HIV Institutional Committee in 2009. The consultative development of the policy was based on the sector strategic goals and the National Strategic Plan (NSP) for HIV and AIDS. The revised policy also contains a strategic implementation plan that includes priorities for HIV research, curriculum development, human rights and prevention.

### *Guiding principles*

The composition of the student population coupled with low HIV prevalence makes it necessary to address the HIV problem in different ways than in high prevalence situations, with a need to see it more in the context of general problems of sexuality or in a wellness context. The importance is to teach students to understand sexuality and to be able to set boundaries. Being locked into discussion around the abstinence of the ABC approach is not helpful. In addition, the issue of HIV prevention is also considered a leadership priority, including the professional and personal development of students.

### *Underlying determinants:"drivers of the epidemic"*

Alcohol is an important factor at campus, but very difficult to tackle. Gender issues are taken up, while such subjects as male circumcision are not, as it is not relevant to the mainly white student population.

### *Human rights and stigma*

Some issues in this area are difficult to tackle at SU as students take on a politically correct attitude on a number of issues related to race and sexuality. It is also complicated by the different world views of the students from different cultures. Discussions about human rights and stigma form an integral part of communication initiatives by the OIHC.

### *Monitoring*

SU has designed an electronic Patient Management System that should provide more detailed data and trends for 2010 and beyond: VCT data January-Sept 2009

- Campus Health Services: 360
- After Hours Clinic: 344
- VCT Campus Campaigns: 1756
- STI January-September 2009 (Campus Health service data only): 21.

Emergency Contraceptive use January-September 2009 (Campus Health service data only) is 75. The pregnancy

statistics were not available, but we believe Emergency Contraception is a better indicator of unprotected sex.

*Research*

Besides the national KAPB survey, research within the student population has been small-scale and did not generalise trends or data.

## PREVENTION ACTIVITIES

*Peer Education*

Stellenbosch University trained 61 student and 25 staff peer educators in 2009. Peer education mass media VCT data January-September 2009: exposure included articles in the local student paper, radio interviews and public service announcements, poster campaigns and announcements, and student web portals and university websites.

*Condom distribution*

Condoms, along with other risk reduction strategies, play a significant role in the University's response to sexually transmitted diseases. The Condom Distribution Project in its current form has been implemented since September 2004. It has distributed approximately one million public sector condoms on the Stellenbosch campus with an estimated 227,000 condoms being distributed in 2007.

Male condoms are provided free of charge through the HIV programme. They are widely available from 34 distribution points in bathrooms on the academic campus as well as in student centres and a few hostels. Paying student volunteers a stipend to fill the condocans and submit reports and numbers to the co-ordinator ensures accessibility and availability. Most points are stocked at least once a week, with higher traffic sites being stocked more frequently. Female condoms are provided free of charge at 3 sites on SU campus.

*Life Skills training*

Students are given some training in Life Skills & Resilience through PE-led workshops. The Centre for Student Counselling and Development assists students with problems, but is not focused on HIV. It is run by psychologists, but does not operate at a large scale.

*IEC and the Internet*

The use of the internet features very prominently as a means of communication at SU.

*24-hour helpline*

The Centre for Student Development and Counselling has a 24-hour counselling helpline that is operated by trained, final-year psychology students and is available to students only.

### Health services at Campus Health

The Campus Health Service offers free and confidential VCT to students and staff on a daily basis. The OIHC arranges an annual "*Know Your Status*" campaign, which makes provision for students and staff to test in larger numbers because of increased counselling and testing capacity. A peer educator-driven marketing campaign challenges the management and student leadership structures to participate

*STIs*

Treatment of STIs is available.

*Emergency contraceptives*

Available at Campus Health.

*Post Exposure Prophylaxis (PEP)*

The service is provided for both staff and students. However, no statistics are kept for the provision of PEP services and costing was not available.

*Opportunistic Infections (OIs)*

Treatment available at Campus Health.

### *Referrals*

The Institution is not a registered ARV site. Students who need ARVs are referred to the local ARV site at the Ida Valley Clinic or an After Hours Walk-in Clinic close to campus.

### *Care and support*

The treatment, care and support programmes on campus are well-developed and include a referral system, the use of peer helpers, health promotion, psychosocial support, counselling and medical care for opportunistic infections.

### *Curriculum integration*

A curriculum-development initiative has been in place only since June 2008 with HEAIDS/EU funding.

SU does not have a formal policy that includes the mainstreaming of curricula in all faculties. HIV and AIDS courses are mainstreamed within the Faculty of Health Sciences because it is considered core business to them. However, this is not enforced through Policy as this would support the view that HIV and AIDS is seen as a health issue and not as a developmental challenge.

The largest specialised HIV curriculum programme is currently presented by The African Centre for HIV and AIDS Management, a unit for teaching, research and community service that resides under the Faculty of Economic and Management Sciences. The postgraduate diploma is an on-line teaching programme supplemented with interactive satellite broadcasts. It is presented on a part-time basis and students attend a compulsory summer school. Students are assessed on a continuous basis throughout the year. Training is presented in 6 modules of 20 credits each; and students must complete 120 credits to qualify for the diploma. If the diploma is completed with an average of 60% or higher, students qualify to enter the masters programme.

A few faculties such as Theology, Health Sciences, Social Sciences and Education touch on HIV teaching within specific modules within undergraduate and postgraduate courses. There are, however, no specific models used and modules are so limited that it cannot be referred to as mainstreaming, but are rather generic. In 2009, 5 out 10 faculties had integrated an HIV-specific component into existing academic modules. These integrations will be sustained in the future.

There is no specific model of curriculum integration in under- or postgraduate programmes as HIV and AIDS is not highlighted as an institutional priority. This view is reflected in the limited implementation of components of HIV and AIDS, included primarily in the humanities, social sciences and education. There are no HIV and AIDS foundation courses in any of the fields of study. The teaching of life skills and managing HIV and AIDS in the workplace are included in the Life Orientation teacher training course and the Industrial Psychology department, respectively.

### *Extracurricular courses*

A Generic e-learning HIV course (a core, separate course) was launched in 2009 for first-year students. It has 7 modules. Up to December 2009, it had been completed by 1,624 of the 4,000 first year students.

### *Community outreach activities*

There are 10 outreach programmes. These include *"Door-to-door awareness and HIV testing campaigns"* (Cloetesville, Jamestown, Chris Nissan Park and Groendal (Franschoek), Kaymandi and Gugulethu), and *"Outreach to state-based institutions"* (municipal clinics and correctional services).

## DESCRIPTION OF THE MAIN PREVENTION PROGRAMMES

The PE programme started in 2004 with 20 students. The goal of training 60 PEs has now been reached. They attended 2 follow-up group mentor sessions, attended by 31 and 19 student peer educators respectively. 20 peer educators were additionally trained as VCT counsellors (5-day short course) in 2009. Almost all of

the PEs are at the main campus. There is a male/female ratio of 30/70 among the PEs. Most of the PEs are first-year students (42%), while 33% are second years and the remaining 25% are third years or older. PEs receive no remuneration.

## Recruitment

PEs are recruited through an on-line application. There are no interviews. The only strict criteria applied to recruitment is a commitment to attend the full training programme and to participate in a minimum set of outreach activities. Although the number of applicants increased significantly for the Stellenbosch campus, finding PE's in the Health Sciences have been difficult.

## Training

The basic training of the PEs consists in a 36-hour training programme conducted over 2 weekends. It has been supported by PEPFAR and includes bio-medical and epidemiological aspects as well as socio-cultural aspects including sex, race, gender and positive living. It also includes the Men as Partners Programme taught in collaboration with Engender Health. The training is mainly based on three Behaviour Change theories: The Health Belief Model, the Social Cognitive Model and the Stages of Change Model. These models are applied to campus-based case studies. Motivational techniques are not used.

## Activities

The main introduction activity to HIV/AIDS is the abovementioned e-learning module (see Curriculum Integration). This is subsequently followed up with peer education activities. Peer education mass media production included articles in the local student paper, radio interviews and public service announcements, poster campaigns and announcements, and student web portals and university websites.

The peer educators also participated in 10 community outreach projects and a total of 6,980 individuals were reached with either VCT, HIV information sessions, or door-to-door contact to promote HIV testing services. Approximately 2,000 students visited the Information stand of a peer educator-based VCT campaign in the student centre in March (09). 1,100 students participated with written comments in a peer-based HIV campaign called "Stellenbosch Exposed". Students gave anonymous comments on issues like condom use, gender roles and HIV prevention in September 2009.

## Supervision

Peer educators are supervised via internet through the website and through e-mails. They also have a bi-monthly meeting with the sole PE supervisor. Previously, there were also 2 supervisor assistants, but these posts have now been withdrawn. The supervisor always has an open door for PEs who want to ask questions or seek advice. Peer educators complete monthly chat forms in an attempt to measure individual discussions with peers. Peer Educators also register volunteer hours as part of a documented system.

## Retention

Attrition is high and many drop out. Relations with the PEs are sometimes troublesome.

## Application of the Framework Indicators to the different prevention components

SU scores high for most Framework Indicators. It has an overall score of 85%.

## Application of the Good Practice in Operations Model to HIV prevention at SU

The OIHC works closely with the university's Staff Wellness programme (Human Resources), Campus Health Services, Division Research Development, the Centre for Teaching and Learning and academic faculties. The OIHC resides under the Vice-Rector for Staff and Community Interaction and shares reporting status with Human Resources, Campus Health,

Community Interaction, Sport and Diversity and Equity and also reports to the HIV Institutional Co-ordinating Committee.

The number of staff is low in relation to the task and the difficulties inherent in the socio-cultural and epidemiological situation. Still the programme seems to do well.

## Good Practices at SU

On the basis of case descriptions and observations made during the visit, the Good Practice Indicator Framework and the Good Practice in Operations concept, we identified the following Good Practices at SU.

**What programme components are particularly good according to the Programme Director and the supervisors?**

- The programme is contributing to the national HIV control strategy that SU finds important.
- The tendency of integrating teaching and counselling on HIV into other wellness aspects is important.
- E-learning is also important for SU and works well.
- The programme encourages experiential learning and views the diversity of its peer educator profile as an important tool to address issues of human rights, culture, gender and discrimination.
- The range of interventions including PE, VCT and community outreach is good.
- Collaboration with the Sociology Department on service learning (voluntarism) has been successful, including voluntary work for NGOs that is undertaken.

**What programme components need to be improved?**

The recruitment of males and students from Health Science remains a challenge. Also, a less time- consuming peer education programme for the Health Science students who struggle with a very full academic year, as better integration between peer education and curriculum activities might be part of the solution. Improved incentives for peer educators might address problems with retention.

The specific HIV competencies that should be included in curricula need to be better defined. The increasing demands on the existing academic programme call for better utilisation of existing programmes like the e-learning concept.

**SUMMARY**

SU is in a peculiar situation both regarding the socio-cultural composition of the student population and the epidemiological situation with a low HIV prevalence. The programme director, therefore, judges it important that the HIV issue is seen in a wider context of student wellness. In half of the faculties, HIV will be integrated into 6 modular programmes within specific academic departments in the future. Such an approach would reduce AIDS fatigue and be likely to seem more reasonable for the students. Many of the activities build on e-learning approaches. The PE programme lacks sufficient human resources, as two posts have been withdrawn. The computerised monitoring system is gradually coming into operation.

# CASE 4. TSHWANE UNIVERSITY OF TECHNOLOGY (TUT) – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

## General Overview [1]

The Tshwane University of Technology (TUT) was established on 1 January 2004, with the merging of the former Technikon Northern Gauteng, Technikon North-West and Technikon Pretoria. Geographically it covers four of South Africa's nine provinces (Gauteng, Mpumalanga and Limpopo and the North-West Province). Campuses located in Tshwane (Pretoria, Soshanguve, Ga-Rankuwa, Arts & Arcadia) are referred to as urban learning sites. Nelspruit, e-Malahleni (previously called Witbank) and Polokwane (previously called Pietersburg) are referred to as distant learning sites[2].

Large numbers of students are also drawn from other provinces and from neighbouring countries, such as

Botswana, Zimbabwe, Namibia and Swaziland. Of the total 50,726 students, 47,946 were enrolled for undergraduate studies (94%) and 2,567 for postgraduate studies (5%). Only 213 were occasional students. The majority of students were Black-African (86%).

## Opinions on the HIV-related context at campus – towards a definition of the HIV problem in the student population

Our VCT statistics reflect that 0.1% of the student population is infected. However, we believe that this is not a true reflection of the HIV circumstances at TUT as most of the students who opt to test have a lower risk of being infected or opt to do an Elisa test with a private doctor, since they don't have confidence in a rapid test. On the other hand, the lower incidence rate could be owed to the strength of the HIV prevention programme at TUT.

## HIV control activities

### *Structures and management*

TUT has an executive management structure in place that will drive the mainstreaming process, namely the HIV Co-ordinating Committee (HICC). This committee has Terms of Reference according to sector recommendations. An institutional officer has been appointed to co-ordinate all HIV and AIDS activities in relation to sector priorities.

The "AIDS Clinic" is situated in the Health and Wellness Centre, Campus Health, which is situated in the same building or close to the Student Life Centre that houses the Campus Radio Station, SRC offices, etc. The centre is thus accessible to students as they go about their everyday business. There also seemed to be seamless integration between VCT and Peer Education. Although PEs were not directly involved in VCT, they were readily available in the Health and Wellness Unit.

### *Policies*

TUT has an HIV and AIDS policy. The policy as it stood in 2007 did not balance the interests of the institution, students and staff. The policy does have procedures that guide the implementation thereof at management and operational level.

**Table 3–Annex 5** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own funding | 1,529,646 |
| Donor funding | 2,945,950 |
| DoE | 250,000 |
| **Total** | **4,725,596** |

The principles of the policy are reflected in the institution's strategic plan which has a holistic approach. TUT has designed a priorities document and business plan for 2008 for the HIV programmes. However, the TUT HIV policy is in the process of being reviewed in accordance with the HEAIDS guidelines and is expected to be completed in 2010.

### *Guiding principles for HIV prevention activities*

Although these were not communicated as such, it soon became clear that the ethos driving prevention and care initiatives is that of integrating PLWHA into the programmes. For instance, the Health Promoter, who is in many respects "the face" of HIV initiatives for the institution, is living openly with HIV.

### *Budget*

Operations budgets and student generated fees were utilised to carry out all HIV and AIDS activities. The amount allocated in 2007 was approximately R100,000. It was indicated that the amount of R250,000 was allocated for staff training and skills development. (Table ???)

# PREVENTION ACTIVITIES

All activities are led by the Health and Wellness Centre. TUT provides a wide range of HIV prevention services (with a strong focus of living positively with HIV/AIDS): These include:

- Rapid and confirmatory HIV testing
- Walk-in HIV testing facility
- Individual and couples counselling
- Rape counselling
- Referral for TB testing and directly observed treatment for students of TB treatment (role played by PE)
- Partner notification through a small slip of paper inviting the partner to visit the service (if the partner is not a student the slip will be a referral note to another service)
- STI diagnosis and treatment
- Nutritional supplements and bactrim
- Referral for HIV management (ARV, CD4).

The Health Promoter is the face of HIV interventions. Her cv speaks for itself: she was seconded from a long-standing community-based NGO that to date supports 25 other support groups in Tshwane. When the different campuses merged into TUT, she was retained as a University-wide Health Promoter after she had been a volunteer on a satellite campus. She brought to her position a wealth of knowledge and partnerships with other community-based/non-governmental organisations. This is reflected in the plethora of resources that she cited as the training of PE, for instance. Thus, the position of Health Promoter is occupied by an HIV/AIDS activist who leads by example, who is also highly involved in the HIV/AIDS community and has a track record of involvement in HIV/AIDS issues. This has also led to the creation of a number of partnerships.

## Partnerships

The following are four partnerships that were highlighted during the course of data gathering at TUT:

### *DramAidE*

The University has a long-standing relationship with DramAidE, with some staff positions in the Health and Wellness Unit subsidised by DramAidE. This partnership not only exposes PEs to innovative methods of HIV messaging, but also provides tools that expand their repertoire of skills relating to HIV prevention and care.

Health promoters (young people living openly and positively with HIV), are recruited and trained to conduct interactive workshops and campaigns on the prevention of HIV and also issues relating to living openly, testing for HIV and literacy. Health Promoters work with peer educators to promote delaying sexual debuts, to inform about the risks involved in multiple concurrent partners, and to promote VCT and HIV counselling.

DramAidE has its roots in the concepts of communication for development and the applied arts for social change. DramAidE is an intervention applying theories of behaviour change, interactive participatory learning and strategies for health communication campaigns. DramAidE conceptualises communication as a dynamic cultural circuit involving complex social interactions whereby meaning is produced, interpreted, negotiated and exchanged. All the projects have been evaluated by independent evaluators.

The work is undertaken as participatory action research with the aim of disseminating research findings through publications and advocacy aimed at the broader community (DramAidE website).

### *Foundation for Professional Development (FDP):*

While training offered by FPD is available to all HEIs, TUT displayed enthusiasm and a record of using these training facilities. All PEs underwent the 3-day training offered by FPD. PEs also attended VCT training with FPD, although they are not actively involved in VCT. FDP has the following characteristics (from the FPD website):

> The mission of FPD is to ensure the availability of skilled professionals and managers, who will be able to deliver a service to the public that is affordable, evidence-based and congruent with international best practice.

The course is taught through a combination of self-study and a 3-day interactive workshop facilitated by leading experts in the field. The workshop is interactive through a combination of case studies and discussions.

Assessment: Participants are assessed on the self-study component of the course through means of a multiple-choice questionnaire. These are submitted to the Foundation for Professional Development for assessment

**Modules**

- Epidemiology and prevention of HIV infection.
- Pathogenesis of HIV infection.
- The diagnosis of HIV infection.
- The tests used to monitor HIV disease.
- Clinical features of HIV and AIDS.
- Understanding opportunistic infections and their treatment.
- Antiretroviral management of HIV infection.
- Drug combinations.
- Changing treatment.

### *Scrutinize*

Scrutinize is a unique partnership that brings together the collective efforts of the United States Agency for International Development (USAID), Johns Hopkins Health and Education in South Africa (JHHESA) and its 21 partners, the iconic youth brand Levi's®, and Matchboxology, the creative incubator behind the campaign.

A number of South African universities have been scrutinised so far this year, reaching several thousand of students, learners and community members, with more such visits on the cards. These include the universities of Zululand, North West, QwaQwa and Venda, as well as the various Tshwane University of Technology campuses.

Peer educators on the campus were trained by DramAidE to share information about Scrutinize with fellow students on their respective campuses. During the events, they showed students the award-winning Scrutinize "animerts", and unpacked the campaign message through workshops, presentations and a range of activities designed to encourage young people to "scrutinize" their sexual behaviour.

This fun, interactive entertainment-education approach included the use of kwaito, gospel, choral, isicathamiya; hip-hop music; pantsula, gumboot and traditional dancing; sports such as soccer and netball; impromptu plays and comedy as well as poetry to reinforce the Scrutinize message.

The training of the peer educators built up to a Scrutinize Live event featuring Scrutinize Ambassador and local comedian Joey Rasdien and several local musicians selected by the students themselves. Several competitions and giveaways added to the jollity of these events, and the male and female condom usage demonstrations proved instructive as well as entertaining.

Young people were encouraged to debate and share their thoughts on aspects such as multiple concurrent partners, transactional sex, condom use, drugs and alcohol. In addition, there were stimulating question-and-answer sessions, role-playing games, quizzes and even mock talk shows.

At all Tshwane University of Technology's campuses and the University of Venda, students were so eager to participate in Scrutinize that even before the activities began, they were queuing up to undergo voluntary counselling and testing (VCT) to ascertain their HIV status (www.scrutinize.org.za).

### *Department of Health (DoH)*

As with the relationship with FPD (above), all HEIs have at their disposal IEC and training material provided by the DoH. TUT highlighted use of the training material developed by the DoH. It is safe to say that almost all HEIs have a set HIV intervention calendar that includes an awareness campaign during the university Orientation Week, the STI awareness/condom week around Valentine's Day, the reproductive health week in August, as well as the HIV/AIDS commemoration day on Dec 1, plus others. These are in line with National and International HIV prevention calendars. TUT, however, went a step further with the following events.

- A systematic university residence-focus spearheaded by the PEs
- Scrutinize campaign

- Community-focused awareness campaigns in partnership with SASVO
- A particularly innovative initiative: "think before you unbuckle". A number of students who take part in an HIV education campaign are given a belt reinforcing the message: "think before you unbuckle".

### *Peer Education*

The student peer education programme was not funded in the past. Operational budgets were used to carry out these education programmes. Peer educator programmes were not standardised in 2007. The peer education programme assists in ensuring that a large number of members of TUT and the surrounding community are reached. There are 200 peer educators providing these services. However, since 2008, Peer Education has been standardised across all TUT campuses.

Prevention programmes focus on students and staff. Peer Educators provide education and support. The Peer Educators are trained and supervised by the Health and Wellness staff.

### *Level of visibility and activity*

When asked what aspect of PE he is particularly proud of, a peer educator responded that it is the sheer structure of support that PE offers the broader student community. "We are very relevant," he said. This was demonstrated by the presence of PEs in the student life centre. PEs appear to be an integral part of student life at TUT. They have an active calendar whose reach is across all campuses and beyond into the neighbouring communities. The active presence of PE in Halls of Residence affords students support after hours. The active involvement of PE is reflected in the paraphernalia at their disposal. The set-up at TUT encourages seamless integration of HIV prevention and management services as well as all role players. For instance, PE, VCT and managerial staff are housed in one building. This encourages integration of services and enhanced channels of communication. However, negative unintended consequences may include role confusion and increased vulnerability of confidential information as well as neglect of structured support for PE in favour of an open-door policy.

### *The need for a balancing act*

While there may be challenges that relate to the visible presence of PE in the Primary Health Care Centre, where VCT is being offered, such as students not feeling comfortable using the facilities owing to the presence of their peers, the opposite may be true. There is, thus, a need to balance the ethical imperatives of client privacy and confidentiality with the social need to make VCT centres student-friendly, fostering a sense of student ownership. Perhaps such considerations may shift attitudes to HIV testing and HIV in general at HEIs.

### *PE recruitment*

According to the Health Promoter who also supervises PE, their PE recruitment strategy aims to recruit volunteer students who reflect the diversity of the TUT student population. HIV status is never used as a criterion for admission into the programme. However, volunteer students are expected to have at least some knowledge of HIV, have good interpersonal and communication skills, as well as a good academic record.

### *PE Support*

PEs at TUT have a committee that represents them at weekly meetings with the PE supervisor.

### *PE Training*

PEs at TUT are exposed to an array of training opportunities that equip them with a range of skills. Their active involvement in student life affords them an opportunity to use and refine these. Refer to Partnerships (above).

## VCT

TUT has adopted the Health and Wellness concept since January 2008, through the merging of the

campus health services with counselling and the HIV and AIDS services. The new concept uses a co-ordinated Wellness model to address health needs to advocate and support the wellbeing of TUT students at individual, group, and institutional levels. The programmes and services offered aim to support the academic and personal development of students. Comprehensive services and programmes are tailored with the primary focus being on health care, HIV prevention, care, and support and counselling. All aspects of Health and Wellness services focus on programmes and activities that ensure the development of physical, cognitive, behavioural, spiritual and psychosocial aspects of student wellness. All urban learning sites' Health and Wellness Centres are accredited VCT sites, but not ART. In 2007, clinic services were provided at the following TUT learning sites: Pretoria, Soshanguve and Ga-rankuwa.

TUT reported that a doctor is in session once a week per urban learning site. There are also six nurses, three counsellors and three support staff (one full-time and two part-time) employed at the Health and Wellness Centres.

Professional nurses at distant learning sites, health promoters and health and wellness assistants are contract appointments funded by HEAIDS and DramAidE. All learning sites have interviewed and appointed peer educators who assist the Health and Wellness directorate to reach more students. Peer educators receive training on HIV and AIDS information, basic counselling, healthy lifestyle, and other relevant health and wellness topics.

Daily statistics are kept for all those who receive Pre-test, Testing and Post-test Counselling. The nursing sisters and the counsellors record their daily clients in the client register. The student or staff number which is also used as the file number, the name of the client, gender and age, and the fact that they are in the window period or not are all recorded in the client register. It is also noted in the register whether the client is a staff member, contract worker, day student or resident student. In 2007, 874 students and 15 staff members were counselled and 403 students and 10 staff members were tested. The Institution indicated that there were no costs incurred by those counselled as the service is provided free of charge.

## Condom Distribution

Condoms are widely distributed throughout TUT and at student functions. However, the uptake of female condoms is low. TUT reports that obtaining female condoms from the DoH is quite challenging as they are unavailable at times.

In 2007, approximately 68,000 male and 800 female condoms obtained from DoH were distributed. The service is provided free of charge.

## Community outreach

The informants who came from the Soshanguve Campus, which is located in the community, painted a picture of a relationship with the surrounding neighbourhood that evolved over time. Here the relationship is 2-way; the university responds to the needs of the community as these arise and, for its part, the neighbouring community supports university-initiated interventions. The informants from this campus related the cyclical relationship between the university and the community; none are closed off and, thus, self-sufficient.

The following points were raised with regard to community involvement:

- The university has "adopted" a local school; PEs do awareness-raising/educational talks at the school
- The school refers cases of (suspected) child sexual abuse to the university wellness centre
- PEs are involved in door-to-door HIV awareness campaigns
- One PE is the chairperson of the South African Student Volunteers Organisation (SASVO) and is spearheading greater PE involvement in the community. He mentioned, in particular, the need to involve men as partners in the fight against HIV. He also highlighted that men are also victims of social ills, such as drug addiction, perpetration of

violent (sexual) behaviours towards women, and socialisation that discourages showing weakness.

## IEC

IEC is generally an integral part of HIV prevention and management. Some IEC materials have been internally-generated and respond to internal needs, tailored to the institutional culture. Such IEC outlines the details of services available on campus. HIV/AIDS-related IEC is also shared across HEIs and across different sectors. Such IEC is generated by the DoH, for instance, for consumption by the general South African public. TUT is one of the universities that has sustained Campus Radio in its repertoire of IEC in which the Directorate of Health and Wellness is allocated a dedicated slot.

## Circumcision advice

It is indicated that 85 students received advice in 2007.

## 24-hour helpline

Staff can access the 24-hour helpline of ICAS which was implemented in 2007. Students currently do not have access to this institutional helpline, but information about national helplines is distributed on campus. Since 2008, students have access to the 24-hour services of ER 24, anywhere across SA.

### *Application of the good practices framework: the case of TUT*

Here, we consider how the good practices framework applies to the programmes and operations at TUT.

#### *Cross-cutting issues*

Students, as recipients of services, are highly active in HIV/AIDS related issues, mainly through the peer education programme. The active involvement of PEs means that they are in touch with issues on the ground. The involvement of students in HIV/AIDS programmes allows them the opportunity to influence the design and the implementation of activities.

#### *Peer Education*

Feedback from PEs remains the next best way to solicit recipient views in the absence of systematic needs assessment processes. This is one way to begin aligning services to recipient needs.

The emphasis that PEs need to have some personal experience with HIV/AIDS allows for an empathetic, sensitive, and informed engagement with the human side of the HIV/AIDS epidemic. The level of visibility and activity of PEs at TUT means that PEs are an integral part of the HIV prevention strategy at the university. For this reason, PE programmes necessarily receive institutional support. But, more than that, the day-to-day operations of the PE programme should remain high on the agenda of the bodies concerned with HIV/AIDS management at the university.

The PE programme at TUT has strong links with VCT. While PEs do not deliver VCT, they have been trained in VCT. They therefore understand the VCT process. More than that, PEs are always on hand to receive recipients of VCT where necessary. The links with VCT also mean that activities and projects can be co-ordinated to give a concerted response to particular issues.

The systematic involvement of PEs in residences affords students round-the-clock support. The considerations highlighted above regarding the benefits flowing from partnerships with training and support linkages apply to VCT.

#### *VCT*

The knowledge and skills bases of HIV counsellors are positively enhanced by exposure to continuous and diverse training.

#### *IEC/BCC*

Use of media: the employment of radio as a conduit through which HIV messages can be communicated and shared throughout the university community is good.

**Application of the Good Practice in Operations Model to HIV prevention**

The location of VCT in a student-life building facilitates access to VCT. In turn, the location of VCT in

Health and Wellness facilitates easier access to holistic health care for students. VCT stands to benefit from any positive changes that take place at Health and Wellness; Health and Wellness, as a programme, is likely to enjoy support in case of limited financial resources. Therefore, VCT can be sustained through its association with Campus Health.

The many strategic **partnerships** that TUT has forged with external institutions enable training, support, and opportunities for multi-skilling and refinement of such skills. The many opportunities for training presented by the partnerships allow PEs to develop an intricate understanding of the complex issues associated with HIV prevention and management. The benefits derived from these partnerships can only engender a feeling of personal development and satisfaction with involvement in the programme. Exposure to the external links also allows PEs an array of referral points for client care.

**Examples of Good Practices at TUT.**
On the basis of case descriptions and observations made during the visit, the Good Practice Indicator Framework and the Good Practice in Operations concept, we identified the following Good Practices at TUT.

*The Health Promoter living positively with HIV*

This approach is a Good Practice on many levels:

- The Health Promoter lives openly with HIV, thus actively countering issues related to fear and stigma
- The Health Promoter was promoted through the ranks of HIV initiatives over time in the institution, she thus has intricate knowledge of the institution's evolution and culture
- The Health Promoter is highly visible and involved in the broader HIV/AIDS community
- The Health Promoter plays a pivotal role in influencing the direction and thrust of HIV prevention and care initiatives
- Ethical guidelines stated in an information brochure (motto: live your life, create your destiny)
- Every individual is treated as a unique and total being
- Confidentiality is emphasised.

*Several partnerships with external organisations*
The above partnerships demonstrate Good Practice for the following reasons:

The partnerships are long-standing

- The partnerships demonstrate an awareness/knowledge of resources available to maximize
- PE training
- Utilizing various partnerships enhances PE exposure to a multitude of skills
- Although the availability of the various partnerships does not necessarily mean good outcomes, it does offer HEIs an opportunity to choose programmes that best meet their needs
- Using such partnerships is cost-effective both from the point of view of the individual institution and also on the larger national scale
- Solid partnerships bode well for the sustainability of institutional programmes
- These partnerships use international best practice standards
- Campaigns/HIV intervention calendar.

*Innovative practices added to Prevention campaigns mentioned above*

These are Good Practices on a number of levels:

- Systematic integration of issues affecting students in residences in the PE programme
- PE involvement in residences affords students support after hours
- The "Scrutinize" campaign is innovative, fun and relevant to issues relating to local concerns about HIV. The modalities used in this campaign are responsive to the all-prevailing AIDS fatigue demonstrated by the target group
- Community relevance/involvement is generally regarded as Good Practice
- The "think before you unbuckle" campaign is exciting in that, not only are students enticed to participate in an HIV education campaign by the prospect of receiving a belt, but the belt also remains a tangible, long-term reminder to consider practicing safer sex

- TUT has amassed an impressive collection of infrastructures, such as gazebos, to use in mobile outreach activities. The ability to organize such activities with minimum expense increases visibility of VCT and PE on campuses.

### *Peer Education*

PE activities at TUT follow Good Practice in the following ways:

- Peer educators at TUT are highly visible on campus and beyond
- Peer educators at TUT are given responsibility that involves them in student life
- The active involvement of peer educators in student life entrenches the idea of peer-to-peer engagement on issues of mutual concern
- Peer education/peer activity is integrated into the Health and Wellness Programme at TUT
- A Good Practice in the PE recruitment strategy used at TUT is that HIV/AIDS is elevated from being an abstract, theoretical concept to one that is infused with emotion and human understanding. The tendency to impose one's experiences on clients can be countered by training. The involvement of PLWHA in PE increases the chances of influencing the development of materials and the overall thrust of HIV prevention and management activities.
- Peer educator training is wide-ranging and comprehensive.

### *Community Outreach*

This approach is a Good Practice on the following levels:

- Awareness of the relationship between the neighbouring community and the university
- The university is socially relevant
- The recognition and utilisation of the different hats that PE wears.

### *Campus Radio*

Campus Radio is a Good Practice because:

- It engenders the idea of a "community", thus facilitating ownership of issues that affect the university
- It offers a platform to generate conversation on important issues
- It gives all concerned a voice that reaches throughout the university community
- A dedicated slot has potential to attract a dedicated audience, thus engendering a health-savvy population
- It can be used to respond to issues as they arise
- It is well-placed to influence the institutional sexual culture
- It can be used as a conduit for diffusion of innovation
- It offers a good platform for peer behaviour modelling
- It can be used to garner support for important HIV-related campaign.

**SUMMARY**

There are a number of Good Practices in Operations at TUT. The overall impression of HIV prevention and management at TUT is of these services being entrenched in the Health and Wellness Programme of the University. Student peer educators are an integral part of the everyday running of the services. The university has fostered and maintained a number of strategic partnerships that enhance the implementation and sustainability of services. Combining services and activities together enhances the overall HIV prevention and management package offered to students and staff. This is further strengthened through the leadership of PLWHA. Therefore, the capacity of staff, including PEs, is systematically strengthened, systems are well-entrenched as are structures for the delivery of a good standard service package. TUT demonstrates a strong community involvement ethos. There are a number of Good Practices in Single Components. These include both VCT and Peer Education. There are also innovative practices. These include the use of Campus radio, gazebos and mobiles, and additions to the prevention campaigns, including the Scrutinise and 'Think before you unbuckle" campaigns.

## CASE 5. UNIVERSITY OF JOHANNESBURG (UJ)[1] – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

The University of Johannesburg (UJ) was founded in 2005 through the merger of the former Rand Afrikaans University (incorporating the Soweto and East Rand

Vista campuses) and the former Witwatersrand Technikon. UJ now has more than 41,000 students. The University offers academic programmes , assisted by mixed modes of delivery. UJ has five campuses of which four are located in Johannesburg: the Auckland Park Kingsway (APK), Auckland Park Bunting Road (APB), Doornfontein (DFC) and Soweto (SWC). The East Rand campus is situated in the Ekhuruleni Municipality at Daveyton, close to the OR Tambo International Airport.

The campuses are different in size, culture and character and have the infrastructures needed to deliver education and services to students. Out of the total of 41,740 students, 35,581 were enrolled for undergraduate studies (85%) and 5,999 for postgraduate studies (14%). Only 160 were occasional students. The majority (66%) of students were Black (African) followed by White (25%), most of whom come from the province of Gauteng.

# GENERAL OVERVIEW

## Opinions on the HIV-related context at campus – towards a definition of the HIV problem in the student population

UJ has taken an approach that emphasizes knowing and understanding the student population. To this end, several inward focused research projects have been undertaken. These include a students' needs assessment as well as a KAPB study. The rationale for these studies is that a composite understanding of the student population will inform the university's response.

## HIV control activities – structures and operations

The Management and Administration for HIV and AIDS is monitored by the UJ HIV and AIDS Committee. This Committee is one of four health-related committees that report to the university's Health Advisory Committee (HAC). An executive committee makes decisions on HIV and AIDS-related issues when these arise or when responses are required in between scheduled meetings. The executive committee also consults with the convener of the HAC for additional input before final decisions are made.

### *Policy*

UJ has an HIV and AIDS policy that was developed in 2006. Monitoring and evaluation of the policy are conducted by the AIDS Committee. The Policy is divided into sections that include definitions, purpose and implications, strategic plan for HIV and AIDS, HR policy on HIV and AIDS, and HIV and AIDS procedures and practises. The policy and UJ strategic plan are based on the National Strategic Plan of the national Department of Health.

### *Budget*

(Table 4–Annex 5)

## Cross-cutting issues

### *Research on the student population.*

As already alluded to above, UJ has adopted an HIV prevention approach that begins with thorough knowledge of the student population. This all-encompassing approach also extends to the overall HIV/AIDS management approach displayed by UJ. UJ has systematically sought to build a tailored, informed and comprehensive response to HIV management within the University. A review of systems and approaches adopted by UJ leaves one with a sense of an overhaul that is futuristic in its view and thus addresses relevance and sustainability. UJ has invested heavily

**Table 4–Annex 5** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own Funding | 666,159 |
| Donor Funding | 2,837,837 |
| DoE | 250,000 |
| **Total** | **3,753,996** |

in putting together structures that work. These structures facilitate the centralisation and co-ordination of efforts. The whole UJ approach to HIV management is in line with and indicative of the merger imperatives that allowed the university space to reconceptualise and refashion systems and operations, including Management Information Systems.

## Prevention Activities

### *Peer education*

The University of Johannesburg has put together an innovative peer education programme called The Link, so called as the programme provides a nodal point from which a cascade of HIV-related activities can flow.

The UJ peer education programme is informed by Rutanang, although it has been adapted to the needs of the university. PEs are recruited during their first year at the University, so they can grow with the programme as they advance with their studies. This approach maximizes the investment that the university can get from the programme. Link members are also involved in residence awareness campaigns.

**What commitment is required to become a LINK member?**

- Commit to the programme for one year
- Attend the 12-hour Basic HIV and AIDS training programme
- Attend the 5-day Advanced Training in their relevant groups (i.e. Prevention and Awareness,
- Community Outreach, Care and Support)
- Attend at least 80% of any additional training provided throughout the year
- Participate in at least 80% of the groups' projects and campaigns during the year
- Attend weekly meetings
- Submit a completed Portfolio of Evidence for assessment purposes at the end of the year.

The Link is conceptualised as both a behaviour change catalyst and as **going beyond an individualistic behaviour change model** to a systems oriented approach that emphasizes social networking and social change. This is a fundamental point in HIV prevention (especially in a generalised epidemic such as in South Africa) and one that was emphasised by the psychologist at UJ who supervises and manages the Link programme. The shift in emphasis from individual behaviour change to a systems oriented focus acknowledges the structural, social, economic and political aspects that drive the epidemic. This is in line with contemporary social science theories that take a more holistic view of HIV, contrary to bio-medical and public health theories emphasizing the individual role and responsibility in curbing the spread of HIV.

Objectives of the LINK programme include:

- Serving as a unique behaviour-change intervention
- **Empowering** students to become active agents of change by:
  - Providing students with accurate **knowledge** and practical **experience** in the field of HIV/AIDS
  - Providing students with **relevant skill-building opportunities** & training to deal effectively with HIV/AIDS
  - Engaging students in HIV **projects** and campaigns on all campuses at UJ, as well as at schools, clinics and NGOs in the surrounding community
  - Encouraging students to **advocate** against HIV-related stigma on and off campus
  - Stimulating **debate** around relevant HIV-related issues
  - Promoting **care and support** for students living with HIV
  - Providing a platform to expand on HIV/AIDS work within their **career paths.**

### *Staff Peer Education*

More than 30 staff members from all campuses volunteered to be trained as Staff Peer Educators (SPEs). They received theoretical training and have submitted portfolios which allow for the assessment of their understanding of what is required of this position. Further training was also provided later in the year. The SPEs participated in various projects, including UJ World AIDS Day on 27 September 2007 and a community project in December

2007. The estimated amount of R190,000 is allocated to Staff Peer education (funded by UJ).

### *HIV and AIDS Information*

The student peer educators also participate in leadership and team-building workshops.

- Condom/STI week, 12-17 February. APB, DFC and SWC hosted annually
- Condom and STI week during the week of Valentine's Day
- Candlelight Memorial. At SWC and DFC, the candlelight memorial was observed on 15 and 16 May respectively, and a person living with AIDS (PLWA) addressed over 100 students at APB on 18 May 2007
- VCT campaign, 13-17 August (in collaboration with campus health clinics)
- Peer educators at APB and DFC addressed fellow students on the importance of VCT; Residence Projects were held on some campuses in May and August
- Students watched HIV-based movies followed by discussion at APB and DFC. In addition, students participated in a gender debate and discussion in August at APB and DFC
- Community Outreach DFC peer educators visited and presented a special programme for abandoned people in the Johannesburg CBD in September, while APK peer educators visited Saziwe "Hope for life" hospice in October
- Awards Ceremony, 18 October. Peer educators received certificates in recognition of their successful participation in the peer education programme for the year.

### *Voluntary Counselling and Testing (VCT)*

The health clinics on all campuses are accredited by the provincial DoH for primary health care and VCT and receive free test kits and funding for lay counsellors from the Department of Health (DoH). The South African Youth Council provides counsellors for VCT at APB and SWC and these counsellors are funded by the DoH. APK and DFC counsellors are intern psychologists from the Student Counselling and Career Development Department and the Institute for Child and Adult Guidance, who render this service as part of their internship (funded by UJ). In 2007, *2,161 individuals* received VCT services provided by the University and the calculated HIV prevalence value of 1% is 0.4% lower than what was reported in 2006.

VCT follows the standard format that is to be found elsewhere, hence the accreditation by the Department of Health. Issues include HIV risk assessment and reduction, history of VCT, communication with partners, how to disclose one's HIV status, and checking understanding of test results. The student VCT recipients who participated in this research were generally happy with the VCT service. In particular, they commented on the convenience of accessing VCT between classes. Some of the students have undergone VCT elsewhere, for example at a community-based VCT site, so they had a basis on which to compare their experiences of VCT on campus. The students indicated that they came on their own, but having heard about the service from other students who had used the service. The students also suggested that rather than having to make an appointment for VCT (by which time they may have lost the nerve and not show up), a walk-in policy should be considered.

### *Condom distribution*

Condoms are distributed by the cleaning services on a monthly basis to all UJ campuses. The control points are the Institutional Office for HIV and AIDS at APB and DFC, and the Campus Clinics at APK and SWC. Female condoms are only distributed from the Campus Clinics due to the complex nature attached to usage. In 2007, approximately 50,000 male and 2,000 female condoms were distributed. UJ has indicated that it does not incur any costs for condoms as they are supplied by the Dept of Health free of charge and the distribution is done by cleaning services and this forms the part of their daily duties.

### *Curriculum Integration*

The *Faculty of Education* at UJ forms part of a pilot project, initiated by HEAIDS, concerning the integration of HIV and AIDS into a module used for teacher education. This project will be completed in 2009.

Various Departments at the *Faculty of Humanities* (Psychology, Social Work, Politics, Historical Studies, Anthropology & Development Studies, and Sociology) have integrated HIV and AIDS into their curricula. Prof Ria Smit is currently implementing an NRF research project on family resilience and wellbeing in South Africa. The research studies the effects of HIV and AIDS on family life.

The *Faculty of Management* does not have any formal curriculum activities on HIV and AIDS. At the *Faculty of Law*, relevant case law is dealt with in the modules for the Introduction to Legal Studies and Labour Law. The Department of Biomedical Technology in the *Faculty of Science* has integrated a HIV and AIDS curriculum as part of the syllabus for Patho-physiology, Immunology, Microbiology and Blood Transfusion.

Within the *Faculty of Engineering and the Built Engineering*, there are no implemented curriculum activities on HIV and AIDS. However, they do deal with the impact of HIV and AIDS on the employment sector, e.g. mining sector within their Civil Engineering Technology programme (DFC). More specifically, they study the structural (percentage of workforce affected) and economic impacts of HIV and AIDS on the employment sector.

In the *Faculty of Science*, lectures are given to new students during pre-registration. In this lecture, support services available on the campuses are identified to assist incoming students along with information on the nature of the disease. Students are advised where to go for testing, counselling and support. Topics on HIV and AIDS are included in academic courses where appropriate.

### *Community outreach*

Community outreach is an integral part of the Link Project.

**Application of the good practices framework: the case of UJ**

In this section of the UJ case description, we carry out a comparative analysis of the good practices found at the university and the framework that denotes good practice.

**Cross-cutting issues**

The approach to HIV prevention adopted by UJ entails a thorough understanding of the student population. Their KAPB and needs facilitate the imperative of tailoring programmes and activities to the needs of the students. From this point of view, questions of gender inequality, cultural practices that may pose an HIV risk, stigma and others will be raised as they apply to the student population.

### *Peer Education*

As is generally the case across HEIs, peer education is the focal point of HIV prevention and the primary vehicle through which students get involved in HIV prevention efforts. For this reason, the Link, the UJ peer education programme, has strong institutional support. The Link model incorporates a number of established principles such as presenting a dedicated student body that is involved in the HIV prevention strategy of the university, that provides a link between internal and external organs concerned with HIV, and that is trained in multiple modes of delivering key HIV messages such as drama. To this end, PE training necessarily has to be comprehensive and diverse. The Link is rigorously structured to follow a particular model. Use of a model that informs the conceptualisation and implementation of the peer education programme presents many advantages: the model can be replicated across campuses; changes to the model are deliberate and informed; impact can be assessed; modelling means that operations cannot veer far from the intended trajectory; and everyone involved in the programme understands its aims/objectives and modes of implementation. The internal validity offered by modelling generates confidence in the programme as well as structural support to those involved at the various levels of the programme. Training and other interventions are synchronised towards a widely-shared goal. Providing a model for peer education is an efficient way of communicating a complex phenomenon in a simple and therefore easy to assimilate way.

**Applying the Good Practice in Operations Model to HIV prevention**

See description of the Link Project

**Good Practice at UJ**

On the basis of case descriptions and observations made during the visit, the Good Practice Indicator Framework and the Good Practice in Operations concept, we identified the following Good Practices at UJ.

The UJ peer education programme constitutes good practice on the following bases:

- Peer educators are given a central role in the university's HIV management strategy
- Peer educators are recognised as playing a bridging role between stakeholders at different levels within the university
- Peer educators undergo extensive training
- The PE programme is well-structured with clear expectations
- PEs are given support to carry out their mandate
- Submitting a Portfolio of Evidence helps in deciding whether or not a peer educator should be retained for the following year
- The Portfolio of Evidence is a good way for PEs to reflect on and learn from their experiences throughout the year
- Keeping a record of Portfolios of Evidence from the various Link members can be a good source of information for planning and/or for research.

**SUMMARY**

**Good Practices** at UJ include defining the problem in the student population and the PE Link Project. The UJ student body is particularly diverse due to the widespread nature of its campuses: some are metropolitan and others are based in the townships. It was, therefore, a good starting point to disaggregate the various trends that may emerge from these disparities. As such, HIV prevention work can be tailored and honed to the various needs and challenges that may be campus-based.

The Link programme also stands out as a good practice as it actively involves students in the various university forums that are concerned with HIV/AIDS. The structured nature of the programme gives support to students and allows them to grow in HIV prevention work.

# CASE 6. UNIVERSITY OF VENDA (UNIVEN) – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

## General Overview

UNIVEN had around 11,800 students in 2007. Almost all students were Black African (11,747 students, i.e. 99%), as were most of the teachers. There is only one campus. It is located in Thohoyandou in the province of Limpopo.

## Opinions on the HIV-related context at campus – towards a definition of the HIV problem in the student population

### *HIV control activities – structures, management*

#### *Structures*

A HICC Committee exists. It works as an institutional co-ordinating committee that co-opts members from time to time, according to needs.

#### *Staff*

The current staff at Campus Health include: four professional nurses, one acting as HIV/AIDS co-ordinator, two PLWHA in health promotion, a part-time doctor, plus over 40 volunteer student peer educators. The educational levels of the staff vary. 54% of the staff are female, 46% are male.

#### *Staff training*

Training is broad and includes topics such as sensitivity, discrimination, confidentiality, harm reduction and disclosure. Some of the staff have received training in behaviour change theory and its application. It was unclear whether staff received training on harm reduction counselling. However, staff are not trained to apply structured decision-making or problem-solving techniques, such as decisional balance techniques. When asked about the training provided, it transpired that training in behaviour change and diversity management was conducted.

**Table 5–Annex 5** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own Funding | 331,618 |
| Donor Funding | 1,923,382 |
| DoE | 250,000 |
| **Total** | **2,505,000** |

The Bridge Model was used. The co-ordinator provided training on The Bridge and how to apply it. The Model was described as helping trainees identify the obstacles that may create a barrier to change. Clients may have all of the information they need, but there is an attitude or a perception that can block the application of the information. Participants apply the Model by strategizing how to remove the barriers so that change can take place.

### *The Budget*

Current sources of funding: donor funding such as HEAIDS, DramAidE and the institution. The institution currently benefits from a project with a value of R2,250,000 from HEAIDS, of which 10% came from the institution. The purpose of this funding is to establish and develop sustainable strategies for the control of HIV and AIDS at the University of Venda.

HEAIDS funding met the programme needs to an extent. It was indicted that it allowed them to carry out some training, and buy promotional materials, office equipments and T-shirts. T-shirts were worn to make the peer educators more visible to the other students. In terms of financial help, multiple funding is received for VCT. Not only was HEAIDS money available, but funds were also provided by the government, private funders and DramAidE.

### *Policies*

Formalised, clarified and written policies relating to discrimination, confidentiality and gender equity did exist. However, no formalised policies related to the utilisation of PLWHAs in the programme or the extent of disclosure. No functioning Quality Assurance Committee for VCT existed. This is a good practice that should immediately be included to ensure well-trained, sensitive and effective staff.

### *Plans*

There is a functioning HICC, a plan with clear objectives, and a log frame that focuses the planning and implementation process. However, there is neither a website nor an organisational chart of the HEAIDS programme.

### *Services provided*

HIV/AIDS Prevention at the University provides the following services:

- pre- and post-test counselling for HIV
- rapid testing for HIV
- walk-in care
- emergency contraceptives
- screening for TB diagnostics (with TB testing, the samples are sent to a local laboratory)
- couples counselling
- for more in-depth, individual counselling, clients are referred to the psychologist
- with rape counselling, they may talk to the counsellor initially but then are referred to the hospital for professional counselling and to protection services to begin the process of legal action.

## Cross-cutting issues

Cultural issues are addressed within the training and programmes provided. For example, in collaboration with DramAide, awareness campaigns were developed and implemented about issues related to alcohol use and likelihood of becoming infected with HIV as well as addressing the special needs of transvestites. In all aspects of the programme, condom use and STIs were discussed. However, male circumcision was not discussed unless the client raised the subject.

### *Monitoring system*

Monitoring is part of the programme. They keep track of attendance, student pregnancy rates, trends

in HIV prevalence, number of recipients of PE, number of students who have undergone VCT, number of condoms distributed, number of STIs, and number of emergency contraceptives requested.

### *Research*

The professional nurses also participate in collaborative research with the Department of Microbiology. Some of the areas that have been covered include:

- Drug sensitivity and resistance to ARVs among students
- Screening for cholera among student attendees of the health and wellness centre
- Attitudes on condom use by students
- Tracing clients who test HIV-positive to the province of origin.

## PREVENTION ACTIVITIES

- Behaviour Change/Counselling (source: counselling questionnaires)
- Life Skills Training (source: counselling questionnaires)
- IEC/BCC

The programme co-ordinator reported that the following prevention programme components are provided: (Table 6–Annex 5).

### Peer Education

There were 40 student peer educators, trained by the professional nurses in 2007. The peer educators received basic HIV information (three days) and diversity management training (two days). They were trained on gender, culture and political issues. They also received training on behaviour change theory. On average, 20 students are trained per year in three sessions per year at a cost of R5,000 per session, mainly for catering. This was funded by DramAidE.

There are three campaigns per year of which two are for VCT and AIDS awareness and one for STIs and condom use at a cost of R5,000 each. There is also an AIDS Day campaign which costs R20,000. Costs for pamphlets are R3,000. These are funded by Univen.

Not all of the critical positions and functions are filled. Two additional counsellors, a tester/nurse and someone to work with staff on a one-to-one basis, are all needed. No co-ordinator position exists in the institution, but there is an HIV/AIDS programme assistant. There is a great need for an administrator to handle office matters, such as filing, etc. The present person fulfilling the role of administrator has too many tasks.

PLWHAs are involved in the prevention programme. Their involvement has greatly improved the outreach of peer educators. People living with HIV/AIDS are providing a more realistic picture of the realities involved in reducing risky behaviours and the true meaning of having to live with HIV/AIDS. Staff have knowledge

**Table 6–Annex 5** HIV/AIDS Prevention Programme

| Component | |
|---|---|
| Peer Education | Yes |
| VCT | Yes |
| Behaviour change activities | Yes |
| Counselling | Yes |
| Life skills/resilience training | Yes |
| BCC | Yes |
| Condom distribution | Yes |
| Health services | Yes |
| STIs | YES |
| ART | -- |
| IOTB | Yes |
| PEP | Yes |
| PMTCT | -- |
| Circumcision | -- |
| Small media | Yes |
| Internet | Yes |
| Radio | Yes |
| Others, specify: | |
| Community outreach to primary & secondary schools | Yes |
| FET – Training | Yes |
| Local nursing college – training | Yes |
| Awareness training | Yes |

of, and access to, prevention programmes and related services in the community. They can refer students to these services as needed, such as HIV treatment and those organisations that provide spiritual support, etc.

The programme co-ordinator expressed concern that the peer educators do not receive a stipend or any other compensation in recognition of the important work they carry out. This affects their commitment to, and involvement in, programme activities. Peer educators use their own transportation. UNIVEN is currently negotiating with the Department of Education for stipends and to strengthen the structure. Programme staff would like to go out with a mobile unit and service more clients. This would mean that the HIV/AIDS Prevention Programme would become an independent unit rather than attached to Campus Health. It would have control over its own programmes.

### *Good Practice and Innovation*

The University also selected the Traditional Healers' Programme as one that exhibits good practices.

The Prevention Programme Co-ordinator has played a major role in building the relationship between the client, the healer and the staff of the HIV/AIDS Prevention Programme that she represents. She has a unique relationship in that she works co-operatively with traditional healers to ensure that clients who are treated by them maintain their good health. A large group of students believe that they do not have HIV/AIDS, but that they have been bewitched. They resist traditional drug treatment and go to healers. Christian or otherwise religious individuals, often use prayer as their mode of treatment. One female client tested positive then re-tested negative, but refused to be tested using the Elisa method. When she was asked to take the Elisa test, she refused because it would have implied that she was questioning the ability of her prayers to heal her. These clients are encouraged to come back for check-ups on the CD4 count, that is, every three months.

The Co-ordinator insists on monitoring the clients who see the traditional healer. She described a client who refused to take ARVs and insisted on going to the healer for treatment. The client was using the healer's "muti" and responding positively to it. As long as she was responding well, the Co-ordinator did not interfere with the healer's treatment. Then the client started to decline. When asked about it, the client said that neither she nor her family had the 20 rand to travel to and from the healer. Because of this, she had not been going to him. The Co-ordinator got in contact with the healer and talked with him, and told him that she was going to give the client the 20 rand. She said, as long as the "muti" was helping the client she would not interfere. The healer was willing to support the client's need to be monitored at the clinic. The Co-ordinator got him to agree that, if there was a negative turn, he would support the client in using prescription drugs. The Co-ordinator, a nurse, is a very pragmatic person. She understands the impact of a belief system on one's health. She is clear that she would not compromise the health of the client, but as long as the healer doesn't comprise it either, she will support the client's treatment choices.

### *Condom distribution*

Condoms are collected from the district DoH by ambulance – a 30-km round trip (no cost is attributed for collection). In 2007, 19,540 male and 5,000 female condoms were distributed throughout the campus by 40 peer educators who are unpaid volunteers.

### *Voluntary Counselling and Testing (VCT)*

In terms of planning, evaluation and feedback, Campus Health has a multi-year strategic plan, collects client satisfaction data, client outcomes and behavioural data, uses data available through previous surveys, etc. They do not have an MIS system; therefore, they do not enter data into any system.

The staff has good client rapport. Staff and volunteers are qualified to do their job and are culturally and linguistically appropriate for their clients. They maintain client confidentiality.

There is one professional nurse who is employed on a full-time basis to provide VCT on average for between 10 to 20 students per day. In 2007, 1,790 received pre-test counselling of whom 1,498 were tested and 33 found to be positive. This number does not include students who seek assistance from the local hospital or private doctors.

For those students who test positive, blood is taken and sent to a laboratory for CD4 counts. But tests for viral load are referred to Tshilidzini Regional Hospital. The testing kits as well as the laboratory tests are paid for by District Health.

### *Curriculum Integration*

The University of Venda intends to opt for the integrated approach model for mainstreaming HIV and AIDS in the curriculum. It was indicated that some schools/departments have infused HIV and AIDS into specific modules. These include the School of Health Science, the School of Human and Social Science, the Department of Microbiology, the School of Agriculture and the School of Education.

Furthermore, the University of Venda believes that developing a separate module will be a long process that will require formal accreditation, not to mention the difficulties of incorporation into already overcrowded courses. However, it is envisioned that the introduction of the SAQA HIV/AIDS Unit Standard for all new students is feasible. UNIVEN will identify the appropriate Unit Standard that will include the following: basic HIV/AIDS information, legal and ethical issues related to HIV/AIDS, attitudes and self-awareness, positive living, stigma and discrimination, behaviour change.

The curriculum infusion process is lead by HICC, curricula development experts and members of the institution.

There is also an Orientation Week for newly enrolled students (approximately 2,100 per intake) that incorporates sexual health (including HIV and AIDS awareness), services offered by the Health and Wellness Centre, and booklets on various HIV/AIDS policies.

There are also health and wellness days during which the professional nurses give talks to students and schools and are present on radio. These are on average 12 such days per year. The professional nurses also facilitate at workshops on HIV and AIDS that are held by the Departments of Education and Health.

A pilot project to infuse HIV and AIDS into a module for English Communication Skills, which is compulsory for all first-year students, is under discussion.

### *Current Curriculum Activities*

The School of Health Sciences has already integrated HIV and AIDS into the curriculum as an integral part of their courses. For instance, in the Psychology Department, HIV/AIDS forms part of the life skills module at first-year level; at fourth-year level it is incorporated into the trauma counselling module. In nursing, it is incorporated at all levels of training. In the first year, the focus is on promotive, preventative health; in the second year, it is on the management of opportunistic infections and HIV and AIDS; in the third year, the focus is on specialised areas (e.g. PMTCT); and in the fourth year on local and international approaches including policies set out by the WHO and the Department of Health. At the Department of Nutrition, HIV and AIDS are incorporated into the module on Nutrition and Disease Prevention at third-year level; HIV/AIDS seminars and a research project are conducted at fourth-year level. Public Health emphasises Primary Health Care: assessment, diagnosis and treatment of all communicable and non-communicable diseases, including HIV and AIDS. The School of Education has a HIV/AIDS stand-alone module guided by the HEAIDS pilot project. Although the module is offered at exit point, offering it at entry point is being considered.

### *Community outreach*

The schools are involved through their programme of community outreach. UNIVEN has a community

awareness programme that uses participatory learning techniques to teach HIV/AIDS Prevention.

### *Hotlines*

UNIVEN did not have any hotlines specifically for gay and lesbian students, but did have them for PLWHA and those not infected. More comprehensive peer education training that includes refresher courses would enhance the peers' capacity to educate clients and encourage behaviour change. In addition, some incentives for peers could improve the motivation and commitment of peers. This has been shown to be a good practice in the field.

**Application of the Good Practice in Operations Model to HIV prevention**

There seems to be some tension between those in charge of prevention and Campus Health. There is a lack of staff in many positions and few functioning committees. The PEs are not remunerated. Still, the programme seems to function relatively well on limited resources. It has good contacts with the surrounding community.

**What good practices does this programme exemplify?**

Firstly, the programme tailored their activities and interventions to be responsive and acceptable to the populations it serves, i.e. the programme is culturally appropriate. Furthermore, staff were able to negotiate and provide services that would benefit client health, even when there were dual relationships involved, such as the Co-ordinator as part of the medical staff and the healer.

Peer Education services follow good practices described in the literature. Peer education activities are comprehensive and include: 1) curriculum-based HIV/AIDS education prevention interventions; 2) individual one-to-one student social support by PEs; 3) peer education HIV outreach to students; 4) formal support groups for students (rap sessions and structured sessions); 5) referral for individual counselling for students; 6) distribution of condoms; 7) psycho-educational groups for students; 8) campus-wide education campaigns; 9) arts/music/theatre & HIV participation programmes; 10) PLWHA involvement as Health Promoters; 11) mass media public information campaigns: presentations/lectures (i.e. one-time events: designing new health education materials, e.g. videos, brochures, manuals); community mobilisation; community-wide events (health fairs, festivals); community focus groups; logistic; etc. They also conduct monitoring and programme evaluation.

**SUMMARY**

Peer education services follow good practice as described in the literature. Peer education activities are comprehensive.

Programme enhancements could include domestic violence/abuse assistance, support and referrals. Peer educator training – and hence their offerings to students – contained no discussions about how sex roles and gender relations infect or protect against HIV infection/transmission. There are no written policies and procedures for staff, peer educators, or students about stigma or discrimination including gender, HIV status, culture, language, or sexual orientation. Specific professional development pertaining to stigma and discrimination for staff, peers and students would expand the comprehensiveness of the programme and the ability of peers to discuss these critical variables that affect HIV transmission. Unfortunately, the programme has no future plans to include these vital services. They are planning to design and implement faculty-led courses on HIV or infusion into existing courses.

The peer educators who were interviewed, did not know how many PLWHAs were involved in the programmes, nor what type of clinical support was available. Although staff were aware of community support and programmes available for students, it appears that the programme has no organised way of identifying PLWHA community residents, staff or students who might be interested in participating in the peer education interventions. Staff would need to be trained in how effectively to include PLWHAs in the programmatic work. If PLWHAs were meaningfully involved in peer education, the interventions would be richer. A training programme would need to be put into place for PLWHAs in specific interventions within the peer programme. The literature indicates that having PLWHAs as an integral part of the peer education programme can diminish stigma and improve understanding among students.

The programme could also use specific skill-building exercises, discussion topics and activities to develop participants' self-empowerment, based on proven methods of assisting young people to make healthier decisions. Methods such as motivational interviewing techniques, decisional balance, force field approaches, etc. can aid in strengthening decision-making, planning, action-taking and negotiation skills.

# CASE 7. UWC – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION

## General Aspects

There are three campuses at UWC (Tygerberg, Mitchell's Plain and the Main Campus). Of the total of 14, 927 students in 2007, 12, 042 were enrolled for undergraduate studies and 2,885 for postgraduate studies. The majority of students were non-white (Coloured: 7,147 (47%); African: 5,464 (37%) and Indian: 1,236 (8%). There were more female (60%) than male students in 2007.

### *Opinions on the HIV-related context at campus – towards a definition of the HIV problem in the student population*

The students, according to a focus group discussion with peer educators, do not see HIV as the major problem for themselves, but see the risk of pregnancy as greater than that of HIV. However, this is not substantiated by other research done on campus.

### *HIV control activities – structure & management*

The UWC HEAIDS has not appointed a HICC, but the programme is run by the HIV&AIDS programme director, who reports directly to the Vice Chancellor of UWC. Management reports detailing expenses are forwarded to the Director of the HIV and AIDS programme on a quarterly basis or as per donor requirements. The Director reports personally on a monthly basis on all activities relating to HIV and AIDS to the Vice Chancellor. He takes up matters with the relevant committees and decision-making bodies at the university.

There is no HIV/AIDS umbrella plan that covers all activities, but the HIV & AIDS Programme has been tasked with implementing the HIV & AIDS Policy. In addition, specific objectives have been set for donor-funded projects. These objectives/milestones have been captured in an implementation plan and are supported by the programme's own funded activities. HIV/AIDS activities are also incorporated into several student plans.

The University has an annual budget allocated for the HIV and AIDS programmes. A cost centre is created specifically for HIV and AIDS. This cost centre accounts for operational costs and the salaries of two VCT counsellors. The University also provides for the running costs of the programme, the salary of the programme director and contributes towards the peer education manager salary. In addition to this, donor funding makes up the bulk of the budget for curriculum integration, prevention, treatment, care and support. The total budget for HIV/AIDS in 2007/2008 was around R4m. Out of this, 0.4 is UWC funding, while 3.3 is donor and 0.3 is DoE funding.

The Programme is also run in parallel to a Norwegian-supported programme named Zamanawe in four countries in Southern Africa. HEAIDS has been of great importance for HIV control activities. It has meant support both for the employment of staff and for interventions.

## Cross-cutting issues

### *Policies and plans*

UWC has an HIV and AIDS policy that applies to both employees and students at the University. The HIV policy has been accepted and ratified by the council. All key policy documents are published on the web. HIV and AIDS are considered as a risk factor and as such form an important part of the Institutional Strategic and Operational Plan (IOP).

### *Guiding principles*

Although the programme adheres to the ABC approach including abstinence, receiving support from PEPFAR, it also communicates a positive view on sexuality, realising that students do have sex and that it is important for them. This latter tone is now dominating. To address AIDS fatigue there has been

**Table 7– Annex 5** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own funding | 437,193 |
| Donor funding | 3,310,772 |
| DoE | 250,000 |
| **Total** | **3,997,965** |

a move to cover wider areas where HIV is also an issue, but one of many, such as general wellness, male-female relations and gender power issues. The issue of *sustainability* features strongly in the thinking.

### *Underlying determinants – "drivers of the epidemic"*

The subject of *gender inequality* and gender power issues feature prominently in peer education. The main target group is first-year students, and the importance of involving men as partners and working with men is stressed and thought to be of great importance. Empowerment of women is also central. Some women are true victims of gender imbalances – maybe mainly students coming from rural areas – but other women also use their sexuality at campus to get what they want. Transactional sex is not uncommon and not only for survival purposes.

*Alcohol* is an important factor and plays a significant role in unsafe sexual practices on campus. The programme is attempting to address it via messaging and also through strengthening decision-making strategies, empowering women to say no, and enhancing knowledge about the link between alcohol and unsafe sex.

### *Human rights and stigma*

These feature prominently in the work of peer educators and health promoters, but some students may be particularly judgmental when they enter the university according to anecdotal evidence. Students do not disclose their status to the wider student population. There have been very few disclosures of positive HIV status to the wider student population during the past 7 years. Some disclosure of status does occur in support groups and in some cases to staff in the HIV & AIDS Programme.

### *Monitoring & Evaluation*

Monitoring activities include monitoring the attendance at VCT as well as the number of distributed condoms, STIs and pregnancies. There is also a system to monitor marketing outcomes, including the role of different media to attract the students to VCT. A monitoring system is in place for all peer educator interventions. The programme keeps registers of all participants attending small group interventions and, where possible, larger group interventions. Furthermore, for PEs there is a knowledge pre-test and journal writing on attitudes towards HIV, post-testing of PEs and of a general control group. Evaluation is built into the programme in a number of ways. A dedicated register is kept for all VCT activities and annual statistics of attendees are kept by the programme. External evaluation of the PE programme has been accomplished over the past four years. Some of these evaluation reports and close-out reports are forwarded to funders and posted on the programme website.

### *Research*

Research into the student population includes an annual KAPB survey with all incoming 1st-year students. These findings are captured in a research report and used to plan interventions.

The HIV & AIDS Programme also conducts an annual survey of HIV/AIDS research on campus. This data is captured in an extensive HIV & AIDS research audit, which is posted on the website and printed in a hard copy format.

## PREVENTION ACTIVITIES

### Peer Education programmes

Peer Education is a very important component of HIV prevention at UWC. There is a strong view that peer education programmes go hand-in-hand with an effective condom dispersal system, VCT and care and support services for students (see below)

## DESCRIPTION OF THE MAIN PREVENTION PROGRAMMES

### *Condom distribution*

- Free male condoms (80 locations on campus, including all residence halls and toilets).

- Free female condoms from student health services on request.
- In 2007, 360,000 male and 14,956 female condoms were distributed.

### *IEC*

- IEC activities (pamphlets, posters, films, publications). Most of the posters are produced in collaboration with a local graphic design company.

### *Counselling*

Behaviour change group counselling for HIV prevention by professional staff is not carried out at the university. There is a Counselling unit at Student Support Services on campus, but psychologists there mainly do individual counselling that is not focused on HIV but on general wellness issues. The main HIV behaviour change counselling takes place through VCT and PE activities.

### *Life Skills training*

The Life Skills training that takes place is part of the information delivered by PEs. There is no professionally-led, large-scale group- or community-level activity aimed at behaviour change that is grounded on behaviour change theory. It is difficult to indicate causality as far as behaviour change is concerned. There is no solid evidence of behaviour change among the students, except an increased awareness.

### *Health services at Campus Health*

VCT is offered both as a regular service at Campus Health and through special campaigns twice every year. There are two counsellors who do the pre- and post-test counselling at Campus Health, where around 1,000 students are tested every year. Around 1,100 students undergo VCT during each campaign. Campaigns are held three times a year.

### *Care and support*

Two people, one female and one male health promoter, who both live openly with HIV, are available for support to students who test positive for HIV – as are the VCT counsellors, a private out-sourced psychologist, and student support services. They offer both individual and group support to all members of the university community infected with or affected by HIV. They also participate in outreach activities. If the need arises, a professional psychologist also comes in.

### *Curriculum integration*

UWC is of the view that separate courses are very expensive to run as they are very labour intensive, and that there is no evidence that such modules constitute best practice. UWC is not in favour of special HIV courses. The integration of HIV into curricula is funded by the faculty teaching budgets.

In 2007, the Education Faculty offered an ACE (Advanced Certificate in Education) with focus on HIV & AIDS. Plans are well underway to offer a one full year postgraduate course on HIV and Education as part of the PGCE (Post Graduate Certificate in Education), which is part of the curriculum in Education. There is also a Master's course in Development and HIV, which is part of the curriculum in Development Studies. HIV is also integrated into undergraduate studies for first-year students.

The "Your Moves" programme is used to teach students computer literacy when they start university. There is also an EED course that all students have to take, which puts them into contact with the HIV programme. HIV is mainstreamed across the university – it is part of courses at all levels and across all faculties

### *Community outreach activities*

There is a variety of community outreach activities that focus on HIV and AIDS (volunteer programme, peer educators working in schools, community service components in various courses e.g. occupational therapy, nursing, social work etc). Some of these are part of courses, whereas others are entirely voluntary. The PEPFAR-supported

programme includes programmes at 15 schools, with parental involvement.

## Description of the main prevention programmes

Peer Education activities started in 2004. The Vice Chancellor saw the need for student-centred activities after the "Turning the Tide" gap analysis, and thought peer education activities could have a role to play. They were initiated in the abovementioned ZAMANAWE project, supported by Norway, and involving four countries. After that, support from the EU and PEPFAR was added and the programme gradually grew. The current peer education project has elements of the Rutanang approach.

For the 2009 academic year, the programme enlisted 70 peer educators to work at the main campus site. Female/male distribution is 40/60. Only senior students are recruited as peer educators. First-year students are the main recipients of the programme. The PEs have multiple roles. One is to serve as a role model. Another is to inform their peers. A third is an advocacy role, which to a large extent means advocacy for VCT (Know your Status campaign). There is individual counselling for HIV-positive individuals by health promoters, as mentioned above. PEs deliver life skills training and behaviour change messages without using any specific behaviour change theory. A combination of different such theories is used in PE work.

### *Recruitment and selection.*

Positions as peer educators are initially widely announced through the university intranet, flyers and posters. Students who have already been serving as peer educators assist the staff in the selection process. Selection criteria include the following:

- academic; above-average-performing students are selected
- sensitivity and comfort with issues related to sexuality
- good communication skills
- previous involvement in HIV/AIDS activities
- potential to be a good role model.

### *Training of Peer Educators*

PE training follows an "island approach" with students being taken away from campus for the training. The training follows a number of themes including team building, personal growth, presentation skills, report writing, referral procedures, etc. It also includes learning facts about HIV/AIDS – biomedical aspects, STIs, TB and opportunistic infections, ARV/ART basics, as well as legal, gender and psychosocial aspects. Training also includes learning how to use different media such as drama, role play, music, the arts and song and dance. Moreover, PEs are taught how to write personal journals and letters, how to reflect on the training they had given, and how to conduct small group discussions and formal large-group lectures. Training to a large extent takes place with the use of the Be Aware of HIV booklet.

### *Main peer educator activities*

The main activities take place on campus. The main functions of PEs are providing information and raising awareness, advocacy for VCT, and PEs as role models. The intensive activities during Orientation Week for first-year students are crucial and constitute the basis. After the initial orientation, PEs conduct a number of activities. These include:

- "Digital storytelling project". Storytelling workshops to allow survivors of gender-based violence, witnesses of abuse, and individuals who have been subjected to HIV- and AIDS-related stigma to write and record first-person narratives about their lives. The goal of the storytelling circle is to provide these individuals with the support, skills and equipment they need to create original multimedia pieces (using still images, video clips, photos and music) to illustrate the impact these events had on their lives.
- "AIDS Act". An educational theatre project, aimed at relaying the message of HIV prevention in a creative and fun way. The students who form

AIDS ACT were drawn from HIV and AIDS peer educators and from other students interested in drama.

- "Gender-Based Peer Education Project". The aim of this project is to address gender power issues, masculinity issues, issues of sexual consent, sexual and reproductive health, gender-based violence, gender-based barriers to testing for HIV and other sexually transmitted infections, and to look at safer sexual behaviour within a gender context. Peer educators are trained on an annual basis to conduct a series of 10 workshops with first-year students in the evenings at the residences.

Awareness raising takes place through a variety of media. Much information is given through small group meetings with students, but also through discussions in larger groups on subjects selected by the students. The HIV-positive health promoters often participate in these discussions, which take up pertinent questions that are formulated by the students including such topics as rape, gender inequality, homosexuality, gender-based violence and issues related to relationships and sexuality.

Awareness raising also includes the use of a number of other media including drama, music, and innovation in the design of posters and cards. The interventions, to a large extent, build on interaction with the students, who play a very active role.

Much work is spent on advocacy for VCT. Here, the PEs do the advocacy work and may distribute cards that inform the students and invite them to participate.

### *Analysis of a FDG with 7 PEs*

Interestingly, the students did not see HIV as their main sexuality-related problem, but identified pregnancy as the main threat. However, this may not be representative of the whole student community.

### *Monitoring of PEs*

One-to-one meetings with the individual PEs are conducted in the form of a performance appraisal. All PE activities are recorded and registers of recipients are maintained. Recipients sign the register at the beginning of each session they attend, be it a one-to-one session, small group session for 10 to 20, or a larger group session.

### *Output*

There are X recipients of one-to-one sessions, Y recipients of small group interventions and Z recipients of large group sessions.

Almost 1,000 students undergo VCT through the regular activities at Campus Health, whereas a little over two thousand are tested through the VCT campaigns (two per year). Of the tested students, around two thirds are female and one third is male.

### *Application of the Framework Indicators to the different prevention components*

This shows that, regarding the **cross-cutting issues,** the programme is partly theory-based. The main drivers of the epidemic are addressed and the programme is highly participatory. **Counselling** is limited by the fact that there is no large-scale behaviour change counselling, but the VCT counselling receives sufficient resources, the *programme elements* are covered, and counselling is of sufficient duration. **VCT counsellor**s have high *professional competence* and maintain good client records. Good internal linkages are maintained.

Similarly, regarding **Life skills and resiliency strengthening,** there are no large-scale, professionally-led activities at UWC. The life skills training on offer is rather basic and takes place within VCT and/or PE interventions. However, what is done, is well-recorded and supervised.

**Peer education** is of a high standard regarding both the *programme elements* and *professional competence*. The PEs are well selected, trained, supported, supervised, monitored and evaluated.

Regarding **BCC/IEC**, major efforts are made to pretest messages. Design is in collaboration with an external graphic design firm of a high quality.

**Monitoring** is not yet optimal and does not receive sufficient resources. Computerised MIS is not yet operational.

*Application of the Good Practice in Operations Model to HIV prevention*

The HIV programme enjoys strong support from the Vice Chancellor and is effectively led by the Director. It is run by very dedicated people. The main Peer Education supervisor, in particular, has a very heavy workload in terms of training and supervising the 70 peer educators on the main campus. There seems to be a very close working relation between the staff members. Apart from the formal weekly planning meetings, there are several informal smaller meetings. Peer educator morale is very high and attrition is very low, despite the small remuneration of R1,000-R2,000 per student per annum. However, there is not an optimal exchange of information between the programme elements. If monitoring were to be optimised, results from Campus Health could be more readily fed back to PE; findings from surveys on the student population could be used to inform activities. But this would demand additional resources.

*Identified good practices at UWC*

Strong support from top management. Dedicated, hard-working staff. The quality of Peer Education depends on the managing staff and is very labour intensive. UWC has a team of very dedicated individuals.

The participation of persons living with HIV. They are an invaluable resource as they have a unique, albeit tragic experience.

IEC, mainly posters and a dedicated programme website have been successful. Good Practices include the comprehensiveness of PE as well as the behaviour change in the PEs. Some recipients are also likely to be moving along the continuum of change.

### What programme components need to be improved?

Not much evidence of behaviour change among the students, but the PEs themselves benefit greatly.

The monitoring system is not ideal, but a HIV & AIDS MIS was started with EC funding in 2009.

Research findings need to be disseminated both on campus and through publications. The university will sustain the programme, but it may not be possible to retain all functions. However, the view is that if government were to fund HIV and AIDS programmes in the higher education sector, it should "ring-fence" such money for the curriculum, prevention, treatment and an HIV and AIDS office.

**SUMMARY**

Prevention activities at UWC are dominated by peer education. UWC has a vibrant, very well run and comprehensive programme. It constitutes an example of **Good Practices in operations**. Around 3,000 VCTs are carried out on a student population of a little less than 15,000 (many make >1 test). There are 70 peer educators corresponding to one PE per 200 students, which is four to five times more than the suggested standard. Still, even this may not lead to major behaviour change. There are no large-scale behaviour change/life skill interventions led by professionals. The monitoring system needs to be improved and efforts at strengthening community outreach and research should be made. But this will demand additional resources.

**Good Practices in Components** include the comprehensive and well-run PE programme and the profound behaviour change of the PEs themselves, as well as the strong involvement of persons living openly with HIV in different programme activities. Innovation can be seen in poster productions and in many programme details.

## CASE 8. UNIVERSITY OF THE WITWATERSRAND (WITS) – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

### General Overview

WITS is an urban, comprehensive university comprising seven major 'clusters' spread over 400 hectares in Braamfontein and Parktown: East and West Campuses, Sturrock Park, the Education Campus, the Management Campus, the Health Sciences Campus and the Wits Donald Gordon Medical Centre. WITS

is a racially mixed university. Of the total of 25,156 students in 2007, 16,796 were enrolled for undergraduate studies (67%) and 7,896 for postgraduate studies (31%). Almost 50% of students were Black African (12,183 students). Only 464 were occasional students.

### *Towards a definition of the HIV problem in the student population*

There seem to be limited attempts at systematically increasing the understanding of the epidemic and its determinants in the student population. The interviewed PEs at Wits did not communicate any understanding of the main drivers of the epidemic on campus. The student population at Wits is drawn from diverse backgrounds and the drivers of the epidemic in the student population will reflect this. Students may join WITS already with HIV or they may contract HIV while they are students, but not necessarily from other students who make up the WITS community. Or they may contract the virus from sexual liaisons with fellow students. Either way, issues that bedevil sexually active persons in a generalised epidemic apply. For this reason, it may be a bit far-fetched to talk of specific and peculiar known drivers of the epidemic among the Wits students. Perhaps one proposition to this end may be lack of ownership of risk; thinking that fellow students make up an island of uninfected South Africans.

### *HIV control activities*

#### *Structures and Operations*

The institutional executive committee in place to drive the mainstreaming process is the AIDS Forum. Members (DVC and VC) of the HIV and AIDS structure serve on the Council and Senate. This is the HIV and AIDS co-ordinating institutional structure. A number of people are responsible for activities related to HIV and AIDS in their own sectors. The following is a list of the representatives.

**Counselling:** A dedicated staff member works with the Counselling and Careers Development Unit (CCDU) in all aspects of counselling, HIV and AIDS awareness campaigns, and support for those infected and affected by this condition.

**Curriculum:** Curriculum development is carried out by academic staff members, by the undergraduate Affairs Committee within each of the 37 schools, and the Faculty Undergraduate Affairs Committee. There is also the HIV ESP co-ordinator who is the liaison with the different departments for curriculum support.

**Teaching and Learning Committees:** (in each of the five faculties) comprising representatives from all faculties.

**Research**: The DVC for Research facilitates collaboration among researchers by sponsoring conferences, disseminating information and providing publicity for research activities.

**Health Care:** Campus Health Care has several staff members who provide VCT services and referrals for students. VCT is carried out in Campus Health.

#### *Policy*

WITS has an HIV and AIDS policy as well as a Chronic Illness Policy. The former is primarily concerned with HIV and AIDS and the latter outlines how to deal with students with a chronic illness. The monitoring and evaluation of the HIV and AIDS policy is done via an AIDS Committee, which meets quarterly. Those active in the various aspects of carrying out the AIDS policy report on their activities, and plans for the future are discussed.

The policy balances the concerns of students, staff and the institution. The AIDS policy was originally designed in 2000 (many authors of the old NSP were involved in the design of the policy) and is aligned with the NSP. The policy does not set goals as found in the NSP. The policy does not stipulate implementation, although there is a strategic plan for implementation. The policy was developed in a consultative process with specialists in the field of HIV and AIDS, the Dean of the Faculty of Health Sciences, the approval processes of Senate and Registrar offices as well as approval from

the SRC and PGA. The policy has not been implemented completely; the reason is that **no one has been appointed to oversee all activities related to AIDS**. The decision had been taken previously that separate offices (research, counselling, teaching, patient care) would be retained in each of the areas.

WITS does not have a social corporate investment policy that makes provision for AIDS activities. Evidence of commitment in terms of resolutions taken at Senate/Council relate to a general assembly that was held on the library lawns in 2001. The institutional mission and the strategic plan are two separate documents. These three documents include support for student welfare in the broadest sense, but do not mention HIV and AIDS specifically. Evidence of commitment regarding the operationalisation of the policy is reflected in the many advocacy campaigns and the general assembly of 2001. The institutional strategic plan does not specifically reflect the sector strategic plan 2006-2011 and beyond. A relatively high proportion (25%) of funding for HIV control comes from own resources.

### *Guiding principles*

The ethos that informs HIV prevention and management systems at Wits is that of students taking a lead role in preventing their own susceptibility to HIV infection and, for those living with HIV, its management. But staff also take a proactive role in encouraging prevention through workshops, presentation campaigns and discussions. However, students' privacy and the respect of such privacy seem to be major considerations. Students are entrusted with their own sexual health care as they are entrusted with their general academic development.

**Table 6–Annex 5** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own funding | 1,043,834 |
| Donor funding | 2,831,653 |
| DoE | 250,000 |
| **Total** | **4,125,487** |

### *Underlying determinants – "drivers of the epidemic"*

Incidentally, the Wits peer volunteers that were interviewed did not isolate HIV/AIDS as a primary concern among the student body. Nor did they indicate concern about other sexual- or gender-related issues, such as the sexual harassment of women students or gender inequality *per se*. Their concerns centred on issues such as lack of job opportunities now and after graduating as well as the prohibitive cost of education. This may be because these peer volunteers were new or to some extent sheltered from seeing and dealing with HIV among their peers as HIV-related issues at Wits are dealt with by professionals either at VCT or at CCDU. They may also not be fully representative of the PEs.

### *Human rights and stigma*

Wits, at present, does not offer support groups for PLWHA. This is attributed to the lack of participants in such groups. But support groups are advertised regularly during the year.

### *Monitoring and evaluation*

Monitoring activities are relatively limited. Documentation includes attendance at VCT, STIs and pregnancies as well as the number of condoms distributed. Monitoring of peer education activities also takes place and includes the number of residence interventions, the number of students reached, etc., but qualitative data is still missing.

### *Research*

There is no specific research on the student population. Estimates of HIV prevalence on campuses could realistically be extrapolated from the recent National HIV prevalence survey that was carried out throughout SA universities in 2009. Statistics kept by Campus Health are limited in that not all Wits students have access to Campus Health or use it to test for HIV. No known KAPB studies have been conducted thus far.

### *Prevention Activities*

HIV prevention programmes include education interventions: lectures, plays, posters, website, while awareness campaigns, talks and counselling are done campus-wide by the HIV and AIDS Education and Support Officer (ESP), from the Wits Counselling and Careers Development Unit. It also includes staff. HIV prevention activities offered at WITS include:

- STI diagnosis and treatment
- Partner notification
- Pre- and post-test counselling for HIV
- Rapid and confirmatory HIV testing
- Individual and couple counselling.

## Peer Education

The WITS peer volunteers (as they are referred to as opposed to the standard "peer educator" equivalent) are adamant that they do not do HIV/AIDS counselling. However, they offer lay counselling and support advocacy programmes delivered by the CCDU on HIV/AIDS and sexual harassment. They avoid many HIV/AIDS-related issues as these are potentially ethically challenging. These peer volunteers are particularly aware of the ethics of human interaction in a counselling encounter. They maintain that they are not equipped to do any sort of counselling, especially that which involves HIV issues. They redirect such needs back to professional counsellors.

The peer volunteers were particularly aware that they need to take care of themselves, i.e. not allow burnout so that they can be effective in the work that they do. The WITS peer volunteers are involved in specific drives that are spearheaded and directed by the CCDU. In particular, peer volunteers are involved in advocacy initiatives. Peer volunteers have dedicated space for group meetings as well as space to meet with client/peers for peer volunteer business. The responsibilities of peer volunteers are phased in to allow for gradual, supported assumption of responsibilities. The WITS peer volunteers meet with supervisors on a weekly basis to discuss case management. Peer volunteers therefore have routine, structured support.

### *PE recruitment and selection*

Peer volunteers indicated that they had heard of the programme from other people. In some cases, the interest was sparked by the fact that the students were involved in similar initiatives at school. For others, peer volunteering was a way of career testing. Peer volunteers are screened and recruited via an e-screening routine during which they are asked an array of questions regarding their motivations, individual strengths and competences and the value they think they will add to the programme. There is also an in-depth face to face individual and group interview process.

### *PE training*

Training is provided by several service providers. The training programme has defined goals. The peer volunteers are trained in basic counselling covering a wide range of psycho-social issues. Training also includes ability to support and refer students who request their services. They are also trained in advocacy regarding HIV/AIDS and sexual harassment.

**The peer volunteers expressed the following concerns in the focus group discussion:**

- that there could be more synergy and co-ordination of services with Campus Health
- that they could be made more visible on campus
- that students are left with no counselling support after hours
- that there should be more initiatives to acknowledge HIV on campus. The lack of a support group for PLHWA was seen as a reflection that HIV/AIDS is relegated to the fringes of student life/support at WITS.

Overall, the easy relationship that was apparent during the FGD as well as the support that peer volunteers are receiving were impressive. The gender dynamics were easy and respectful with both female and male volunteers participating in the proceedings. There are approximately 30 student peer educators who operate mainly in the residences.

The ESP Project Officer also manages the Peer Education Programme, which includes training, supervision and overall administration of the programme. This programme is one of the key functions of the CCDU. The collaboration of the peer education programme is through the ESP officer. The issue of addressing gender/masculinity in the peer education programme, for example, is addressed by the ESP Officer who manages the peer education programme on campus as part of the advocacy team within the CCDU that also comprises the Sexual Harassment Office. Student counselling services encourage students to take up VCT during counselling sessions and other educational programmes. Through such strong collaboration, gender, sexuality and issues of sexual violence are prioritised. Care and support services may be accessed at the campus health service and counselling is available at CCDU. The internal and external referral system forms part of the functioning of the CCDU and the ESP Officer, who is also part of the team that is actively involved in maintaining, developing and strengthening these referral systems.

## Counselling and life skills

Counselling and life skills training is a big part of the CCDU mandate. The CCDU is a fully-fledged, long standing student service that operates every weekday from 8:00-16:30. It is a walk-in facility that is located in an accessible location. Counselling is done by professional psychologists and social workers. Counselling is concerned with a wide range of issues that are central to student life, including career counselling, emotional and spiritual well-being, making the most of the first- and final-year experience at university, dealing with sexual harassment, HIV/AIDS counselling and life skills training. An average time with a therapist is between 3-6 sessions depending on the needs of the client. Further therapy is referred to other service providers. In other words, all facets of student life are considered and given priority. CCDU has an easy to access and easy to follow website that details available services, hours of operation etc. The CCDU recruits, screens and supports/manages peer volunteers.

## Condom distribution

WITS provides male condoms across the University. Female condoms are available through the clinic as stipulated by DOH the supplier. Females are taught about effective use. The continuous availability of condoms is ensured by contract through the cleaning services Super Care, responsible for the distribution of condoms in all the toilets on campus. The ESP officer monitors the availability of condoms on campus and communicates this to the Services division.

Approximately 20,000 condoms per month are distributed by the cleaning service. There are no costs allocated as the contract for cleaning does not charge for the service.

## Campus Health /Voluntary HIV and AIDS counselling and testing (VCT)

*Voluntary Counselling and Testing (VCT)*

VCT is carried out at Campus Health. Campus Health is, in turn, housed in the Matrix, the student life Centre in which the SRC offices, the book shop, cafeterias and other non-academic student-centred amenities are located. The Centre is accessible to students as they go about their everyday business. Students are channelled to VCT after reporting to Reception on arrival. Integrating VCT to general health care services offered by Campus Health is a good way to maximize client privacy and confidentiality i.e. students who visit Campus Health for VCT are not singled out from the rest of the clients.

WITS Campus Health is well-established, boasting ample space and state-of-the-art facilities. The VCT room, although small, is comfortable with space designated for counselling and space designated for the drawing of blood for HIV testing. A dildo is prominently displayed to precipitate a discussion on appropriate/correct condom use.

VCT at WITS is offered by the following staff:

- Counselling is offered by a counsellor with a psychology background and an additional VCT qualification from UNISA. The counsellor is full time dedicated to VCT.

- 4 nurses (with VCT training) divide their time between VCT and the primary health care services offered at Campus Health.
- The above staff are supervised by the VCT supervisor, who is also the clinic supervisor.

In general, VCT at WITS follows the standard format and content that are seen across all facilities that offer VCT. The counsellor has been in this position for approximately six years. The long tenure is reflected in the wide and intricate knowledge and understanding of the needs of the student population displayed by the counsellor. In other words, the counsellor has had enough time to grow in the job and so is able to offer a good service to students. In particular the following observations need to be highlighted:

- the approach used by the counsellor was able to solicit risk information from the clients; she had devised skills to do this in a non-judgemental, friendly and easy manner
- the counsellor emphasised that her sessions with clients are solution focused
- she highlighted that some students who come for VCT are pre-sexual and are there just to get more information on how to deal with future sexual encounters
- very interestingly, the counsellor indicated that she does not encourage a mass display/access of condoms. Rather she preferred that students make a conscious choice to buy condoms because this way taking condoms is not a reflex action, rather a well-thought-out decision after the counselling session. The counsellor at WITS was one of the few that we came across during this research who was cognisant of the need to tailor approaches and communication to behaviour change objectives. She was able to engage in a constructive discussion about the merits and possibilities of this in VCT.

VCT at WITS is also conducted according to the demands of academics on the client population. For instance, it was emphasised that during exams VCT may be confined to pre-test counselling. The client is, then, encouraged to return for the actual test and post-test counselling after the exams. As with other VCT centres across the HEIs, VCT did not carry out VCT on Friday afternoon so that the timing is conducive to immediate follow-up counselling for clients who test HIV-positive. Continued counselling for life skills and behaviour change was routinely referred to CCDU. The client referral system between Campus Health and CCDU was very good. Steps were being taken to forge closer referral paths with community-based service providers.

Overall, VCT at WITS was well-established and followed the National HIV calendar that includes an awareness campaign during the university orientation week, STI awareness/condom week around Valentine's Day, reproductive health week in August, as well as the HIV/AIDS commemoration day on 1 December, and others. Lack of PE integration in Campus Health Activities was mentioned as a limitation by the peer counsellors.

The Campus Health co-ordinator, who also supervises VCT, indicated that VCT at Wits would benefit from more public drives to make VCT more visible and accessible to students. Campus Health is only established on the Main Campus. Students from other campuses have to travel on the shuttle bus to get to the Main Campus. Issues of access and convenience are indicated here.

An HIV prevention programme that was identified as having worked particularly well at WITS is STI management. Successful follow-up has meant that a large proportion of STIs were cured. Education has also resulted in less STIs among the student population.

## Curriculum Integration

The institutional policy on HIV and AIDS includes HIV and AIDS curriculum infusion/mainstreaming. The Institution does not offer any on-line HIV and AIDS courses where simulated examinations and self-evaluations can be conducted. Computer-based learning, however, is supported with the availability of WebCT to support innovative teaching strategies. There are no on-line behaviour or attitude change assessment activities regarding HIV and AIDS

available to staff or students. HIV and AIDS is not part of an institutional assessment policy. The curriculum model used for undergraduate programmes is based on the lecturers providing the courses and the Undergraduate Affairs Committee within each of the 37 schools and the Faculty Undergraduate Affairs Committee. Concerned lecturers are the staff who initiate HIV and AIDS infusion. There is a foundation course on HIV and AIDS that all students are exposed to (short course) by the counsellor. The programme design and the mode of delivery are in line with the HEQC and related bodies. The institution does provide teaching to medical students, where their service learning involves direct interaction with patients who are HIV-positive and in need of treatment. The institution does not cater for distance learning programmes.

The Institution does present some challenges with regards the inclusion of HIV and AIDS in the curriculum, namely that a few disciplines refuse to integrate HIV and AIDS into their curricula, for example geology and physics courses do not have anything to do with HIV and AIDS because the lecturers responsible for the academic content say that it does not form part of their fields. Also, by putting HIV and AIDS into every discipline, it is reported that the institution is encouraging student fatigue – "Oh no! Not AIDS again."

The breadth and depth of HIV and AIDS content in the curricula of specific programmes are integrated with the majors and not taught as a separate subject. The extent to which this has occurred cannot be quantified. The general aspects of HIV and AIDS are incorporated into many courses e.g. the biology of the virus and the immune system are covered extensively in the curriculum of the School of Molecular and Cell Biology. Many schools in the Faculty of Health Science include aspects of the disease and its associated infections in their curricula. Behaviour change learning interventions are covered in Psychology and Sociology in several of their courses. Life Skills courses address general problems, many of which are related to HIV and AIDS. Legal aspects/human rights are covered in the Law School, which has several courses that include this material, as does the Ethics Programme of the Faculty of Health Sciences. The integration of gender/masculinity was indicated as being in the process of being integrated, but no comments were provided.

The model of postgraduate curriculum infusion is an interdisciplinary Master's course called "AIDS in context" taught through the Department of Sociology. This course is entirely about HIV and AIDS and is offered across disciplines at Master's level. The law school does a postgraduate course on AIDS and the Law. The Drama Dept runs a Master's programme called "Drama for life". Wits has no distance instruction programmes. Lecturers incorporate HIV and AIDS into their curricula by staying current in the fields in which they lecture and incorporating recent findings into lectures. They attend seminars and conferences. Curricula are revised on an ongoing basis to stay current. Wits does not have in-service education programmes in place for other relevant community stakeholders in the respective fields of study, nor does this form part of a community outreach programme. Participatory action and community research are implemented in Psychology, medicine, law and education. These departments are thus engaged in the promotion of service learning as part of their programme.

## 24-hour helpline

WITS does not provide a 24-hour helpline and finds the use of the national AIDS line sufficient and that this functions very well. There is no on-line chat room for HIV and AIDS peer support programmes, nor does WITS have any virtual help centres, such as rape crisis centres. There are also no on-line, user-friendly HIV risk assessments for staff and students to support "Know your Status" programmes.

## Community Outreach

Community engagement around HIV and AIDS is not specifically monitored. The Wits Rural Facility near Bushbuckridge and the Hillbrow Health Precinct are directly involved in the communities where they are

located. The marketing office often uses community engagement for publicity for the university, but there is no special mechanism for monitoring this.

## AIDS Research Initiative (ARI)

The ARI is the central database for all staff and student HIV-related projects. These range in size and scope from postgraduate projects to large-scale community-based projects. The ARI is also instrumental in disseminating funding, conference and related information to the WITS AIDS research community. ARI also sources funding for PhD student projects, a few of whose proposal were presented for HEAIDS funding. ARI also organizes seminars for the WITS AIDS research community.

## Application of good practices framework: The case of WITS

### *VCT*

A brief observation opportunity while we were waiting at reception indicated a well-run professionalised service. This observation and the overall impression gained from the field visit to Wits Campus Health confirm standard health care procedures such as respecting client privacy and maintaining confidentiality through professional handling of client records. Time spent with the counsellor highlighted the basics such as receiving and greeting clients, the introductory part of VCT that clarifies the rights and responsibilities of both the client and the counsellor, and how the counsellor facilitates the session to meet the peculiar needs of the individual clients, assess their risk and work out a plan to mitigate the risk and deal with the HIV test results. The counsellor demonstrated the pre- and post-test counselling procedures that pertain to VCT. Further, the counsellor demonstrated knowledge of behaviour change theories and communication that may facilitate such behaviour change. The counsellor was further able to highlight the limitations of such theories in the VCT setting. Overall, the impression from the interaction with the counsellor was that counselling left clients with improved knowledge and skills that relate to HIV prevention or living positively with HIV/AIDS.

### *Internal linkages*

The limited ability of VCT to impact client behaviour in any substantial way was carried by the CCDU, which deals with life skills counselling. The VCT counsellor had easy and ready access to CCDU counsellors to whom cases that required further attention were referred. CCDU counselling was comprehensive, responding to all facets of student life ranging from personal wellbeing and development to academic concerns. CCDU was also instrumental in recruiting, training and supporting peer volunteers.

### *Peer education programme*

It was well-structured with clear expectations and clearly-defined scope/boundaries. The recruitment process of peer volunteers was rigorous. They were provided with structured, routine support from the psychologists and social workers to whose mentorship they were entrusted. There was an appropriate balance between the number of males and females in the peer volunteer programme. Gender inequality and discrimination were some of the issues raised by the peer volunteers. Peer volunteers were mainly involved in advocacy work including student alcohol use.

### *Research*

The AIDS Research Initiative offers opportunities for all role players in HIV/AIDS programmes to come together to learn about new developments in the field of HIV/AIDS, about available resources and the research undertaken by PhD students at the university. In this way, everyone is kept in the loop and is also exposed to work carried out by WITS-affiliated community-based NGOs.

VCT is run from Campus Health. Integrating VCT into general health care services offered by Campus Health is a good way to maximize client privacy and confidentiality. Students who visit Campus Health for VCT are not singled out from the rest of the clients. Counselling is conducted by professional psychologists at CCDU. The linkage between Campus Health and CCDU is very good. Lack of PE integration in Campus Health Activities was mentioned as a limitation by the peer counsellors.

## Good Practices

On the basis of case descriptions and observations made during the visit, the Good Practice Indicator Framework and the Good Practice in Operations concept, we identified the following Good Practices at WITS:

### *The Peer Educator programme*

The following are Good Practices that could be highlighted regarding PE at WITS:

- Peer volunteers display an understanding of ethical issues that may arise in professional human interaction
- Peer volunteers have a good support system
- Peer volunteers have a dedicated space in which to carry out their core business
- The responsibilities of peer volunteers are phased in to allow for gradual, supported assumption of responsibilities.

### *Student Counselling CCDU*

The following attributes can be highlighted as Good Practice by the WITS CCDU:

- The CCDU is a longstanding student service; it has managed to remain relevant and to sustain itself
- The CCDU offered much-needed support to VCT services, and thus to HIV prevention in general
- It has client-friendly hours of operation
- The CCDU is optimally-located for student access
- The CCDU offers a friendly atmosphere
- The services offered at CCDU are professionalised to meet client needs
- The CCDU generates IEC on a number of issues that are pertinent to students and student life
- The CCDU offers a structured service that is tailored to respond adequately to the needs of clients
- Students are viewed and treated in a holistic manner
- The CCDU has a functional website to inform prospective clients
- The CCDU has systematically integrated students in the form of peer educators in its programmes.

### *VCT*

Good Practices that are associated with VCT at WITS include:

- counselling is done by a professional psychologist
- the counsellor has been in this position for approximately six years. The long tenure is reflected in the counsellor's wide and intricate knowledge and understanding of the needs of the student population. In other words, the counsellor has had enough time to grow in the job and so is able to offer a good service to students. In particular the following observations need to be highlighted:
  - the approach used by the counsellor was able to solicit risk information from the clients; she had devised skills to do this in a non-judgemental, friendly and easy manner
  - the counsellor emphasised that her sessions with clients are solution focused
  - she highlighted that some students who come for VCT are pre-sexual and are there just to get more information on how to deal with future sexual encounters
  - the counsellor indicated that she does not encourage a mass display/access of condoms. Rather she prefers that students make a conscious choice to buy condoms because, this way, taking condoms is not a reflex action, rather a well-thought-out one after the counselling session
  - the counsellor at WITS was one of the few that we came across during this research who was cognisant of the need to tailor approaches and communication to behaviour change objectives. She was able to engage in a constructive discussion about the merits and possibilities of this in VCT.
- VCT at WITS is also conducted according to academic demands on the client population. For instance, it was emphasised that during exams VCT may be confined to pre-test counselling. The client is then encouraged to return for the actual test and post-test counselling after the exams
- as with other VCT centres across the HEIs, VCT did not carry out VCT on Friday afternoons to ensure the timing is conducive to immediate follow-up counselling for clients who test HIV-positive

- continued counselling for life skills and behaviour change was routinely referred to CCDU; the client referral system between Campus Health and CCDU was very good
- Steps were being taken to forge closer referral paths with community-based service providers.

### *Campus Health*

- The location of Campus Health allows for easier accessibility of VCT.
- Queues are managed to facilitate easier access to VCT.
- Students who visit Campus Health for VCT are not singled out from the rest of the clients, allowing for client privacy.

### *AIDS Research Initiative (ARI)*

ARI is a Good Practice on the following levels:

- the central database is an efficient way of organising research
- ARI is very active in disseminating funding and conference information. ARI is thus a gateway to WITS' AIDS research community and a bridge between WITS' initiatives and national/international initiatives
- ARI is actively involved in supporting emerging researchers by sourcing funding for them
- ARI facilitates ongoing communication through seminars and symposia between the diverse programmes/projects that are to be found at WITS.

**SUMMARY**

Counselling at WITS is run by professional psychologists at CCDU answering the needs and demands of the students. There is no large-scale behaviour change counselling. VCT is carried out at Campus Health by a counsellor who is a professional psychologist. The referrals between Campus Health and CCDU are running smoothly. Peer educators are supervised by CCDU and are not doing counselling.

While the data on WITS presented here reflect on-campus HIV prevention activities, WITS has a number of community-based initiatives that are widely acclaimed. WITS has well-established facilities and structures that are ready to give the best services to students. The university can benefit from inward-focused research that will further strengthen service provision to students. In many respects, students' privacy is respected, as is the ability of students to take the initiative in their health care and management. Although HIV drives and campaigns form part of the HIV calendar at WITS, HIV does not seem to permeate student life in any generalised way

ANNEX 6

# Good practices at other HEIs

## UNIVERSITY OF CAPE TOWN (UCT) – GOOD PRACTICES IN HIV PREVENTION

At UCT, like many other selected universities, the PE programme is the backbone of prevention and is closely connected to health services at Campus Health. There are also Care and Support services. The PE activities here take place within a clearly defined theoretical framework.

As its framework, the UCT HIV/AIDS programme has adopted the social theory of "an AIDS-competent community" of Catherine Campbell, London School of Economics. This theory serves as the theoretical framework for PE activities and aims at building an AIDS-competent community through:

- sexual behaviour change
- reduction of stigma
- support for people living with HIV
- access to services.

Arriving at this involves:

- building knowledge and skills
- creating social space for dialogue
- promoting ownership and responsibility
- confidence in local strength and agency to mobilize these
- building solidarity in the form of bonding relationships
- building partnerships in the form of bridging relationships.

Although these activities are similar to much PE work at other HEIs, the fact that they take place within a theoretical framework has several advantages, particularly when it comes to monitoring and evaluation. This approach, however, requires that the theory is good and reflects realities on the ground. This demands verification thorough situation analysis.

Even within this framework, students only devote a short time to HIV – a one-day workshop during Orientation Week followed by information mainly through small media. The workshop, called "Me and AIDS', is central to the HIV information activities and closely linked to the PE programme.

1/3 of PEs are men and 2/3 are women. No first-year students are selected as PEs. PEs only remain as PEs for one year. The "Me and AIDS" workshop at the Health Science Faculty has been subject to thorough external evaluation. The findings are summarised below.

### Introduction

The "Me and HIV/AIDS Programme" of the Faculty of Health Sciences is a module within the Becoming a Professional (BP) foundation course for all first-year students. The course counts for ten per cent of the summative assessment marks for the BP course.

The Programme was designed to bring awareness to all first-year Health Science students about HIV and AIDS. The course is intended to educate students about HIV and AIDS transmission, prevention and treatment, but mostly to raise awareness about students' own behaviours that may put them at risk of contracting HIV. The underlying aim is for students to become reflective, empathic and AIDS-competent health care professionals who can make better choices personally and professionally. It is implemented by means of a compulsory one-day workshop offered over two weekends in April each year. Approximately 120 students attend each of the workshops.

The course content covers general information on the nature of HIV and AIDS; transmission and prevention; risk and risky behaviours; stigma and myths; support services available for HIV-positive persons; and facing HIV and AIDS as a health professional. Participatory and experiential methods are used to deliver the workshop. This combines plenary sessions, small group work, role play, and presentations by various people such as people living with HIV, doctors and senior students. As the module title suggests, the primary focus is on the students themselves.

The workshop is implemented by facilitators with experience in HIV and AIDS. Some of the facilitators are AIDS Community Educators (ACES) and BP Facilitators, who are trained by HAICU. Various monitoring and evaluation tools have been put in place for the programme. Constant feedback is given by the students through a pre-workshop and post-workshop survey to assess knowledge gained through the workshop. Facilitators also give written feedback after being trained by HAICU and after facilitating workshops.

The IT staff in the Science Faculty play an important monitoring and evaluation role as they are responsible for data collection and analysing information provided by students in the pre-workshop and post-workshop surveys. The results are then analysed and reported by the HIV/AIDS Working Group to inform the curriculum design for the following year.

Until recently, only internal evaluations were conducted. A need was thus identified to evaluate the "Me and HIV/AIDS Programme" objectively, through use of an external evaluator: Southern Hemisphere Consultants.

The objectives of the evaluation were to:

- Assess the impact of the HIV and AIDS curriculum component "Me and HIV/AIDS" on Health Faculty students
- Identify which messages were effective and which were not
- Identify the 'Most Significant Changes' brought about in students through their participation in this Programme
- Identify ways to improve the curriculum component in the future, in terms of content and process
- Focus on the effectiveness, impact and relevance of the curriculum component.

### *Sample and Method*

A total of 332 students from UCT, 229 (69%) of whom were female and 103 (31%) were male, completed the pre-survey. The post-survey was conducted with the same group of students in the afternoons, following the workshops. Figure 3 shows that the majority (57%) of the sample was 18 years of age, and a further 21% were 19 years old.

With regard to longer-term impacts and to assess the sustainability of workshop impacts, the evaluators spoke to first-year students only two months after the workshop, and they conducted focus groups with second-year students who had completed the workshop the previous year.

An on-line survey called 'Vula' was completed by three groups of students pre- and post-workshop on 5, 6 and 12 April 2008. A self-completion structured questionnaire was used, comprising mostly multiple-choice questions, the ranking of statements, and a few open-ended questions. The aim of the pre-workshop survey was to determine the extent of the knowledge, attitude and behaviours of the students on sex-related

issues prior to attending the workshop. A similar set of questions was then posed in the post-workshop survey to see if there were any differences in their level of knowledge, attitude and behaviours after attending the workshop.

### *Findings*

In terms of effectiveness, the evaluation looked at how the course was managed and implemented. Again, the views of key stakeholders were mostly very positive.

The impact of the workshop was also found to be good. The focus groups with the second-year students showed that they remembered the workshop well, and that they had been able to apply some of the positive changes in their lives, particularly with regard to stigmatisation.

Comparison of pre- and post-survey results from the 2008 first-year group show the following:

For most aspects, the students had a **positive view** of the workshop. The students found the **presentations** profound and enjoyable. The most popular aspect was testimonies by diverse people living with HIV, as it added a sense of realism to the disease, and highlighted that the disease does not discriminate. One student commented:

> "The testimonies made the disease real. It was a wake-up call and made you ask yourself, 'Where do I stand?'" (Focus Group).

Respondents' knowledge and understanding of sexual safety as well as HIV and AIDS increased significantly in the post-survey. This could be seen in changed responses to various questions:

- Participants' faith in condoms as a means of protection against HIV increased following the workshop. The majority (84%) of respondents in the pre-survey believed condoms could protect from contracting HIV, while 14% did not believe they would offer sufficient protection, and 2% indicated they did not know. Participants' faith in condoms as a means of protection against HIV increased by 14% after the workshop was conducted, with almost all (98%) students indicating that condoms can protect against HIV if used properly. Only four students (three women and one man) still expressed reservations about the efficacy of condoms.
- Trust that free condoms are as effective as bought ones increased.
- Knowledge about HIV concentration in various bodily fluids increased.
- Awareness of means of transmission increased, particularly regarding mother-to-child transmission during birth and breastfeeding, transmission through needle-prick injuries, oral sex, kissing with an open mouth when there are open cuts in the mouth, and through blood-transfusion.
- Awareness of where HIV tests can be obtained increased, particularly knowledge that such tests can be obtained on campus.
- Awareness that test results can be obtained within 15 minutes increased.
- Awareness that PEP treatment is made available to rape victims by the State, as well as the time period within which such treatment is effective, increased.
- Respondents' willingness to disclose their HIV results if positive increased, showing heightened awareness of the value of such disclosure.
- Awareness of risk factors such as alcohol use, unprotected sex, and non-penetrative sex showed a slight increase in the post-survey.
- Respondents' perception of the risk they, their family members, friends and other UCT students face of contracting HIV all increased in the post-survey, showing heightened awareness of such risk amongst all groups.

Areas where the workshop appears to have been **less effective** include:

- Knowledge and understanding of conditions that could put one at risk of contracting HIV. The post-survey showed a larger number of omissions in response to this question, potentially showing some confusion in this regard. Actual responses were also varied, with some potential risk factors such

as having open genital sores or STIs *decreasing* in the post-survey.

- The number of respondents that omitted the question about the risk they, their family, friends, and other UCT students face of contracting HIV increased in the post-survey. This could denote increased uncertainty or heightened discomfort about answering this question.

Students' perceptions of the value of the workshop improved from the pre- to the post-workshop survey, with a 7% increase in respondents who believed the workshop to have been worthwhile compared to those who believed it would be worthwhile in the pre-survey. It is worth noting that the vast majority (96%) of respondents to the post-survey believed knowledge they had gained would help them to become better health care practitioners.

In **the focus groups,** the students noted that one of the key reasons why the workshop made such a large impact on them was because of the non-judgmental and non-prescriptive nature of the Programme, which was different to the kind of sex education that they had received at school. Hearing personal testimonies and receiving information from doctors was also meaningful. Responses from the focus groups showed that the workshop mostly affected students in terms of their attitudes towards people with HIV, as they said they were more caring and sensitive, and less likely to alienate people with HIV. The diversity of the speakers made them realize that HIV does not discriminate and this raised their consciousness of their own vulnerability. They were also able to reflect on their own sexual practices, and realised that they are more vulnerable to HIV than they imagined.

They mentioned factors such as alcohol, peer pressure, the freedom of student life and student parties as being risk-contributing factors. The reflective nature of the workshop did help them with their decision-making about safe sex, and some would have preferred to spend more time on these aspects. There is still, however, a perception that UCT students generally, and medical students specifically, are less 'risky' as their social status is perceived to mean they are more responsible about their behaviour. The workshop did encourage students to get tested and to know their status. Students felt it was good that there were "get-tested" campaigns held soon after the workshop. Some students felt moved to share their knowledge and new beliefs with friends, peers, patients, family, partners and community members, and definitely thought they would be better health professionals as a result.

The evaluation also uncovered key elements for the sustainability of the workshop. These include: curriculum integration; relevant content focused on the personal and professional lives of students; participatory methods; and support and continuity. These are all held together by stakeholder commitment and ownership. More could be done on the continuous learning and support aspects, and perhaps similar workshops could be held for second-year and third-year students, focusing on where they are in terms of their curriculum and lives.

It is compulsory to attend the *"Me and HIV/AIDS"* module in order to gain admittance into the examination. Students thus took the course more seriously and felt it was important to learn and study the material because the course ended with an examination.

The workshop in its current form costs R77 per student, which is a low cost considering the intensity and value of the workshop, and the high calibre of the many inputs (including project management, course design, speakers and facilitators).

### *The impact*

The overall aim of the *"Me and HIV/AIDS Programme"* was for students to become reflective, empathic, AIDS-competent and knowledgeable health care professionals who can make better choices both personally and professionally.

In terms of impact, the evaluators looked at two levels. First, at short-term outcomes of the workshop. For example, what were the types of key messages and most significant changes in terms of learning, awareness, knowledge, attitude, skills, opinions, aspirations

and motivations? Secondly, the evaluation examined whether there were any changes in terms of the students' actions i.e. their behaviour, practices, and decision-making. With regard to the longer-term impacts, the evaluators spoke to first-year students only two months after the workshop, and conducted focus groups with second-year students who had completed the workshop the previous year.

Respondents in the focus groups described how they had been 'bombarded' with HIV and AIDS messages at school and through the media and had become somewhat de-sensitised. Yet this course helped them to be more conscious and more receptive to the messages. Three reasons were provided for this; *firstly*, meeting people with HIV personalised the messages; *secondly*, hearing it from doctors was significant; and, *thirdly*, the tone was neither patronising nor prescriptive, which increased their receptiveness to the messages.

As one student commented during a discussion about safer sex:

> "People need to make a personal policy so that when you are in the heat of the moment, you can have a decision to fall back on." (Focus Group).

Others reflected that the consequences still seemed unreal, and that they may still make unsafe choices:

> "It's like wearing a seatbelt. Sometimes you do it and sometimes you don't. The consequences seem far away. So in the heat of the moment, you might not be careful." (Focus Group).

The focus groups confirmed that the workshop did raise students' awareness that being under the influence of alcohol would put them at greater risk, and that peer pressure to conform to student life on campus is also a contributing factor. The sentiment in one first-year group was that the social life at university pressures people, and they were able to reflect that as first-year students they were more receptive to it and that it makes them more irresponsible. They commented that the above risk factor is compounded by the newfound freedom they experience being away from the authority of their parents.

Many students felt that the workshop impacted positively on their own sexual behaviour. They mentioned aspects such as:

- being able to talk more openly about sex and prevention with their partners
- being more demanding about safer sex practices, and
- reflecting on sexual behaviours of their own that they may not have considered risky before.

Some students even reported committing to abstinence before marriage. Seeing the diverse speakers who were HIV-positive also raised the students' awareness that HIV affects people from all backgrounds and social standing:

> "You realise that you are vulnerable to it." (Focus Group). "I was under the impression that it is a disease of poverty and ignorance. I didn't consider myself at risk before the workshop." (Focus Group)

Second-year students in the focus groups confirmed this. They reported that they were able to contain their reactions and be more caring when confronted with open wounds, but they still did not feel adequately prepared for this eventuality.

> "My mother and father have this idea that people who are HIV-positive are careless or they did this to themselves. They didn't say this in words but I feel as though that's how they kind of feel. After the workshop I can now talk to them more openly and with more solid knowledge." (Focus Group)

> "We can now have more informed conversations." (Focus Group)

As community members, students said that they would be **less judgemental** of those in their communities who were living with HIV and that they would be **more compassionate and caring**. Some respondents also said that they were inspired to **communicate HIV**

**and AIDS messages** to community members (mostly their peers) and to **counteract gossip and stigma**.

> "Having heard the speakers and the way they live their lives actually gives you great respect for people living positively and I realised that we need to stay away from stigma." "When I am back home, I now look at people with HIV differently and am not as prejudiced as I was before." (Second-year students)

One student noted that community norms dictate that young people cannot talk to older people about HIV, but she believed that she would be able to inform her peers:

> "In the North-West, the disease is so stigmatised. You can change yourself but it is difficult to change the community and their perception of people with HIV. It is more acceptable amongst adults to talk about it. As a young person I cannot talk to an older person about it." (Second-year student)

Some respondents reflected that they had wanted to be more involved in community activism, and to help people regarding HIV and AIDS. For example, they had joined HIV and AIDS societies on campus.

The course certainly did "consciencitise" students. However, second-year students still said they found it shocking in practice to be confronted with raw wounds and blood. Yet these same students highlighted that they were able to contain their reactions because they were more sensitive as a result of having been on this workshop. This shows that the impacts of the Programme have lasted.

Lastly, the evaluation concluded that it is important for the impact created on students to be **sustained through continuous support**. This support should take place, firstly, through immediate support after training by way of forums where students can ask questions related to HIV and AIDS. Secondly, HIV and AIDS training should continue at higher levels of learning and should build on the modules covered in the previous years. Modules at the foundation level should focus on personal risk, while modules at later levels should focus on HIV and AIDS challenges faced by professionals, as these issues would be more relevant at that stage. None of these support mechanisms are currently in place and definitely should be considered by the Programme.

**SUMMARY AND COMMENTS**

The "Me and AIDS" module constitutes an important introduction to HIV/AIDS at UCT. It is later followed-up by Peer Education activities through different media during the rest of the year. The evaluation concluded that the workshop had been effective and was well appreciated by the students. However, it was also noted that contact with PEs mainly takes place during Orientation Week, which limits what the PE programme can potentially offer. Moreover, the observation period was short and the observed changes in knowledge and attitudes were small. Furthermore, it was recommended that more professional involvement of behaviour change researchers should be sought.

UCT is one of the few institutions to have allocated money to an evaluation of the project. It was found that the workshop was both cheap and showed good results regarding awareness. But it is not clear how much further it brought individuals along the continuum of behaviour change and how sustainable this was. We think it is unfortunate the report did not include any statistical analysis as this would have made the results easier to generalise. Most of the qualitative results were from a few FGDs, which although interesting and valuable, offer no impression of the scale of the issues raised.

Despite the evaluation's limitations, the use of a theoretical framework for PE constitutes an important step and constitutes a Good Practice. It also facilitates monitoring and evaluation as this also falls within the same framework.

## UNIVERSITY OF THE FREE STATE (UFS) – COMMUNITY FOCUSED SUPPORT

Six areas have been identified as key components of the HIV/AIDS strategy at the University of the Free State:

- Staff-focused support
- Student-focused support
- Teaching and learning
- Research
- Community-focused support
- Monitoring, evaluation and MIS.

Each of these components will need to be headed by an appropriate person with a supporting team – in co-ordination with the other components. They will be responsible for developing and implementing the interventions for that component, aligning it with the overall strategy of the UFS HIV/AIDS Programme – i.e. an operational or action plan will need to be developed for the programme. For the purpose of this document, community-focused support will be highlighted.

## Community-Focused Support

Prevention, treatment, care and support initiatives must be extended in the form of community outreach. Community service is an integral part of UFS core activities, and co-operative partnerships have been developed with the communities in the form of 'flagship' programmes.

The most appropriate vehicles for the University's community engagement should be:

## Community flagships

One of the UFS flagships is the Free State Rural Development Partnership Programme (FSRDPP). Community outreach programmes for prevention, treatment, care and support have been implemented in the communities of Philippolis, Trompsburg and Springfontein on the basis of, and as part of, the Free State Rural Development Partnership Programme (FSRDPP). What follows is a description and analysis of an intervention that took place over a period of 10 months in the abovementioned towns and surrounding farms. It should be noted that this is an ongoing programme.

**HIV/AIDS vulnerability among farm workers in the southern Freestate. Education for Behaviour and Attitude Change in the Context of Living with HIV/AIDS: An Interdisciplinary Approach to Community Development amongst Farm Workers in the Southern Free State of South Africa.**

## Abstract/ Summary

The farming industry in South Africa is under serious economic threat due to the death rate among farm workers caused by HIV/AIDS-related illnesses. The author analysed an educational intervention focusing on HIV/AIDS prevention and understanding, involving 8 farms and 90 workers. Interactive and didactic methods included self-reflection, storytelling and group work. Data were collected through questionnaires and interviews. The workers learned the importance of knowing their HIV status. Their knowledge about HIV/AIDS increased and they developed skills to better manage their health. They became more positive towards people living with AIDS, about condom use, and status disclosure.

Farmers in the Southern Free State, and specifically those in and around Springfontein, have been trying for years to engage in some kind of discussion in order to assist their employees to better deal with the impact of HIV/AIDS on their respective families. In the past, mobile clinics visited the farms for Primary Health Care including HIV-related services, but as relationships with Government deteriorated over the years, the services were terminated. As a result, farm workers in this area became a neglected and forgotten group as far as AIDS awareness programmes were concerned. The low literacy levels among most of the workers disadvantaged them further, as most of the material printed for awareness passed them by.

This study investigates the possibility that a specifically designed HIV/AIDS awareness programme will impact on the knowledge, attitudes and behaviour of farm workers in the Springfontein region. The programme will be evaluated continuously in order to improve the methodology and content of the programme. The ultimate aim will then be to design an HIV/AIDS awareness programme that will assist

farmers and farm workers to better deal with the impact of HIV/AIDS.

## INTRODUCTION, BACKGROUND AND CONTEXT

HIV and AIDS are one of the main challenges facing developing countries such as South Africa. It is estimated that of the 39.5 million people living with HIV worldwide in 2006, more than 63% were from sub-Saharan Africa.

South Africa ,with more HIV-positive citizens than any other country in the world, is at the epicentre of the pandemic affecting all aspects of society. The social impact of HIV/AIDS is potentially devastating to families and households; as breadwinners die, the number of orphans increases, the household dependency relationships change and community resources become exhausted.

Sub-Saharan Africa is home to just over 10% of the world's population but accounts for more than two-thirds (67%) of all people living with HIV. More than 40% of the region's population lives on less than one US dollar a day.

The HIV epidemic has resulted in history's single sharpest reversal in human development. In the most heavily affected countries, HIV has reduced life expectancy, deepened poverty amongst vulnerable households and communities, skewed the size of populations, undermined national systems, and weakened institutional structures. Recent data from 11 African countries clearly link higher education levels with lower HIV prevalence. A recent study in rural South Africa found that each additional year of educational attainment reduced the risk of HIV infection by 7%.

## HIV/AIDS AND THE AGRICULTURAL SECTOR

The commercial agricultural sector in South Africa is significantly impacted by HIV/AIDS. Farm-worker vulnerability to HIV has its roots in a combination of low knowledge of HIV/AIDS and poor living conditions. The FAO has estimated that since 1985 more than 7 million agricultural workers have died from AIDS-related disease in 27 severely affected African countries (SA included). The anticipated labour loss in SADC is estimated at between 12.7% and 26%.

Figures on the prevalence of HIV/AIDS in the agriculture sector in South Africa are not readily available, although a 2002 study indicated that there was an 11.3% prevalence of HIV amongst people between the ages of 15 and 49 years of age living on farms. Women and children are particularly vulnerable, having to take over traditionally male roles when men die, as well as fulfilling their own traditional roles.

Farm workers are particularly vulnerable to HIV/AIDS. Not only do their living and working conditions often place them at risk, but also their rights and labour protection. Farm workers are the most under-serviced workers in South Africa. Poor access to health care and health-related information is partly due to their remote location of work. Rural people are therefore less likely to know how to protect themselves from HIV, and if they fall ill, less likely to get care. The high incidence of poverty and the low level of knowledge make the farm worker even more vulnerable to the impact of HIV/AIDS. The multiple factors influencing the HIV infection rate in farming communities warrants concern. Factors that lead to HIV vulnerability include: poverty; a lack of access to appropriate information, education and communication (EIC) materials on HIV; cultural attitudes and practices; belief in HIV myths; gender-based violence; very few interventions from government and non- governmental organisations targeting the farm workers; lack of incentives or facilities to test for HIV; and lack of access to condoms. Almost all government interventions on HIV/AIDS transmission are communicated to the general public in the form of mass media. These include, among others, the Love Life campaign and the Soul City television series. Due to the low levels of education and literacy in rural areas, farm workers might interpret the messages these campaigns are conveying differently. This makes them more susceptible to HIV infection.

From work by various groups on farms, including the University of the Free State, it is clear that women remain by and large dependent on their male partner/family members for both food and tenure security. Located within a prevailing power framework of patriarchy and paternalism, gender-based violence is particularly pervasive. In the context of systematic discrimination and gender-based violence, women and children living and working on farms remain most vulnerable to HIV/AIDS.

## THE STUDY AREA IN CONTEXT

The project focused on the farming areas in and around the town of Springfontein, a typical livestock farming community in rural Southern Free State about 150 km south-west of Bloemfontein. According to Mr. Blackie Swart, one of the farmers in the area, the estimated population of Springfontein is about 6,000. Unemployment is estimated at 60%. The reason for this is mainly that Spoornet had scaled down its workforce and business in the area since the early nineteen hundreds. There are about 30 farms in and around Springfontein where farmers mostly farm with Merino (wool) and Dorper sheep (meat). There are also about 3 black subsistence farmers in town, one commercial farmer and a few emerging farmers. The community is typically rural with three main groupings: Sotho and Xhosa-speaking black people, Afrikaans-speaking brown people, and Afrikaans- and English-speaking white people. The region has a high level of illiteracy, with almost 20% having received no schooling at all. The town became a municipality in 1912. The town has a clinic with no doctors, 2 churches and 2 schools. The nearest ARV sites are Jagersfontein (80 km away) and Edenburg (90 km away). By studying the map, the reader will get a good indication of the challenges people in these areas face, keeping in mind that there is no public transport available. The farmers we worked with indicated to us that it is the responsibility of the farmer's wife to make sure that the farm workers get to the clinic for whatever need they have. This again is proof of how important it is to encourage disclosure to the employer as this will ensure support from the farmer and his wife.

In an HSRC survey conducted in the Free State and Northern Cape in 2003, farmers overwhelmingly regarded ill health, HIV and domestic violence as the most pressing problems facing farm workers. Numerous farmers suggested that the general health of their workers had radically declined over the past three years. All attributed this decline to the spread of HIV/AIDS. The decline was apparent enough for some farmers to see it in the general productivity and physical strength of the workers.

Because farm workers are scattered among farms and areas that are often remote and neglected, farm workers as a group are invisible in society. Although it is a worldwide phenomenon, it is particularly severe in South Africa.

Not only is there concern because of the number of people sick and dying, but also because of the lack of certain attitudes and values, and the exercising of certain cultural practices, contributing to the spread of the disease. If attitudes, values and certain cultural practices could be understood, then they could perhaps be changed. This study explores these attitudes, beliefs, values and cultural practices amongst farm workers in the Southern Free State by exploring specifically the relationship between the above and HIV infections.

The programme will be based on the premise/assumption that people who:

- have knowledge about HIV/AIDS
- understand their risk, and
- have the necessary attitudes regarding HIV, PLWA, condoms, lifestyles etc

will not only look at their behaviour and lifestyle critically in order to minimize their risk of contracting and spreading HIV, but also take control of their life and live a healthy lifestyle.

## OVERALL OBJECTIVES

The development of an HIV/AIDS awareness/intervention programme for farm workers, with the focus

on transfer of knowledge and development of values and attitudes that might lead to possible behaviour change.

The study will therefore be directed by the following research questions:

- Can an awareness programme dealing with HIV knowledge, information and skills bring about change in values, attitudes and behaviour?
- Was the knowledge provided suitable, sufficient and enough?
- What methodology should be used to ensure effective transference of knowledge and skills as well as retention thereof?
- What values, in the context of HIV/AIDS, need to be transferred to facilitate this change?

## PROJECT DESIGN

### Gaining entry

Bearing in mind the importance of the agricultural sector in the region, a meeting was held with local farmers, their wives and community members to discuss the project and ensure the support of the local farming community as well as the general community at large. Participation was to be voluntary, and those farmers who were willing to participate were to be included in the program. Taking into consideration that the farm is a private business, individual meetings were held with each farmer to clarify issues and discuss concerns. It was also important regularly to inform the farmer of the progress with workers on his farm, without disclosing confidential information about the workers. Ongoing interaction with the farmers became a very important way of involving them in the HIV/AIDS prevention/care/treatment strategy. It was also important because they would be crucial in providing support to the farm workers who might test positive, or who were already positive.

### Methodology

The evaluators chose a qualitative approach for the programme. This method was chosen because an in-depth understanding of issues involved in HIV prevention programmes was needed. The qualitative approach was also expected to complement quantitative data collected among the same farm workers in pre- and post-test questionnaires. This approach also captured the perceptions and feelings of the group targeted during project implementation. As the evaluation had to cover information from several types of groups, pre- and post-test interviews and observations were chosen as the main collection method. Three tools were developed, a pre-test questionnaire, a post-test questionnaire and a template matrix for note taking and observations. While the discussions were semi-directed, there was scope for discussion and open-ended responses. The study and data collection at the project sites took 8 weeks per site. The methodology included interactive and didactic methods including self-reflection, storytelling and group work, suitable for people with lower levels of literacy.

The awareness programme consisted of 10 weekly interventions per farm on 3 farms. Each intervention consisted in a 2-hour workshop each week (10 sessions in total per farm). The programme was designed so that the farm workers were actively involved in all activities. Scripture reading, suitable teaching aids, group work and games were used for each session. As there are an average 7 families on each farm, 30-35 participants were included in each session. The initial contact with farmers was on 19 May 2009 on the Rondefontein farm. Twenty-four farmers and their wives came to listen to a presentation by us on the farm interventions planned for the Southern Free State. The aim was to obtain their acceptance of the project as well as to identify a group that might be trained as peer educators to serve as a support network to the farm workers after the programme. 14 women including farmers' wives, teachers and community members volunteered to be trained in an 8-week programme in HIV-related issues.

Training and educating the Springfontein care givers (farmers' wives, teachers and community members) was a critical step within this programme to lay the groundwork for supporting the farm workers, and, ultimately, the broader Springfontein community. It is hoped that, as these women have participated in the

very same workshop course material, their increased knowledge and skills will create an open environment where issues of HIV testing, transmission prevention, ongoing health care needs, nutrition, and confronting stigma can be addressed on their farms and in the Springfontein community.

These women were and are still extremely excited about responding to other social needs beyond HIV and AIDS as a result of this training programme. After the women were trained, the farms were identified. The facilitators were introduced to the farm workers and the project commenced. The first group had 26 members. It included husbands, wives and children from 5 different farms. The farms were in close proximity to each other and the farmers allowed the workers to attend the sessions.

The following is a brief description of the training programme.

The programme is intended to influence individual, family and social factors that affect the lives of the farming community. More specifically, the programme intends to influence:

- qualities of families
- knowledge of HIV/AIDS, gender and sexuality
- social problem skills..

### *Session 1: Meeting, introduction and pre-test questionnaires*

During session one, the facilitators made contact with the workers and introduced themselves. An introduction to the group work process was given and the aim of the project explained. Pre-programme interviews were conducted to test levels of knowledge as well as the group's attitudes towards HIV/AIDS-related issues such as PLWHA, condoms and knowing one's status. Students from the University's Social Works department assisted us with the interviews. It was very important to establish a relationship of trust with every worker who took part in the programme because this would form a very valuable foundation for the programme.

### *Session 2: Attitudes*

Activities for exploring one's attitude towards certain HIV/AIDS-related issues allowed participants to really think and talk about their own feelings regarding these issues.

### *Session 3: Transmission and immune system*

A very simplistic methodology was used to explain these concepts to the respective groups. They had to look at different picture cards and explain to each other how they made sense out of the pictures. The researcher then facilitated a session on the role of WBC in protecting the body against infections as well as what happens in the blood when the virus gains entrance.

### *Session 4: Testing*

During session four, the group discussed the reasons for people not wanting to test for HIV. They were able to share their own fears regarding this. The group was led to realize that by testing for HIV they would be able to take control over their lives. By the end of the session they agreed that it is important to go for testing.

### *Session 5: Stigma surrounding hiv/aids*

The group members were able to take part in discussions and share examples of stigma that they had experienced in their community towards people living with the virus. The farm workers are Christians and this was identified as a strength that could be built on to prohibit stigmatisation of HIV+ people.

### *Session 6: Healthy living including nutrition and knowing your status*

The message that "HIV is preventable and manageable" was given to the farm workers. It is important to know that if a person is HIV+ it is not the end of their lives. By living healthily, life can be prolonged. They were given information on the different treatment options as well as about protagonists in the community that can aid them – such as the mobile clinic.

*Session 7: Closure*

The final session featured a DVD of the story of a person living with HIV. A special candlelit ceremony was held and guests were invited to share the occasion. The role of the farmer as well as the newly trained support group was explained to the farm workers, and arrangements were made for Voluntary Testing and Counselling in September.

*Session 8: Evaluation*

evaluation questionnaires were completed and the programme received positive feedback. It was communicated by the workers that they would like the programme to be for a longer duration. When asked how their lives had changed since the start of the programme, they shared that they now made use of preventative measures. They felt that they had a relationship of trust and respect with the facilitators and that they had gained valuable knowledge. Many of the workers shared that they had tested for HIV and will continue to do this to ensure that they will be around to see their children grow up.

## Choosing the participants

During the course of this study, three techniques (group work, interviews and observations) were used to gather information from couples on several variables including understanding of HIV/AIDS issues, willingness to participate in the programme, attitudes and values regarding HIV/AIDS issues, quality of interpersonal relationships and self-esteem. The first group consisted of 26 members and included husbands, wives and children from 5 different farms. The farms are in close proximity to each other and the farmers allowed the workers to attend the sessions.

## Interview instrument

The following tools were used as interview instruments as well as to monitor and evaluate the programme as we progressed:

- Structured interviews with individuals before and after the interventions
- Questions before and after each session regarding levels of knowledge and skills
- Facilitator's checklist of topics covered
- Observer recordings/report
- Tape or video recording with the consent of the farm workers
- Pre- and post-test questionnaires containing demographic questions/ statements, questions that test respondents' knowledge, values, attitudes and behaviour patterns regarding HIV/AIDS.

## Gathering data

Two researchers were responsible for gathering data. The team consisted of a researcher and an assistant. Potential participants were contacted via the farmer after a meeting to discuss the aim of the programme with the latter. A meet-and-greet session was then arranged with the farm workers. The researchers introduced the study and agreed on where the programme was to be carried out as well as a time convenient to all. A programme and schedule were prepared by the assistant and pasted on a wall where everybody could see it. We were dependent on the time given to us by the farmer to avoid interference with the work programme. Quantitative data was gathered through individual and key informant interviews. This is presented and described in Tables. Comparisons were made using the following variables:

- Gender
- Level of education
- Age
- Location/place.

Open-ended questions and observation reports from both the research assistant and some farmers contributed to the qualitative nature of the study.

# CONCLUSION

While awareness of HIV/AIDS and basic prevention knowledge is quite widespread amongst the populations of South Africa, it has been confirmed that there are still areas where sub-populations, e.g.

farm workers on commercial farms, are still lacking access to information and among whom myths are still very much alive. The HIV epidemic cannot be removed from sexuality, substance use, poverty and grief. Our experience was that the programme was well accepted because it covered all theses aspects, was taken to the farming community, had no political involvement or agenda and built on some of the strengths owned by families.

This project can pave the way for other intervention programmes. It can point out the types of knowledge needed to bring about attitude change regarding matters of HIV/AIDS. It can also highlight the shortcomings of such programmes. Based on the above, the development of a programme for people with lower literacy levels, as well as the training of peer educators to form a support network, become very important.

According to Whiteside, prevention campaigns must be maintained as new generations become sexually active; they have to be reached and educated. HIV prevention is not something that can be "done" and ticked off a list. That is why it will be very important for close co-operation between stakeholders including Government Departments, the University of the Free State, local NGOs, CBOs and farmers associations, etc, to form the basis of these interventions to ensure long-term sustainability.

## CASE 9. UNIVERSITY OF ZULULAND (UNIZULU) – REPORT ON GOOD AND INNOVATIVE HIV PREVENTION PRACTICES

### General Aspect

The University (UNIZULU) is a comprehensive university north of the uThukela River in KwaZulu-Natal. UNIZULU has two campuses. The main campus is situated in KwaDlangezwa, about 150 kilometres north of Durban and 45 kilometres south-west of Richards Bay, the second campus (Richards Bay City Campus). The majority of the students, from KwaZulu-Natal, are campus residents (99%). Of the total of 13271 students, the majority of students are between 22 and 29 years old. The majority of these students are Black African, with 188 foreign students enrolled.

The University provides some funding for the AIDS Programmes of which R86,000 was provided in 2007 and R50,000 in 2008 mainly for office administration. The University also pays the salaries of the Manager of the AIDS programme, the Secretary, the Health Promoter and the ARV nurse who is based at the Campus Health Clinic. Other funding for the Programme is from donors. The HEAIDS funding of R2.5m has been used for the purchase of a mobile clinic, the provisioning of support staff to the HIV and AIDS Programme Manager, equipment and supplies, office supplies, capacity building and services. Services include publications, research studies, the translation of policy and seminars.

Start-up funds for HIV and AIDS activities were provided by the United States Agency for International Development (USAID) on a three year cycle at a value of 872,000 rand. From this money, a voluntary counselling and testing (VCT) site was established, as well as the peer education programme and a number of communication campaigns. Quilts and murals were also made by the students.

#### *Structure, management and operations*

UNIZULU has established an HIV and AIDS policy, launched in 2002, and currently under review. The Policy provides guidelines for the University's response to HIV and AIDS, specifically the university's ability to prevent the epidemic from undermining its ability to provide its mandated services. To ensure

**Table 1–Annex 6** Funding of HIV and AIDS Interventions 2007/2008

| Source of Funding | Amount |
|---|---|
| Own funding | 220,561 |
| Donor funding | 2,405,048 |
| DoE | 250,000 |
| **Total** | **2,875,609** |

that the Policy is implemented, the University has established an HIV and AIDS Committee, answerable to the University Council. This serves also has a HICC committee. UNIZULU strives to ensure that on-going support of Senior Management exists. Senior Management is also involved in strategic planning and the implementation of the HIV and AIDS Programme. When Voluntary Counselling and Testing (VCT) is promoted, Senior Management leads by example.

Other activities of the Unit include curriculum integration and peer education for both staff and the students. Structures have been created to evaluate the supervisors and staff of these programmes.

In terms of financial health, staff have not instituted a fundraising plan to pay for the future costs of the HIV/AIDS Prevention Program. For now there is funding available. DramAidE usually supports Health Promotion activities as part of prevention programmes.

In terms of administration, formalised, defined, and written HIV-related policies exist to address issues of discrimination, gender equality, confidentiality and PLWHA. A policy booklet has been published but has never been distributed.

The position of the Health Promoter is the only one that is vacant. The level of staff morale has not been scientifically tested or assessed. However, in the Prevention Programme, staff-client rapport, retention, morale and organisational commitment are good. Employee handbooks are available. Staff and volunteer training is sufficient. Clinic confidentiality is in place. Staff/volunteer awareness and commitment to HIV prevention services are good. Staff and volunteers are qualified to do their jobs and they are culturally and linguistically appropriate for their clients.

### *Cross-Cutting Issues*

At all levels, networks exist that have been developed and expanded to provide for a continuum of care. Furthermore, referral relationships with other stakeholders/strategic partners exist, as do linkages with other service providers.

While there are support groups for PLWHAs, students with HIV/AIDS may get involved after they are recruited as peer educators. The only way that PLWHAs are identified is if they disclose after testing. Nutritional packs are provided for the support groups. Given the liberal nature of the tertiary environment, addressing student behaviour patterns is a challenge. To make some inroads, student peer educators use site impacts and talk shows as forms of intervention. There are prospects of working with the Bay TV station to put on a TV programme about HIV/AIDS prevention. The staff also engage in social dialogue on campus. The peer educators design topics and identify staff to be involved. There are a number of sessions, one every two months.

It is difficult to recruit men for HIV/AIDS services. Staff are hoping to involve more men in the programme, but to date it has been very difficult. Plans to involve *Brothers for Life* are underway. During the formation of the programme, the Staff Sports Club invited the HIV/AIDS Prevention Programme staff to do a presentation.

#### *Theory Driven*

Staff use a group work theory called Social Goals Model as a theoretical base. They use this theory as the basis for developing their peer education manual and apply the concepts when planning mass media and public information campaigns. They embrace the behaviour change model in their communication programmes to a limited extent.

#### *Rutanang*

In the beginning, the programme staff followed Rutanang. However, as they became more experienced, they saw problems in applying certain aspects of the programme. Rutanang did not work for their framework, for example. On the other hand, staff expanded the gender-focused part of the Rutanang program. These modifications were implemented because staff believed that the programme was not applicable to their unique needs.

#### *HIV Policy*

Currently, the university has an HIV policy. In terms of administration, a formalised, defined and written set of

HIV-related policies exists. A new book of policies has been produced, but so far has not been distributed.

*Guiding Principles*

The Guiding Principles of the framework include:

- Supportive and committed leadership: staff are committed to providing information and services to the student population. The low staff turnover, good morale and other positive responses have been noted.
- Promotion of human rights: actions and also written policies help to ensure that students know their rights and can advocate for them.
- Comprehensive response: there is a broad range of services, counselling, and supplies of male condoms available on campus.
- Effective partnerships: networks have been created – between Senior Management and students, for example, for campaigns such as making VCT more effective. There is a solid partnership between the University and the Department of Health and also with DramAidE.
- Effective advocacy and communication: building relationships in the communities, particularly rural areas, where services are often sparse or non-existent, expands the services of the university to those who are often left out of the loop.

*Underlying determinants – "drivers of the epidemic"*

One of the drivers of the epidemic is that the student population and the staff come from a rural area with strong ties to the tribe. Norms and social imperatives promote gender inequality, unprotected sex, etc. There are taboos around discussing sex except in instances where the issues are discussed among peers. Because they have a rural-based student and staff constituency, cultural issues are difficult to address, such as those dealing with sexuality, male-female relationships, etc. The staff are moving slowly on these issues.

*Stigma*

HIV-related stigma remains a problem given the rural backgrounds of students and staff and the tribal norms, mores and social imperatives of their families and friends.

*Planning, Monitoring, Evaluation and Research*

Monitoring of the programme activities is limited. VCT attendance is recorded. In terms of planning, evaluation and feedback, a multi-year strategic plan exists. However, interviewees reported that they need to improve their ability to collect client satisfaction data. In addition, data on client outcomes and behavioural data need to be collected. A research interest group has been formed with the aim of promoting translational research among the natural science researchers and social science researchers. The AIDS Research Initiative (ARI), funded by HEAIDS, is aware of the need for research, monitoring and evaluation. It is the central database for all staff and student HIV-related projects. Initiatives range in size and scope from postgraduate projects to large-scale community-based projects. The ARI is instrumental in disseminating information about funding and conferences, etc. ARI also sources funding for PhD student projects. Research is funded by HEAIDS. Data are being collected by staff at the Campus Clinic and routinely entered into the MIS system. However, if the client previously attended a government clinic, upon coming to the campus clinic that client's information is not available.

## Prevention Activities – Peer Education

*Condom Distribution*

**UNIZULU promotes the use of male and female condoms and access to these barrier devices.** The DoH has seconded two counsellors on a full-time base from the Uthungulu District. The DoH provides test kits and the condoms, which they deliver or which are picked up by UNIZULU.

Condom Week has been dubbed "Valentine's Week". The university holds a Memorial Candle-Lighting Day during HIV and AIDS Week and International World AIDS Day. During the campaigns, peer educators display quilts, posters, pamphlets and the University's HIV and AIDS Policy Document is placed at strategic points, so as to maximize the number of students who are made aware of the document. Sometimes, the university invites activists who can share their life stories. Usually, these celebrations are associated with

a remarkable increase in the number of persons testing for HIV immediately afterward.

*Life Skills Training*

USAID funding was used to upgrade offices at the Campus Clinic for accreditation for counselling by the KwaZulu DoH. Skill building activities sponsored by the HIV/AIDS Prevention Programme are only provided to the peer educators.

*IEC/BCC and Awareness Campaigns*

Peer educators engage students in what they call "Special Events Days". These days are used for social dialogue on issues related to HIV and AIDS. Top Management becomes part of such dialogues. The social dialogue involves topics such as sexual networks, condom usage, discordant couples, etc. The Health Promotion Officer and student peer educators work with the staff during Orientation, but they do not do counselling. Their focus is on education.

*Community outreach activities*

UZL's focus is on linkages or building ties with the community. They realised early on that to be successful, they had to work with community groups.

## Description of the main prevention programmes

*Peer Education*

*Training*

Peer Educators are trained in team building, working as a team, and on their "cluster model". The Department of Health provides them with basic information on HIV/AIDS. The cluster model encourages PEs to work in teams, making it easier for staff to monitor and supervise peer educators. They are still responsible for writing up reports on their work.

*Other Peer Education Activities*

The HIV/AIDS Prevention Programmes is composed of a Project Manager, 35 staff Peer Educators, one Researcher, a Peer\Education Co-ordinator, a Nurse who specialises in ARVs and Nutrition, and 2 VCT Counsellors. Of these members of the programme, the Researcher, the Peer Education Co-ordinator and the Nurse are on the HEAIDS payroll. The Peer Educators are volunteers.

On an individual level, the Programme has VCT, secondary prevention and case management, individual supportive counselling, and other health services including contraceptives, rape counselling and abortion referral but not antenatal care.

On a group level, aside from workshops conducted by peer educators, workshops are also presented by the HIV Prevention Programme. There are psycho-educational groups. Because the peer educators are volunteers, the Programme provides skill building groups for them as a reward, along with other group activities. Skill building is not provided for the student population. While no activities focus primarily on substance use, given that the behaviours can be a precursor to engaging in risky behaviour, the peers may discuss substance use as part of their interaction with students. There is no peer to peer outreach, but referral networks do exist.

**SUMMARY**

The University of Zululand has a very homogeneous population of students and staff. The majority of the population is from rural areas and, as Zulus, come from very traditional and conservative backgrounds. Because of their backgrounds, staff must be very sensitive to the norms and social imperatives that they bring to the university setting. There are proscriptions against discussing sex. Certain acceptable sexual behaviours create gender imbalances. The result is that staff must be very sensitive to these issues and careful when designing interventions so that individuals will not be offended. Nevertheless, UZ offers a variety of programmes to attract students as well as to motivate them to use, for example the VCT clinic. Since some of UZL's locations are in rural settings, they are particularly interested in, and have a commitment to, engaging with the community in order to develop a working relationship.

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