Findings and recommendations from the *Study on HIV seroprevalence and related factors for Higher Education South Africa*

Laura Myers, Researcher

Centre for AIDS Development, Research and Evaluation

laura@cadre.org.za

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higher education & training
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Summary of the Project

- HIV Prevalence Study, Knowledge, Attitude, Practice and Behaviour (KAPB) survey and risk assessment
- Conducted at 21 of the 22 state Higher Education Institutions (HEIs) in South Africa where contact teaching takes place
- *Quantitative component* comprised of a cross-sectional HIV prevalence and KAPB survey (an 'unlinked, anonymous HIV survey with informed consent').
- *Qualitative component* aimed at interpreting and contextualising findings, including informing recommendations

Study Objectives

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- To determine, amongst staff and students:
  - prevalence and distribution of HIV
  - knowledge, attitudes, behavioural risks, social contexts of HIV/AIDS
- To explore associations between socio-demographic and behavioural results and HIV
- To determine the current and future risks posed by HIV on institutions and the higher education sub-sector; to make recommendations on how to reduce and manage such risks.

Methods

- Each HEI population was stratified by campus and faculty/class and then clusters of students and staff were selected using standard randomisation techniques.
- An overall sample of 25 000 respondents was targeted.
- Self-administered questionnaires were used to obtain demographic, socioeconomic, behavioural and HEI-related data
- Blood spots were obtained by finger prick.
- HIV status of participants was determined by laboratory testing of dry blood spots obtained using standard methodology.
- Field work for the study was conducted between August 2008 and February 2009.

Participation Levels

- Out of a total of 29,856 eligible participants available at testing venues, 23,605 (79,1%) participated fully by completing questionnaires and providing specimens.
- Final database comprised of 23,375 individuals:
  - 17,062 students
  - 1,880 academic staff
  - 4,433 administrative and service staff

Results: HIV Prevalence among Students

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- The mean HIV prevalence was 3,4%
- Among the two thirds (65%) of students who reported having had sex, HIV prevalence was 3,8%
- Among females, HIV prevalence was more than three times higher(4,7%) than among males (1,5%); consistent across the provinces.
- The province with the highest HIV prevalence (6,4%) was the Eastern Cape (EC) while Western Cape (WC) was lowest at 1,1%

HIV Prevalence among Students

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Large differences in HIV prevalence by race:

- Africans: 5,6%
- Coloureds: 0,8%
- Whites: 0,03 %
- Indians: 0,3%

Strong association between age and HIV prevalence:

- Aged 18–19 years: 0,7%
- Aged 20–25 years: 2,3%
- Over 25 years: 8,3%

Multi-variate analysis among sexually experienced students identified the following factors associated with HIV infection:

- Age, race, gender and socioeconomic bracket.
- Self reported symptoms of sexually transmitted infection
- Sexual partner 10 years or more older

HIV Prevalence among Academics

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- The mean HIV prevalence was 1,5%
- The province with the highest HIV prevalence at 3.3% was the Eastern Cape
- HIV prevalence was similar among female academic staff (1,4%) and males (1,5%)
- The prevalence of HIV was highest amongst African academics – 5,9%
- No cases of HIV among Coloured and Indian academic staff
- Among White academic staff – 0,1% were HIV positive

HIV Prevalence among Administrative Staff

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- The mean HIV prevalence was 4,4%.
  - KZN had the highest HIV prevalence at 9,2%
  - WC was lowest at 0,9%
- Female staff HIV prevalence - 3,1%
- Male staff HIV prevalence - 6,2% (p=0,006)
- Again, differences in prevalence by race:
  - African staff - 11,5%
  - White staff - 0,2%
  - Coloured staff - 0,3%
  - Indian staff - 1,7%

HIV Prevalence among Service Staff

- The mean HIV prevalence was 12,2%
  - KZN HIV prevalence was 20,3% - the highest
  - WC was lowest at 1,2%
- Female HIV prevalence was 11,3%
- Male HIV prevalence 13,0%

KAPB findings

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Student demographic risk factors [wgt%]

- 73% of all students have ever had sex, and 85% of this group had sex in past year [no sex or low sexual frequency is protective]
- 8% of males and 16% of females reported recent STI symptoms [untreated STIs are a risk factor]
- 1% of males and 2% of females reported forced sex in past year [sexual violence is a risk factor for HIV]

Sex and risk factors: Students
[age standardised %]

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- Of ever had sex
  - 19% are parents
  - 41% had >1 partner past year [risk factor]
  - 16% >1 partner in past month [risk factor]
  - 7% had partner 10+ years older [risk factor]
  - 23% had recent sex while drunk [risk factor]
  - 27% had most recent sex partner from HEI [reduces risk]
  - 62% used a condom at last sex [reduces risk]
  - 48% had ever had an HIV test [negligible impact on HIV-]

  - Males >1 partner in past year – 19% [HIV 3.5% vs 2.6%]
  - Females >1 partner in past year – 6% [HIV 6.9% vs 6.9%]

Other factors: Students [wgt%]

- Used condom at last sex – 60% [HIV 5.1% vs 4.8%]
- Often tricked or pressurised into having sex – 5% [HIV 7.4% vs 4.8%]
- Expect money or gifts for sex – 2% [HIV 8.5% vs 4.9%]
- Tested for HIV in past year – 30% [HIV 4.7% vs 2.3%]
- Drink alcohol weekly or more – 11% [of all] [HIV 0.9% vs 3.7%]
- Drunk in past month – 35% [of all] [HIV 2.1% vs 4.2%]
- Marijuana in past month – 9% [HIV 1.7% vs 3.6%]
- Injecting drug use in past month – 1% [HIV 3.2% vs 3.4%]

Exposure and vulnerability: Students
[wgt%]

In past year:

- Know person with HIV (18%); know person who has died (30%)
- Know student or staff member who has died (4%)
- Provided care to HIV+ person in household (9%)
- Missed classes for AIDS-related funeral (6%)
- Positive attitudes to PLHIV (88%), but perception of support at HEI if known to be HIV positive low (36%)
- Know of place to go at HEI if HIV positive (62%)
- Feel safe from harm at this HEI (61%)
- Female students safe from sexual harassment (38%)

Leadership and response: Students [wgt%]

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- Management at this HEI serious about HIV – 52%
- Student leaders at this HEI serious about HIV – 38%
- Need more emphasis on HIV in classes – 66%
- Attended meeting about AIDS in past year – 35%
- Received information about AIDS in past year – 58%
- Obtained free condoms – 51%
- Involved in research about AIDS in past year – 11%
- Contacted AIDS helpline in past year – 7%
- Take AIDS seriously
  - Talking to friends; AIDS statistics (40%)
  - Campus radio (13%); Campus newspaper (18%)

Sex and risk factors: Staff
[age standardised %]

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Of ever sex

- Had >1 partner past year (Acad, 9%; Admin, 14%; Service, 20%)
- Had >1 partner in past month (Acad, 4%; Admin, 7%; Service, 14%)
- Condom at last sex, males ≥25 (Acad, 21%; Admin, 30%; Service, 43%)
- Condom at last sex, females ≥25 (Acad, 17%; Admin, 22%; Service, 33%)

Of all

- HIV test in past year (Acad, 29%; Admin, 29%; Service, 28%)
- Drink alcohol weekly or more (Acad, 25%; Admin, 13%; Service, 10%)
- Marijuana in past month (Acad, 2%; Admin, 3%; Service, 45%)
- Injecting drug use in past month (Acad, 0%; Admin, 1%, Service, 1%)

Knowledge, attitudes and exposure: Staff [wgt%]

- Good overall correct response to basic HIV knowledge questions (multiple partner risk; low risk--casual contact; underage sex; ART)
- Poor awareness of HIV transmission through breastfeeding; Post-exposure ART in event of rape
- My friends have more than one current partner varies by staff category and sex (5%-25%)

In past year:

- Know person with HIV (Acad, 18%; Admin, 20%; Service, 27%)
- Positive attitudes to PLHIV high, but perception of support at HEI if known to be HIV positive low (Acad, 43%; Admin, 37%; Service, 41%)
- Know of place to go at HEI if HIV positive (Acad, 62%; Admin, 64%; Service, 60%)
- Attended meeting about AIDS in past year (Acad, 29%; Admin,28% ; Service, 34%)
- Received information about AIDS in past year (Acad, 48%; Admin, 49%; Service, 49%)

Qualitative study

Aimed at interpreting and contextualising findings and developing recommendations.

- 67 focus group discussions (318 students; 222 staff)
- 60 key informant interviews
- Participation of people known to be living with HIV: 58 students; 49 staff
- Categories of investigation: 1) contextual factors affecting HIV infection; 2) institutional responses focusing on HIV prevention & support initiatives
- Focus groups with specific risk populations: 3 with addictive drug users, 2 on alcohol consumption and party drug use, and 3 with men who have sex with men

1. HIV vulnerability and susceptibility

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Sexual experiences of younger students

- First year female students in particular, unused to their newfound freedom, often naively expose themselves to risk associated with alcohol use and sex.
- Targeted due to their vulnerability—by older students and non-students who frequent campuses.
- Strong social pressures for students to engage in sexual relationships.

HIV vulnerability and susceptibility (2)

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Patterns of sexual relationship

- Concurrent partnerships are not generally socially condoned, but are tolerated and tend to be accepted as inevitable; seen as preferable to terminating a relationship. There are strong cultural influences on the acceptability of concurrent partnerships, particularly in males.
- Little awareness of the risks of multiple and overlapping partnerships and even peer educators and health educators were often not able to explain why such relationships constitute higher risk.

HIV vulnerability and susceptibility (3)

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Transactional sex

- Sex work among students is rare. However, exchanging sex for social and material gains is commonplace, and takes many forms.
- Some poorer students struggle to meet the most basic requirements: a safe place to stay and money for food; and are driven into materially supportive relationships where they have little power to negotiate safer sex. Especially common in formerly disadvantaged institutions.
- Females students, are particularly prone to being enticed into relationships with older and wealthier 'sponsors' who often have concurrent partnerships. This is evident at most HEIs, and there was no strong sense of such relationships being disapproved. Rather they are sometimes connected with status.
- Such relationships often involve high age differences between partners.

HIV vulnerability and susceptibility (4)

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Condom use

- It is normative and mostly 'expected' that people will use condoms in casual relationships and new sexual relationships.
- Condom use in established relationships tends to diminish over time.
- In some institutions disapproval by staff of students having sex leads to reluctance to supply condoms.
- Overestimation of the infectivity of the HIV virus ironically leads people not to practice HIV prevention (e.g. if they think they may already be infected they continue with unprotected sex; especially in relationships).

HIV vulnerability and susceptibility (5)

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Alcohol use

- Binge drinking reported to be the major recreational activity on many campuses over weekends.
- Existing alcohol policies are not enforced on many campuses.
- Much evidence was presented to suggest an association between drinking and casual, unprotected sex.

Vulnerability of disabled students:

- People with visual, aural or physical disabilities are vulnerable to manipulation and this entails added susceptibility to HIV risk.
- Their vulnerability is increased by failure to address their special information needs; even on campuses with programmes for accommodation and inclusion of disabled students.

HIV vulnerability and susceptibility (6)

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Sexually transmitted infections

- Education about, and the diagnosis and treatment of STIs on campus have been neglected on many campuses; and there has been strong positive reactions to efforts to provide information about STIs where this has been provided.

Pregnancy and emergency contraception

- High demand for emergency contraception on campus clinics indicates persistent risk-taking in unplanned sex by some students; which is supported by ready availability of emergency contraception.

HIV vulnerability and susceptibility (7)

Addictive drug use:

- Although drug use is limited to small sub-cultures there is evidence that those involved in addictive drug use sometimes expose themselves to high HIV-risk behaviours to support their drug habits.

Men who have sex with men:

- Communities of men who have sex with men are segmented in terms of their risk behaviour; with evidence of very high risk behaviours in some such communities and misconceptions about infection risk.

2. Institutional response environment

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Campus leadership and HIV and AIDS management structures

- On most campuses, HIV/AIDS responses are divided across a number of different institutional structures which often do not communicate adequately and where areas of responsibility are not well defined.
- Policies have not been translated into strategies with specific goals, targets and responsibilities on many campuses .
- Common perception from those on the service delivery end of prevention and care programmes, that they have not been adequately supported.
- Little involvement of HIV-positive people in official campus HIV response management.

Institutional response environment (2)

HIV positive care and support

- Available health care, psychosocial services, and basic needs for support for those who test positive varied across institutions, with overall low levels of HIV-specific support available.
- When services and support group opportunities are available, students and especially staff are reluctant to use them, due to the perceived risk of being labelled HIV-positive. Support groups are almost exclusively provided for and attended by students.
- HIV-positive students and staff experience stigmatising attitudes from peers and seniors at all institutions, and feel they should not be exceptionalised marginalised.
- The DramAidE health promoters programme on more than 20 campuses has been very meaningful for creating a supportive environment for PLHIV and challenging negative conceptions about what it means to be HIV-positive.

Institutional response environment (3)

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Campus health services

- Campus health services are not all oriented to the SRH needs of students; questions about confidentiality and acceptance were raised on many campuses.
- The responsibilities of HEIs in serving the health needs of HIV-positive service staff is often vague and inconsistent.
- Lack of access to ART on or near campuses is a major problem for staff and students who lack medical aid and have to queue for hours to retrieve their treatment each month – often missing classes or work.

Institutional response environment (4)

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Campus support services

- Linkages between HIV programmes and other campus support services (e.g. counselling) are generally not well developed, drawn upon for HIV support, or perceived to address the needs of HIV-positive people.

Voluntary counselling and testing

- An important factor affecting VCT uptake is the perception that there is limited support available on campus for those who test positive.

Institutional response environment (5)

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Staff outreach

- The majority of universities did not target the needs of staff in HIV and AIDS campaigns; especially service staff who are most likely to be infected and affected by HIV.

Funding support for poor students

- Many students come from poor socioeconomic backgrounds and lack adequate funding to provide for their basic needs.
- On many occasions in discussion groups it was reported that some students were “hungry”.
- Poor students and especially poor HIV-positive students require food support.

1. General recommendations

- Each HEI should review its responses in light of HIV prevalence profiles in the institution and **develop HIV/AIDS response plans** that direct resources and efforts to where they are most needed.
- **Service staff** is the most affected campus sub-community, but has been paid least attention in HIV prevention and support efforts.
- Need to consider the relative emphasis on **prevention vs care and support** needs. The neglect of care and support has likely contributed to the 'invisibility' of HIV, even in high prevalence contexts.

2. Prevention recommendations

- **Focus on service and administrative staff:** HIV prevention education should be systematised and include contract staff; develop treatment, care and support programmes for staff.
- **Condom availability and promotion:** Condoms should be readily available in residences and other public places.
- **VCT**: services must be strongly linked to other health and support services, especially where VCT is externally provided. VCT should be available on all campuses and strongly tied to HIV prevention. An emphasis on knowing the status of one's partner must be introduced.
- **SRH:** Prioritise education about & treatment of STIs, given the high levels of self-reported symptoms of STI.

Prevention recommendations (2)

- **Peer education**: Programmes for staff should be instituted at all HEIs. Greater institutional support should be provided to student peer education programmes.
- **Addressing age-disparate sex:** It is important to promote messages about the higher risk of having older partners among younger students and staff and address the pattern of predation by older males who are not part of the campus community.
- **Concurrent sexual partners**: Focus on avoiding concurrent or overlapping sexual partners in campaigns and promote understanding of why such relationships involve higher HIV risk.
- **Positive prevention:** Focus on prevention among HIV-positive people thru support groups and care settings; almost no evidence of this emerging approach to prevention on campuses..

Prevention recommendations (3)

- **Gay and lesbian staff and students**: Gay and lesbian staff and students must be recognised as having special HIV prevention needs. Representative associations exist on some campuses and must be engaged in planning HIV prevention programmes. A national initiative to support this should be developed.
- **Students and staff with disabilities**: A national programme should be instituted to support HIV prevention among students and staff with disabilities.
- **Low prevalence institutions:** At low prevalence institutions, adopting the goal of 'no new infections' would be relevant as a focal strategy to sustain motivation around HIV prevention, which could be eroded by perceptions of low HIV-risk.

3. Reducing contextual risks

- **Addressing vulnerability to transactional sex:** HEIs should provide opportunities for students to supplement income through work on campus to reduce temptations to engage in risky behaviour in order to subsist.
- **Addressing vulnerability of women:** Disciplinary bodies and procedures should be reviewed, considering that these appear to be largely dysfunctional on some campuses. Regulations and disciplinary procedures relating to sexual harassment should be publicised on all campuses and disciplinary procedures should be seen to work.
- **Bridging programmes:** Given the challenges that new students have in adjusting to university life and the risks they face, it is important to expand bridging programmes, which typically do not last beyond the first week of university;
- **Residence programmes:** The management and conditions in residences and student accommodation must be addressed in the interest of reducing susceptibility to HIV risk behaviour.
- **Alcohol abuse**: There should be a nationally supported drive to curb high levels of campus drinking and to promote non-alcohol oriented forms of recreation. Regulations relating to alcohol availability and access on campuses should be reviewed and better enforced.

4. HIV/AIDS care and support

- **ART access:** All HEIs must adopt measures to ensure that ART is available on or near campuses. A subsector treatment access project should be adopted as a priority by HESA, to support HEIs to achieve this.
- **Support to people living with HIV and AIDS**: A working group on each campus should be convened to consider ways of achieving better support.
- **Peer support:** It is important to establish programmes of peer support led by HIV-positive people where these don't exist.
- **Wellness programmes for HIV-positive people**: A sector-wide approach to promoting physical and psychological well-being of people with HIV on campuses is needed.

5. Institutional leadership

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- **Institutional leadership**: In each HEI there should be an established and functioning decision-making HIV and AIDS steering committee or task team. This committee should have representation on each campus, with clear lines of responsibility and accountability.
- **Human resource departments**: Human resource departments must be required to show what they are doing in response to HIV and AIDS and be actively involved in campus programmes.
- **Staff organisations:** Trade unions and staff bodies must be called on to play a much stronger role in HIV and AIDS.
- **Student leadership**: A sector-wide initiative to promote student leadership is recommended; noting perceptions that student leadership has been weak.

6. Research and learning environment

- **Mobilising research:** HEIs have mostly gathered little understanding of their own epidemics. A research agenda should be drafted for each institution; and staff and students should be encouraged to conduct policy and strategy-relevant research on HIV and AIDS issues.
- **Integrating HIV and AIDS into subject curricula:** Strong perceptions that HIV and AIDS have not been sufficiently incorporated into the academic curriculum suggest that there should be a review of what is being done and a national project launched for addressing this need.

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"In the university, the most powerful people are the students. So if the students get together and talk about it, as much as the Vice-Chancellor can do something, if we're not for it, there's nothing he can do. So as students, it's up to us to now to go outside and say, 'People, let's talk about it'".

A copy of the report can be found on:
www.heaids.org.za

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