



# **HIV and AIDS in the Higher Education Sector**

**Findings of the study on  
HIV seroprevalence and related factors  
at the University of KwaZulu-Natal**

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# Contents

EXECUTIVE SUMMARY .....	7
Background and context .....	7
Findings.....	8
Recommendations.....	10
SECTION ONE - INTRODUCTION.....	16
1.1 Background and context.....	16
1.2 Objectives of the study .....	17
1.3 Institutional context .....	18
SECTION TWO – STUDY METHODOLOGY .....	19
2.1 Overall methodology and rationale .....	19
2.2 Ethics approval process .....	19
2.3 Quantitative study .....	19
2.4 Qualitative study.....	20
2.5 Sampling .....	22
2.6 Data collection .....	23
2.7 Data collation .....	25
2.8 Data analysis .....	26
2.9 Strengths and limitations .....	27
SECTION THREE – FINDINGS.....	29
3.1 HIV prevalence by demographic factors.....	29
3.2 Sexually transmitted infection symptoms.....	31
3.3 HIV prevalence and reported sexual behaviours and practices .....	31
3.4 Social practices.....	44
3.5 Knowledge, attitudes and relation to HIV and AIDS.....	46
SECTION FOUR – INSTITUTIONAL RISK ASSESSMENT .....	52
4.1 Institutional risk assessment.....	52
SECTION FIVE – CONCLUSIONS AND RECOMMENDATIONS.....	58
5.1 Conclusion .....	58
5.2 Recommendations .....	60
SECTION SIX – REFERENCES.....	64
SECTION SEVEN – APPENDICES.....	66
Appendix 1: HIV laboratory based testing algorithm for making a diagnosis of HIV ..	66
Appendix 2: Ethics approval letter .....	67
Appendix 3: VCT during the study .....	68

## List of Tables

Table 1a	Key indicators at the University of KwaZulu-Natal .....	14
Table 1b.	Comparison of HIV prevalence between UKZN and regional and national results .....	15
Table 2	Staff and student numbers at the University of KwaZulu-Natal .....	24
Table 3	Demographic description of the sampled population at the University of KwaZulu-Natal.....	24
Table 4	Response rates at the University of KwaZulu-Natal.....	24
Table 5	Response rates by various characteristics.....	25
Table 6	HIV prevalence among staff and students .....	29
Table 7	Estimated numbers living with HIV and AIDS .....	30
Table 8	Medical aid and HIV prevalence .....	30
Table 9	Genital sores/discharge in the past three months .....	31
Table 10	Sexual experience.....	31
Table 11	Ever had sex - by age among students .....	32
Table 12	Reporting of same sex practices among students and staff in the last year...	33
Table 13	Number of sexual partners in past 12 months .....	33
Table 14	Intergenerational sex among males and females.....	34
Table 15	Most recent sexual partner by category.....	36
Table 16	Age group, partner numbers and condom use at last sex.....	37
Table 17	Perceptions of sexual partners .....	39
Table 18	Attitudes to casual sex, multiple partners and transactional sex .....	41
Table 19	HIV testing.....	43
Table 20	Frequency of alcohol consumption .....	44
Table 21	Recreational drug use in the past month .....	45
Table 22	Attitudes related to alcohol and drug consumption by students .....	45
Table 23	Basic HIV and AIDS knowledge .....	46
Table 24	Attitudes related to HIV and AIDS.....	46
Table 25	Experiences related to HIV and AIDS in community and institution in the past year .....	47
Table 26	Perceptions of institutional response to HIV and AIDS .....	48
Table 27	Perceptions of institutional safety .....	51
Table 28	Have any of the following made you take HIV and AIDS more seriously in the past year? .....	51
Table 29	Prevalence, ART demand and medical aid coverage .....	54
Table 30	HIV prevalence – students .....	56

## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment/Therapy
CADRE	Centre for AIDS Development, Research and Evaluation
DBS	Dry Blood Spot
DoHET	Department of Higher Education and Training
EU	European Union
HEAIDS	Higher Education HIV and AIDS Programme
HEI	Higher Education Institution
HEMIS	Higher Education Management Information System
HESA	Higher Education South Africa
HICC	HIV Institutional Coordinating Committee
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSRC	Human Sciences Research Council
KABP	Knowledge, Attitude, Behaviour and Practice
LSD	Lysergic Acid Diethylamide
MSM	Men who have sex with men
SABCOHA	South African Business Coalition on HIV and AIDS
SANAS	South African National Accreditation System
SAT	Standardised Assessment Tests
STI	Sexually Transmitted Infection
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WSW	Women who have sex with women
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV and AIDS

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## **EXECUTIVE SUMMARY**

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### **Background and context**

Like all institutions, workplaces and communities in South Africa, Higher Education Institutions (HEIs) are affected and impacted upon by HIV and AIDS. Institutional responses to the disease in the form of policies and programmes have been implemented over the past two decades with an emphasis on capacity building of personnel and mainstreaming of activities. To date, however, the extent of HIV infection within institutions has not been known and this has constrained strategy development.

Higher Education South Africa (HESA) – an umbrella body for universities and universities of technology – includes the Higher Education HIV and AIDS Programme (HEAIDS) which is involved in developing and strengthening HIV and AIDS response. HEAIDS is an initiative of the Department of Higher Education and Training undertaken by HESA to reduce HIV prevalence among students and staff and to mitigate impact of the disease with a view to maintaining core functions of teaching, training, and research as well a community engagement. HEAIDS is funded by the European Union (EU) under the European Programme for Reconstruction and Development in terms of a partnership agreement with the Department of Higher Education and Training (previously known as the Department of Education).

In November 2007, a national survey was commissioned by HESA to establish the knowledge, attitudes, behaviours and practices (KABP) related to HIV and AIDS and to measure the HIV prevalence levels among staff and students.

This report deals only with the findings from the University of KwaZulu-Natal (UKZN). Separate reports have been produced for the other HEIs as has a national report for the higher education sector. It must be noted that the primary aim of this research was to develop estimates for the sector. Therefore, whilst HIV prevalence estimates at institutional level are reasonably precise, the sampling at institutional level is not necessarily representative of all faculties and campuses.

Furthermore, it is recommended that the institutional reports should be read in conjunction with the national, sector-level report so that each HEI can be benchmarked against other HEIs in the region as well as nationally.

### **Study methodology**

The study populations consisted of students and employees at all 21 Higher Education Institutions (HEIs) in South Africa where contact teaching occurs. The cross-sectional study design used is categorised by UNAIDS/WHO as an “unlinked, anonymous HIV survey with informed consent”. The study comprised an HIV prevalence study, a KABP survey, a qualitative study and a risk assessment.

Each HEI was stratified by campus and faculty and then clusters of students and staff were randomly selected. Self-administered questionnaires obtained demographic, socio-economic and behavioural data. The HIV status of participants was determined by laboratory testing of dry blood spots obtained by administering finger pricks to participants.

The qualitative study consisted of focus group discussions and key informant interviews at each HEI. The purpose of this component of the study was to contextualise and deepen the understanding of results emanating from the survey.

The results of the quantitative and qualitative research formed the basis for a risk assessment for each HEI and the sector.

Ethical approval was provided by the University of KwaZulu-Natal Ethics Committee. Participation in all quantitative and qualitative research was voluntary, and written, informed consent was obtained from all participants. The study was conducted anonymously and no identifying information such as individual identity numbers or student numbers was obtained from any participant. Separate VCT was provided at no cost to any participants who wished to know their own HIV status.

Field work for the study was conducted between August 2008 and February 2009.

## Findings

A total of 1 317 people participated at UKZN comprising 1 593 students, 116 academic staff and 129 administrative/service staff. The overall response rate at the University of KwaZulu-Natal among those who arrived at the testing venues was 77,0%.

At the University of KwaZulu-Natal, the overall prevalence of HIV among students and staff is 2,8% [CI:1,9%-4,2%]. The prevalence of students living with HIV is 2,4% [CI:1,5%-3,8%] and among academic staff it is 1,0% [CI:0,1%-7,0%]. Prevalence of HIV is higher among administrative staff at 5,5% [CI:1,7%-15,9%], and highest among service staff at 16,3% [CI:7,3%-32,6%].

It is estimated that a total of 675 students, 15 academic staff and 240 admin/service staff at the University of KwaZulu-Natal are living with HIV.

All cases of HIV among staff were only among African staff while 4,5% of African students were HIV positive, only 0,5% of other students were HIV positive.

More female students (2,8%) than male students (1,8%) were HIV positive.

Slightly less than two thirds of all students (60%), and most staff reported that they had ever had sex (94%). Less than a third of students aged 18 had ever had sex (29%) but this rose to 59% among those aged 20, and to 75% among those older than 20 years. This suggests that younger students are likely to have their first sex encounter during the period that they are at university.

More male students reported having had more than one sexual partner in the past year (51%) in comparison to females (26%). Around a quarter of male students (26%) reported more than one partner in the past month, many times higher than female students and male and female staff, where this was 2%, 7%, and 7% respectively.

HIV prevalence was higher among male and female students who reported more than one partner in the past month in comparison with those who did not (2,9% vs. 1,0% for male students; 14,9%

vs. 7,6% for female students). This was also the case for male staff where HIV prevalence was 6,4% for those who reported more than one partner in the past month, in comparison to those who did not (2,5%).

Qualitative findings indicate that it is common to have multiple partners, either in short-term relationships or concurrently. "It's very rare for me to have met someone who does not at least have two people at one time," said a female Howard College student.

The majority of students and staff who have had sex in the past year had most recent partners who were not from the institution. Among students, around a quarter most recently had sex with other students (28%). There was very little reported sexual mixing between staff and students, with the exception of 2% of academics saying their most recent sexual partner was a student. However, focus group participants felt strongly that there is a high level of sexual activity taking place between university staff and students.

Around a third of students (37%) and around half to three quarters of staff reported ever being tested for HIV. Of those who had ever been tested, around three quarters (78%) of students had been tested in the past year. Around a quarter of students (24%) had ever been tested at the institution, as had 11% of academic staff, 19% of administrative staff and 13% of service staff.

About two fifths of students (44%) and staff (41%) of both sexes reported never drinking. While half of all students (50%) and around two fifths of staff (42%) reported drinking once a week or less, around a third of all students (32%), and around a fifth of staff (21%) reported being drunk in the past month. Qualitative data suggests that there is a campus culture of excessive drinking on weekends and at campus 'bashes'. Older students may be more likely to socialise at clubs in Durban or at house parties than newer students, who are more likely to socialise on campus initially.

Very little recreational drug use in the past month was reported by students with the exception of marijuana, which is used by 9% of students and 4% of staff. A small proportion of staff reported injecting drug use (2%).

Although most respondents provided correct responses to basic HIV and AIDS knowledge questions, there were noteworthy gaps in some important areas. Knowledge of HIV transmission via breastfeeding was inadequate with only around two thirds of students and academic staff, and half or less of administrative and service staff answering correctly.

Though respondents evidently have basic knowledge about HIV and AIDS and "will tell you all the right things", focus group participants shared that most people still don't perceive themselves to be at risk of getting infected. A female student felt that most people are scared of HIV, but think that it's "somebody else's [problem], not mine." "They don't personalise it, that's the only reason why they don't protect themselves," said a staff member from Howard College.

Attitudes related to HIV and AIDS among students and staff were overall supportive of people living with the disease. However, less than half of students and staff felt that they would be supported by their friends at the institution if they were living with HIV, with lowest levels of agreement being found among service staff. Focus group participants felt that the institutional culture is not supportive to HIV-positive people; "it becomes a problem for somebody to come out of the denialism, only to end up completely isolated," said a Howard College student.

Around half or more students, academic and administrative staff felt that university management take the problem of HIV and AIDS seriously, although this was lowest among service staff (46%). Qualitative findings revealed a perception that senior leadership is supportive in some ways (as evidenced by the number of HIV and AIDS research initiatives) but see more potential for leaders to demonstrate their commitment to HIV and AIDS response by personally speaking out about the issue or supporting VCT drives by testing publicly, for example.

The UKZN AIDS Programme has a campus support unit on each campus. These units provide a platform for HIV and AIDS activities, debates, forums, and care and support to take place. Focus group participants felt HIV and AIDS were seen as the sole responsibility of these units, that there is little involvement from other departments, and that the institution's HIV and AIDS response should be driven centrally, rather than from one programme.

Three quarters of students (75%) and more than half of staff knew of a place at the institution where they could go for help and support if they discovered they were HIV positive.

## Recommendations

Over and above review of the findings of this report, the development of a strategic response at UKZN requires review of the national report for all institutions. This latter report provides deeper insight into HIV and AIDS in relation to higher education in South Africa.

### HIV prevention

- ❑ The university community should be made aware of the severity of the HIV epidemic at the institution, especially among the students and service staff. This should be accompanied by an intensive and clearly sequenced campaign to prevent HIV infection and mitigate its impact.
- ❑ Among students, emphasis should be on increasing knowledge of sexual risk behaviours, in particular those involving high turnover of sexual partners and overlapping sexual partnerships, with a further emphasis on staying HIV negative throughout university study. Students should be supported throughout their time at university; the brief orientation programme for new students is not sufficient and ongoing mentorship programmes for first and second-year students is recommended.
- ❑ The risks of inconsistent condom use must be emphasised, with the goal of 100% condom use in all relationships where there is the possibility of sero-discordance. Condom use should be strongly promoted in all new, casual and concurrent sexual relationships with irregular partners where condom use uptake already tends to be greater. However, given that condom use is resisted in longer-term relationships, knowing one's own and one's partner's status should be promoted in such contexts. Misconceptions over the efficacy of the free government condoms should be addressed and alternative sources of condoms explored. Female condoms should be promoted further.
- ❑ The symptoms of STI infection in both males and females are strongly associated with HIV infection. The high levels of self-reported symptoms of STI infection indicate the need for a strong campaign to identify and treat STIs. Key messages on sexual health and STI prevention

should be continuous and systematic and STI treatment services need to be accessible to all in the university community.

- ❑ Additional creative strategies of addressing prevention of HIV and AIDS should be explored, including the use of debate and drama which facilitate meaningful engagement. The peer education programme should be expanded, and available information in campus media should be strengthened in order to reach a greater number of students with prevention messages.
- ❑ The differences between males and female students with respect to norms and expectations around fidelity in relationships and casual sex are notable. Student programmes should address gender and assertiveness, and challenge accepted definitions of femininity and masculinity. HIV awareness programmes should strive to involve males, learning from successful projects such as EngenderHealth's Men as Partners programme at other institutions, which promotes equitable relationship norms and encourages males to know their HIV status and take responsibility for limiting partners. The institution should encourage students to engage in relationships with their peers (rather than older partners) and promote the idea that it is acceptable not to be in a relationship.
- ❑ Given the high pregnancy statistics, it is evident that greater education about family planning is needed, emphasising the significant responsibility in becoming a parent. Contraception should be strongly advocated in combination with consistent condom use.
- ❑ The relationship between alcohol intake, pregnancy, STIs and HIV and AIDS needs to be made known, and there should be a drive to curb high levels of student drinking, promote non-alcohol oriented forms of recreation and improve regulation of alcohol consumption at university-sponsored bashes. Furthermore, condoms should be available at campus social events.

### **Care and support for people with HIV and AIDS**

- ❑ With an estimated 675 students, 15 academic and 240 administration and service staff that are HIV positive, the institution faces a burden of care and support that appears currently to be unrecognised and unmet. With almost half of students and a significant number of administrative and service staff without access to medical aid support, there will not be access to good quality external medical care and psychological support when this becomes needed. Furthermore, whereas students will ultimately move on from UKZN and their health care does not necessarily become the care burden of the institution, this is not the case for staff. UKZN will ultimately need to face the challenge of 255 of its staff having health problems and support needs associated with HIV and AIDS, and needing to commence anti-retroviral therapy.
- ❑ There is a need to reach out to students and staff who have undergone HIV testing, who know their HIV status but do not access or benefit from support services. Resources should be directed towards the development of HIV support groups, realising that many HIV-positive people are not receiving any kind of support. It is important to establish a programme of peer support, led by HIV-positive people. The Health Promoter programme offered by DramAidE at other institutions should be considered, especially given its great success in creating positive attitudes to living with HIV and mutual support among HIV-positive staff and students.

- ❑ Concise information about resources and services for antiretroviral therapy (ART) and how to manage HIV should be provided. Institutional medical aid schemes should also be responsive to supporting HIV-positive people and these should be reviewed if necessary.
- ❑ VCT services should continue to be promoted in the institutional context, and availability expanded. Emphasis should be placed on couples counselling and the importance of disclosure of HIV status to sexual partners in relationships where condoms are not used and/or in marital or long-term partnerships. The institution should highlight the importance of testing early if one is HIV positive and that it is better to know one's status than not.
- ❑ The HIV and AIDS support units and the campus health facilities should work together to ensure that successes in HIV prevention are paralleled by good HIV support services. As the HIV and AIDS support units are not being utilised by a great number of HIV-positive staff and students, consideration should be given to placing HIV and AIDS care and support within a broader context of wellness, sexual health, and student and staff support to reduce the stigma of accessing care. Non-medical needs of HIV-positive students and staff should also be assessed and responded to - for example, the extent to which food assistance is needed.
- ❑ Stigma remains a concern at UKZN and stigma reduction programmes need to be part of any programme on HIV prevention and care.

## **Response management**

- ❑ There needs to be a comprehensive review of all HIV and AIDS programmes and services on campus. This should be part of an institutional reorientation that would result in a better integrated set of services for students and staff. A consolidated plan for providing a more thorough response is required which will need to include HIV prevention, stigma reduction, HIV support and care and a comprehensive impact mitigation plan.
- ❑ Campus management in all sectors and student leadership need to take heed of the perception on the part of a significant proportion of students and staff, that they do not take HIV and AIDS seriously. This is a reflection of a lack of consistent, visible HIV and AIDS response across departments and a lack of vocal champions, including HIV-positive campus leadership. The institutional HIV and AIDS policy should be better monitored and implemented. Strong institutional leadership among students, management, labour unions and other key stakeholders is a necessary foundation for addressing the epidemic. Such efforts should be intensive and collaborative and include people living with HIV.
- ❑ Considering that HIV prevalence is highest among administrative and service staff, the university must prioritise and reconceptualise prevention efforts directed at staff. Concern must be given to staff needs, recognising that current prevention efforts on campus are mainly directed at students. Other institutions have launched successful staff peer education programmes, which UKZN could emulate.
- ❑ A programme to train workplace managers and residence leadership in the needs and appropriate support for HIV-positive people must be systematised and full coverage ensured. Every line manager should be HIV literate, trained in basic methods of prevention, care and support, and in the importance of confidentiality. For staff to feel comfortable asking for help, managers should instil confidence that they can be approached about HIV needs. Furthermore,

the health care and education of outsourced staff should be catered for. Human Resources should take a lead in addressing issues related to the management of HIV-positive employees by developing a strategic HIV and AIDS programme, creating a management guide, establishing an Employee Assistance Programme, and including HIV and AIDS issues and services in employee induction programmes.

- Campus leadership must take heed of the fact that female members of the campus community do not feel secure on campus and feel vulnerable to sexual harassment and reluctant to report instances of it. It should be a matter of priority to create an environment where students feel safe and protected, including from sexual harassment. Examples of other campuses which conduct well-regulated disciplinary procedures and publicise the outcomes of disciplinary hearings might be studied and emulated.

## Table of Key Indicators

**Table 1a Key indicators at the University of KwaZulu-Natal**

Indicator	Students n=1,072	Academic n=116	Admin n=89	Service n=40	All n=1,317
<b>HIV prevalence</b>					
HIV positive	2,4%	1,0%	5,5%	16,3%	2,8%
Males HIV positive	1,9%	0,0%	8,7%	16,9%	2,6%
Females HIV positive	2,8%	2,2%	3,0%	15,7%	3,1%
18-24 year olds HIV positive	1,1%	0,0%	16,7%	0,0%	1,2%
25-35 year olds HIV positive	15,1%	5,8%	3,1%	19,0%	12,7%
35+ year olds HIV positive	2,0%	0,0%	5,6%	16,0%	5,0%
<b>Sexual behaviour and practices</b>					
Ever had sex	60%	91%	91%	94%	64%
Condom use at last sex (of all who had sex in past year)	62%	22%	30%	35%	56%
Sex in last year with more than one sexual partner (of all who had sex in last year)	47%	13%	21%	19%	41%
Sex with more than one sexual partner in the past month (of all who had sex in last year)	14%	3%	6%	16%	12%
Students whose most recent partner was a member of staff	1%				
Academics whose most recent partner was a student		0%			
Admin and service staff whose most recent partner was a student			3%		
<b>HIV testing</b>					
Ever had an HIV test	37%	76%	57%	53%	40%
Had an HIV test in past year (of ever tested)	78%	40%	52%	65%	72%
Ever had an HIV test at this institution (of ever tested)	62%	16%	33%	23%	54%
<b>HIV and AIDS knowledge and perceptions</b>					
Know that HIV can be transmitted via breastfeeding	66%	69%	50%	46%	65%
Know that ARVs can help people with HIV live longer	92%	92%	89%	87%	92%
Believe that they would be supported by friends at the HEI if they disclosed that they were HIV positive	40%	44%	41%	28%	40%
<b>Activities and perceptions about HIV and AIDS response</b>					
Attended a meeting or function about HIV and AIDS at this HEI in the past year	25%	27%	12%	20%	24%
Know of a place at this HEI where they could go for help and support if they were discovered to be HIV positive	75%	60%	60%	55%	73%
Believe that management at this HEI take HIV and AIDS seriously	55%	51%	65%	46%	44%

**Table 1b. Comparison of HIV prevalence between UKZN and regional and national results**

Indicator (%)	UKZN	UKZN 95% CI	Region KZN	Region 95% CI	National	National 95% CI
<b>Student HIV prevalence (n=1,072)</b>	<b>wgt HIV + %</b>		<b>wgt HIV + %</b>		<b>wgt HIV + %</b>	
HIV positive	2,4	[1,5-3,8]	6,1	[4,5-8,2]	3,4	[2,7-4,4]
Males HIV positive	1,9	[0,8-4,2]	4,1	[2,8-6,0]	2,0	[1,4-2,8]
Females HIV positive	2,8	[1,3-5,6]	7,8	[5,4-11,2]	4,7	[3,6-6,1]
<b>Academic Staff HIV Prevalence (n=116)</b>	<b>wgt HIV + %</b>		<b>wgt HIV + %</b>		<b>wgt HIV + %</b>	
HIV positive	1,0	[0,1-7,0]	2,4	[1,3-4,4]	1,5	[0,9-2,3]
Males HIV positive	0,0	na	2,0	[0,9-4,2]	1,5	[0,9-2,5]
Females HIV positive	2,2	[0,3-17,0]	3,0	[1,6-5,7]	1,4	[0,8-2,5]
<b>Administrative Staff HIV Prevalence (n=89)</b>	<b>wgt HIV + %</b>		<b>wgt HIV + %</b>		<b>wgt HIV + %</b>	
HIV positive	5,5	[1,7-15,9]	9,2	[4,9-16,5]	4,4	[3,2-6,0]
Males HIV positive	8,7	[2,2-28,8]	11,9	[5,6-23,6]	6,2	[4,1-9,3]
Females HIV positive	3,0	[0,4-20,0]	6,7	[2,6-16,3]	3,1	[2,1-4,5]
<b>Service Staff HIV Prevalence (n=40)</b>	<b>wgt HIV + %</b>		<b>wgt HIV + %</b>		<b>wgt HIV + %</b>	
HIV positive	16,3	[7,3-32,6]	20,3	[13,4-29,4]	12,2	[9,9-14,9]
Males HIV positive	16,9	[5,6-41,1]	20,6	[13,4-30,5]	13,0	[9,9-17,0]
Females HIV positive	15,7	[4,8-40,8]	19,8	[9,2-37,6]	11,3	[8,4-15,1]

In this context, “Region” refers to the prevalence from pooling the HIV prevalence levels from all participating HEIs in the region in which this institution is situated. “National” refers to the pooled estimates for the country from all participating HEIs for each population.

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## SECTION ONE - INTRODUCTION

---

### 1.1 Background and context

HIV and AIDS are a severe national problem in South Africa with 5,7 million adults and children estimated to be living with HIV in 2007 representing 11,9 percent of the total population of 47,8 million in 2007.<sup>1</sup> Of the total population aged 15 years and older in 2007 (32,6 million), 5,4 million people were estimated to be living with HIV – a prevalence of 16,5%. This falls within the UNAIDS definition of a hyperendemic HIV epidemic.<sup>2</sup>

Like all institutions, workplaces and communities in South Africa, Higher Education Institutions (HEIs) are affected and impacted by HIV and AIDS. Institutional responses to the disease in the form of policies and programmes have been implemented over the past two decades with an emphasis on capacity building of personnel and mainstreaming of activities. To date, however, the extent of HIV infection within institutions has not been known and this has constrained strategy development.

Higher Education South Africa (HESA) – an umbrella body for universities and universities of technology – includes the Higher Education HIV and AIDS Programme (HEAIDS) which is involved in developing and strengthening HIV and AIDS response. HEAIDS is an initiative of the Department of Education undertaken by HESA to reduce HIV prevalence among students and staff and to mitigate impact of the disease with a view to maintaining core functions of teaching, training, and research as well as community engagement. HEAIDS is funded by the European Union (EU) under the European Programme for Reconstruction and Development in terms of a partnership agreement with the Department.

In November 2007, a national survey was commissioned by HESA to establish the knowledge, attitudes, behaviours and practices (KABP) related to HIV and AIDS and to measure the HIV prevalence levels among staff and students.

The only previous national level HIV prevalence study with bearing on the education sector was a study conducted by the Human Sciences Research Council (HSRC) in 2004 that focused on educators in public schools.<sup>3</sup> The study found an overall HIV prevalence of 12,7% among a sample of 17 088 public school educators, with males and females having similar prevalence levels (12,7% - 12,8%). The 25-34 year age group was most affected with a prevalence of 21,4%, and prevalence ranged from 1,1% in the Western Cape to 21,8% in KwaZulu-Natal.

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<sup>1</sup> See UNAIDS, 2008.

<sup>2</sup> A hyperendemic epidemic is defined by UNAIDS as a situation where 15% or more 'adults' aged 15 years and older are living with HIV. UNAIDS 2008, p 100.

<sup>3</sup> Shisana et al, 2005.

A study of HIV prevalence among students at the University of Johannesburg – formerly Rand Afrikaans University – conducted in 2001 found an HIV prevalence of 1,1%.<sup>4</sup> This prevalence level was noted to be unexpectedly lower than estimates based on prevalence of HIV in Gauteng province.

Although no national-level qualitative studies have been conducted, there are a wide range of quantitative and qualitative studies that have been conducted at the HEIs that have explored knowledge, attitudes, behaviours and practices as well as aspects of higher education policies, strategies and interventions including evaluations of interventions. Populations studied include students and staff, with many studies having been conducted by students as part of postgraduate study.

The present survey was conducted at 21 public higher education institutions providing contact education in South Africa. The only HEI providing contact teaching that did not participate was the Tshwane University of Technology due to unrest on the campus during the scheduled field work period.

The study includes HIV antibody testing, a questionnaire and a qualitative sub-study that together provide the first national baseline for HIV prevalence, as well as a quantitative and qualitative understanding of knowledge, attitudes, behaviours and practices related to HIV and AIDS.

Data for the study was gathered between August 2008 and February 2009.

The institutional risk assessment examining the risk exposure of the HEI to the HIV epidemic based on the findings of the sero-prevalence, KABP and qualitative studies was also conducted and is presented in the main report. The institutional risk assessment identifies the sources of undesired outcomes from the epidemic, the possible causes and the consequences at the institutional level. The risk assessment provides decision makers and managers with appropriate information to manage risks. The conceptual framework used in this report is based and adjusted from the risk analysis procedure explained in Rausand (2004).<sup>5</sup>

It must be noted that the primary aim of this research was to develop estimates for the sector. Therefore, whilst HIV prevalence estimates at institutional level are reasonably precise, the sampling at institutional level is not necessarily representative of all faculties and campuses.

Furthermore, it is recommended that the institutional reports should be read in conjunction with the national, sector-level report so that each HEI can be benchmarked against other HEIs in the region and nationally.

## **1.2 Objectives of the study**

The primary objective of the study is to report on HIV and AIDS in the higher education sector at national level including HIV prevalence, as well as knowledge, attitudes, behaviours and practices

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<sup>4</sup> Uys et al, 2002.

<sup>5</sup> Rausand, M., (2004), "Risk Analysis: An Introduction", presentation dated 7 October 2005, in *System Reliability Theory* (2nd ed.), pp.1- 41, Wiley Publisher.

among students and staff. The study also includes an economic risk assessment of HIV and AIDS in the higher education sector

A further objective is to provide an overview of findings at each institution in the form of institution-level reports.

### **1.3 Institutional context**

The University of KwaZulu-Natal (UKZN) was formed on 1 January 2004 as a result of the merger between the University of Durban-Westville and the University of Natal. UKZN is one of four African institutions rated among the top 500 universities in the world and is one of the largest universities in sub-Saharan Africa. It is located in two cities (Durban and Pietermaritzburg) on five founding campuses.

Formerly the Edgewood College of Education (before its incorporation in 2001), the Edgewood campus in Pinetown is the university's primary site for teacher education and the home of the university's Faculty of Education.

Howard College campus, situated on the Berea in Durban, was opened in 1931. Howard College campus offers a full range of degree options in the fields of Science (including Geography and the Environment), Engineering, Law, and the Humanities (including Music) and Social Sciences (including Social Work). In addition, the campus offers Architecture and Nursing.

The Medical School was founded in 1950 as a "black faculty in a white institution", although it is now open to all races.

Pietermaritzburg is located in the centre of the Natal Midlands; the city is the birthplace of the former University of Natal and its forerunner, the Natal University College, which opened its doors to 57 students in 1910. The campus offers a wide range of academic programmes in Science, Agriculture, Education, Law and Management Sciences. Unique to the Pietermaritzburg campus are the disciplines of Agriculture, Theology and Fine Art.

The Westville campus is located about eight kilometres from the CBD of Durban and Pinetown. The campus currently offers programmes in Science, Engineering, Law, Management Studies and certain Health Sciences.

The University of KwaZulu-Natal's students reflect the broad demographics of South Africa's population. There are almost 40 000 students at the university, including international students from more than 70 countries. UKZN employs 4 103 permanent staff, and in excess of 6 500<sup>6</sup> temporary workers. Temporary workers include part-time lecturing staff.

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<sup>6</sup> HEMIS database 2007.

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## **SECTION TWO – STUDY METHODOLOGY**

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### **2.1 Overall methodology and rationale**

The overall methodology of the study comprised three components:

- ❑ An HIV prevalence survey utilising dry blood spots (DBS) obtained via finger pricks;
- ❑ A questionnaire comprising demographic measures along with measures of knowledge, attitudes, behaviours and practices;
- ❑ A qualitative study comprising two focus groups of students and staff at each institution as well as focus groups addressing alcohol, drugs and males who have sex with males (MSM) at selected institutions.

The study is part of a wider programme to address HIV and AIDS in the higher education sector and is intended to inform response regarding policy, funding, and appropriate interventions. These include HIV prevention policies and practices and support services for staff and students who are affected by HIV and AIDS.

### **2.2 Ethics approval process**

The study design and methodology was consolidated into a formal protocol which was submitted to the ethics committees or nominated committees and/or ethical review boards of each HEI.

In instances where queries were raised, detailed responses were provided and where relevant, minor modifications were made.

At the University of KwaZulu-Natal, ethical approval for the study was received on 14 August 2008 and the letter of approval is included as Appendix 2.

### **2.3 Quantitative study**

A cross-sectional study design was used for the study. This design is categorised by UNAIDS/WHO as an ‘unlinked, anonymous HIV study with informed consent’<sup>7</sup>. It comprised an HIV prevalence study and a questionnaire exploring demographic factors in conjunction with knowledge, attitudes, behaviours and practices.

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<sup>7</sup> World Health Organization, UNAIDS, USAIDS, CDC. Guidelines for Using HIV Testing Technologies in Surveillance: Selection, Evaluation, and Implementation. 2001. Geneva, Switzerland, World Health Organization and Joint United Nations Programme on HIV and AIDS.

The study population comprised all students as well as academic, administrative and service staff at the institution. Employees of organisations providing contract services to institutions were excluded.

The questionnaire was designed to be self-administered and included a range of measures relevant for national-level comparison as well as measures related to the specifics of higher education institutions.

Questionnaires were available in three formats related to respondent categories: students, academic staff and a combined questionnaire for administrative and service staff. Questionnaires were identical apart from a small subset of questions related to the characteristics of each respondent category.

The questionnaire was pre-tested with students and staff prior to final implementation. Printed versions were available in English and Afrikaans, while translations of other South African languages were made for use as reference in instances where English or Afrikaans were potentially not clearly understood.

The questionnaires and DBS were designed to be collected in a group setting and the timeframe for the entire process was designed to be completed within 50 minutes.

Members of the study team engaged with key stakeholders at each institution prior to the field work phase of the study. This included a presentation and question and answer session for stakeholders and links were established with relevant personnel. Links typically included the Deputy Vice Chancellor of each institution, the Chair of the HIV Coordinating Committee (HICC), chairpersons of the students' representative council, union leaders and key HEI support personnel.

Participation was voluntary and the study was conducted anonymously. No identifying information such as individual identity numbers or student numbers was obtained from any participant. Participants received a voucher to the value of R30 as compensation for time taken to participate in the study.

Blood spots for HIV antibody testing were obtained via a finger prick and a Guthrie card was used for blood spot collection. The resultant dry blood spots (DBS) were linked to questionnaires via a barcode.

Given that the DBS were collected anonymously and tested for HIV antibodies at a later point, sampled participants were not able to obtain their HIV results. Separate anonymous and confidential counselling and HIV antibody testing was made available during the study period for participants who were interested in finding out their HIV status.

Although sample size calculations were based on developing a national picture rather than aiming for statistical significance at institutional level, sample sizes and randomisation at each HEI were sufficient to inform understanding of HIV and AIDS at individual institutions.

## **2.4 Qualitative study**

The qualitative study was designed to understand contextual factors underpinning risk of HIV infection at HEIs, as well as factors influencing the effectiveness of prevention, support, treatment and impact mitigation efforts. It was also intended for this component of the study to capture

perspectives of members of each HEI on existing responses and perspectives on what was needed.

Two focus group discussions were planned for each campus, consisting of eight members each, although ten participants were targeted to cover for possible last-minute unavailability or non-attendance. Recruitment was conducted through designated campus contacts, selected in consultation with campus HIV and AIDS authorities. At the University of KwaZulu-Natal, recruitment was assisted by several members of staff from the UKZN AIDS Programme.

Participants in discussion groups were to include male and female undergraduate students, postgraduate students, service staff members, academics or administrative staff members, and males and females living openly with HIV.

Attempts were made to include participants representing a broad range of people within the campus community. This is described below with respect to the general study, but the factors that needed to be taken into account on each campus varied and the details of recruitment at UKZN are described in section 2.6.2 below.

In some instances, additional discussion groups were planned when difficulties in recruitment or non-attendance of recruits resulted in inadequate representation of important sectors of the university community. This was particularly important in the case of HIV-positive students and staff. In most cases these individuals were reluctant to join general discussion groups and were accommodated in smaller groups attended by other HIV-positive people. At some HEIs with multiple campuses, additional focus groups and interviews were conducted to cover the variation in contexts across campuses; for example, urban and rural campuses.

In addition to focus groups, individual interviews were conducted with key informants to further understand unique features of HIV risk and response on campus, or to develop understanding of campus communities in preparation for focus group recruitment.

Six 'special issues' focus groups were also conducted in each of the following areas: 1) HIV risk and responses among males who have sex with males; 2) alcohol and 'party drug' use as a context of risk; and 3) drug addiction and HIV risk. Selection of HEIs for this component of the study was done with a view to maximising coverage given the limitation of only six groups.

Discussion group protocols were prepared for the study covering a set of questions and follow-up questions. This was done after reviewing the literature on what is known about factors underpinning HIV infection at HEIs and responses to HIV and AIDS, and after consideration of information collected through the quantitative questionnaire. Discussion groups lasting on average 1,5 hours were conducted by two members of the study team. These were audio-recorded and transcribed for analysis. Ethics protocols as agreed with the ethics authority of each institution were closely adhered to.

The findings are integrated with the survey findings and discussion sections of this report, and were also used in developing the conclusions and recommendations.

## 2.5 Sampling

### 2.5.1 Quantitative sampling

According to the HEMIS 2006 data, contact students accounted for approximately 93% of the sum of contact students and staff nationally. If students and staff were sampled proportionately, the sample size for staff would have been relatively small and the prevalence estimate confidence intervals large. In order to decrease staff confidence interval widths, staff was oversampled. Approximately 20% of staff and 3,4% of students were sampled.

Universities were categorised as large, medium and small based on the numbers of staff and students so as to allocate the sample among the universities. Actual numbers sampled from each institution varied from the target numbers depending upon the response rates and upon the specific classes selected at each institution.

The target sample size per institution for students was 562 at small institutions (< 20 000 students); 737 at medium institutions (21 000-35 000 students) and 1 053 at large institutions (> 35 000 students). The University of KwaZulu-Natal with 35 000 contact students was considered a large university and therefore the sample of students was 1 125. In order to take account of possible non-response, the sample size was increased by 15% to 1 294. With a sample of this size, the HIV prevalence at this institution can be estimated to within +/-2,3% assuming an HIV prevalence of 10%, a design effect of 1,5 and a confidence level of 95%.

A total of 39 154 permanent staff were reported at 22 universities with contact students. These institutions varied in size from 455 at Mangosuthu University of Technology to 4 284 at the University of KwaZulu-Natal. The institutions were stratified into three categories and sampled proportionately. Staff were further stratified by job category: academic and administrative/service).

The target sample size per institution was 159 at small institutions (< 1 000 staff); 341 at medium institutions (1 000-2 500 staff) and 681 at large institutions (> 2 500 staff). The University of KwaZulu-Natal with almost 4 300 permanent staff was considered a large university and therefore the sample of staff was 674. In order to take into account the possibility of non-response, the sample size was increased by 15% to 775.

The detailed demographics of each institution were determined through interaction with each institution's administrative staff and it was from this data that the final sample was determined.

In the case of students, a list of courses including course code, subject title and number of students enrolled in the course was obtained from the institution. Courses were assigned to faculties using the first letters of the course code and faculties were combined into groups to facilitate data collection. For each selected faculty, all courses offered by that faculty were randomly ordered with larger classes having a greater probability of being at the beginning of the list.

From each faculty, the departments offering courses on the list were identified. Discussions were held with faculty and department heads in order to gain access to lecture time. At the selected class meeting, up to 50 students were selected for inclusion. The lecturer responsible for the class was also selected.

For the selection of other academic staff, departments from the faculty used for the student sample were ordered by size and clusters of up to 25 staff members were selected from each cluster.

However, data collection staff was faced with a challenge because academic staff tended either to be in their offices or teaching and seldom came together in groups.

A variety of measures were taken to get around this problem. In some instances, the Dean or Head of Department (HoD) was prepared to call together a special meeting of staff at a time and venue convenient to the field workers. However, not all departments were as accommodating and in many instances HoDs would not call meetings. In these cases, the field managers who were scheduling staff obtained a listing from the university that showed when each department was holding a meeting. Permission was then obtained from the Dean or HoD to access staff during this meeting and the field staff returned to the campus especially to conduct the study during this scheduled meeting time.

In the case of administrative and service staff, departments were selected proportional to size.

## **2.6 Data collection**

Field work for the quantitative and qualitative components at the University of KwaZulu-Natal was conducted between August 2008 and February 2009.

A range of communication activities was implemented to highlight the study among the prospective study population at each institution prior to commencement. These included meetings with institutional stakeholders supported by a communiqué to senior management and staff, an overview of the study that could be disseminated via email as well as a leaflet and poster. A telephone helpline and email address was also available to address enquiries.

### **2.6.1 Quantitative data collection**

Detailed schedules were developed prior to study implementation at UKZN. At the identified venues, a field worker addressed each sampled group and provided an overview and background to the study and the study processes. The voluntary and anonymous nature of study participation was explained and individuals who were sampled were free to leave at any point including at the outset of the study introduction. The availability of separate voluntary counselling and testing (VCT) was also highlighted. See Appendix 3 for information on VCT implementation during the study.

Those agreeing to participate were provided with consent forms for signature and then proceeded to self-complete the questionnaire. The questionnaire was available in English and Afrikaans and translations were available in other languages. Field workers were on hand to answer queries and provide guidance regarding the questionnaire questions and completion process. Additional support including answering questions of clarification and translation into other languages was also provided by field workers as needed. A small proportion of participants who were illiterate were provided with assistance in questionnaire completion by study field workers.

No personal identifiers were collected on the questionnaire but a tear-off barcode was used to link the questionnaire to the DBS. Following questionnaire completion, participants were required to complete a second consent form for DBS collection. The DBS was collected by trained nurses using sterile single-use lancets for a finger-prick. Five blood spots were collected per individual on Guthrie cards.

Participants completing the study questionnaire were provided with R30 vouchers for their time. It was also possible for participants to elect to donate the voucher to a charity nominated by the institution.

**Table 2 Staff and student numbers at the University of KwaZulu-Natal**

	Academic	Admin/Service	Contact students
	Permanent	Permanent	
Number	1 531	2 731	28 716

The demographic profile of the sampled population is described in Table 3.

**Table 3 Demographic description of the sampled population at the University of KwaZulu-Natal**

	Students				Academic				Admin				Service			
	HEMIS 2007		Database		HEMIS 2007		Database		HEMIS 2007		Data base		HEMIS 2007		Data base	
<b>University</b>	28 716		28 326		1 531		1 557		2 331		1 938		400		860	
<b>Sex</b>	n	%	wgt n	wgt %	n	%	wgt n	wgt %	n	%	Wgt n	wgt %	n	%	wgt n	wgt %
Male	13 327	46	13 258	47	864	56	882	57	909	39	828	43	290	73	426	50
Female	15 389	54	15 068	53	667	44	675	43	1422	61	1110	57	110	28	434	50
<b>Race</b>																
African	13 246	46	13 068	46	327	22	333	21	958	41	786	41	273	68	488	57
Coloured	749	3	874	3	34	2	28	2	104	4	72	4	6	2	30	3
Indian	9 859	34	7 826	28	470	31	362	23	770	33	720	37	118	30	327	38
White	4 862	17	6 558	23	686	45	834	54	499	21	360	19	3	1	15	2
<b>Age group</b>																
<24	20 959	73	25 334	89	17	1	36	2	84	4	108	6	3	1	18	2
25-34	4 543	16	2 450	9	306	20	260	17	719	31	579	30	52	13	190	22
35+	3 214	11	542	2	1208	79	1261	81	1528	66	1281	66	345	86	652	76

The overall response rate (i.e. those students that answered questionnaires and provided DBS) at the University of KwaZulu-Natal among those who arrived at the testing venues was 61,8% and is shown in Table 4.

**Table 4 Response rates at the University of KwaZulu-Natal**

Participation	All	
	n	%
Number present at testing venue	2 155	100
% completed questionnaires	1 880	83,4
% completed questionnaire and DBS	1 332	61,8

Table 5 shows the response rates by various characteristics.

**Table 5 Response rates by various characteristics**

Characteristics	Students			Academic			Non academic		
	Total	DBS	Response rate	Total	DBS	Response rate	Total	DBS	Response rate
<b>Total</b>	1 593	1072	67%	127	116	91%	141	129	91%
<b>Race</b>									
African	780	619	79%	22	20	91%	57	53	93%
White	267	165	62%	73	66	90%	22	17	77%
Indian	493	253	51%	30	28	93%	55	53	96%
Coloured	53	35	66%	2	2	100%	7	6	86%
<b>Sex</b>									
Male	632	426	67%	54	47	87%	82	77	94%
Female	961	646	67%	73	69	95%	59	52	88%
<b>Age group</b>									
18-24	1 446	961	66%	3	3	100%	7	6	86%
25-34	123	91	74%	24	21	88%	37	32	86%
35+	24	20	83%	100	92	92%	97	91	94%
<b>Field of study</b>									
Business, Commerce, Law	41	22	54%	0	0	0%			
Education, Humanities, Social Sciences	1 068	726	68%	55	52	95%			
Science, Technology	484	324	67%	72	64	89%			

### 2.6.3 Qualitative data collection

At the University of KwaZulu-Natal, three focus groups were convened. To allow for greater insight into UKZN's varied campus environments, one group was conducted at the Westville Campus, one at Edgewood Campus, and a third at Howard College (which was attended by some students from the Medical School). All focus groups were well-attended by a mix of undergraduate and postgraduate students and non-academic staff. Although much effort went into the recruitment of focus group members, academic staff did not attend.

To make up for gaps in qualitative data, additional information was collected through interviewing the Director of the UKZN AIDS Programme and two campus HIV and AIDS coordinators.

In total, there were 36 participants in the qualitative study including 23 females and 13 males. That includes 3 interviewees, 9 in the Howard College discussion group, 13 from Edgewood, and 11 from the Westville campus focus group. Of those, 11 were HIV positive (7 students and 4 staff).

## 2.7 Data collation

Following DBS collection, Guthrie cards were placed in Ziploc bags along with their barcodes. Questionnaires were placed in session envelopes along with the DBS bags. Consent forms, questionnaires and DBS samples were collated at the end of each session, and at the end of each day session forms and barcodes were scanned.

All collated data was sent to the offices of CADRE in Johannesburg on a weekly basis. Barcodes attached to questionnaires and DBS were checked and scanned into spreadsheets for each institution.

The questionnaire data capture method involved a computer-based scanner reading pencil marks made by respondents on the questionnaires and this allowed for rapid processing of data into datasets.

DBS were sent on to a laboratory in Durban where the following South African National Accreditation System (SANAS) accredited tests were conducted (see Appendix 1 for HIV testing algorithm):

- ❑ Screening assay (Vironostika Uniform II Plus O – semi-automated A1)<sup>8</sup>
- ❑ Second test (Siemens Bayer HIV 1/2 fully automated chemiluminescent assay A2)
- ❑ Third test (Elecys 2010 – Roche Diagnostics for indeterminants (A3)
- ❑ Five percent of samples were retested as an internal quality control using A2 tests.

DBS and questionnaire data were linked via barcodes and completed datasets were checked using various statistical processes.

## **2.8 Data analysis**

Due to differential response rates and difficulties in accessing selected classes and departments, the demographic characteristics did not always reflect that of the university's population. A weighting procedure was therefore undertaken to ensure that the results of the survey could be generalised to the local population at the university.

Students' weights were calculated to reflect numbers by major fields of study, race and gender of the university. Staff weights were calculated to reflect numbers by race and gender. For both groups, the HEMIS 2006 and 2007 database was used as the reference population.

Questionnaire and HIV databases were received in Excel, converted to STATA and merged. Frequencies were run to check for missing data and miscodes. Where data was missing or inconsistent, the values were imputed from other data in the database. For example, a missing age was estimated as the age of students in a similar year of study. Contextual checks were made on behaviour questions to avoid contradictory responses.

Demographic characteristics of respondents were compared between those answering the questionnaire but without an HIV result and those who agreed to both. Unweighted data was used in the comparison.

All subsequent tables are based on weighted data on respondents answering a questionnaire with a valid HIV test result. Quantitative data was compiled into tables based on analysis criteria determined by the study team. Estimates of HIV prevalence, significance values and confidence

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<sup>8</sup> 'A1, A2, A3' refer to the testing flow chart in Appendix 1

intervals were done in STATA 10 software (svy methods) which takes into account the complex survey design and individual weights. Significance testing was not done where cell sizes were small and use of the test was inappropriate. A p value < 0,05 was regarded as statistically significant.

Tables in the report present weighted data and unweighted counts.

Qualitative data was collected in the form of digitally recorded information that was then transcribed by professional transcribers. Data was translated into English wherever necessary. Transcriptions were reviewed and checked by researchers prior to analysis.

The qualitative study team read through transcripts and conducted a workshop to determine categories and codes for data analysis. The transcripts were then coded and analysed using NVivo software for qualitative data analysis.

## **2.9 Strengths and limitations**

### **2.9.1 Strengths**

- ❑ The national study comprises a very large sampled population that is representative of 21 HEIs offering contact education in South Africa. The sample is also adequate for reporting findings at an institutional level, albeit with less precision.
- ❑ The study design emphasised sound ethical practice and was granted ethical approval by all 21 HEIs.
- ❑ For the most part questionnaires were self-administered which has the benefit of confidentiality while at the same time overcoming potential mismatches and lack of trust that may occur between study respondents and field workers when questionnaires are administered on a face-to-face interview basis.
- ❑ High levels of participation were obtained among respondents who attended briefing sessions and the vast majority of respondents who completed questionnaires also provided DBS samples. Lecture periods were used for students who constituted the majority of the sample, and sampled students were not warned that the survey was taking place during their lecture. This limited the possibility of non-participation bias among students.
- ❑ While national household survey reports refer to difficulties in obtaining adequate participation from all race groups – for example, as a product of not being allowed entry into households in some areas<sup>9</sup> – the present HEI survey obtained high levels of participation among all race groups.
- ❑ The inclusion of a qualitative component allowed for deeper levels of analysis and interpretation of the quantitative findings.

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<sup>9</sup> Shisana et al. 2005.

- The qualitative component included a rich diversity of students and staff from four different campuses and extensive participation by HIV-positive students and staff, all of which enhanced the discussions' findings.

## 2.9.2 Limitations

- While institution-level sampling is adequate for reporting of findings, the overall sampling method was designed for a national-level study and alternative sampling approaches should be considered in a study design focusing only on a single institution.
- Deeper analysis of HIV at institutional level requires comprehensive understanding of HIV and AIDS response at the institution. The study was not designed to achieve such understanding. Complementary information was however gathered in parallel HEAIDS research and, in conjunction with other information available at institutions, the present study can be contextualised with a view to informing an overall understanding.
- The study timeframe was constrained by contracting requirements and it was only possible to conduct the field work between August 2008 and February 2009. Logistical arrangements were further hampered by the need to consider HEI vacations and exam periods. These factors impeded the smooth implementation of the study.
- The response rate at the University of KwaZulu-Natal was low, at just over 61%. It is not possible to assess to what extent participation bias may have influenced the findings. It was noted by field staff that as the study was conducted in part during Ramadan, Muslim students were not keen on providing blood specimens for religious reasons.
- Illiteracy and/or inability to clearly understand English or Afrikaans among a small subset of staff members meant that questionnaires could not be self-administered. In these instances questionnaires were completed via face-to-face interview or via small group administration.
- In all institutions, a small proportion of those who were sampled for the study were not present at scheduled sessions. While students were not warned that particular lecture periods would be used for the study, staff was generally aware that they were being requested to attend a session related to the study. Where sampled participants were absent from sessions, reasons for non-participation may have included illness as well as other commitments or constraints unrelated to the study. However, non-participation may have extended to a concern about the study and therefore a failure to attend the scheduled session. It was not possible to calculate to what extent this may have contributed to non-participation bias.
- At a number of institutions, students and academics were keen to engage with the study rationale and complexities of the study protocol and sampling approach. In some instances, especially with regard to academic and some administrative staff, this included critiques that resulted in blanket refusals to participate. Concerns were also voiced among a small subset of staff members that the study was not relevant for them because HIV and AIDS did not affect them. This resulted in alternative groups being sampled and this impacted on the smooth implementation of the study.

## SECTION THREE – FINDINGS

The following section reports on findings of HIV prevalence as well as knowledge, attitudes, behaviours and practices. Where relevant, staff have been categorised according to the nature of their work within the institution.

Tables related to biological measures report findings to one decimal point. Other data is reported without the decimal point to avoid the spurious inference of precision. Where numbers are too small to be statistically reliable, this is indicated with an asterisk in the tables.

The tables presented here are largely descriptive and it has not been possible to conduct deeper statistical analyses as a product of the relatively small size of the institution-level data. In addition, where the sample size is sufficiently large, the category of staff has been split into academic, administrative and service staff. However, in the case where numbers are small in these various categories, administrative and service staff have been collapsed into a single category. Categories have also been collapsed where biological risk factor analysis is done and staff category is not relevant to the analysis.

While tables might suggest apparent causal associations, the complexity of HIV infection and HIV risk are seldom adequately revealed in bivariate data analysis, and caution is therefore advised in drawing conclusions. Complex statistical analysis was conducted with the larger dataset that spans 21 institutions, and it is thus recommended that the separate national report be considered along with the present report when developing policy and strategy.

### 3.1 HIV prevalence by demographic factors

**Table 6 HIV prevalence among staff and students**

	Students		Academic		Admin		Service	
	n	HIV+	n	HIV+	n	HIV+	n	HIV+
<b>Institution</b>								
University of KwaZulu-Natal	1 072	2,4%	116	1,0%	89	5,5%	40	16,3%
<b>Sex</b>								
Male	426	1,9%	47	0,0%	51	8,7%	26	16,9%
Female	646	2,8%	69	2,2%	38	3,1%	14	15,7%
<b>Age group</b>								
18-24	961	1,1%	3*	0,0%	5*	16,7%	1*	0,0%
25-34	91	15,1%	21	5,8%	25	3,1%	7*	19,0%
35+	20	2,0%	92	0,0%	59	5,6%	32	16,0%
<b>Race</b>								
African	619	4,5%	20	4,5%	33	13,5%	20	28,7%
Other	453	0,5%	96	0,0%	56	0,0%	20	0,0%

\* = number too small to be statistically reliable

At the University of KwaZulu-Natal, the overall prevalence of HIV among students and staff is 2,8% [CI: 1,9%-4,2%].<sup>10</sup>

The prevalence of students living with HIV is 2,4% [CI: 1,5%-3,8%] and among academic staff it is 1,0% [CI: 0,1%-7,0%]. Prevalence of HIV is higher among administrative staff at 5,5% [CI: 1,7%-15,9%], and highest among service staff at 16,3% [CI: 7,3% - 32,6%].

**Table 7 Estimated numbers living with HIV and AIDS**

	Estimated total number	% HIV+	Estimated total number HIV+
Contact students	28 716	2,4	675
Academic staff (permanent)	1 531	1,0	15
Admin/Service staff (permanent)	2 731	8,8	240
<b>Total</b>	<b>32 978</b>	<b>2,8</b>	<b>930</b>

Based on HEMIS data, it is estimated that a total of 675 students, 15 academic staff and 240 admin/service staff at the University of KwaZulu-Natal are living with HIV.

**Table 8 Medical aid and HIV prevalence**

	Students		Staff		Students		Staff	
	n	%	n	%	n	HIV+	n	HIV+
<b>Medical Aid</b>								
Yes	1 072	56%	245	86%	563	0,8%	213	5,0%
No	1 072	44%	245	14%	509	4,4%	32	11,9%

\* = number too small to be statistically reliable

Just over half of students (56%) and most staff (86%) have medical aid. Among students who do not have medical aid, 4,4% are HIV positive, in comparison to 0,8% who are HIV positive and do have medical aid. Similarly, among staff, those without medical aid have higher HIV prevalence (11,9%), in comparison to the HIV prevalence of those that do have medical aid (5,0%).

<sup>10</sup> It is of some interest to note that of 2 749 people tested in VCT drives and by health services across all campuses of UKZN in 2008, 82 (3%) were HIV positive.

## 3.2 Sexually transmitted infection symptoms

**Table 9 Genital sores/discharge in the past three months**

	All	
	n	%
<b>Male (ever had sex)</b>		
Sore on genitals	403	4
Unusual discharge from genitals	403	2
<b>Female (ever had sex)</b>		
Sore on genitals	495	4
Unusual discharge from genitals	495	12

With regard to subjectively experienced symptoms of sexually transmitted infections in the past three months, 4% of males reported a sore on their genitals, while 2% reported unusual discharge. Among females, 4% reported sores and 12% reported unusual discharge. A member of the clinic staff reported in a focus group that the number of students presenting with STIs was unacceptably high. As the presence of an STI increases susceptibility to HIV infection, more education, diagnosis, and treatment of STIs is an important area for the institution to address.

## 3.3 HIV prevalence and reported sexual behaviours and practices

**Table 10 Sexual experience**

	Students	Staff
	%	%
	(n=1 072)	(n=674)
<b>Ever had sex</b>		
All	60	92
Males	62	94
Females	59	89
<b>Had sex in past year (of ever had sex)</b>		
All	86	83

Around two thirds of all students (60%) and most staff had ever had sex (94%).

The findings for students are similar to those in a study conducted among students in KwaZulu-Natal Province during 2007,<sup>11</sup> although with a higher proportion of African students (68%) in the sample. This study found that 70% of students had ever had sex.

<sup>11</sup> Mulwo et al. 2009.

**Table 11 Ever had sex - by age among students**

	Students	
	n	%
<b>Ever had sex</b>		
18	130	29
19	170	48
20	195	59
>20	577	75

Less than a third of students aged 18 had had sex before (29%). Sexual experience among students increases to 59% among those aged 20, and to 75% among those older than 20. This suggests that many younger students are likely to have their first sex during the period that they are at university.

Focus groups reported that many students arrive having been brought up under 'restrictive' parental surveillance; the norm of students having sex means that whatever home environment they have come from, they tend to soon become involved in sexual relations. This means that existing cultures of sexuality on campus are important in shaping students' approaches to sex. A female member of staff from Edgewood surmised that "the kind of culture in the residences is totally different from what is happening at the home environment." "Some of the things I do here I wouldn't do when I'm home. You find people actually lead double lives," added a student. A female student from Howard College said, "You come here and you are free and there is this world that you did not expect. Things are quite different from home and you want to experience everything. And in the process of experiencing everything, sex comes along, which your mother never told you about."

The first few years at university, and the first year in particular, were described as an 'experimental' or 'exploratory stage' where students are likely to have a number of different partners before starting to look for a serious partner to possibly settle down with 'in the senior years'. A male Howard College student described how "you can have up to 15 boyfriends during the period of a junior degree." Focus group participants described how they faced social pressure to have a sexual partner while at university. A female student from Edgewood remembered her experience arriving at university: "We saw lots of couples, so as a first year you wanted that boyfriend. I want a boyfriend. I want the whole campus to see my boyfriend." A male student described how males face this pressure as well: "You have to be seen as having a girlfriend. It's status."

For those who choose to abstain from sexual intercourse, religious motivation was given as the primary motivation. As campus culture is generally accepting of students having sex, in this context it seems unlikely that promoting abstinence is going to have a strong effect. Although in each of the age bands above there are students who have not had sex, they are likely to be under some pressure to have sex in relationships, given prevailing norms.

**Table 12 Reporting of same sex practices among students and staff in the last year.**

	Students		Staff	
	n	%	n	%
<b>Males</b>				
Male with male – MSM (of all males)	426	8	124	6
<b>Females</b>				
Female with female – WSW (of all females)	646	0*	121	1*

\* = number too small to be statistically reliable

Same-sex practices in the last 12 months were reported by 8% of male students and 6% of male staff. No female students reported same-sex practices, which were reported by 1% of female staff. Numbers are however too small to be statistically reliable.

**Table 13 Number of sexual partners in past 12 months**

	Students		Staff	
	%	% HIV+	%	% HIV+
<b>Partners in past 12 months (Of those who ever had sex)</b>				
<b>Males</b>				
0	14	4,5	13	0,0
1	35	3,7	69	7,8
>1	51	2,2	18	9,8
<b>Females</b>				
0	14	17,9	21	0,0
1	55	3,2	68	6,2
>1	30	0,8	11	15,2
<b>Partners in the past month (Of those who had sex in past year)</b>				
<b>Males</b>				
0	20	7,5	13	1,4
1	54	1,0	80	2,5
>1	26	2,9	7	6,4
<b>Females</b>				
0	21	8,0	13	0,0
1	77	7,6	81	9,3
>1	2	14,9	7	0,0

Among male students who reported ever having had sex, 14% had no sexual partner in the past year and 20% had no partner in the last month. Among female students who reported ever having had sex, 14% had no sexual partner in the past year and 21% had no partner in the last month.

Among male staff that reported ever having had sex, 13% had no sexual partner in the past year and 13% had no partner in the last month. Among female staff reported ever having had sex, 21% had no sexual partner in the past year and 13% had no partner in the last month. A finding of 23% on the same indicator was found in a 2007 study of university students in KwaZulu-Natal Province.<sup>12</sup>

<sup>12</sup> Mulwo et al. 2009.

Male students had much higher reported levels of having more than one partner in the past year (51%) in comparison to females (26%).

Both male and female staff reported being less likely to have had more than one partner in the past year as compared to students. However, the denominator in the present study is those who have ever had sex.

Around a quarter of male students (26%) reported having more than one partner in the past month, many times higher than female students and male and female staff, where this was 2%, 7%, and 7% respectively.

Prevalence of HIV was higher among male and female students who had had more than one partner in the past month (2,9% vs. 1,0%, 14,9%, 7,6%). This was also the case for male staff where HIV prevalence was 6,4% for those who had had more than one partner in the past month, in comparison to those who did not (2,5%). Among female staff, HIV prevalence was lower (0,0% vs. 9,3%), although there were only three female staff in this group, and no conclusions can be drawn from this.

It is noteworthy that HIV prevalence was highest among male and female students who reported having no sexual partners in the last year. This may be because they are aware of their HIV-positive status and hence abstain from sex in order to prevent transmission. This hypothesis is worth further investigation.

Qualitative findings indicate that it is common to have multiple partners, either in short-term relationships or concurrently. “It’s very rare for me to have met someone who does not at least have two people at one time,” said a female Howard College student.

**Table 14 Intergenerational sex among males and females**

Had sex in past year	All	
	n	%
<b>Males</b>		
Aged <=24, partner 10+ years older	202	5
<b>Females</b>		
Aged <=24 partner 10+ years older	309	3

Among students and staff aged 24 years or younger, a small proportion reported that their most recent sexual partner was 10 or more years older than themselves.

Focus group data provided evidence that there are students who are involved with older partners, which was most often described with regard to younger females being with older males. There are specific residences on campus that have a reputation for attracting older males, who park outside and “come to check on them.” University students are often targeted by older outsiders; as an example, a male student told how Westville Campus has a reputation among working professionals as having “nice girls there.” “If I’m a woman in my fourth year, I wouldn’t be interested in a first-year boy. But when it comes to the older men, for them I don’t think there are any limitations,” said one student. A staff member commented how many students are in relationships where there is “a big age gap, but they are quite happy.”

A female student described her motivation for dating older men who she perceived as more mature than her peers:

*I feel that I am at a point in my life where I need something serious, more stable, and I just don't see how somebody who has not started working, who has not found himself yet, can provide that. So that's the reason I am doing it, that's why most of the people I date are always older than me. But you do find people who do it because that's their only means of survival; it's their 'daily bread'.*

Participants from the three focus groups consistently described the primary reason for involvement with older partners in terms of economic gain. A female Howard College student shared how she has friends whose school fees are paid by married men, while others described receiving other benefits such as gifts, clothes, or alcohol from older partners or 'sugar daddies'. It was also said that 'sugar daddies' tend to seek out poor students, which gives them greater advantage: "It's an advantage for the guys who drive beautiful cars. He knows that he is going to be her financial support and then that girl is hooked, it's not hard," said a staff member from Westville.

Age differentials between sex partners also happen within the campus community, between senior and new students. In this case the age differences are not likely to be as much as 10 years, and thus are not reflected in the above table. First-year students were frequently described as 'vulnerable' or 'naive' and regarded as the most likely to date older students. "What you normally see is that a lot of girls tend to go for older guys," explained a Howard College student. A male staff member from Westville explained that first-year students are "easy targets" for Honours students who "can easily sleep with them." A female Edgewood student recalled how new students are sought after: "When we came here for Orientation Week, the people we saw were fourth-years that were more attractive than anyone else. But once the lectures started, you saw them with their girlfriends. And then you started to have second or third-years, everyone approaching you." For many, arrival at university marks a significant transition into a culture that is very different from their home environment; in the absence of supervision, the excitement and new-found freedom leads many students to get carried away or taken advantage of.

Education students from Edgewood campus described how four-week student practical assignments produced an environment that exposes many students to heightened HIV risk. One student explained how during student practicals, male teachers are seen driving 'all sorts of different cars' as they collect students from campus in the morning and drop them back off in the afternoon. Another female student told how teaching practicals "open us up to other people that we can engage with in sexual activities. As student teachers, we come in looking all 'glam' and for some godforsaken reason, we take the guys, the teachers from there, potential sexual partners which we probably wouldn't have seen if we didn't have teaching practice."

The increased sexual opportunity of practicals appears not to be limited to older teachers, but also involves young learners. Several examples were shared of secondary school students who tempt student teachers by wearing "these short skirts" for those four weeks or seeking "extra tuition in biology." "She's a Grade Nine and she's thinking about the teacher as someone that she can actually date and it makes you think. In the field, it's a common thing," explained a female student. Worryingly, there are male university students who will take advantage of this: "A group of girls will come with a group of student teachers to visit them on a Friday and they'll drink together and obviously, they'll... And the guys are actually really looking forward to this," according to a male staff member.

A male student shared how:

*Last year I was embarrassed because a Grade Eight student was here in my residence. I was going to take a shower and she was coming out of the shower. Grade Eight. From the same school where I was doing my teaching practice. She didn't know what to do. She said 'Morning Sir'. And it was like...*

Extensive preparation about HIV risk and professional codes of conduct should be incorporated into teacher training and disciplinary action should be taken in cases where students abuse their position with underage learners.

**Table 15 Most recent sexual partner by category**

<b>Had sex in past year</b>	<b>Students (n=583)</b>	<b>Academic (n=88)</b>	<b>Admin (n=71)</b>	<b>Service (n=30)</b>
No, not from this institution	69%	85%	91%	92%
Yes, they are my husband/wife who is at this institution	3%	14%	5%	8%
Yes, they are a student at this institution	28%	0%	4%	0%
Yes, they are a member of academic staff at this institution	0%	2%	0%	0%
Yes, they are member of the admin/service staff at this institution	0%	0%	1%	0%

The majority of students and staff who reported having had sex in the past year had most recent partners who were not from the institution. Among students, around a quarter had most recently had sex with other students (28%). There was very little reported sexual mixing between staff and students, with the exception of 2% of academics saying their most recent sexual partner was a student.

Focus group participants felt strongly that there is a high level of sexual activity happening between university staff and students: "They need to leave students alone," said a female student from Howard College. Participants reported many examples: of a lecturer being caught in a student's residence room, of another who gave his student girlfriend a parking disc and took her on trips overseas, of administrative staff who offers financial incentives, a lecturer who consulted the clinic about a student's intimate sexual health concern, and so on. A variety of reasons for such entanglements were offered; for most, some kind of favour was sought such as improved marks, a job, student housing, material gain, alcohol or to gain support for a leadership position. A Howard College student told how a friend of hers "is busy with someone in management who gives her money. Even people in management date students."

Participants regarded some advances from staff as unwelcome sexual harassment. A male student from Edgewood remembered escorting some of his peers to give protection from a lecturer who was "really coming on strong, so he wouldn't bother the students that much." There are also students that pursue relationships. A student said that with a "hard lecture like Geography, you would probably date the lecturer just to get the marks." A female student recalled a friend who told her, "There's nothing wrong with that. I like my lecturer and he likes me". A male staff member described the 'temptation' of receiving "a lot of attention from young girls. I think that especially in a residence setting, the temptation is high. Some of them do all sorts of strange things but it's up to you how you handle the situation."

Relationships with service staff, such as cleaners and security guards, also occur, especially towards month end. A student told how “the guys empty their little wages, buying [name of fast food brand] and so on. They will make an impression for a few hours.”

**Table 16 Age group, partner numbers and condom use at last sex**

Had sex in the past year	Students		Staff	
	n	%	n	%
<b>Males</b>				
18-24	197	68	5*	100
25-34	27	77	21	44
35+	6*	36	76	22
One partner in past year	112	62	81	22
>1 partners in past year	118	74	21	62
<b>Females</b>				
18-24	307	59	2*	0
25-34	35	42	23	42
35+	11*	23	62	19
One partner in past year	262	51	78	25
>1 partners in past year	91	66	9*	34

\* = number too small to be statistically reliable

The majority of male students and younger male staff reported using condoms during their last sexual encounter, as did younger female students. Condom use was higher among male students and staff who reported more than one sexual partner in the past year in comparison to those who had had only one partner (74% vs. 62%,  $p=0,1$ ; 62% vs. 22%,  $p<0,001$ ). This also applied to female students (66% vs. 51%,  $p = 0,01$ ; 34% vs. 25%,  $p = 0,6$ ).

The qualitative data indicated that students in relationships tend to stop using condoms after a few weeks of protected sex (once they “start feeling stable”) and it is rare to find established partners regularly using condoms. The likelihood of using a condom is greatest in casual or new sexual relationships. In one sense, the perception is that casual and new sexual partners pose the greatest risk is positive, and this may guard against risks of infection in concurrent relationships where condoms are used with the less regular partner. However, it poses a risk for those in established relationships who only have one partner but whose partners have other partners. A female student described the sexual risk of stable relationships:

*That’s the sad part, because you never get HIV from someone you don’t trust, because that is when you are vigilant. You only get it from somebody that you do trust, because I will never take a one-night stand and sleep unprotected. So I don’t understand why people don’t get that; you only get it from somebody you trust enough, too late.*

Students from Howard College described how the responsibility for providing condoms usually belongs to men. “Guys would carry condoms with them wherever they go, but we never carry condoms around. Right now I don’t have a condom in my purse,” said a female student. Males were said to often initiate condom use as well; and if they don’t (because “in reality, sex is different with a condom”), many females will “just sit there and close their eyes” rather than insist on condom use. A female student described how it is easy to talk to one’s friends about sexual issues, but harder to discuss them with a partner. A female staff member felt that “in South Africa there is a

culture that men are supposed to be the ones who initiate sex and females are supposed to be submissive and not show an interest in sex, as they will be viewed as promiscuous.” These examples point to a strong need for the institution to address female assertiveness as a prevention focus.

It was reported that students clearly take condoms, given that dispensers consistently need to be refilled. Impressive campus statistics revealed that the university distributes over a million condoms each year,<sup>13</sup> in large part due to the strategic employment of a staff member who oversees this process. Participants described that for many the motivation to use condoms is to avoid pregnancy rather than HIV; “When there is no condom used during sex, they always say that they are afraid of pregnancy but they never think of HIV,” said a staff member from Howard College. There are members of the campus community who perceive the ‘aftermath’ of becoming pregnant as carrying greater consequence than being infected with HIV. There are students who appear to use emergency contraception as their preferred method of birth control; “we have cases where students would come in even five to six times for the ‘morning-after’ pill,” said a staff member working in student health. The use of non-prophylactic birth control further reduces the likelihood of condom use, as explained by a male Westville student: “In a relationship where the girl is using contraceptives maybe they feel the need for condoms is not necessary.” Given this, dual forms of protection should be robustly encouraged by campus health service staff, to counteract the notion that taking hormonal birth control supersedes the need to use condoms.

Statistics from the campus health service<sup>14</sup> show high rates of pregnancy across UKZN’s campuses (“it’s high, it’s really high”), indicating that not all students are using condoms or using them consistently (“people use condoms, but not all the time”). A female student said, “When you look at the high rates of pregnancy, you ask yourself ‘What are people doing? They use the condom today and tomorrow it’s okay? Then the following day it’s a condom’.” A staff member told how there are more requests for pregnancy tests following period breaks, such as the July and December holidays, and following student practicals. She also described how abortion is casually regarded: “Termination of pregnancy is nothing for them. As soon as you diagnose them, they don’t even think of it [and ask] ‘Can I terminate...?’.”

Some students become pregnant (apparently at the Medical School and Edgewood Campus in particular), feeling it’s “not a big deal to be a parent” or worrying that they’ll be too old when they finish their course, often giving the infant to someone else to raise. “They’ve got ‘Edgewood babies’ now. That’s how common pregnancy is,” said a male participant. A staff member involved in HIV and AIDS felt the university should therefore emphasise to students that becoming a parent is “a big responsibility. It’s *yours*.”

Ever since the controversy regarding the quality of the Department of Health’s free condoms, Choice, they have not been popularly regarded by students and staff. The staff member who oversees condom distribution described how “nobody wants Choice,” they don’t need to order them

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13 1 018 451 condoms were distributed in 2007 and 1 067 685 in 2008, according to the UKZN AIDS programme.

14 According to the UKZN AIDS Programme, in 2007, 777 students tested for pregnancy, 646 requested emergency contraception, and 394 pregnancies were confirmed, of which 147 were carried to term. The figures in 2008 were slightly lower: 539 students had pregnancy tests on campus and 329 turned out to be pregnant, of which 284 were referred for termination.

as frequently as before, and students would like to see another kind of condom available on campus. Many students prefer to purchase other brands from pharmacies; when Choice is all that is available, apparently some will have unprotected sex rather than use Choice. A recent study<sup>15</sup> conducted at seven university campuses in KwaZulu-Natal, including five of the University of KwaZulu-Natal campuses, strongly confirms these findings, noting the perceived fallibility of Choice condoms, their off-putting smell and their unappealing branding.

Female condoms are freely available from the campus health service, but can only be given out after the student or staff member has received an explanation of their correct use. There is a lack of awareness about and interest in using female condoms, according to discussion participants.

It was reported on two campuses that as an alternative to condom use, there are some students who engage in 'thigh sex', with the added motivation of some to protect virginity or avoid pregnancy. Other sex practices mentioned as ways of avoiding HIV infection included self- and mutual masturbation, oral sex and 'withdrawal' (to avoid ejaculation and supposedly also to prevent pregnancy).

**Table 17 Perceptions of sexual partners**

Had sex in past year	Students		Staff	
	n	%	n	%
<b>Male</b>				
I believe that my most recent sexual partners have also had other sexual partners in the past month (of had sex in past year)	230	28	102	7
Many of my friends have more than one current sexual partner (of all)	426	30	124	13
I am often tricked or pressurised into having sex when I don't want it (of had sex in past year)	230	4	102	8
I often expect money or gifts in exchange for sex (of had sex in past year)	230	3	102	2
<b>Female</b>				
I believe that my most recent sexual partners have also had other sexual partners in the past month (of had sex in past year)	353	20	87	12
Many of my friends have more than one current sexual partner (of all)	646	14	121	6
I am often tricked or pressurised into having sex when I don't want it (of had sex in past year)	353	9	87	1
I often expect money or gifts in exchange for sex (of had sex in past year)	353	1	87	0

Around a quarter of male students (28%) and a fifth of female students (20%) believed that their most recent sexual partner had also had other partners in the past month. This was also reported by 7% of male staff and 12% of female staff.

Around a third of male students (30%) and 14% of female students believed that their friends had more than one current partner. This was noted by 13% of male staff and 6% of female staff.

15 Mulwo et al. 2009.

Multiple and concurrent partners were frequently mentioned in the qualitative study; that one may have a main or 'straight' partner, while seeing additional people 'on the side'. "The boyfriend is long-lasting, steady; here she might be just exploring to find out what it is like to date someone else," explained a male Westville student. Partners from 'home' tended to be seen as ongoing and these relationships tend to continue over periods of time, although opportunities to be together are intermittent. In the interim, the student will have relationships at university and this may mean that the student effectively has more than one steady partner.

A staff member from Howard College described how different needs are fulfilled by different types of relationships: "Some of them will provide transport, someone finances, you know, and then the other one is good in bed, the other one, so it becomes quite a few."

Discussion participants described how there are students involved in long-term stable relationships on campus, though they may be in the minority. A male student from Edgewood felt that:

*In most cases there is a lot of cheating involved in those relationships; mostly with [by] the guys. I know a lot of people who have been tight [in an established relationship] since my first year here, but I know a lot of stories about them and other girls they've slept with outside the relationship. You may not go for a long relationship with someone else, but you do have someone else on the side.*

Acceptance of this risk behaviour among people on campus seems to have an element of resignation to it, that infidelity is an inevitable part of a relationship. Several students described how a female who knows she is the "'regte cherrie', the one, the right one, the wifey" will overlook that her partner sees other women because "I know that he will always come back here. He can play around with the little first-years when they come, but around March, April, he's coming back to me."

While 4% of male students said they felt tricked or pressurised into having sex when they did not want it, more than twice as many females agreed with the statement (9%). In the case of staff, 8% of males agreed in comparison to 1% of females.

Focus group participants provided several examples of sexual coercion; for example, when "the guy thinks that the girl is interested and ends up forcing the girl." Sometimes pressure is experienced more subtly than outright date rape, as when a partner lacks the confidence to speak up for themselves. A female student from Howard College described how, "When they are younger, they don't know that they have control of themselves and have the power to say no and to stand for what they want." It was also suggested that poorer students may have less assertiveness to negotiate sex than those with more resources and assertiveness. A female student explained that "in our social upbringing, men are always seen as the providers. We come from different places of bargaining; I don't have to sit there and have sex with a man if I don't want to but that's because of the bargaining position I am coming from."

Only a small proportion of male students, female students and male staff mentioned expecting money or gifts in exchange for sex. The qualitative data suggests, however, that even if not expected, material support is a strong component of many sexual relationships.

It is common that students approach relationships and potential partners in terms of what they can provide. A Howard College student explained that dating is more about "'what am I going to gain'; it's not really a love factor anymore. That's a big dynamic in terms of how people approach their sex life - is there something beneficial?" A male student shared how a friend of his "asked a girl to

go out with him and the girl said ‘Do you have money? Do you have a car?’ He said ‘No’ and the answer [from her, about going out] was ‘No’.” There were a number of other examples provided, confirming the importance of ‘benefits’.

Sexual relationships characterised as having a transactional element were described in all three discussion groups. This was mostly described in terms of female students being the beneficiaries of gifts such as groceries, transport, alcohol, money, or academic fees in exchange for sexual favours. When students find that their peers do not have the resources they desire, they will often look to additional older partners (‘sugar daddies’), particularly from outside the university. A female student told how “your stable boyfriend, probably he can’t provide for you as much as the sugar daddy.” A female Howard College student said the practice is common:

*You’ll be surprised at what people give. Personally I have had people who give me money on a regular basis. It’s common, it’s not abnormal, they are willing. I will not lie, you’re not talking small amounts, we are talking about people who are willing to do your groceries for you. A girl I know was bought a car by a guy, they do that level of stuff.*

Poorer students are more vulnerable to being enticed into relationships for material gain, especially since entertainment and alcohol cost money and social desirability is mediated by what money can provide access to. A female student described how there are students who engage in transactional sex “as a means to survival;” if they don’t, “they will not eat.” The desire to possess social status means that wealthier female students are also among those involved in relationships with off-campus ‘sugar-daddies’. A female student from Howard College described this:

*It’s worse for people who need it and rely on this. I feel that I have more bargaining power than some first-year who comes from a poor family background and is not getting financially supported or has not found her feet in varsity so now she is relaxed. So I feel like I have a bit more bargaining power, I can tell him to ‘jump’ if I really don’t want something.*

She went on to say that “If you are not providing, [the man will say] ‘you must have sex with me or you will not get’, you must now play along. I think that we do it as females; I think it’s sad but it is our reality.”

**Table 18 Attitudes to casual sex, multiple partners and transactional sex**

	Students n=1005		Staff n=533	
	Males	Females	Males	Females
I believe that it is acceptable to have a one-night stand (agree/agree strongly)	32%	3%	13%	11%
It is acceptable to me for a man to have more than one girlfriend at a time (agree/agree strongly)	13%	1%	15%	4%
It is acceptable to me for a woman to have more than one boyfriend at a time (agree/agree strongly)	3%	1%	9%	2%
I believe it is acceptable for students to have sex for money to support their studies (Disagree/Disagree strongly)	6%	0%	3%	1%

Among both students and staff there was an overall negative attitude towards promiscuous sexual

behaviour, but it is notable that 32% of male students agree and 13% of male staff agree that it is acceptable to have a one-night stand.

There was a stronger overall strong disagreement with males and females having multiple partners and of students having sex to support their studies. Among both student and staff males it is more acceptable for a man to have more than one partner at a time than for a woman to have more than one partner. However, about one in eleven male staff found it acceptable for a woman to have more than one partner. It is also relevant to note that there are some male students and staff that find it acceptable for students to have sex to support their studies.

Focus group participants discussed how casual sex is common across campuses. A female Edgewood student explained in simple terms, "People just want to have sex. Whether there's a bash at school and there's been music and alcohol, or financial aid has just come out and we see people bringing bags with bottles clanking, people want to have sex." Casual sex was described in terms of short-term relationships, alcohol-induced one-night stands or 'friends with benefits' arrangements, where a distinction between sex and love is made: "it's just my sex buddy, it doesn't mean I love him" or, "You just hook up to kiss or have sex or go out but there's no relationship," said students from Howard College and Westville.

Participants felt that university residence environments are particularly conducive to sexual opportunity; "when you come into res, it's really about sex" said a male Edgewood student. Day students were felt to be less likely to be involved in casual sex partly due to their lessened opportunity, though it was reported that residence students will sometimes loan or even rent out their rooms to day students to use for sex.

A staff member described how multiple concurrent partnerships are a 'big problem' at UKZN and that there is too much acceptance of it: "guys will even cover for each other, while girls know it's happening and accept it." He felt that peer pressure to be in a relationship is so great that it leads students to "keep them at all costs," even when their partners are not faithful. A female student from Edgewood explained that sexual partners often look for different things in a relationship, that "girls go into those relationships thinking, 'okay we're gonna have a relationship'" while males just "want to have fun."

Competition among males was described, with one's popularity measured by their number of sexual partners. A staff member from Westville explained, "They want to be respected by the other guys. If you've got good skills in terms of getting the beautiful women, the guys respect you, they say 'uyiskhokho', meaning you are a player, you got great style. And if you're known to be a player then women tend to fall easily for you."

Qualitative findings suggest that having a generous partner or 'sugar daddy' is widely accepted among students. "Everyone wants to be seen with the best car, best man. When you come back, you want to be seen with plastics from [name of supermarket]. A lot of people would rather have it with people who live off-campus and have cars," explained one female student. She continued,

*Here on campus it's a known fact that some girls sleep with people for money. And it's just becoming normal. When someone spends on you, you feel that you owe that person something, you feel compelled that you have to sleep with this person because he is doing everything for you. Guys they take advantage of that.*

**Table 19 HIV testing**

	Students		Academic		Admin		Service	
	n=1 072	%	n=116	%	n=89	%	n=40	%
Ever had HIV test	1 072	37	116	76	89	57	40	53
HIV test in past 12 months (of ever tested)	441	78	86	40	52	52	18	65
Ever been tested at this institution	1 072	24	116	11	89	19	40	13

Around a third of students (37%) and around half to three quarters of staff had ever been tested for HIV. Of those who had ever been tested, around three quarters (78%) of students had been tested in the past year. Around a quarter of students (24%) had ever been tested at the institution, as had 11% of academic staff, 19% of administrative staff and 13% of service staff.

Focus group discussions reported nervousness on the part of students about finding out their HIV status. Some described that it is better to test after they've completed their studies, claiming that they are not "psychologically stable" at the moment. Others have the sense that "deep down, they know" they are HIV positive and would rather wait until they experience symptoms before testing or feel that testing positive will suddenly make them sick: "They say they don't want to kill themselves," said a female student. This kind of thinking angered one staff member, "because they might not be [HIV positive]. But because they know the sexual partners they've had, because they sleep with every Tom, Dick, Harry and Siphso, so they seem to think 'Oh my God...'"

Another member of staff involved in VCT felt that most people who test on campus are relatively confident about their sexual behaviour, while some feel safer going off campus, and others will never test anywhere, due to their own denial. It is of some interest to note that of 2 948 people tested in VCT drives and through the campus testing services in 2008, 85 (3%) were HIV positive<sup>16</sup>. A student thought that to counteract the idea that "HIV kills," messages like "You can live a long time with HIV" should be underscored. Participants felt that if there were more HIV-positive people who discussed their status in the open, it would encourage more people to test. But due to the stigma on campus, "people are shy."

The counselling process itself was cited as another reason why more people don't test. Participants felt that VCT should be offered on a 'drop-in' basis, as the current system of waiting for an appointment discourages some from testing. The offices that are used for VCT are apparently stigmatised: "When you go there, definitely, you are HIV positive." Campus testing drives featuring external service providers were viewed positively for normalising HIV testing. It was felt that with more staff capacity, UKZN would be able to test more people. There are plans to incorporate a mobile testing unit to increase access to this service.

Perceptions of stigma and gossip on campus remain a disincentive to knowing one's HIV status and the perceived risk of disclosing to others in the campus community is great. A male Westville student said that students "would not want to be near them for fear of being infected if their status

<sup>16</sup> Campus statistics were provided by the UKZN AIDS Programme.

were to be revealed, I think that's how people would react to it.” A female student said that it was easier for HIV-positive students to keep their status private. That way “everyone treats you the same as everyone else.”

### 3.4 Social practices

**Table 20 Frequency of alcohol consumption**

	<b>Students</b> (n=1 072)	<b>Staff</b> (n=245)
Never drink	44%	41%
Once a week or less	50%	42%
More than once a week	6%	18%
Drunk in past month	32%	21%
Attend alcohol venue (bar, shebeen, nightclub) once a week or less	52%	38%
Attend alcohol venue (bar, shebeen, nightclub) more than once a week	3%	2%

Around two fifths of students (44%) and staff (41%) of both sexes reported never drinking. While half of all students (50%) and around two fifths of staff (42%) reported drinking once a week or less, around a third of all students (32%) and around a fifth of staff (21%) reported being drunk in the past month. This data must not be taken as an indication that alcohol use is not a significant contributor to HIV risk. Occasional high levels of alcohol intake rather than regular drinking appear to be the most notable pattern and it is significant that a third of students and a fifth of staff have been drunk in the past month.

More than half of students attend a venue where alcohol is served once a week or less, although much lower proportions of students (3%) and staff (2%) do so more than once a week.

Qualitative data suggests that there is a campus culture of excessive drinking on weekends and at campus ‘bashes’. Older students may be more likely to socialise at clubs in Durban or at house parties than newer students, who are more likely to initially socialise on campus. Participants at the Edgewood campus indicated that there is a lack of recreational opportunities available to resident students, which exacerbates a party culture.

Excessive drinking often leads to unplanned, casual and unprotected sex which would probably not otherwise occur. “Most students go to bashes and that’s where they use alcohol and that’s where they engage in sexual activities when they are drunk,” said a staff member from Westville. A Howard College student described how alcohol contributes to a friend’s involvement in casual sex: “So every time we went to a party she would sleep with somebody and yet she has a boyfriend. She sleeps with different people; it doesn’t matter whether they dating or not, if they just like each other then they can do it.” Participants were aware of drinks being ‘spiked’ at bashes.

Clinic staff described how STI incidents and requests for pregnancy tests and emergency contraception are higher following large university ‘bashes’, such as during orientation, suggesting that alcohol consumption increases the likelihood of unprotected sex. Participants said that condoms were not available at bashes.

**Table 21 Recreational drug use in the past month**

	<b>Students</b> (n=1 072)	<b>Staff</b> (n=245)
Marijuana/dagga	9%	4%
Mandrax / white pipe	0%	0%
Ecstasy	1%	0%
Cocaine powder	1%	0%
Cocaine rocks / crack cocaine	0%	0%
Tik / methamphetamine	0%	0%
Cat / Methcathinone	0%	0%
LSD / Acid / Hallucinogenic drugs	0%	0%
Heroin	0%	0%
Have you injected any drug in the past month – for example heroin?	0%	2%

Very little recreational drug use in the past month was reported by students with the exception of marijuana, which is used by 9% of students and 4% of staff. A small proportion of staff reported injecting drug use (2%).

**Table 22 Attitudes related to alcohol and drug consumption by students**

	<b>Students</b> (n=1 072)	<b>Staff</b> (n=245)
It is acceptable for students to drink alcohol on weekends	62%	38%
Students should not drink alcohol at all	21%	30%
It is acceptable for students to use marijuana/dagga	11%	8%
It is acceptable for students to use drugs like cocaine	3%	3%

Around two thirds of students (62%) and around two fifths of staff (38%) felt that it was acceptable for students to drink on weekends. In comparison, around a fifth of students (21%) and around a third of staff (30%) felt that students should not drink alcohol at all. There was a low acceptance of hard drug use, although students and staff were more inclined to be accepting of marijuana use. A focus group participant discussed how students are influenced by their social backgrounds, which for many have a high acceptance of alcohol and dagga.

### 3.5 Knowledge, attitudes and relation to HIV and AIDS

**Table 23 Basic HIV and AIDS knowledge**

	<b>Students</b> (n=1 072)	<b>Academic</b> (n=116)	<b>Admin</b> (n=89)	<b>Service</b> (n=40)
The more sexual partners you have, the more likely it is that you will be infected with HIV (True)	91%	92%	87%	84%
You can be infected with HIV by touching a person who is HIV positive (False)	93%	92%	91%	76%
A mother can pass HIV on to her baby through breastfeeding (True)	66%	69%	50%	46%
If a person is raped, there are drugs available that can prevent HIV infection (True)	58%	80%	66%	55%
It is against the law for a girl younger than 16 to have sex with a much older man, even if she agrees to it (True)	86%	86%	73%	77%
There are drugs available called antiretrovirals that can help people with HIV and AIDS live longer (True)	92%	92%	89%	87%

Although most respondents provided correct responses to basic HIV and AIDS knowledge questions, there were noteworthy gaps in some important areas. Knowledge of HIV transmission via breastfeeding was inadequate with only around two thirds of students and academic staff, and half or less of administrative and service staff answering correctly. Knowledge of prophylactic HIV treatment for people who have been raped was similarly inadequate among students, administrative and service staff.

Though students and staff evidently have basic knowledge about HIV and AIDS and “will tell you all the right things,” focus group participants shared that most people still don’t perceive themselves to be at risk of getting infected. A female student felt that most people are scared of HIV, but think that it’s “somebody else’s [problem], not mine.” “They don’t personalise it, that’s the only reason why they don’t protect themselves,” said a staff member from Howard College. Furthermore, students from the Medical School felt that their peers are unlikely to perceive their own HIV risk; though knowledgeable about health science, they still “don’t want to know their status.”

**Table 24 Attitudes related to HIV and AIDS**

	<b>Students</b> (n=1 072)	<b>Academic</b> (n=116)	<b>Admin</b> (n=89)	<b>Service</b> (n=40)
It is a waste of money to provide further education to someone who is HIV positive (Disagree/Disagree strongly)	89%	93%	86%	80%
If I told my friends at this institution that I had HIV, most of them would support me (Agree/Agree strongly)	40%	44%	41%	28%
If a teacher has HIV but is not sick, she/he should be allowed to continue teaching (Agree/Agree strongly)	91%	89%	84%	81%

Attitudes related to HIV and AIDS among students and staff were overall supportive of people living with the disease. However, less than half of students and staff felt that they would be supported by their friends at the institution if they were living with HIV, with lowest levels of agreement being found among service staff.

Focus group participants felt that the institutional culture is not supportive to HIV-positive people, “it becomes a problem for somebody to come out of the denialism, only to end up completely isolated,” said a Howard College student. A male Westville student said, “I don’t blame them [for not disclosing] because they will be open to so much criticism.” An example was given of a student who publicly disclosed her status on Edgewood campus and faced pity from the campus community; this was seen as possibly discouraging other HIV-positive people from disclosing. A Howard College student described how the university is a reflection of society: “The stigma that is suffered by people who are HIV positive, it is the very same one within the campus; it is not easy.”

A Westville staff member felt that the exceptional consideration given to HIV and AIDS reinforces the stigma associated with the disease. She felt that HIV testing and treatment should be more routine: “It’s a chronic illness. We don’t fuss about asthma and epilepsy, so why this?”

**Table 25 Experiences related to HIV and AIDS in community and institution in the past year**

	<b>Students</b> (n=1 072)	<b>Academic</b> (n=116)	<b>Admin</b> (n=89)	<b>Service</b> (n=40)
Someone I know personally has told me that they are HIV positive	16%	23%	25%	28%
Someone I know personally has died of AIDS	25%	30%	29%	29%
I know of a student or staff member at this institution who has died of AIDS	5%	31%	15%	11%
I have provided care to an HIV-positive child or adult in my household	6%	8%	5%	2%
I have missed classes or work to attend a funeral of a person who has died of AIDS	4%	7%	7%	8%
I have attended a meeting or function about HIV and AIDS at this institution	25%	27%	12%	20%
I have received information in the form of leaflets or booklets about HIV and AIDS at this institution	62%	48%	52%	41%
I have obtained free condoms at this institution	63%	36%	40%	43%
I have worn a t-shirt, cap, red ribbon or other item of clothing with an AIDS message at this institution.	18%	27%	28%	15%
I am a member of an HIV and AIDS club or organisation at this institution	4%	3%	0%	2%
I have been involved in conducting HIV and AIDS research while I have been a student or have been working at this institution	14%	22%	7%	6%

In the past year, one in six students and around a quarter of staff had been told by someone they personally knew that they were HIV positive, and a quarter or more personally knew someone who died of AIDS.

There was very low awareness of student and staff members at the institution who had died of AIDS among students, although this was higher among staff, including around a third of academic staff (31%) agreeing with the statement. A small proportion of students and staff reported providing care to an HIV-positive child or adult in their household, or missing classes or work to attend a funeral of a person who had died of AIDS.

There were varying levels of engagement or exposure to AIDS activities, AIDS communication or related resources at the institution. In comparison to staff, students were more likely to have received information about AIDS, or obtained free condoms from at the institution. A staff member involved in HIV and AIDS response felt that when awareness events are held, usually “only ‘black’ students come. The others would just shy away.”

Focus group participants felt that prevention messages would be more effective if they were presented in an engaging manner, such as through interactive drama or thoughtful discussions that would help people internalise the message. A male staff member blamed the way HIV messages are presented “because they don’t open a chance for them to actually debate and talk about it; that’s what we need to do. They just say ‘here is the thing, so take it or don’t take it.’” A Westville student told how the previous day he’d seen people at the library handing out booklets about the consequences of having sex: “Everyone threw it aside. No one looked at it. Some people even made paper airplanes out of them.”

The peer education programme was positively regarded in the focus groups. A male student from Howard College suggested that creating a system of incentives would help ensure commitment from students to stay involved: “The university should commit some resources to create an atmosphere for these peer educators to be acknowledged.”

Qualitative participants felt that the brief orientation programme is not sufficient for helping students transition to university: students need to be supported throughout their higher education, not just when they first arrive on campus. A male staff member said that second-year students also “don’t know how to cope, but we leave them on their own.”

An innovative prevention effort that emerged was the UKZN AIDS Programme’s development of HIV and AIDS prevention material in Braille. While the particular needs of disabled people have gone largely unnoticed in prevention programmes, this initiative is a model to other institutions and will help ensure that blind students and staff can more easily learn about HIV prevention and care.

All institutional categories reported some involvement in HIV and AIDS research including more than a fifth of academic staff (22%). Participants felt it would be useful to carry out research within the university community to ensure that relevant prevention and care messages are delivered and to increase participation.

**Table 26 Perceptions of institutional response to HIV and AIDS**

	<b>Students</b> (n=1 072)	<b>Academic</b> (n=116)	<b>Admin</b> (n=89)	<b>Service</b> (n=40)
The management of this institution take HIV and AIDS seriously (Agree, Agree strongly)	55%	51%	65%	46%
The student leaders of this institution take HIV and AIDS seriously (Agree, Agree strongly)	47%	44%	-	-
There should be more emphasis on HIV and AIDS in academic classes at this institution (Agree, Agree strongly)	59%	69%	-	-
If you discovered you were HIV positive, is there a place at this institution you could go for help and support (Yes)	75%	60%	60%	55%

Around half or more of students, academic and administrative staff felt that university management take the problem of HIV and AIDS seriously, although this was lowest among service staff (46%). Qualitative findings revealed a perception that senior leadership is supportive in some ways (as evidenced by the number of HIV and AIDS research initiatives) but see more potential for leaders to demonstrate their commitment to HIV and AIDS response by personally speaking out about the issue or supporting VCT drives by testing publicly, for example.

The UKZN AIDS Programme has a campus support unit on each campus. These units provide a platform for HIV and AIDS activities, debates, forums, and care and support to take place. Most prevention services are aimed at students and there is not a formal workplace HIV and AIDS programme for staff. Focus group participants felt HIV and AIDS was seen as the sole responsibility of these units, that there is little involvement from other departments, and that the institution's HIV and AIDS response should be driven centrally, rather than from one programme.

Less than half of students and academic staff felt student leaders took the problem of HIV and AIDS seriously. Focus group participants felt that the Students' Representative Council (SRC) should have fewer bashes and do more to raise awareness about HIV and AIDS.

The majority of students and staff agreed that there should be more emphasis on HIV and AIDS in academic classes at the institution. Focus group participants from Edgewood felt that there was little integration of HIV and AIDS in their curriculum but they had found ways to include HIV in their own studies. Howard College staff told how many academic staff on that campus have not been receptive to having the unit make presentations about HIV and AIDS in lectures; another staff member felt that academics reached out to the HIV support units for research purposes, but seldom attended HIV and AIDS events. A female student from Edgewood agreed that lecturers should be more concerned about HIV and AIDS and said:

*The lecturers don't care. The reality is we are going to face those problems. There are HIV- positive people that we are going to meet; teachers. There are kids that are going to be HIV-positive. But we are not prepared for that situation. So they need to be workshopped so that we cover that.*

Three quarters of students (75%) and more than half of staff knew of a place at the institution where they could go for help and support if they discovered they were HIV positive.

For HIV-positive people who know their status, fear of stigmatisation is a strong obstacle to utilising available psycho-social and health care support. Qualitative research indicated that the fear of being publicly identified as HIV positive creates resistance to accessing campus services as the perception exists that "only HIV-positive people" go to the HIV and AIDS support units. The risks of being seen as HIV positive in this context creates the likelihood of losing friendships, inviting unwanted pity, and being unable to engage in courtship and relationships. One student said that "if you're going to pronounce that you are HIV positive then it means you are not going to have a boyfriend because nobody is going to have the courage to approach you."

A female staff member from Edgewood gave an example of a student who resisted asking for help and whose student companions also did not respond to his obvious need for help:

*He was so ill he couldn't even walk. I don't care that he's got AIDS or whatever he had, but the students around him totally ignored him. We had to cook for him; he couldn't even cook his own food. And he didn't want to go home, he didn't want us to phone his parents. It worked out that he had TB, a very bad state of TB. I mean, why didn't he come to me and say, 'I need someone to help me'? Students still feel that they don't want to come forward. We gave him food, we brought him to Sister [name of health service member] and he still didn't want to go home. Eventually his parents took him home. But he had a student living with him in the room, and that student didn't even come to me and say, 'this student needs some assistance'.*

It appears that the stigma and fear of HIV prevent people from seeking help and helping each other, even when the need for help is blatantly apparent. It was said that only the most self-driven HIV-positive people access the clinic and HIV and AIDS support units, with most feeling that the risk of being stigmatised is too risky.

There are no formal support groups for HIV-positive people at UKZN, except at the Edgewood campus where a group of 'affected' (though not necessarily infected) students meet on a regular basis to discuss HIV and AIDS. There is also a small group of HIV-positive students that meets in private on their own initiative. Other campuses have been unsuccessful at facilitating support groups, as HIV-positive students were said to find it difficult to talk to their peers and choose to handle their status privately rather than access support from the HIV unit. In lieu of a formal group, VCT counsellors sometimes connect HIV positive students with each other to give informal support. It is evident that there are a significant number of people who know they are HIV positive and are disconnected from any campus-based system of positive support.

The campus health service provides counselling, nutritional supplements, treatment for TB, STIs and opportunistic infections and makes referrals for antiretroviral treatment [ART] to McCord hospital. The UKZN AIDS Programme covers treatment costs for students who need it; in 2008, 35 students were on ART and 16 were referred to begin treatment.<sup>17</sup> Campus clinics are in high demand and it was reported that HIV-positive staff and students may struggle to get appointments. A male staff member raised an important concern that HIV-positive students need food and other assistance in order to manage their health, not just ARVs:

*Sometimes we run a fragmented service to people who are enrolled in this ARV treatment; we provide ongoing support in terms of counselling and so on but what about food? How can you take the medication without having something in your stomach, you understand? So if maybe as service providers, we can be empowered that we render a total and complete service to them then it might be better. To say what's happening academically, what's happening in terms of your fees, food, do you have food and so on.*

A male staff member explained that there is no logical place for staff to go for social support and no employee assistance programme to assist staff with alcohol problems or HIV and AIDS. Staff need a letter explaining why they need time off to access ART; without it, their pay gets deducted. HIV-positive staff must then disclose when they wouldn't otherwise and often to supervisors who are not well trained in HIV and AIDS management. This was identified as an issue needing to be addressed.

There was also some concern expressed about the plight of outsourced employees. Questions were raised by one staff member involved in providing HIV support services at UKZN, about the responsibility of the university to people with HIV and AIDS and the influence it might have on agencies it contracts. As an example, it was said that some companies do not allow their staff to attend VCT campaigns run on the campus during working hours, and the staff members of such companies may have little appreciation of HIV issues. It was felt that the university should insist on

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<sup>17</sup> According to the UKZN AIDS Programme.

some form of 'HIV compliance' policy for the companies it contracts, relating to HIV education, sensitivity of employees to HIV issues and rights of HIV-positive people in those companies.

**Table 27 Perceptions of institutional safety**

	<b>Students</b> (n=1 072)	<b>Academic</b> (n=116)	<b>Admin</b> (n=89)	<b>Service</b> (n=40)
I feel safe from physical harm at this institution (Agree, Agree strongly)	62%	65%	55%	60%
Female students are safe from sexual harassment at this institution (Agree, Agree strongly)	36%	33%	32%	35%
Violent crime where people are physically injured is a serious problem at this institution (Agree, Agree strongly)	14%	18%	17%	22%

Agreement with the statement “I feel safe from physical harm at the institution” was only expressed by less than two thirds of students and staff. Only around a third of students (36%) agreed that female students were safe from sexual harassment, as did a similar proportion of staff.

Perceptions of risks of violent crime were present, and were lowest among students (14%) and highest among service staff (22%).

Focus group discussions pointed out that gender-based violence occurs on campus, including date rape and partner abuse. Disciplinary processes on campus were not regarded as having an important role in campus life. Communication of disciplinary outcomes is important, given the current situation where many are reluctant to report instances of sexual harassment and rape. A male staff member from Westville explained, “I think that sexual assault does happen, but most people don’t want to go and report it because they are afraid of the processes that are involved in terms of reporting and then also disclosing their privacy. I think they just afraid of that.”

**Table 28 Have any of the following made you take HIV and AIDS more seriously in the past year?**

	<b>Students</b> (n=1 072)	<b>Academic</b> (n=116)	<b>Admin</b> (n=89)	<b>Service</b> (n=40)
Campus radio programmes	5%	0%	11%	13%
Campus newspaper articles	17%	3%	22%	28%
Leaflets, booklets or posters at this institution	27%	10%	23%	30%
HIV and AIDS activities at this institution	25%	16%	18%	41%
Knowing or talking to someone with HIV	23%	22%	36%	37%
Knowing someone who has died of AIDS	32%	26%	29%	35%
AIDS statistics	43%	40%	29%	23%
Talking to a health worker	26%	13%	25%	5%
Having an HIV test	29%	17%	28%	33%
Talking to friends	33%	30%	25%	33%
Talking to family members	25%	20%	26%	28%
Information on the internet	21%	19%	27%	14%

Campus-level and personal communication about HIV and AIDS were only weakly credited for making students and staff take HIV and AIDS more seriously, with some variation by medium. Campus radio received the lowest rating as a medium for effective HIV and AIDS communication. Interestingly, AIDS statistics were the factor seen by most students as taking HIV and AIDS more seriously.

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## SECTION FOUR – INSTITUTIONAL RISK ASSESSMENT

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### 4.1 Institutional risk assessment

#### 4.1.1 Introduction

The institutional risk assessment focuses primarily on the risks that HIV and AIDS pose to the mandate and functions of tertiary education institutions in South Africa. As such it is neither an economic impact assessment nor a cost-benefit analysis. The format and content of the institutional risk assessment are consistent with the recommended approach by the Committee of the Institutional Means of Assessment of Risks to Public Health (1983)<sup>18</sup>. The risk assessment provides decision makers and managers with the appropriate information to manage risks:<sup>19</sup> “Risk management is the term used to describe the process by which risk assessment results are integrated with other information to make decisions about the need for, method of, and extent of risk reduction” (p.28). Therefore, there is a deep-rooted connection between the identification and evaluation of risks, and the cost-benefit analysis that follows a risk assessment. A risk assessment is therefore the first essential step in the process of risk management and it must provide practical conclusions.

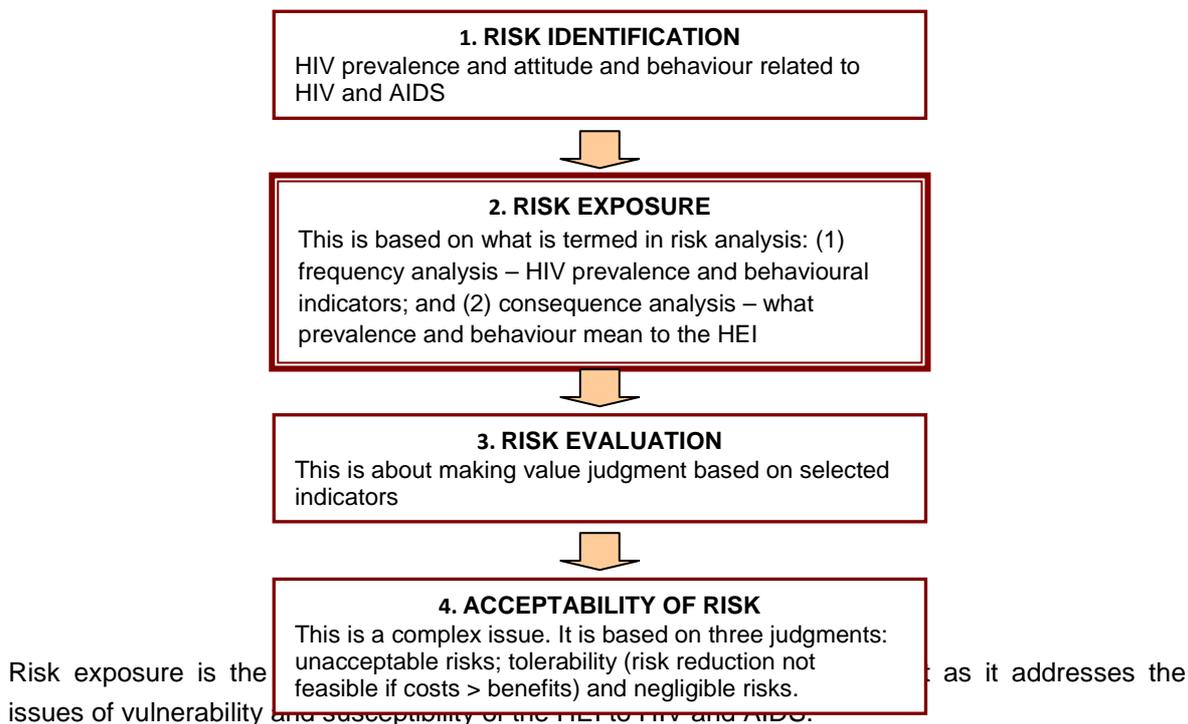
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<sup>18</sup> National Research Council, Committee on the Institutional Means of Assessment of Risks to Public Health, Commission on Life Sciences, (1983), “Risk Assessment in the Federal Government: Managing the Process”, Washington DC: National Academy Press.

<sup>19</sup> National Research Council, Committee on Risk Assessment of Hazardous Air Pollutants, Board of Environmental Studies and Toxicology, Commission of Life Sciences, (1994), “Science and Judgment in Risk Assessment”, Washington DC: National Academy Press.

## 4.1.2 Conceptual framework

The institutional risk assessment framework is described in the figure below:<sup>20</sup>



## 4.1.3 Risk exposure

The institutional risk assessment assumes that HIV and AIDS prevalence and the attitude and behaviours related to HIV and AIDS and reported by staff and students pose risks to the functioning of UKZN. The purpose of risk exposure is to test the extent to which HIV and AIDS affect the achievements of UKZN's vision and mission.<sup>21</sup>

Is the HIV epidemic at the university endangering the capacity of the university to realise its vision and mission? This section aims to answer this question. In this section we will distinguish between staff and students.

### Staff

Previous sections have indicated differences in HIV prevalence between academic, administrative and service staff. It is difficult to make strong conclusions based solely on HIV prevalence. In

<sup>20</sup> The conceptual framework described in the figure is based and adjusted from the risk analysis procedure explained in Rausand, M., (2004), "Risk Analysis: An Introduction", presentation dated 7 October 2005, in *System Reliability Theory* (2nd ed.), pp.1- 41, Wiley Publisher.

<sup>21</sup> The vision and mission of UKZN can be found at <http://www.ukzn.ac.za>

addition to HIV prevalence, one should consider the likelihood that a number of staff may have AIDS and are in need of ART, as well as mortality of staff with AIDS. Table 29 depicts these calculations for UKZN. It is important to note that these are estimates.

**Table 29 Prevalence, ART demand and Medical Aid coverage**

Staff	Number	HIV prev ■	E. No. of HIV+ ■	In need of ART ●	Estimated No. of deaths while on ART ◇	Medical Aid Coverage ■
Academic	1531	1,0%	15	3	0	95%
Administrative	2331	5,5%	128	26	3	85%
Service	400	16,3%	65	13	1	73%
Temporary Academic	2720	1,0%	27	5	1	-
Temporary other staff	3846	8,8%	338	68	7	-

Sources:

- HIV prevalence study
- Estimated number of HIV positive = Number X HIV prevalence
- Assumption: 20% of HIV positive people are in need of ART
- ◇ Assumption: 10% mortality affecting people in need of/receiving ART
- HIV prevalence study

As can be seen, HIV prevalence among administrative and service staff is high, with an associated higher anticipated need for ART.

Medical Aid coverage for permanent staff is quite high at 86%, although it is not compulsory (see Table 8). While medical aid may reduce the impact of HIV and AIDS on the institution by providing care and treatment, it is of concern that HIV prevalence among staff without medical aid is more than two times higher than among staff with medical aid (11,9% vs. 5%). Temporary staff can be considered less of a risk to UKZN regarding HIV and AIDS than permanent staff as it is assumed that temporary staff are more easily replaced and at a lower cost to the institution.

The risks assessment aims to provide the future likelihood of HIV impacts on UKZN. Future impact of HIV is contingent on the actions UKZN is taking at the moment and whether those actions are adequate to prevent new infections and mitigate the impact of the epidemic in the workplace.

According to the SAR (2008),<sup>22</sup> UKZN has an HIV and AIDS workplace policy and programme which complies to a certain extent with the South African Business Coalition on HIV and AIDS (SABCOHA) Code of Practice. However, there is no HIV and AIDS strategy, and no dedicated budget. The fact that UKZN seems to be committed to HIV and AIDS in the workplace is

<sup>22</sup> HEAIDS, "Situation Analysis Report of the HIV/AIDS Workplace Programme – University of KwaZulu-Natal", October 2008.

encouraging and may reduce UKZN's exposure to HIV risks. The detailed evaluation of it can be found in the SAR (2008).

### **Risk exposure for staff**

The absolute level of current risk is represented by HIV prevalence among staff, and especially academic staff. As the main indicator of risk exposure to staff we used the percentage of staff reporting more than one sexual partner in the past 12 months. As the lower boundary of risk exposure we took the percentage of staff reporting more than one sexual partner in the past 12 months who did use a condom at the last sex act. As the higher boundary we took all reporting more than one partner in the past 12 months, regardless of condom use, since condom use tends to be inconsistent, and diminishes over time. Since most of the sexual contacts were with partners from outside the university, and since we have no information on the prevalence of infection in those partners, these estimates of risk exposure are approximations only. Both boundaries of risk allow for a calculation of a range of the proportion and number of staff at risk, which in turn provides an indication of risk to the institution's ability to fulfil its mandate. An assessment of economic costs to the institution, in terms of direct and indirect costs, is beyond the scope of this analysis.

HIV prevalence among staff is 4,9%, although it should be noted that prevalence among academic staff was 1%, while prevalence among administrative and service staff was 5,5% and 16,3% respectively. A total of 13,6% of staff had had more than one sexual partner in the last 12 months, and 7% of staff had had more than one sexual partner in the past 12 months, but used a condom at last sex. Risk exposure for staff at UKZN would then be between 7% and 13,6%. This translates as a total number of staff at risk between 298 and 579. Risk exposure for academic staff is between 6,5% and 10,1%, or between 100 and 155 academic staff.

Unrelated to HIV prevalence among staff, HIV and AIDS could have an impact on the functioning of the university if this leads to increased absenteeism. While 23% of service staff report having been absent from work to attend the funeral of someone with AIDS, only 2% of academic staff report such absences. At this stage, it is estimated that these absences present little risk to UKZN.

Based on HIV prevalence and selected behavioural risk factors, initial findings from a situation analysis of the UKZN workplace policy and programme, coupled with the findings from the qualitative study (see conclusions), we can conclude that were UKZN to maintain its response to HIV and AIDS for staff as it is now, its risk exposure to HIV and AIDS would increase. UKZN has all the preconditions for the HIV epidemic to increase and to result in a much higher impact than may be felt presently. A minimum of 7% and a maximum of 13,6% of overall staff are at risk based on high risk behaviour. The minimum and maximum estimates were based on the proportion of staff engaged in risky sexual behaviour under UKZN's current HIV and AIDS workplace policy and programme.

As far as the acceptability of risks is concerned, the UKZN management needs to be aware that the university's current response to HIV and AIDS (such as its workplace programme) and the availability of Medical Aid schemes may not be enough to prevent an increase in HIV prevalence.

## Students

An institutional risk assessment needs to treat students differently as students are considered the clients of an HEI and therefore they form the 'output' of higher education. HIV infection among students is unlikely to have an effect on the functioning of the university in meeting its mandate. Most students who are HIV infected will have been infected recently (or indeed during their studies), and there will thus be little or no AIDS-related mortality while at university. However, the higher the prevalence of HIV among university graduates, the higher the human, societal and economic impact. The economic impact would not only include direct and indirect costs to the graduate or future employers, but also a reduced return on the higher education investment made by the sector.

For the purposes of this risk assessment we will consider the prevalence of HIV among students, the proportion of students that had more than one sexual partner in the last 12 months, and the subset of these who used a condom at the last sex act. These data points will give us the absolute low boundary of current risk (prevalence of HIV), and the lower and higher boundaries of risk exposure.

At UKZN, the overall prevalence of HIV among students is 2,4%, which means that currently some 680 students at UKZN are HIV infected. The aggregate HIV prevalence among students hides a worrying dynamic: while 1,1% of students aged 18-24 are HIV infected, HIV prevalence among the 25-34 year olds is 15,1%, illustrating the high level of risk students are exposed to. A total of 24,1% students had had more than one sexual partner in the last 12 months, and 17,1% had more than one sexual partner and used a condom at last sex. Thus, the risk exposure to students is between 17,1% and 24,1%.

**Table 30 HIV prevalence – students**

Students	% HIV+
18-24	1,1
25-34	15,1
>35	2
Overall	2,4

Thus, at the moment, at least 15% of graduates of UKZN are HIV infected when joining the workforce.

### 4.1.4 Conclusion

#### Staff

- HIV prevalence for administrative and service staff is high (**institutional risk enhancing factor**).

- ❑ Medical Aid coverage is available for permanent staff but is not compulsory and HIV prevalence is higher among those without medical aid than among those with medical aid (**institutional risk enhancing factor**).
- ❑ There is an HIV and AIDS workplace policy and programme in place but with some important shortcomings: there is no HIV and AIDS strategy in place, and no dedicated budget (**institutional risk enhancing factor**).

Based on the above information and under the current HIV and AIDS workplace policy and programme, it was estimated that 7-13% of overall staff could be at risk of infection (in addition to the already high prevalence among staff).

If no action is taken, permanent staff will be increasingly exposed to HIV and as a consequence become infected: absenteeism, mortality, replacement costs and higher medical aid costs may become a problem.

These conclusions present several risk increasing factors that increase the vulnerability of UKZN to HIV. Steps should be taken to reduce the risk exposure of the university to HIV and AIDS.

## Students

- ❑ The HIV prevalence of students graduating from UKZN is approximately 13%, i.e. over 1 in 10 UKZN graduates are HIV positive. Although this will be analysed in the context of the sector, it is important that UKZN management take action to reduce such prevalence.
- ❑ It was estimated that 17-24% of students could be at risk of infection.
- ❑ There are external environmental risks: the ANC HIV prevalence rate in Free State is approximately 26% which is quite high (risk enhancing factor).
- ❑ As for staff, leadership for HIV and AIDS is perceived to be limited and the health services by the health centre are at a minimum level. (**institutional risk enhancing factor**).

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## SECTION FIVE – CONCLUSIONS AND RECOMMENDATIONS

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### 5.1 Conclusion

- ❑ Students and staff at the University of KwaZulu-Natal are facing variable levels of HIV infection which can potentially increase to be a severe epidemic if prevention measures are not implemented and effective. HIV prevalence is 2,4% among students, 1,0% among academic staff, 5,5% among administrative staff, and 16,3% among service staff.
- ❑ Vulnerability to HIV infection is related to complex factors, including overall HIV prevalence in the context within which one lives in combination with exposure to a number of factors. Some of the risk factors (sexual behaviour, attitude, social practices) associated with HIV infection, and the response environment of the university community to the epidemic are discussed below.

#### 5.1.1 Prevention

- ❑ HIV prevalence among students was highly associated with age as only 1,1% of students younger than 24 years were HIV positive compared to 15,1% among students between 24 and 34 years of age.
- ❑ HIV infection at UKZN is confined almost exclusively to the African population.
- ❑ Just less than two-thirds of students and almost all staff reported having already initiated sex at the time of interview, respectively 60% and 92%. Reported secondary abstinence is low among the students with 86% reporting having had sex 12 months before the survey.
- ❑ Approximately 4% of male students and 4% of females reported sores on their genital areas. The figures for reported unusual genital discharge were higher for females (12%) than for males (2%). STIs have been associated with increased risk of HIV transmission by people living with HIV and AIDS as well as increasing the risk of acquisition among people who are HIV negative.<sup>23</sup>
- ❑ More than half of male students (51%) and more than a quarter of females (26%) reported having more than one sexual partner in the past year. Fewer reported multiple sexual partners in the past month. The number of students declaring more than one partner, especially in the past month, could suggest a high partner turnover which can be linked to wider sexual networks which increase vulnerability to HIV infection considerably.<sup>24</sup>
- ❑ Condoms are recognised as an effective barrier for HIV transmission if used consistently and correctly. Male students reported a higher percent of condom use as opposed to female

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23 Vernazza et al, 1999; Freeman et al, 2006; Gray et al, 2001.

24 Morris & Kretschmar, 1997; Morris & Kretschmar, 2000; Halperin & Epstein, 2007.

students; more than two thirds of those in the age group 18-24 years reported using a condom during their last sexual act.

- ❑ Concurrent partnerships were perceived to be relatively low among students, with 28% of males and 20% of female students believing that their most recent sexual partner had other sexual partners in the past month. These averages were lower among staff; where 7% of males and 12% of females stated that many of their friends had more than one current sexual partner. These results are consistent with the large percentage of students and staff who agreed with the view that “it was unacceptable” for a man or woman to have more than one partner at a time.
- ❑ Alcohol consumption, particularly at alcohol venues such as bars and clubs, is linked to a higher likelihood of casual sex in combination with diminished judgment including disinhibition in relation to the use of condoms for HIV prevention.<sup>25</sup> Frequent alcohol consumption is not common in the population, with 6% of students and 18% of staff members drinking more than once a week. However, binge drinking appears to be a problem with a third (32%) of students and fifth (21%) of staff reporting being drunk in the past month.
- ❑ Reported recreational drug use is low except for marijuana which was the drug used most commonly by students (9%) and staff members (4%).

### **5.1.2 HIV and AIDS impact and response environment**

- ❑ A moderately high proportion of academic (76%), administrative (57%) and service staff (53%) had ever had an HIV test. Only a third of students had ever had an HIV test. It is also noteworthy that a low percentage of students, administrative, academic staff, and service staff tested at the institution. In the absence of information about the motivation for testing, the university may consider investigating further why such a large proportion of staff did not use the VCT services at UKZN as this may be a reflection of access constraints to VCT services.
- ❑ Of concern is the sizeable proportion of students and staff who are not on medical aid and yet are HIV positive. It is likely that HIV-positive individuals who are not on medical aid may have lower levels of access to ART than their counterparts, thus possibly experiencing higher levels of morbidity and mortality.
- ❑ The questions on what has contributed to people taking HIV and AIDS seriously at UKZN suggest a multipronged approach to developing preventive strategies, including peer education. For all categories except administrative and service staff, AIDS statistics contributed the most in making respondents take HIV and AIDS more seriously. Campus radio and newspaper articles did not feature high, cited by 5% and 17% of students respectively. In this context, there should be room for more institutional response to HIV.
- ❑ A sizeable number of staff and students felt that “the management of this institution” were taking HIV and AIDS seriously. Perceptions on student leadership taking HIV and AIDS

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25 Weiser et al, 2006; LaBrie et al, 2005.

seriously were much lower. This suggests room for the university to intensify its HIV activities with greater participation of the student body.

- ❑ At UKZN, knowledge levels about HIV and AIDS are generally high but not on all key issues. For instance, HIV transmission risks associated with breastfeeding and drugs for post exposure prophylaxis were less well known.
- ❑ Stigma remains an important issue at UKZN with only about 40% of students, academics and administration staff believing that they would be supported by friends if they disclosed their HIV status as being positive. Only 28% of service staff believed their friends would be supportive.
- ❑ Less than two thirds (62%) of female students feel safe on campus and only just over one third (36%) feel safe from sexual harassment.

## **5.2 Recommendations**

Over and above review of the findings of this report, the development of a strategic response at UKZN requires review of the national report for all institutions. This latter report provides deeper insight into HIV and AIDS in relation to higher education in South Africa.

### **5.2.1 HIV prevention**

- ❑ The university community should be made aware of the severity of the HIV epidemic at the institution, especially among the students and service staff. This should be accompanied by an intensive and clearly sequenced campaign to prevent HIV infection and mitigate its impact.
- ❑ Among students, emphasis should be on increasing knowledge of sexual risk behaviours, in particular those involving high turnover of sexual partners and overlapping sexual partnerships, with a further emphasis on staying HIV negative throughout university study. Students should be supported throughout their time at university; the brief orientation programme for new students is not sufficient and ongoing mentorship programmes for first and second-year students is recommended.
- ❑ The risks of inconsistent condom use must be emphasised, with the goal of 100% condom use in all relationships where there is the possibility of sero-discordance. Condom use should be strongly promoted in all new, casual and concurrent sexual relationships with irregular partners where condom use uptake already tends to be greater. However, given that condom use is resisted in longer-term relationships, knowing one's own and one's partner's status should be promoted in such contexts. Misconceptions over the efficacy of the free government condoms should be addressed and alternative sources of condoms explored. Female condoms should be promoted further.
- ❑ The symptoms of STI infection in both males and females are strongly associated with HIV infection and indicate the need for a strong campaign to identify and treat STIs. Key messages on sexual health and STI prevention should be continuous and systematic and STI treatment services need to be accessible to all in the university community.
- ❑ Additional creative strategies of addressing prevention of HIV and AIDS should be explored, including the use of debate and drama which facilitate meaningful engagement. The peer

education programme should be expanded and available information in campus media should be strengthened, in order to reach a greater number of students with prevention messages.

- ❑ The differences between males and female students with respect to norms and expectations around fidelity in relationships and casual sex are notable. Student programmes should address gender and assertiveness, and challenge accepted definitions of femininity and masculinity. HIV awareness programmes should strive to involve males, learning from successful projects such as EngenderHealth's Men as Partners programme at other institutions, which promotes equitable relationship norms and encourages males to know their HIV status and take responsibility for limiting partners. The institution should encourage students to engage in relationships with their peers (rather than older partners) and promote the idea that it is acceptable not to be in a relationship.
- ❑ Given the high pregnancy statistics, it is evident that greater education about family planning is needed, emphasising the significant responsibility in becoming a parent. Contraception should be strongly advocated in combination with consistent condom use.
- ❑ The relationship between alcohol intake, pregnancy, STIs, HIV and AIDS needs to be made known, and there should be a drive to curb high levels of student drinking, promote non-alcohol oriented forms of recreation and improve regulation of alcohol consumption at university-sponsored bashes. Further, condoms should be available at campus social events.

### **5.2.2 Care and support for people with HIV and AIDS**

- ❑ With an estimated 675 students, 15 academic and 240 administration and service staff that are HIV positive, the institution faces a burden of care and support that appears currently to be unrecognised and unmet. With almost half of students and a significant number of administrative and service staff without access to medical aid support, there will not be access to good quality external medical care and psychological support when this becomes needed. Furthermore, whereas students will ultimately move on from UKZN and their health care does not necessarily become the care burden of the institution, this is not the case for staff. UKZN will ultimately need to face the challenge of 255 of its staff having health problems and support needs associated with HIV and AIDS, and needing to commence anti-retroviral therapy.
- ❑ There is a need to reach out to students and staff who have undergone HIV testing, who know their HIV status, but do not access or benefit from support services. Resources should be directed towards the development of HIV support groups, realising that many HIV-positive people are not receiving any kind of support. It is important to establish a programme of peer support, led by HIV-positive people. The Health Promoter programme offered by DramAidE at other institutions should be considered, especially given its great success in creating positive attitudes to living with HIV and mutual support among HIV-positive staff and students.
- ❑ Concise information about resources and services for antiretroviral therapy (ART) and how to manage HIV should be provided. Institutional medical aid schemes should also be responsive to supporting HIV-positive people and these should be reviewed if necessary.
- ❑ VCT services should continue to be promoted in the institutional context and availability expanded. Emphasis should be placed on couples counselling and the importance of disclosure of HIV status to sexual partners in relationships where condoms are not used and/or

in marital or long-term partnerships. The institution should highlight the importance of testing early if one is HIV positive and that it is better to know one's status than not.

- ❑ The HIV and AIDS support units and the campus health facilities should work together to ensure that successes in HIV prevention are paralleled by good HIV support services. As the HIV and AIDS support units are not being utilised by a great number of HIV-positive staff and students, consideration should be given to placing HIV and AIDS care and support within a broader context of wellness, sexual health, and student and staff support to reduce the stigma of accessing care. Non-medical needs of HIV-positive students and staff should also be assessed and responded to; for example, the extent to which food assistance is needed.
- ❑ Stigma remains a concern at UKZN and stigma reduction programmes need to be part of any programme on HIV prevention and care.

### **5.2.3 Response management**

- ❑ There needs to be a comprehensive review of all HIV and AIDS programmes and services on campus. This should be part of an institutional reorientation that would result in a better integrated set of services for students and staff. A consolidated plan for providing a more thorough response is required which will need to include HIV prevention, stigma reduction, HIV support and care and a comprehensive impact mitigation plan.
- ❑ Campus management in all sectors and student leadership need to take heed of the perception on the part of a significant proportion of students and staff, that they do not take HIV and AIDS seriously. This is a reflection of a lack of consistent, visible HIV and AIDS response across departments and a lack of vocal champions, including HIV-positive campus leadership. The institutional HIV and AIDS policy should be better monitored and implemented. Strong institutional leadership among students, management, labour unions and other key stakeholders is a necessary foundation for addressing the epidemic. Such efforts should be intensive and collaborative and include people living with HIV.
- ❑ Considering that HIV prevalence is highest among administrative and service staff, the university must prioritise and reconceptualise prevention efforts directed at staff. Concern must be given to staff needs, recognising that current prevention efforts on campus are mainly directed at students. Other institutions have launched successful staff peer education programmes, which UKZN could emulate.
- ❑ A programme to train workplace managers and residence leadership in the needs and appropriate support for HIV-positive people must be systematised and full coverage ensured. Every line manager should be HIV literate, trained in basic methods of prevention, care and support, and the importance of confidentiality. For staff to feel comfortable asking for help, managers should instil confidence that they can be approached about HIV needs. Furthermore, the health care and education of outsourced staff should be catered for. Human Resources should take a lead in addressing issues related to the management of HIV-positive employees by developing a strategic HIV and AIDS programme, creating a management guide, establishing an Employee Assistance Programme, and including HIV and AIDS issues and services in employee induction programmes.

- Campus leadership must take heed of the fact that female members of the campus community do not feel secure on campus and feel vulnerable to sexual harassment and reluctant to report instances of it. It should be a matter of priority to create an environment where students feel safe and protected, including from sexual harassment. Examples of other campuses which conduct well-regulated disciplinary procedures and publicise the outcomes of disciplinary hearings might be studied and emulated.

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## SECTION SIX – REFERENCES

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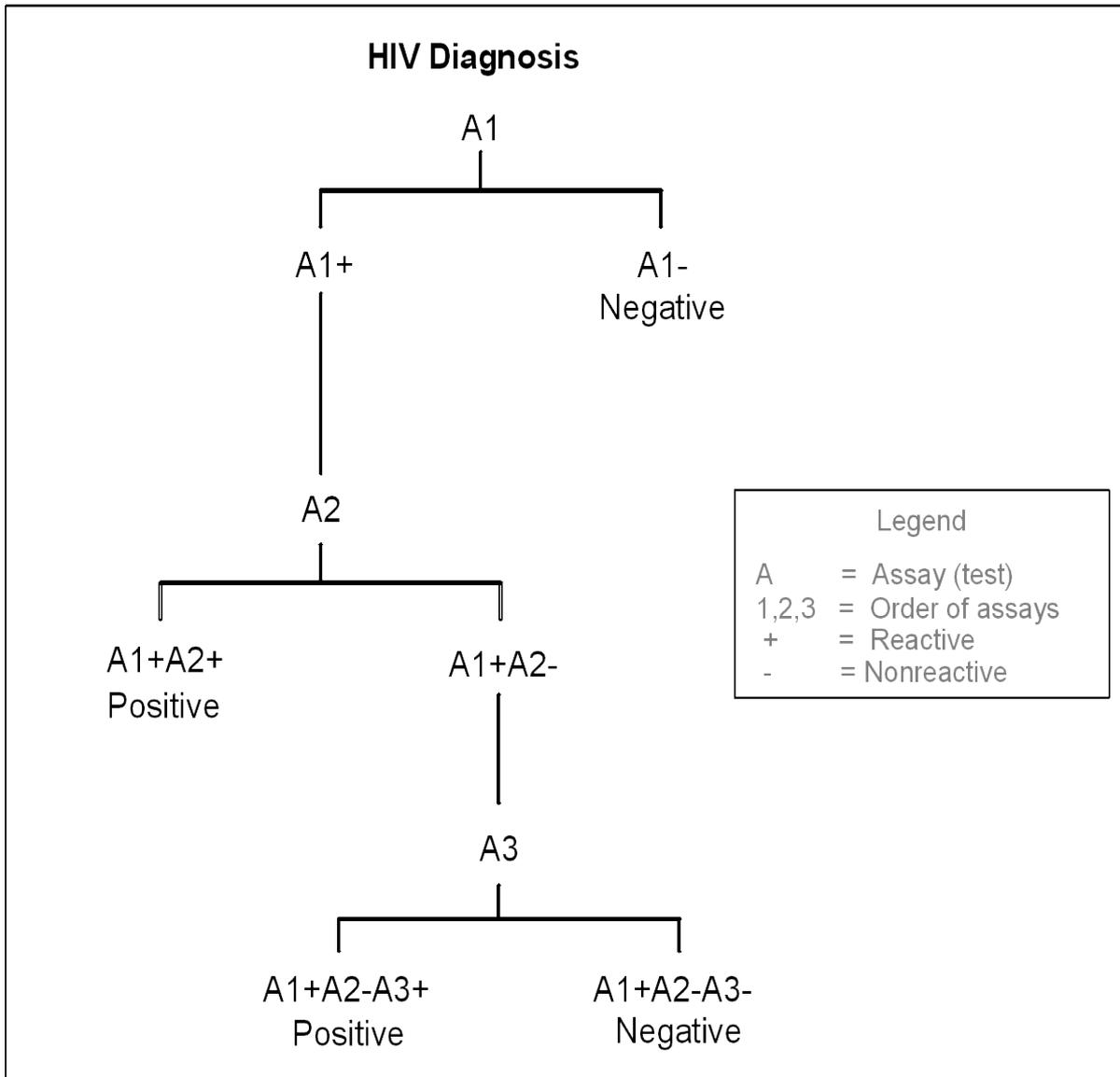
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## SECTION SEVEN – APPENDICES

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### Appendix 1: HIV laboratory based testing algorithm for making a diagnosis of HIV



## Appendix 2: Ethics approval letter



11 August 2008

Dr Mark Colvin  
Maromi Health Research  
Private Bag x07  
Dalbridge  
4041

Dear Dr Colvin

**PROTOCOL: Sero-prevalence Study, KAPB Study and Risk Assessment with Respect to HIV/AIDS in the Higher Education Sector (Europe Aid/ 124407/D/SER/ZA). Dr Mark Steven Ernest Colvin, Maromi Health Research, Ref No: BF067/08.**

The Biomedical Research Ethics Committee considered the abovementioned application and the protocol was approved by a full sitting of the committee at a meeting held on 10 June 2008 pending appropriate responses to queries raised. Your responses dated 24 July 2008 to queries raised on 03 July 2008 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given full ethics approval and may begin as at 11 August 2008.

This approval is valid for one year from 11 August 2008. To ensure continuous approval, an application for recertification should be submitted a couple of months before the expiry date. In addition, when consent is a requirement, the consent process will need to be repeated annually.

I take this opportunity to wish you everything of the best with your study. Please send the Biomedical Research Ethics Committee a copy of your report once completed.

Yours sincerely

PROFESSOR D WASSENAAR  
Chair: Biomedical Research Ethics Committee

### **Appendix 3: VCT during the study**

Voluntary Counselling and Testing (VCT) for HIV was provided by the consortium for the duration of the study and this was done in collaboration with the campus health services. Prior to the survey, there were posters available at the campus on some of the billboards. During the survey, posters and flyers were conspicuously displayed at various venues on the campus. The flyers were also given to each of the participants during the survey to promote VCT.

Dr R Croxford was assigned to the institution to quality assure the VCT service available to students and staff participating in the study. Dr R Croxford did a site visit on 10 October 2008. This was managed by the Epicentre site supervisor, Karen Furner, and study subjects were able to access VCT directly at the Epicentre base offices that were provided by Epicentre staff. The office phone number was given for booking purposes. Two students were tested, one at the base office and the second actually at the lecture hall after the sampling when everyone else had departed. No referral was required. A 24-hour help desk was available for anyone needing additional information or support.

Only three people attended VCT during the study period.