YOUTH-FRIENDLY HIV PREVENTION AND SRHR PROGRAMMES AND SERVICES AT POST-SCHOOLING INSTITUTIONS: A REVIEW OF THE LITERATURE.

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# ACRONYMS

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<th>Description</th>
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<tbody>
<tr>
<td>ABC</td>
<td>Abstain, Be faithful, [use] Condoms</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<td>AYFS</td>
<td>Adolescent and Youth Friendly Services</td>
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<td>CADRE</td>
<td>Centre for AIDS Development, Research and Evaluation</td>
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<td>DHET</td>
<td>Department of Higher Education and Training</td>
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<td>Department of Health</td>
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<td>FET</td>
<td>Further Education and Training</td>
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<td>Higher Education South Africa</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IHL</td>
<td>Institution of Higher Learning</td>
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<td>NAFCI</td>
<td>National Adolescent-Friendly Clinic Initiative</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
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<td>SAVUCA</td>
<td>South African Universities Vice-Chancellors Association</td>
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<td>SGBV</td>
<td>Sexual and gender-based violence</td>
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EXECUTIVE SUMMARY

The objective of this literature review was to provide a background to the current context relating to the provision of comprehensive and integrated youth-friendly SRHR and HIV prevention services to students at post-schooling institutions in South Africa and in the Eastern Cape. This review is the initial phase of a situation analysis of sexual and reproductive health and rights (SRHR) and HIV prevention services at post-schooling institutions within three priority districts in the Eastern Cape, leading to the development and design of a Behaviour Change Communications Strategy for selected institutions in the Province. The review was intended to provide an historical background as well as conceptual framing for the situation analysis.

For the purposes of this review, the term post-schooling institution will be used, as this refers to a broad range of institutions including Universities and Tertiary Vocational Education and Training (TVET) colleges – formerly known as FETs. The term Higher Education Institution (HEI) and Institution of Higher Learning (IHL) is typically used to refer to Universities only.

This was a desktop review using policy and strategy documents, as well as peer-reviewed academic literature on the issue of HIV prevention and youth, SRHR, adolescent and youth-friendly services (AYFS) and interventions at post-schooling institutions. The study documented several trends in the literature related to:

1. HIV prevalence amongst youth in South Africa.
2. Contextual factors contributing to vulnerability of youth to HIV/AIDS.
3. The development of national approaches to SRHR at primary health-care level, including an increased focus on the needs of youth and the national adolescent-friendly clinic initiative (NAFCI).
4. The scaling up of the response in terms of the provision of AYFS, including successes and challenges.
5. Shifts in approaches to HIV prevention from focusing on individual behaviour change to a more nuanced understanding of how young people’s sexual decision-making is influenced by particular social and structural contexts.
10. HEAIDS interventions.
11. Recommendations from HEAIDS on provision of HIV prevention and SRHR services and programmes at Higher Education Institutions (HEIs).

12. Overall conclusions and recommendations from review, including gaps in research and intervention that need to be addressed.

**METHODODOLOGY**

This was a desktop review using resources available online. Statistical evidence on HIV prevalence amongst young people in South Africa was captured. Literature was reviewed on the policy and programmatic developments related to sexual and reproductive rights, HIV prevention, sexuality and gender, and youth-friendly services. A number of policy documents from the Department of Higher Education and Training (DHET) relating to their national HIV prevention initiative, HEAIDS, were reviewed. This literature was synthesised into a comprehensive review, illustrating existing knowledge and information about the issue, as well as gaps that demand further investigation.

**YOUNG PEOPLE AND HIV**

The literature tells us that there are more than a million new HIV infections among people aged 15–24 years worldwide each year, which account for 41% of new infections among those aged 15 years and older (UNAIDS, 2010). In South Africa young people refer to those falling within the age group of 14 to 35 years (National Youth Policy). The World Health Organisation (WHO) defines youth as those between the ages of 10 – 24, further dividing this group between adolescents 10 -19 and youth 15 – 24 (du Plessis & Futwa, 2014). For the purpose of this assessment, the WHO definition of youth, which is also used in the draft National Implementation Guidelines for Adolescents and Youth Friendly Services: 2013 – 2017, will be used.

In South Africa in 2011, HIV prevalence was 12% among young women (aged 15-24 years) and 5% among young men (UNAIDS, 2012, cited in Geary et al., 2014)). Levels of HIV infection have been found to be significantly higher among women at younger ages, with male prevalence exceeding female prevalence after age 35-39 years. (Shisana, et al., 2005, cited in Peacock et al., 2008). Half of women have given birth by the age of 20 years and two thirds of adolescent (15-19 years) pregnancies are reported as unwanted (Panday, Makiwane, Ranchod, & Letsoalo, 2009).

A South African study which looked at HIV prevalence and sexual behaviours amongst young people, found that HIV prevalence rose from 4% among 15 and 16-year-old females to 31% among women age 21 years (Pettilor et al., 2005). Among males, HIV prevalence was relatively constant at 2–3% between ages 15 and 19 years and then steadily increased to 11–12% by age 23–24 years. Among 20–24 year olds, nearly one in four young women was infected with HIV in comparison with 1 in 14 young men of the same age. Among those who reported never having had sex, 2.5% of males and 3.8% of females were HIV positive.
The results of this national prevalence study suggest that young people of post-school education-going age are those most likely to become infected with HIV. The results also confirm the magnitude of the HIV epidemic among the general population in South Africa and emphasize the enormous gender disparity in HIV prevalence among young men and women in this population.

**CONTEXTUAL FACTORS CONTRIBUTING TO VULNERABILITY OF YOUTH TO HIV**

It is important to take note of the contextual factors underpinning the vulnerability of young people to HIV infection. Much of the literature points to high-risk behaviours, such as having multiple and concurrent relationships, older partners, or not using condoms or other STI prevention methods. Studies indicate that such risk factors do not act in isolation to increase HIV risk, but rather work together (Pettifor et al., 2005). They are also rooted in contexts where structural factors such as poverty, gender inequality and social norms prevail (ibid).

A quantitative and qualitative study of young people’s (18–30) sexual behavior, undertaken by CADRE in South Africa, concluded that cultural beliefs and ideas about masculinity and femininity interacted with underlying socio-economic contexts and individual psychological factors related to self-esteem and fatalism, to produce patterns of sexual relationships that can facilitate the spread of HIV (Parker, Makhubele, Ntlabati, Connolly, 2007, cited in Peacock et al., 2008) –

Multiple partnering is closely tied to constructions of masculinity, which define them as the norm for men. Ideas and beliefs about male sexuality create expectations among men that having ‘main’ and ‘other’ sexual partners is both natural and central to their gender identity (Peacock et al., 2008)

Gender based violence is also a key driver of HIV infection in women, and South Africa has among the highest rates of violence against women in the world. Research shows that gender power inequity in relationships and intimate partner violence places women at enhanced risk of HIV infection (Jewkes & Morrell, 2010) Forced sexual initiation is reported by almost a third of adolescent girls (Jewkes & Abrahams, 2002). In addition coerced consensual sex is a common problem in schools, workplaces and amongst peers (ibid).
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

There have been significant developments in policy and practice addressing sexual and reproductive health and rights, in South Africa and internationally. Sexual and reproductive health refers to sexuality and also the reproductive process of having children.

The World Health Organization states that:

"Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence." [1]

Encompassed in reproductive rights are the rights of men and women to be informed about and to have access to safe, effective, affordable and acceptable legal methods of contraception and fertility regulation of their choice, and the right of access to appropriate health care services that enable women to go safely through pregnancy and child birth and provide couples with the best chance of having healthy infants.

Women and men should also be entitled to sexual rights, which are distinct from reproductive rights. The Aids Law Project has articulated sexual rights in the following way: “All women and men are entitled to:

• Control over their own bodies
• Only have sex when, with whom and how they want to
• Live out their sexual orientation
• Not be forced to have sex through the use of violence or coercion
• Have sexual enjoyment
• Be protected from diseases such as HIV and STIs
• Exercise the responsibilities that go with sexual rights.” (cited in Peacock et al., 2008)

THE DEVELOPMENT OF SEXUAL AND REPRODUCTIVE RIGHTS IN SOUTH AFRICA

There is a particular development to the history of sexual and reproductive rights in South Africa. Cooper et. al (2004) state that South African reproductive health policies and the laws that underwrite them are among the most progressive and comprehensive in the world in terms of the recognition that they give to human rights, including sexual and reproductive rights. Changes to policy and legislation in relation to SRHR in South Africa symbolizes a significant shift from under apartheid when South African society was racially segregated and black South Africans were denied political, social, economic and health rights.

Before 1994, there were no comprehensive reproductive health policies in South Africa. In keeping with international trends, women’s health services consisted mainly of maternal and child health services, with an emphasis on contraceptive services aimed at limiting population growth (Cooper et. al, 2004). Civil society has played a major role in securing these legislative and policy changes, and health activist groups continue to pressure the government to introduce further changes in policy and service delivery, especially in the area of HIV/AIDS.

The changes over time have included the adoption of the Primary Health Care approach in 1994. This approach emphasised health as a human right, equity in resource distribution, expanded access, decentralised services aimed at promoting local health needs and community involvement through the district health system, and preventive and promotive health care.

NATIONAL ADOLESCENT-FRIENDLY CLINIC INITIATIVE (NAFCI)

The National Adolescent-Friendly Clinic Initiative (NAFCI) was launched in 1999 by a national NGO, Lovelife, with support from the Department of Health. NAFCI involved training service providers, efforts to improve facilities, multi-media campaigns and activities in the community and with other sectors (Pettifor et al. 2007, cited in Geary et. al, 2014). This led to the development of a set of “adolescent-friendly” standards that included those relating to the types of services provided, policies supporting adolescents’ rights to healthcare and the clinic environment were defined for clinics to work towards using a facilitated approach ((Dickson-Tetteh, Pettifor & Moleko, 2001, cited in Geary et al., 2014). By 2005, 350 clinics nationwide were involved.

NAFCI Adolescent Sexual and Reproductive Health Rights

Dickson-Tetteh, Pettifor and Moleko (2001) cite the NAFCI standards and criteria.

A young person irrespective of age, sex, race, religion, culture, social status, mental or physical ability has basic health rights that include:

- The right to information on health.
- The right to a full range of affordable health services.
- The right to privacy when receiving health care.
- The right to be treated with dignity and respect when receiving health care.
- The right to be assured that personal information will remain confidential.
- The right to be given an explanation of the processes that the young person goes through when receiving health care.
- The right to be treated by people who are trained and knowledgeable about what they do.
- The right to continuity of services.
- The right to be treated by a named provider.
- The right to express views on the services provided and to complain about unsatisfactory health services.
- The right to gender equality.
- The right to a healthy and safe environment.
The right to make free, informed choices in matters relating to sexual expression, sexual pleasure and sexual orientation.

There are certain NAFCI standards, together with an NAFCI “essential package”, that were formulated and are listed in addendum to this review.

WHAT ARE AYFS?

The Youth Friendly Services (YFS) programme in South Africa was scaled up from the National Adolescent Friendly Clinic Initiative (NAFCI). This has historically been managed by the non-governmental organization (NGO) LoveLife between 1999 and 2006. In 2006, the Department of Health agreed to take over the management of a simplified version of NAFCI, comprising training healthcare providers and facility accreditation, under their Youth Friendly Services (YFS) programme (Geary et al., 2014).

The Youth Friendly Services programme (to be implemented in primary healthcare facilities) aimed to improve the sexual and reproductive health of both young men and young women. YFS’s target group is young people aged 10-24 years and it aims to: promote access and utilisation of YFS, improve the health status of young people, build the capacity of health care providers to provide YFS and to promote services for HIV-infected and HIV-exposed young people. The “adolescent-friendly” standards defined for NAFCI remain integral to YFS (Geary et al., 2014).

The revised “Adolescent and Youth Health Policy Guidelines (2012)”, identifies Sexual and Reproductive Health and Rights (SRHR) services as a key priority area for health interventions (du Plessis & Futwa, 2014). The Adolescent and Youth Friendly Services (AYFS) model in the revised drafted guidelines (2013 to 2017) offers standard based quality improvement programmes for Primary Health Care facilities, to optimize the use of available community resources and to provide an integrated SRHR/HIV service package for young people.

This programme advocates for provision of quality AYFS to ensure that health services are acceptable, accessible, affordable and effectively meet the individual needs of young people.

BARRIERS TO ADOLESCENT AND YOUTH FRIENDLY SERVICES (AYFS)

Historical challenges in providing good quality services that are youth and adolescent friendly have been well-documented in the literature. (Dickson-Tetteh, Pettifor and Moleko, 2001) A lot has been written about the barriers that young people face when attempting to get health services, specifically SRH at public health facilities. A 2004 study found that there are certain barriers in accessing family planning services, especially for young women (Cooper et al., 2004). These include concerns over lack of privacy, inconvenient clinic opening times, and discouragement by clinic staff who disapprove of youth being sexually active. Contraception
method choice is frequently limited in the public sector by the opinions and practices of primary care nurses.

According to Geary et. al, 2014) - knowledge about sexuality and reproductive health among young men and young women is limited and young people report a need for more information on relationships, pregnancy and STIs. Fear of judgmental attitudes of healthcare workers has been reported as a barrier to young people’s use of a range of health services in South Africa (ibid).

With the HIV/AIDS crisis disproportionately affecting young people in South Africa, there has been an increased interest in expanding youth centred services. To improve the quality and utilization of the health services by young people, the health service provision must be made adolescent and youth-friendly, to increase the likelihood that young people would be able and willing to obtain the health services they need (Geary et al., 2014). However, there are ongoing challenges and barriers to the development of comprehensive AYFS services.

Studies taking place internationally, and in South Africa, have confirmed that most of the changes that are needed to make health services youth friendly, are attitudinal and not structural (du Plessis & Futwa, 2014). In other words the attitudes and response of health-care providers play a significant role in the youth-friendliness of services around SRH at public health facilities.

A recent review of the National Maternal, Newborn, Child, Women’s Health and Nutrition (MNCWH&N) Strategic Plan 2012-2016. Adolescents and Youth Health found that there is lack of investment in setting up and coordinating AYFS programmes including human resources. There is inadequate inter-sectoral collaboration around AYFS. Standards for accreditation of AYFS health care facilities takes too long, because they are too stringent. Additionally, there is insufficient capacity building of service providers to provide AYFS. The barriers already mentioned featured strongly, namely inadequate infrastructure at health facilities, poor and insensitive attitudes of health-care providers, and lack of privacy and confidentiality. Systems of monitoring and evaluation are inadequate in that they are not capturing the right data to allow for evidence-informed strategies to be developed.

An assessment of adolescent and youth friendly services models implemented in 5 districts in the Eastern Cape (du Plessis & Futwa, 2014) found that, while policies and standards have been put in place for AYFS at primary health care facilities, on the ground there is no specific package of health/SRH services are available to adolescents and youth. The study found that the 14 facilities selected from the 5 districts participating in the assessment, are not youth friendly and lack the infrastructure to be conducive to AYFS. One key finding was that provider attitudes are the main barrier for adolescents and youth accessing the services. Recommendations were made for improvements at a facility and capacity and resource level, for better inter-sectoral collaboration, and for increased community and youth participation in programmes.
HIV PREVENTION AND SRHR POLICY AND PRACTICE

SHIFT IN APPROACHES TO HIV PREVENTION AND BEHAVIOUR CHANGE

Approaches to HIV prevention and youth SRHR have shifted over the past few decades. It is important to take note of these changes, and how they have paved the way for a more nuanced and contextualized way of understanding young people’s decision-making and actions related to sex and reproduction.

HIV prevention work has historically been based on the “knowledge-to-action” model, which is rooted in an individualist model of personhood (Wood, 2003). This model is underpinned by the straightforward assumption that risk calculation constitutes a strong predictor of safer sex practices (Gupta, 2008). Such a focus on the rational decision-making capabilities of the individual has underpinned information-based health education campaigns. The ‘ABC’ [Abstain, Be faithful, [use] Condoms] campaign is one example – which focuses on biomedically defined risk.

This approach has been counter-balanced by the social science work that sought to understand individuals as situated interactive agents engaging in (high or low risk) practices with others in particular settings or circumstances (Wood, 2003). According to Campbell and Macphail (2002), the past decade has seen a drift away from information-based health education towards participatory approaches within HIV prevention. This change in practice has gone hand in hand with a conceptual shift away from understanding ‘sexual behaviour’ as the product of individual decisions, in favour of a preference for the concept of ‘sexuality’ as a socially negotiated phenomenon, strongly influenced by group-based social identities, and more particularly peer identities (ibid).

APPLYING A SEXUALITY LENS

Sexuality and sexual and reproductive health has been re-caste in recent thinking beyond traditional, didactic approaches to SRH programming that are overtly biomedical and focus on behaviour change as a means of controlling disease. Instead, there is an understanding of how sexual behaviour is a complex phenomenon involving emotions and identity. Sexuality also involves types of sexual partnerships and family arrangements within the confines of social pressure and expectations about one’s sexual behaviour (Hawkins, Cornwall and Lewin, 2011). Rather than only focusing on the negative aspects of sexuality, such as disease, violence and abuse, academics, researchers and activists have suggested that sexuality should be understood as being about pleasure, control and empowerment (ibid).
According to Bennett and Reddy (2007) it has been recognized that policy initiatives to prevent HIV/AIDS often fail because of inadequate recognition of the ways in which sexuality, culture, and identity organize the possibilities of “policy uptake” within different contexts. This is one of the reasons for an increased engagement in African-based questions of gender and sexuality.

**STRUCTURAL APPROACHES TO HIV PREVENTION**

Another recent development has been the focus on structural approaches to HIV prevention. Structural factors can be defined as physical, social, cultural, organisational, community, economic, legal, or policy aspects of the environment that impede or facilitate efforts to avoid HIV infection (Gupta et. al, 2008). Structural factors can act as barriers to individually oriented HIV prevention and care services and the adoption of HIV-preventive behaviours. For example, fear of HIV/AIDS-related stigma and discrimination discourages people from seeking HIV counselling and testing and from disclosing their status.

A key message for current HIV prevention efforts, is that they cannot succeed in the long term without addressing the underlying drivers of HIV risk and vulnerability in different settings. HIV prevention programmes therefore need to incorporate structural approaches. Gupta et. al, (2008) conclude that success in mainstreaming structural approaches into HIV prevention will revolve around the extent to which prevention does not simply respond to pressure for lists of interventions or overly simplistic magic bullets and individual approaches.

**SEXUALITY, GENDER AND IDENTITY: SUCCESSFUL PEER EDUCATION PROGRAMMES**

The shift in approaches to HIV prevention and youth SRHR has also led to an increase in peer education as one of the most commonly used strategies of HIV prevention worldwide (Horizons, 1999, cited in Campbell & Macphail, 2002). However, according to Campbell & Macphail (2002) we still do not fully understand the processes and mechanisms underlying the successes or failures of such peer education programmes.

Social psychologists have attempted to conceptualize the process and impact of peer education work at the level of young people’s social identities. Simply put, social identity is a person’s view of who they are derived from perceived membership in a relevant social group. Young people are in the process of forming and negotiating their social identities, and sexuality and relationships are a key component of this journey of discovery. Individual and collective norms and attitudes are often formed within a peer-group setting. This occurs at a physical level within a peer-group, and also, at another more symbolic level, according to how a person perceives themselves in relation to that peer-group.

Gender inequality prevails in society, and this has been evidenced to be an underlying driver of the South African HIV epidemic (Jewkes & Morrell, 2010). There are certain gendered social norms around identities and relationships that young people encounter and are often pressured to conform to that form part of this context of gender inequality. For example, the dominant ideal of a man emphasizes toughness, strength and expression of prodigious sexual success and the dominant ideal of femininity embraces compliance and tolerance of violent and hurtful behaviour by male partners, including infidelity (Jewkes & Morrell, 2010).
Identities play a role in changing power relations. In a context of poverty and inequality – there are often constraints to how young people can construct and reconstruct images of themselves that adequately reflect their potentialities and interests. Ideally, peer educational settings should provide a context within which a group of young people may come together to construct identities that challenge the ways in which traditional gender relations place their health at risk. Ideally, peer educational settings should provide a context within which a group of young people may come together to construct identities that challenge the ways in which traditional gender relations place their sexual health at risk (Campbell & Jovchelovitch, 2000).

**INTERVENTIONS ADDRESSING HIV PREVENTION AND SRHR WITH YOUTH**

A study of eight youth HIV prevention interventions in South Africa, operational since 2000, was conducted (Harrison, Newell, Imrie, Hoddinott, 2010). The authors state that, moving beyond individual-level measures of knowledge and psychosocial factors to address social and structural factors underlying HIV risk is the main success of these interventions.

An important feature - and their area of greatest impact- was the focus on HIV causal pathways relevant to southern Africa, namely gender, sexual coercion, alcohol use and economic risk. Programmes such as Stepping Stones was provided were reported to lead changes in gender beliefs and values, thus impacting the structural context of risk.

A further significant lesson was for the need for interventions to adopt structural approaches that can alter the context of young people’s HIV risk. For instance, a ‘structural intervention’ such as in the IMAGE project where women’s access to economic resources apparently increased personal empowerment, leading to reduced sexual risk behaviour.

Third, changing social norms related to HIV risk and protective behaviours is important. Stepping Stones’ success was clearly associated with altering beliefs about gender and HIV risk, particularly among men, and with offering viable alternative normative behaviours.

There are a number of national-level programmes that have been developed in response to the need to address HIV and SRHR with South Africa’s youth. These programmes have integrated a gender and sexuality approach to address youth SRHR. Some of the main interventions are listed here, including Stepping Stones as mentioned above :

‘Stepping Stones’ is a community training and dialogue programme that addresses gender norms as integral to young people’s attitudes and actions around sexuality, SRHR, and Sexual and Gender Based Violence (SGBV). Stepping stones has worked in multiple countries to reduce the acceptability of violence and promote discussion and awareness of HIV/AIDS.

Sonke Gender Justice Networks’ ‘One Man Can’ campaign uses a human rights framework to help men and boys take action to stop domestic and sexual violence, to halt the spread of HIV/AIDS and promote healthy, equitable relationships.
LoveLife is the largest youth focused intervention aimed at HIV prevention in South Africa. It is a national initiative combining a sustained multi-media awareness and education campaign with comprehensive youth-friendly sexual health services in public clinics nationwide, and countrywide outreach and support programmes.5

Restless Development South Africa runs a Youth Empowerment Programme in the Eastern Cape. The programme mobilises and trains young people to engage youth to:

- Decrease risk of HIV infection and of other STIs
- Reduce teen pregnancy levels
- Improve livelihood opportunities

CONTEXT OF POST-SCHOOLING EDUCATION IN SOUTH AFRICA

The post-school system is understood as comprising all education and training provision for those who have completed school, those who did not complete their schooling, and those who never attended school. It consists of the following institutions, which fall under the purview of the DHET (2013):

- 23 public universities (with two more being established in 2014);
- 50 public technical and vocational education and training (TVET) colleges (formerly known as further education and training [FET] colleges);
- Public adult learning centres (soon to be absorbed into the new community colleges);
- Private post-school institutions (registered private FET colleges and private higher education institutions, also to be renamed TVET colleges);
- The SETAs and the National Skills Fund (NSF);
- Regulatory bodies responsible for qualifications and quality assurance in the post-school system – the South African Qualifications Authority (SAQA) and the Quality Councils.

The White Paper sets out strategies to improve the capacity of the post-school education and training system to meet South Africa’s needs. It outlines policy directions to guide the DHET and the institutions for which it is responsible in order to contribute to building “a developmental state with a vibrant democracy and a flourishing economy” (p. xi). Its main policy objectives are:

- A post-school system that can assist in building a fair, equitable, non-racial, non-sexist and democratic South Africa;
- A single, coordinated post-school education and training system;
- Expanded access, improved quality and increased diversity of provision;
- A stronger and more cooperative relationship between education and training institutions and the workplace;
- A post-school education and training system that is responsive to the needs of individual citizens, employers in both public and private sectors, as well as broader societal and developmental objectives.
The DHET's White paper for post-school education and training provides a social justice framing of what needs to change to improve access to and quality of higher education South Africa, in order to build a developmental state with a vibrant democracy and flourishing economy. This is a useful lens through which to envision how post-schooling institutions play a role in the development of young people to live healthier lives through increasing access to SRHR and HIV prevention services. Such thinking resonates with certain principles around sexual and reproductive health and rights that have become mainstream within international development discourse as well as national efforts to address SRH and HIV in South Africa. A key example is a national initiative of the Department of Higher Education and Training called ‘HEAIDS’ is rooted in a concept of the responsibility of Higher Education Institutions to address the HIV/AIDS pandemic on a human rights basis.

HIV/AIDS AT POST-SCHOOLING INSTITUTIONS: CONTEXT AND RESPONSE

This section will give attention to the current situation with regards research, strategies and current interventions related to a) the context for HIV and AIDS at post-schooling institutions, and b) the response. Much of this work has been conducted by the Higher Education HIV/AIDS programme (HEAIDS). In order to provide a broad context, the nature of HIV and AIDS in terms of prevalence and behaviours, and the programmatic response in terms of HIV prevention, treatment and care, and SRHR, are considered here.

It is noted that much of the research has been conducted with Higher Education Institutions, in other words Universities, and not as much with other post-schooling institutions such as Tertiary Vocational Education and Training Institutions (TVETs). However there are certain research papers that have included other institutions, and they are represented here.

HIV PREVALENCE AT HIGHER EDUCATION INSTITUTIONS

A Higher Education study of HIV Prevalence and Related Factors (2010 [1]), a component of the HEAIDS programme, found that the measured prevalence in the combined Higher Education Institution (HEI) sector population is substantially lower than found among the general population in South Africa.

This was a qualitative and a quantitative study, that obtained a range of data related to HIV prevalence, attitudes and behaviours. The study population consisted of students and employees at 21 HEIs in South Africa where contact teaching occurs. "Contact" teaching refers to the situation where academic instructors hold face-to-face classes with students.

This study did not include other post-schooling institutions such as Tertiary Vocational Education and Training (TVET) institutions (formerly known as Further Education and Training colleges – FETs).
The study found that the measured prevalence in students, academics and administrative staff is substantially lower than expected in comparison to national prevalence levels. However, the HIV prevalence among service staff is more similar to estimates from other studies.

Findings from the study are captured here, including prevalence among students, academics, administrative staff and service staff.

The mean (average) HIV prevalence for students was 3.4%. Among the two thirds (65%) of students who reported having had sex, HIV prevalence was 3.8%. The province with the highest HIV prevalence at 6.4% was Eastern Cape while Western Cape was lowest at 1.1%.

However, there were often wide variations in HIV prevalence between HEIs within regions. For example, the Eastern Cape has the HEI with the lowest HIV prevalence amongst students nationally and the HEI with the second highest HIV prevalence.

Amongst students, females, with an HIV prevalence of 4.7% were more than three times as likely to be HIV positive compared to males 1.5% and this difference was statistically significant. This pattern was consistent across the provinces. Prevalence was higher amongst older students: 0.7% for 18-19 year olds; 2.3% for 20-25 year olds; and 8.3% for those over 25 years.

The mean HIV prevalence for academic staff was 1.5% The province with the highest HIV prevalence at 3.3% was the Eastern Cape while the Free State was lowest at 0.0%.

The mean HIV prevalence for administrative staff was 4.4%. The province with the highest HIV prevalence at 9.2% was KwaZulu-Natal (KZN) while the Western Cape was lowest at 0.9%.

The mean HIV prevalence for service staff was 12.2%, the highest of all four institutional categories and significantly higher than academics and students. The province with the highest HIV prevalence at 20.3% was KZN while the Western Cape was lowest at 1.2%.

KwaZulu-Natal has the highest prevalence by institutional category, followed by the Eastern Cape. The Eastern Cape had the highest prevalence among students, at 6.4%, followed by KwaZulu-Natal at 6.1%. The lowest overall prevalence among all groups was found in the Western Cape, ranging from 0.2% for academic staff, to 1.2% for service staff.

**SEXUAL BEHAVIOURS AT HEIS**

Qualitative findings about sexual behaviours amongst students at HEIs from the HEAIDS study indicated that, during first months / first year of university students were less likely to make risk-aware decisions regarding sexual liaisons and use of alcohol. This is in keeping with a common sense understanding that young people of post-schooling age who participate in further education are likely to be experimenting and discovering themselves sexually (Saint, 2004). This is a period of high-risk for HIV infection and transmission of other sexually transmitted diseases (ibid).
Generally, the HEAIDS study found to be more acceptable among males for males to have more than one partner at a time. Whereas concurrent partners are not openly acknowledged or accepted in relationships, there is in many cases, a tacit social acceptance of both men and women having more than one partner.

Findings from the study indicate that transactional sex is commonplace, especially amongst female students. While the conditions underlying sex for gain can be attributed to vulnerability, it is also the case that social aspiration and recreation are motivational factors. Intergenerational relationships were reported to be frequent, and in such sexual relations females have little power to negotiate condom use.

Students reported that condoms are most often used in casual, once-off, and new sexual relationships – unless these are accompanied by substance abuse, particularly alcohol, in which case condom use drops sharply.

Findings also indicate that there is limited uptake of VCT on campus. Barriers to uptake include fear of being rejected and stigmatized, and lack of understanding about positive living if HIV positive.

**STUDENT SERVICES FOR HIV AT HEIS**

The same study on HIV prevalence and Related Factors found that there are a range of student support services across campuses. At some campuses, students did not know about services, other campuses there were a range of health and counselling support services and students appeared well informed about them.

Campuses with strong student support services provided comprehensive services, from academic support to strong residence management and support structures, university-funded counselling services, health services with an active outreach and health education component, student peer-education, and disciplinary procedures aimed at creating well-regulated social environments and closely managed campus security measures.

Students using campus sexual and reproductive health services at campus health clinics often felt that health service staff were critical of their being sexually active and were unsympathetic to their needs. On a number of campuses students felt that it was preferable to use other services which were perceived as more youth-friendly.

**HIV POSITIVE CARE AND SUPPORT**

Qualitative findings from the HEAIDS report on HEIs showed that profound levels of perceived stigma exist on campuses. In the qualitative study, disclosure, even in private settings, was deemed too risky for many HIV-positive people to consider.

While students and staff might be encouraged to know their status, available health care, psychosocial services, and basic support for those who tested positive varied across institutions, with overall low levels of HIV-specific support available.
Lack of access to ART on or near campuses was a major problem, and staff and students who lacked medical aid described having to queue for hours to retrieve their treatment each month – often missing classes or work.

LEADERSHIP

In the HEAIDS study at HEIs, there was the perception amongst a significant proportion of students and staff that campus management and student leadership do not take HIV and AIDS seriously. Such perceptions were shaped by the lack of visible and vocal HIV leadership.

COURSE CONTENT ON GENDER, SEXUALITY AND HIV AT HEIS

A project looking at the interaction of higher education, sexualities and gender, with a particular focus on teaching, was conducted in five countries, including South Africa (Bennett & Reddy, 2007). Within South Africa, the researchers wanted to map the terrain of disciplinary engagement with sexualities and gender in South African higher education.

This research project was informed by a vision of how a critical education in sexualities and gender for young South Africans is a prerequisite for engaging citizenship. The project offered an opportunity to understand what those in higher education could be expected to encounter as part and parcel of their academic and professional development.

The components of the study included a database of information on gender and sexuality at higher-education sites, intensive engagement with different faculties, and feedback from students involved in selected sites of teaching.

The researchers conclude that there are diverse courses on South African university campuses that take gender and sexualities seriously. However, these are overwhelmingly located in the humanities and the health sciences. Certain medical disciplines include reproduction and HIV as “sexual risk” as part of the curriculum, but this is presented within a bio-medical model.

THE ROLE OF EDUCATORS AT POST-SCHOOLING INSTITUTIONS

HEAIDS conducted a study on “The Roles of Educators in Mitigating the Impact of the HIV/AIDS Pandemic on the Education System in South Africa” (2009) Participants in this research included educators from the Higher Education (HE), FET [now TVET] and schooling subsectors.

Findings included that reported roles currently played by educators in mitigating the impact of HIV/AIDS were much more prevalent among survey respondents at schools and FET colleges than at universities.
In the HE subsector no HIV/AIDS-specific educator roles are prescribed in policy. In the FET subsector relevant roles for educators in relation to the HIV/AIDS pandemic are embedded in policy requirements, but no role is explicitly defined.

The analysis of the qualitative data demonstrated a difference between the FET and schooling subsectors to the Higher Education (University) subsectors. There were more positive attitude to the inclusion of HIV/AIDS-related issues in the curriculum in the FET and schooling subsectors, and this is likely to be a result of the greater immediacy of the impact of the pandemic in these two subsectors. However, interviewees in these subsectors reported that they often found it difficult to talk about sexuality with their learners, and this clearly inhibited effective curriculum approaches.

A continuum of approaches adopted by educators, from possibly ‘enabling’ to possibly ‘inhibiting’ (in terms of the extent to which they may contribute to mitigating the impact of the pandemic) was identified. The continuum included a practically orientated ‘campaigning approach’, a ‘critical approach’ (for example taking issue with the emphasis on sexual abstinence as an HIV prevention method in the national message) and a ‘moralistic approach’ characterized by conservative and religious values. (p.12)

Those educators who reported playing roles in mitigating the impact of the pandemic indicated that they do not have enough time to do so. Sufficient support seems to be generally more available at universities than at colleges or schools, and resources to facilitate the roles played by respondents are generally in extremely short supply in the schooling and FET subsectors. Resources are clearly not meeting the demand, in this regard, as other findings demonstrate that a) roles are embedded in policy for educators in relation to HIV/AIDS and b) there is a positive attitude in these subsectors for inclusion of HIV/AIDS related-issues into the curriculum. It was reported that there is a significant need for training and resources for future roles. This need is especially intense at colleges and schools.

A striking finding of the research was that many educators are tired of being the recipients of messages about the pandemic rather than active agents in planning to mitigate its impact in the very different contexts in which they work. In response to this, a strategic dilemma was explicitly presented, between institutional strategies of allowing individuals to develop their own responses to the HIV/AIDS pandemic – in contrast to the notion that they should be obliged to undertake specific actions. It was stated that this strategic dilemma needed to be resolved.

**PROMISING HIV/AIDS INTERVENTIONS AT HEIS**

In the study on HIV prevalence and related factors conducted as part of the HEAIDS initiative, promising interventions were documented from the qualitative research component. Some of these are documented here, including promising interventions at HEIs in the Eastern Cape.

The HIV and AIDS peer-education programmes at the University of Pretoria and the University of the Western Cape stood out as particularly successful, featuring a range of engaging student-led prevention activities including drama groups, residence workshops, media and marketing projects, marches, games, poetry slams, VCT counselling, community outreach and more. The peer educators at these institutions received extensive training and the programmes were structured in a way that presented a variety of opportunities for
Students to develop their leadership, grow within the organization and participate in a variety of activities.

Some institutions had taken initiative in developing approaches that addressed HIV and AIDS curricula across departments, thereby stimulating students’ intellectual curiosity on the subject. The University of Cape Town and the University of Pretoria were notable in this respect.

Stellenbosch University and the University of Cape Town created an appealing student culture around voluntary counselling and HIV testing through launching testing campaigns that featured attractive bracelets that are given to students.

In a report to Council by the Deputy Vice-Chancellor of the University of Cape Town, it is stated that UCT has an ongoing drive to develop and implement HIV and AIDS curricula and co-curricula activities across the institution (Soudien, 2012). This is aligned to the University’s strategic goal of making sure its graduates are AIDS-competent. However, he states that there is still much work to be done at UCT in the pursuit of delivery of a comprehensive curriculum response to HIV across all faculties.

The Dean of Student’s Office at Rhodes University conducted research on alcohol use on campus. The department undertook a strategy to promote responsible drinking and engaged with student societies to host events that were alcohol-free – thus offering students an alternative kind of social activity. A research project at Rhodes University was also launched focusing on HIV and AIDS in the curriculum.

The University of Fort Hare notably assisted HIV-positive people in accessing treatment by facilitating appointments at, and providing transport to, the local hospital ART sites.

**GOOD PRACTICE HIV PREVENTION PROGRAMMES AT HEIS**

In 2010 a study was conducted to identify HIV prevention programmes and practices that have been implemented at HEIs (Universities), and the extent to which they cohere with good practice as described in the literature (HEAIDS, 2010 [4]).

The outcome of this process informed the development of an HIV/AIDS Prevention framework with clear indicators to guide the design, development and implementation of effective HIV/AIDS Prevention interventions appropriate for students in the higher education sub-sector.

Next, the study team applied this instrument to a selected number of HEIs to identify and review good practices that had been adopted. 12 HEIs (universities) where selected for the study.

In general, the team found that the HEIs implemented good practices. Prevention activities in 7 out of 8 selected HEIs are dominated by Peer Education and VCT; and in all 8 HEIs, VCT is prominent. These programmes all demonstrated good practices according to the framework indicators. However, there was room for improvement and recommendations were made in relation to VCT and peer education programmes.
PEER EDUCATION

As the 2010 HEAIDS study on prevalence and related factors found, certain peer educator programmes are working well. For example “DramAidE Health Promoters” were considered a valuable and trusted source of support, providing an example of how to live healthily, accept one’s status, access treatment, and maintain a positive attitude towards life. DramAidE is a non-profit organisation based at the Universities of Zululand and KwaZulu-Natal, that implements public health communication campaigns. They run rights-based, sexual & reproductive health programmes as well as psycho-social support projects for orphaned and vulnerable children.6

The 2010 [4] study conducted by HEAIDS on best-practice interventions made recommendations based on specific findings about the nature of peer education at HEIs. The research found that peer educators are often first or second-year students with limited life experience and no training in behaviour change theory or techniques. A key recommendation was to involve psychologists at student counselling units more closely in skills training and in counselling. It was stated that psychologists have experience and skills in behaviour change techniques and use psycho-social theory for groups and the community.

Overall it was recommended that additional resources be made available to assist programme staff and volunteers to use evidence-based practices and theoretical approaches in their prevention activities, and include monitoring and evaluation as on-going activities to help ensure the effectiveness of the programmes. This should include conducting more research about behaviour change: i.e. how to develop appropriate messages for specific populations; which is the most effective type of media for disseminating the messages; and so on.

Recommendations related to peer education at post-schooling institutions, as well as other, broad recommendations, are made in an overall section at the end of this review.

6 http://www.dramaide.co.za/
RATIONALE FOR YOUTH-FRIENDLY HIV PREVENTION AND SRHR SERVICES AT POST-SCHOOLING INSTITUTIONS.

The need for comprehensive and youth-friendly HIV prevention and SRHR services at post-schooling institutions has been widely acknowledged. It should be noted that much of the literature available focuses on Universities, rather than other post-schooling institutions such as TVETs. However, there are some studies that mention other tertiary institutions. A range of reasons for establishing good HIV programmes at HEIs have been presented in the literature. One is that young people of post-schooling age who participate in further education are likely to be experimenting and discovering themselves sexually. This is a period of high-risk for HIV infection and transmission of other sexually transmitted diseases:

“University campuses constitute a potentially fertile environment for the spread of HIV/AIDS. They bring together, in close physical proximity devoid of systematic supervision, a large number of young adults at their peak years of sexual activity and experimentation. Combined with the ready availability of alcohol and perhaps drugs, together with divergent levels of economic resources, these circumstances create a very high risk environment from an HIV/AIDS perspective” (Saint, 2004: 6, cited in Gobind & Ukpere, 2014).

The literature indicates the need for comprehensive youth-friendly and HIV prevention services to young adults in such an environment is crucial. Services should include clinical / medical services for SRHR as well as innovative, appropriate HIV prevention programmes that engage with issues around sexuality, gender and identity.

Another reason for the provision of HIV and SRHR services at post-schooling institutions is to improve the health of employees of the institutions themselves: “there is reason to believe that the pandemic may claim lecturers, researchers, managers, and a significant number of employees from HEIs” (Chetty, 2005: 77, cited in Gobind & Ukpere, 2014).

A further reason often mentioned in research and policy related to HIV services at HEIs is the role of institutions in developing professionals and citizens who are socially responsible and conscious of their role in contributing to that national development needs of the country, and its subsequent social transformation. This responsibility is particularly relevant when it comes to mitigating the impact of the HIV/AIDS pandemic. (Education White Paper 3, 1997, National plan for Higher education, 2001, cited in HEAIDS, 2010 [5])

Many academics and educators have a similar view of how engaging young people on issues of HIV, sexuality and development is part of building critical consciousness and engaging citizenship (Bennett & Reddy, 2007). This perspective is informed by a vision of how a critical education in sexualities and gender for young South Africans is a prerequisite for engaging citizenship (ibid). Saint (2004, p.8) also concurs that “tertiary level staff and students are traditionally among the leaders of their societies, and their active commitment is essential to the development of open national debate and action responses related to the HIV/AIDS pandemic”.
Other key reasons proposed for why tertiary institutions should engage with the challenge of HIV/AIDS include that the epidemic conditions national capacities for economic and political development, and is therefore a legitimate topic for university inquiry (Saint, 2004). There is the argument is that HIV/AIDS poses a threat to the economy, because of the potential loss of tertiary level educators and staff, “the most valuable and productive citizens in the economy” (ibid). Universities are charged with the mission of generating new technologies, practices and understanding through research to help African countries prevent and cope with HIV/AIDS.

**HEAIDS POLICY FRAMEWORK**

The Higher Education HIV/AIDS Programme (HEAIDS) is South Africa’s nationally co-ordinated, comprehensive and large-scale HIV prevention effort at public Higher Education Institutions (HEIs). HEAIDS exists to “develop and strengthen the capacity, systems and structures of all Higher Education Institutions (HEIs) to prevent, manage and mitigate the causes, challenges and consequences of HIV/AIDS”. It stresses that “Higher Education (HE) in South Africa has a vital role to play in mitigating and managing the effects of the HIV/AIDS epidemic through all aspects of its core operations of teaching, learning, research and community engagement”.

HEAIDS is an initiative of the Department of Higher Education and Training that is undertaken by Higher Education South Africa (HESA), the representative body of South Africa’s 23 public Higher Education Institutions.

The HIV and AIDS Policy and Strategic Framework for Higher Education (2012) is aligned with The 2012-2016 National Strategic Plan for HIV, STIs and TB (NSP). The vision of the Policy and Strategic Framework is therefore also aligned with the NSP’s 20 year vision for reversing the burden of disease from HIV, STIs and TB and aims for ‘four zeros’:

- Zero new HIV and TB infections
- Zero deaths from HIV and TB
- Zero new infections due to HIV transmission from mother to child (MTCT)
- Zero discrimination

There are three key objectives of the HIV and AIDS Policy and Strategic Framework, which are outlined below. Beneath these are key components and action points. Illustrated here are those points pertinent to the provision of comprehensive, integrated and youth-friendly HIV prevention and SRHR services at Institutions of Higher Learning:

**Objective 1**

To ensure the comprehensive and appropriate use of the Higher Education mandate of teaching and learning; research, innovation and knowledge generation; and community engagement to effectively respond to the epidemic drivers of the pandemic.

Key components and action points falling under objective 1 that are relevant to provision of HIV prevention and SRHR services:
1. Develop graduates with relevant professional and personal HIV and AIDS knowledge and skills to become leaders in society and who are able to engage the impact of HIV and AIDS.

2. Provide access to comprehensive prevention programmes for staff and students across all campuses and residences. This includes designing and implementing social and behavioural change programmes, interventions and curricula to address the main drivers of HIV and AIDS in the sector which include unprotected sex, gender inequalities, alcohol and substance abuse.

3. Implement a comprehensive social and behavioural change communication strategy that serves to encourage positive attitudes and behaviours and to promote and sustain change.

**Objective 2**

To promote the health and well-being of the Higher Education community at individual, group and institutional levels through strengthening capacity, systems and structures responding to the pandemic.

Key components and action points falling under objective 1 that are relevant to provision of HIV prevention and SRHR services:

1. Develop and implement a comprehensive Health and Wellness HIV and AIDS programme aiming to promote and maintain the physical and mental health of students and staff within the sector.

2. Build the necessary capacity of Campus Health Services, based on the norms and standards developed by the Department of Health for a typical HIV clinic which provides primary health care services, to ensure that all students and staff have equitable access to treatment and wellness services.

3. Ensure that the needs of persons living with HIV/AIDS-related illnesses are reasonably accommodated for as long as possible, and that correct procedures are followed in a non-discriminatory way.

4. Where relevant, ensure that the appropriate linkages are made with other key departments such as occupational health and safety, training and health care provision.

5. Seek to form partnerships that will facilitate the implementation and management of targeted interventions.

6. Strengthen existing HIV and AIDS Workplace programmes for Higher Education that will reduce the negative impact of the pandemic on all individuals employed by the institutions.

7. Each Higher Education Institution should seek to understand the impacts of HIV infection and illness on its employee base, including direct and indirect costs, and identify programmatic gap areas as well as attitudinal and behaviour changes required.
8. All Higher Education Institutions should have an established structure and appointed person(s) to manage and lead the workplace programme components of the institution’s HIV and AIDS programme.

9. Each HEI should develop a treatment and care strategy for employees infected with HIV and AIDS which aligns the institutional workplace programmes to relevant individual institutional policies thereby promoting a level of equal access to and standardisation of treatment.

Objective 3

To create an enabling environment to ensure a comprehensive and effective response to HIV and AIDS within the Higher Education sector, free of stigma and discrimination.

Key components and action points falling under objective 1 that are relevant to provision of HIV prevention and SRHR services:

1. Mobilise strategic leadership through all stakeholder participants of the Higher Education sector.

2. Ensure that the institution has a comprehensive institutional policy and a strategy on HIV and AIDS in alignment with the *Policy and Strategic Framework on HIV and AIDS for Higher Education*.

3. Reduce and eliminate acts of stigma and discrimination through the promotion of equity, fairness and respect for self and others.

4. Ensure coherent and consistent communication.

5. Create strategic partnerships

6. Ensure consistent and appropriate allocation of resources.

7. Develop comprehensive Monitoring and Evaluation systems.
HEAIDS INTERVENTIONS

HEAIDS has run a number of interventions around HIV/AIDS at Higher Education Institutions (Universities), based on research into the context and requirements. Interventions have often been based on existing research conducted by HEAIDS. Three main programmes deemed relevant to the issue of provision of youth-friendly HIV/AIDS and SRHR services at post-schooling institutions are mentioned here: Workplace Programmes, training of teachers to address HIV/AIDS, and the First Things First HCT Campaign.

WORKPLACE PROGRAMMES AT HEIS

A situational analysis was undertaken of each HEIs to determine the state of HIV/AIDS workplace programmes. Subsequently, 22 detailed reports were produced (HEAIDS, 2010:1). The findings indicated that no HEI currently has a comprehensive Workplace HIV and AIDS Programme although all have some elements in place.

A sector-level workplace programme framework was developed by HEAIDS, against which the individual HEIs may develop their own customised workplace programmes (HEAIDS, 2010: 3). The overall purpose of the HIV and AIDS Workplace Programme Framework is to guide and inform Higher Education Institutions in the development of sustainable HIV and AIDS Workplace programmes that will reduce the negative impact of the pandemic on all vulnerable individuals employed by the institutions. An Implementation Guide was developed in order to translate the principles and guidelines in the framework into strategic and operational plans and ultimately institutional workplace programmes.

TRAINING OF TEACHERS TO ADDRESS HIV/AIDS

One key area of focus in HIV prevention work has been on capacitating teachers on how to respond to HIV/AIDS, including SRHR amongst youth. Sex education in South Africa has become synonymous with HIV prevention and the need to provide accurate information about the disease (Francis, 2011). These needs are reflected in policies such as the National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions (Department of Education, 1999) and The HIV and AIDS Emergency: Guidelines for Educators (Department of Education, 2000) (cited in Francis, 2011).

HEAIDS piloted an intervention at HEIs to enhance the personal and professional competencies of teacher education graduates so that they are equipped to deal with the challenges posed by teaching and learning in an HIV/AIDS affected and infected society (2010 [5]). This would be achieved through:

- The provision of support for the piloting of an HIV/AIDS teacher education module in teacher education faculties, and
- The identification, evaluation and dissemination of effective strategies for incorporation of HIV/AIDS related education into teacher education and other curricula.
Several key areas informed the Pilot Module and teacher development in the area of HIV/AIDS:

- The significance of instructors' own self-knowledge and how they engage with HIV/AIDS (through reflexivity and self-study), and the need for ongoing professional support;
- Participatory methodologies and pre-service and in-service teacher engagement;
- Flexibility, multiple modes of delivery and differentiated curricula;
- Collaborations (for example, team teaching) and partnerships;
- Greater support for curriculum integration; and
- Interrelatedness of curriculum (design, planning, evaluation) and up-to-date knowledge in the area of HIV/AIDS.

The pilot model was evaluated by HEAIDS in 2010 [5], and conclusions and recommendations point to lessons of experience which can inform the module’s on-going development and refinement.

**FIRST THINGS FIRST HCT CAMPAIGN**

The First Things First HIV Counselling and Testing (HCT) campaign is aimed at mobilising students and staff at Higher Education Institutions across South Africa to know their HIV status, stop HIV stigma and fight the HIV pandemic as a direct contribution to an objective of the 2012-2016 National Strategic Plan for HIV, STIs and TB to maximise opportunities for testing for HIV. In 2011, the campaign achieved in testing 22 000 students at 17 universities. 58% of these students had never been tested before.
HEAIDS POLICY AND PRACTICE: IMPLICATIONS FOR THE EASTERN CAPE

Down to here: What are implications? Put this in with the recommendations (under HEAIDS recommendations)

to then a section explaining the policy in practice as it relates to institutions across the Eastern Cape – if we know this??

Then summarize section below.

HEAIDS RECOMMENDATIONS FOR HIV RESPONSE AT HEIS.

The following recommendations were synthesised from the HEAIDS policy, research and strategy reports. They refer to programmes and responses specifically at HEIs, or Universities.

**Need for a diversified and customized response**

The HEAIDS (2010 [1]) HIV prevalence and related factors report found that HIV epidemic is varied between and within HEIs. The response therefore needs to be diversified and customised towards specific needs rather than a generic, ‘one size fits all’ approach. Each institution should endeavour in the short-term to present an HIV and AIDS response plan that takes into account the specific drivers of infection at the institution and its sub-campuses (HEAIDS, 2012).

One striking finding in research conducted by HEAIDS (2009) on the role of educators in responding to HIV/AIDS was that educators are tired of being the recipients of messages about HIV, and would rather have the autonomy to be active agents in planning their institutional response in very different contexts. This was particularly amongst Higher Education respondents. There is a need to resolve a strategic dilemma between institutional strategies of allowing individuals to develop their own responses to the HIV/AIDS pandemic – in contrast to the notion that they should be obliged to undertake specific actions.

**Prevention strategies**

- There should be a modified and improved VCT strategy – depending on prevalence at the institution.

- Increased focus on generating knowledge of PEP and PMCTCT promotion is recommended.

- There is a need for improved knowledge about and treatment of STIs – there were high-levels of self-reported symptoms of STIs.
• HIV and health services are needed for staff, especially service staff who have the highest prevalence of HIV as compared with other staff and with students.

• Efforts should be made for peer education programmes for students and staff – institutional support should be provided to peer education where it is externally financed and managed.

• Should be a focus on positive prevention (bringing HIV positive people into prevention activities).

• Education should be focused on higher-risk groups.

• HIV prevention programmes should address vulnerability to transactional sex

• HEIs must address vulnerability / lack of security on campus – women feel vulnerable and to sexual harassment. Efforts to address issues must be intensified through emphasizing gender rights and mutual respect.

• Bridging programmes should be established for new and young students during first 6 months at the HEI – to support young people to make good and risk-aware decisions.

• HIV prevention programmes need to depart from simple awareness campaigns, condom provision and VCT provision.

Support to people living with HIV/AIDS

• All institutions should strive to become environments that are sensitive to and accommodation of the needs of HIV positive people.

• ART should be made available on or near campuses

• Support to PLWHA should be provided including peer support

Leadership and commitment

• According to the HEAIDS policy and strategic framework (2012), the Higher Education sector occupies an advantageous position that allows it to set an example in terms of critical debate, policy development and creative responses to this epidemic.

• There should be strong institutional leadership: To assist this, HEIs should establish institutional HIV and AIDS committees.

• Staff organisations/unions/bodies should be actively involved in addressing HIV and AIDS

• A sector wide initiative to promote student leadership is recommended.
**Building agency and leadership amongst young people to respond to HIV**

Moving beyond traditional prevention and treatment programmes, the HEAIDS strategic framework (2006-9) indicates that students should be empowered to understand and address HIV/AIDS in all aspects of their lives and in their communities. The vision here is also that the Higher Education sector will develop leaders who will shape future societies.

Thus, through a comprehensive and multi-faceted approach to education on HIV/AIDS, as outlined in the HEAIDS strategic framework, students should be exposed to the following (cited in Soudien, 2012):

- Knowing how to keep themselves healthy;
- Understanding the gender dimension of HIV transmission and the role of women in sexual decision-making;
- Intellectual debate and inquiry about the medical, social, demographic and economic issues relating to HIV and AIDS;
- An informed understanding of how HIV and AIDS will affect their future professional careers;
- The implications of managing HIV and AIDS in universities and work places;
- The potential impact of HIV and AIDS on the economic and social development of South Africa and the world;
- Developing a caring, tolerant, and non-discriminatory approach to persons living with HIV and AIDS; and
- Engaging with the wider community.

**Research and learning environments**

- HEIs should mobilize research on HIV and AIDS on their own campuses.

- HIV and AIDS should be integrated into subject curricula. There have been promising initiatives e.g. University of Pretoria and UCT, also a research project at Rhodes.

**HEIs should design HIV policies and programmes that reach employees**

HEAIDS (2010, [2]) asserts that HEIs must as employers “recognise the potential impact of HIV and AIDS on both infected and affected employees and design policies and programmes to prevent/reduce infection rates and mitigate its impact on employees and the institution” (cited in Soudien, 2012)

Service and contracted staff in particular, asserts HEAIDS, should be included in the response to HIV. HEAIDS notes that service staff, the most affected by HIV and AIDS at HEIs, have been largely overlooked in campus prevention, care and support programmes.

Additionally, HEAIDS recommends that “AIDS-related engagement with and service to society” should be incorporated into professional programme requirements. Staff should also, states HEAIDS, receive sufficient information and education to be able to effectively and fully
integrate a relevant HIV and AIDS component into the curriculum, examining the issue of high-risk sexual behaviour.

**Innovative and participatory approaches to teaching and learning**

HEAIDS calls for innovative and participatory approaches to teaching and learning (2010 [2]). It states that staff development needs to be at the centre of HIV/AIDS curriculum integration initiatives and that there is a corresponding need to research a variety of teaching interventions, curriculum models and conceptualisations.

**Community partnerships**

HEAIDS (2006) highlights the importance of engagement with the community by staff, students and civil society, in a two-way flow of expertise and support, which emphasizes partnerships and sponsorship programmes (cited in Soudien, 2012).

HEAIDS suggests an institution could investigate ways in which the surrounding community may benefit from the HIV and AIDS curricula and applied and operational research-based learning.

**Co-ordinated response**

The HEAIDS policy and strategic framework (2012) calls for a co-ordinated and effective Higher Education Sectoral Response. It states that the coordination of sector efforts towards a collective response would strengthen and enhance these initiatives.
CONCLUSIONS

Young people are particularly affected by HIV, and there are a number of contextual factors that contribute to risk of infection. Much of the literature points to young people’s high-risk sexual behaviours, as well as vulnerability to sexual and gender-based violence. It is also now widely acknowledged that structural factors such as poverty, inequality, and gendered social norms about relationships and sex play a significant role in young people’s behaviours and consequent susceptibility to HIV infection.

There have been significant developments in addressing sexual and reproductive health and rights in South Africa. Laws and policies have foregrounded human rights, including SRH rights, in South Africa’s post-apartheid democracy. While there is still progress to be made to translate these policies into practice, there have been developments in the provision of adolescent and youth-friendly clinical services. This started with the National Adolescent-Friendly Clinic Initiative (NAFCI), which was scaled up to the Youth Friendly Services Programme in 2006. Some progress has been made in the provision of AYFS, however there are still challenges and an Eastern Cape study of primary health care facilities has made important recommendations as to the way forward.

Providing adolescent and youth-friendly clinical services is key to improving SRHR and preventing and mitigating the effects of HIV amongst youth. Another, crucial role of HIV prevention is to empower young people to make strong and positive decisions about sex and relationships, including having safer sex. There has been a shift in thinking away from the ‘knowledge to action’ behaviour change model that informs information-based health education campaigns and is underpinned by assumptions about the rationality of the individual. The most successful HIV prevention programmes are those that take account of sexuality in its broad sense, as being about a young person’s evolving identity which is influenced by a range of social and psychological factors including gendered social norms, and peer identities.

Peer education, a commonly used strategy for HIV prevention with young people, is a useful tool for opening up collective dialogue and reflection around social norms and identities that influence sexual behaviours, encouraging youth to make positive and healthy decisions about relationships and sex. This review has documented a few national programmes that address HIV prevention and SRHR with youth, several of which use peer education as a key component of their work. Organizations that use peer education as an intervention strategy, such as Restless Development’s work in the Eastern Cape, are instrumental to empowering young people to make critical decisions about their sexuality, as well as building peer networks of support.

The post-schooling context is outlined in this review, as conveyed in DHET’s White Paper on post-schooling education and training. This paper provides a social justice framing of what needs to change to improve access to and quality of higher education in South Africa, in order to build a developmental state with a vibrant democracy and flourishing economy. This is a useful lens through which to envision how Institutions of Higher Learning play a role in the development of young people to live healthier lives through increasing access to SRHR and HIV prevention services.

The Higher Education HIV/AIDS Programme (HEAIDS) is South Africa’s nationally coordinated, comprehensive and large-scale HIV prevention effort at public Higher Education
Institutions (HEIs). This initiative is based primarily with Universities, rather than other Tertiary Institutions. HEAIDS has published a number of reports on their research projects, interventions and policy and strategy for HIV prevention at HEIs.

One significant finding of a HEAIDS HIV prevalence study conducted with HEIs is that the overall prevalence amongst students and staff is lower than that of the general population. However service staff have a higher prevalence that is more in keeping with national trends, and therefore HIV workplace programmes at HEIs should make more of an effort to involve and include such staff.

The study found that the Eastern Cape has the highest prevalence of HIV amongst students, at 6.4%, whilst the Western Cape has the lowest at 1.1%. This could suggest that there is a significant need to build effective HIV prevention and SRHR services and programmes at Higher Education and other Tertiary Institutions in the Eastern Cape. Other prevalence statistics that are of interest are that HIV prevalence is higher amongst older students who attend Higher Education Institutions, and that young women are three times more likely to be HIV positive than young men.

HIV prevention programmes are present at some Universities, and there were examples of good practice including the peer education programmes at the University of Pretoria and the University of the Western Cape which featured a range of engaging student-led prevention activities.

Campuses with strong student support services provided comprehensive services, from academic support to strong residence management and support structures, university-funded counselling services, health services with an active outreach and health education component, student peer-education, and disciplinary procedures aimed at creating well-regulated social environments and closely managed campus security measures. However, at several institutions students using campus sexual and reproductive health services at campus health clinics often felt that health service staff were critical of their being sexually active and were unsympathetic to their needs.

There are a number of HEAIDS policy and research papers as well as interventions that have been evaluated that are documented in this review. Recommendations from these reports are captured, including the need for HEIs to play a leadership role in addressing HIV, to improve the quality and scale HIV prevention programmes at HEIs, to provide support to people living with HIV, to establish community partnerships, and the importance of developing young citizens who have the commitment and potential to play a transformative role in society including addressing HIV and AIDS – to name but a few. A significant recommendation worth foregrounding came out in a report on the role of educators in addressing HIV/AIDS, including educators from Higher Education, FET (now TVET), and schooling subsectors. Namely, that there is a strategic dilemma that needs to be resolved around whether institutions should encourage individuals to develop their own responses, rather than prescribing specific actions. The underlying implication of this is that educators should be understood as active agents planning to mitigate the impact of HIV and AIDS in very different socioeconomic and subsectoral contexts, rather than as passive recipients of messages that they must then communicate to youth.

HEAIDS has developed a Policy and Strategic Framework for addressing HIV and AIDS with a number of objectives and components. This includes providing access to comprehensive prevention programmes for staff and students, building the necessary Campus Health Services, based on the norms and standards developed by the Department of Health,
strengthen HIV and AIDS Workplace programmes through recommended minimum components. The Policy and Strategic Framework does not make specific reference to the provision of youth-friendly services, even as it mentions the norms and standards developed by the Department of Health.

A major gap identified in this review is the lack of research or interventions targeted at other post-schooling institutions, apart from Universities. HEAIDS focuses on Higher Education Institutions, namely Universities, and sometimes conducts research with other Institutions. One key finding that arose from such research is that sufficient support seems to be generally more available at universities than at colleges or schools, and resources to facilitate the roles played by respondents are generally in extremely short supply in the schooling and Tertiary Vocational and Training (TVET) college subsectors. Thus, although it is recognized that there is a significant need for training and resources to address HIV and SRHR at TVET’s, this is a gap that is not being addressed.

In this literature review on the provision of youth-friendly HIV prevention and SRHR services at post-schooling institutions, no similar study was found. This points to a major gap in the literature on HIV prevention amongst youth, as well as on HIV services at post-schooling institutions. While HEAIDS has assisted with the development of HIV prevention and SRHR services at HEIs, and conducted a number of studies on the subject, there has not been a specific focus on whether these services are youth-friendly. Similarly, in the literature on AYFS services, the focus has been on primary health care clinics, rather than on educational institutions.

In light of the trends identified in the literature, as well as gaps and the need for further action to be taken, key recommendations are made.
RECOMMENDATIONS FOR FUTURE INTERVENTIONS AND RESEARCH

1. MAKE HIV/AIDS SERVICES YOUTH FRIENDLY

There is a need to develop HIV/AIDS and SRHR services at post-schooling institutions to be comprehensive, integrated and adolescent and youth-friendly. A practical point to make as regards policy, is that the HEAIDS Policy and Strategic Framework for addressing HIV and AIDS should speak to the need for services to be youth-friendly. At present the term youth friendly services is not present in the Framework.

2. IMPROVE ATTITUDES OF SERVICE PROVIDERS, AND RANGE OF SERVICES.

Essential to the provision of youth-friendly clinical services at post-schooling institutions is addressing the attitudes and behaviours of campus health-clinic providers so that they are more receptive and sensitive to sexually active students. It is also important for there to be a range of services available, including academic support, strong residence management and support structures, university-funded counselling services, health services with an active outreach and health education component, student peer-education, and disciplinary procedures aimed at creating well-regulated social environments.

3. EMULATE GOOD-PRACTICE IN HIV PREVENTION

Good-practice models of HIV prevention programmes should be captured and emulated at other HEIs, and at other post-schooling institutions including TVETs. An in depth analysis of the approaches taken by the University of Pretoria and the University of the Western Cape will give rise to process-level recommendations of how to develop such programmes at other Institutions.

4. STRENGTHEN PEER EDUCATION STRATEGIES

Peer education strategies should be understood for their potential in addressing gendered social norms and engaging with understandings of sexuality in order to empower young people to make good decisions about relationships, sex and sexual health. This should be informed by a strong theoretical understanding sexuality, identity and behaviour. Young peer educators should also be equipped with an understanding of such a conceptual underpinning to HIV prevention peer education strategies.

5. FORM PARTNERSHIPS WITH NATIONAL YOUTH-DEVELOPMENT PROGRAMMES
Post-schooling institutions should form partnerships with national programmes in South Africa that are having significant impact in engaging youth in HIV prevention and SRHR activities so that they can have greater impact. Organizations that they could partner with include, for example, Sonke Gender Justice, and Restless Development South Africa. This will also enable an exchange of approaches to HIV prevention and the provision of AYFS services in order to develop improved strategies and programmes.

6. INVOLVE OTHER POST-SCHOOLING INSTITUTIONS IN HIV AND SRHR WORK

HEAIDS and other national-level interventions should make efforts to include and involve other post-schooling institutions, as well as Universities, in their HIV prevention and mitigation programmes. Institutions such as TVET’s may lack the resources of Universities to respond to HIV amongst their student and staff population. Yet TVET’s are more numerous than Universities, are attended by students of a younger age (who may not have finished school) a range of socio-economic backgrounds who are also affected directly by HIV.

7. TAKE HEED OF PREVALENCE STATISTICS

The HEADS prevalence report indicates that a) the highest HIV prevalence amongst students is in the Eastern Cape, b) that those most likely to be infected are older students (25 and older) and c) women are three times more likely to be HIV positive than men. Taking heed of these statistics would mean focusing efforts on Provinces most affected, such as the Eastern Cape, and reaching older students with treatment and prevention programmes. It is also important to conduct more in depth research into the factors affecting HIV infection in female students at post-schooling institutions, including Universities and TVETS. While there is evidence in the literature as to why women are more likely to be infected, a context-specific analysis should be conducted at post-schooling institutions.

8. ESTABLISH WORK-PLACE PROGRAMMES

Post-schooling institutions should establish comprehensive HIV work-place programmes that target both students and staff. The needs of service staff in particular should be addressed. The issue of addressing HIV and SRHR amongst youth who attend post-schooling institutions should not be viewed in isolation of employees of the institutions. Rather, a holistic approach should be taken where the needs of students and staff are considered and their participation in programmes and utilization of services is encouraged.

9. NEED FOR FURTHER RESEARCH AND ANALYSIS

a. Finally, this review was unique in its focus on the provision of youth-friendly HIV prevention and SRHR services at post-schooling institutions. No other study or intervention was found to focus on this combination of criteria (youth-friendly services and services that are based at post-schooling institutions.) This presents a gap in the literature that can be addressed, a gap that the second phase of this project will contribute to. This will be achieved through a situation analysis of
whether and how HIV prevention and SRHR programmes and services in the Eastern Cape are and can be, youth-friendly.

b. Other gaps in the literature include Provincial-level studies of post-schooling institutions. A Provincial-level study has been conducted in the Western Cape. However, as yet there do not seem to be studies conducted in other Provinces, including research into the nature of the HIV epidemic in these institutions and the response with regards to programmes and services.

c. No research was found on post-schooling institutions other than Universities (Higher Education Institutions), meanwhile institutions such as TVETs are likely to have students who are just as affected by HIV and AIDS.

d. As mentioned above, more research is needed to understand why particular people are more or less affected by HIV. For example why older students are more affected, and more women than men. The fact that service staff are particularly affected by HIV/AIDS at Higher Education Institutions is an issue that should also be researched into further.
REFERENCES


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