Staff and students` perception of an HIV/AIDS` strategy: a case study of a South African rural-based university

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Abstract

Background: South African communities have high rates of people living with HIV and AIDS. Universities, particularly those in rural regions are examples of communities noted to be high risk areas of these infections. HIV/AIDS strategies were developed and implemented by higher education institutions to address this concern. Despite this, the prevalence and incidence of HIV and AIDS remain high in academic settings. Yet studies in this area in South Africa are rare. Aim: This paper reports on a study that explored the perceptions of students and staff of the HIV/AIDS strategy of a rural-based university in South Africa. Method: Hermeneutic phenomenological methodology was adopted. Data were collected using semi-structured individual interviews (n=12 student, n= 10 staff). The data were analysed thematically using Diekelmann, Allen & Tanner`s (1989) seven-stage framework of data analysis. Results: Three major themes emerged from the data analysis: HIV/AIDS services, management of HIV/AIDS services, and barriers to utilisation of HIV/AIDS services. Conclusion: Staff working in HIV/AIDS service requires training and support to enhance their skills, knowledge and adopt non-discriminatory practices.

Keywords: *hermeneutic phenomenology, HIV/AIDS strategy, rural-based university, perceptions, South Africa.*

1. Introduction

South Africa is one of the countries with the highest prevalence and incidence of HIV and AIDS in the world (National Department of Health, 2013). Whilst this is the case, universities are noted in the literature to be high-risk areas for HIV infections (South Africa National AIDS Council, 2011). This is a function of high-risk sexual behaviours, like unprotected casual sex and multiple concurrent sexual partners, commonly observed among university students (Otaala, 2007). Engagement in these behaviours may expose both students and other members of university communities, such as academic and non-academic staff to the risk of being infected with HIV. A survey carried out between 2008 and 2009 revealed high prevalence and incidence of HIV in these communities (Higher Education HIV/AIDS Programme, 2010).

There is significant evidence to indicate that HIV and AIDS had and still have negative effects on institutions in South Africa, including higher education establishments. Taking students for example, a study by Dorrington, Johnson, Bradshaw & Daniel (2006) reported a decline in academic performance and an increase in attrition or drop-out rates among HIV-positive students. These outcomes were in the main attributed to increased ill-health, ill-health related absenteeism, discrimination and stigmatisation (Booysen et al. 2003). Discriminatory and stigmatising experiences are not only related to students, university employees are also sometimes, if not frequently, exposed to these encounters. Chilisa, Bennell & Hyde`s (2001) study conducted thirteen years ago, is used in this report to indicate the historical nature of these experiences. They reported that academic and non-academic staff are sometimes transferred from one department to another and / or terminated from employment because of being HIV-positive. While these encounters may lead people to conceal their HIV statuses, they are inconsistent with the South Africa's Constitution of 1996 that advocates the provision of non-discriminatory approaches to all South Africans irrespective of age, gender, social and health statuses (Barret-Grant, Fine, Haywood & Strode, 2003).

Negative regard from others in the form of stigmatization, prejudice and discrimination can lead to negative self-regard or negative self-perception, which is frequently referred to as internalised homophobia or sometimes as internalised homonegativity (Morris, DeGelder, Weiskrantz & Dolan, 2001). This term refers to an active process of directing negative social attitudes toward the self, leading to a devaluation of the self and resultant intrapersonal conflict

and poor self-image (Meyer, 2007). Outcomes of a wide range of research studies revealed positive relationships between internalised homophobia, anxiety symptoms, HIV-risk behaviours, suicidal ideations, self-harm and subsequent suicides (Lewis, 2003; Sandy, 2013). Suicide attempts and successful suicides are not uncommon among people living with HIV and AIDS. Even though there are limited empirically generated data in South Africa in support of this (Department of Health, 2001), a first-hand clinical experience of the researchers of this study indicates the same.

We are aware of ten individuals who took their lives because they were tested positive for HIV. Two were reported to succeed after several attempts.

Deaths of university staff and students living with HIV and AIDS are not only attributable to suicides, but they are also attributable to opportunistic infections, like tuberculosis and pneumonia (Campbell, Foulis, Maimane & Sibiya, 2005; Basson & Roets, 2013). Irrespective of the reasons of death, these forms of loss can generate in others negative emotions, like feelings of hopelessness and helplessness (Sandy, 2013). Added to this, loosing work colleagues through death could lead to burnout, which in this case is associated with work overload and psychological pains of losses. Burnout is a state of physical and emotional fatigue caused by prolonged exposure to stressful situations (Schaufeli, Leiter & Maslach, 2009). Repeated exposure to the experiences of burnout may result in the development of diseases, such as depression, associated with negative self-evaluation. The outcomes of these may include an increase in absenteeism, and subsequent termination of employment (Bakker, Demerouti & Verbeke, 2004).

The discussions thus far indicate that HIV and AIDS are serious concerns for higher education institutions. Hence, in 1996 the Ministry of Education formulated a national HIV/ AIDS policy for all higher education institutions in South Africa. This policy encourages these institutions to develop and implement strategies for tackling HIV and AIDS and their impact. Some of the key aspects to be incorporated in these HIV/AIDS-related strategies include the development of individual institutional HIV/AIDS policies that clearly specify evidence-informed preventive and management approaches. Examples of these approaches are raising awareness of HIV and AIDS, counselling and testing. Added to this, it was required for the institutional strategies to incorporate the development of HIV/ADIS committees. The remit of these committees is to ensure effective implementation, monitoring and evaluation of preventive and management approaches. Despite the implementation of the institutional strategies, the prevalence and incidence of HIV and AIDS remain high and continue to increase in academic settings of South Africa (Higher Education HIV/AIDS programme, 2010). It is precisely these issues that this study seeks to respond to within the context of rural-based universities, which were reported to have higher rates of HIV and AIDS relative to the metropolitan (urban) institutions. The healthcare professionals of a HIV and AIDS clinic of a specific rural-based university provided worrying accounts.

The HIVand AIDS-related deaths of students and employees are on the rise in this institution.

Such clinical accounts generated further doubts about the effectiveness of the HIV/AIDS strategy of the rural-based university concerned.

2. Method

2.1 Aim

This paper reports on a study that explored the perceptions of students and staff of the HIV/AIDS strategy of a rural-based university in South Africa.

2.2 Design

Taking into account that little is known about the effectiveness of HIV/AIDS strategies used in rural-based universities in South Africa, this study adopted a phenomenological methodology, using the principles of the Heideggerian Hermeneutic approach (McConnell-Henry, Chapman & Francis, .2009). The goal of this strand of phenomenology is to enter and understand participants` world. In essence, this relates to researchers engaging in a dialogue with participants (texts) in order to develop understanding of phenomena. Thus, hermeneutic phenomenology requires researchers to go beyond the description of phenomena, reporting not just what participants relate in relation to their experience, but also offering expert analysis of these experiences. In Heidegger`s views, such interprevity activity can be achieved by repeated engagement with participants (texts) using reflective and critical questioning approach to understand meanings of phenomena (McConnell-Henry, Chapman & Francis, 2009). He added that researchers using hermeneutic phenomenological methodology also set out at the outset of studies to develop empathic understanding of participants` experiences, in order words, texts. The notion of text is used here to include not just written text (e.g. transcripts and notes) but also situations and participants` actions or behaviours. The rationale for engaging with textual material is to

understand the whole of the text (HIV/AIDS strategy) in terms of its parts and the parts in terms of the whole (Gadamer, 1996). It is this rigour described that prompted the use of this approach in this study.

2.3 Sampling and participants

The study was carried out in one rural-based university of a province in South Africa. Historically, rural-based universities are academic institutions established during the apartheid era for black people (Nkomo, 2007). Each of these universities was established for only one specific ethnic group; an approach adopted at the time to promote segregation of black people. To date, these universities are still predominantly made up of black students and staff.

The university has a Health Centre that provides HIV/AIDS services to both students and staff. A letter was sent to all students and staff of the university who used the HIV/AIDS services and / or involved in running the same during the month of February 2011, inviting them to participate in the study. In South Africa, the month of February has a period entitled *sexually transmitted infections` week*. During this period, South Africans are expected to make use of health services for sexually transmitted infections, including those related HIV/AIDS. The letter sent contained brief explanations of the purpose of the study, its benefits and eligibility criteria for participation. 30 students and 20 staff made contact with the researchers and expressed their willingness to participate in the study. Sampling was criteria purposive. 12 students and 10 staff met the inclusion criteria for participation (table 1). A follow-up letter was sent to each of the students and staff eligible for participation confirming date, time and venue of interviews.

Table 1: Participants category and inclusion criteria

Category	Characteristics
Staff	Two nurses from the HIV/AIDS Clinic, who were HIV-negative. They were rendering health care services for people living with HIV and AIDS.
	Three Health promoters. These staff who were openly living with HIV and AIDS working in the HIV/AIDS Clinic to promote positive living with HIV and AIDS.
	Five staff members living with HIV working in different university departments who were receiving services from HIV and AIDS Clinic.
Student	Five students living with HIV and AIDS who were receiving services from HIV and AIDS.
	Five peer educators. These were students who were HIV-negative. They were involved in the HIV/AIDS related activities, such as awareness campaigns and condom distribution.
	Two students with disabilities who have also received services from the HIV/AIDS unit.

2.4 Data collection and analysis

Ethical clearance was required and obtained from the Rural-based University Research Ethics Committee. Informed consent was sought and obtained from each participant before data collection. Interviews were conducted using a semi-structured interview format. All interviews stemmed from a broad question: ***How is HIV/AIDS managed in this university?*** Follow-up questions were in part influenced by an interview topic guide that covers aspects, such as policies, organisation, financing, staffing, programmes, monitoring and evaluation. Each interview lasted for about 50 minutes and was audio-taped.

All interviews were transcribed verbatim. A team approach to analysis was adopted for each transcript using Diekelmann, Allen & Tanner`s (1989) seven-stage framework of data analysis outlined below. This framework enabled the researchers to generate shared experiences and meanings of the phenomenon studied.

Stage 1: Read each transcript gain understanding of phenomenon.
Stage 2: Interprete and summarise each transcript.
Stage 3: Select specific transcripts and analyse by a team of researchers.
Stage 4: Resolve any disagreements of interpretations by examining texts.
Stage 5: Identify themes that reflect common meanings and shared practices.
Stage 6: Identify emergent relationships among themes.
Stage 7: Develop a table of themes with associated excerpts from transcripts.
Diekelmann, Allen & Tanner's (1989) Seven-Stage Framework of Data Analysis

3. Findings

Three main thematic categories emerged from the data analysis. They were (1) HIV/AIDS services, (2) management of HIV/AIDS services, and (3) barriers to utilisation of HIV/AIDS services. These main themes were further divided into sub-themes indicated in bold italics. Excerpts from transcripts are used to support discussions presented. Data from health promoters, peer educators, nurses, staff and students are identified by the initials 'HP', 'PE', 'N', 'SF' and 'ST' respectively.

3.1 HIV/AIDS services

Participants repeated talked about an urgent need to prevent the spread of HIV infection among students, staff and members of communities surrounding the university. This was a function of the reported increases in the incidence and prevalence of this condition in the university community, which they claimed can be tackled with the use of multiple and integrated approaches. An approach that was considered significant by most participants for the prevention of the increase of this infection relates to raising awareness campaigns. According to participants, this involves conducting roadshows and distribution of leaflets containing information on the causes, impact and prevention of HIV.

We conduct mass communication forums, like 'Scrutinise Campaigns' and 'One Love'. During these activities we talk about risk behaviours, such as multiple partners. We also supply information leaflets on HIV/AIDS (PE).

While providing factual information about HIV/AIDS, including its causes and prevention would reduce ignorance about this condition, few participants stressed that this approach on its own would not prevent stigmatisation and the growing incidence of the same. These participants therefore suggested for a complimentary service of HIV counselling and testing to be offered to staff and students. Such a service focuses on sexual risk behaviours and the importance for individuals to know their HIV status.

This university has a HIV/AIDS unit that provides a HIV counselling and testing service. An outside agency, New Start, visits the university on specific weeks, such as 'sexually transmitted infections` week', to offer conselling and testing service (N).

There was an agreement among some participants that knowing HIV status is a necessary, but not a sufficient condition for the prevention of this infection. What is therefore need, participants asserted, is the provision and utilisation of physical preventive measures, such as condoms.

Condotainers containing condoms are placed in a number of easily accessible places, like toilets, to encourage their use. The HIV/AIDS unit also employs a door-to-door distribution approach to promotion of condom use. Combining information giving approaches with condom use prevents or at least reduces the spread of HIV (ST).

Students and staff who are tested positive for HIV have a great need for emotional support. However, because of past negative experiences (stigmatisation and discrimination), asserted by participants, some find it extremely hard to seek and even accept professional help. Failure to reach out for help could lead to the spread of the infection. According to some participants this indicates the need for an unpressured way to express feelings. An HIV/AIDS support group serves as a forum that would ensure psychological safety for emotional expression.

We meet monthly with other people living with HIV and AIDS. At these meetings, we discuss our challenges, future plans and ways of coping with our problems (HP).

In addition to discussions relating to specific services, participants also talked about how these services were managed, in other words, led and coordinated.

3.2 Management of HIV/AIDS services

Some participants agreed with the view that the policy of the HIV/AIDS service guided their day-to-day approaches to the provision of support and care. They went on to say that it provided a structure that enabled them to manage their anxieties in relation to meeting the needs of users. Whilst the guidance of the policy assisted in ensuring consistency in the application of services, some participants described variations in responses to the needs of users.

Here we have our HIV/AIDS policy that we follow. Users of the service are human, and they have different needs. So, we sometimes make adjustments to meet their individual needs (N).

The provision of individualised support and care was an important facet of the HIV/AIDS service, but it was and still particularly important for the service recipients. This assertion was a function of the view that it created opportunities for the latter to be provided with the care they need and deserve. The HIV/AIDS service had a coordinator, a healthcare professional that managed and led the functions of this service. According to participants, the coordinator ensured

effective implementation of the HIV/AIDS services.

All the workers in this unit have their specific responsibilities and duties. The coordinator sees us on a regular basis for supervision to offer support and ensure that we carry out our duties. The coordinator also receives support from her supervisor (HP).

Support in the forms of supervision was not a luxury in the HIV/AIDS service, but was an integral part of the strategy for effective working. Few participants reported that it enabled them to develop and deliver good practice to service users. There was consistency in the views of a minority of participants with regard to the usefulness and effectiveness of the HIV/AIDS service. They claimed that the service is useful and effective as it generally meets the needs of both students and staff who make use of it. The Quality Assurance department, which remit is to monitor and evaluate the functions of the facets of the university, including the HIV/AIDS service, agreed with the participants`` views.

The recent evaluation report of this HIV/AIDS service highlighted that it working well. People who have used it praised it a lot. They found the staff helpful. But there are few areas that need attention. An example is staffing levels and support for its staff (SF).

While this extract does explicitly indicate a positive HIV/AIDS service, it covertly demonstrates participants` perceptions of factors that may impede individuals from using the same.

3.3 Barriers to utilisation of HIV/AIDS service

Understanding the factors that may influence utilisation of HIV/AIDS service is crucial for enhancing the quality of support and care offered to users. Hence, attempts were made during interviews to explore participants' perceptions and/or experiences of using the HIV/AIDS service. Stigmatisation of people living with HIV and AIDS was talked about as a key obstacle to preventive approaches and service utilisation.

Both students and staff are worried about using this service; HIV testing and Counselling. This is because of the stigma attached to this disease. So, we have to address this issue to encourage staff and students to make use of all the services in this unit (N).

Stigmatization served as a strong deterrent to student and staff seeking HIV/AIDS-related help. Participants stressed that HIV and AIDS are in the main associated with promiscuous sex and drug abuse in African rural communities. Such an association was considered by some participants as devaluing and disrespectful.

Stigmatisation is a process of devaluation of people infected with HIV and those living with AIDS. Others call them sex maniacs or sinners or drug addicts. It is also a devaluation act of people related to or associated with those who are living with these diseases (SF).

To be stigmatised because of association (association stigma) with an individual living with HIV and AIDS may result in this individual being subjected to discriminatory practices.

Some people thought I am also infected because I am friend of someone with HIV. So, I had to move away from him. I no longer invite him to my parties. He recently told me that my actions make him to feel more stigmatised (ST).

From participants' point of view, "to feel stigmatised" (enact stigma), does not only make people look down upon themselves (negative self-regard or negative self-perception), it is also an unpleasant place to be as such experiences usually generate feelings of discomfort and insecurity. Thus, victims may adopt strategies to alleviate such discomfort. Few participants reported that concealment is a common and frequent approach used to cope with discrimination and stigmatization.

Many students and staff are infected with this virus. Some have AIDS. They are not using our services because they are scared to be seen entering the HIV/AIDS unit, which share the same building with the Health Clinic. This is a huge threat to our privacy and confidentiality (HP).

Respecting the right to privacy and confidentiality is a vital element of the care and support for people living with HIV and AIDS. While the threat to privacy was noted to impede attendance to the HIV/AIDS clinic, accessing care and support offered in the same was reported to be dependent on ability to pay.

People in rural-based communities are generally poor. This is the case for students and staff. Most of them cannot afford to pay for the HIV/AIDS service. This tends to prevent them from seeking help (HP).

Another factor that was considered a deterrent to help-seeking was the limited number of staff working in the HIV/AIDS service. Although less visible and thus hard to detect, few participants claimed that association stigma was a significant contributory factor to the shortage of staff working in this service. According to some participants, the shortage of staff not only hinders access to the HIV/AIDS unit, but also negatively affects the quality of service offered. These participants attributed these outcomes to work overload and subsequent burnout they experienced. It was for this reason they stressed for supervision of staff in the HIV/AIDS service to be given high priority. They claimed that offering

supervision would enable staff to cope with difficulties, like work load as well as ensure the provision of quality service.

Like supervision, most participants reported the need for training on how to support and care for people living with HIV and AIDS. They claimed that not knowing what to do is among the reasons for the limited attendance of staff and students to the HIV/AIDS service.

A colleague of mine said to me that he was not spoken to nicely when he attended the clinic. He said the person who attended to him did not seem to know what he was doing. It was that experience that made him to stop visiting the clinic (SF).

The above account is certainly an emphasis on the need for training on the subject of HIV/AIDS, including the general management of HIV/AIDS services. Undertaking such training, some participants asserted, would ensure effective care of service users presenting with these conditions.

4. Discussion

South Africa has the largest number of people living with HIV and AIDS in the world (Shisana et al. 2010; National Department of Health, 2010). It communities, including Higher Education Institutions are therefore considered to have very high rates of infection with HIV. This assertion is consistent with outcomes of the present and predecessor studies. In relation to this inquiry, participants reported a high and growing rate of HIV and AIDS in the university community studied. While this finding was attributable to high sexual risk behaviours (Otaala, 2007), participants believed that the growth in rate of these conditions can be halted with the use of multiple and integrated approaches. Examples of these include peer education; awareness campaigns, training, provision of condoms and HIV counselling and testing. The success of these approaches in reducing the incidence of HIVand AIDS is in the main a function of their complimentary nature. It was for this reason some participants asserted that an awareness of HIV statuses and increased knowledge of HIV/AIDS using, for example, information leaflets and mass communication fora, are necessary but not sufficient conditions for the prevention of this infection. They therefore claimed that a combination of knowledge enhancement approaches and physical measures, like promotion of condom use can result in an enhanced potential to prevent or at least reduce the spread of HIV. While this is the case for HIV-negative individuals, staff and students already living with this virus may not find even a combined approach helpful. According to participants, this is a function of past negative experiences of stigmatisation and discrimination. Staff and students living with HIV and AIDS are reported here to hardly seek and accept professional help. Failure to seek and accept help may lead to an increase in incidence of HIV among members of the university community. Strategic management approaches are needed to encourage help-seeking behaviours, which in turn may assist to avert this possibility; increase in incidence of HIV.

Participants reported a range of management approaches used by staff of the HIV/AIDS service. Examples of these include policy, supervision and quality assurance. In relation to the HIV/AIDS policy, there was a shared view among participants that it served as a structure that ensured a consistent approach in the implementation of services. However, adoption of a consistent approach can be perceived as a stance that ignored people`s individual needs. Taking into account that the provision of individualised support and care is a critical aspect of HIV/AIDS services, the policy of the studied area was occasionally adjusted to accommodate personalisation of support. The provision of personlaised care may promote help seeking behaviour. This is because users may perceive it not only as an indication of respect, commitment and willingness to offer support, but also as a non-judgmental approach. However, maintaining commitment and willingness to offer help in an understaffed setting, like the HIV/AIDS service is a difficult task to achieve. Such difficult is attributable to workload and experiences of burnout staff may encounter. Staff experiences of burnout can hinder users` access to services and quality of care and support (Simons & Jankowski, 2007). It was therefore not surprising for participants to request for support in the form of supervison, as they claimed that it will help alleviate stress and improve the quality of the HIV/AIDS service. Contradictions in relation to the quality and effectiveness of the HIV/AIDS service were noted among participants. The majority claimed that it was not effective and associated this claim to a number of factors, discussed here as barriers.

Stigmatization was one of the main obstacles for both students and staff to seek HIV/AIDS-related help and /or work in the HIV/AIDS service. In South African rural communities, HIV and AIDS are generally associated with promiscuous sex, drug abuse and homosexuality (Azwihangwisi & Sandy in press). Such attitudes were considered by some participants of this study as disrespectful and devaluing; an outcome that is clearly explained by one of the assumptions of the Social Identity Theory. It reads: 'human beings have a fundamental need for positive self-esteem and often seek to achieve this by making making favourable comparisons between themselves and others' (Hornsey, 2008). Acknowledging this, it was not surprising for participants to report instances of stigmatisation of students and staff living with HIV and AIDS. For example, students and staff with these conditions were ascribed labels like sinners, addicts and

sex maniacs. In relation to the Social Identity Theory, the use of labels or labelling was a strategy employed by HIV-negative staff and students to enhance their self-esteem and differentiate themselves from those living with the same. Enhancement of self-esteem in this case was related to gaining respect from the university community for being HIV-negative. Arguably, being HIV-positive and living with AIDS do compromise people`s respectability in rural communities. This is noted in this study in the acts of ascription of labels and discrimination. For instance, one participant explained that he refrained from socialising with his HIV-positive friend for fear of being associated with this infection. According to the participant, this action made his friend to feel more stigmatised.

Negative regard from others in the form of stigmatization and discrimination can lead to negative self-regard or negative self-perception, which is often referred to as internalised homophobia or internalised homonegativity (Morris et al. 2001). It is an active process of directing negative social attitudes toward the self, leading to a devaluation of the self and resultant poor self-image (Meyer 2007). Negative self-perception, particularly if experienced over a prolonged period, is an unpleasant place to be, as such experiences may lead to feelings of discomfort, low self-esteem, mental health problems, like self-harm, and subsequent suicide (Lewis, 2003; Sandy, 2013). Certainly, nobody likes to be traumatised, and these possible outcomes are a call to adopt strategies for alleviating them. Concealment of HIV statuses was frequently talked about by participants as a strategy people with HIV and AIDS commonly use to cope and deal with problems, such as low self-esteem associated with discrimination and stigmatization. However, concealment can have a paradoxical effect of leading to feelings of guilt, inferiority, anxiety and hopelessness (Sandy, 2013). This is because of the constant preoccupation with hiding, which in turn may promote sexual risk behaviours like sharing of sexual partners that may lead to an increase in incidence and prevalence of HIV.

5. Study Implications

Stigmatisation and discrimination were noted in this study as factors that can deter students and staff from using HIV/AIDS services. These factors are in the main associated with lack of or limited knowledge of HIV and AIDS, including their modes of transmission and prevention. Hence, increasing people`s knowledge of these conditions through training and education may prevent or at least reduce stigmatizing and discriminatory acts. Achieving these outcomes will enhance access, utilisation of HIV/AIDS services, and quality of care and support. Thus, most participants of this study expressed at interviews the need for training on how to support and care for people living with HIV and AIDS. It would be helpful for such training to be provided to both the university and surrounding communities.

The discrimination and stigmatisation students and staff living with HIV and AIDS face make them to hide or conceal their HIV statuses. Not accessing and seeking help are among some of these approaches this population uses to hide their HIV statuses. But not seeking help would lead to deterioration in health, increase in sexual risk behaviours, and incidence of HIV and AIDS.

6. Limitations

This study indicated that individual interviews were effective for exploring South African rural-based university communities` perception of an HIV/AIDS strategy. The study was carried out in a single rural-based university. Although the sample was appropriate for a qualitative mode of inquiry, the findings generated from this cannot be generalised across all rural-based universities in South Africa. However, they provided insights and contexts for understanding of HIV/AIDS strategies for promoting access, support and care for people with these conditions, and to prevent or at least reduce new cases. Thus, policy makers of university communities can use these findings to improve their approaches to support students and staff living with HIV and AIDS.

7. Conclusion

It is indicated in the extant literature and findings of this study that the prevalence and incidence of HIV and AIDS are high in South African university communities. This is particularly the case for universities in rural communities. The study recognised the importance of adopting multiple and integrated treatment and supportive approaches to address these rates. Examples of such approaches include awareness campaigns and HIV counselling and testing. Effective implementation of these approaches by the HIV/AIDS service requires leadership in the context of co-ordination, and monitoring and evaluation of their effectiveness. Contradictory opinions in relation to the usefulness and effectiveness of the HIV/AIDS service were expressed by participants. A minority of participants claimed that the service is useful and effective as it met the needs of students and staff living who used it.

Caring and supporting people living with HIV and AIDS is a demanding and complex task. It is revealed in the extant literature and in this study that staff working in HIV/AIDS services of rural universities generally lack the necessary skill and knowledge of supporting individuals with these conditions. There is therefore a great need for staff of these services to be supported and empowered in order to provide relevant and appropriate care and support to individuals living with HIV and AIDS. Hence, the need for the provision of tailor-made training and education programmes for staff taking into account the levels of health illiteracy and barriers to utilisation of HIV and AIDS services. Examples of such barriers include stigmatisation and discrimination.

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