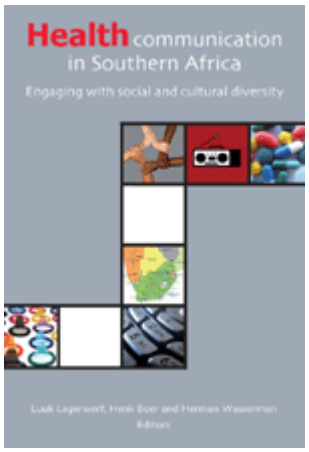
Health Communication In Southern Africa ~ The Employment Of HIV Positive Young People For Health Promotion In Higher Education: A Case Study Of The DramAidE Health Promoters Project, South Africa



Abstract

This paper explores two essential questions related to health promotion and HIV/AIDS education.

1: Do HIV positive health promoters and peer educators have positive effects on students' health attitudes, behaviours and HIV stigma reduction?

2: Which programme characteristics have better effects on health education performance? The paper seeks to address these questions with relation to the DramAidE Health Promoters Project run at a number of Higher Education Institutions in South Africa. The project makes use of HIV positive young people to live openly as role models with HIV on campus, to break stigma around the disease, increase prevention efforts, and encourage testing for HIV and positive living with HIV. A project evaluation conducted in 2007 included interviewing students, staff and the HIV positive health promoters working at nine campuses across South Africa, and forms the basis for this study.

Introduction

This chapter introduces the DramAidE Health Promoters Project and gives some background on its history and the rationale for its inception, with an overview of the current situation and response to HIV/AIDS at Higher Education Institutions in South Africa. The Health Promoter Project is rooted in the fields of peer education and entertainment education, and this chapter explores some of the theories that inform those practices, as well as an overview of some of the literature on similar projects that employ HIV positive people.

The chapter then explores two areas of study, namely the effect that HIV positive peer educators have on other students, and the programme characteristics that have better effects on health education performance; in an attempt to highlight good practice in the field of health promotion and HIV prevention efforts in South Africa. Some of the data relevant to the DramAidE Health Promoters Project are presented and discussed, with conclusions regarding the successes, challenges and potential of this strategy.

The DramAidE Health Promoters Project

The social impact of the HIV/AIDS epidemic in South Africa highlights the need to ensure that communities band together to deal with all aspects of the disease. Social behaviour change theories suggest that it is most effective to educate, sensitise and mobilise individuals by addressing the community in which these individuals find themselves, and to make HIV/AIDS a community concern (UNAIDS, 1999b). A number of commentators on HIV/AIDS behaviour change interventions agree that behaviour change can only happen in a supportive context where individuals are empowered to act within the group (Tomaselli, 1997; Airhihenbuwa & Obregon, 2000; Papa et al, 2000; Kelly, Parker & Lewis, 2001; Tufte, 2002).

The Health Promoters Project is a project running in Higher Education Institutions across South Africa, where these institutions are seen as able to respond to HIV/AIDS in a strategic and focused manner, as communities that find themselves within other broader communities. It is understood that the Higher Education sub-sector in South Africa may be disproportionately more affected by HIV/AIDS than other sectors, as the majority of students found on campuses across the country are in the in the age group with the highest prevalence of HIV infection (SAUVCA, 2006). According to a 2000 study conducted by the research organisation Abt Associates, the rate of HIV infection at a university

undergraduate level was estimated to be roughly 22. This was expected to rise to 33 by 2005 (Thom & Cullinan, 2003).

Higher Education Institutions are often places where young people first explore serious relationships, and may form opinions and develop behaviour patterns in relation to sexual behaviour. They are also the training grounds for the leaders and trend-setters of the future. Training these young people to develop a positive attitude towards managing the HIV/AIDS epidemic could ensure that they respond accordingly when they take on positions of power in society. Furthermore, Higher Education Institutions are often well-resourced and well placed to share information and expertise with surrounding communities that may have access to fewer resources. This means that the influence of campus based programmes may spill over into surrounding communities.

The project was developed by DramAidE, a South African based NGO working in educational institutions, and the Johns Hopkins Bloomberg School of Public Health Centre for Communication Programmes (now known in South Africa as Johns Hopkins Health and Education South Africa, JHHESA). It was initially established on nine historically disadvantaged campuses. It involved recruiting young people living openly with HIV to live and work on the campus and to provide information and support to students, as well as to provide a public "face" of the epidemic.

From its inception, the project has grown and gathered popularity. From the initial nine campuses in 2002, DramAidE has been approached over the years by a number of institutions wishing to implement the programme on their campuses. In 2006/7 the project was implemented on 23 campuses and reached an estimated 762.000 students (DramAidE Annual Report, 2007).

The Health Promoters Project aims to personalise the risk of HIV infection and to demystify HIV and AIDS and reduce the stigma attached to living with HIV and AIDS. Through providing health information and support, promoting campus-wide voluntary counselling, testing and treatment and the concept of Positive Living amongst the student population, the project hopes to reduce the number of HIV infections on campus. The health promoter is tasked with spear-heading and facilitating a number of initiatives on campus. These include providing basic HIV/AIDS information to students and staff through workshops and entertainment education based events, providing individual support to students and staff

both affected and infected with HIV/AIDS, providing information to students as well as access to appropriate referral services, and providing assistance and leadership with HIV/AIDS programmes on campus and for community outreach programmes.

In practice, the health promoters work in orientation programmes for new students, provide workshops for peer educators, and develop support groups for students who are HIV positive. Peer education models provide the framework for this project by supporting HIV awareness events such as Candlelight Memorial Services, concerts and events that emphasise Voluntary Counselling and Testing (VCT) and ABC ('Abstain, Be faithful, use Condoms') prevention techniques. Literature review

HIV Positive health promotion
Using specifically chosen individuals as peer educators and role models in health education is a common practice. The practice of using HIV positive people in HIV prevention campaigns has become more common-place in the past decade, as people living with HIV speak out more openly about the disease and have become involved in structured programmes.

Although there is little published South African literature on the issue of the impact of communication campaigns including people living with HIV and AIDS, there are studies from other countries. Studies from both Australia and the United States (Markham et al., 2000; Paxton, 2002) found that HIV positive speakers were highly popular with students and teachers, and had a positive short-term impact on students' attitudes. Both studies found that meeting HIV positive people decreased stigma, fear and prejudice, increased audience awareness about prevention messages and made young people more aware of their own vulnerability to HIV infection. These changed attitudes were still significantly different up to three months after an intervention. The studies found similar reports from Zimbabwe, North America and Thailand.

An early evaluation of the DramAidE programme (Frizelle, 2002) involved a case study of two campuses where HIV positive people were employed on campus in HIV prevention efforts. The evaluation found that the programme had played a valuable role in developing dialogue on stigma and discrimination both on and off campus. The HIV positive young people who were employed were seen as rolemodels by other students, who were assisted to develop their own confidence

in their ability to make better lifestyle choices and build healthy relationships. A follow-up evaluation (Mukoma, 2003) found that peer educators working with these HIV positive people had developed a more in-depth understanding of HIV/AIDS, the social issues that place people at risk, gender issues, and VCT through the project. In its conclusions, the research found that the strategy of using an HIV positive health promoter was effective for impacting on students' knowledge, attitudes and behaviours. All of these studies suggest that health education on HIV that involves people who are themselves HIV positive assists in combating stigma and in allowing people to recognise and assess their own risk behaviours.

Peer education

Peer education typically involves members of a particular group working to educate and develop other members of the same group in order to effect change. Peer education is generally used as a method to influence and change knowledge, attitudes, and behaviours at the individual level. It is also used, however, to effect change more broadly at the community and societal level. Educating a group of individuals can mean that group norms are modified, and that individuals are encouraged to work together to effect changes in their environment (UNAIDS, 1999a).

Peer education has been used globally with groups of all sorts, in schools, factories, religious groups and prisons, in an attempt to share information about HIV/AIDS and to encourage healthy behaviour change. A UNAIDS global study of 30 peer education programmes found that peer educators are seen as "credible teachers and facilitators who possess critical and unique access to their intended audiences" (UNAIDS, 1999a, p. 21). A 1998 study conducted in the United States compared a peer-driven HIV intervention, using intravenous drug users as peer educators with a traditional outreach intervention using professional outreach workers (Broadhead et al, 1998). The study found that utilising active drug users in the intervention allowed access to larger and more diverse networks of the target audience, and that the programme was more cost-effective and more effective in reducing risk behaviour among the target group. The programme used drug users to recruit their peers into an education and counselling programme, based on an incentive system. Results showed that those recruited into the programme by other drug users used their social influence to recruit others to both be educated and to become peer educators. Through peer

education these individuals stake their reputation on the sincerity and content of what they convey, and are therefore more likely to practice what they promote, namely safe needle use and safe sex to prevent HIV transmission. This points to the potential of genuine behaviour change through peer education programmes.

Study 1 below seeks to ask whether the DramAidE HIV positive health promoters and peer educators have had positive effects on students' health behaviours and attitudes, and in HIV stigma reduction.

Programme characteristics and effect on health education
Health communication has come along way from the Shannon and Weaver model of "sender, signal, receiver" (1949), and more importance has been placed on the role of receiver as an active participant in the communication process, encoding and decoding information in an attempt to fully understand and engage with the content of the message. Kincaid's convergence model, redefines communication as "a process in which the participants share information with one another in order to meet a mutual understanding" (Kincaid, 1979). The model suggests that "effective communication begins with the audience, the client, or the consumer and continues over time as a process of mutual adjustment and convergence" (Piotrow et al, 1997, p. 18). One of the key components to the success of any communication intervention is an understanding of the knowledge and attitudes held by the prospective
audiences.

Singhal and Rogers (1999) outline a number of factors that influence the effectiveness communication strategies for health promotion (particularly in the field of entertainment education, on which DramAidE bases many of its programmes, including the Health Promoters Project). These six factors include audience characteristics; organisational factors; the media environment in which the programme finds itself; audience research; programme specific factors; and infrastructural factors such as access to support services.

Singhal and Rogers' research suggest that audience members actively negotiate meaning when processing health education messages, and that this meaning can be intended or oppositional. Audience research and the pre-testing of messages can facilitate a dominant intended reading of these messages. They also suggest that audiences interpret messages selectively. The second determinant, organisational factors, includes the presence of champions and strong leadership,

access resources such as time and funding, the collaboration of relevant stakeholders and the presence of technical experts including project managers. The third determinant, the media environment, suggest that the degree of media saturation, media credibility, the appropriate channel and the penetration of the target audience through integrated campaigns all influence the success of the programme. Fourthly, Singhal and Rogers (1999) suggest that the quality of audience research, both formative and summative, can determine a programme's success. The fifth component includes programmespecific factors specific to such interventions, including the use of colloquial language, the employment of both celebrities and real-life characters, programme scheduling and repetition. They suggest that for success, these programmes must be theory based and must contain a balance of education and entertainment. The theories that provide the foundation for entertainment education communication programmes include marketing principles, persuasive communication theory; play theory and social learning theory. The sixth factor that Singhal and Rogers highlight is the need for strong infrastructure to support the programme, including service provision that allows the audience to enact intended behaviour change. Study 2 below refers to these success-determining characteristics identified by Singhal and Rogers (1999) and seeks to find which programme characteristics have better effects on health education performance in the Health Promoters Project.

Study 1: *HIV positive health promoters and peer educators' effects on students' health attitudes, behaviours and HIV stigma reduction.*

Method

The data for this paper were collected at 9 Higher Education sites across South Africa. This selection crossed a range of provinces in both semi-rural and urban areas. Selected campuses reflect both previously disadvantaged campuses, as well as the previously advantaged campuses, and the student population across campuses covers a variety of race groups, both genders, and a range of students enrolled in both technical and theoretical academic courses. Annual reports are prepared by Health promoters and their campus supervisors and submitted to DramAidE. A collection of reports from 2004-2007 informed this study.

A fieldworker familiar with each site was appointed and briefed about the purpose and methods of the evaluation research project. Instruction was given about fieldwork procedures and data collection methods. As the project unfolds differently across campuses, set questions were not drawn up for these

researchers, so as to allow them to develop their own picture of the project on each campus. Evaluation reports are cited and added to the References.

Focus group discussions and interviews. Open ended interviews and focus group discussions were held with all respondents. These were recorded on tape, and notes taken during the sessions. Transcriptions of these interviews and focus group discussions were analyzed and form the basis of this evaluation.

Health promoters. The health promoters at each campus were individually interviewed by the researcher in person. Some follow-up questions were addressed by telephone or via email. A total of nine health promoters were interviewed.

Health promoter Supervisors. Nine health promoter supervisors were interviewed individually by the researchers and notes taken during these interviews. These supervisors generally hold positions within the HIV/AIDS units of health clinics at each institution.

Peer educators. Peer educators or other students who had attended DramAidE workshops and involved in peer education programmes on the campuses were interviewed, either individually or in focus group discussions. A total of 71 peer educators were interviewed. The sample included a balanced mix of male and female students.

Students. Fifty-two students were randomly selected; exposed and not exposed to the programme they completed questionnaires at two of the campuses.

Reliability. A guideline was drawn up for researchers but no formal protocol or list of questions was specified for the research. This has resulted in different questions being asked and answered at different sites, and the content of the data varies accordingly. The quality of the data at the different sites also varies, as some of the regional researchers were closer to the programme and therefore more able to ask probing questions with an informed understanding of the project.

Results

The key difference between the Health Promoters Project and many other HIV/AIDS initiatives is the employment of HIV positive individuals to fulfill the role of health promoters. According to the DramAidE programme plans, the

health promoter must be a person who is living openly and positively with HIV. The benefits of using people who are HIV positive are highlighted in the interviews with students and staff.

It has made a huge difference. I was diagnosed this year in June and I couldn't cope. I was frustrated and lonely because I haven't told my family yet. But talking to the Health promoter really helped. She made me realise that I have more to live for and that this is just another challenge I need to face positively (HIV positive student).

Peer educators at most campuses reported that knowing the health promoter personally makes the workshops that they run easier, as they can refer to a close and relevant example of living with HIV.

She's like a living example, which makes your message stronger. You can say to people, 'I know a person like this, she's with us. She's healthy and strong. If someone gets HIV, they can live beyond that (Peer Educator, Cape Peninsula University of Technology).

On some campuses, the health promoter is linked with the clinic and a great deal of their time is spent counselling students for VCT. The benefits to the health clinic of having an HIV positive person on the team are noted from staff at these clinics on many campuses. VCT Campaigns conducted as part of the project are reported as having been successful at most campuses, and result in an increased uptake of campus VCT services. The health promoters are seen as good role models for those who are thinking about testing.

Students find it easier to go for a test because they see someone else who is living openly with HIV (Supervisor, Cape Peninsula University of Technology).

The continued visibility of students living positively with HIV on the campuses helps to counter stigma. Living openly with HIV means being a positive example to students, and the health promoter has taken on the mantle of support at most campuses.

He acts as the pillar of our care and support towards HIV positive students… The emotional and social support he gives students is incredible (Programme supervisor, University of the Western Cape).

The research across campuses suggests that the health promoters offer support to those both affected by and infected with HIV, as well as to other students and staff who have family members who are affected.

When the time came I was ready, I had accepted my father's status and I could help my mother accept it too. Even afterwards at the church, my mother and I could be there for others who came to us to help them… (the health promoter) helped me a lot (Student, Durban University of Technology).

Peer educators and others who attend the health promoters' workshops report a change in attitude and a move towards safer sex behaviours, which are part of the prevention efforts of the project. Both peer educators and clinic staff across campuses suggest that the health promoter has a great effect on attitudes and moving people to take responsibility for their lives.

He came to residence and spoke and he was so strong, if he can stand up, encouraging me to be strong, so I went the next day. It was not about the result, but only but that I could stand up and choose for myself and show that strength in myself (Student).

The health promoters' presence on campus normalises HIV and allows students the opportunity to reassess their prejudices.

At first I knew the virus was there, but when I saw the living proof in (her), it changed everything. I thought maybe someone who was positive would be different from us. But it's not written on their face, you can't see it. Seeing her over and over, it's like normal now (Peer Educator, Cape Peninsula University of Technology).

Students comment that they find it difficult to think of the health promoter as 'different' from themselves. This reduces 'othering' and stigma on campus.

We forget his status; we admire him so much as a person. He does not preach but practices strength and positive living. He is a leader and I have taken this into my life (Peer Educator).

Students report on the empowering experiences of workshops that they have attended, and reflect on how they now practice reformed behaviours and attitudes. These differ from the patriarchal and often stereotypical learnt

behaviours that are sometimes experienced in more familiar environments. On most campuses, peer educators are directly affected by the health promoter, and research at one campus noted that they agreed unanimously that the health promoter was having an impact on other students (Burman, 2007). Students confirm that the role of the health promoter is a powerful force in their lives. They say that the programme works as both a stimulus and inspiration. The research findings suggest that the HIV positive health promoters, together with the peer educators challenge students' attitudes towards those who are HIV positive, as well as their attitude towards their own personal HIV vulnerability and their ability to cope with a positive diagnosis.

Campuses report a direct correlation between the involvement of the health promoters in VCT campaigns and the number of students reporting for testing, suggesting that student health behaviour is also influenced by the health promoter. The research undertaken at the selected sites also suggests that stigma levels have decreased since health promoters started working on campuses. This may be attributed to a multitude of factors outside the project such as increased portrayals of HIV positive characters on television, national media campaigns and increases in disclosure by celebrities. The health promoter, however, is a personal role model to whom the campus has access to.

Study 2: Programme characteristics' effects on health education performance

The 2007 project evaluation uncovered a wealth of information on the varying efficacy of the project on each of the campuses in which it runs. For the purposes of this study, I have arranged the data collected on the programme according to the six factors affecting programme efficacy as determined by Singhal and Rogers (1999).

Method

The data for this study were collected at the same 9 campus sites across the country, in a series of focus group discussions and interviews.

Health promoter Supervisors. Nine health promoter supervisors were interviewed individually by the researchers and notes were taken during these interviews. These supervisors generally hold positions within the HIV/AIDS units of health clinics at each institution.

Senior management. The Vice-Chancellor, Rector, Student Affairs manager or

other senior management member knowledgeable about the programme and its relationship to other HIV or health programmes and policies in the Higher Education Institution was interviewed at seven of the nine campuses.

Institution staff. Health clinic staff was interviewed on each campus. HIV/AIDS programme managers or clinic managers were targeted for these interviews, and at some campuses additional interviews were conducted with clinic nurses and doctors. Six random lecturers from two campuses were interviewed for their views on the programme. In addition to these meetings, the individuals involved in the DramAidE programme management were interviewed with a view to understanding the dynamics and challenges of managing the programme. Specifically, DramAidE Manager Mkhonzeni Gumede was interviewed in June 2008; and researcher and consultant Laura Myers in July, 2008.

Results

Audience characteristics
The target audience for the project is students living and studying at the institutions, as well as institution staff and members of the surrounding community. The fulltime presence of a Health promoter on site allows for a continuous negotiated meaning of the health promotion messages between the audience and the health promoter.

She's always here 24/7. If someone has a crisis, someone will know that there's this health promoter on campus that you can go to (Peer Educator, Cape Peninsula University of Technology).

Audiences are exposed to messages continually, and this increases their message retention.

Organisational factors
The presence of champions and persons of influence involved in the project continues to strengthen it. Where the Vice Chancellor or other upper management is aware of the programme, they comment favourably on it:

I think institutions of higher learning are environments where this kind of intervention should be promoted. [When] a person is affected, it makes more sense for them to talk to someone who has personal experience. It has more

impact in that way than other projects. For that, I would urge institutions to promote this…. These kinds of positions need to be established as mainstreamed positions (Vice Chancellor, Cape Peninsula University of Technology).

Not all campuses enjoy the same level of support though, and this affects the manner in which the Health Promoter Project is viewed by the entire staff:

I feel like we are doing this work alone. It would make such a difference to know the management was giving us support … Staff members do not know about me. I try to make myself visible, but it's not happening [that I am] received as someone who's making a difference in this institution. Some faculties don't even want to offer me a slot. That's the kind of attitude I get from most lecturers (Health Promoter).

It is clear that the institutions seem more committed to the programme if they pay the health promoters salary.

The importance of becoming institutionalised is very important as it helps to make you feel welcome and a part of the institution. If not, you don't have as much influence and reach people higher up. I can now participate in a more meaningful way. You have to be recognized as a part of the structure. It has an impact on how I run programmes (Health promoter).

This formalisation of the health promoters' role in the institution may ensure that the programme is more sustained, with longer-term funding and programmes guaranteed, as well as an improvement in the care and support that can be offered to health promoters themselves as permanent employees of the institution. This has also been raised as an issue by project managers, DramAidE. As the health promoters are not employed by DramAidE itself, the organisation cannot provide benefits or care. Since the inception of the project, a number of health promoters have become ill and four have died. This is a situation which demands attention from the institutions where they are working.

Employing the health promoter means that most campuses have had to ensure that there is a flexible and workable HIV policy for the institution, affecting both staff and students. A number of programme managers and supervisors interviewed for this study reported that this was a challenge for the institution.

On paper, we want HIV to be something manageable, that we can control, but

there is much more to learn about having a colleague with HIV …. We wouldn't have learned that in other ways. It challenges us every time in terms of our own workplace policies (Programme manager, Stellenbosch).

At one campus, the peer education programme manager comments that in terms of total funding for HIV/AIDS interventions on campus, the cost of hosting the health promoter is their smallest cost. In terms of costs and outputs, the project is seen as bringing the greatest value to the campus prevention projects.

The environment in which the programme finds itself
While students often claim "AIDS fatigue" (HIVAN, 2008), the Health Promoter Project seems to be seen in a different light to other AIDS education campaigns, because of its highly personalised message, thereby avoiding media saturation. Because the health promoters themselves are HIV positive, they give the health messages a certain amount of credibility as part of a more integrated campaign on each campus.

I'm now well-known on campus. They refer to me as the HIV lady… I get stopped in corridors here by people asking questions about HIV… If they know of anyone who is HIV positive, they know who to come to. I'm here for them… (Health Promoter, Cape Peninsula University of Technology).

Health promoters fit into programmes run by campus health clinics as well as other bodies on campus. One of the most widely reported relationships is that that the health promoter has with the peer education programmes on campus. In some cases the health promoter runs the peer education programme, in others he or she is an advisor to the peer educators and a resource for them. Many health promoters fit into campus orientation programmes for new students entering the institution. A number of students recall that their first meeting with the health promoter was during Orientation Week. The health promoter is often responsible for all health calendar events on the campus and in many cases has ensured that HIV/AIDS issues are on the agenda of recognised student bodies. Some health promoters assist lecturers in presenting some HIV/AIDS related content for the curricula, often presenting guest lectures to students, or assisting students with HIV/AIDS related academic projects.

Student services and clinics report that the health promoter has offered them additional impetus and legitimacy, as well as offering additional capacity in order

for them to deliver more effective services, particularly with regard to VCT and support. Many health promoters are also involved with housekeeping and maintenance staff on campuses, and keep them informed of activities as well as running awareness workshops for these groups.

Audience research

DramAidE conducted two evaluations of early phases of the project in an attempt to find what would work best for students at these institutions. This gave rise to a number of suggestions for improvements to the project, and the 2007 evaluation further highlighted areas for attention. This practice has meant that the programme is constantly evolving. The research conducted for this study shows that the primary target audience (students) respond particularly well to the health promoters, in contrast to health professionals on campus. This suggests that the dual factors of youth and HIV positive status of the health promoter are key to the project's success.

Programme specific factors

Across campuses, programme managers and others report that the project has added value to already existing campus programmes, as well as bringing new programmes to the attention of students. The health promoters use participatory methodologies such as workshops and entertainment education as a way to reach and move students.

Workshops and drama are very important in so far as everything you do has meaning. I use them to create empathy, and develop a spirit of sharing so that we can learn together. People also see the need to respect each other and see each other challenges, as well as finding ways to deal with these challenges. We work through fear through games, and learn to participate which helps us to face up to issues (Health Promoter).

It is reported by peer educators that workshop methodologies that are drama based are most often appreciated and successful. The workshops seem to be effective in the development of responsible and empowered young people who have HIV/AIDS agency skills. It is suggested that this kind of small scale strategy and peer education will add to the mobilisation of a social movement that will have far reaching effects in society more broadly.

We see the students willingly engaging in this project in high numbers. This in

turn will reduce the spread of this disease which is in our midst (Campus Nurse, University of Venda).

Infrastructural factors

All of the campuses involved in the study link the Health Promoter Project with VCT services, which are offered on campus. This means that there are direct links between the messages of positive living and the services provided. Health promoters also distribute condoms on campus.

Six of the campuses included in the study make specific reference to the fact that the health promoter offers a referral system for students to doctors and hospitals, and advises on where the best and most affordable care can be found. It is unclear as to how many of the campuses are registered as anti-retroviral distribution sites, but would seem that many health promoters refer students to services off-campus. Almost all campuses report that most of the students who test HIV positive seek out the health promoter, whose influence and support for these students is evident. A number of campuses report that before the Health Promoter Project was initiated, their own HIV/AIDS campaigns and services were sporadic and not sustainable. In many cases, students regarded the clinic staff running such programmes as unfriendly and unhelpful. Campuses report increased use of these services since the health promoter came on board. The findings of this research suggest that the factors influencing the programme has been maximised to meet the potential for success as defined by Singhal and Rogers.

General discussion

Campuses report that the sphere of influence of most of the health promoters is significant and includes students, community members, and, on some campuses, staff. Health promoters are seen across campuses as visible HIV positive activists advocating acceptance, and challenging discrimination against students or employees who are living with AIDS. They serve as valuable resources to the university community, in providing information about HIV that supports prevention efforts, serving as an example of how to live openly and positively, and in being an instrumental part of the institution’s effort to care and support staff and students who are HIV positive.

The health promoters challenge HIV related stigma and discrimination by encouraging students to examine their stereotypes and preconceptions of what it

means to be HIV positive. Where health promoters are living in the campus residences, their impact is noted, as they are always available and visible to other students. Peer educators and other students report that meeting the health promoters brings HIV closer to home and has affected their views on people living with HIV. It is apparent through the research across the campuses, that the health promoters have added value to campus campaigns and HIV/AIDS initiatives. Health promoters also believe that the programme is vital and that without it, there would be a negative impact on students.

I know more people would be positive. So many people still get infected and it is because there are not enough people like us openly talking about our status. If we weren't around, more people would be infected (Health promoter, 2007).

Health promoters add to the peer education programmes on campus by encouraging them to use new participatory methodologies in workshops, and assisting in developing other skills, including facilitation, organisation and advocacy skills. They also offer new and engaging methodologies for campus campaigns, including using popular media that engage campus communities in an exciting way. Some health promoters offer activity based programmes and support that contribute to a supportive environment for marginalised students who may have experienced stigma and discrimination. They have also initiated and strengthened off-campus programmes and allowed the institutions to develop new links with the surrounding communities.

On some campuses, health promoters have directly contributed to the development of the institutional policy on HIV/AIDS. Having HIV positive, and sometimes sick employees, has challenged the institutions to be able to effectively manage HIV positive employees and put their policies into practice.

Health promoters help students to personalise the risk of infection and in most instances, the health promoters are good role models for students who are thinking about testing, and as examples of positive living. Students who test HIV positive report that having a health promoter on campus has helped them to come to terms with their own diagnoses. Students who are infected relate to the health promoter on a personal level and feel an affinity with them. The support offered by the health promoters is invaluable, and they assist peer educators, students and staff to accept HIV as normal.

Although all of the evidence points to overwhelming benefits to employing HIV positive people for such a programme, there are a number of challenges to doing so. These include issues such as employment policy, illness and fatigue on the part of the health promoter, and in extreme cases death. Health promoters also report difficulty in separating their private lives from their public appearances, and without ongoing counselling and support are prone to burn-out. For the successful implementation of the project, these are issues that must be addressed.

The programme is afforded varying degrees of recognition on different campuses, depending on its level of institutionalisation. It is noted that staff support for the programme is vital for its survival on campus. Where the health promoter is recognised by staff, it seems that there is greater access to students and more visibility on campus. Access to funding and campus resources affects the success of the programme, and is another issue that needs to be negotiated for the successful continuation of the project.

While there are ongoing administrative issues that threaten the success of the project at many of the institutions, a number of campuses report that the Health Promoter Project has become the flagship HIV/AIDS project that contributes towards creating a supportive healthy environment amongst both staff and students on campus.

The DramAidE Health Promoter Project meets a number of key success criteria, including the involvement of HIV positive people in interventions, costeffectiveness, relevance, replicabililty, innovativeness, and sustainability, and should be seen as an example of best practice with regards to HIV prevention projects.

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