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Crafting Institutional responses to HIV/AIDS:

Guidelines and Resources for Tertiary Institutions in Sub-Saharan Africa

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The Response Begins at Home: *HIV/AIDS and Tertiary Education in Sub-Saharan Africa*

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Introduction

“Much innovation goes on at any first-rate university. But it is almost never conscious innovation in the structure or practices of the university itself. University people love to innovate away from home.” The quotation comes from John Gardner, an intellectual leader in the field of American education during the latter half of the 20th century. Although Gardner was referring to institutional reforms in higher education, the statement could well apply to other areas of university endeavor. Virtually by definition, the orientation of tertiary institutions is outward looking. Research, community service, and – to a lesser extent – teaching are all externally focused activities. Moreover, any institutional tendency to be introspective has historically been viewed as “parochial” or “incestuous” in light of prevailing norms within the international higher education community. Consequently, there is little in the institutional culture of universities and other tertiary institutions that encourages, or even facilitates, analysis or constructive critique of the institution itself. Any assessment of institutional responses to the threat of HIV/AIDS must therefore be cast against this backdrop.

With the emergence of strategic planning over the past decade as a fundamental tool for institutional development and management (Ekong and Plante, 1996; Hayward and Ncayiyana, 2003), internal resistance to institutional assessment has begun to erode. Tertiary institutions are increasingly obliged to take stock of their performance, and to address the source of identified shortcomings. At the same time, perhaps not coincidentally, higher education management has emerged as a new discipline for graduate study, fostering research on this topic by both students and academic staff. As a result, in-house issues, such as learning performance, student financing, budget effectiveness, graduate performance in the labor market, and many others have now become legitimate topics for academic inquiry. In the process, academics are beginning to acknowledge a new agenda driven by internal institutional reviews and innovations.

One topic, however, remains largely outside the scope of concern in many tertiary institutions. That topic is HIV/AIDS, the newest challenge to emerge in the “threat” category on the institutional SWOT (strengths/weaknesses/opportunities/threats) analyses so common to strategic planning. Africa is no exception in this regard. But for African tertiary institutions, the challenge of HIV/AIDS looms larger and is more deeply rooted than on other continents. Unfortunately, long established traditions of autonomous governance and management within institutions of higher learning tend to shield campus communities from intervention, even when it is well intentioned, by other agencies of government. In the case of HIV/AIDS, for example, these institutions may not readily respond to calls for action by National AIDS Committees or Ministries of Health. For this reason, it is far more effective when responses to HIV/AIDS within systems of tertiary education begin at home.

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This is, in fact, what is now beginning to occur within some tertiary institutions of Sub-Saharan Africa. Various innovative responses to the threat of HIV/AIDS by African universities, polytechnics, and teacher training colleges were documented and communicated as part of a regional conference, held in Accra, Ghana on September 22-25, 2003, that focused on *Improving Tertiary Education in Sub-Saharan Africa: Things that Work!* The papers that comprise the present publication were prepared for that conference. They provide an overview of what tertiary institutions in Africa are doing to combat HIV/AIDS (Barnabas Otaala), offer practical guidance on how universities can go about the process of developing and implementing institutional policies on HIV/AIDS (Dhianaraj Chetty), and present a case study of how one teacher training college in Kenya undertook this task (Margaret Ojuando). All of them emphasize that the response to HIV/AIDS must begin at home – in the Vice-Chancellor’s or Principal’s office, in Senate meetings, in the classroom, and within academic staff unions and student associations.

Context

The UNAIDS annual status report on HIV/AIDS worldwide, released in December 2003, presents the following summary conclusion for the African continent:

“In a belt of countries across Southern Africa, HIV prevalence is maintaining alarmingly high levels in the general population. In other Sub-Saharan African countries, the epidemic has gained a firm foothold and shows little sign of weakening....The epidemic in Sub-Saharan Africa, in other words, remains rampant.”

The data that support this conclusion are compelling. An estimated 26.6 million Africans now live with HIV. This includes approximately 3.2 million persons who became infected during 2003. During the same year, some 2.3 Africans died of AIDS. At least 12 million AIDS orphans now struggle to cope on the continent. Overall, UNAIDS estimates that one out of every twelve persons in Sub-Saharan Africa is HIV positive.

The good news is that intensive awareness and prevention campaigns by government agencies, churches, and non-governmental organizations can exert a significant deterrent on infection rates. In Senegal, a 1% prevalence rate is due largely to aggressive government action. In East Africa, prevalence rates in Ethiopia, Rwanda and Uganda have declined substantially over the past decade as a consequence of concerted societal efforts (Table 1). For example, HIV prevalence in Uganda was 30% in 1992, but is only 8% today (UNAIDS, 2003).

Taking stock of these prevention efforts, UNAIDS concludes that although basic knowledge of HIV/AIDS has increased among young people in recent years, it is still disturbingly low in numerous countries. It notes that voluntary testing and counseling have not yet been established in many places, and that almost half of African nations have not adopted legislation to prevent discrimination against people living with HIV/AIDS.

African women are considerably more likely to be infected with HIV than men. Among young people aged 15 – 24 years, this ratio is the highest. Note that this age group comprises most of the tertiary student population. In six different national surveys, young women were two to four times as likely to be HIV-positive as young men. In Zambia, for example, HIV prevalence for young adults aged 20-24 years was 16% for women and 5% for men (UNAIDS, 2003).

Table 1.

HIV Prevalence Among Pregnant Urban Women, 2003	
<i>Southern Africa:</i>	
Botswana	39%
Lesotho	30%
Mozambique	18%
Namibia	23%
South Africa	25%
Swaziland	38%
Zambia	20%
Zimbabwe	25%
<i>East Africa:</i>	
Ethiopia	11%
Kenya	10%
Rwanda	13%
Uganda	8%
<i>West Africa:</i>	
Cote d'Ivoire	10%
Ghana	3%
Mali	2%
Nigeria	5%
Senegal	1%

Source: UNAIDS, 2003

What is the situation among Africa's institutions of tertiary education? After all, their campuses constitute a potentially fertile breeding ground for 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 AIDS perspective.

Just four years ago, virtually nothing was known about the status of HIV/AIDS on African tertiary campuses. In his groundbreaking exploration of this area, Prof. Michael Kelly of the University of Zambia found that "a conspiracy of silence" was associated with the subject. He observed that "The most striking feature of the university response to HIV/AIDS is what can only be described as the awe-inspiring silence that surrounds the disease at institutional, academic, and personal levels. Notwithstanding some qualifications, for all practical purposes both individuals and institutions conduct themselves as if the disease did not exist." (Kelly, 2001).

Since this assessment, substantial progress has been registered. At least ten cases studies of HIV/AIDS within different institutions of higher learning have been undertaken.² The Association of African Universities has incorporated an AIDS component within its core services program for 2000 – 2005. The Association of Commonwealth Universities has produced guidelines for institutional response (ACU 2002). In South Africa, a partnership of three higher education organizations (the National Department of Education, the South African Universities Vice-Chancellors Association, and the Committee of Technikon Principals) launched in 2002 a nationally coordinated program to improve the capacity of tertiary institutions to prevent, manage and mitigate the impact of HIV/AIDS. Encouraged by these efforts, at least twenty tertiary institutions – all from Anglophone countries – have developed formal institutional policies for managing HIV/AIDS (Table 2). And in October 2003, the university vice-chancellors from thirteen countries of the Southern Africa Development Conference (SADC) agreed to take a series of actions intended to establish essential services, promote policies and management practices, and create institutional capacities for easing the impact of HIV/AIDS on their campuses. As a result of these experiences, tertiary education policymakers, leaders, staff and students are gaining an understanding of what is needed as well as what works in the battle against HIV/AIDS.

In spite of these accomplishments, the challenge posed to tertiary institutions by HIV/AIDS remains formidable. By way of illustration, a modeling exercise conducted among the tertiary institutions of South Africa concluded that the university undergraduate HIV infection rate was estimated at 22%, rising to 33% in 2005; that the technikon undergraduate infection rate was estimated at 24%, rising to 36% in 2005; and that the infection rate among post-graduate students was estimated at 11%, rising to 21% in 2005 (Kinghorn, 2000).

Projections aside, the impact of AIDS on African universities is already being felt. Copperbelt University in Zambia reports losing 17 – 20 staff members per year. Kenyatta University in Kenya estimates that at least one of its staff or students dies every month. The University of Natal informs that one-third of the nurses it graduated three years ago are now dead (ACU 2001).

Table 2. African Tertiary Institutions with Formal Institutional Policies on HIV/AIDS.

<u>South Africa:</u>		
University of Port Elizabeth	Potchefstroom University	University of Natal
Rand Afrikaans University	Medical University of South Africa	University of Pretoria
University of Cape Town	University of South Africa	University of the Free State
University of Witwatersrand	University of Stellenbosch	Rhodes University
University of the Western Cape		
<u>Namibia:</u>		
University of Namibia		
<u>Botswana:</u>		
University of Botswana		
<u>Kenya:</u>		
Highridge Teachers College	Jomo Kenyatta University	Mombasa Polytechnic
Kenyatta University		
<u>Uganda:</u>		
Nkumba University		

Source: Author's information.

² Anarfi (2000), Barnes (2000), Magambo (2000), Mosso (2000), Mwape and Kathuria (2000), Nzioka (2000), Seclonde (2000), Otaala (2000), Chilisa and Bennell (2001), University of Natal (2000).

Why should tertiary institutions be concerned with HIV/AIDS?

Prof. Michael J. Kelly, former Dean of Education at the University of Zambia, was recently awarded the Symons Medal by the Association of Commonwealth Universities in recognition of his outstanding contributions to the universities of the British Commonwealth in the field of HIV/AIDS awareness and prevention. In accepting this award, Prof. Kelly stressed the fundamental role played by education, including higher education, in the struggle against HIV/AIDS:

“In the absence of biomedical remedies, the only remedy left to society is education. Education is part and parcel of every intervention against the disease. It is the social vaccine we must rely on. Evidence is growing that formal education, not necessarily education about HIV or reproductive health, makes a huge difference. Hence we must use all our energies to ensure that every young person has access to good quality education. In addition, the impact of education in rolling back the disease will be increased if there is good HIV education in the curriculum.”

With reference to tertiary institutions, the universities of South Africa have identified five important reasons why tertiary institutions should explicitly engage the challenge of HIV/AIDS (Chetty, 2000). These reasons are pertinent for other African tertiary institutions as well.

1. *HIV/AIDS is a development issue, not just a health issue.* It affects the social, economic, and psychological well-being of individuals and communities. It conditions national capacities for economic and political development. It is therefore a legitimate topic for university inquiry.
2. *HIV/AIDS affects not just individuals, but institutions.* Tertiary education institutions are vulnerable to the negative impact of HIV/AIDS on their core operations of management, teaching, research, and community outreach.
3. *HIV/AIDS directly conditions the possibilities for human resource development.* Tertiary level educators are among the most skilled individuals in most economies, and tertiary students are particularly vulnerable to infection. At risk is the loss of the most valuable and productive citizens in the economy.
4. *The struggle against HIV/AIDS requires new knowledge.* Universities are charged with the mission of generating new technologies, practices, and understanding through research. These contributions are needed to help African countries prevent and cope with HIV/AIDS.
5. *The fight against HIV/AIDS requires leadership.* 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 epidemic.

In addition, practical financial reasons should motivate institutional managers to recognize and tackle the threat of HIV/AIDS. One university from Southern Africa reports spending 10% of its recurrent budget on AIDS-related expenses such as funerals, death benefits, and health care (ACU, 2001). In addition, the indirect costs of the disease to an institution can be substantial. They include lost productivity due to staff illness, loss of staffing resources through death, loss of institutional expertise, the cost of recruiting replacement staff, the cost of re-training staff to take on additional responsibilities when AIDS-induced absenteeism occurs, the financial losses when student loans are not repaid due to illness or death, the loss of public and family investment when

a student is forced to drop out of school for AIDS-related reasons, higher insurance premiums, and increased death benefits and funeral expenses for staff (ACU, 2002).

Taken together, the above reasons comprise a compelling argument in favor of an explicit engagement of the HIV/AIDS challenge by all tertiary institutions.

The First Step: An Institutional Policy

Developing an institutional policy on HIV/AIDS is the first action that tertiary institutions should take. A written institutional policy provides explanation for internal decisions and legitimacy for actions taken in the process of AIDS control and prevention. Surprisingly, more than a decade after the appearance of HIV/AIDS, less than half of one hundred member universities surveyed in 2002 by the Association of Commonwealth Universities had developed an institutional policy on HIV/AIDS. Although such policy formulation is perhaps best carried out in the context of institutional strategic planning, it is too important an undertaking to be left until the next strategic planning exercise begins.

Accumulating experience in this area (see Table 2) indicates that a tertiary institution's AIDS policy is generally comprised of four main components: (i) the rights and responsibilities of staff and students; (ii) integration of HIV/AIDS into teaching, research, and community service; (iii) preventative services and supportive care on campus; and (iv) structures for policy implementation, monitoring, and review (Otaala, 2003).

An institutional policy on HIV/AIDS typically contains the following elements: a statement of the problem; a commitment to non-discrimination and confidentiality; safety procedures for staff and students; services and resources; legal aspects of HIV/AIDS; conditions of service, issues related to teaching and research; and a commitment to community action (ACU, 2002).

Ultimately, however, an institutional policy will only be as effective as the leadership that owns and support it. Perhaps the most unequivocal lesson learned in this area is that leadership by senior management can make the difference between a positive impact and no impact. "Without leadership, there is no commitment to change, and little chance of shifting institutional culture, of creating a sense of urgency, or of mobilizing key stakeholders" (ACU, 2002).

Developing an Institutional Policy on HIV/AIDS

Experience also confirms that AIDS prevention activities are important, but by themselves are insufficient. An institutional response to AIDS must be based on a conscious continuum of actions that address prevention, treatment, care, and support. To guide such a response, the Association of Commonwealth Universities offers the following checklist for devising an institutional policy statement:

- ✓ Minimum performance standards
- ✓ Finance (employee benefits, sick leave, pension, recruitment, training)
- ✓ Human resources development (policy, procedures, safeguards)
- ✓ Programs (prevention, treatment, care, support)
- ✓ Student and staff welfare
- ✓ Gender/women/sexual harassment
- ✓ Workplace issues (health and safety procedures)

To support the development of institutional responses to HIV/AIDS within the African context, the Association of African Universities has produced an HIV/AIDS “toolkit” for tertiary institutions (Chetty, 2003). Intended specifically for use by institutional managers within the campus community, this toolkit is a package of reference materials designed to support the development and management of comprehensive institutional responses to AIDS. It includes resource materials, advocacy strategies, and practical guidelines.³

The toolkit seeks to help an institution define a response that makes sense within the context of tertiary education. Among the distinguishing characteristics of this context are: sexually active young adults, risky social behavior, social experimentation, and a sense of personal independence and invulnerability. Circumstances of poverty increase the potential for transactional sex on campus. Financial constraints make it difficult for institutions to address AIDS as a priority. Managers are besieged by more vocal demands for attention, and may lack the training necessary to act with confidence. And surrounding the campus community may be a culture of silence in which HIV/AIDS is cast as an individual, personal matter where institutional involvement is inappropriate (Chetty, 2003).

The toolkit poses four specific tasks for institutional leadership. First, to break the silence surrounding HIV/AIDS and legitimize its discussion on campus. Second, to recognize publicly the concrete threat that AIDS presents to the institution. Third, to support whatever work is already being done on AIDS within the institution and use this as a platform to build upon. Finally, to make a response to HIV/AIDS an integral part of the institution’s mission and strategic plan.

How is an institutional policy on HIV/AIDS developed? The process typically involves the successive stages of gathering and analyzing information, developing a strategy, incorporating the strategy into an implementation plan, carrying out the plan, monitoring its results, and evaluating the need for subsequent adjustments.

The case of Highridge Teachers College in Kenya is illustrative. The College’s management began by establishing an AIDS committee comprised of respected staff and student representatives. The committee then carried out a confidential baseline study in the effort to understand the scope and impact of AIDS on the institution. Next, the committee drew upon the expertise of other institutions (e.g., Ministry of Education, Ministry of Health, specialized non-governmental organizations) to educate the college community and build awareness of the need for action. Then the college hired a technical specialist to facilitate stakeholder workshops and foster consensus concerning appropriate courses of action. Finally, the resulting institutional policy proposal was reviewed and approved by the College’s governing board. In the process, the College defined its target community to include everyone physically present on campus, including domestic workers, drivers, and watchmen (Ojuando, 2003).

The Role of Academic Staff Unions

For the most part, academic and non-academic staff unions in African tertiary institutions have given little attention to the threat that HIV/AIDS poses for their membership and for their own organizational viability. This is surprising in view of the fact that their very existence might conceivably be at stake. Staff unions at African universities, polytechnics, and teacher training colleges should be concerned about HIV/AIDS.

³ Further information can be obtained from Alice Lamptey, Association of African Universities, P.O. Box 5744, Accra-North, Ghana; fax: 233-21-774.821; email: alamptey@aau.org

Among the more obvious issues that should interest them would seem to be the following: measures to prevent the sexual harassment of union members, prevention of infection among union members, ensuring that union members living with AIDS are treated fairly, safeguarding the confidentiality of their members in the course of AIDS counseling and voluntary testing, ensuring that union members work in an environment safe from the risk of contracting AIDS, protection of union members from discrimination and recourse to redress when discrimination occurs, shielding of employee benefits from dilution in the face of AIDS, and guarantees for union members' training and promotion opportunities regardless of their AIDS status.

Teaching, Research and Community Outreach

Tertiary institutions in Africa are not only giving attention to HIV/AIDS as an internal management matter. They are also incorporating it as a legitimate subject for teaching, research, and community service. Prof. Otaala's paper, which is included in this document, provides an overview of activities underway in these areas.

Briefly, it should be noted that voluntary counseling and testing are proving to be a key contributor to behavioral change in Kenya, Senegal, Tanzania, Uganda, and Zambia. Masters level programs in AIDS care and counseling have been introduced at the University of Cape Town and the University of Botswana, prompting an initially positive enrollment response. Peer education programs, serving university campuses as well as nearby secondary schools, have demonstrated their effectiveness at the University of Namibia, the University of Cape Town, and Jomo Kenyatta University in Kenya. Subject matter on HIV/AIDS has been incorporated into the mainstream curriculum in various universities, including study programs in life skills, psychology, business, and nursing.

University researchers in Africa, as elsewhere, pursue the quest for a cure or vaccine for AIDS, but also contribute to enhanced understanding of the disease in other ways (Kelly, 2002). For example, university researchers have assessed the impact of social messages on adolescent behavior, analyzed the emergence of a large cohort of AIDS orphans, and illuminated the sexual dynamics of AIDS among prostitutes, truckers, migrant workers, and other high-risk groups. A small but growing body of scientific output on this topic is materializing in the form of graduate theses and dissertations.

Resources

A major resource for shaping institutional responses to HIV/AIDS is the institutional toolkit contained in this document (Chetty, 2003). The guidelines developed by the Association of Commonwealth Universities have also been referenced (ACU, 2002). The ACU is reportedly completing a further resource document on good practice regarding university responses to HIV/AIDS worldwide. In addition, the Paris-based International Institute for Educational Planning has established a reference clearing house on AIDS and education at the following website: <http://hivaidsclearinghouse.unesco.org/ev.php> . This website contains over 450 downloadable reference documents, a listing of 100 additional AIDS websites, a members directory, and discussion forums. Within Africa, a similar resource, specific to the continent and designed as a repository for AIDS-related tools, technical papers, and research reports, is being established at the University of the Western Cape.⁴

⁴ The University of Western Cape contact for this undertaking is Tania Vergnani.

A principal source of funding for HIV/AIDS initiatives within specific countries is the World Bank Multi-Country AIDS Program (MAP) for Africa. This program is financed by USD 1 billion from the World Bank and other partners. These funds are provided as grants (not loans) to any country that meets several simple eligibility criteria, including a national AIDS strategy, a high level governmental implementing committee, and a government commitment to rapid implementation. Typically, the MAP includes an AIDS Emergency Fund for each country that provides grants directly to all types of organizations, including public agencies, non-governmental organizations, communities, civil society, faith-based organizations, and private enterprises. Such grants support capacity building for program delivery, specific services, technical support teams, training workshops, good practice manuals, and the strengthening of monitoring and evaluation systems. Additional information on MAP is provided at the following website: www.worldbank.org/afr/aids/map.htm Details on the AIDS Emergency Fund for a particular country are normally available from that country's National AIDS Committee.

The current status of MAP projects approved for African countries is presented in Table 3.

Table 3. Approved HIV/AIDS Projects as of October 1, 2003

Country	Status	Commitment (USD millions)
Benin	Effective July 2002	23.0
Burkina Faso	Effective March 2002	22.0
Burundi	Effective October 2002	36.0
Cameroon	Effective September 2001	50.0
Cape Verde	Effective July 2002	9.0
CAR	Approved but not effective	17.0
Eritrea	Effective March 2001	40.0
Ethiopia	Effective January 2001	59.7
Gambia	Effective July 2001	15.0
Ghana	Effective May 2002	25.0
Guinea	Effective March 2003	20.3
Kenya	Effective January 2001	50.0
Madagascar	Effective November 2002	20.0
Malawi	Approved but not effective	35.0
Mauritania	Approved but not effective	21.0
Mozambique	Effective August 2003	55.0
Niger	Approved but not effective	25.0
Nigeria	Effective April 2002	90.3
Rwanda	Effective August 2003	30.5
Senegal	Effective January 2003	30.0
Sierra Leone	Effective October 2002	15.0
Tanzania	Approved but not effective	70.0
Uganda	Effective May 2001	47.5
Zambia	Effective July 2003	42.0

Lessons Learned

Experience acquired over the last several years by tertiary institutions in their efforts to combat HIV/AIDS now seems sufficient to enable some stock-taking. What has been learned to date? At least five general conclusions can be drawn:

Leadership is the most important single factor. Where vice-chancellors, principals and other senior managers have made AIDS an institutional priority, the effect on their institutions has been immediate and visible. Decision-making and program management structures have been established. Networks have been created, resources have been found, and the climate of silence and denial that surrounds AIDS has begun to be broken down (Chetty 2000). Apart from serving as an advocate for attention to AIDS within their institutions, managers are likely to find that the following four actions can be highly effective: undertake an assessment of the impact of AIDS on their institution; train key staff (Dean of Students office, health services, library, union leaders) in AIDS awareness, counseling and confidentiality; personally challenge instances of shame, stigma, and discrimination; and promote respect for women staff and students, particularly through anti-sexual harassment policies (Otaala, 2003).

Institutions that establish AIDS Coordination Units have better organized programs. New initiatives do not happen by themselves. Sustainability and accountability for results cannot depend entirely on voluntary workers. A visible focal point – an office with two or three competent staff – is necessary to provide day to day attention, encouragement to other units, strategic reflection, and a means of disseminating new knowledge and ideas in the AIDS arena (University of Natal, 2000). AIDS coordination units have been established at the University of Cape Town, the University of Botswana, the University of Natal, the University of Namibia, the University of Witwatersrand, the University of Dar es Salaam, and elsewhere. Their impact is clearly being felt on those campuses. However, very few institutions have taken the next step and actually established a budget for their AIDS programs.

AIDS activities planned and executed with student involvement are far more effective. Peer education programs are but one example of such effectiveness. Students generally have an understanding of their social milieu that older adults often lack. Peer counselors are also likely to be present where they are needed most, and to be available nearly twenty-four hours a day. In addition, the action of peer counseling serves as an important role model and also impacts positively on those who do the counseling as well as on those who are counseled.

AIDS prevention is important, but insufficient by itself. An institutional response strategy to AIDS must be based on a continuum of prevention, treatment, care, and support. All campuses contain persons living with AIDS. They deserve understanding, encouragement, respect, and occasional accommodation. A large number of staff and students are required to deal with the psychological stress and trauma associated with the knowledge that a family member or close friend is battling AIDS. Students in particular require support, counseling, and timely intervention to help them to remain in school under these circumstances. The weakness of most current tertiary institutions' responses to AIDS is that they tend to be one-dimensional. They often concentrate on awareness campaigns and do not do enough in terms of voluntary testing, counseling and support, care and treatment, curriculum integration, community outreach, research, and the creation of external partnerships.

Women students are much more vulnerable to HIV infection than men. Sexual harassment comprises unwanted approaches or remarks directed at women, seductive behavior, sexual bribery, sexual coercion, and sexual assault (Wilken and Badenhorst, 2003). It has long been recognized that sexual harassment and exploitation of young women within African tertiary institutions is a serious problem. These practices, together with the poverty pressures that may lead women into transactional sex or “sugar daddy” relationships, combine to produce generally higher rates of HIV infection among women. Fragmentary evidence from various countries suggests that university-age women are two to four times as likely to contact HIV/AIDS than men. As a result, institutional responses to AIDS must incorporate policies and sanctions that safeguard women from the risks of assault, intimidation, and exploitation. Wilken and Badenhorst (2003) provide an instructive review of sexual harassment policies among various South African universities, including a checklist of 30 desirable policy elements and five recommendations regarding policy implementation. Another useful reference is the resource handbook on sexual harassment produced by the Africa Gender Institute at the University of Cape Town (Bennett, 2002).

Conclusion

Tertiary institutions have long cherished a tradition of autonomy that surpasses that of many other institutions in society. With regard to HIV/AIDS, this autonomy can become a liability, as it often leaves tertiary institutions outside the field of action taken by ministries of education or health to tackle the disease at a national level. For this reason, initiatives to confront AIDS within tertiary institutions must begin at home. Vocal and visible concern with this problem must be demonstrated by institutional leaders. Development of an institutional policy for managing the challenge of AIDS is an essential step in asserting control over the threat of AIDS. Responding to AIDS is both a social and ethical responsibility for tertiary institutions. But in doing so, they also fashion opportunities to regenerate themselves and realign their capabilities to contribute to national development within a constantly changing economic and social environment (Chetty, 2000).

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Institutional Policies for Managing HIV/AIDS in Africa

Barnabas Otaala⁵

INTRODUCTION⁶

HIV/AIDS is without doubt one of the most tragic and challenging health problems of our days. Africa certainly carries the heaviest burden with respect to HIV/AIDS. For a continent representing one-tenth of the world's population, nine out of 10 HIV positive cases originate from Africa (FAO Focus 2000).

HIV/AIDS does not respect race, ethnicity, gender, age, or economic status: everyone, including unborn babies, is to a greater or lesser extent, vulnerable to infection.

The pandemic is a "threat that puts in balance the future of nations" (Nelson Mandela, 1997). AIDS kills those on whom society relies to grow the crops, work in the mines and factories, run the schools and hospitals, and govern the countries. It creates new pockets of poverty when parents and bread winners die and children leave school earlier to support remaining children – themselves affected and infected by HIV/AIDS.

The statistics make grim reading. HIV/AIDS is the deadliest scourge on the African continent. For those who are unable to contemplate the scope of the disaster, these numbers will shock. An estimated 28 million people are currently living with AIDS in Sub-Saharan Africa. This number represents nearly two thirds of all AIDS cases reported globally. In 2001 there were 3.4 million new infections and 2.3 million deaths. The continent harbors 21 countries with the highest prevalence of HIV in the world. In at least 10 countries, prevalence rates among adults exceed 10 percent. To bring the matter down to the individual level, 44 percent of pregnant urban women in Botswana were HIV positive in 2001. One in four adults in Zimbabwe and Botswana carries the virus. Of the 13 million AIDS orphans world-wide, 10 million of them live in Sub-Saharan Africa (Africa Today, Vol. 9, No. 5, May 2003, p. 19). Calisto Madavo, the World Bank Vice-President for Africa, emphasizes this tragic situation differently. He states: "Let us not get caught up only in numbers – HIV infection rates, HIV prevalence rates, mortality rates. Behind these numbers there is flesh and blood. Behind these numbers there are husbands, wives, parents, children, farmers, teachers, doctors. It's the wellspring of African knowledge and wisdom being drained before our eyes. According to a West African proverb, "Every time an elder dies, it's as if a library has burned down..."⁷

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⁶ I acknowledge with gratitude the help I received from the following colleagues who provided information used in this paper: Mary Crewe, University of Pretoria; Wendy Orr, University of Witwatersrand; Barbara Michel of the South African Vice Chancellors' Association; Mandy Govender, University of Cape Town; Mary Kabanyama-Zigira, Kigali Institute of Science and Technology; Philip Owino, Kenyatta University; Mosarwa Segwabe, University of Botswana,;and Mark Winiarksi, University of Namibia.

⁷ Calisto Madavo, Vice President for Africa, World Bank, at an address to a gathering of German development officials in Berlin, March 29, 2001).

What has been the African response to this tragic development, which is not merely a health issue, but is a development problem? Specifically, what has been the response of African tertiary institutions?

To answer this question, this paper addresses the following topics:

- The level of priority to be given to HIV/AIDS and the reasons for this;
- The obligations African tertiary institutions have to their staff with regard to HIV/AIDS;
- Policies and practices currently in place, with particular reference to policy development; peer counseling mentoring and tutoring; curriculum integration, and voluntary counseling and testing. The paper makes suggestions with respect to what tertiary education leaders/managers can do to further limit the spread of HIV/AIDS within their campuses, and makes suggestions to conference participants which they might wish to consider in order to make their HIV/AIDS- related work more effective on their return to their respective institutions. We briefly examine these issues, in that order.

WHY SHOULD TERTIARY INSTITUTIONS BE CONCERNED WITH HIV/AIDS?

President J.F. Kennedy stated in his message to Congress on 20th February, 1961, “Our progress as a nation can be no swifter than our progress in education ... The human mind is our fundamental resource.” This statement is universally true, and in the case of Africa is doubly so, particularly in relation to tertiary education and economic and national development.

African tertiary institutions face a number of challenges, globalization and ICT development among them. More recently, the challenge posed by HIV/AIDS has taken a paramount place in our thinking, actions, strategies, and programming.

Underlying all these challenges is the traditional role of a tertiary institution or university embedded in:

- Transmitting the accumulated body of global knowledge relevant to the development of society through **teaching**;
- Creating new knowledge and extending boundaries of knowledge through **research**;
- Preserving knowledge on national and international values of culture, history, art and science, through **technology, publication and library acquisitions**; and
- Providing **advisory, extension and consultancy services** on issues which are relevant to the socio-economic advancement of society at large.

Tertiary institutions are well placed to respond to these varied and daunting challenges for a variety of reasons including the following:

1. To paraphrase the words of Boyer, the university campus (tertiary institution) can be considered as a purposeful, open, just disciplined, caring, and celebrative community.

It is an educationally **purposeful** community, a place where staff and students share academic goals and work together to strengthen teaching and learning on campus. It is an **open** community, a place where freedom of expression is uncompromisingly protected and where civility is powerfully affirmed. It is a **just** community, a place where the sacredness of the person is honored. It is a **disciplined** community, a place where individuals accept their

obligations to the group and where well-defined governance procedures guide behavior for the common good. It is a **caring** community, a place where the well-being of each member is sensitively supported and where service to others is encouraged. And it is a **celebrative** community, one in which the heritage of the institution is remembered and where rituals affirming both tradition and change are widely shared. Given such a community, one would expect it to rise to the occasion, by “challenging the challenger” - - HIV/AIDS.

2. HIV/AIDS has clearly affected the core business of tertiary institutions – teaching and learning; research; management and community engagement. HIV/AIDS is no respecter of institutions. In fact, tertiary institutions that have large numbers of sexually active young people in the age bracket of 19 – 25 years are particularly vulnerable.
3. “Tertiary education is more than the capstone of the traditional education pyramid; it is a critical pillar of human development worldwide. In today’s lifelong-learning framework, tertiary education provides not only the high-level skills necessary for every labor market but also the training essential for teachers, doctors, nurses, civil servants engineers, humanists, entrepreneurs, scientists, social scientists and myriad personnel. It is these trained individuals who develop the capacity and analytical skills that drive local economies, support civil society, teach children, lead effective governments, and make important decisions which affect entire societies.” (World Bank, 2002)
4. Given the magnitude of the crisis that HIV/AIDS has brought into the lives of individuals and counties, the education system – especially tertiary institutions – has a serious obligation to cooperate with all other bodies in stemming the spread of this infection. As one of the major socializing forces in society, it has a grave obligation to educate the young on this matter, providing knowledge, fostering awareness, promoting life-asserting attitudes. It also has an obligation to those who work in the system, heightening their awareness and strengthening their determination and efforts to remain uninfected. The education system has a further responsibility towards those who are already infected, helping them in a compassionate and unpatronizing manner, to live positively. This latter responsibility is all the more grave and delicate in relation to school-going children who are HIV/AIDS infected.
5. We recognize that the burden of fighting HIV/AIDS cannot rest only with our national governments. Together with our governments and external partners (including NGO’s), tertiary institutions **can** and **must** make a difference if we are to succeed.

Having briefly referred to some of the reasons why tertiary institutions should be concerned with issues related to HIV/AIDS, we now turn to a brief examination of what has been done in policy development.

POLICY DEVELOPMENT

In each undertaking, policies are needed to guide the vision and goals of the enterprise, before strategic planning and implementation are begun. In the area of HIV/AIDS, institutional policy development has been slow, particularly within tertiary institutions where AIDS is often viewed as a private matter.

At the University of Namibia (UNAM), our experience goes back to 1997 when we developed HIV/AIDS guidelines for the University which were approved by the University Senate. But it was not until our visits to other sister institutions in the SADC region (University of Botswana;

University of Natal; University of Pretoria) and numerous exchanges on HIV/AIDS issues with several universities which fall under the South African Vice Chancellors' Association (SAUVCA), that UNAM began to actively develop its own policy – drawing heavily on its 1997 guidelines; and drawing liberally from other HIV/AIDS policies which had been adopted then or which were in draft form.

The University of Namibia's Policy on HIV/AIDS articulates with, and supports, the National Strategic Plan on HIV/AIDS Medium Term Plan II (1999 – 2004) as well as the 2001 Namibian HIV/AIDS Charter of Rights. The Policy is strongly shaped by normative considerations and the Human Rights provisions embodied in the Constitution of the Republic of Namibia. The Policy has four principal constitutive components. These are:

- The Rights and responsibilities of Staff and Students
- The integration of HIV/AIDS in teaching, research and community service
- Preventive care and support services, and
- Policy implementation, monitoring and review.

MANAGEMENT

The University ensures that all members of staff are familiar with the HIV/AIDS policy and the legislation that governs HIV/AIDS in the workplace. Most of the universities and technikons in South Africa have HIV/AIDS policies. The few that do not have them are in the process of developing them, often with financial support from DfID. In other Anglophone countries, many tertiary institutions do not yet have HIV/AIDS policies. More recently, however, with the ADEA-WGHE support, a number have either developed or are in the process of developing such policies. These include the Mombasa Polytechnic and Highridge Teachers Training College, in Kenya; Nkumba University in Uganda; and the University of Botswana, Gaborone, Botswana.⁸

To my knowledge, practically all Francophone and Lusophone tertiary institutions do not yet have HIV/AIDS policies. However, many of them follow unwritten understandings with regard to HIV/AIDS patients. People who are infected have an equal opportunity to services and privileges as those who are not infected, as well as an equal chance for further training. Moreover, a number of them, such as the Kigali Institute of Science and Technology (KIST) in Rwanda, are preparing institutional policy development proposals for submission to ADEA-WGHE for a competitive award available for institutions in Francophone countries.

In addition to policies, some tertiary institutions have actually set up separate structures charged with carrying out these policies. Some institutions (University of Botswana; University of Cape Town; University of Natal; Kenyatta University; and University of Namibia) have established HIV/AIDS Units to coordinate activities across the institutions and to combat “ad hocism” or the temptation to leave it to a few people with “a fire in their belly.” The University of Pretoria supports a Centre for the Study of AIDS in Africa whose primary purpose is to mainstream HIV/AIDS through all activities of the university to ensure that it is able to plan for and cope with the impact of HIV/AIDS on the whole tertiary education sector in South Africa.⁹

⁸ Alice Lamphey, personal communication, 2003.

⁹ See page 18 for the websites containing HIV/AIDS policies of selected institutions.

We now turn to a brief examination of how HIV/AIDS policies have been translated into action in terms of programmes developed and plans in hand. We specifically refer to peer counseling, tutoring and mentoring; curriculum integration, and voluntary counseling and testing.

PEER COUNSELING, TUTORING AND MENTORING

Several variations of youth engagement in counseling and interacting with fellow youth have proved very promising in Southern Africa. We cite a few illustrative examples: the UNAM Youth Radio Station; My Future is My Choice Programme; and University of Cape Town SHARP Programme.

Youth Radio Station

The University of Namibia established a radio station in 2001 (under the auspices of the United Nations and currently in partnership with Johns Hopkins University), which uses music, jingles, drama and talk shows as a means of mainstreaming HIV/AIDS issues among youth. The radio programme **must be highly entertaining** in order to attract young Namibians to not only listen to it but also engage in dialogue with and about its content. An interactive variety show with segments such as, drama, music, discussions (with youth and “experts”), telephone call-ins, and contests enable the programme to attract young people. Young, enthusiastic and knowledgeable radio hosts add to the market appeal of the programme. After the initial series is aired it will be evaluated for impact, and the data will be incorporated into the redesign of the programme and its expansion.

Recent success in HIV/AIDS communication interventions (i.e., Uganda and Zambia) demonstrate a need to go beyond “messaging” and begin dealing with the “contexts” on how young people live and interact with each other. More emphasis needs to be placed on abstinence (including secondary abstinence) and partner education. Gender is another excellent topic that should be explored. In order to address these issues, the heart of our proposed framework goes beyond information provision and explores means to motivate the audiences to act and to strengthen their skills and reasons to act, thereby empowering:

- Individuals to protect themselves against HIV/AIDS
- Communities to support individuals to prevent the spread of HIV/AIDS
- Local organizations (NGOs, GOs, FBOs and others) to be more effective in their efforts to prevent the spread of HIV/AIDS.

This framework is based on the overall concepts of instilling the youth with a sense of self and collective efficacy, providing the youth with information, motivation and life skills to make informed choices, and linking media to community health and social services. Each of these concepts will be explored in this radio programme.

The successes of this programme involves: (i) developing self and collective efficiency; (ii) getting information, motivation, and life skills; and (iii) making use of the Integrated Model of Communication for Social Change.

My Future is My Choice (MFMC) is a University of Namibia initiative that aims to empower learners by giving them information and skills that will enable them to make the personal choice to change their behavior. The training provided covers ten sessions and covers topics such as

reproductive health and HIV/AIDS, decision-making skills, saying “NO”; relationships and values, and alcohol and drug use and abuse.

To date over 100 000 school learners and out-of-school youth have been reached and over 200 University of Namibia students instructed. So impressive has the programme become that not only did it win the Commonwealth Award for Actions on HIV/AIDS in 2001, but the Ministry of Basic Education, Sport and Culture in Namibia has declared it a compulsory extramural activity for all secondary schools.

The Students Peer Education Project of the University of Cape Town (SHARP) started in 1994 to recruit and train 200 students per year to present interactive workshops for other students and pupils in the Cape Metropolitan region. Training modules cover a range of topics similar to those of the *My Future is My Choice* programme described above.

There are also a number of other peer education programmes run by other institutions which are well developed and well utilized though they may not be in every instance part of a coherent tertiary institution response to HIV/AIDS.

CURRICULUM INTEGRATION

A number of courses, both voluntary and compulsive, have been introduced in various institutions at different levels, even though these do not constitute “mainstreaming” HIV/AIDS throughout the curricula. We provide brief illustrative examples of some of these efforts at curriculum integration:

University of Cape Town

The HIV/AIDS Unit is involved with incorporating HIV and AIDS material into formal curricula at UCT. Drawing on staff from various departments, courses are developed, taught and evaluated to ensure that UCT students graduate knowing how to respond to HIV personally, professionally and as responsible members of the community. The Unit offers training to UCT staff members through a series of three workshops run every term. Workshops cover topics such as basic information, communicating with children about AIDS, and living with HIV. UCT also focuses on work-place issues, looking at managerial responsibilities and the rights of employees with HIV, and understanding the UCT policy on HIV/AIDS. The Unit will be presenting a module on HIV/AIDS in the Psychology I course in 2003 as well as a Commerce Faculty foundation course entitled “*Thinking about Business*”.

University of Namibia

The University of Namibia has introduced a compulsory examinable module for **all** first year students. The module entitled “Social Issues” deals with gender, ethics, and HIV/AIDS. Various departments have also made efforts to incorporate aspects of HIV/AIDS.

Kenyatta University

Kenyatta University offers a wide variety of HIV/AIDS-related courses at the certificate, diploma and post-graduate levels, as well as a compulsory core unit for all students. At the last graduation, 85 students received certificates for one or other of these HIV/AIDS courses. These courses are

proving to be increasingly popular because of their reputation for helping graduates to secure good jobs (ACU, 2001).

In addition to the various programmes cited above, a number of universities currently offer Masters' degrees with a specialization on HIV/AIDS. At UCT, for instance, an MPhil course in HIV/AIDS in the Faculty of Humanities is being offered. At the University of Botswana, MEd degrees in Counseling and Human Services (which have HIV/AIDS components) have been mounted.

All in all, commendable efforts are being made to integrate HIV/AIDS into tertiary institutions curricula. However, not many institutions have yet joined in this effort, and complete "mainstreaming" of HIV/AIDS into academic programmes has not been fully achieved.

VOLUNTARY COUNSELING AND TESTING

Voluntary Counseling and Testing (VCT) is generally defined as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV. People affected by HIV/AIDS want counseling and testing services for future planning (including planning for marriage and children), emotional support, medical and other referral services, and insurance.

Voluntary counseling and testing (VCT) has proven to be one of the early factors in behavioral change in countries such as Uganda, Senegal, Kenya, Tanzania, and Trinidad and Tobago. It is also efficacious and cost-effective. It can be assumed that people who want to know about their HIV status are willing to change their behavior. In Namibia, the number of persons demanding VCT is growing steadily. Private industry, in particular the mining industry, has played a decisive role in this regard, showing positive results in condom use and infection rate. VCT is in high demand in rural areas. However, VCT facilities have still to be made available throughout the country.

At UNAM one of our objectives is to have a VCT Centre available to UNAM students by September 2003. These students, the country's greatest resource for future development, are at extreme risk of infection. Informed estimates now suggest that between 1 in 7 and 1 in 4 will be HIV positive upon graduation. To look at these students' faces and imagine their apparent fates is heartbreaking. The campus VCT Centre project is not envisioned to simply be a counseling/test facility ruled by numbers in and numbers out. Rather, we envision a **New Start** on campus to have a multi-dimensional social marketing function. On campus, the Centre would be a salient reminder to students about the epidemic. Conveniently located on campus, it would promote thinking and conversation about the epidemic, the necessity for testing, and the imperative for healthier living. Ultimately, the Center's function would be to counsel and test. I don't think any of us believe there would be an immediate rush to the Centre. Rather, we anticipate a gradual increase in utilization as the social marketing messages increase in effectiveness.

My own experience in my visit to the University of Zambia, which houses a functioning VCT Centre, confirms this. Initially students there were slow to use the Centre, but over time they came forward in increasing numbers. Moreover, a post-test counseling group of students there has attracted a large and active membership. This group has encouraged many more students to be tested.

The slow uptake to testing is often related to issues of shame, stigma and discrimination which we deal with later in this paper.

Various universities sponsor active and functional VCT Centers. These include the University of Botswana, the University of Durban-Westville, the University of Cape Town, the University of Pretoria, the University of the Witwatersrand, the University of Natal, and the University of Stellenbosch. Others provide voluntary counseling without necessarily maintaining Centres on campus, as actual testing is done on a referral basis.

An important element of any prevention and care strategy is access to information about one's HIV status. However, Voluntary Counseling and Testing services are still rare in most African nations. More viable centers need to be set up so that universities and other tertiary institutions, as the key agents in the response to HIV/AIDS, can encourage students and staff to obtain information about their HIV status and get counseling that they need, as well as support to maintain a negative HIV status or to live positively with HIV. In addition, it is only through voluntary counseling and testing that vertical transmission of HIV from parent to child can be reduced. Tertiary institutions can themselves set up VCT Centres where this is feasible.

In the foregoing pages we have looked at some of the responses of the tertiary institutions in Africa to the HIV/AIDS pandemic. We turn now to a consideration of three effective things that, in addition to activities already cited, leaders/managers could undertake to limit the spread of HIV/AIDS within their campuses, as well as within the communities of which they are a part.

THREE EFFECTIVE THINGS MANAGERS CAN DO

1. Provision of immediate training and conduct of impact and tracer studies

Within tertiary institutions, capacity development is an immediate need. Key personnel require training to deal with AIDS in the workplace as well as staff to ensure that there is peer education and program support. Members of the Dean of Student's Office and other student support services, the campus clinic, the library, and the key members of the Unions should all have some basic training on how to handle issues related to HIV/AIDS in the workplace.

Secondly and equally important is the need to develop an extensive research programme, planned probably in collaboration with other tertiary institutions. One area to begin would be to assess the impact of the HIV/AIDS on the particular tertiary institution. In this regard an excellent recent example of a serious attempt to bring together all available data for analysis of the AIDS situation at the University of Botswana is provided in the article by Chilesa and Bennell (2001). The main conclusion of the assessment is that, at least up until 2000/01, the University had been less affected by the epidemic than might be expected given that the overall adult prevalence rate in Botswana was almost 40 percent in that year. However, the role of on-campus AIDS prevention activities in creating this unexpected variance is not investigated.

The results of such impact assessments should lead to concrete recommendations of what tertiary institutions could do to develop a comprehensive programme on prevention, care and support of those infected and affected by HIV/AIDS, and to mitigate the impact on individuals and tertiary institutions, as well as communities.

For tertiary institutions in existence for ten years, it would be instructive to undertake tracer studies of past students. Information from such studies would, among other things, assist

institutions to plan intakes more realistically, taking into account losses inflicted by the HIV/AIDS epidemic.

2. Tackling shame, discrimination and stigma: the need for a research programme ¹

The most effective health interventions are worthless if they are not used. What is it about our cultures that compels us to overlook a major barrier to improved healthcare: the entwined issues of stigma, discrimination, and shame (hereafter referred to as SDS)?

SDS is such a powerful force that, if there is a chance their conditions would be revealed, people would rather suffer and die, and have their children suffer and die, rather than seek treatment that could improve their quality of life or save their lives. Currently, those with any number of illness are stigmatized and rejected, as are family members, if those illnesses are made public. People also hide their medical conditions because they fear, oftentimes justifiably, that they will lose friends, jobs, housing, educational or other opportunities, if their conditions are publicly known. The many conditions affected by SDS include forms of cancer, Hansen's Disease, mental illness, mental retardation, tuberculosis, domestic violence, substance abuse and dependence, sexual dysfunction, and sexually transmitted diseases, now most notably HIV disease.

Repeatedly, loudly and for decades, experts at the international level and service providers at local levels have described the powerful forces of SDS. No less a personage than the late Jonathan Mann, then Director of the WHO Global Programme on AIDS, warned the world about SDS in regards to HIV. Speaking to the UN General Assembly in 1987, he "identified three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination, and denial." He noted that the third phase is "as central to the global AIDS challenge as the disease itself" (Parker et al, 2002).

"Each year, more and more people die from the [HIV] disease and it is the stigma and misinformation around HIV that is killing people," Juan Manuel Suarez del Toro, president of the International Federation of Red Cross and Red Crescent Societies, said in a recent World Red Cross Day message. "People place themselves at high risk from infection or refuse to seek treatment rather than face the consequences of social stigma, such as losing their homes, businesses and even their families," he said (Olafsdottir, 2003).

Despite the insistent voices of warning, no concerted action has been initiated to understand and confront SDS across many cultures. I suspect that we may be ashamed of the existence of SDS. Studying these constructs would plumb our basest aspects, and would not be pleasant. Perhaps we don't want to know, so scholars, founders, etc., have turned a blind eye to SDS. Alternatively, perhaps research institutions and founders find it difficult to embark on explorations into areas – psychological, social, and attitudinal – that cannot be neatly measured in laboratory values and that have many cultural complexities. Understandably, medical scientists may continue to believe a great biomedical intervention will be easily accepted, welcomed by all. Tragically, that may not be the case.

Some scholarship regarding shame and stigma suggest the topic is approachable. Kaufman (1996) has studied these factors in terms of Western psychological factors, but little Third

¹ I am grateful to my colleague, Mark Winiarski, Fulbright Professor at UNAM, for his contribution to this section.

World research is documented. Parker, Aggleton and collaborators (2002) have addressed stigmatization and discrimination regarding HIV disease and have articulated a research agenda, including studies of social processes and aspects across cultural boundaries. Others have reviewed 21 interventions that explicitly attempted to decrease stigma associated with other diseases (Brown, Trujillo, & Macintyre, 2002). They concluded that the reviewed studies indicate something can be done about stigma through interventions such as information, counseling, coping skills acquisition, and contact. Underlining the scarcity of SDS interventions, the authors found only two national level efforts to combat stigma and no documented studies on the effects of mass media campaigns.

While these studies hint that something can be done, in fact we still know very little and perhaps whatever we “know” is only culture specific. The grand challenge is to understand and diminish shame, discrimination and stigma so peoples and individuals are willing to access available and effective biomedical and psycho-social interventions. Basic questions still exist: Do the constructs of shame, discrimination and stigma have commonality across cultures? Are these constructs indeed conceptually entwined? Is it useful to think of them in this way or do we need alternative, as yet unconceptualized, factors? What are the bases for shame in different cultures –sexuality, pride versus weakness, inability to perform gender-based roles, illness, or issues that we cannot guess? What are the psycho-social bases in various cultures for stigmatization and discrimination? Interventions to reduce SDS, if there are to be any, require some theoretical underpinnings, even if these are different from culture to culture.

We then need to move to the issues of interventions regarding SDS. Funders need to support more scientifically based intervention studies. Researchers and communities will require encouragement for large- and small-scale interventions. Perhaps researchers will need to start with neighborhood or ethnic-group level interventions. In this regard our African researchers may also need to note that the Ford Foundation recently awarded the Centre on AIDS and Community Health of the Academy for Educational Development (AED) a grant to implement its HIV/AIDS Anti-Stigma Initiative. AED will examine the impact of HIV/AIDS related stigma and will work with community-based organizations to create strategies to combat it.¹⁰ This suggested research agenda may be a “tall order” but is a direct challenge to tertiary institutions, particularly in Africa, because their role is critical in resolving some of Africa’s problems.

3. Societal standards: the need for moral regeneration, supported by sexual harassment policies.

Many people, especially among the young, are not given sufficient help by society in their efforts at HIV prevention. They find that double standards for sexual and other behaviors prevail for men and women, for old and young. Men and boys tend to have more sexual partners than women and girls. Males are expected to be knowledgeable about sexual matters, whereas females who show knowledge or interest in sexual issues may be regarded as immoral or promiscuous. Communication on sexual matters for boys and men may consist in little more than boastful accounts of ‘conquests’, whereas women and girls discuss issues more sensitively and intimately between themselves and within their families. For the greater part, virginity is highly prized in a girl, whereas in some cultures it is viewed with suspicion and concern in a boy.

¹⁰ The Academy News, Spring 2003, p.6

As they strive to adapt themselves to the gender norms that their culture prescribes for their biological sex, young people experience difficulties with these ambivalent attitudes of society. Their difficulties are increased when they see older people behaving and living in ways they would condemn in the young. Many societies create an almost impossible task for young people, expecting them to behave in certain ways but confronting them with social norms, expectations and role models that point in a very different direction. The models placed before the young through advertisements, in the media, and through the entertainment industry glorify the physical aspects of sex, but say little about the arduous task of building enduring human relationships that support and are supported by sexual practice. (Kelly and Otaala, 2002)

The horrific litany of abuse of women and children, the soaring level of criminal violence in many African countries, the place of corruption in public life, all have helped us to see that moral values have been destroyed in many of our countries. We have found ourselves to be societies with very little private or public morality. It is not that there has been a moral vacuum; immoral practices have replaced our moral values and our moral capital has vanished. We African societies are morally bankrupt. How can tertiary institutions contribute to a strengthened public morality?

Tertiary institutions need to be proactive and have gender sensitive policies for staff and students, as well as provide leadership in research on gender issues. Such policies include the anti-sexual harassment policies recently introduced by the University of Botswana and the University of Namibia. Sexual Harassment Policy and Procedures should be available to assist any case where a member of the university community feels that he or she is being or has been sexually harassed and to designate penalties for those who are found guilty.

In the case of Namibia, as presumably in many other African countries, the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) is currently being implemented. Tertiary institutions should be at the forefront of those supporting the implementation of this and similar conventions designed to better the lot of African girls and women. Tertiary institutions can help by providing moral leadership as well as conducting research related to traditional African core values on sexuality.

Encouraging Public Debates on HIV/AIDS Issues

In our work with the *My Future is My Choice* programme, we have found that the programme teaches young men and women in a very dynamic and interactive way, so that the learners and out-of-school participants become part of the learning process. We make use of other young people to be facilitators. These facilitators are usually just a few years older than the target group.

Young people discuss the often difficult issues that surround HIV/AIDS. “Is it true that circumcised men are less likely to get HIV?” “Can woman over 40 still contract HIV?” “Doesn’t one get sick when one abstains for a long time?” These are just some of the questions posed by young people in their sessions. In a recent question and answer session, a young man asked, “If the condom does not fit, can I use cello-tape?” I leave it up to you to come up with an appropriate answer.

Discussions such as these encouraged for participants in the *My Future is My Choice* programme can be extended to public debate on HIV/AIDS issues. To undertake such debate, it would be crucially important to understand the political and social context within

which one is working; the varying target and audiences' capacities to participate, and key ethical issues, such as informed consent; confidentiality, and the use of information.

In many African contexts, people infected with AIDS and those around them are in great fear. As William A Doubleday wrote in his essay *Spiritual and Religious Issues of AIDS*, "Many are talking about an even greater disease than AIDS, which is affecting the person infected, those who are suffering with him or her, and those who are the 'worried well'. It is the disease known as *AFRAIDS*, that is "*Acute Fear Regarding AIDS*". Tertiary institutions can provide leadership in promoting and participating in public debates to engage and eliminate such fears, including issues of shame, discrimination, and stigmatization, as described earlier.

A FEW SUGGESTIONS

In responding to the issues of prevention, care, support, management, and mitigation of the impact of HIV/AIDS, individual countries and institutions have to take into account the different contexts in which they operate. Nevertheless, a couple of general lessons learned can be shared.

1. Collaboration and Partnership

Collaboration has become a buzz word in discussions on the fight against HIV/AIDS, referring to a variety of efforts to bring people together for shared goals, projects or tasks. Funders and policy makers favor collaborative efforts among institutions or organizations to bring about synergy. But true collaboration requires a set of dispositions, beliefs, commitments, and skills. Even then, it is not easy to collaborate, especially across significant differences in geographical distances, cultural perspectives, experiences, and personal, institutional or organizational histories. Collaboration is not a passive phenomenon; nor is it something one can check off one's strategic plan or assessment tool. It is an ongoing work in progress, with all the highs and lows of human frailty and experience.

"Collaboration, on the surface, is about bringing together resources, both financial and intellectual, to work toward a common purpose. But true collaboration has an "inside," a deeper, more radical meaning. The inner life of collaboration is about states of mind and spirit that are open ..." (Jones & Nimmo, 1999)

An illustration of effective collaboration in HIV/AIDS work would be two or three institutions (within a country or across borders) coming together for a two-three day meeting/workshop. The purpose of the meeting might include:

1. Advocacy to sensitize participants on the actual and potential impacts of HIV on the operations of their institutions.
2. Clarification of needs and responsibilities in the four domains of knowledge and understanding of the epidemic, teaching and preparation of students, research and dissemination of knowledge and service to or engagement with society.
3. Reaching agreement on the need for institutional response and what this implies in terms of a way forward at the institutional and group level.
4. Considering a new mechanism that ties all the institutions together to fight the HIV/AIDS epidemic, with a view to institutionalizing the response throughout the respective institutions (in country or cross-border).

2. Learning from exchanging visits with other institutions

Our experience at the University of Namibia has taught us that much can be gained through personal visits to other institutions as well as inviting colleagues to visit us. When we developed our HIV/AIDS Policy, we arranged for a number of our colleagues of the UNAM HIV/AIDS Task Force to visit the Universities of Botswana, Natal and Pretoria to meet and interact with their colleagues in the various HIV/AIDS Units. We followed this by inviting those individuals to present papers at our workshops, and held consultative meetings with them. From these experiences, and in the belief that there was no need to “re-invent the wheel”, we developed our HIV/AIDS Policy as well as our strategic plans.

3. Doing activities at zero-budget

Whenever a project must be undertaken, one main preoccupation we often think about is the financial cost. A number of activities, however, can be undertaken at very little cost, or at no cost at all. A couple of illustrative examples follow:

- a) The Child-to-Child Approach. The Child-to-Child approach to health education was introduced in 1978, following the Alma Alta Declaration on Primary Health Care. The approach helps us to realize the potential of children to spread health ideas and practices to other children, to families, and to communities. The methodology has now spread all over the world and has the same central ideas developed in partnership between education and health. In our communities, this approach can be used effectively in sensitizing them since it has been indicated that “the answer to controlling HIV has remained and will remain, **social action**: responses by societies, communities, families and individuals to come to terms with the risk of infecting and becoming infected and vulnerability to exposure or exposing others to a formidable threat ...” (Brenzinger and Harms, 2001).
- b) Free Information and contact with others. A creative search for information from the several agencies in our respective towns/cities will provide our institutions with material for use in our programmes. In our capital cities many development agencies provide libraries and free information sheets and booklets. Invitations can be made to various stakeholders: faith-based persons, government ministers; foreign embassies, to come and address our institutions on various issues related to HIV/AIDS. These are just but a few of many creative but inexpensive ways that can be used to make our work more effective.

CONCLUDING REMARKS

It has been demonstrated that HIV prevention works. In the USA, prevention has helped to slow down the rate of new infections from over 150 000 in the mid-1980s to around 40 000 per year in 2002. Prevention programmes have been effective with a variety of populations: clinic visitors; heterosexual men and women; youth at high risk; prisoners; injection drug users; and men having sex with men. Intervention programmes have been extended to individuals, groups and communities in settings ranging from storefronts to gay bars, from health centers to public housing, and from schools to universities.

These prevention successes were accomplished by collaboration among the infected and affected communities, national agencies, local organizations, the private sector, community-based groups. They demonstrate the power of a collective effort to fight HIV/AIDS (CDC, 2002).

It is also pointed out that to succeed, HIV prevention efforts must be comprehensive and science-based. The following conditions must be fulfilled in order for HIV prevention to work:

- An effective community planning process.
- Epidemiological and behavioral surveillance; compilation of the health and demographic data relevant to HIV risks, incidence or prevalence.
- HIV counseling, testing and referral and partner counseling and referral, with strong linkages to medical care, treatment and needed prevention services.
- Health education and risk reduction activities, including individual-, group- and community-level interventions.
- Accessible diagnosis and treatment of other STDs.
- Public information and education programmes.
- Comprehensive school health programmes.
- Training and quality assurance.
- HIV prevention capacity-building activities.
- An HIV prevention technical assistance assessment and plan.
- Monitoring and evaluation of major programme activities, interventions and services.

The magnitude of the fight against HIV/AIDS is enormous. Consequently, the responsibility taken by the community of tertiary institutions through present and future activities designed to arrest the spread of HIV/AIDS must be equally enormous. We believe that the message is not at all bleak, for the future does not have to be like the past. We know how to prevent the spread of HIV. We can deal with the consequences of AIDS. We believe that with strong and visible leadership from the Administration of tertiary institutions there will be resonance from below.

They say:

“Nothing great was ever achieved without enthusiasm” -- Ralph Waldo Emerson.

“Enthusiasm is contagious. Be a carrier” -- Susan Rabin and Barbara Lagowski.

I would merely add: “Commitment and determination are contagious. Be a carrier!”

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UNIVERSITY HIV/AIDS POLICIES WEBSITES

1. University of Botswana (UB)
<http://www.ub.bw/initiatives/hivawareness/index/html>
2. University of Cape Town (UCT)
<http://web.uct.ac.za/depts/hivaids/policy.htm>
3. The University of Pretoria (UP)
<http://www.up.ac.za/services/registrar/intranet/reg0209.html>

An HIV/AIDS Toolkit for Tertiary Institutions

Dhianaraj Chetty¹¹

ABBREVIATIONS

AAU	Association of African Universities
ACU	Association of Commonwealth Universities
ADEA	Association for the Development of Education in Africa
AIDS	Acquired Immune Deficiency Syndrome
ASO	AIDS Service Organization
COREVIP	Conference of Vice Chancellors Rectors and Principals
DVC	Deputy Vice Chancellor
GIPA	Greater Involvement of People with HIV/AIDS
HIV	Human Immunodeficiency Virus
HR	Human Resources
M&E	Monitoring and Evaluation
MTT	Mobile Task Team on the Impact of HIV/AIDS in Education
NGO	Non Government Organization
PWA	Person/s Living with HIV/AIDS
SAUVCA	South African Universities Vice-Chancellors Association
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing

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INTRODUCTION

The HIV/AIDS pandemic is now more than two decades old. In Africa, the pandemic has taken its greatest toll on our economies and societies that are often weakened by poverty, internal conflicts and constrained in their responses to such a profound threat. For much of the recent past, evidence of the pandemic's crippling impacts has dominated the headlines and the development agenda (UNAIDS, 2002).

In education, the response to HIV/AIDS has often been narrowly centered on the need to 'teach HIV/AIDS' as our best hope of keeping the threat at bay. In practice, the response has centered on using the school curriculum to make children aware of the pandemic and give them the knowledge skills and values necessary to respond to the epidemic. Life skills programmes, sexuality education, peer education and health promotion – all of which were in the school system to some degree - have now taken on different dimensions in the face of a pandemic that affects children, their parents, their teachers, their school managers and ultimately the education system.

Tertiary education poses a radically different set of educational, institutional and social issues. The need to define a response that makes sense in the tertiary education context is the primary motivation behind the HIV/AIDS Toolkit, a project of the Association of African Universities that is discussed in this paper.

What makes a specific response necessary and different in tertiary education? The findings are drawn from a cross section of studies that have surveyed the extent of the impact and the preparedness of African institutions to respond to HIV/AIDS (Chetty, 2000, Kelly, 2001, Anarfi, 2000, Nzioka, 2000, Magombo, 2000).

- Evidence is growing that students, staff and communities linked to tertiary institutions are all showing the impacts of HIV/AIDS –either because of being infected or affected.
- However, there are a range of different responses within tertiary education that address HIV/AIDS in varying depth and scope. The trend towards a comprehensive response that addresses prevention, treatment, care and social support is taking hold but too many responses have to date been ad hoc and unsustainable.
- Tertiary education institutions educate and train sexually active young adults, unlike most of the school system. Therefore, students are often vulnerable because of risky social and sexual behavior that is common amongst young adults in residential campus settings (alcohol abuse, drug use, low quality housing, sexual abuse etc.)
- Students are largely free to choose what they want to study and therefore not obliged to participate in formal or non-formal prevention interventions – even when these are available.
- Though critically important as part of a comprehensive response, prevention remains the dominant trend in a context where treatment, care and support need to be addressed.
- Poverty is a factor that makes young people especially vulnerable to transactional sex – an observable phenomenon in educational institutions.
- Financial and other resource constraints make it difficult to motivate HIV/AIDS as an institutional priority.

- Not all institutional managers are convinced of the role they are expected to play in the fight against HIV/AIDS and many do not have the skills needed to develop and manage a response to the pandemic.
- Not enough institutions have taken seriously the need to mitigate the pandemic through planning and pro-active responses.
- A culture of denial and silence – even in tertiary education - continues to hamper efforts to mobilize students and staff.

The HIV/AIDS Toolkit is not intended to provide a quick fix to such a complex set of issues. However, it signals the seriousness with which tertiary education views the issue of HIV/AIDS, it emphasizes the strategic and specific role which tertiary education institutions play in the education sector's response to HIV/AIDS, and most importantly, it elaborates practical ways for motivating and comprehensive responses.

WHAT IS THE TOOLKIT?

The HIV/AIDS Toolkit is a package developed specifically for tertiary institutions by the Association of African Universities (AAU) in 2003 with the aim of supporting the development and management of comprehensive institutional responses to HIV/AIDS. It is available in hard copy in both English and French. The Toolkit is the outcome of a project initiated in 2001 with the support of the ADEA Working Group on Higher Education.

The package comprises:

- resource materials on HIV/AIDS in the African tertiary education context
- advocacy strategies for use within tertiary institutions and amongst their constituencies/social partners
- and, practical guidelines for the design, management and implementation of HIV/AIDS policies and programmes in African tertiary education institutions.

WHERE DOES THE TOOLKIT IDEA ORIGINATE?

AAU's role

The Toolkit stems from a number of sources within the African tertiary education community and the international higher education community. The AAU is responsible for harnessing these strands in the form of a package.

It is fair to say that for more than a decade, African tertiary institutions have been active in a range of ways in the fight against HIV/AIDS usually in the form of advocacy and research. The range of responses has now broadened and deepened to include far more sophisticated projects and structural reforms that are making HIV/AIDS more integral to the core business of tertiary education.

Since 2001, AAU has moved towards formalizing its activities in the area of HIV/AIDS. Firstly, WGHE provided support to AAU's workshop for senior managers entitled SUMA in Cairo, which targeted African senior university managers and included a dedicated module on HIV/AIDS.

At the same time, AAU was awarded a grant to develop a 5-year Core program and to develop an HIV/AIDS toolkit for further training of its members.

In 2002, ADEA/WGHE provided institutional grants to 4 African institutions to develop and implement policy on HIV/AIDS. 'African Universities Against AIDS', the core statement that drives AAU's response to the HIV/AIDS epidemic was developed at the same time.

By 2003, the need for a comprehensive response within the education sector was clearly articulated in AAU's 2003-2013 Vision and Strategic Plan.

In March 2003, the AAU presented the first draft of the Toolkit to a Master Trainers Workshop at the COREVIP meeting in Mauritius that included roughly 20 selected participants. The feedback from that process has been integrated into the package.

International collaboration

The HIV/AIDS Toolkit is also the product of inputs and collaboration from many sources. It has been trialled with sample groups of higher education representatives in Anglophone and Francophone countries. Expert assistance has come from a range of sources including the United Nations Development Programme (UNDP), Johns Hopkins University, and the South African Universities Vice Chancellors Association (SAUVCA). It draws on research and advocacy studies developed by many organizations including: the Association of Commonwealth Universities (ACU), the Mobile Task Team on the Impact of HIV/AIDS in Education (MTT) and a host of individual higher education institutions on the continent. Wherever appropriate, these sources are acknowledged.

HOW SHOULD THE TOOLKIT BE USED?

Firstly, the HIV/AIDS Toolkit provides *a framework and a process* within which an institution, organization or project is able to do the following:

Assessment: Analyze the nature of the problem confronting your institution and its constituencies

Planning: Decide on which policy objectives and programmes to pursue

Design: Plan and develop HIV/AIDS related interventions that meet the objectives you have identified

Implementation: Move from policy and planning to action

Monitoring: Know that your implementation is in line with the agreed plans

Evaluation: Assess whether the strategy and interventions are working

Secondly, the Toolkit also provides some of the information and tools that are required at each step for specific types of interventions. Where specific resources (e.g. design guidelines for a peer education project) are available elsewhere, the Toolkit provides suggestions on appropriate sources. A sample of the best electronic resources is listed in the Links section of this paper.

If the Toolkit does not cover all the aspects of a problem, users are encouraged to use the network that the Association of African Universities provides along with its national level counterparts. The AAU offers access to nearly 300 member institutions and many partners elsewhere in the world at which significant expertise has now been developed in the area of institutional responses to HIV/AIDS.

Thirdly, the structure of the Toolkit is organized in line with the core business areas of higher education institutions (teaching and learning, research, community engagement). In the Toolkit, the functions, which fall within each of these areas, have been specifically identified and discussed in relation to whether and how HIV/AIDS affects them.

Who is the Toolkit aimed at?

Not all tertiary education institutions are prepared for dealing with issues that may be regarded as extremely “personal” and “cultural”. However, the fact that HIV/AIDS is spread largely through sexual behavior, makes it imperative for organizations to not only raise awareness, but also to actively promote policies and procedures which assist students, employee, staff and management and other community stakeholders to combat the epidemic. Active management of HIV/AIDS requires managers to step into a sphere in which management itself is confident and competent to raise previously “personal” issues, for the benefit of the individual and the organization.

The emphasis in this Toolkit is on the role of institutional managers and project leaders in academic (deans, heads of department or senior faculty) and non-academic functions (e.g. head of student services, head of human resources, head of the campus clinic). Likewise, student organization leaders, trade union shop stewards or a peer education project leader will hopefully find the package equally useful. Many of the issues raised here also have a generic application beyond tertiary education institutions.

What are the intended outcomes of the Toolkit?

The Toolkit looks at the pandemic and proposes a range of responses from the perspective of the education sector. The harsh reality is that HIV/AIDS is already taking a toll on students, staff and tertiary education communities in a host of unexpected ways.

Challenge: Why should higher education institutions be involved in the fight against HIV/AIDS? Firstly, because we care; secondly, because it is clear that this epidemic affects all areas of core business in tertiary education. Thirdly, because tertiary education institutions are leaders in our education community and leadership is desperately needed on many levels in the fight against this epidemic. Fourthly, because we recognize that the burden of fighting HIV/AIDS cannot rest only with national governments.

Challenge: The African tertiary education community must ensure that it uses all the means available to within African institutions and through our partnerships with the international community, to **prevent** the spread of the epidemic, **mitigate** its impacts on our communities and institutions and **manage** the epidemic in a proactive sustainable programme of action. The Toolkit is intended to provide the users with the *practical and intellectual tools* that can be harnessed in developing, planning and managing a response to HIV/AIDS across all the core business areas of their institutions.

Is there a model on which the Toolkit is based?

The Toolkit uses an education management perspective rather than a specific model as its point of departure. This approach is in keeping with the AAU's capacity building programme for African university managers, entitled 'SUMA'.

Why a focus on management? Because HIV/AIDS cuts across institutional boundaries. More importantly, it affects the **management systems** upon which institutions depend for their every day operations and their long-term future. What are some these systems: student support services (residences, prevention programmes and services, campus health services, counseling and psychosocial support), human resource planning and development (workplace policy for affected and infected staff, programmes to educate and support affected and infected staff), student finance (bursaries, insurance, non discrimination policy).

Tertiary education in Africa comprises a variety of institutional types (universities, colleges, teacher training institutions, technical institutes etc). The form and structure of these institutional types differs by country and history and the Toolkit's approach therefore needs to be adapted accordingly. The vice chancellor of a large, urban teaching and research institution will have a very different remit to the head of a small primarily rural teacher training college. Ideally, the Toolkit must work for both audiences.

In the same vein, the context and regulatory environments within which higher education institutions differs widely across the continent. These factors have a major influence on the roles which institutions fulfill in the education sector, the economy and the societies within which they operate. Many of the recommendations in the Toolkit, which depend on larger policy frameworks – usually set by government – and will need to be synchronized with a national policy context. For example, if an institution promotes voluntary counseling and testing (VCT) as a care and support strategy, it should ideally do so within the framework set by national or state level governments. It should be said that there are other competing – and very compelling – approaches to addressing HIV/AIDS in tertiary education. For some institutions, research has proved to be their most relevant and effective way of contributing to the fight against HIV/AIDS. In other cases, African higher education institutions have provided a home for advocacy and human rights NGOs focusing on HIV/AIDS that have

established global reputations for their work. Both these approaches have a common thread that sets them apart from the approach in this Toolkit: they have an *external focus*. In contrast, the Toolkit is about developing a sound *internally focused* response to HIV/AIDS. More importantly, it is about the importance of leadership within the institution as a basis for being a leader in society.

WHAT RESULTS CAN BE EXPECTED FROM THE TOOLKIT?

The use of the Toolkit has not yet been evaluated through a formal process but the strategies and lessons that it promotes are drawn from accepted current good practice, as the case study examples show. Time is an important consideration in this case.

For example, the focus on policy by AAU, ACU and other national bodies representing tertiary education (e.g. SAUVCA) is borne out by the significant change in number of institutions that now have policy in some form. In 2000, a handful of institutions in South Africa had policy on HIV/AIDS. By mid 2003, nearly all have developed policy of some form on HIV/AIDS.

What concrete examples of responses to HIV/AIDS are available from Africa and elsewhere?

The examples selected for use in the Toolkit (University of the Witwatersrand, University of Botswana, University of Zambia, University of the Copperbelt, University of Nairobi) represent a small sample of the growing corpus of innovative, high quality responses that are coming from African institutions.

They were chosen to represent good practice in a range of different country settings, institutional contexts and specific functions. At present our knowledge does tend to rely mostly on examples from universities – particularly from Anglophone countries. Fortunately, through monitoring by organizations like ACU and more recently AAU, there will be more systematic tracking of these responses across the international tertiary education community. In this way our understanding of qualitatively different environments in low prevalence countries and different educational systems will be enhanced.

The case studies summarized briefly below - and presented in full in the Appendices - focus on the key areas in which responses to HIV/AIDS have developed: *policy development, teaching/curriculum change, research and community outreach*. None of the case studies is a Toolkit by itself; instead the case studies show examples of what should flow from the implementation of the Toolkit.

University of the Witwatersrand

The University has invested considerable effort in developing and implementing what is widely viewed (within South Africa) as a very comprehensive policy response to HIV/AIDS. As a large comprehensive research and teaching institution, it is fortunate to have a number of leading academics that have made major contributions to national policy development on the health, legal and social aspects of HIV/AIDS. The institutional policy covers all of the key aspects to which an institutional policy must respond. These include: the institution's approach to HIV/AIDS and how HIV/AIDS affects the institution's mission; the rights and responsibilities of students and staff, the resources and services it will commit to fighting HIV/AIDS, the implementation arrangements it will use and the process through which the policy will be reviewed. Policy development has been accepted by an increasing number of African institutions as a central component of an institution wide response to HIV/AIDS and as the basis for driving programmatic interventions.

University of Botswana

The University has responded to the threat of HIV/AIDS through a number of interventions (curriculum change, an impact assessment, health services etc). The example used in the Toolkit -- a life skills programme -- is driven by the need to provide students with the knowledge, skills and values that equip them to deal with the threat of HIV/AIDS on a personal level. This approach highlights the need to intervene in the curriculum in ways that are directly relevant to the needs of students and to make them more aware of the larger threat that confronts their communities. It supplements a range of other curriculum reforms, which are geared more towards skills, that graduates need to confront HIV/AIDS in the world of work.

University of Nairobi

The University of Nairobi is a leading institution in vaccine research and trials in Africa. Three things make the example an important case study. Firstly, it shows the responsibility which faculties of medicine/health sciences must be prepared to take on the in fight against HIV/AIDS. This responsibility is typically expressed in the commitment to bio-medical research. Secondly, an off-shoot of the research process is the advocacy role which health sciences professional can play in breaking the barriers to understanding, assisting government in efforts at social and political mobilization and also setting better standards for policy and practice in the provision of health services. Thirdly, this example illustrates the value of sustaining research capacity in African institutions and the ways in which this capacity can be used to build international partnerships (in this case Oxford University) and leverage additional resources in the fight against HIV/AIDS.

University of the Copperbelt

The 'In But Free' project, developed by Copperbelt University, is a path-breaking example of a university responding to the needs of an atypical and vulnerable community – prison inmates. Using interventions like peer education, VCT and home-based care, it demonstrates the power of reducing risk to inmates themselves and their families. It also brings to life a basic principle that tertiary institutions must be engaged with the world in which they operate and be responsive to their communities so that they can make meaningful contributions to real, immediate problems. Also, it breaks the silence around a world in which it is well known that HIV infection thrives because of a range of risky social and sexual behaviors.

University of Zambia

This case study highlights a question that should be at the core of student services in the context of HIV/AIDS. How well do we know and understand the behaviors and needs of students in tertiary education? At the University of Zambia, the relatively simple intervention of KAP studies revealed important insights into the levels of stigma around HIV/AIDS and the prevalence of risky sexual behaviors. The University responded with an IEC programme based on counseling and education with a focus on the needs of students. This case study underlines the importance of the complex interactions that make tertiary institutions both exciting and challenging – as well as being vulnerable. Managing and supporting student life in the age of HIV/AIDS requires that institutional managers actively intervene in what may previously have been considered 'the private life of individuals' – and having the skill to do so effectively.

WHAT DIFFICULTIES MIGHT ONE ENCOUNTER IN USING OF THIS TOOLKIT?

The role of the focal person using this Toolkit has many dimensions. The Toolkit is designed for use by specialists and non-specialists, who are required to work in a capacity where they mobilize expertise (medical, legal, psycho-social) as part of a comprehensive response. This could be the newly designated HIV/AIDS coordinator who is usually responsible for student services and is now required to develop policy, initiate programmes, raise funding, conduct impact monitoring and a host of other tasks which are specific to HIV/AIDS.

Assuming responsibility for developing an institutional response to HIV/AIDS is not a small task. Neither is it free from difficulties. It demands leadership in a variety of contexts where commitment, decisiveness, foresight and tenacity are all required. The simple act of breaking the silence about HIV/AIDS will in some cases unleash personal, political and cultural dynamics within the institution, which can be positive, negative, unwieldy, unforeseen or even extraordinary. Whatever the response, as a lead/focal person one has the responsibility to prepare 'champions' who can carry a clear and informed message about the importance of the epidemic to higher education, why our institutions should be involved and how best to shape their responses in terms of **prevention, treatment, care and support** – particularly for those living with HIV and AIDS and those immediately affected by the epidemic.

There is no simple, formulaic model that responds to the challenge that HIV/AIDS poses to each institution. There are good examples that tell us that the same intervention can often have very different impacts in two different contexts. The Toolkit should be read and used as a framework from which an institution develops its own approach to HIV/AIDS rather than as a set of rigid prescriptions.

The Toolkit has been developed bearing in mind the regional variations of the epidemic across the continent. Overall, West Africa could be characterized as a relatively low prevalence environment with differing factors driving the epidemic. For example, 'the HIV epidemic in Ghana to date has shown a different pattern from that in many other countries in sub-Saharan

Africa. National levels of HIV infection are estimated to have risen more slowly than seen elsewhere, from around 2.4% in 1994 to around 4% in 2002' (Schierhout and Johnson, 2003). Cultural factors and early interventions appear to have kept the pandemic at bay countries like Senegal. In contrast, Southern African countries are higher prevalence areas with South Africa and Botswana showing critically high levels of prevalence based on survey data from ante natal clinics. In East Africa, Uganda has shown the most compelling results from social mobilization around HIV/AIDS, changes in behavior and community based responses to care and support. Within the recent past, levels of prevalence have declined to 6.4% in 2001 from a high of 21.1% in 1991 (Low Beer and Stroneburner, 2003). Other countries in the region – for a range of reasons have not made equally significant gains in reversing the tide.

The point here is that differing strategies will be needed to address these variations across the continent. In high prevalence contexts, it is urgent to intensify and improve implementation of programmes across the education sector. In low prevalence contexts, it is urgent to scale up the response. Users of the Toolkit will need to tailor the message and the uses of the Toolkit for each of these environments.

Roles

It should be evident from the outline above that a focal person working within an institutional context will have to fulfill a number of different roles. Identifying these roles to potential trainees is important in the process of selection and training. They can be summarized as follows:

- ✓ Advocacy
- ✓ Sensitization
- ✓ Resource mobilization
- ✓ Partnership development and management
- ✓ Policy development
- ✓ Programme design
- ✓ Implementation support for projects
- ✓ Co-ordination
- ✓ Stakeholder liaison
- ✓ Networking
- ✓ Research
- ✓ Evaluation

What are the obstacles and how might the difficulties be overcome?

Working with HIV/AIDS in a tertiary education context comes with both personal and professional rewards, pressures and constraints. Educational institutions are conservative in nature and take time to respond to new ways of thinking and working. There will be times when nothing moves, where fatigue sets in and the challenge becomes overwhelming. There will be other moments where good leadership and the innovative qualities of higher education institutions are cause for pride and celebration. If a checklist of survival skills were necessary, it might include the following:

- ✓ Start by focusing attention on the big picture – ‘the mission of the institution’
- ✓ Use the resources already available
- ✓ Use networks
- ✓ Use partnerships
- ✓ Avoid the trap of developing programmes that are easily available elsewhere
- ✓ Find a way of being relevant/useful within government’s overall strategy and programme

Practical advice to institutions that might wish to use this HIV/AIDS Toolkit

This paper presents a summary of a project that is large and complex. Not every institution will be able to mount a comprehensive response to HIV/AIDS and that may be for justifiable reasons (lack of capacity, resources etc). There are good reasons to develop and sustain a smaller response such as focusing on high quality research in the area of HIV/AIDS – if that is where the emphasis of the institution lies. The approach developed by the Toolkit is not to say ‘drop research and invest in prevention’. Likewise, the manager of a research institute should not feel compelled to take on the roles that fit best with the departments concerned with student services. Tertiary institutions become more difficult to manage each year and the Toolkit should not be seen as an ‘all or nothing model.’ Instead, it would be far more pragmatic and productive to get managers and other leaders to take from it what is appropriate to building a better response in their own terms.

It requires institutional leaders to define a path that is appropriate, relevant and feasible in the context in which the institution operates. Whatever the choice, the Toolkit offers a ‘starter pack’ of information, techniques and advice. As in any new initiative, there are always pre-conditions for success. In the case of HIV/AIDS, there is one universally acknowledged factor: **leadership**. Where it comes from does matter: vice chancellors make a distinct impact but a shop steward could be equally effective at work place level.

At the very minimum, leadership must address itself to four challenges that have the potential to create a fundamental shift.

- Break the silence
- Recognize the threat which HIV/AIDS poses to the institution and its stakeholders
- Support and build upon the work already being done (small student projects, small scale research or basic prevention)
- Make a response to an HIV/AIDS affected world an integral part of the institutional mission.

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LINKS

ACMC, Association of Canadian Medical Colleges, www.acmc.ca

ACU, Association of Commonwealth Universities, www.acu.ac.uk

AEGIS, www.aegis.org

AF-AIDS, www.af-aids.org

AFRICASO, African Council of AIDS Service Organizations, www.enda.sn/africaso.org

AVERT, www.avert.org

HEARD, www.und.ac.za/und/heard

Higher Education Against HIV/AIDS (South Africa), www.heaaids.org.za

HIV INSITE, University of California San Francisco, <http://hivinsite.ucsf.edu/>

KIT, Royal Tropical Institute, www.kit.nl

SYNERGY Project, www.synergyaids.com

UNAIDS, Joint United Nations Programme on AIDS, www.unaids.org

UNESCAP, UN Social Development Information on the Internet, www.unescap.org

WORLD BANK, www.worldbank.org and eservice@worldbank.org



CASE STUDY: POLICY DEVELOPMENT

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HIV/AIDS POLICY

Preamble

The University recognizes that South Africa, with the rest of southern Africa, is experiencing a devastating HIV/AIDS epidemic. The University also recognizes that HIV/AIDS is not only a health issue, but one which concerns the entire University community and our society in every possible respect. As an institution that strives to engage with society and be responsible to it, the University is committed to playing an active role in mitigating the impact of HIV/AIDS, both on its internal constituency of staff and students, and on society as a whole. The University will aim to achieve this by integrating HIV/AIDS into its core functions of teaching, research and service, the components of which are outlined in this policy. In doing so, the University hopes to be a caring community where all are equally valued.

Values underlying the policy

The following values guide this policy:

- People living with HIV/AIDS will not be discriminated against in obtaining access to education and/or employment at the University;
- People living with HIV/AIDS have the right to dignity, respect, autonomy and privacy concerning their HIV/AIDS status; stigma and prejudice will be actively countered;
- HIV/AIDS can affect any of us; the policy should in no way perpetuate stereotypes of HIV/AIDS as belonging to gay or straight, white or black, young or old, men or women; it should, however, recognize specific vulnerabilities and risk factors arising from physiology or social power relations;
- HIV/AIDS concerns all of us; an appropriate response to HIV/AIDS can be achieved only by ensuring that consideration of HIV/AIDS is a part of every activity at the University; the full range of stakeholders should be involved in defining and implementing the response to HIV/AIDS at the University;
- HIV/AIDS has to be understood and addressed in its social context; this includes power relations between men and women and sexual violence against women, changing values and meanings around sexuality, and the multiple legacies of apartheid.
- Appropriate strategies for caring for and the treatment of persons living with HIV/AIDS are essential.

Components of the policy

The policy has the following five components:

1. Rights and responsibilities of staff and students affected by and living with HIV/AIDS;
2. Integration of HIV/AIDS into teaching, research and service activities of all Faculties;
3. Provision of prevention, care and support services on campus;
4. Implementation: structures, processes, monitoring and evaluation.
5. A provision for policy review.

1 Rights and responsibilities of staff and students affected and infected by HIV/AIDS

1.1 Rights of staff

In accordance with the Constitution of South Africa, the Employment Equity Act (No 55 of 1998), the Labor Relations Act (No 66 of 1995), the Medical Schemes Act (No 131 of 1998), and the government's draft Code of Good Practice on Key Aspects of HIV/AIDS and Employment:

- 1.1.1 Generally, no employee, or applicant for employment, may be required by the University to undergo an HIV test or disclose their HIV status¹²;
- 1.1.2 If a person's HIV status becomes known to the University, it shall not be the basis for refusing to enter or renew an employment contract;
- 1.1.3 HIV status shall not be a criterion for refusing to promote, train and develop a staff member;
- 1.1.4 An employee may not be dismissed simply because he or she is living with HIV/AIDS;
- 1.1.5 No employee shall have his/her employment terminated on the basis of HIV status alone, nor shall HIV status alone influence decisions on retrenchment or retirement on the grounds of ill-health;
- 1.1.6 With regard to sick leave and continued employment, HIV related illness will be treated no differently to other comparable chronic or life threatening conditions; if an employee, in the opinion of the Head of School/Division, is unable to continue working because of ill-health, the usual conditions pertaining to disability or ill-health retirement will apply;
- 1.1.7 HIV status will not be reflected on any personnel files, and the HIV status of any employee will not be disclosed by another member of staff without the informed consent of the employee;
- 1.1.8 The University requires that the trustees and administrators of retirement, provident and medical scheme funds may not disclose the identity of an employee living with HIV/AIDS to the University without the member's written permission;
- 1.1.9 The University believes that it is in interest of all parties to prevent unfair discrimination against employees with HIV/AIDS with regard to access to employment benefits such as medical scheme, provident and pension funds. However, the University recognizes that the governance and rules of these funds are not entirely within its control.
- 1.1.10 The University endeavors to provide a working environment in which employees with HIV/AIDS are accepted, and are free from prejudice and stigma;
- 1.1.11 Staff have a right to know of possible risks of occupational exposure to HIV in their working environments.
- 1.1.12 The University endeavors to provide a working environment in which occupational exposure to HIV is minimized, and will provide the necessary protective equipment and

¹² HIV testing may be determined to be justifiable by the Labor Court in terms of Section 50 (4) of the EEA.

provide access to post occupational exposure prophylaxis (PEP). Where service is in a hospital environment, however, it is the hospital's responsibility to provide protective equipment and PEP for staff. The University is responsible only for work conducted in a university environment.

1.2 ***Rights of students***

- 1.2.1 No applicant may be required to have an HIV test before admission to the University;
- 1.2.2 No student or applicant may be required to reveal his or her HIV status before admission or during the course of study;
- 1.2.3 Notwithstanding Rule M1, in which applicants to the University are required to be physically capable of study, HIV status may not be a factor in the admission of students to higher degrees, to specialized fields of study or for employment as tutors or auxiliary workers;
- 1.2.4 HIV status alone may not be a ground for refusing to grant loans, bursaries and scholarships;
- 1.2.5 No student may be required to have an HIV test before field trips or other activities of the University, unless there are special circumstances which warrant it;
- 1.2.6 No student will be refused admission to University residences because of his/her HIV status, nor will an HIV test be required prior to admission to residence;
- 1.2.7 Unless medically indicated, HIV/AIDS is not a reason to terminate a student's registration;
- 1.2.8 Should a student have an HIV test using Campus Health and Wellness Centre or other University facility, the results will remain confidential between the student and the person authorized to give the result;
- 1.2.9 No member of staff or student may disclose the HIV status of a student without their informed consent, which should preferably be in writing;¹³
- 1.2.10 The University endeavors to provide a learning environment in which students with HIV/AIDS are fully accepted and safe from prejudice and stigma;
- 1.2.11 The University endeavors to provide an educational environment in which accidental exposure to HIV is minimized, and will provide the necessary protective equipment, and will arrange access to post exposure prophylaxis (PEP). Where service is in a hospital environment, however, it is the hospital's responsibility to provide protective equipment. The University remains responsible, even in the hospital environment, for the provision of PEP to students.

1.3 ***Responsibilities of staff and students***

- 1.3.1 Staff and students have a responsibility to become informed about HIV/AIDS, and to develop a lifestyle in which they will not put themselves or others at risk of infection;
- 1.3.2 Staff and students who are living with HIV/AIDS have a special obligation to ensure that they behave in such a way as to pose no threat of infection to any other person;
- 1.3.3 Health professionals and Health Science Faculty students who are living with HIV/AIDS have an obligation to choose professional paths that minimize risks of transmission to their patients;
- 1.3.4 Staff and students must respect the rights of other staff and students at all times. No prejudicial or discriminatory attitudes or behavior towards people living with HIV/AIDS will be tolerated;
- 1.3.5 No employee or student can refuse to work, study with or be housed with other employees or students living with HIV/AIDS;

¹³ However, Health Professions' Council guidelines on the duty of medical doctors to disclose HIV status to partners and other health professionals, will apply for those staff who are governed by such regulations.

- 1.3.6 Staff and students who do display discriminatory attitudes to colleagues living with HIV/AIDS will be counseled in the first instance, but if the discriminatory behavior persists, formal disciplinary procedures will be instituted;
- 1.3.7 Unless medically justified, no students may use HIV/AIDS as a reason for failing to perform work, complete assignments, attend lectures or field trips or write examinations;
- 1.3.8 Expected behavior with regard to HIV/AIDS will be incorporated into the University's Code of Conduct. Staff and students will be required to sign the Code of Conduct when registering for study and signing a contract of employment, respectively.
- 1.3.9 Willfully undermining the privacy and dignity of a member of staff or student with HIV/AIDS will constitute a breach of discipline, and appropriate disciplinary steps will be taken.
- 1.3.10 Students are encouraged to develop and implement their own student-led responses to HIV/AIDS. The University will support these initiatives.

2 Integration of HIV/AIDS into teaching, research and service activities of all Faculties:

2.1 Teaching

HIV/AIDS education will, where appropriate, be incorporated into the curriculum of all faculties. This could take the form of debate and an understanding of how HIV/AIDS will impact on their future professional lives. In addition, students will have training in relation to HIV/AIDS in the workplace. They should enter the workforce fully equipped to manage HIV/AIDS programmes, deal with colleagues and staff who are infected, and to monitor and sustain workplace initiatives. They should also know the legal implications of HIV/AIDS.

- 2.1.1. All Schools and Faculties will be required to consider how to achieve integration of HIV/AIDS into the curriculum at both undergraduate and postgraduate level. If they decide not to integrate such material into the curriculum, they will be requested to account for this to the Dean or Faculty Board. This will include aspects of HIV/AIDS relevant to the subject area of the Department/Faculty, HIV/AIDS in the workplace and general life-skills education.
- 2.1.2 Support will be provided to Faculties to develop and implement plans to integrate HIV/AIDS into curricula.

2.2 Research

Tertiary institutions have an obligation to provide leadership in the battle to combat HIV/AIDS and to ensure that programmes are effective. The University is well placed to do this, as well as to generate debate and critique and to try to give leadership and inspiration to the state and civil society in finding new and creative ways to prevent HIV transmission and mitigate its impacts.

- 2.2.1 The University Research Committee will develop policy to establish a variety of incentives and forums to promote research on HIV/AIDS within and across faculties.
- 2.2.2 In particular, mechanisms will be established to support HIV/AIDS research activities that are innovative, address strategic priorities, and are inter-disciplinary.

2.3 *Service*

Service learning would be an appropriate approach to synergies teaching, research and service in the field of HIV/AIDS. All Departments/Faculties will be required to consider, develop and implement annual plans to ensure their contribution to the:

- 2.3.1 prevention, care and support needs of staff and students on campus;
- 2.3.2 environment outside of the University. This will be easier for faculties training professionals who are required to undertake practical training.

3 Provision of prevention, care and support services on campus;

3.1 *Information and prevention*

- 2.3.3 Appropriate and sensitively presented information on all aspects of preventing and coping with HIV/AIDS will be made widely accessible to staff and students. This information will address and be directly relevant to the day-to-day realities of staff and students;
- 2.3.4 All students and staff will be offered education that examines the relevance of HIV/AIDS to their own lives, in the context of broader challenges facing them as young adults. Through this training students will be encouraged to understand social attitudes and develop a caring and non-discriminatory approach to HIV/AIDS as well as a tolerance for and understanding of different social groups;
- 2.3.5 Condoms will be freely available and widely distributed through multiple channels, on campus and in residences;
- 2.3.6 The use of free STD care provided through the Campus Health and Wellness Centre will be promoted;
- 2.3.7 Affordable confidential and voluntary HIV testing will be provided through the Campus Health and Wellness Centre;
- 2.3.8 Peer education programmes will be developed and implemented on campus and in student residences;
- 2.3.9 Particular attention will be paid to addressing issues of loss, grief and bereavement;
- 2.3.10 Adequate measures to prevent the spread of HIV in contact sports will be instituted (see annexure 1- extract from SARFU Policy Statement on HIV and Rugby participation);
- 2.3.11 Universal precautions (annexure 2) will be implemented whenever the potential for exposure to blood or other high risk body fluids exists;
- 2.3.12 Staff in managerial or supervisory positions will receive training in all aspects of this policy and how to implement it.
- 2.3.13
- 2.3.14 Care
- 2.3.15 Staff of the Campus Health and Wellness Centre will be trained in the comprehensive management of HIV/AIDS.
- 2.3.16 The University will investigate the possibility of providing cheap, affordable anti-retroviral treatment.
- 2.3.17 An affordable ambulatory HIV/AIDS wellness programme will be developed and provided for students with HIV/AIDS. This will include provision of inexpensive prophylactic therapies, blood tests, contraception, nutritional interventions and early treatment of opportunistic infections;
- 2.3.18 Referral networks with health services will be developed and maintained.

- 3.1.1 Information on services in and around campus will be made available to all staff and students.
- 3.1.2 The University believes that it is not appropriate for students with any terminal illness, including end-stage AIDS, to be in residence. The necessary palliative care and support cannot be provided in such an environment. Every attempt will be made to relocate the student to an appropriate environment e.g. hospital, hospice, home.
- 3.3 *Counseling and support***
 - 3.3.1 All staff and students will have access to confidential counseling on campus;
 - 3.3.2 Counseling services on campus will be coordinated and promoted;
 - 3.3.2 Referral channels for other forms of social support for both students and staff will be identified.
- 3.4 *Post exposure prophylaxis***
 - 3.4.1 In environments where the risk of occupational exposure to HIV exists, procedures for notification of exposure and access to post-exposure prophylaxis will be adequately sign posted.
 - 3.4.2 Mechanisms to address the needs of individuals who are currently vulnerable to occupational exposure to HIV and who are not covered by the Wits Medical Scheme or the Faculty of Health Sciences Student Insurance will be investigated.

4 Implementation: structures, processes, monitoring and evaluation.

- 4.1 The HIV/AIDS policy will be supported and championed by the senior executives of the University. This includes the Vice-Chancellor and Deputy Vice-Chancellors, Executive Directors and Deans of Faculties, Heads of Schools and the Senior Management Group;
- 4.2 All heads of schools, departments and units will be briefed on the policy, its content and its implementation;
- 4.3 HIV/AIDS will be a standing item on meetings of the Senior Executive Team, Faculty Boards and other University governance structures;
- 4.4 Deans will designate a person responsible for ensuring implementation of the policy in each Faculty and to represent the Faculty at central coordination and monitoring processes; this person will convene an HIV/AIDS task team in her/his faculty which is representative of students, academic and support staff; s/he will be required to report on activities on a quarterly basis;
- 4.5 An HIV/AIDS office, reporting directly to a Deputy Vice-Chancellor will be established, and staffed by a person appointed at senior level. The functions of this office will include: to coordinate and act as a secretariat for the implementation of the policy across the university; establish task teams to support implementation of specific aspects of policy within faculties; access outside expertise and materials which can assist faculties in integrating HIV/AIDS into teaching, research and service; convene periodic meetings of faculty representatives to assess and support implementation of policy; establish and implement a monitoring and evaluation process which can track the impact of HIV/AIDS on campus as well as the impact of interventions;

4.6 In the implementation of the HIV/AIDS Policy, the University will seek to collaborate with other tertiary educational institutions. This includes the Tertiary Education HIV/AIDS Initiative.

5. Policy review

HIV/AIDS is not static and policies addressing aspects of the pandemic as they affect the institution, must be revised from time to time. The University will thus review this policy on a regular basis to:

- evaluate its effectiveness;
- take cognizance of fresh initiatives around HIV/AIDS, whether these be from government, within the tertiary educational sector or elsewhere;
- consider appropriate amendments to the policy in light of the above.



CASE STUDY: CURRICULUM CHANGE

UNIVERSITY OF BOTSWANA

THE HIV/AIDS EDUCATION, PREVENTION AND CONTROL COURSE

Introduction

The HIV/AIDS course is taken as a General Education course to provide life skills to students in order to enable them to participate in HIV/AIDS prevention activities as individuals or aggregates. It will also assist the students to take responsibility for their own health especially the prevention of sexually related infections and the improvement of health seeking behavior. The course comprises a single module taken over one semester (14 weeks), either during the first or second semester.

Code: ENE 100/GEC 147

Credits: 2

Course Synopsis

This course focuses on increasing awareness and understanding of HIV/AIDS. An understanding of human sexuality, predisposing factors, causes and the nature of HIV/AIDS are examined. The epidemiological trends of HIV/AIDS nationally, regionally, and internationally are explored. The management of HIV/AIDS with emphasis on primary and secondary prevention are the major concepts of the module. The course equips students with the knowledge, skills and attitudes to enable them to adopt positive behavioral changes regarding HIV/AIDS. The course should also discuss strategies for mitigating the HIV/AIDS epidemic.

Course Objectives

At the end of the course students should be able to:

- Demonstrate an understanding of human sexuality and their own sexuality;
- Develop social, moral, ethical and communications skills as well as negotiation assertiveness;
- Review factual information on HIV/AIDS;
- Identify factors that precipitate the spread of HIV/AIDS
- Discuss the impact of HIV/AIDS on individuals, families and the community;
- Suggest solutions for combating the spread of HIV/AIDS, especially among youth;
- Participate in interactive activities that are geared towards behavioral change;
- Identify ways of mitigating against the spread of HIV/AIDS

Target Group

The module is targeted for University students and the UB community and any other interested persons

Course Structure

The course is divided into seven units of one to two lecture hours each, taken in the order in which they are documented.

The students can opt to take these units in a one-week block in a training seminar/workshop or as a semester course.

The units will be offered in series every week of the semester. Students will also be encouraged to make some field visits to suggested sites where necessary, and if possible to expose themselves to in-country HIV/AIDS problems and related intervention programmes.

Course Units

Unit 1: Focuses on the epidemiology, background and natural history of HIV/AIDS. The importance of studying HIV/AIDS is also included.

Unit 2: Discusses issues of human sexuality as it relates to HIV/AIDS transmission and care. The unit addresses human physical, physiological, social, emotional and sexual development. It also includes individual, family and societal reactions to these human developmental changes, and their possible impact on individual and/or group behavior.

Unit 3: Explains the HIV/AIDS disease process in terms of the nature of the disease, the immune system and the organ system changes, clinical manifestations, diagnosis and management of the infection, with emphasis on the preventive strategies at all levels.

Unit 4: Addresses predisposing factors to HIV infection and transmission. Special attention is drawn to the socio-economic, biological, social, demographic and cultural determinants of HIV infection. Gender and reproductive health issues and concerns related to HIV transmissions are discussed.

Unit 5: Articulates the impact of HIV/AIDS, including the educational, economic, social, demographic, psycho-emotional and religious impact of the disease on the individual, family, community and the entire society.

Unit 6: Provides information on the strategies and programmes for the prevention and control of the HIV/AIDS pandemic.

Unit 7: Covers life skills development in order to assist students to acquire the necessary survival skills for appropriate personal development, and to promote healthy and personally resourceful life styles. Emphasis will be laid on identifying and defining morally and socially acceptable life styles and behaviors.

Key commitments

The Faculty of Education invites you to an educational programme that instills a sense of sharing, caring and change. We all need to share, care and change in light of the pandemic that has hit on us all.

Share: We need to share our experiences, fears, sorrows and hopes. We need each other's skills and support. Wherever you are, just call to come and share what you can offer.

Care: We are all we have for each other. We need to care for one another. We must care for our feelings, our bodies and minds. We must care for our friends and families together as a united force. Humility is the lead ingredient in this programme.

Change: Our behavior and those of others around us, our attitudes towards ourselves and others, and our outlook on life must reflect concern and resourcefulness to self and others. Let's act now to reflect these important human attributes. We are committed to that.

Benefits of Attending the Course

- Increased knowledge of the epidemiology, disease process, causes, prevention, and control of HIV/AIDS, and life skills for dealing with the pandemic at individual group, family and community levels;
- Increased motivation to participate more actively in self care (especially preventive care) and in other HIV/AIDS activities, locally, nationally and internationally;
- Confidence building in dealing with and providing support for those infected and affected by the HIV/AIDS;
- Certificate of attendance will be provided;
- The course will appear in the transcript.



CASE STUDY: RESEARCH

Trials of First AIDS Vaccine Candidate Designed for Africa Officially Begin in Nairobi

NAIROBI, Kenya, 6 March 2001—The first AIDS vaccine candidate designed specifically for Africa officially entered human trials in Nairobi today when Dr. Pamela Mandela Idenya of the Kenyatta National Hospital became one of the first volunteers to be inoculated in the Phase I trial.

The preventive vaccine candidate is based on subtype A of HIV, the most common strain in East Africa. The vaccine candidate is the product of an International AIDS Vaccine Initiative (IAVI)-funded partnership between the research teams of the Medical Research Council's Human Immunology Unit at Oxford University in the United Kingdom and the University of Nairobi in Kenya.

"A universally accessible AIDS vaccine is the world's best hope for ending this pandemic," said Dr. Seth Berkley, MD, president and chief executive officer of IAVI. The New York-based organization recently launched a \$550 million capital campaign with a \$100 million challenge grant from the Bill & Melinda Gates Foundation.

IAVI acts as a virtual vaccine company, canvassing the globe for the most promising scientific prospects. IAVI currently has five different AIDS vaccine candidates under development, all for Africa, and intends to launch vaccine development projects in India and China this month. "We salute Dr. Idenya and, indeed, all of those who have volunteered to participate in AIDS vaccine clinical trials," Dr. Berkley said. "They are the true heroes of this endeavour. With 15,000 new HIV infections every day, there is no time to spare."

"Global problems require global solutions," said Dr. Gro Harlem Brundtland, director-

general of the World Health Organization and chair of the Global Alliance on Vaccination and Immunization. “A vaccine is the best hope for controlling this epidemic -- in Africa and throughout the world.”

Dr. Brundtland added that vaccines have traditionally taken far too long to trickle down to countries that need them most. “I commend IAVI and its partners for planning ahead to assure global access to this vaccine should it prove to be successful,” she said.

In December the three nonprofit partners announced an agreement under which all existing and future patents covering the vaccine candidate will be owned jointly by the Medical Research Council, the University of Nairobi and the International AIDS Vaccine Initiative. The partners agreed to use their patent ownership and any resulting royalties to help ensure access to a successful AIDS vaccine in Kenya and in other developing countries.

Phase I testing of the subtype A DNA vaccine began last August in Oxford, when Dr. Evan Harris, a member of the British Parliament, became the first individual to be injected with the vaccine.

Prof. Andrew McMichael, head of the Medical Research Council’s Human Immunology Unit in Oxford and one of the world’s leading researchers in cellular immunity, said: “We are excited that trials have begun in Nairobi for this approach. Our research indicates that this vaccine has a very good chance of stimulating cellular immune responses to HIV. Research also suggests that white blood cells activated by the vaccine can destroy virus-infected cells. For HIV, this approach may be more effective than the traditional vaccine approach of stimulating antibodies.”

The rationale for this approach comes from extensive studies of sex workers in Nairobi and elsewhere. Despite frequent exposure to HIV, a small minority of these women has resisted infection over many years. “We hope this vaccine will stimulate the same strong cellular immune response to HIV that we have seen in these women,” said Prof. J. J. Bwayo, who is chairman of the Department of Medical Microbiology at the University of Nairobi.

Bwayo said: “Until now, most AIDS vaccines have been made from strains circulating in the North, specifically, subtype B. The development of this vaccine begins to address the great need for vaccines designed specifically for Africa.” He added: “We recognize that vaccine trials on HIV/AIDS present unique challenges. This trial has gone through rigorous safety and ethical protocols. With HIV we insisted on even higher standards of safety and ethics. The vaccine candidate is not curative but preventive. It is inspired by findings by our scientists in Nairobi.”

The International AIDS Vaccine Initiative is an international non-profit scientific organization founded in 1996 whose mission is to ensure the development of safe, effective, accessible, preventive HIV vaccines for use throughout the world. IAVI’s work focuses on four areas: creating global demand for AIDS vaccines through advocacy and education; accelerating scientific progress; encouraging industrial involvement in AIDS vaccine development; and assuring global access. IAVI is a UNAIDS collaborating centre. Its major donors include the Bill & Melinda Gates Foundation, the Rockefeller Foundation, the Sloan Foundation and the Starr Foundation; the governments of the United Kingdom, the United States, the Netherlands, Canada and Ireland; and the World Bank.

⇒ **CASE STUDY: COMMUNITY ENGAGEMENT**

‘IN BUT FREE’ – an HIV/AIDS intervention in an African prison

Dr OSCAR SIMOOYA
Copperbelt University, Zambia

Dr Simooya is currently project leader of IN BUT FREE an HIV/AIDS intervention in Zambian prisons and also serves as a Board Member of the Copperbelt Health Education Project in Zambia. His research interests include studies of the epidemiology of AIDS in prisons, studies of antiretroviral, maternal to child transmission and the relationship between HIV infection and tropical diseases. Provision of Comprehensive HIV&AIDS care in Prisons

Unprotected male-to-male sex, sharing of razor blades, tattooing and injecting drug use have been recognized as risk factors for HIV transmission at Kamfinsa Prison in Zambia. Beginning July 1995, an intervention called ‘In But Free’ and led by inmates trained as peer educators (PEs) has been implemented at the prison with support from the University of the Copperbelt. Activities include face-to-face information giving, provision of HIV/AIDS educational materials. Distribution of scissors, voluntary HIV counseling and testing and the promotion of better standards of hygiene. No condoms have been distributed. The project has been well received by inmates and staff. A total of 119 PEs have been trained and hold regular meetings with other inmates. Sixty pairs of scissors have been made available. Reports from inmates and staff indicate a reduction in tattooing and injecting drug use but male to male sex and the sharing of razor blades continues. HIV testing shows prevalence rates of 75% compared to the national average of 19% in adults. These findings suggest that the risk HIV transmission at the prison is still high and measures to address this situation are urgently needed. Condom distribution in prisons must now be considered as well as steps to improve the poor living conditions in most Zambian prisons.

Although it is now more than two decades since the AIDS pandemic was recognized as a major public health problem, prisoners throughout the world continue to receive less protection and care against HIV/AIDS compared to the communities outside. In countries where attempts have been made to initiate programmes for inmates, most of these efforts have been imported from outside and do not reflect the reality of the epidemic inside jails.

Prisons are not closed off worlds. Prisoners and indeed prison staff move in and out of jail each day. Many prisoners are in jail for only a short period of time and return to society after release. Any infection acquired inside can therefore be readily transmitted outside. Protecting inmates against HIV will in the long run protect society from HIV/AIDS.

Additionally, it is a fact that prisoners go to jail to serve their sentences for offending society and not to get AIDS or other infectious diseases. Denying prisoners the right to be protected against infectious diseases is a denial of fundamental human rights. Programmes to protect prisoners are therefore desperately needed.

There are different approaches that may be used to develop HIV/AIDS programmes in prisons but I believe that certain conditions must be met in order to ensure the long life of the project:

1. Prisons are primarily high security institutions and for most prison staff, security considerations will most often override public health concerns. The participation of the prison command in the development of an intervention is therefore crucial to the long-term future of the programme.

2. Baseline surveys must be conducted to define the extent of the HIV/AIDS problem in any country's prison system. National trends on seroprevalence and risk behaviors may not necessarily be the same inside jail.

Once the trust of the prison community has been established and the magnitude of the epidemic inside defined, the next step is to consider the appropriate response. In general, the response to HIV/AIDS in prison must be guided by the prevailing situation in each country. The intervention must however comprise programmes for the prevention of new infections and the care of those already living with HIV/AIDS. Although lack of funds may be a hindrance, a lot can be achieved with limited resources.

HIV/AIDS awareness is high but there are inmates who still believe that you cannot get HIV from another man and tattooing. Current IEC materials are inappropriate and do not highlight the risks observed in prisons.

Activities offered in the programme include: aggressive health education/promotion led by inmates and staff trained as peer educators, development of IEC materials relevant to prisons, VCT, provision of medical clinics, support for recreational activities, advocacy for improved social services in prisons and home based care for terminally ill inmates. The project does not distribute condoms, as it is believed condom availability would encourage homosexuality a punishable offence in Zambia.

The project is evaluated through monthly project reports, an annual prison conference, focus group discussions with inmates and staff, peer educators reports, KABP studies, clinic records and results of VCT.

Our main challenges are: high levels of STIs and TB, lack of drugs in most prison clinics, poor hygiene and overcrowding, and the issue of terminally ill inmates. An approach to government has been made for a fast track release, on compassionate grounds, for those with terminal AIDS.

References:

Detailed discussion of our work can be read in: Simooya et al. (2001). Culture Health & Sexuality, Vol 3 (2), pp 241 - 251 and Simooya et al. (2001). AIDS, Vol 15(13), pp 1741 -1744.

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⇒ CASE STUDY: STUDENT SERVICES

HIV/AIDS AND UNIVERSITY OF ZAMBIA (UNZA)

Prof Hector Chiboola
Deputy Dean of Students
University of Zambia

Presentation to the Association of Commonwealth Universities Workshop, Lusaka, Zambia, November, 2001.

HIV/AIDS education programmes have been established in many workplaces in Zambia; and anti-AIDS clubs formed at many schools, including the University of Zambia. Zambia has been one of the pioneers in sub-Saharan Africa in developing a multi-sectoral response to the HIV/AIDS epidemic. In part, this has happened partly because of the recognition that AIDS adversely affects the development efforts in virtually all sectors in the country. Many of these impacts have been reported elsewhere, and it is apparent that in education, for example, AIDS among teachers results in increased absenteeism and disruption in the routine functioning of schools.

Because an AIDS death to an adult results in the loss of household labor and income, children are often required to leave school and remain at home or go to work to compensate for losses. Girls, in particular, may have to forfeit their educational opportunities for less honorable activities such as prostitution or commercial sex work to raise income for livelihood. HIV infection rate is often highest in the younger age group (15 – 25 years) because of their vulnerability. The younger age group form a relatively large proportion of the adult population in Zambia, and are therefore a potential factor in the HIV/AIDS epidemic.

Most students at UNZA are aged between 19-26 years, the age group which is highly vulnerable to HIV incidence. The students as well as having important roles in the economy of Zambia are likely to become the wage earners not only for themselves and their immediate family, but also for their extended family. Given the many challenges that are often faced by students, and in recognition of the impact of HIV/AIDS in all sectors of society, the UNZA Counseling Centre in conjunction with KARA Counseling and Training Trust (KCTT) conducted a study to determine the knowledge and attitudes to HIV/AIDS and sexual practices amongst UNZA students in 1993. This is the only credible source of information that specifically explored the knowledge, attitudes and practices (KAP) toward HIV/AIDS of students at University level. It involved a sample of 1,240 students.

The KAP study revealed that knowledge regarding HIV transmission was only moderately good considering that the students are among the most highly educated group in the country. Most students knew that HIV infection was spread through blood, semen and vaginal fluids; and nearly 50% also thought that HIV could be transmitted through saliva and mosquitoes seems popular among different study groups (4,12,14,15), probably indicating a need for further exploration of these issues in the context of situational factors.

The study also revealed that despite the fact that the majority of students knew someone with HIV/AIDS they still held very negative attitudes to those with the disease. For instance, 8% felt that people with HIV/AIDS had led immoral lives, 14% felt that people with HIV/AIDS

should be isolated, and 15% did not like the idea of working with people who have HIV/AIDS. Such negative attitudes seem predominant in the general population and greatly contributes to the mystification, stigmatization, and perpetuation of inappropriate fears of HIV/AIDS.

Sexual behavior among UNZA students tended to agree with other surveys where men state th they are more sexually active than women. On admission into UNZA, 53% of male and 24% of female students said that they had had one or more sexual partner (in reference to “freshers’ or new students). When the same question was asked among the continuing students, 85% of male and 61% of female students indicated that they had had one or more sexual partner. This clearly demonstrates that sexual behavior amongst University students is quite permissive and celebrated undertaking. This scenario is made possible because of the newly gained freedom and independence from parental control as well as the desire for sexual experimentation characteristic of adolescence and young adulthood.

INTERVENTIONS

As a result of this study the UNZA Counseling Centre instituted a programme of HIV/AIDS information and education to students in 1994. A confidential HIV counseling and testing facility was also introduced at campus through a USAID funded project coordinated by Kara Counseling and Training Trust. Although 53% of students had earlier indicated that they would like to take an HIV test the demand was extremely low, with only 10 students submittin for the test, though a larger number attended to counseling alone. Apparently this seems to be a common finding in other projects in the country where people frequently express interest in HIV counseling and testing but seldom take the test even when it is made accessible, convenie and cheap for them to do so. The low utilization demand for HIV counseling and testing led t its discontinuation toward the end of 1994, although there is need to evaluate better avenues fo providing voluntary HIV counseling and testing in the existing health care delivery system.

The information, education and communication (IEC) strategy involves social skills training in peer counseling and education for HIV/AIDS, assertiveness and negotiation for safe sex practice, condom promotion and use, and sustainable social behavior change. This strategy aims to empower the students and encourage them to take a leading role in HIV prevention, mitigation and advocacy.

The students have formed anti-AIDS clubs and actively participate in processes for the planning, implementation and appraisal of HIV/AIDS related activities and interventions. The clubs are used as forum for continued debate and discussion of issues related to HIV infection and AIDS. A booklet on HIV/AIDS awareness suitable for University students was developed in 1994, and it addresses the many misconceptions and knowledge gaps common among most students. The booklet is used as a teaching aid and relevant information material on HIV/AIDS.

At the national level UNZA has, in collaboration with the Zambia Counseling Council and the National AIDS Programme, participated and facilitated the development of a national policy on HIV/AIDS counseling. The Policy provides guidelines and a framework for counseling service provision, including voluntary HIV counseling and testing. The document is currently receiving ministerial attention prior to its ratification and adoption for implementation by the Government.

Institutional framework should be established at higher education establishments for the implementation of HIV/AIDS related activities. The involvement and participation of students in these activities is paramount and a key to their success and progress. Effective networking and collaboration among institutions of higher learning on HIV/AIDS issues is necessary and must be promoted.

The successful implementation and management of HIV/AIDS programmes at whatever level calls for the provision of adequate resources in respect of financial, human, logistical and technical. It is apparent that there is inadequate resources mobilized for the implementation and management of HIV/AIDS programmes at higher education establishments not only those obtaining in Zambia, but also in other countries worldwide. Efforts should be advanced to mobilize adequate resources to address the various facets of the HIV/AIDS pandemic as we enter the next millennium: Universities should spearhead this process.

CONCLUSION

The problem of HIV/AIDS requires concerted efforts to address it using a multi-sectoral approach. It should not be viewed as a health problem alone, but rather as a social problem whose effect has impacted all sectors of society. Operations research is required so as to continually inform and aid the planning and management of HIV/AIDS programmes. There are many unanswered questions, misconceptions and knowledge gaps that may require further exploration to understand their occurrence and what needs to be done to address them.

The Highridge Teachers' College Experience with Developing an Institutional Policy on HIV/AIDS

*Margaret Achieng Ojuando **

BACKGROUND

Kenya has twenty-one public primary school teachers' training colleges, regionally distributed and admitting between 8400 and 8600 trainees each year. Over 90 percent of the students are within the 18 and 30 year age range. HIV high prevalence is known to be within the age group of 18-24. If Highridge Teachers' College fails to influence behavior change within these vulnerable groups in whom the government and parents have heavily invested and if education will be wasted through the killer disease, then there will be difficulties in providing enough teachers for the primary schools.

In 1999, 21 years after the first cases of HIV infections were recorded in Kenya, an estimated 2.1 million adults and children were living with HIV/AIDS. The then President of Kenya, Mr. Daniel T. Arap Moi said:

“AIDS is not just a serious threat to our social and economic development, it is a real threat to our very existence.....AIDS has reduced many families to the status of beggars..... No family in Kenya remains untouched by the suffering and death caused by AIDS... the real solution of the spread of AIDS lies within each and everyone of us.”¹

In 2000, the National Aids Control Council (NACC) recorded adult prevalence in Kenya of 13.5 percent, up from 13.1 percent in 1999. It was higher in urban areas by 17 – 18 percent.² 80 to 90 percent of HIV infections in Kenya are among young people within age 15 – 29 years and 5 percent in children under five years.

A focus on young people must be clearly reflected in National Strategic Plans and other key HIV/AIDS planning documents. The Ministry of Education, Science and Technology (MOEST) among other sectors must scale up its interventions if Kenya is to meet the targets of a significant decrease of HIV prevalence rates among young people, and substantially increase access of the vulnerable age groups to HIV/AIDS-related information, education and other services.

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¹ Statement made in parliament by former President of Kenya, Mr. Daniel Arap Moi, while declaring HIV/AIDS a national disaster in November 1999.

² Daily Nation Newspaper. May 18,2003, “AIDS Therapy: The Real Challenges.” Nation Media Group.

In Kenya, the education sector is the largest employer of those with higher levels of education and professional skills, over and above the functions of imparting knowledge and skills and supporting large numbers of dependants. A high death rate from HIV or AIDS among teachers affects institution performance as it causes disruption of school activities. HIV/AIDS has affected and will continue to affect many students as thousands are forced out of school due to poverty or the need to take care of ailing parents.

THE COLLEGE

Highridge Teachers' College (HTC) located in the city of Nairobi is a public institution under the Ministry of Education, Science and Technology. It is a tertiary institution offering residential training to primary school teachers. The college's mission is to provide a suitable environment for the training of an all round competent, professional and innovative teacher, who is of exemplary conduct in society.

The college offers a two year certificate programme for students from all over Kenya. Enrolment is 250 in first and second year respectively. Student ages range from 18 to 41; over 89 percent in age group 18 to 25; 22 percent in age 26 – 30; and 8.3 percent in 31 – 41 age. Two thirds of student population are female, 35.6 percent of them in the high prevalence HIV age bracket of 18 – 24. The college has 24 visually impaired (VI) trainees, 12 women and 12 men; within the 21 to 25 and 26 – 30 age groups.

WHAT LED HIGHRIDGE TO DEVELOP AN INSTITUTIONAL POLICY ON HIV/AIDS?

Highridge recognized in 2000, the magnitude of the threat of HIV/AIDS in Kenya. The college felt challenged as a tertiary institution admitting young teacher trainees from all the districts in Kenya, to openly start debating HIV/AIDS and attempt to find effective responses to the threat posed by the pandemic on the supply of trained teachers to the primary schools and their retention in the system's teaching service. It recognized the leading roles played by the government, Non-Governmental Organizations (NGOs) and the private sector, and believed that it too had a role to play in influencing behavioral change among the students, the teachers and the college community to achieve a greater impact on mitigating the pandemic.

In September 2000, Highridge started its HIV/AIDS Sensitization Programme (HASP); a non-profit college-based program to deal with the scourge. The program gives teacher trainees the knowledge, attitudes, skills and values that influence behavior change and subsequently allow the trainees to teach about HIV/AIDS in the schools and the community. The programme provides a forum to tutors to share ideas among themselves and with students; its goal is behavior change among the youthful teacher trainees by strongly fighting against the moral vices that are a fertile ground for STDs and HIV/AIDS.

The activities of the Highridge HIV/AIDS Sensitization Programme (HASP) involve participation in open forums for discussing HIV and sharing information on AIDS, sexuality, drug abuse, discrimination, stigmatization and health issues between staff and an age group prone to infection. The college realizes the need to intervene instead of waiting for the problem to

manifest itself. Trainees take HIV/AIDS lessons as part of building of knowledge and sensitization. Organized seminars and workshops for staff and students are undertaken. All these activities require backup.

The college therefore decided to develop its institutional policy in order to strengthen the ongoing activities of HASP because with such a policy it will be better placed to:

- Plan and prioritize its programmes
- Formulate preventive and control activities
- Collect and monitor data
- Implement effective interventions
- Monitor and evaluate impact of mitigation
- Source for funding and resources internally and externally and
- Collaborate with partners

An institutional policy document gives legitimacy to internal decisions made and actions taken in the process of prevention and advocacy.

Developing and implementing an Institutional HIV/AIDS Policy for HTC has increased awareness and knowledge of HIV and AIDS and the possible impact of the pandemic in the institution in particular and the country in general. It demonstrates the college's position, concern and commitment in taking active steps to manage, prevent and contain the scourge.

WHY GIVE PRIORITY TO HIV/AIDS?

Highridge has distinct and challenging problems, but it is committed to giving HIV/AIDS priority because doing so is part of the solution to the diverse college and national problems.

One of the many problems is the rate of absenteeism presented by the students and staff. Between January and March 2002, 69 percent of students were absent at different times due to fees problems and 52 percent because they were sick. Of the students with fee problems, 45 percent were also the ones absent because of sickness; and 83 percent whose close family members were sick had fee problems.³ None of the students indicated the nature of their illnesses or that of their family members. A significant number of members of staff also took compassionate leave to attend burials of close family members.

Absenteeism does impact on staff performance and on students' academic achievement and therefore the quality of the graduating trainee because much of the course content is missed, acquisition of knowledge, skills, attitudes and values emphasized on by the college are lost.

Students' absenteeism due to illness or financial problems result in the college experiencing decreased growth and productivity. The college becomes heavily indebted to suppliers; the health unit cannot provide adequate and necessary medicines to students and staff. The college cannot maintain institutional facilities, for example the halls of residence, sanitation, kitchen and dining hall and classrooms. The quality of training is grossly affected.

³ Highridge Teachers College.2002. Absenteeism and Sickness Rate. January to March 2002.

The health facility in Highridge lacks space, human resource and medicines. The baseline survey conducted in July/August 2002 indicated that 66.9 percent of students confirmed the unit's inadequacy in medical supply. No student indicated that they visit the unit for STD treatment although the nurse recorded treating STD infections. Majority of cases treated were women students. Lack of privacy due to its location and presumably therefore, confidentiality led to unsatisfactory service delivery from the health unit. The college's efforts to provide satisfactory health interventions are hampered by financial constraints.

Tutors lack relevant and accurate information for the prevention of HIV/AIDS as a killer disease. They must be equipped with relevant knowledge and skills first, for their own self protection from the pandemic and secondly for imparting to the trainees who, through the multiplier effect will deliver the same to their pupils. It is Highridge's responsibility to organize and ensure the provision of these interventions because the institution admits the vulnerable age group and gender.

The provision of Free Primary Education (FPE) caused increased enrolment of children into the public primary schools from 5.8 million to 7.3 million.⁴ There is therefore need in the country for additional trained teachers to facilitate the government's implementation of the FPE launched in January 2003. FPE will introduce more of the most vulnerable age group at the college and therefore the reason for giving HIV/AIDS priority.

Curriculum for primary teacher training programmes addresses emerging issues which include HIV/AIDS, drug and substance abuse, children's rights, rights of the disabled, morality and social responsibilities. Tutors' knowledge and information base must therefore be addressed for trainees to benefit and have an impact on the primary school children they will be responsible for in the classrooms. The college admits more female students as a policy. Seventy five percent of students as well as the teaching staff are women. The college also has visually impaired female students. It is the serious responsibility of Highridge to empower women with knowledge, correct information, skills and attitudes on HIV/AIDS.

“In the long term, good quality “Education for All” contributes to economic well being and socio-cultural changes such as female empowerment and decision making”.⁵

HOW WE DEVELOPED AN INSTITUTIONAL POLICY ON HIV/AIDS

ADEA/WGHE's Challenge to Highridge Teachers' College

In January 2002, the Working Group on Higher Education (WGHE) that functions within the Association for the Development of Education in Africa (ADEA) challenged Highridge to submit a funding request for the development of an Institutional Policy on HIV/AIDS.

Alice Sena Lamptey, Coordinator ADEA/WGHE, traveled to Kenya in July and visited HTC with the pleasant information that our proposal made it to the finals and that the college had been awarded a grant of US \$ 10,000 to develop an Institutional HIV/AIDS Policy.

⁴ Government of Kenya. February 2003. *Report of the Task Force on Implementation of Free Primary Education*, Republic of Kenya. Jomo Kenyatta Foundation, 2003.

⁵ UNAIDS. Education and HIV/AIDS. Modeling the impact of HIV/AIDS on Education Systems. A Training Manual.

The college valued ADEA/WGHE's funding because the presence of an Institutional HIV/AIDS Policy would improve and strengthen the many activities the college was already undertaking and implementing.

Establishing Environment for Policy Development

The college had in place HASP which was founded in September 2000 by the college administration with the major objective of reaching out to the students and staff who are infected, affected or stigmatized by HIV or AIDS. The target group was generally the college community but it was also necessary to include residents, domestic workers, drivers and watchmen employed within the vicinity of the college who would be informed by posters, strategically posted within the college environs. The community is also involved through participation during organized forums.

The HASP programme appreciated the fact that the college students do not live on an island but are part of the wider community while in and out of the institution and hence the need to incorporate the rest of the society in HASP. The teachers in the college run the programmes on voluntary basis. The college nurse and cateress fully participate as key members in the programme.

When founded, HASP concentrated on HIV/AIDS forums for sensitization because it had not designed intervention modules. It needed to do that for effective implementation of its aims and objectives, and therefore the necessity for a policy to legitimize its activities.

The college management formed a technical arm of HASP. The members are the principal, deputy principal, dean of curriculum and dean of students, two representative heads of departments, two tutors, the college nurse and cateress. The committee administers and coordinates college programmes and is responsible for the implementation of BOG policies within HASP.

The committee assists in organizing workshops, seminars, sensitization forums and networks externally for HASP. Board members may participate in these forums by representation and are informed during Board meetings about the progress of HASP programmes. Support for HASP activities comes from the various college administrative structures and the committee is on the ground to oversee, provide guidance and help integrate the project into routine activities.

With ADEA/WGHE funding, the college was able to start on the process of developing its institutional HIV/AIDS policy.

Sensitization on Importance of Institutional HIV/AIDS Policy and Baseline Survey

The HIV/AIDS Committee was assisted through consultancy to carry out confidential baseline survey in the months of July/August 2002 just before the college broke for end of semester. The intention of the survey was to establish the extent of the HIV/AIDS problems in the college, define specific activities to be undertaken to address the problems and obtain key indicators for monitoring future performance.

The survey focused on demographic characteristics, knowledge of HIV/AIDS and STD's, attitude towards people living with AIDS, counseling, perception of the impact of AIDS on the institution, access to health, information and education facilities, the proposed HIV/AIDS policy,

prevention and care programmes and integration of HIV/AIDS in the teaching services at the college.

The respondents filled in the questionnaires but were not allowed to put their names on them to encourage accuracy and secure privacy. The survey targeted all staff, students and members of the college environs. Unfortunately it was initiated at a time when examinations were in progress being end of semester and despite efforts to get all students to participate, many of them left on completing examinations and failed to complete the questionnaires. A total of 125 students (26 percent of the total) and 29 staff (31 percent) of the total participated. Majority of the teaching staff responded to the questionnaire.

Before administering the questionnaires, it was necessary to have several brief meetings with students for sensitization on the need to develop an institutional policy on HIV/AIDS and the importance of responding to the questionnaire, an activity not common to the majority.

The survey results formed the basis for Highridge to have an institutional HIV/AIDS policy.

Workshops and Seminars

Policy-making process for Highridge was in itself very educational because participants were drawn from a broad section of the society in order to make the document comprehensive. Resource was drawn from MOEST sectors, Ministry of Health (MOH) and medical doctors, legal sector, Kenya National Union of Teachers (KNUT), People Living with AIDS (PLWA), religious groups, NGO's, BOG, tutors, non- teaching staff members, the student body (STUBO) which had the largest representation and the external college community.

Workshops and seminars were advocacy forums for a number of reasons. Participants had diverse professional backgrounds and held credibility within their mandates. They provided a rallying point for decision and action; helped to define issues and acceptance solutions. They had the authority to make others do what is necessary; organize communities and groups for effective responses to the pandemic and help mobilize and distribute internal and external resources. Board participation facilitated approval of the draft policy.

The workshops and seminars were participatory in nature and created partnerships and networks for effective implementation of the policy.

DIFFICULTIES ENCOUNTERED AND OVERCOME

One of the difficulties encountered while carrying out a needs assessment/baseline survey revolved around a number of students who were reluctant to participate in the survey. Many were still uncomfortable while discussing or addressing issues concerning HIV/AIDS. The difficulty was of great concern because free discussion and sharing knowledge and information on HIV/AIDS is a significant objective of HASP. The reluctance was a pertinent indicator to HASP and the committee and needed to be addressed.

The committee and tutors held a number of awareness campaigns with students to agree on a common purpose so that they understand the objectives of the policy. A few minutes were spent at every assembly on Mondays; Fridays and Saturdays for 2 weeks, to talk about the significance of a needs analysis and baseline survey in the development of the policy. A draft questionnaire was formulated and tested with a section of the students and staff to gauge acceptance and obtain input and commitment before administering the final questionnaire.

Despite all these efforts to get the students to participate in the study, only 26 percent respondents finally participated, indicating either that many young people were still not willing to share feelings or that the questionnaire was circulated at the wrong time as it was during examination and end of semester. This problem had not been envisaged and it affected timing within the policy development process.

However, the survey helped in assessing the knowledge, attitude and practice on HIV/AIDS by the staff and students and gauging the management's commitment to the whole process.

The institution lacked a computer and printer at the beginning of the development process. This hindered preparation and production of materials and put a lot of pressure on the staff who had to combine their daily routine with responsibilities related to HIV/AIDS activities. The acquisition of a computer made possible by ADEA/WGHE funds facilitated preparation and production of materials for the survey and documents for workshops and seminars. The facility contributed immensely and saved time where delays would have been experienced.

WHAT SUPPORT AND RESOURCES WERE NECESSARY?

Highridge owes a special gratitude to ADEA/WGHE for initiating the challenge to Highridge to develop an Institutional HIV/AIDS Policy and for providing financial support which determined the successful production of the policy. The institution had commitment and conviction that a policy was required for prevention, control and reduction of HIV/AIDS but did not have adequate capacity and resources to develop the policy. The US\$10,000 from ADEA/WGHE financed the hosting of advocacy workshops and seminars, production of baseline survey materials and information for participants, consultancy services and publication of the policy document. The college procured a computer and printer for HIV/AIDS activities and other college functions. The college is soon to be connected to internet. Highridge would not have successfully developed the policy without ADEA/WGHE support.

In producing the policy the college benefited from the insight and knowledge of many stakeholders. Valuable contribution and support from MOEST Aids Control Unit is acknowledged. The Unit is responsible for coordinating the mainstreaming of HIV/AIDS into the core functions of MOEST and is funded by NACC.

Kenya Institute of Education (KIE), the curriculum technical department of MOEST hosted one of the major prevention and advocacy workshops. The institute presented the government's policy on the teaching of HIV/AIDS in schools and tertiary institutions. Their major contribution involved articulating strategies and methods of integrating and infusing HIV/AIDS information contained in the KIE teachers' guides and pupils' texts into the college curricula that the policy would address.

The college found it absolutely necessary to involve the external support of a legal expert during the process of developing the policy. The chairman of the Task Force on law relating to HIV/AIDS in Kenya participated in our major stakeholders' workshop and seminar. Issues during these forums ranged from the existing legal framework for teaching HIV/AIDS, to specific legal implications of our institutional policy on counseling and testing; religion; culture; admission of students and employment of staff; confidentiality; discrimination and stigmatization, research and development of information; external and internal partnerships and collaboration; prevention and control of HIV/AIDS within the institution that would be covered by the policy.

The Federation of Kenya Employers (FKE) and the Kenya National Union of Teachers (KNUT) as partners discussed the code of conduct on HIV/AIDS in our workplace and the rationale for the code. Some of the issues discussed on policy development for AIDS education and prevention programmes included: the impact of HIV/AIDS on organizations like ours; protection of the employee from stigmatization and discrimination; reasonable changes in working arrangements; protective devices and strategies for combating the HIV/AIDS pandemic. These issues were addressed by the policy.

MOH and medical doctors supported the college during the process by donating current publications and posters for necessary information on the HIV/AIDS pandemic in Kenya and the available medical interventions and accessibility for inclusion in our policy where relevant to us.

Maokwa Services provided consultancy services. They contributed in drafting the questionnaire for the baseline survey and analyzed the data. The consultancy firm also drafted the policy document and oversaw its printing and production process.

The contribution of all the above participants and organizations in the process of developing our HIV/AIDS policy is acknowledged. Their willingness to share information, knowledge, experiences and plans, and their commitment to confronting the challenges posed by HIV/AIDS pandemic in Kenya is appreciated.

BOG, staff and students, members of HASP and the HIV/AIDS Committee had a mission to develop an Institutional HIV/AIDS Policy for HTC. Their determination and commitment to the task is most sincerely acknowledged.

Highridge is already integrating the outputs of the policy into its ongoing programmes and wishes to be strengthened and supported in its commitment and determination to overcome this threat to our country and our mother continent, Africa.

PRACTICAL LESSONS LEARNED

The institution is a unit of a sector and its members interact at personal level. Interaction between administration and teachers and between teachers and students enhances a partnership so that all parties move in the same direction for the success and sustainability of any process. Students and tutors are the main target groups in the policy and must be included as important participants in all aspects of advocacy of HIV/AIDS programmes in the institution. The target group must not simply be beneficiaries of the policy but also participate in its development and its implementation. An environment that builds internal collaboration strengthens understanding and support from within the institution for the development of the HIV/AIDS policy. Members will not only identify with it but also take ownership.

First, effective networking helps the institution to identify committed partners to collaborate with in its actions in addressing the challenges of HIV/AIDS in the policy. Networking is fundamental in securing resources to support the development of the policy. The institution's commitment is supported and reinforced. The partnership with ADEA/WGHE enhanced Highridge's commitment to the development of its policy. The fulfilled funding pledge from ADEA/WGHE supported the development process of the policy. Highridge's prospect for success in the implementation of the policy is therefore high because the process of developing the policy introduced new directions which must be followed up for further support.

Secondly, the production of the policy is in itself affirmation of Highridge's commitment and resolve to be a key player in prevention and advocacy campaigns for control of the HIV/AIDS pandemic. Highridge is committed to getting more involved and use the opportunities available to fight HIV/AIDS among the young students, in particular the female students in the institution.

Finally, advocacy has created an enabling environment for peer counseling programme at the institution. The principal, four members of teaching staff out of the total, and 200 students out of the total are participating in the programme. Advocacy has supported the ongoing programme which should affect behavior and lead to behavior change. The institution's commitment has been enhanced by this programme for which participants have paid Ksh.1, 200(US \$16) for 52 hours. It is facilitated by Pathfinder International trained lecturers from Kenyatta University. A Pathfinder International/Kenyatta University Certificate of Attendance is awarded on completion. The certificate gives credentials to the student trainees to conduct peer counseling in their schools and communities. The college hopes to conduct a study to establish the impact of this programme in the institution in 2003/2004 and intends to seek support for the study. These among other actions provide some prospect for success in our undertakings on the fight against HIV/AIDS pandemic.

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