



# ASSOCIATION OF AFRICAN UNIVERSITIES (AAU)

An HIV/AIDS Toolkit for Higher  
Education Institutions in Africa

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## Foreword

African tertiary institutions - universities, polytechnics and teacher training colleges- are increasingly aware that their communities, by reason of the age groups (19-45 years) of the majority of members, and the dominant lifestyles, are especially vulnerable to the human immune-deficiency virus (HIV). This development is reflected in the introduction, within the last few years, of individual and collective awareness-creation and action programs, especially in regions of highest prevalence of the epidemic. Among university-related actions on the continent is that of the South African Universities Vice-Chancellors Association (SAUVCA), which has begun a co-ordinated program of activities for its members. The Association of Commonwealth Universities (ACU) has also commenced a number of very critical initiatives with some African universities.

Recognizing not only their vulnerability, but also the potential of African higher education institutions as a unique social resource for the development and application of country and community-specific knowledge and solutions to the HIV/AIDS pandemic, the Association of African Universities (AAU) is collaborating with several of its partners to document the role and contribution of its members to the fight against the pandemic. A major gap revealed by the studies is the virtual absence of institution-specific targeting and action. This emerges from the set of nine case studies of HIV/ AIDS and African Universities commissioned by the Working Group on Higher Education (WGHE) of the Association for the Development of Education in Africa (ADEA) and disseminated in collaboration with the AAU at the Nairobi meeting of the Working Group in 2001.

In an online discussion on how are African Universities responding to the HIV/AIDS pandemic, conducted by the AAU with the support of the Africa-America Institute (AAI) in March 2003, participants highlighted the lack of trained person power as a key factor hindering the ability of universities to respond adequately to the threat posed by HIV/AIDS to their institutions.

This AAU HIV/AIDS Toolkit is therefore aimed primarily at supporting the efforts of African universities to initiate or improve their institution-specific HIV/AIDS prevention programs. It is intended to fill the gap in the availability of trained personnel by giving training to academic staff, students and support staff of the institutions to work with their peers to reduce personal risk and to engage with families and communities.

The sub-regional training workshops planned for the launch of the kit will provide an opportunity for trainees and trainers to share ideas and experiences in order to develop good practices and to build networks.

This project, which was commissioned with a seed grant from the ADEA/WGHE at a time when there were obvious concerns about the ability of such a kit to recognise and meet the linguistic and cultural diversity of AAU's membership, is part of a five year core HIV/AIDS program, which includes advocacy for the development of institutional HIV/AIDS policies; HIV/AIDS integration into curricula; research; and information sharing and networking.

I take this opportunity to commend the author, the editors and the AAU HIV/AIDS Program Manager for their tireless efforts in bringing the first phase of this project to a successful close. Many thanks also to our numerous partners, who in diverse ways have supported our efforts

from the idea stage, through the development, design and printing of the Toolkit.

We look forward to your continuing support for the next phase, which is to train trainers in a series of sub-regional workshops and hopefully, in all the three working languages of the AAU.

**Akilagpa Sawyerr**  
**(Secretary General - Association of African Universities)**

## **Acknowledgements**

The AAU HIV/AIDS Toolkit has its origins in the foresight of Professor Akilagpa Sawyerr, then Director of Research and later Secretary-General of the Association of African Universities, and the Work Program of the ADEA Working Group on Higher Education (WGHE), which the AAU now co-ordinates. While giving due credit and appreciation to the author, Dhianaraj Chetty, the editors, Emmanuel Fiagbey and Patrick Fish, and the AAU HIV/AIDS Program Manager, Alice Sena Lamptey for their tireless efforts in realising the expected results, a number of individuals and AAU partner organisations and institutions deserve credit for their part in moving the Toolkit from conception through to development, design, and production. These include the Steering Committee and members of the ADEA/WGHE, in particular, William Saint, Senior Education Specialist, the World Bank and former Coordinator of the Working Group. Piyushi Kotecha, Chief Executive Officer, the South African Universities Vice-Chancellors' Association and a member of the WGHE Steering Committee, for her supportive role and foresight at the final stages of design and production. Barbara Michel, Program Director, the South Africa's Higher Education AIDS (HEAIDS) Programme, for her professionalism and drive for partnerships. The financial support provided by the UNDP HIV/AIDS Regional Project, Pretoria, towards the AAU Conference of Rectors, Vice-Chancellors and Presidents (COREVIP) and specifically, the technical contributions of Roland Msiska, Lemma Merrid, Lamine Thiam and Jean Baptiste Gatali cannot go without mention. We are particularly appreciative of the invaluable comments and suggestions of the participants at the Master Trainers' workshop which was held in Mauritius in March 2003 during the COREVIP to pre-test the kit and which resulted in its further improvement. Our deepest appreciation goes to the Commonwealth Secretariat (COMSEC), in particular, Gari Donn and the Commonwealth of Learning (COL) specifically, Ashar Kanwar, UNESCO, in particular, Professor Komlavi Seddoh for the timeliness of financial and moral assistance to finalise and reproduce the Toolkit and to conduct the training workshops which are planned. Finally, AAU wishes to acknowledge the support of the donors to the SAUVCA/HEAIDS Programme for their support to the design and reproduction of the kit. Particular mention must be made of DfID and Development Co-operation Ireland for their support in assisting in the bringing to fruition of this Toolkit. The review of this toolkit has been made possible with the financial support from Sida Lusaka who has supported AAU with funding for its HI&AIDS project since 2009.

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## **Abbreviations/Acronyms**

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 Organisation
COREVIP	Conference of Vice-Chancellors Rectors and Principals
DVC	Deputy Vice-Chancellor
GIPA	Greater Involvement of People with HIV/AIDS
HEAIDS	Higher Education 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 Organisation
PWA	Person/s Living with HIV/AIDS
SAUVCA	South African Universities Vice-Chancellors Association
STI	Sexually Transmitted Infection
SUMA	Senior University Management Workshop
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing
WGHE	Working Group on Higher Education

## OBJECTIVES

- Trainers and users of the Toolkit are aware of the context within which it has been developed.
- Trainers and users begin to establish consensus about the objectives of the Toolkit within a management perspective.
- The roles of trainers and trainees are Identified and discussed.

## Introduction

**Defining tertiary institutions**, tertiary level or higher education institutions (used interchangeably) include universities, polytechnics, teacher training colleges and/or other specialized colleges of further education and training. The African higher education community is poised at the brink of a new era since the formation of the African Union and the declaration of an implementation strategy in the form of NEPAD. Despite the opportunities presented by these changes in the African landscape, the continent faces the most serious threat in recent memory to individuals, to our institutions, our economies and social systems from the HIV and AIDS epidemic. Predictably, the epidemic has been treated mostly as a health problem. This Toolkit 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 higher education communities in a host of unexpected ways.

In light of this, the African higher education community, through the Association of African Universities, has resolved to ensure that we use all the means available to us within our 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 programme is entitled 'African Universities against HIV/AIDS' (AAU, 2002).

### **Groups addressed by the toolkit**

- *The academic and administrative staff* (administrators and facilitators in the HIV/AIDS programmes).
- *The non-teaching staff* and particularly the group employees
- *The spouses and relatives of the staff* in the institutions particularly those living within the institutions.

Various staff members in the institutions are often as vulnerable as (if not more than) the students. Within the neighboring communities, they are looked at as people of a high class with good, stable and prestigious employment. This perception puts them at a great risk of HIV/AIDS infection they are targeted for love relationships. They need HIV/AIDS programmes that could empower them to cope with the challenges.

## **2. The Programme structures**

HIV and AIDS programmes are expected to both formal (incorporated within the structured academic schedules of the institutions) and informal (integrated into non-academic activities and programmes such as sports, entertainment, debates, etc). One of the challenges is that most institutions are accustomed more to the more formal and structured programmes. Such programmes are based on the pedagogical philosophy of learning. Higher institutions need to orient academic and non-academic staff to embrace the non-formal programmes alongside those that are structured as a way of addressing practical needs of communities. There is need to give more prominence to non-formal programmes that could benefit all sections of the institutions community. A detailed, discussion of edutainment is made to illustrates how multimedia could be central in the HIV/AIDS programmes. Edutainment could potentially be used for both formal academic and the nonconventional, non-academic HIV/AIDS programmes

### **Beneficiaries; structure of HIV/AIDS programmes**

<b>Target beneficiaries</b>	<b>Source/type of HIV/AIDS risk</b>	<b>Appropriate programming</b>	<b>Appropriate media</b>
Students	Financial: fees, living costs, etc: psycho-social; transitional issues	Mandatory foundation courses, HIV/AIDS integrated in existing courses: debates, quiz, edutainment	Exposition; classes, guest speakers, MDD, Institutional newspapers, institutional/nearby radio stations, online forums (facebook, etc), video shows, sports events
Academic staff	Community perception of staff Social status; students targeting academic favors	Debates, edutainment, public testimonies	Guest speakers, MDD, Institutional newspapers, institutional/nearby radio stations, online forums (facebook, etc), video shows, sports events
Administrative staff	As above	As above	As above
Support staff	As above	As above (in local languages)	MDD, Institutional newspapers, institutional/nearby radio stations, video shows, sports events
Spouses/families of all staff	Possible infection from spouses, promiscuous relationships,	As above (in local languages)	As above
Immediate	promiscuous	University-based	MDD, institutional/nearby radio

neighboring households	relationships,	Community service programmes,	stations, video shows, sports events
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### I. Why focus on HIV and AIDS?

Why should higher education institutions be involved in the fight against HIV and AID? Firstly, because we care; secondly, because it is clear that this epidemic affects all areas of our core business -teaching and learning, research and community engagement. Thirdly, because higher 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 and AIDS cannot rest only with our national governments. Together with our governments and external partners, higher education institutions can and must make a difference.

### 2. 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 and 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 and AIDS in the African higher 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 and AIDS policies and programmes in African higher education institutions.

### 3. What are the objectives of the Toolkit?

Firstly, this Toolkit is intended to mobilise the higher education community in Africa to make a difference in facing this new challenge, by developing a systematic response to HIV and AIDS. In practical terms, it should provide higher education leaders with the resources to advocate for greater awareness, greater commitment and planned responses in terms of prevention, mitigation and management at institutional level.

Secondly, the Toolkit is intended to provide the African higher education leader with the practical and intellectual tools that can be harnessed in developing, planning and managing a response to HIV and AIDS across all the core business areas of their institutions.

#### 4. Where does the idea originate?

The Toolkit stems from a number of sources within the African higher education community and the international higher education community. The AAU is responsible for drawing these strands together into one convenient resource pack.

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 and AIDS. This has usually taken 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 and AIDS more integral to the core business of tertiary education. Since 2001, the AAU has moved towards formalising its activities in the area of HIV/ AIDS. Firstly, WGHE provided support to the AAU's workshop for senior managers entitled SUMA in Cairo, which targeted African senior university managers and included a dedicated module on HIV and AIDS. At the same time, the AAU was awarded a grant to develop a five-year Core Programme and to develop an HIV/AIDS toolkit for further training of its members.

In 2002, ADEAWGHE provided institutional grants to four African institutions to develop and implement policy on HIV/AIDS. 'African Universities Against AIDS', the core statement that drives the AAU's response to the HIV and 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 this package.

#### 5. Role of the AAU

As a multi-lateral agency representing nearly 270 member institutions, the AAU has chosen a specific role in the fight against HIV and AIDS within the framework of a five-year core programme.

These include:

- working across the boundaries between higher education and other institutions (technical institutes, polytechnics, teacher training institutions);

- creating stronger linkages between African institutions and international partners - other higher education institutions, NGOs, governments and development partners and
- promoting higher education institutions as stronger national and local resources in the fight against HIV and AIDS.

## 6. Comparative Advantages

Over three decades, the AAU has developed comparative advantages that complement the role of national governments and create a synergy amongst international partners. These include:

- **Convening power**-the mandate to bring together the leadership of African higher education on a regular basis (COREVIP and General Assembly).
- **Access** -access to key decision makers in higher education and more broadly in the education sector.
- **Reach** -the AAU has the ability to bring together higher education institutions from North Africa, sub Saharan Africa, the Anglophone, Lusophone and Francophone communities under one umbrella.
- **Authority** -to speak with the collective voice of African higher education.
- **Partnerships** -experience in creating and managing partnership agreements between multi-lateral and bi-lateral institutions.
- **Networking** -an established network capability for the gathering and sharing of information across geographic, political, language and cultural borders.
- **Infrastructure** -a platform of well established organisational infrastructure and management capacity in information gathering and dissemination, programme development and management and the management of grants.

## 7. International Collaboration

The HIV/AIDS Toolkit is also the product of inputs and collaboration from many sources. It has been trialed 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, SAUVCA and HEAIDS. It draws on research and advocacy studies developed by many organisations 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.

## 8. Is the Toolkit based on a particular model?

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 the threat of HIV and AIDS cuts across institutional boundaries. More importantly, it affects the management systems upon which institutions depend for their daily operations as well as their long-term future.

What are some of these systems? Student support services (residences, prevention programmes and services, campus health services, counselling and psychosocial support), human resource planning and development (workplace policy for affected and infected staff, programmes to educate and support affected and infected staff) and student finance (bursaries, insurance, non-discrimination policy).

The AAU's call to action is not limited to universities. It is to the higher education community in Africa that is made up of a variety of institutional types (universities, teacher education colleges, technical institutes etc). The form and structure of these institutional types differ by country and history and the Toolkit's approach will therefore need to be adapted accordingly. The issue of where to locate HIV/AIDS and AIDS interventions should refer back to a fundamental question: where best can we locate the intervention within the structure and operations of the institution?

In the same vein, the context and regulatory environments within which higher education institutions operate, differs widely across the continent. These factors have a major impact on the roles which institutions fulfill in the education sector, the economy and the larger society. Many of the recommendations in this document, which depend on larger policy frameworks - usually set by government - will need to be synchronized with national policy. For example, if an institution promotes voluntary counselling and testing as a care and support strategy, it should ideally do so within the framework set by national or state policy objectives.

It should be said that there are other competing - and very compelling - approaches to addressing HIV and AIDS in higher education. For some institutions, research has proved to be their most relevant and effective way of contributing to the fight against HIV and AIDS. In other cases, African higher education institutions have provided a home for advocacy and human rights NGOs focusing on HIV and AIDS that have established global reputations for their work. Both approaches have a common theme that sets them apart from the approach in this Toolkit: they have an external focus. In contrast, this Toolkit is about developing a sound internally focused response to HIV/ AIDS. More importantly, its focus is on institutional leadership and its implications for the role of higher education within society.

## 9. The role of the trainer/focal person

The role of the trainer/focal person using this Toolkit has many dimensions. It can be used by an individual planning an intervention, or a trainer working with a project team or, a newly established institutional task team.

The Toolkit is designed for use by non-specialists and specialists alike, who are required to work in a capacity where they mobilize expertise (medical, legal, psychosocial) as part of a comprehensive response. This could be the newly designated HIV/ AIDS co-ordinator who is usually responsible for student services, and is now required to chair a Task Team, develop policy, initiate programmes, raise funding, conduct impact monitoring and a host of other tasks which are specific to HIV and AIDS.

Assuming responsibility for developing an institutional response to HIV and AIDS is not a small task. Neither is it free from difficulties. It demands leadership in a variety of different contexts where commitment, decisiveness, foresight and tenacity are all required. The simple act of breaking the silence about HIV and AIDS will in some cases unleash personal, political and cultural dynamics within the institution, which can be positive, negative, unwieldy and unforeseen. Whatever the response, as a trainer you have to prepare 'champions' who can carry a clear and informed message about the importance of the epidemic to higher education. This will involve addressing issues like 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 as well as those immediately affected by the epidemic.

## 10. Contextual responses

There is no simple, formulaic model that responds to the challenge that HIV and AIDS poses to each institution. There are good examples which tell us that the same intervention can often have very different impacts in different contexts. For example, the vice-chancellor of a large, urban teaching and research institution will have a very different task to the head of a small primarily rural teacher training college. Ideally, the Toolkit must be flexible enough to cater for both types of institutions.

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.

Use the Toolkit like a set of tools, each one individually or a number of them in combination to solve a problem.

The Toolkit has been developed with an awareness of the regional variations of the epidemic across the continent. Overall, West Africa could be characterised by 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 in 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 antenatal clinics. In East Africa, Uganda had shown the most compelling results because of social mobilization around HIV and AIDS and the levels of prevalence

declined from 21.1% in 1991 to 6.4% in 2001 (Low Beer and Stoneburner, 2003). However, the gains in reducing the prevalence have not been sustained. The current HIV/AIDS prevalence in Uganda rose from 6.4% in 2005 to 7.3 % 2012 and from 7.5% to 8.3% among women compared to 5-6.1% for men (2011 Uganda AIDS Indicator Survey (UAIS) report) <http://www.newvision.co.ug/news/632452-hiv-prevalence-rate-increases.html>

## II. Activity

Consider the roles of the focal person by reflecting on the personal dimensions of HIV and AIDS and your preparedness to deal with the disease as a public and professional issue. If you are working with a group, adapt this to a group exercise.

### Additional activities for participants

- I. What are some of the key issues when dealing with HIV and AIDS?
- II. Identify ways in which proper management of HIV/AIDS issues is likely to create opportunities for your institution in the following respects
  - Management processes
  - Quality of teaching
- III. Identify opportunities and challenges of HIV/AIDS programmes as they relate to the following categories of people in institutions
  - Academic staff
  - Non-academic staff,
  - Spouses and other relatives of staff
  - Students
  
  - Neighboring communities
- IV. Conduct a SWOT analysis of your institution with respect to institutional management HIV and AIDS (Strength weaknesses opportunities Threats)

### Suggested activities for facilitators

Analyse what the participants have identified as SWOT analysis; compare it with the following views about the centrality of higher education in HIV/AIDS management

#### *Opportunities and strength*

- I. The institutions are in position to influence and shape debate, action and policy with regard to HIV and AIDS at various levels; local, institutional, regional and societal global
- II. The cream of the country (with regards to manpower and human resource) is prepared by the institutions. These products could be empowered to influence the societies which they serve.
- III. The members of the communities respect the products and will be most likely to listen to them. In essence, products of the institutions could provide leadership in terms of critical debate, policy development and research;

- IV. The institutions have facilities and personnel that can perform medical and social research to generate new knowledge needed for dealing effectively with HIV and AIDS; they also have facilities to disseminate the knowledge effectively

Weaknesses (and threats)

- I. Some of the institutions may lack effective monitoring procedures and surveillance systems; in essence, they may not have accurate and efficient data storage and retrieval systems on impacts of HIV on institutional staff and students (Nzioka, 2006).
- II. Inability to address socio-cultural constraints that rotate around HIV/AIDS such as stigma, denial, silence etc
- III. Fragmented nature of HIV/AIDS management within the institutions; lack of interdepartmental collaborations and multi-disciplinary integrations; the lack of 'holistic approach', reduces the capacity to develop, implement and evaluate programmes effectiveness;
- IV. Lack of incentives and inspirations to motivate the few individuals and groups within the institutions who use personal resources and time to work on HIV/ AIDS projects
- V. Absence of any formally recognised actions and absence of policies in some institutions on HIV and AIDS
- VI. Lack of comprehensiveness: Focus on some aspects of HIV/ AIDS and neglect of others (either on prevention, treatment care, etc)
- VII. Other weaknesses or threats:

Examining the role of higher institutions of learning in the management of HIV/AIDS programmes calls for a critical analysis of traditional functions, structures and modes of operations of higher education institutions. In this way it would be possible to determine opportunities and limitations that are likely to be experienced in introducing HIV/AIDS programmes. The following are some of the salient features of Tertiary or higher education institutions (and universities in particular);

- I. Predominance of theory-based academic programmes
- II. Requirement for advanced skills for research programmes and professions
- III. Prominence of advanced study and original research leading to high research qualifications (UNESCO, 2005: 397)
- IV. Transmission (mainly through conventional teaching and research) of accumulated knowledge relevant to development through teaching (UNESCO, 2006)
- V. Undertaking research to generate knowledge by which the frontiers of knowledge could be extended;
- VI. Disseminating and preserving accumulated knowledge through print and digital processes
- VII. Conducting extension, advisory and consultancy services to the local, national, regional and global communities

Activity for all

Which of the above features are likely to contribute dynamically to HIV/AIDS programmes and which are likely to be limiting attributes?

## OBJECTIVES

Trainers and users can use the Toolkit effectively as a framework for scoping, planning, designing and implementing HIV and AIDS interventions.

### The Challenge

What makes a specific response necessary and different in tertiary education? The findings below 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 and AIDS (Chetty, 2000, Jolly, 2001, Anarfi, 2000, Nzioka, 2000, Magombo, 2000).

- Evidence is growing that students, staff and communities linked to tertiary institutions are showing the impacts of HIV and AIDS to varying degrees -either because of being infected or affected. Cohorts of young people born with HIV/AIDS are now at university levels and beyond. Some of them could be virgins (with all the innocence). They have a right to love and reproduction. Existing educational and psycho-social interventions need to address these developments. Efforts need to be made to ensure that HIV/AIDS awareness and educational programmes prepare the young people to meet these challenges.
- There are a range of different responses within higher education that address HIV and 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.
- Higher 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 behaviour that is common amongst young adults in residential campus settings (alcohol abuse, drug use, low quality housing, sexual abuse etc.)
- Modern HIV treatment enables people to live with HIV unnoticed. This implies that the concept of impact changes with time (appearances may not be relied upon)
- Sexually\_active students: In many African countries, students join Universities from Single-sex high schools. They come to mix with students of opposite sex for the first time at the university. There are no formal programmes that orient these students to cope up with the new developments. This creates a fertile ground for the boys and girls to be sexually exploited by the continuing students or by the communities around the university. Equally, many students who have lived almost their entire life in villages come to live at the urban university environment for the first time. The change of living condition and lifestyle is potentially a fertile ground for spread of HIV and AIDS

- 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.
- Institutions of higher learning ought to consider making some courses (for example *Basic elements of health*) mandatory during the first year; HIV/AIDS and other health concepts could be addressed to all students).
- 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. Participation in non-formal prevention interventions could be promoted through systematic use of attractive social, economic or academic incentives. Students-led organisations could be encouraged to develop their own programmes which should be supported by the administrations. Universities could develop collaborations with companies which may support interventions through the framework of Corporate Social Responsibility)
- Not all institutional managers are convinced of the role they are expected to play in the fight against HIV and 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 mobilise 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 higher 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 and AIDS, and most importantly, it presents practical ways for achieving comprehensive responses.

The following factors need more attention; it is imperative to determine the extent to which the factors could hinder the successful development of institutional based HIV and AIDS initiatives:

Lack of trained personnel and lack of formal structures

The challenge of HIV/AIDS is unprecedented, very sophisticated and diverse. By the time it surfaced, various professionals and institutional managers were not technically prepared for it. This is illustrated as follows:

1. For many generations, the focus of many educational institutions has been on the cognitive (typically academic; theoretical) and psychomotor (practical) domains of learning. Dealing with HIV/AIDS effectively revolves around behavioral change and entail a big focus on the affective domains of learning. Developing objectives, content,

learning experiences, monitoring and evaluations in the affective domains of learning is not a preserve of many academicians and trainers (see in the appendix, a

2. Many Institutions of higher learning could be lacking the structures and facilities needed to engage meaningfully in behavioral change programmes. The necessary facilities may include those needed for educational entertainment (such as theatres for artistic performances), films/video facilities, etc. with regard to personnel; it may call for collaborative engagement of various professionals (and existence of administrative structures that bring them together)
3. A number of institutions of learning have crowded academic programmes which may make it difficult to support HIV/programmes (which by their nature require a lot of time in planning and implement).

In summary, filling the gaps in the availability of trained personnel means that:

- Designs of the training have to be modified and improved
- Innovative administrative and training structures have to be provided
- Plans are made to make optimum use of non-academic time (such as the evening). This means that training materials will have to be built within an edutainment mode to maintain the interest and participation of the various target audiences.

#### I. How to Use this Toolkit

Firstly, this HIV/AIDS Toolkit provides a framework and a process within which you and your organisation are able to do the following:

- **Assessment:** Analyse the nature and extent of the problem confronting your institution and its constituencies.
- **Planning:** Decide on which policy objectives and programmes to pursue.
- **Design:** Plan and develop an HIV and AIDS intervention that meets the objectives you have identified.
- **Implementation:** Move from policy and planning to action.
- **Monitoring:** Now that your implementation is in line with the agreed plans.
- **Evaluation:** Assess whether the strategy and interventions are working.

Secondly, this Toolkit also provides information and tools which a manager requires at each step in the process 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.

If this document does not cover all the aspects you need to know, you are encouraged to use the network that the Association of African Universities provides along with its national level counterparts (<http://www.aau.org>). The AAU offers access to nearly 270 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 and AIDS.

Thirdly, the structure of this document is organised in line with the core business areas of higher education institutions (teaching and learning, research, management, 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 and AIDS affects them.

Icons have been used at points in the document to emphasize issues. Some of these are indicated below:

Management Issues	Student Services
Occupational Health	Gender Issues
Human Resource Issues	Important Points

## 2. Who should use this document?

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 organisation 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 higher education institutions.

Few organisations 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 behaviour, makes it imperative for organisations to not only raise awareness, but also to actively promote policies and procedures which assist students, employees, staff, management and other community stakeholders to combat the epidemic. Active management of HIV and 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 organisation.

It is important to be prepared for resistance and anxiety about HIV and AIDS. Unless their disciplines are in some way impacted upon by HIV and AIDS, many academics will ask 'is this my responsibility'. Making them share the responsibility for responding to HIV and AIDS will also require attention. The point to stress is 'shared responsibility' because even if they are unable to address the complexities of the disease with their students, they have a responsibility to make the knowledge available.

## 3. Basic Facts about HIV/AIDS

This section presents some of the basic facts which you need to have for quick reference. As a trainer, you are expected to be confident about providing the essential information about HIV

and AIDS but there is no way of being totally up to date with every aspect of the HIV/AIDS epidemic. Wherever possible, use the support of a trained health professional in dealing with more complex medical issues. It is important that whatever information you communicate is clear, unambiguous and supported by evidence from a medical standpoint.

### **What is HIV and AIDS?**

HIV/AIDS stands for Human Immunodeficiency Virus. In 1983, HIV was found to be the cause of the Acquired Immune Deficiency Syndrome (AIDS). It is as yet unclear where the virus comes from or why it appeared.

However, it is possible to determine the reasons for the rapid spread of the HI Virus:

- The movement and migration of people across long distances.
- Socio-economic instability.
- Sexual activity.
- Other sexually transmitted infections (STIs).
- Intravenous drug use.

HIV attacks and slowly destroys the immune system by entering and destroying important cells that control and support the immune response system. These important cells are called the CD4 or T4 cells.

After a long period of infection, usually 3-7 years, enough of the immune cells have been destroyed to lead to immune deficiency. When a person is immune-deficient the body has difficulty in defending itself against many infections and certain cancers.

### **How is HIV transmitted?**

For HIV to be transmitted from one person to another, there must be an exit point for the virus to pass out of the infected person and an entry point into the body of the uninfected person. Exit and entry points for the virus exist where the skin is not intact and body fluids such as blood and sexual fluids can enter through this break in the skin.

### **There are 3 ways in which HIV is transmitted:**

- By sexual contact;
- When infected blood is passed directly into the body or
- From an infected mother to her child during pregnancy, childbirth or breastfeeding.

There is no risk of HIV transmission through casual contact between workers, staff and students. This includes sharing lecture rooms and other facilities, shaking hands etc.

### **When does a person have AIDS?**

A person is described as having AIDS when the immune deficiency caused by HIV is so severe that various life-threatening infections and/or cancers occur. These infections are called "opportunistic diseases" because they take the opportunity to invade the body which is provided by the weakened immune system.

HIV versus AIDS: HIV stands for the Human Immuno-deficiency Virus the virus which causes AIDS. AIDS is the phase of HIV infection when the person becomes sick. The virus can be present in the body for several years before the person starts to become sick.

After a person has been infected with HIV, it takes 2-12 weeks for the immune system to develop antibodies which can be detected in the bloodstream. This is called the window period. These antibodies are not able to overcome or destroy the virus. It is these antibodies that form the basis of the HIV antibody blood test used in diagnosing whether a person has HIV. If a person is tested for HIV during the window period, the virus will NOT be detectable and the person will test negative, when he/she is really positive. This is known as a false negative result.

The stages through a person infected with HIV progresses can be summarised as follows:

- Stage 1: HIV infection**
- Stage 2: Window Period**
- Stage 3: Seroconversion**
- Stage 4: Asymptomatic HIV Infection**
- Stage 5: Related Illnesses**
- Stage 6: AIDS**

For more detailed information on the medical and physiological issues that arise at each stage, please consult the list of website links at the end of this Toolkit.

### **Data and information**

The range of data available on the prevalence of HIV and AIDS is huge and ever changing. For up to date information, you are advised to consult with your national AIDS council, reliable local NGOs or the Ministry of Health. International agencies also provide ready sources of information but at a nationally aggregated level. These include UNAIDS, WHO and various others for which contact details are listed in the References and Links section.

Data is an essential part of understanding the HIV/AIDS epidemic and planning a response. To date, there have been no reliable or comprehensive seroprevalence studies specific to higher education institutions based on actual test data. At best, a few institutions have conducted demographic modelling exercises which have yielded possible scenarios. For present purposes, the tables in the References section provide a quick snapshot of recent data on global and African trends.

#### **4. How is this Toolkit organised?**

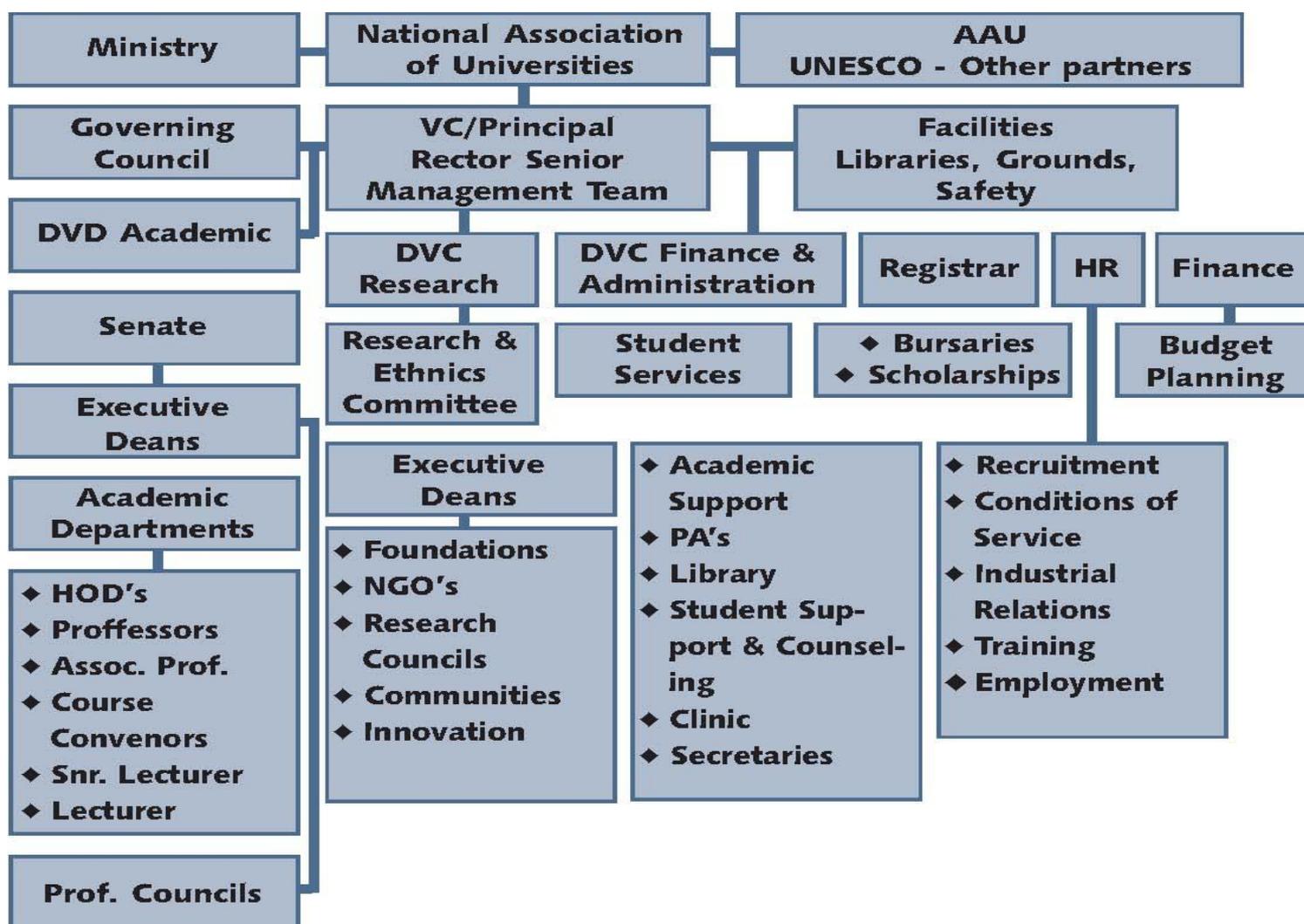
This document is organised into 10 modules, of which most correspond to the core business of higher education institutions: teaching and learning, research and community engagement. Of these 10 modules, those on the management implications of HIV and AIDS are the most detailed, demanding and time consuming because of the scope of portfolios captured under that heading at institutional level. Some parts of the Toolkit, like the module on monitoring and evaluation, can be used generically. Activities, sometimes focused around examples or case studies, are included at key stages in the Toolkit.

A range of links and other resources are listed in the final modules which are far from exhaustive and will need to be updated regularly.

### 5. Activity

- Consider how the organogram below relates to the structure and operations of your own institution.
- Will you need a structure to manage HIV and AIDS and where should it be located?
- Try to locate where HIV/AIDS interventions will be and how they will be implemented.

The example is based on the structure of a large teaching and research institution and is provided as a focus for discussion. This is not intended as a template.  
Institutional structure - university example





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2. Links ACMC, Association of Canadian Medical Colleges, [www.acmc.ca](http://www.acmc.ca) ACU, Association of Commonwealth Universities, [www.acu.ac.uk](http://www.acu.ac.uk) AEGIS, [www.aegis.org](http://www.aegis.org) AF-AIDS, [www.af-aids.org](http://www.af-aids.org) AFRICASO, African Council of AIDS Service Organisations, [www.enda.sn/africaso.org](http://www.enda.sn/africaso.org) AVERT, [www.avert.org](http://www.avert.org) HEARD, [www.und.ac.za/und/heard](http://www.und.ac.za/und/heard) Higher Education HIV/AIDS (South Africa), [www.heaids.ac.za](http://www.heaids.ac.za) HIV INSITE, University of California San Francisco, <http://hivinsite.ucsf.edu> IIEP/UNESCO HIV/AIDS Impact on Education Clearinghouse <http://www.unesco.org/iiep> or [hiv-aids-clearinghouse@iiep.unesco.org](mailto:hiv-aids-clearinghouse@iiep.unesco.org) KIT, Royal Tropical Institute, [www.kit.nl](http://www.kit.nl) SYNERGY Project, [www.synergyaids.com](http://www.synergyaids.com) UNAIDS, Joint United Nations Programme on AIDS, [www.unaids.org](http://www.unaids.org) UNESCAP, UN Social Development Information on the Internet, [www.unescap.org](http://www.unescap.org)

3. Data Users are encouraged to obtain the most current data on prevalence and other

indicators from [www.unaids.org](http://www.unaids.org)

#### 4. Resource Persons

Ms Alice Lamptey, Association African of Universities, [alamptey@aau.org](mailto:alamptey@aau.org)  
Ms Barbara Michel, South African Association of Universities Vice-Chancellors Association, [barbara@sauvca.org.za](mailto:barbara@sauvca.org.za) or [info@heaid.ac.za](mailto:info@heaid.ac.za)  
Ms Lynne Sergeant, IIEP/UNESCO HIV/AIDS Impact on Education Clearinghouse, [l.sergeant@iiep.unesco.org](mailto:l.sergeant@iiep.unesco.org)  
Prof Michael Kelly, Member: Mobile Task Team on the Impact of HIV/AIDS in Education, [mjkelly@zamnet.zm](mailto:mjkelly@zamnet.zm)  
Dhianaraj Chetty, Member: Mobile Task Team on the Impact of HIV/AIDS in Education, [chettyd@iafrica.com](mailto:chettyd@iafrica.com)

#### 5. Resource Documents

Examples of institutional policies and course outlines with HIV/AIDS content have proved to be the much needed and valuable in developing HIV/AIDS responses. Due to limitations of space, only one of each type is reproduced here.

Example: Teacher Education Course University of Botswana Source: [www.ub.bw](http://www.ub.bw)

**Duration: Entry Requirements: Course Structure:**

##### **Year 1:**

##### **Year 2: BEd Primary Education**

4 Years

Applicants must have:

- a) At least three credits in the Botswana General Certificate of Secondary Education (BGCSE) or its equivalent
- b) Primary Teacher's Certificate (PTC), and
- c) Two years experience as a Primary School Teacher or a Primary Teacher Training Tutor or an Education Officer (Primary)

• Students who do not have BGCSE or equivalent but have Junior Certificate (JC) in addition to (b) and (c) above shall apply through the Mature Age Entry Scheme as in General Regulation 00.52.

• Applicants with a diploma in Primary Education of this university or equivalent qualification approved by Senate will enter at Year 2 of the degree programme.

##### LEVEL 100

Semester 1 EPA11 Introduction to Educational Planning (3 Credits) EPA 112 Introduction to Resources Management (3 Credits) MGT 100 Principles of Management (3 Credits)

Semester 2 EPE 114 Introduction to Education in Botswana (3 Credits) EFP110 Introduction to Educational Psychology (3 Credits) EFA 200 Managing Quality Schools (3 Credits)

Optional Courses (one of the following per semester):

BNS 205 The Teacher and the Health Care System (3 Credits)

EFM 110 Communication and Technology in Education (3 Credits) EFH 110 Introduction to the History of Education (3 Credits)

LEVEL 200

Semester 1 EPA 200 Personnel Policies and Decision Making (3 Credits) EPI 226  
Principles of Guidance and Counselling (3 Credits)

**Year  
2:**

**Year 4:**

EPA 201 Classroom Management (3 Credits)  
Semester 2 EPA 202 Managing Educational  
Resources (3 Credits) EPA 203 Theories of  
Leadership and Supervision (3 Credits) EPA 204  
Introduction to Investigation in Education (3  
Credits)  
Optional Courses (one of the following per  
semester):

**Year  
3:**

EPI 227 Practice of Guidance & Counselling (3  
Credits) EFS101 Introduction to Exceptional  
Children (3 Credits) EPE217 Human Growth and  
Development of Primary School

Children (3 Credits) EPI 224 Foundations of  
Environmental Education (3 Credits) EDT 310  
Instructional Materials for Primary Schools (3  
Credits)

LEVEL 300

Semester 1 EPA 304 Advanced Investigation in  
Education (3 Credits) EFH410 Philosophy of  
Education (3 Credits) EPA 301 Leadership  
Styles and Organizational Behaviour (3

Credits) Semester 2 EPA 300 Action Research in  
Education (3 Credits) MGT 200 Organizational  
Design and Development (3 Credits) EPA 303  
Planning and Management in Education (3  
Credits)

Optional Courses (one of the following per  
semester):

EPE 316 Assessment in Schools (3 Credits)  
EFS 203 Education of Students with Learning  
Disabilities/ difficulties (3 Credits) EPI 333  
Remediation in Lower Grades (3 Credits) EPI  
333 Remediation in Upper Grades (3 Credits)  
EDT 310 Instructional Materials for Primary  
Schools (3 Credits)

LEVEL 400

Semester 1 EPE 442 Research Project (3  
Credits) EPA 400 Staff Development in

Eduat (3 Credits) MGT 406 Negotiation and Conflict  
ation Management (3 Credits)  
for Higher Education Institutions in Africa

**Year 4:**

**Year 5:**

EPA 402 Contemporary Issues in Education Management (e.g. HIV/AIDS, Sexual Abuse, Access, Equity, Gender) (3 Credits) Semester 2

EFS 411 Educational Policy and Administration (3 Credits) EPE 411 Educational Management and Curriculum Development (3 Credits)

MGT 406 Negotiation and Conflict Management (3 Credits) EPE 419 Computer Applications in Primary schools (2 Credits)

Optional Courses (one of the following per semester):

EFH 420 Teacher Education (3 Credits)

EPI 414 The Management of Early Childhood Programmes (3 Credits) EPE 316 Assessment in Primary Schools (3 Credits) EDT 310 Instructional Materials for Primary Schools (3 Credits)

**ASSESSMENT**

All courses except EPA 304 and EPE 442 shall be assessed as stipulated in general regulation 00.8.

EPA 304 and EPE 442 assessments shall be based on the research proposal and the research report respectively without an examination.

**Progression from Semester to Semester**

- At the end of each semester the Grade Point Average (GPA) shall be calculated on the basis of the total weighted scores divided by the number of credits.
- Cumulative Grade point Average (CGPA) is calculated as per General Regulation 00.86
- Retaking and Probation shall be considered as per General, Regulation 00.92 and 00.93

**Award of the Degree**

- In order to be awarded a degree, a student shall have accumulated a minimum number of 120 credits at the end of the programme as stipulated in General Regulation 00.851 and 00.852

**ED 20.80-Degree Classification**

The degree of the Bachelor's of education (Primary) shall be classified in accordance with general regulation 20.4.

## UNIVERSITY OF NAMIBIA

### **POLICY ON HIV/AIDS (abridged)**

Full text available at [www.unam.na](http://www.unam.na)

#### **1. CONTEXT**

##### **1.1 Introduction**

In less than a decade, HIV/AIDS has emerged as a leading cause of death in Namibia. The UNDP has identified the disease as a major national development challenge. The country ranks third in the SADC region in terms of HIV/AIDS infection, third in the world per population and seventh in Africa. One in five Namibians, aged between 15-49, are infected with the virus and are expected to die within the next seven years. The country has a growing population of AIDS orphans. Clearly, the HIV/AIDS pandemic has far-reaching socioeconomic impact, particularly in the health, education and employment sectors as well as for the national fiscus. The impact of HIV/AIDS in the education sector in Namibia is only beginning to be researched and is one which requires urgent research attention.

This Policy has been drafted by an ad hoc Senate committee on HIV/AIDS and has been widely discussed with experts within and without the University. The current policy guidelines of the University of Namibia (UNAM) on HIV/AIDS were drafted in September 1997 and approved by Senate in that year. In the four years since while UNAM's 1997 policy guidelines provided a basis for action, the country and the region have seen a massive escalation in the HIV/AIDS pandemic. The 1997 guidelines do not promote a coherent focus on HIV/AIDS across the curriculum and in all faculties and are not informed by a strategic work plan. Accordingly, Senate decided that an integrated and more coordinated policy be developed.

Senate mandated this ad hoc committee to review and recast existing policy guidelines.

The purpose of this policy is to provide a framework of information and action that will guide the University community to develop an adequate response to HIV/AIDS. As such, this policy framework commits UNAM to mitigate the impact of the disease on the University community and their dependents, as well as on the wider community through its community service remit. It is inevitable that the HIV/AIDS pandemic will have a profound effect on student recruitment and enrolment, both directly and indirectly. Accordingly this policy is intended to provide an institutional response to both the national, as well as personal challenges that the HIV/AIDS pandemic poses.

##### **1.2 National Policy Response**

The University's HIV/AIDS Policy supports the National Strategic Plan on HIV/AIDS Medium Term Plan II 1999-2004 and the recent Namibian HIV/AIDS Charter of Rights. The Human Rights provisions contained in the Constitution of the Republic of Namibia provide the overall normative framework for policy.

Other policies that influenced this Policy include, among others, the Labour Act No. 6 of 1992 and the National Gender Policy of 1999. The University recognises that there is an undeniable link between human rights and public health in the context of HIV/AIDS. One aspect of the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection. In particular, people will not seek HIV-related counseling, testing, treatment and support if this would mean discrimination, lack of confidentiality and other negative consequences. Therefore, it is evident that coercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support. The protection and promotion of human rights are thus necessary both to the protection of the inherent dignity of persons affected by HIV/AIDS and to the achievement of public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV/AIDS on those affected and empowering individuals and communities to respond to HIV/AIDS.

### **1.3 The University Response**

A 1999 study conducted by UNAM, showed that over half of entering students are sexually active; the frequency of students' sexual activity increased over the course of their studies at UNAM. For this reason, among many, it is imperative the University develops a response to the HIV/AIDS pandemic for three principal reasons.

- (1) The University is the principal agency for the development of high-level human resources to the nation. UNAM has a responsibility to build high-level research capacity relevant to all areas of national development.
- (2) The nature of the university community with its diverse membership and strategic national importance.
- (3) Leadership: through this policy the University will provide leadership in teaching, research, and community engagement on HIV/AIDS and its impact. The University can also provide leadership in promoting a human rights based approach to HIV/AIDS in Namibia.

Community involvement lies at the heart of this policy and is key to its overall success.

## **2. PREAMBLE**

Recognising that Namibia is currently experiencing a devastating HIV/AIDS pandemic and is striving, as an institution of higher learning, to be socially engaged;

And further acknowledging the relevant provisions of the Constitution of the Republic of Namibia, the Namibian HIV/AIDS Charter of Rights, the National Gender Policy, the Labour Act of 1992, the National Policy on Population and Sustainable Development;

And further accepting the importance of addressing stigma on the basis of HIV/AIDS and the need to promote a human rights based approach to HIV/AIDS;

And further recognising that a 1999 study revealed that over half of entering students are sexually active and that the rate of students' sexual activity increased over the course of their University career;

Therefore the University is committed to playing its full part with other sectional, regional and international partners in mitigating the impact of HIV/AIDS, both on its internal constituency of staff

and students and on the Namibian society.

The University will aim to achieve this by integrating HIV/AIDS into its teaching, research, and community service, the components of which are outlined in this policy.

In achieving the above, the University hopes to build a caring and socially-engaged community based on the integrity of, and respect for, the human person.

The University is guided by the following norms and values as the bedrock of this policy:

- “Create awareness among the University community through giving health information in the prevention of HIV/AIDS as a killer disease.”
- People living with HIV/AIDS will not be discriminated against in obtaining access to education, scholarships, accommodation, employment and accompanying employment benefit at the University;
- People living with HIV/AIDS are guaranteed equal protection under the law;
- People living with HIV/AIDS have the right to dignity, respect, and privacy concerning their HIV/AIDS status;
- Voluntary and confidential rapid testing (on and off campus in Windhoek and Oshakati) and counselling for persons with HIV/AIDS should be encouraged;
- HIV/AIDS has to be understood and addressed in its social context that includes gender power relations, sexual violence against women and children and changing values and meanings around sexuality;
- The University has an obligation to provide access to information, prevention, care and support services for students, staff, and their dependents infected and affected by HIV/ AIDS. Staff and students are encouraged to seek this information and these services;
  - The University must create a learning and working environment that is supportive, sensitive, and responsive to employees, students, and their dependents with HIV/AIDS.

The University does not have an obligation to accommodate employees and students who “refuse to work with, study with, or be housed with other employees or students living with HIV/AIDS”.

### **3. POLICY COMPONENTS**

This policy has four principle components:

- 1 Rights and responsibilities of staff and students affected and infected by HIV/AIDS.
- 2 Integration of HIV/AIDS into teaching, research and service activities of all University faculties, centres and units.
- 3 Provision of preventive, care and support services on campus.
- 4 Implementation of policy: structures, procedures, monitoring and review.

#### **3.1 Rights and Responsibilities of Staff and Students Infected and Affected by HIV/AIDS**

### **3.1.1 Rights of Staff**

- 1 No employee or applicant for employment at the University shall be required to undergo an HIV test, or disclose his or her HIV/AIDS status.
- 2 The University acknowledges that HIV status is not on its own an indication of fitness for employment. The University shall thus not use the HIV/AIDS status to deny an employment contract or refuse to renew a contract. UNAM shall actively promote the GIPA (Gender Involvement of People Living with AIDS) principles of UNAIDS.
- 3 HIV/AIDS status shall not be used as a criterion in human resource development, including promotion and training.
- 4 Employment shall not be terminated on the grounds of HIV/AIDS status. HIV/AIDS status shall not be used to influence retrenchment or retirement decisions on grounds of ill health, unless a member of staff is no longer physically or mentally fit to continue his/ her work.
- 5 HIV/AIDS status shall not be reflected in the personal files of employees.
- 6 The HIV/AIDS status of employees shall not be disclosed without the informed consent of the employee concerned.
- 7 While the University practices non-discrimination with respect to its employees' HIV/ AIDS status, it recognises that the practices of parties external to the University (i.e., medical schemes, provident and pension funds) are not entirely within its control. The University, however, shall endeavour to negotiate with benefit providers for equal and non-discriminatory benefits.
- 8 Employees have a right to a supportive and safe working environment in which persons with HIV/AIDS are accepted and not stigmatised.
- 9 Employees have a right to know of possible risks of occupational exposure to HIV in their working environments.
- 10 The University endeavors to provide a working environment in which the occupational exposure to HIV is minimized, and will provide the necessary protective equipment. In addition to providing the necessary protective equipment, staff will be taught how to use it and will be educated in general on the use of universal precautions.

### **3.1.2 Rights of Students**

- 1 No prospective student at the University shall be required to undergo an HIV test, or disclose his or her HIV/AIDS status prior to admission.
- 2 No student at the University shall be required to undergo an HIV test, or disclose his or her HIV/AIDS status.
- 3 The University shall not use HIV/AIDS status in considering the granting of loans, bursaries and scholarships. The University shall actively promote the GIPA (Greater Involvement of People Living with AIDS) principles as announced by UNAIDS.
- 4 The University shall not use HIV/AIDS status in determining admission to residence on campus.
- 5 Students' registration shall not be terminated on the grounds of their HIV/AIDS status, unless the student is no longer physically or mentally fit to continue his/her studies.
- 6 The results of HIV tests conducted at University medical facilities will remain confidential between the student and the person authorised to give the result.
- 7 The HIV/AIDS status of a student shall not be disclosed without the informed consent of the person concerned.
- 8 Students have a right to a supportive and safe learning and working environment in which persons with HIV/AIDS are accepted and not stigmatised.
- 9 The University endeavors to provide a working environment in which the occupational exposure to HIV is minimized, and will provide the necessary protective equipment.

### **3.1.3 Responsibilities of Staff and Students**

- 1 Everyone has an individual responsibility to protect herself/himself against infection. Students and staff 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.
- 2 Medical and science professionals and students who are living with HIV/AIDS have an obligation to choose professional paths that eliminate the risk of transmission to their patients and colleagues.
- 3 Staff and students have a responsibility not to discriminate against and stigmatise members of the University community living with HIV/AIDS.
- 4 "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".

## **3.2 Integration of HIV/AIDS into teaching, research and service activities of all Faculties**

### **3.2.1 Teaching**

UNAM will encourage and support efforts by faculties to incorporate aspects of HIV/AIDS and human rights into curricula, where possible.

The University will provide a compulsory core curriculum on HIV/AIDS, for all undergraduate students. The curriculum will include historical, epidemiological, health and legal and prevention/home based care aspects of HIV/AIDS.

Finally, the University will offer several short courses on HIV/AIDS for senior and mid-level academic and administrative management, as well as for student leaders. One such course will focus on HIV/AIDS in the workplace, including protection, performance management, and legal issues. Short courses in a variety of subjects will be offered, and may, whenever the need arises, be offered to the community, through appropriate centres, departments and faculties.

### **3.2.2 Research**

UNAM will provide leadership on HIV/AIDS through research. The University will use research to inform its policy, teaching, community service, and endeavour to influence developments related to the cure of HIV/AIDS.

Faculties and the Multidisciplinary Research and Consultancy Centre (MRCC) will develop research projects related to HIV/AIDS. The Research and Publications Committee will consider such proposals for funding.

The University commits itself to provide human and financial resources in support of HIV/ AIDS research.

### **3.2.3 Community Service**

The University commits itself to collaborate with the community in training and research on HIV/AIDS. It is essential that there is full community participation in the HIV/AIDS programme and that there is a good flow of support between the University and various communities and community structures. The University will share its experience of best practice and, where practicable, its skills and resources with NGO's and CBOs.

## **3.3 PROVISION OF UNIVERSITY PREVENTION AND SUPPORTS SERVICES FOR HIV/AIDS**

### **3.3.1 Awareness and Prevention**

The University has a duty to educate and inform its members about HIV/AIDS. Appropriate information on all aspects of prevention and care will be made accessible to staff and students. In addition to teaching and research activities, strategies to prevent the spread of HIV/AIDS on campus include:

- Making condoms available throughout campus and in student residences.
- Encouraging responsible sexual behaviour inclusive of abstinence.
- Distributing literature on HIV/AIDS.
- Sponsoring public fora (i.e. dramas, discussions, debates, etc.) on HIV/AIDS.
- Training HIV/AIDS peer educators and counsellors.
- Increasing awareness about sexually transmitted diseases (STDs) and their treatment.
- Acting against sexual harassment of women and child abuse.

### **3.3.2 Counselling, Care and Support**

Staff and students will have access to confidential counselling services on campus. WHO Guidelines on Counselling apply. Peer counsellors and support groups will be available for students and staff affected and infected with HIV/AIDS.

The University will also provide referral services for students and staff and advise on nutritional care to students and staff.

The University will explore the possibility of providing home-based care, including basic nursing care, counselling of the patient and significant others, and training of care givers. Accidental/occupational exposure to HIV is covered under the guidelines for dealing with accidental exposure.

#### **4. POLICY IMPLEMENTATION AND REVIEW**

The overall responsibility for implementing this HIV/AIDS Policy lies with the senior management of UNAM. This includes the Vice Chancellor, Pro-Vice Chancellors, members of the management advisory committee, deans of faculties, centre directors, heads of departments and units, the Student Representative Council (SRC), and the University HIV/ AIDS Task Force.

The University will appoint an officer at the level of a dean who will be responsible for policy coordination and oversight. This officer will chair an implementation committee, comprising of staff and students and will report directly to the Pro-Vice Chancellor Academic and Research. The committee's functions will include:

- Disseminating and coordinating the HIV/AIDS policy throughout the University;
- Organising regular consultative meetings with the University community about matters related to HIV/AIDS;
- Establishing and implementing a system of policy monitoring and evaluation;
- Collaborating with the community and other tertiary institutions and stakeholders.

The University will establish an appropriate budget line for the implementation of this policy.

A strategic work plan will guide the implementation of this policy. This policy will be subjected to regular review and appraisal.

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## NOTES

1. This formulation comes from the University of Witwatersrand proposed Draft HIV/ AIDS Policy, August 200, p.1;
2. A similar provision exists in the HIV/AIDS Policy of University of the Western Cape, (UWC), South Africa, October 2000, pp.1-18;
3. University of Witwatersrand proposed Draft HIV/AIDS Policy, August 2000, pp.1-2.
4. Medical schemes registered in Namibia, all provide for claims against prescribed drugs for the treatment of HIV/AIDS (such as ante-retroviral drugs) as well as for hospitalisation. Namibia Medical Care Administrators administers medicine for HIV/AIDS under a confidential in-house code. A member claims against an HIV/ AIDS benefit. For this purpose he/she has to complete a special application and declare his/her HIV status to the service provider. Information on a member's HIV/AIDS status is treated as confidential and apart from the member, is only disclosed (with consent) to the person who administers the medication. Most medical schemes, such as "Prosperity Health" cover medication for HIV/AIDS subject to the limits specified under the different membership categories.
5. This formulation comes from the University of Witwatersrand Draft HIV/AIDS Policy, August 2000, p.4.

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[<http://www.uhs.harvard.edu/COOIS>] Harvard Student Peer Counselling

## **Module one**

### **Management**

#### **OBJECTIVES**

- Institutional leaders show visible commitment to fighting HIV and AIDS.
- HIV and AIDS are accepted as a priority issue amongst academics, students, managers and non-teaching staff
- Strategic plans for a comprehensive response and implementing structures are designed and established.
- Policies and programmes responding to HIV and AIDS are developed and implemented (e.g. HIV and AIDS literacy for all academic and support staff, workplace policy and procedures).
- Institutional and external resources are mobilized towards implementing strategic plans.
- Essential capacity and services for prevention (a campus clinic, education campaigns, materials, counselling, VCT), treatment (STIs and opportunistic infections), care and support exist.
- Institutional leaders involve diverse stakeholders in the initiation, design, implementation, monitoring and evaluation of HIV/AIDS initiatives

Management is the most complex area of core business in higher education and requires a skilled balance of priorities that cut across institutional structures, people management (staff and students) and institutional arrangements internally and externally. Successful management and operations are key to the success of teaching and learning, research and community engagement.

#### 1.1 Context

Management in higher education includes many of the following key functions:

- policy making and strategy (institutional policy, academic affairs, stakeholder management, partnerships, resource mobilisation, resource allocation etc.);
- human resources (staffing, recruitment, employment equity, workplace policies, work place programmes, training and capacity development, industrial relations);
- finance (budgeting, planning, pensions, health insurance, housing);
- student services (residences, student health service, recruitment, admissions, counselling, bursaries) and
- support services (facilities, IT, security, libraries and information services).

All of these functions are identified in the organogram presented in Module 2 and the role of trainers will be to identify how best to integrate HIV/AIDS interventions at all levels.

#### **Capacity Building**

Some general points about capacity building are worth noting at this point. Capacity building for management will have to work within, and against, a number of key challenges:

- HIV/AIDS cuts across institutions it is transversal and therefore requires a more integrated approach by institutions and between institutions.

- There are widely differing modalities of intervention each of which requires differing resources and capacity. For example, in a context where the institutional research culture is poorly developed, it makes little sense to prioritise research. Likewise, in a low prevalence environment, treatment services may not be the most immediate need and good quality prevention programmes are likely to be a better investment. The message, in any context, should be 'do what is appropriate, relevant and possible and do it well'.

- The tendency towards seeing HIV/AIDS as a health issue will persist and needs to be addressed consistently. The message to reenforce in this case is 'HIV/AIDS is a development issue' not only a health issue.

- As 'nonmedical sites' educational institutions will need specific types of capacity building. So, for example, if the campus clinic wants to offer voluntary counselling and testing (VCT), the institution needs to have policy, protocols, capacity and management in place because of the sensitivity of VCT. Again, this can be done successfully and many institutions in the AAU network now offer high quality VCT services which can be used as implementation benchmarks.

- A climate of silence and denial is perhaps the most difficult challenge to work against and demands decisive leadership and strategic thinking. The climate is often reenforced by a level of 'AIDS fatigue' amongst both staff and students. Amongst young people, it can also be coupled with an attitude of fatalism or invulnerability to risk. This context underlines the importance of advocacy and the core statement around which AAU has developed its five year programme:

- In institutional settings where operational/discipline boundaries have been distinctively upheld for generations, sectoral and knowledge integration (which is critical for capacity building for HIV/AIDS programmes) is a challenge that need to be addressed. For instance, academic, finance, human resources, estates, students' services and other departments are used to working in isolation of each other. The same applies to individual academic departments (some of which are occasionally on different campuses)
- In situations where labour mobility is on the higher side (academic staff shifting from one university to another), it becomes expensive and unsustainable for individual universities to undertake capacity-building initiatives. In the more formal staff development programmes (which are mostly academic), those who go for further education are *bonded* (to ensure that they serve the universities for specific period of time after completing the courses). *Is it possible to have a similar arrangement for HIV/AIDS initiatives?*
- Cultural sensitivities (occasionally complicated by diverse cultures) which are pronounced in African University settings have a bearing on the capacity building initiatives.
- HIV/AIDS interventions have to rely on testing and disclosure. Even with sustained sensitization, students and staff may not be certain about their continuity in the context of stigma and discrimination.

1. Keep students and staff HIV free for as long as possible.
2. Protect and support those infected and affected by the epidemic.

With these contextual issues in mind we now turn to the task of defining a response.

## 1.2 Defining the response to HIV and AIDS

This Toolkit model draws heavily on work done by the Association of Commonwealth Universities (ACU) in its HIV and AIDS programme and has been adapted to the needs of higher education institutions more generally.

Prior to embarking on this process, it is worth asking: who should initiate the response and where should it begin?

Who? The answer is you – the focal person as designated by the senior management and with their full support.

Where? It is envisaged that this process should be initiated both at the apex of the organisation (governing council, senate and senior management team) and at the level of a union meeting with support staff. It is possible to see each of these steps fitting into a sequence: assessment, planning, design, and implementation.

## **Assessment**

### **Step 1: Leadership**

As a leader with a critical role to play in this process, you commit the organisation to a process of self-reflection by mobilizing the key stakeholders in the your institutional community.

### **Step 2: Situation analysis (institutional impact)**

To what extent has the epidemic already affected the work of your institution and the community it supports?

- To what extent are various stakeholders engaged in situational analysis?
- How are they engaged?
- At what level does the diagnosis begin?
- Does the stakeholder engagement evolve naturally? Do the initiatives come from the grassroots (for example students/staff proposals or agitations) or it is initiated by university management

### **Step 3: Situation analysis (Institutional response)**

Has the institution responded in any way to the reality of the epidemic as an organisation or through the work of individuals (research units, academics, student leaders)? Are the responses adequate and appropriate?

### **Step 4: Potential impacts**

What does this epidemic mean for the core business of the institution, summarised under the following headings?

- Management
- Teaching
- Research

- Community engagement

What approaches are used to determine appropriateness of responses and potential impacts (quantitative or qualitative investigations)? Who are the respondents?

## **Planning**

### **Step 5: Proactive responses**

Within each of these four areas of activity the following questions might be asked: what role in the struggle against HIV/AIDS does the institution see for itself:

- in keeping with its mission;
- in the world in which it operates and
- vis-à-vis its responsibility to students, staff and the community it supports?

## **Design**

### **Step 6: Response mode**

What form should our response to the epidemic take in the areas of policy, strategy, and programmes?

what considerations or factors (contextual) do guide/inform our response to the epidemic and to what extent should such factors influence policy, strategy and programmes development (for instance, how much freedom does an individual institution have to drift from the structures in the modules that have been generically developed)?

## **Implementation**

### **Step 7: Process leadership**

Who will lead and take responsibility for the process of defining your response (focal person, executive deans, HIV/AIDS Task Team)?

Are there structures and framework for *horizontal* inter-institutional collaborations/networking?  
Are there vertical linkages with National/Regional Higher Educational authorities?

### **Step 8: Structure, representation and accountability**

What structure will be put in place to drive the process of developing and implementing the response? To whom will it be accountable?

### **Step 9: Resources**

What resources can be mobilized within and outside the institution to support the response (existing campus clinic, students in health sciences, donor funding)?

## **Monitoring and evaluation**

## **Step 10: Monitoring and evaluation**

How will you measure the success/efficacy of the response and using what indicators?

How and to what extent will you involve stakeholders in participatory processes of developing M&E tools and in the actual processes of M&E?

These steps show clearly that a host of cofactors come into play once the process is underway all of which have a critical bearing on the integrity of the response. They include:

- The will to act;
- Leadership;
- Commitment;
- setting priorities;
- Institutional culture;
- Management structures;
- Decision making processes;
- Capacity to implement;
- Sustainability;
- Resources.

### 1.3 Leadership and advocacy

Leadership is critical in a world so profoundly affected by HIV/AIDS where our institutions must set a standard as advocates for prevention, treatment, care and support; develop and promote curricula that reflects the impact of HIV/AIDS on our societies; uphold the value of new knowledge and research and the need for changes in the management of our institutions to mitigate the impacts of this epidemic. (ACU, 2002)

'The evidence is abundant that higher education institutions can if they chose play a critical role in the struggle against HIV and AIDS. Obviously, no institution will be able to stem the tide of an epidemic by itself, but one factor stands out in almost every example of a strong and well conceived response to HIV and AIDS in the higher education community: leadership. Without leadership there is no commitment to change, little chance of shifting institutional culture, creating a sense of urgency or mobilizing key stakeholders. Leaders can and do change attitudes: leadership is the key to driving management structures to mobilizing resources, overcoming barriers and making resources available. That is the challenge to senior executives in a world severely affected by the HIV/AIDS epidemic' (ACU, 2002).

Leadership can come from a number of places within your community:

#### **Vice-chancellors and principals**

All the available evidence points to the critical role of vice chancellors and senior managers in creating the right climate, in setting a precedent and in mobilising key constituencies within the institutional context.

### **Academic managers**

The extensive influence of academic managers (deans and heads of departments), and senior academic staff is critical in two areas – teaching and research. Deans have major influence over academic policy and research priorities – both of which involve HIV and AIDS. However, one of the great strengths of higher education is that academic staff have some degree of freedom in deciding what to teach and what research is of interest to them<sup>1</sup>. Broadly speaking, any lecturer or researcher with an interest in HIV/AIDS can provide leadership.

The fact that academic staffs have freedom in deciding what to teach and to research on could be strength; as long as institutional administrators have capacity and willingness to persuade academic staff to participate in the programmes. Involving various staff in all stages of programme development could be one of the means of upholding the interest.

There is also a possibility that participation in HIV/AIDS research and projects could enable academic staff to advance their academic credentials. This could be a significant motivation for them.

As the academics closest to the impact of the epidemic, faculties of medicine, health sciences and humanities have a special responsibility in terms of advocacy. They need to be called upon to use their clinical practice, their research and their ability to influence the community as an opportunity for advocacy.

### **Senior executives**

Executives also have substantial powers in affecting the flow of resources and especially those in charge of support functions that promote or monitor university policies must also be recognised.

### **Government**

'The role of executive leaders is significantly enhanced when there is a sense of synergy with national ministries and government agencies that look to higher education institutions as partners and for intellectual guidance' (ACU, 2002).

### **Student leaders**

Student leaders can play a vital role in formulating strategy, in mobilisation and in articulating the concerns of their constituencies. As one of the key beneficiaries of any programmatic intervention, core groups of students must be mobilised to lead the way in changing the attitudes and behaviours that underpin successful programmes.

Besides the existing students guild structures, students-led volunteer associations could play a leading role; some of these are cultural associations, professional associations, spiritual gatherings, sports organisations, entertainment groups and the Alumni. What universities' managers could do is to equip them with appropriate communication and organizational skills.

### ***Organised labour and support staff***

If the issue has not already been raised by organised labour and support staff, then senior executives have the responsibility to put HIV/AIDS policy and management issues into the workplace through collective bargaining processes, training and a host of other ways explored later in this Toolkit. In the workplace context, the shop steward is as important as the vice--chancellor.

This is possible in situations when the administration creates a forum for staff to meet and deliberate on matters of interest. Unfortunately in many of the institutions (mainly private), this forum is deliberately discouraged (due to fear that it may be used as a forum for Trade unions or other work-related agitations).

In addition, staff debates on workplace HIV/AIDS policies/issues may ultimately entail undertaking commitments for more health expenditure by the administration. The administration is inclined to discourage such talks.

This matter could probably be addressed through inter-institutional gatherings such as Vice-chancellors forum or National councils of Higher education or regional inter-university bodies. A forum for organised labour and support staff issues could be made mandatory.

### **NGOs**

Some of the most influential NGOs in the field of HIV/AIDS have used higher education institutions as a springboard for their work. They often have the advantage of working more directly with affected communities, including PLWHAs, and therefore provide a valuable ally in advocacy initiatives.

### **Inter-university bodies**

Lastly, interuniversity bodies, which cover most parts of Africa, have a critical point of leverage in the fight against this epidemic. Like the AAU they have the advantages of reach, a mandate to act on behalf of the collective and a spread of knowledge resources within their community. Partnerships were key to the development of this Toolkit and they are actively promoted by the AAU as a way of developing a stronger national, regional and international response to HIV and AIDS.

Whether the leadership comes from management, student representatives or trade union leaders, all of them can make an immediate impact on attitudes, perceptions and behaviours related to HIV and AIDS.

A strong and committed visionary leadership inspires action, mobilize resources, establish policies and set up responsive organizational structures Kelly and Bain, 2005).

Involvement of senior manager such as vice chancellors sends a strong message within the institution and to the wider community that HIV and AIDS management is a priority.

Institutional communities are likely to take such activities more seriously (Nzioka 2006). Other effective initiatives could include establishing a Chair in the area of HIV/AIDS and Education. This highlights the critical role that higher education institutions can play in the response to HIV and AIDS (Morrissey, 2005).

What is strong leadership likely to achieve?

- Reduce a culture of silence and denial on HIV and AIDS and addressing HIV-and AIDS- related stigma and discrimination
- Amplify the potential threat of HIV and AIDS on the institutions' functions and operations; Make HIV and AIDS activities a priority by way of integrating the activities into the institutional mission, while ensuring that is addressed;.
- Highlight both inward-looking interventions (that safeguards the institution's own functioning) and outward-looking functions (that look at the needs of the wider

society).

#### 1.4 Gender and HIV/AIDS

The process of defining a response to HIV and AIDS will have to take account of a complex set of factors. In taking a leadership position on HIV and AIDS and acting as an advocate, the 'gendered' nature of HIV and AIDS requires special attention. The issue arises in a number of ways in the activity that concludes Module 3. The different ways in which HIV/AIDS affects men and women is the subject of another Toolkit but for present purposes, it is essential to recognise that gender will be kept in the foreground when assessing the risk to the institution, considering policy changes, designing programmes and services and monitoring impacts.

#### 1.5 Activity

The following activity is based on a case study of the 'University of Takondi' which was developed for the AAU's SUMA Programme.

Read and discuss the case study in relation to this section of the toolkit whilst paying particular attention to the following:

- the context of the institution;
- the extent to which the institution is vulnerable to HIV/AIDS;
- the extent to which the institution has already been affected by HIV/AIDS;
- the responsibility which management has to define a response and
- the need for an appropriate response.

#### **HIV/AIDS and the African University**

It has been five years since the University of Takondi underwent major restructuring, as part of a national reform of higher education. One of the results of the restructuring has been a substantial decentralization of the university, such that it now operates more like a network of small cells than a single structure. Despite the drastic reduction in state subvention the university is more financially stable and efficient in its operations. In an overall perspective, there has been a sharp increase in the proportion of women on staff, while women students outnumber their male colleagues everywhere except in mathematics, accountancy and the courses for would-be business executives. These positive features of the current structuring and funding of the university have been accompanied by a reduction in central control and alterations in community life and conditions on campus. Despite the introduction of a comprehensive computerized management system and audio-digital devices in all lecture theatres, it remains hard to know what is really going on across the large campus. A strong women's movement has begun to raise fundamental questions about the atmosphere on campus, including the lack of balance in the relationships between men and women and insensitivity of senior university management to sexual harassment on campus.

At the close of work yesterday you were summoned to the Vice-Chancellor's office to hear a harrowing tale. A young student was raped during Orientation Week, as part of initiation rituals that, despite University regulations banning them, have continued. A report from the Student Health Services indicates she requested an HIV test at a public hospital and is very distressed by

the threat of HIV infection. No charges have yet been laid. The test results cannot be confirmed until a window period of three months has elapsed.

This is not the first incidence of sexual violence on campus and fears of HIV infection as a result of sexual violence have been increasing. The main campus is within the boundaries of a large urban area and is easily accessible to members of the public. Many of the students move from rural homes to temporary accommodation around the university or into single sex residences on campus. Alcohol is easily available, though illegal in the residences. Despite a generally conservative climate in the community, male attitudes to sex promote the ideas of multiple sexual partners and unprotected sex.

The University is aware that nationally determined antenatal data point to a prevalence level of 20% amongst pregnant women attending antenatal clinics in 2001. No attempt has yet been made within the University to establish the extent to which the university community is infected or affected. National government policy exists which promotes abstinence, safe sex and prevention. It also calls on communities to be respectful of human rights, tolerance and confidentiality. Though government is committed to eradicating the disease, little if any support or treatment is available through the public sector.

Up until now, the University has tended to play down such incidents and has failed to take any direct measures for containing the spread of HIV cases on campus or of managing its effects. It has relied instead on education and prevention campaigns introduced three years ago in response to a national HIV/AIDS campaign. The Health Centre distributes pamphlets during Orientation Week. This approach is, in part, the result of fear that the negative publicity that a more vigorous approach might attract, was perceived as likely to affect support from prominent alumni (and alumnae,) as well as Church groups, whose financial contributions now keep the university going. Many staff have also made it clear that they do not see AIDS education as their responsibility.

The effects of the epidemic are becoming evident but there has been little attempt to analyse them within the university or discuss them publicly. Absenteeism at all levels of staff has increased and it has been noted that even academically talented students have de-registered in mid-year. A climate of gossip has developed about the health status of people who are noticeably ill.

The Vice-Chancellor is of the opinion that the University cannot afford such an occurrence again and has established a Disciplinary Committee to investigate and report on the Orientation Week incidents. He wants you to head an emergency task force to look specifically into the issue of HIV and AIDS on campus. He has asked you to form a task group and prepare terms of reference.

The University Task Force on HIV/AIDS will have two months within which to present a report proposing both immediate and longer-term strategies for addressing the incidence of HIV and AIDS on campus, and the challenges it poses to the core business of the university.

(Adapted from SUMA Workshop Association of African Universities November 2001)

**Task:**

Using the process outlined in the chapter on management, outline the key elements of your response to HIV and AIDS.

*Task 2:*

Analyse aspects of HIV/AIDS Management that have been successfully accomplished either in your institution or in other institutions known to you.

Identify gaps that could be addressed within the context of Management of HIV/AIDS response in this specific University.

## **Module two**

### **Management structure; where to start**

#### **Objectives**

Collaborative structure is established to respond to HIV and AIDS with adequate human, financial and physical resources.

The structure is accountable and able to co-ordinate and promotes a range of responses across the institution.

The structure carries a high level of commitment from all quarters of the community.

In the sections that follow, the Toolkit works through the key components of putting in place a response to HIV/AIDS. In practical terms, this means focusing on the following priorities:

- **Structure.**
- **Policy development and legal issues.**

If you are able to achieve some degree of consensus on these two priorities, the framework within which you operate will be clearer and the programmes you put in place are likely to be stronger. Once there is some clarity on these issues, the Toolkit then focuses on interventions in specific areas of management.

#### **2.1 Options**

There is active debate in higher education about this aspect of the management of HIV/AIDS in higher education and the debate revolves around the following questions:

- Is a structure to manage HIV/AIDS a necessity?
- Where should the person or organisation be located in the institutional structure?
- What form should it take (a unit, a focal person, a task team, an existing programme)?
- How should it operate?
- What capacity does it need?
- What resources does it need?

There are indeed a host of options that have been tried, all with varying degrees of success. Higher education institutions are, by nature, organisations with a dispersed authority structure. Management and senate may often take very different positions on an issue. The trend towards devolving authority to executive deans has taken hold in many institutions, which gives greater freedom to academic managers and their staff. What is often at the heart of the debate is the question of institutional autonomy and academic freedom. The perspective advanced by the Toolkit is that a management structure (in whatever form) is an essential part of a comprehensive institutional response to HIV and AIDS.

#### **In the case of HIV/AIDS the following approaches have emerged:**

##### **Option 1:**

A formally appointed high-level institution-wide Task Team or HIV/AIDS committee reporting to senior management with responsibility for overall institutional policy development, coordination

and oversight. Note: it does not implement programmes but it has the power to mobilize and allocate resources.

**Option 2:**

Programmatic responsibility is devolved to the campus health service with or without additional resources and capacity.

**Option 3:**

An HIV/AIDS Unit is established with transversal functions, a dedicated staff and responsibility for coordinating activities and programmes with specific attention to staff and students. The location, form and accountability of this Unit can vary.

**Option 4:**

Schools and departments initiate research, teaching and outreach initiatives independently.

Colleges are replacing Faculties as units of University administration; the phenomenon of Colleges as a unit of University administration is taking root in many universities, particularly East Africa. This could be an opportunity for coordination of HIV and AIDS responses (as long as related faculties are administered at a central unit). But it could be a barrier if: the new structure introduces unnecessary bureaucracies and if faculties that are not homogeneous are brought under one college just for the sake of easing administrative costs.

**Option 5:**

Individual components of the management structure propose and implement their own programmes (student services, human resources, finance).

**Option 6:**

Students and their organisations develop and implement their own programmes independently with or without financial and material support from the institution. For example, peer education projects, church support groups.

**Option 7**

Amalgamation of option 2, 4 and 6: Students-led organisations could be funded by the university, patronized by departments/faculties/colleges and work alongside the university health services (this model is used at Uganda Christian University)

**Concerns for management**

All of these have merits but none by itself is ideal or sufficient. Ideally, a combination of all these options ought to be part of a comprehensive response. Whatever the form the structure takes, it will have to manage the tensions that come with competing demands from different constituencies in the institution. As a trainer/focal person, you will need to manage these concerns in order to take the institution forward. These include:

- Academics are inclined to want complete freedom on whether and how they respond to the issue in terms of teaching and research.
- Students and staff will be concerned about the extent to which they have an active role in defining policies and programmes that are intended to benefit them.

- Managers will be concerned about why the responsibility is being put on them and whether there is adequate time, personnel and money to fulfil the commitments being made by the institution.
- 'Turf wars' are a familiar problem. So too is the tendency towards marginalizing HIV and AIDS interventions as 'a health problem'.
- High level committees have the advantage of a high profile and being closer to management but they also run the risk of being bureaucratic in operation: slow, cumbersome and far removed from the dynamics of HIV and AIDS.
- A big number of Academics in African institutions of higher learning may never have a professional teaching background. They are accustomed to the conventional lecturing methods. They may lack the skills and flexibility to conduct HIV/AIDS related activities.
- Many academics may lack capacities to engage students in participatory/interactive activities which HIV and AIDS programmes call for.
- A number of Universities have congested academic programmes which make it very difficult to accommodate extra (co-curricular) activities.
- On the other hand, integrating HIV/AIDS issues in the existing academic programmes calls for unique skills on the part of lecturers (which at the moment are not abundant). It calls for emphasis on the affective domains of learning which is different from the typically cognitive and psychomotor domains (popular and common in the universities)
- HIV/AIDS activities that are integrated into formal academic courses are likely to be handled in the same way as the rest of the courses are handled by students; committing them to memory for the sake of passing university education. Translation of the learnt materials into the needed psychomotor and affective domains may be difficult to achieve.

### **Practical advice**

Based on a review of recent experience and inputs from managers of HIV/AIDS programmes in higher education, the following recommendations can be made:

- This epidemic is best fought through a multi-sectoral, collaborative approach in which management, staff members, their dependants and students are actively involved.
- In terms of expertise, the mix should ideally include members with a strong understanding of the operations of the institution and its decision making structures, a strong grasp of the medical and social implications of HIV and AIDS and skills in the area of programme design, management and implementation.
- The HIV/AIDS Task Team approach has a high level of support, especially when it has senior management backing and a strong mandate. It may be necessary to consider two types of task team structure one responsible for oversight and the other concerned with implementation.
- Wherever possible, make use of the opportunities that decentralized management allows. If an executive Dean is a willing partner and has the authority to mobilize the resources for an intervention, use the opportunity. If a head of department has the freedom to form partnerships with an NGO or international agency, use the opportunity. What also flows from this approach is that a project leader should also avoid relying on constituencies who are clearly opposed to the initiative.
- High level decision-making structures such as Senate and Council may typically meet only two or three times a year with a packed agenda. This necessitates proactive planning to ensure that matters concerning policy are brought to their attention and resolved.

- The HIV/AIDS Task Team must accept that a large part of its responsibility is to act as a focus of advocacy within the institution and to its stakeholders.
- The Terms of Reference of the Task Team are especially important and should be dealt with carefully. Some of the following roles and responsibilities should be considered as a starting point.

## **HIV/AIDS TASK TEAM**

### **DRAFT TERMS OF REFERENCE**

The Task Team will be a coordinating structure, facilitating implementation of internal policies.

### **ROLE AND FUNCTION**

#### **Advocacy**

- Support the HIV/AIDS Unit or Coordinator.
- Provide a focal point for advocacy across the institution.

#### **Coordination**

- Coordinate the implementation of student, staff and community based HIV and AIDS Programmes.
- Enable integration of HIV and AIDS Programmes into the research, teaching and community outreach programmes of the institution.

#### **Communication**

- Provide a regular link with partners in the NGO community, researchers and with government agencies on all issues relating to HIV and AIDS.
- Initiate and maintain a communication strategy to reach internal and external stakeholders.

#### **Facilitation**

- Form a link between the HIV/AIDS Unit or Coordinator and the Senior Management of the Department.
- Influence Senior Management to ensure implementation of the HIV/AIDS implementation plan of the institution.
- Facilitate management decision-making on HIV/AIDS Programmes.
- Facilitate the allocation of budgets and other resources to HIV and AIDS Programmes.
- Expand the scope of stakeholder base within the institution to support HIV/AIDS initiatives. Getting more people on the job is likely to reduce financial costs and increase resourcefulness towards concerted efforts. Ensure that the initiatives attract wider involvement of people from the grassroots to the uppermost university levels. Some of the stakeholders or interested parties may be companies/alumni/well-wishers from outside the university

## **Advisory**

- Advise Senior Management on HIV and AIDS issues within the institution.
- Support the role of the HIV/AIDS Unit or Coordinator with strategic advice.
- Provide Senior Management with current information on programme implementation.

## **Monitoring and reporting**

- Monitor and report on the institutional implementation plan for HIV/AIDS.

## Mainstreaming the prevention and management of HIV/AIDS

### *What is mainstreaming?*

*the process of analyzing how HIV and AIDS impacts on all sectors now and in the future, both internally and externally, to determine how each sector should respond based on its comparative advantage*

*(Elsey and Kutengule, 2003)*

### *Questions to ask:*

- I. How is epidemic likely to affect the goals, objectives and programmes of the institution, college, faculty, department, or any other unit?
- II. Does the institution, college faculty, department or unit have a niche (comparative advantage) in addressing various aspects of HIV/AIDS?
- III. Is HIV/AIDS integrated into the core operations, functions and curricula of the institution, college, faculty, department, or any other unit? Is it part of the professional studies?
- IV. Is it integrated into non-curricular activities such as sports and performing/creative arts or debates, entertainment, etc?
- V. Are there measures to ensure that the existence of the institution does not itself help in the spread of HIV/AIDS in the communities (through the behavior of students and staff)?
- VI. Are there deliberate procedures (such as policy development) that are developed to protect institutional staff and students from HIV infection?
- VII. Are there actions towards helping PLWA and those affected by the epidemic (at the same time enabling them to be are still able to be optimally productive
- VIII. Are there clear indicators of effectiveness of HIV/AIDS programmes and of mainstreaming in particular with regard to:
  - Prevention
  - Care and support,
  - Impacts mitigation

## 2.2 Activity

Review the list of concerns listed above. Consider the options most appropriate to your institution and draft its Terms of Reference. If your institution already has a structure, reflect on

its strengths and weaknesses.

## **Module 3**

### **Policy Development and Legal Issues**

#### **OBJECTIVES**

- An inclusive process, fully supported by senior management, is established to develop a policy framework in which all institutional stakeholders have adequate involvement.
- The policy is adopted by the highest governing body of the institution.
- Management undertakes to implement and disseminate the policy.

#### 3.1 Why is an HIV/AIDS Policy important?

- A policy locates the institution's response to HIV and AIDS as part of its mission and core business.
- A policy provides an agreed framework within which actions can be taken.
- A policy on HIV and AIDS confirms the rights, roles and responsibilities of all institutional stakeholders.
- A policy prepares the institution for the presence of HIV and AIDS in the classroom, workplace and in the community.
- A policy demonstrates the organization's commitment and concern in taking positive steps to preventing, managing, mitigating and planning for the epidemic.
- A policy enjoins the institution to make capacity and resources available to support a response to HIV and AIDS.
- A policy provides partner organizations and agencies with a framework and a point of access from which to engage with your institution.

#### 3.2 Do you have to have policy first before you do anything else?

No. A policy is a guideline and is based on current trends, legislation and organizational research so that all role-players agree on the basic framework within which to operate.

There is nothing inappropriate with setting up a Task Team without a fully developed policy in place. However, it is strongly suggested that a framework of some kind, agreed upon by role-players, be put in place as a way of guiding the work of the Task Team. This may consist of basic terms of reference that will allow members a shared sense of understanding.

#### 3.3 What are the pros and cons of developing policy?

Be aware of the following preconditions for successful policy development and implementation:

- Policy-making takes time in academic institutions. Developing policy may end up being a time-consuming exercise when the epidemic is a real threat and action is required urgently.
- In order to draft and implement a policy successfully, a reasonable level of consensus is necessary in your community.
- Management must accept the responsibility of allocating the appropriate human, physical and financial resources to make the policy a reality.
- Building awareness throughout the policy making process is essential, as is monitoring the progress of the policy making and implementation phases.
- Policy development does not have to start from a "blank slate". Current government policies, strategic plans, World Health Organisation Guidelines on HIV and AIDS, ILO guidelines and policies, as well as other institutions' best practice documents provide ample examples of how to respond.
- It is preferable that interventions in higher education institutions are in agreement with national priorities and international best practice.
- Policy needs to be backed by regulatory instruments, which are immediately accessible to managers and well communicated within the institution.
- Successful Policy-making entails building consensus from the grassroots of the community within the institution. Insights of all stakeholders must be analysed and accommodated.
- For purposes of policy development, it takes time and skill to harmonize the views and interests of divergent groups (academic staff, administrative staff; highly educated people and semi-literate group employees; single and family persons; youthful and aged employees, students and staff; PLWA and those that are not, etc)

### 3.4 How to respond when policy fails?

Policy failure is a very familiar consequence of good intentions with no implementation strategy. In effect, the policy statements become a piece of paper which stakeholders ignore or actively subvert.

In the case of HIV and AIDS, indifference is less damaging than actively flouting policy. For example, if a member of staff or student discloses their health status confidentially, sanctions based on policy must be applied if that confidentiality is breached or not observed.

Trainers also need to be aware that institutional stakeholders may be impatient with the broader objectives towards which the policy is directed. They may see the policy as "failing" because it is too long term. In that case, institutional managers have a responsibility to communicate the importance of how they see the institution moving towards longer-term objectives - even if it happens in small incremental steps.

## Observation

The likely impatience/indifference by staff to the long term policy objectives could be attributed to the employment tenures; staff with shorter tenures between 2-3 years may not see much personal benefit from the longer term policy objectives. The benefits can only be realised by permanent staff or those whose contracts stretch to or beyond 5 years.

Shorter term policy objectives could also be considered to accommodate the needs of temporary staff. Adoption of Incremental steps is a good idea.

### 3.5 Procedure for developing an HIV/AIDS & STD policy

A consultative policy may not be a quick method; however, all effort should be made to include all the relevant role players:

- Set up a small group/task team with the appropriate mix of expertise and representivity (medical, legal, students etc.)
- The task team should research the needs of the organisation in relation to HIV and AIDS and scan institutional policies which may already make reference to HIV and AIDS or will need to be made HIV and AIDS sensitive.
- The Task Team reviews the research findings and formulates a draft policy.
- Circulate draft policy for discussion and comment.
- Revise draft policy.
- Adopt and launch the policy.
- Programme or service managers use the policy to develop implementation strategies.
- Communicate policy and programme implementation to the entire organization.
- Monitor and evaluate the programme to determine its effectiveness.
- Review policy periodically in light of new information about HIV and AIDS and the changing concerns of the institution.

## Observation

- a. Non-conventional participatory approaches of data collection are needed supplement those that are conventional. For instance, Universities are fond of applying the more commonly known tools such as questionnaire, interviews, documents reviews, etc. these approaches may not be helpful in generating insights needed in addressing sensitive and delicate subject of HIV/AIDS and STD. More innovative probing approaches may be required.
- b. The idea of appropriate mix of expertise is very appropriate for this purpose. It addresses the much needed psychosocial skills.
- c. Involvement of students is also a great idea; could be very instrumental in the whole process of developing and implementing the policy. These students need extensive training/orientation. In interest of sustainability/continuity (every 2 or 3, 4 or 5 years, students leave the university and new ones join), students Alumni Associations need to be strengthened such that they make their contributions even after leaving the university.
- d. Universities could consider opening up newspapers and local FM radio stations (or link up with those that are within their localities); to create an open forum for sharing views and insights.
- e. Social network sites such as facebook, twitter, LinkedIn, etc could also be used particularly for students and academic staff. In so doing, the process of policy development and implementation could receive great insights from many stakeholders; and could generate a wide publicity within and outside the university community.
- f. During the process of collecting views and insights, care should be taken to ensure that individuals (such as group-employees) participate. The medium of communication should be languages and expressions that they understand well. Universities should avoid the temptations of conducting communications in English/French on the assumption that the university is made up of literate people only.

### 3.6 What should the HIV/AIDS policy cover?

In overall terms, the policy must address itself to the following questions:

- What role will the institution assume in the fight against HIV and AIDS – both internally and in society at large?
- What are the rights and responsibilities of all members of the institutional community with specific reference to the protection of HIV infected people, those living with AIDS and those affected by the epidemic?
- Where does HIV/AIDS relate to the core business of the institution in terms of teaching, research, management and community engagement?
- What services and programmes will the institution support in terms of prevention, treatment, care and support?
- What structures will be responsible for managing and implementing the policy?
- How will the institution generate/secure; human, financial, materials resources needed for the fight against HIV/AIDS?
- Who will be responsible for resource mobilization?

- How will the university address non-compliance (by some individuals) to the policies?
- Will there be incentives for extra efforts provided in the implementation of policy instruments? If yes, of what nature?

Institutional policy statements are designed to be broad and overarching. However, managers in specific areas will need more detailed guidance. For example, a human resources manager developing a workplace policy will need to consider many of the following issues, which are taken up later in the Toolkit.

- Job access of applicants with HIV.
- Job retention of employees with HIV.
- Organisation approach to HIV testing.
- Confidentiality and disclosure.
- Protection against discrimination.
- Employee benefits.
- Access to training, promotion and benefits.
- Performance management.
- Grievance procedures.

#### Reflective questions on policy

- I. Does the absence of a written policy mean absence of an institutional framework of action against HIV and AIDS?
- II. Are there institutions that have well developed HIV/AIDS practices and programmes that may not necessarily derive from written policies?
- III. Are there possibilities that some institutions begin by developing activities and programmes before formalizing them into policy framework? Have such practices, activities and programmes been sustained?
- IV. Should there be distinctions between Institutional HIV and AIDS Policy and Workplace HIV and AIDS Policy? The former is broader and more comprehensive; covering all categories of people while the latter is focused on the employees. Each of the categories of people; students and staff has unique and specific needs. However, they interact in ways that permit the spread of HIV/ AIDS within both groups

### 3.7 Activity

Review the example of institutional policy on HIV/AIDS provided below and consider how it can be applied to the development of your organisation's policy. Bear in mind that this example is derived from a social and legal context that is country specific.

#### Additional activities

In case you have an existing HIV/AIDS policy, compare the provisions in this policy with the one that your university has developed. What aspects would you wish to adopt and what aspects do you consider redundant?

#### Activity 3

1. Examine factors that are likely to support or limit the development and implementation of an institutional HIV/AIDS policy
2. Suggest ways in which the supporting factors could be enhanced
3. Suggest ways of addressing the limiting factors

Activity for participants and facilitators

Use the checklist below to evaluate your institutional HIV/AIDS policy

	Item	Yes	No	Not sure
1	Defines the institution's position with regard to HIV and AIDS			
2	Clear guidelines on managing epidemic within the institution			
3	Rights, obligations and responsibilities of all the stakeholders are defined			
4	Rights of affected and infected persons and their partners stipulated			
5	Behavioural standards expected of each member is stipulated			
6	institutional standards for communication about HIV and AIDS are set			
7	Human, material and financial resources for HIV- /AIDS-related activities are identified			
8	institutional actions on HIV/AIDS and institutional responses to the broader national policy framework are aligned and legitimized			
9	guidance to institutional managers and other players and is provided			
10	an overall framework for action is provided			
11	commitment to deal with and control HIV and AIDS is clearly indicated			
12	The policy is ensures consistency with national and international practices			

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**UNIVERSITY OF THE WITWATERSRAND  
JOHANNESBURG, SOUTH AFRICA**

**POLICY ON HIV/AIDS**

## **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 Labour 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 status ;
- 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 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 specialised fields of study or for employment as tutors or auxilliary 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 authorised 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;

1.2.10 The University endeavours 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 endeavours to provide an educational environment in which accidental exposure to HIV is minimised, 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.

## **1.2 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 minimise 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 behaviour 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;

1.3.6 Staff and students who do display discriminatory attitudes to colleagues living with HIV/AIDS will be counselled in the first instance, but if the discriminatory behaviour 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 behaviour 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 synergise 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**

3.1.1 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;

3.1.2 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;

3.1.3 Condoms will be freely available and widely distributed through multiple channels, on campus and in residences;

3.1.4 The use of free STD care provided through the Campus Health and Wellness Centre will be promoted;

3.1.5 Affordable confidential and voluntary HIV testing will be provided through the Campus Health and Wellness Centre;

3.1.6 Peer education programmes will be developed and implemented on campus and in student residences;

3.1.7 Particular attention will be paid to addressing issues of loss, grief and bereavement;

3.1.8 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);

3.1.9 Universal precautions (annexure 2) will be implemented whenever the potential for exposure to blood or other high risk body fluids exists;

3.1.10 Staff in managerial or supervisory positions will receive training in all aspects of this policy and how to implement it.

### **3.2 Care**

3.2.1 Staff of the Campus Health and Wellness Centre will be trained in the comprehensive management of HIV/AIDS.

3.2.2 The University will investigate the possibility of providing cheap, affordable anti-retroviral treatment.

3.2.3 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;

3.2.4 Referral networks with health services will be developed and maintained.

3.2.5 Information on services in and around campus will be made available to all staff and students.

3.2.6 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 eg. hospital, hospice, home.

## **3.2 Counselling and Support**

3.3.1 All staff and students will have access to confidential counselling on campus;

3.3.2 Counselling 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.

## Module four

### Finance

#### OBJECTIVES

- HIV/AIDS focal point persons/trainers, at an institution, are more equipped to inform institutional managers of the financial impacts of the epidemic.
- Financial managers are better informed of the potential economic impacts of HIV/AIDS on the institution, individuals and their families.
- Financial managers are equipped to plan, mitigate and manage the financial impacts of HIV/AIDS on the institution.
- Financial managers are better positioned to develop avenues for sourcing for financial resources to support HIV/AIDS activities in the institutions
- Financial managers have capacity to make optimal use of limited financial resources to manage and sustain HIV AIDS activities in the institutions

#### 4.1 Strategic planning

##### **Problem statement**

- When confronted with the challenge of HIV/AIDS, financial managers are often likely to respond with the following concerns:
- They are unable to respond to the threat because it is 'invisible'.
- There is no reliable data for the institution upon which they can base their understanding of the epidemic.
- They are concerned about commitments to new programmes (e.g. education campaigns) which require already scarce resources.
- They are likely to be unaware of the impacts which the epidemic is already having on productivity in terms of lost work time, sick leave allowances, death benefits paid to families etc.
- Many institutions lack tools that can be used to model financial impacts of HIV/AIDS; tools that can help to determine in concrete terms, HIV/AIDS inflicted losses to the institutions in terms of time, financial resources, man-hours, opportunities, etc

##### **A response**

This section of the Toolkit highlights the issues about which managers with financial responsibilities need to be better informed, the skills they need to develop in the era of HIV/AIDS and how these skills can be best used as part of a comprehensive response to the epidemic.

*How can we afford to prioritize HIV/AIDS when our budget is barely sufficient to pay salaries and provide essential resources?*

This is a common and very valid concern for financial and programme managers even before they engage with the specifics of a proposed new intervention. As a trainer or focal person for HIV/AIDS at your institution you will need to mobilise support and put forward sound arguments in favour of a Programme.

This Toolkit argues that we need to think about the financial implications of HIV/ AIDS in a different way for two strategic reasons:

- Firstly, investing even minimal time and effort in prevention strategies and policy development now will ultimately help in the long-term (a preventive strategy);
- secondly, a commitment to addressing HIV/AIDS is a positive signal to those within and outside the institutional community and may be a way of leveraging additional resources from government, donors or NGOs (a leveraging strategy).

### **Choices**

Funding issues should also be looked at in terms of interventions that are both appropriate to the context and sustainable. This has often been characterised as the choice between the 'Rolls Royce model' and something more modest.

When it comes to programmes, an institution may only be able to offer limited care and support within the institution, but it should make an undertaking to link students and staff with the necessary services outside the university. Referral services, which are dealt with later in the Toolkit, are a good way of sharing costs and building better partnerships.

Good practice strategies promote low cost interventions, which can include a host of small but visible and effective measures that may include internal email postings and invitations to people living with HIV to speak on campus. These interventions cost little or no money. Examples of these interventions are provided in Section 6.S as part of an activity.

Partnerships with non-government organisations have major potential as a way of leveraging resources and providing universities with ways of being more engaged in grass roots level initiatives. Research that makes a visible contribution to national or community level needs is another trusted strategy for leveraging resources with spinoffs for the institution. Research can readily be tied to capacity building for students and staff, investment in infrastructure and new teaching resources. Here is just one example of what is possible through partnerships for Higher Education Institutions in Africa

### **Regional AIDS Training Network (RATN)**

The Regional AIDS Training Network (RATN) was founded in 1997 as a project of the University of Nairobi and University of Manitoba, in response to the need for high-quality HIV/AIDS training in the Eastern and Southern African region.

The goal of RATN is to provide through its member institutions, skills-training, upgrading, extension services and technical assistance to health and allied workers in the region. Coordinated by a Secretariat based in Nairobi, RATN has grown into a network of twenty training institutions based in seven countries in the region.

These institutions collaborate in developing, implementing and evaluating regional training courses in a wide range of HIV/AIDS/STD sub-specialities. Over ninety courses have been delivered to date, attended by over 1400 trainers and managers from twenty-three African countries. In addition, RATN has become recognised internationally as a success story in networking and collaboration, and an authority on training and capacity-development issues in the field of HIV/AIDS. Its programme has attracted the support of a number of international donors as well as UN agencies.

In the final instance, mobilizing the resources to back a commitment to fighting HIV/ AIDS is a test of leadership and institutional strength. Without resources the best of policy statements have little value. As with many other dimensions of work in higher education, managers have a critical role to play in identifying ways of mobilizing existing resources towards fighting HIV/AIDS and of ensuring that new resources are generated.

Based on recent experience, most project leaders will see the 'first prize' as a dedicated HIV/AIDS budget allocated to a Unit or a programme from within the institutional budget. The more likely and more realistic scenario is that the institution will offer a portion of the total budget and the remainder will have to be raised from partners and donors - the 'soft money' option.

An assessment of recent experience shows that higher education institutions can do far more than they are presently doing in developing national and institutional capacities in the response to HIV/AIDS through using a variety of available funds. This should be explored with the Ministry of Health and the Ministry of Education wherever possible.

*How do we analyse and mitigate the impacts of the epidemic on our institutions?*

This is the issue with which the following sections are concerned.

#### 4.2 Direct Costs

HIV/AIDS has direct and indirect costs to institutions and individuals in the education sector. Direct costs will be evident in the financial liabilities that institutions will have to meet in terms of staff costs:

- Health insurance contributions
- Life assurance benefits
- Pension and disability benefits
- Funeral benefits and expenses
- Housing benefits (possibly)
- Death benefits
- Equipment costs; (for instance there are some institutions that consider it necessary to give or subsidize condoms to students).

Financial managers, institutional planners and human resources managers have a vested interest in understanding and being able to respond to the ways in which these costs will affect the viability of the organisation and the extent to which it is able to support students and staff who are affected

by the epidemic. Ministries of Education and a number of higher education institutions are now attempting to quantify these costs through impact assessments. The ADEA supported impact assessments on African universities offer some examples of the costs which universities are already incurring (Anarfi, Magomba, Nzioka et al 2000, Kelly 2001). A growing number of education sector impact assessments also provide some analysis of financial implications based on available data (e.g. Bennell et al. 2001). From an education planning perspective, aspects of the analysis by Kelly (2000) should also be useful. There is substantial evidence that health benefits, welfare benefits and pensions are amongst the first to be affected.

#### 4.3 Indirect costs

Indirect costs are most often in the form of:

- Lost productivity due to illness, absenteeism and death (staff and students). Also, due to lecturers and students attending burials of deceased friends/relatives. Actually, this is one of the issues that may have to be contained in policy development. While in some countries it is not a problem due to existing practices (of having all burials on specific/convenient days/hours), some countries (such as Uganda) are still grappling with the problem of burials taking place any time during the week.
- Loss of skilled staff.
- Loss of expertise.
- Recruitment costs.
- Retraining costs.
- Lost loan repayments (students).
- Loss of student fee income (students).
- Loss of students.

These are usually captured in the form of an economic cost to the institution and the individual rather than a direct financial cost. The methods required to analyse these direct and indirect costs are too time consuming to elaborate in detail within the Toolkit. Specialist resources are available in the African context which can be drawn in to assist such as the Mobile Task Team on the Impact of HIV/AIDS in Education (see [www.ukzn.ac.za/und/heard](http://www.ukzn.ac.za/und/heard)).

#### 4.4 Research

One of the easiest and least well-developed ways of developing an understanding of the financial impact on higher education institutions is through internally generated research. This research should be thought of as part of the management information system for the institution as a whole and may well have to rely on proxy information. As many of the impact assessments have shown so far, finding data where the cause is attributed to HIV/AIDS explicitly is a difficult and overly sensitive issue for most institutions. However, it should be much easier for the head of personnel/staffing services to establish a monitoring mechanism which provides monthly data on the numbers and profiles of staff who are drawing on their medical benefits, the number of staff

who request sick leave, the number of staff who are absent from their jobs on a regular basis and the number of staff who are lost to the institution because of chronic illness and death. All of this

can be done confidentially and sensitively and will effectively provide management with an 'early warning system.'

#### Remarks

Capturing monthly data through a monitoring mechanism on staff is a good idea; however, some challenges could reduce its reliability and validity; the human resource departments may fail to get sufficient data on PLWA if such data was to be based on absenteeism. The concerned people may withhold information on their HIV/AIDS status through the following;

- People secure medication from other sources (other than the institution health centre) so that they are not suspected of being HIV/positive. In this case, their health conditions deteriorate (because they do not have sufficient resources to get good medication)
- Staff at the lower ranks (such as the estates/ dining sections/ sanitary sections etc; have a tendency to cover-up the absence of their colleagues at the work stations; to the extent that the supervisors may not notice the absences.
- Improved HIV/AIDS treatment (typified with ARVs) helps many workers/students to keep strong so that there is reduced absenteeism in class or workstation.
- This system of data generation could operate efficiently if all measures are taken to ensure that those who declare their status are safeguarded and that there are strict actions taken on perpetrators of actions that increase stigma to the PLWA. The issue of testing, openness and stigma need to be sufficiently addressed,
- Incentives should be created for PLWA who give information openly

#### 4.5 Activity

Prepare a response to the following problems:

You are aware that students are dropping out of their programmes for unexplained reasons and that funeral and memorial services have become a major pre-occupation in the life of the institution. How do you engage the financial managers on these concerns? As part of a package of interventions, you need to show that you can keep costs low as a way of leveraging other funding within the institutional budget and from government's HIV/AIDS programme. Consider the list of zero budget interventions below and decide which are workable within your context.

#### **Low cost interventions**

- Free or subsidized condoms from NGO or government sources.
- Brochures from NGOs or government.
- HIV/AIDS messages at meetings.
- Messages on stationery.
- Include messages in the speeches of senior management.
- Messages in student publications.
- Radio talks on campus radio.
- Billboards / resource corners.

- Organise focus group / committees.
- Stickers on doors/cars.
- Condoms in 6-packs of beers.
- Publicity for disclosure of HIV status.
- Sport programmes that carry HIV messages.
- Tavern owners support HIV/AIDS associations.
- Free media slots.
- Senior Managers and student leaders undergo VCT.
- Invite government and NGOs to extend their programmes to your campus.
- Free condoms in toilets and student hostels.
- Hold information meetings with department heads.
- Visits to external educational institutions.
- Advocacy with churches and religious organisations.
- Introduce low cost peer education.
- Computer screen savers.
- (Adapted from Kinghomn A Mobile Task Team on the Impact of HIV/AIDS in Education)
- Use of campus-based ICT facilities for blogging;
- Making use of Social network sites such as facebook, Twitter, LinkedIn, YouTube, MySpace
- Making use of regular public debates, concerts and other forms of edutainment

## **Module five**

### **Human Resources Management and HIV/AIDS**

## **OBJECTIVES**

- HIV/AIDS focal point persons/trainers are more equipped to initiate and support interventions at institutional level.
- Human resource managers are better informed about the potential impacts of HIV and AIDS on the institution and employees and as a result should be well placed to respond adequately and appropriately.
- Human resources managers are informed of and skilled in the management and mitigation of HIV and AIDS in the workplace.
- Human resource managers are able to design, implement and monitor policy and programmes concerning prevention, treatment, care and support in the workplace.
- Human resource managers promote a sensitive and caring approach to HIV infected and affected employees and their dependants.

### **Institutional context**

Human resource management is concerned with the provision, deployment, utilisation and development of people in organisations. Management in this context includes the functions of supporting, motivating, communicating and delegating, as well as those of planning, directing, coordinating and controlling.

The responsibilities of managers in this area can be roughly described as including:

- human resource provisioning (the right number of people with the right skills, knowledge, qualifications, experience and attitudes to carry out effectively the tasks that are necessary to meet the organisation's overall aims and objectives);
- human resource utilisation (those processes and activities that take place within an organisation to ensure that its staff are effectively and equitably deployed, utilised, motivated, rewarded and supported, in ways which enhance the performance and job satisfaction of staff and contribute towards the achievement of institutional and individual goals);
- human resource development (those processes and activities that take place within an organisation to enable it to build individual and organisational capacity, through a variety of measures designed to increase staff skills, performance and morale, and to enable the organisation to function proactively and effectively in a rapidly changing and increasingly competitive environment).

### **Problem statement**

HIV and AIDS affect all dimensions of the HR management portfolio. People are at the heart of the HR function and in higher education this means primarily academic staff, support staff and their respective dependants. Academic and support staff require markedly different approaches and will require that institutional policy, strategy and programmes are sufficiently responsive. Differences of social class, gender, education levels, cultural and religious beliefs, family structures and a host of other factors will come into play. For example, gender relations are important for a prevention programme focused on STIs that needs to reach men and women through different messages and

opportunities. Likewise, social class disproportionately affects those levels of staff in the institution with smaller disposable incomes and lower education levels. Their access to information is less than optimal, their economic status is often fragile and the absence of a health and welfare safety

net means that the impacts of HIV and AIDS are amplified at a personal and family level. The impact of HIV and AIDS is already experienced by employees and their dependants in higher education and that challenge is outlined below.

### **Context**

In a higher education context the HR challenge has some of the following dimensions:

- A climate of secrecy and intolerance around HIV and AIDS in the workplace.
- The loss of highly skilled men and women.
- A decline in productivity in a labour intensive sector.
- Difficulties in replacing experienced and specialised academic and non-academic staff.
- Loss of income to families and dependants.
- Difficulties in training new replacements.
- Difficulties in getting professionals to accept that HIV and AIDS must be part of their professional responsibilities.
- Disproportionate impacts of HIV and AIDS on women.
- Disproportionate impacts of HIV and AIDS on lower skilled and lower paid employees.

### **A response**

As a focal point person on HIV and AIDS you have an integral role to play in the following ways:

- create greater awareness of the threat and impact of the epidemic on the HR component in the organisation;
- improve the levels of understanding and expertise in responding to HIV and AIDS and
- provide the programme manager with implementation support through advocacy, networking and information dissemination.

Human resources managers must consider their role within the following framework:

- Protect the institution against HIV and AIDS (with a focus on core operations).
- Protect the human resources of the organisation (with an emphasis on employees and their dependants).
- Stabilise the institution (if it is already being impacted).
- Develop an integrated response to the epidemic that is supported by the institution, employees and their organised representatives.
- Manage HIV and AIDS in the workplace through policy and programmes.
- Create a caring and non-discriminatory working environment.
- Mitigate the impact of the epidemic by planning in recruitment, training and deployment.

Before going into greater detail in this area, it is important to note that many countries in Africa now have government guidelines on workplace policy and programmes. These are often linked to international conventions such as those developed by the International Labour Organisations. Labour relations regimes do differ however and for that reason, the content provided in the Toolkit needs to be adapted to country-specific regulatory frameworks.

## 5.1 Policy

*Why is workplace policy important as part of a comprehensive response to HIV and AIDS and what are the benefits of having such a policy?*

- An institutional response to HIV and AIDS is stronger if employees and their dependants know their status and their respective rights and responsibilities.
- Employees need to be addressed specifically since their rights are often regulated by a broader legal framework.
- As adults with families and dependants, employees have different concerns and behaviours to students.
- Employees in higher education come from a range of social and economic backgrounds. Equity (race, gender and disability) in the workplace is strengthened through policy.
- HIV and AIDS affect men and women differently. Workplace policy and programmes can address their differing needs and concerns.
- Workplace policy provides a framework within which all stakeholders in the workplace can voice their concerns and work together.
- Policy provides a justification and reference point for programmes that target HIV and AIDS.
- Employers may have legal requirements to fulfil.

*What should workplace policy cover?*

- Commitments of the institution in terms of its role as an employer and its mission in the fight against HIV and AIDS.
- Rights and responsibilities of the employer, employees and their dependants.
- The services and programmes which are available through the institution or its partners (prevention services, counselling and care, testing, employee assistance programmes etc.).
- The structure through which workplace issues around HIV and AIDS are managed and how it relates to employees.

## 5.2 Programmes

*Why the need for workplace specific programmes and what value do they add to a comprehensive response?*

Implementing an HIV/AIDS programme in your organisation has the following benefits:

- Increased awareness and knowledge of HIV and AIDS.

- Increased awareness and knowledge of the possible impact of the epidemic generally, and within your institution specifically.
- Better quality of life for employees with HIV and AIDS.
- Increased productivity.
- Improved planning.
- Support for those individuals and families affected by HIV and AIDS.
- Increase awareness of worker's rights.
- Decrease stigma and discrimination.
- Create a supportive environment.

### **Tools**

This Toolkit provides two primary tools that should assist trainers and human resources professionals in designing, implementing and managing programmes: a checklist and examples of policy and programmes. Minimum standards for HIV/AIDS programmes, which are well developed in international conventions, can be used as part of an evaluation process.

The aim is to achieve what is possible within your institutional context.

It must be remembered that this approach is optimal when all partners are involved in the planning and implementing phases. Key players in this regard may include local clinics, on-site clinics in institutions of higher learning, non-governmental agencies and institutional role players including staff, management and trade unions.

### **Checklist for Programmes**

*Does the programme you are proposing adequately address the following?*

#### **Concerns of Employees:**

- Avoiding infection.
- Fair treatment of people living with HIV and AIDS.
- Confidentiality.
- A safe working environment, including universal precautions.
- Protection of employee benefits.
- Protection of recruitment, promotion and training opportunities.

The responsibilities of employees also need to be specified. They may relate to:

- Adhering to laid down procedures and guidelines that are designed to reduce infection
- While HIV testing may not be made mandatory, having positive attitude towards testing and disclosure
- Ensuring that one does not engage in activities that may lead to HIV infections (deliberately or not) at the workplace

- PLWA restraining from exploiting their HIV condition to abstain from work or seek undue favors
- According fellow employees the dignity they deserve in spite of their HIV status; and respecting their rights

#### **Concerns of Employers:**

- Recruitment of employees who are capable of performing tasks they are required to perform.
- Provision of equitable and sustainable employee benefits.
- Performance management with relation to productivity losses and absenteeism.
- Retaining experienced and trained staff.
- Fair and sustainable approach to training, promotion and benefits.
- Risk of becoming HIV positive at work.
- Employment of people with HIV in high-risk or unhealthy environments.

In order to implement and manage the programme, management and employees need to accept the following responsibilities.

#### **Responsibilities of Managers:**

- Ensure consultation with all stakeholders.
- Assist with developing HIV/AIDS policy and programmes.
- Allow time for employees to take part in programmes.
- Formalise job description of everyone involved in implementing the programme, in order to facilitate their work and increase their credibility.
- Feedback information from management forums.
- Ensure adequate resource availability and build capacity where possible.
- Participate in collaborative partnerships.

**Responsibilities of Shop stewards and Trade Unions:** Ensure that the union develops an HIV/AIDS policy, or that at least there is a clear position put forward in discussions with management.

Show commitment to the Programme.

- Encourage union members and other employees to be involved in the Programme.
- Ensure that the rights of staff are adhered to.
- Feed comments up from the shop floor.
- Participate in collaborative partnerships. The responsibility of employees needs to be specified as they relate to:
  - Adhering to laid down procedures and guidelines that are designed to reduce infection

- While HIV testing may not be made mandatory, having positive attitude towards testing and disclosure
- Ensuring that one does not engage in activities that may lead to HIV infections (deliberately or not) at the workplace
- PLWA restraining from exploiting their HIV condition to abstain from work or seek undue favors to fellow employees, the dignity they deserve in spite of their HIV status; and respecting their rights

Checklist

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### **CHECKLIST**

<b>1</b>	Setting up an HIV/AIDS committee
<b>2</b>	Drafting the policy
<b>2.1</b>	Discussing and revising the draft policy
<b>2.2</b>	Adopting the policy
<b>3</b>	Developing a programme
<b>3.1</b>	Implementing and popularizing the programme
<b>4</b>	Monitoring and evaluating the programme
<b>5</b>	Reviewing the policy and programme

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Remarks: Monitoring and evaluation should be on-going; right from the start of the process. It should not be perceived as a one-stop activity as reflected in item 4 in the table above. The same applies to reviewing. However, one may consider having a final summative evaluation of the entire process.

#### 5.3 Process

Workplace policy, like any other policy process, will require time, effort and commitment. It will also demand a high level of stakeholder interaction to make the policy a reality in the form of a programme. Like other policy initiatives at academic institutions it will be subject to negotiations at the shop floor level, collective bargaining structures, the senior management team, senate and the governing council. The checklist below sketches out a generic process for both policy and programmes, their developments and implementation.

#### 5.4 Principles for Policy and Programme development

- Integration into mainstream activities, and not marginalised.
- Induction modules must contain awareness raising information and activities.
- Social events should promote awareness building and programmatic objectives (e.g. saliva tests of identified target groups for research, condom and femdom stands with safer sex information).
- Consultation, with all stakeholders to ensure a holistic approach to behaviour change.

- Management must demonstrate a clear commitment to the HIV/AIDS policy and strategy. It is important for employees and students to see this commitment through non-discrimination and support for people living with HIV and AIDS.
- Transparency is vital since policy documents should be clearly written and accessible to employees and students.
- Each aspect of the implementation strategy must be thoroughly researched.
- Implementation plans must have clear responsibilities, be costed and have realistic time lines.

## 5.5 Types of Programme

The range of issues that need to be covered in workplace programmes is substantial. In this Toolkit, the topics are only headlined. Detailed information on these issues is available from the organisations listed in the modules on references and links.

### **Programme options include:**

HIV testing in the workplace:

- Background to HIV Testing, if sanctioned by state policy.
- Pre-employment HIV Testing, if sanctioned by state policy.
- Pre-benefit HIV Testing.
- Voluntary HIV Testing.
- Diagnostic HIV Testing.
- Confidentiality.
- Surveillance Screening.
- Counselling.
- Treatment and care.

### **Employee Benefits**

- Basic Principles of Employee Benefits.

### **Prevention Programmes**

- Risk reduction Programmes.
- Awareness Programmes.
- Education Programmes.
- Universal Precautions.
- Basic principles of infection control.
- Condom and femidom distribution.

- The role of health workers in prevention.

This list is not complete but should provide a starting point. There are significant commonalities between programmes aimed at students and employees. More detailed guidelines on programme design issues are contained in the section dealing with Student Services.

### 5.6 Activity

Workplace policy is usually a sub-set of institutional policy; another example of which is provided earlier in this Toolkit. Review the example of workplace policy provided in the toolkit. If your institution does not have an established policy, is this example workable in the context of your institution? What problems do you foresee in developing and implementing such a policy? Prepare a discussion document to the senior manager for corporate services.

### Activity 2

If your institution has a policy in place, try to analyse how it differs or relates with the one provided in the toolkit

## Employee policy

### Conditions of employment

1. Employees with HIV/AIDS will be governed by contractual obligations no less favourable than those applying to other employees.
2. Employees with HIV/AIDS will not be prevented from attending any campus activities.
3. Continued employment for employees with HIV, including appropriate promotion, work alternatives and training opportunities will be available, provided that the employees are able to work effectively.
4. No employee will be dismissed or have his/her employment terminated merely on the basis of HIV/AIDS, nor will HIV status influence retrenchment procedures.
5. HIV in itself will not be used as a justification for the non-performance of duties agreed to by the parties.
6. If an employee is no longer able to work due to HIV or AIDS, the appropriate ill-health policies will apply.
7. Employees with HIV or AIDS will be governed without discrimination by agreed existing sick leave procedures. HIV and AIDS will not preference or prejudice their entitlement to such leave.
8. Willfully undermining the privacy and dignity of a member of staff with HIV and AIDS will constitute a breach of discipline and appropriate disciplinary steps will be taken.

Reflection: Condition 2 (about employees with HIV/AIDS not being prevented from attending any campus activity) needs further discussion and elaboration. There are some vigorous activities like Rugby in which injury and bleeding may occur. The bleeding may have *real or imaginary* HIV/AIDS-related effects on the rest of the players. Detailed discussion on such matters is necessary.

## Benefits

1. It is noted that the University's current medical aid scheme limits the benefits for HIV and AIDS related illnesses. The University commits itself to reviewing restrictions of benefits that discriminate against those with HIV infection or AIDS, and to reconsider its contract with the scheme. The Human Resource Department, in consultation with the relevant trade unions, will assume responsibility for this.
2. Similarly, the University commits itself to scrutinising its provident fund, pension, group and spouse life insurance cover for inappropriate restrictions of benefits which discriminate against those with HIV infection or AIDS. In such cases the University will reconsider its contracts with the insurers. This will be undertaken by the Human Resources Department in consultation with the relevant trade unions.
3. HIV and AIDS-infected employees are entitled to the same benefits as all other University staff. The University will inform all employees of any limitations of medical or insurance benefits - as well as changes to these - in regard to HIV and AIDS.

## **Module Six Students' Services**

### **OBJECTIVES**

HIV/AIDS focal persons/trainers are equipped to provide guidance and support to managers of student services in managing HIV/AIDS.

Programme and service managers are aware of the Impacts of HIV and AIDS on student life and can respond appropriately.

Programme and services managers are informed and skilled in programme design, management and delivery.

Students are better informed of the threat of HIV and AIDS and involved in developing and implementing interventions from which they benefit.

Programme managers are aware of the potential contributions that student' leadership could make in the institutional HIV/AIDS initiatives

### **6.1 Institutional Context**

As the primary stakeholders in institutions of higher education, students are, without doubt, the highest priority. The cost of training higher education students in the African context is inevitably high and our graduates represent the most skilled and valuable economic resource in any country. Many of them continue on to assume positions of leadership in major social, political and economic institutions. The likelihood of a student becoming HIV infected before, during or after their studies has, therefore, far wider implications.

This section of the Toolkit addresses itself primarily to the support services and programmes which are offered to students to enhance the quality of life on campuses. A few contextual issues are worth noting first.

**Young adults:** The majority of students in higher education are typically aged between 18-25 and considered 'young adults'. Distance education institutions that attract students who are already working are likely to have a different profile with older students as a major group. Understanding the age, mobility, expectations, knowledge base, emotional drivers, social behaviours and learning patterns of this target audience is critical to the design and likely success of a programme.

**Socio-economic factors:** Social and economic realities have a direct impact on the quality of life and success rates of higher education students in the African context. Many students have to migrate to towns and cities in order to attend residential institutions. This is often a major burden on the family income and may also place students under severe constraints when it comes to paying for food, affordable housing, leisure activities and health care. Poverty cannot be discounted as a factor affecting both students and their families in contexts where they are the first generation to enter higher education. This has had important consequences which affect the extent to which students are vulnerable to the threat of HIV and AIDS. For example, recent research on African universities notes the increase in sex work - particularly amongst women students and women engaged in inter-generational relationships with older men. In a cultural environment where men believe that younger women are less likely to be HIV infected and also more open to casual transactional sex, women are very vulnerable. Sex in exchange for housing,

food or cash to pay fees is a reality.

Student culture: It is fair to expect young men and women who are away from parental supervision and a family structure for the first time to be adventurous. Part of the adventure may involve sex, drugs, new relationships, new cultural pursuits and religion. A significant number of students will remain sexually inactive or maintain abstinence for much of their time in higher education. The normative assumption for the majority of students is that they will be sexually active with some knowledge of the risks of HIV and AIDS and how to avoid infection - knowledge of HIV and AIDS is not the problem. However, in the worst-case scenario sex becomes recreation and drugs and alcohol fuel attitudes of fatalism and/or invulnerability. HIV/AIDS will thrive in this context and the challenge is therefore about how to engage meaningfully with the culture of student life without alienating students through being overly prescriptive or judgemental. In those institutional cultures where education is sex segregated or where religion plays a major role, sex is a part of life but not publicly acknowledged. It may come to the surface when students are confronted with unintended pregnancies or STIs for which they need care and support. Overall, cultural factors are hugely variable and equally influential in how we respond to student issues and the impacts we hope to make.

## 6.2 Target audiences

Responsibility for different inputs into student life rests with a number of components of the management structure. Clearly, responsibility for academic life rests with academic staff (executive deans, lecturers, tutors). The processes of recruitment, selection, admissions, registration and student finance are likely to be handled by another component of the institution. Outside of the classroom, students need support in terms of health, employment opportunities, psycho-social issues, housing and leisure. In some of these areas, such as leisure, students have always had primary responsibility for organising and delivering activities -which is an important factor to consider when developing student led programmes. One more dimension of the student population is important to acknowledge: students are a transient population. They change every three to four years and those in positions of leadership can change within a year. If academic pressures become dominant, students will feel less inclined to taking on 'extra curricula', activist roles.

The following categories of staff should be prioritised:

- Registrars.
- Dean of Student Services and staff.
- Health Centre managers and staff.
- Residence and hostel managers.
- Student Counsellors.
- Women students' organisations.
- Student Representative Council representatives.
- Student Clubs and societies (religious, social, cultural, student newspaper).
- Student activist and advocacy groups (AIDS clubs, peer education projects, home based care projects etc.).

### **Role of health professionals**

Of these categories, health centre managers and their staff deserve special attention.

A trend exists amongst some institutions to place the bulk of the responsibility for HIV/AIDS with

health professionals. This has both advantages and disadvantages.

Let us examine these.

**Disadvantages:**

- In the least desirable scenario, the 'health professionals' in question are likely to be two nurses operating with minimal resources, no management support and no capacity to handle HIV and AIDS.
- Placing the responsibility with a health centre medicalises and stigmatises the response to HIV and AIDS.
- Health centres do not rank highly as a priority area for new investment on many campuses. Facilities are rudimentary and the services are often perceived as not being 'youth friendly'.
- Students often prefer not to use these facilities because of concerns about quality and confidentiality.
- There is no guarantee that the staff will have been adequately trained or be supervised by a medical practitioner who assures quality and compliance with clinical protocols.
- Some campus health centres also serve communities outside the university, a reality that creates even greater pressures.
- The health centre may not have the resources or inclination to promote health seeking behaviour amongst students and staff.
- Students may not be able to make the best use of the services because of user charges.
- HIV/AIDS is only one of many illnesses that campus health needs to accommodate.
- Health professionals may not have appropriate competences to engage university students in arguments/discussions that rotate around social dimensions of HIV/AIDS or sexuality in general.
- Engaging in behavioral change activities consumes a lot of time which university health units may not have (given their other health responsibilities).

**Advantages:**

- Health professionals are a valuable resource in a comprehensive response to HIV and AIDS.
- If a well-staffed and adequately resourced health centre exists, it can provide a focal point for a range of interventions in terms of prevention, treatment and care.
- If a health centre is linked to an institutional teaching hospital that trains nurses, doctors and other health professionals, it can act as a point of referral and the first point of contact.
- Important advances have been made at some institutions where health centres have successfully transformed themselves into a service which rivals high quality private practices by providing voluntary counselling and testing, contraceptive services, treatment of opportunistic infections and a range of clinical services.
- If they have sufficient human capacity, time and expertise, health centres can act as a node from which support is provided across the institution to service and programme managers.

### 6.3 Policy

- The areas described below are central to institutional policy with respect to students:
- Access (to health services, instruction, work opportunities, training, financial support).
- Information (prevention, treatment and care).
- Support (academic and psycho social).
- Protection (confidentiality, non-discrimination, equity, gender).
- Students' involvement in institutional HIV/AIDS programmes
- Students' rights, duties and responsibilities

#### Policies oriented towards reducing HIV/AIDS vulnerabilities

1. It is noted that some of the additional factors (besides those described in 6.1) that increase students vulnerability to HIV/AIDS are associated with transitional adjustments (students transiting from rural to urban settings; from controlled social environments [*homes/high schools*] to free university settings).
2. There is also a possibility that students who live in privately owned hostels are more vulnerable to HIV risky situations than those who live in institutional halls of residence. It may be imperative to develop unique distinctive/programmes for the former.
3. Students' absenteeism (in comparison with staff): It may not be easy to detect impacts of HIV on students of any particular institution. The deaths are less conspicuous because absenteeism of students could easily be attributed to financial constraints (particularly in institutions where students are meeting costs of tuition). Due to psychosocial factors surrounding HIV/AIDS, students with HIV and AIDS are likely to withdraw quietly from their studies.
4. As part of remedy, the institutions may consider introducing a policy or a recommendation that all fresh students will be residents at the institution campus. After the first year at the university, students may get enough experience of living in urban areas and living on their own. By the time they get into second year, they have developed capacity to manage their lives competently and they could be allowed to be non-residents if they wish.
5. Institutions should conduct a series of orientation programmes for the fresh students at the university. This could be done during the evening/nights (in order not to put more stress on the university day-time academic timetable). One of such activities could be HIV/AIDS related video shows or MDD or other *edutainment* drives in the evening/night in the halls of residents. The shows could be followed by debates and discussions.
6. Action on dress codes; while legislating on dress code may appear trivial or even infringing on students rights; it may reduce seductive factors that accelerate vulnerability to
7. HIV/AIDS.

## 6.4 Programmes

### **Prevention**

Research on higher education responses to the epidemic has highlighted the extent to which universities are relying on prevention and awareness raising strategies (Jelly: 2001, Chetty: 2001). These strategies can take many different forms - from the one-off AIDS day campaign with a blitz of slogans, t-shirts, and banners, to theorising issues around HIV and AIDS and to complex and sustained education campaigns. At whatever level, they rely on the assumption that in the absence of a cure, education is the best social vaccine against the epidemic.

Prevention is key to keeping the majority of students and staff HIV free. Prevention strategies must also be understood in a broader category that includes date rape and partner violence. Strategies focusing on prevention are important and need constant re-enforcement because of the vagaries of communication and the knowledge that the availability of information by itself is not sufficient to cause behavioural changes. Sustaining and building on positive behaviour changes is an even greater challenge.

The range of approaches to prevention has grown steadily with new innovations now focusing on interactive, software based strategies in some countries. A few African countries are venturing into this territory but most rely on more conventional approaches.

While increasing awareness could be the most effective and sustainable approaches to prevention, it may be important for institutions to avail (to the students) practical alternatives or remedies.

Options include the following

- Introducing students' work scheme at the institutions campus: this is based on the premise that economic factors drive students into commercial/transactional sex. Work at the campus may include scheduled hours per week serving in the catering sections, sanitary services, library, institutional farms, etc. Besides giving students some income, it keeps them occupied and focused; and reduces redundant hours.
- *The institution may consider extending more financial support to PLWA (who may also have lost their parents). Without such a support, the PLWA may engage in transactional sex with the rest of the students or staff*
- Positive incentives could be created to encourage testing and openness. These incentives may include mobilizing the university community (students and staff) and other well wishers to create a fund to support the needy PLWA who have disclosed their status.

Emphasis on Care giving; counselling needs to be emphasised particularly for the PLWA and students affected by HIV/AIDS. These include those that may have lost their parents before or during their stay at the institution campus.

### **Peer Education**

Prevention also opens the window to other spin-offs that assist the development of a comprehensive response. Peer education is one such example. As a learning technology, peer education has been proved as one of the most effective ways of reaching young people, and it also offers unparalleled opportunities for social mobilization. The challenge has been to ensure that peer education is sustainable, worthwhile for the student and sufficiently structured to allow for standards to be put in place. These issues are discussed in more depth in the curriculum section of the Toolkit. For more information on the value of peer education as part of a prevention

strategy, refer to Rutanang<sup>3</sup>, a set of peer education guidelines developed within the African context and specifically directed at higher education

### **Beyond Prevention**

While prevention strategies must continue and be built upon, the approach supported by the Toolkit is that we need to think beyond prevention in a context where institutions in many parts of Africa have students and staff who have died, are ill, or whose families are seriously affected by the epidemic. Prevention alone will not address the gravity of the needs of HIV infected or affected individuals and their families - it is simply insufficient.

In this context, powerful arguments are emerging in wider society and within universities that any response to HIV and AIDS has to work across a continuum that includes prevention, treatment, care and support (Cameron, 2000) and that extends to proactive management of the impacts of the epidemic. Some African institutions are now investigating treatment based on anti-retroviral therapy (ARVs) and treatment programmes run by the public sector are a reality in parts of Africa. Medical insurance schemes, to which staff belong are also willing to cover ARV treatment in some instances. This may not be an option for all, but the point still holds -treatment literacy, testing and treatment for opportunistic infections must be part of a comprehensive response.

### **Messages**

A debate has come to the fore - with which we need to engage - in relation to strategies that promote abstinence, as opposed to promoting healthy sexuality. The assumption is that students and staff are already involved in or inclined towards high- risk social and sexual behaviours may have the effect of undermining positive behaviours which are being practiced. Positive behaviours - such as delayed sexual debut and abstinence need to be re-enforced alongside a focus on healthy sexuality. In many societies abstinence would undoubtedly be the preferred message - especially for younger men and women who have not yet become sexually active.

Despite the fact that HIV in many countries has acquired new transmission dynamics, HIV messaging and delivery channels of the past have remained the same. For instance, in Uganda, the modes of transmission study found out that most data generated over the years have not been utilized in designing new prevention interventions<sup>1</sup>. After more than 20 years of intensive sensitization and communications about HIV/AIDS, the media landscape seems to be saturated with the same HIV/AIDS messages<sup>2</sup>.

### **Checklist for programmes**

Prevention campaigns rely heavily on an education focus, and for that reason, this section of the Toolkit concentrates on education programmes as a sub set of what are conventionally known as Information, Education and Communication (IEC) strategies.

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<sup>1</sup> UNAIDS/UAC (2009) HIV Modes OF Transmission and Prevention Response Analysis; Final Report, March 2009

<sup>2</sup> Gray, R.H., Serwadda, D., Kigozi, G. & Nalugoda, F. 2006. Uganda's HIV prevention success: The role of sexual behavior change and the national response. Commentary on Green, J. and Thorogood, N. 2004. Qualitative methods for health Research. London: Sage publications

It is worth making a distinction here, between programmes that raise awareness, those that provide information and those that provide new knowledge and skills.

- Is the programme focused on students or employees and/or members of the wider community?
- Is it intended to raise awareness, provide information and/or develop new knowledge and skills?
- Where is it located and supported within the institution (students representative council, campus health centre, student advocacy group, student services etc.)?
- Is it part of a broader strategy for the institution or a stand-alone initiative?
- Will materials, media or personal interactions support the programme?

The answers to this checklist are, in effect, the pre-conditions for a successful programme. They include:

- Student/staff involvement in design and implementation.
- Gender sensitivity.
- Involving people living with HIV/AIDS.
- More than once off/sustainable
- Accredited/evaluated
- Audience specific
- Integrated into a comprehensive response
- Supported by institutional stakeholders
- Is the programme based on baseline studies/formative research or needs assessments?
- Are there regular monitoring and evaluation (or continuous assessment) incorporated into all aspects of the programme?
- If yes, are the findings used to support programme improvements?

### Remarks

The term *accredited* needs more clarifications. It may be understood in the context that the programme is recognised by National education authorities and, probably, that it carries academic credit of some sort. This has a number of connotations;

1. It could mean that the programmes are standardized such that what happens in one institution is similar to what happens in another. Is this the structure that is aimed at for HIV/AIDS initiatives in higher institutions of learning? If yes, would it not compromise innovativeness and flexibility (in light of varying institutional contexts)?
2. Once a programme (or aspects of it) is associated with academic credit, students' emphasis will be shifted from applying the knowledge/skills for real life situations, to passing examinations/coursework to obtain certification.

## 6.5 Care and support for infected and affected people

### **Policy**

Care and support should be covered clearly in the institutional policy on HIV and AIDS. Trainers and service/programme managers should be aware that care and support components of institutional policy are sometimes difficult to negotiate because of the cost implications of care. Education managers are likely to want to limit their responsibility for covering expenses, which they see as a 'health issue', a cost that should be carried by the public health sector or private individuals (students and staff). Some programmes are easily implementable at low cost whilst others do require specific levels of infrastructure and expertise.

### **Programmes**

Some of the established options are listed below:

- VCT.
- Counselling.
- Referral services (to local clinic, teaching hospitals, NGO service providers).
- AIDS support clubs.
- Home based care.
- Treatment for opportunistic infections (T8, pneumonia, etc).
- Contraception services (condoms, femidoms, oral contraception) .
- STI treatment services.
- Parent and community support groups.

As with other programme interventions, these need to be designed and delivered as part of a comprehensive strategy and adapted for specific target groups (students, staff, parents, community).

Care and support also needs to be looked at as a point of leverage in a comprehensive response. For example, VCT is best used as a way of reaching both uninfected, infected and affected people. For uninfected people, VCT is intended to provide an opportunity for them to know their health status and to develop the knowledge they need to stay HIV free. Likewise, a routine treatment for a STI should be used by the health provider as a way of improving the client's knowledge of HIV and their vulnerability to infection because of STIs. Appropriate treatment of STIs through cheap and easily available public health services has proved to be a key element in reducing vulnerability to HIV infection. In both cases, VCT and STI treatment services require advocacy, strict confidentiality, high quality services, youth-friendly service delivery and observance of health protocols.

The test of policy and programmes in this area comes when the institution has to answer the question: 'If I do test positive, what support can I be assured of?'

### **Remarks**

While it is ideal for institutional policies to cover care and support for HIV/AIDS infected and affected, distinction need to be made on the status of the institution; *private or public (state sponsored)*.

- a. For the private institutions that are already struggling to meet costs of existing programmes (amidst clients that are low-resourced) adding other costs could be unrealistic/ impractical. The extra costs range from medical equipments; to hiring specialized personnel who manage different sectors of the comprehensive HIV/programmes.
- b. On the other hand, public institutions are not only well resourced (by public funding); they also attract more donor support than the private institutions do.

In many countries now, private institutions outnumber public institutions. A policy that may not be operational in private institutions (the majority) may not have sound visibility. A policy that cannot be implemented could be more detrimental than having no policy at all. It raises great expectations that will not be met.

## 6.6 Gender

As a trainer or focal person at institutional level, a major challenge will be in the way you advocate HIV and AIDS issues and how you tailor approaches and interventions across different target audiences. These differences have been flagged throughout the Toolkit. The success of a trainer or advocate depends heavily on the quality of individuals and their ability to create a working consensus in a context of strong competing interests, pressures and perceptions.

The gendered dimension of HIV and AIDS could be written as a separate Toolkit. Within this Toolkit, it is essential that we, at least, recognise the ways in which gender affects all aspects of a comprehensive response.

### **Policy**

- The concerns of women students and staff need to be clearly articulated.
- The disproportionate impacts of HIV and AIDS on women in terms of health, social and economic status needs to be recognised.
- Policies concerning sexual abuse, harassment and rape should be linked to an institutional policy on HIV and AIDS.
- An adequate emphasis should be placed on engaging men in gender specific strategies.

### **Planning and Management**

- Gender issues must be integrated across a comprehensive response.
- Gender specific impacts of HIV and AIDS on key indicators should be monitored.

### **Programmes**

- Gender sensitivity is established as a programme design principle.
- Services are adapted to best suit the needs of women students and staff.
- Men are required to take a significant role in gender specific activities.

- Specific programmes are targeted at women students and staff.

### Remarks

Of late, gender mainstreaming has been a central focus in many aspects of public administration and policy formulation. However, while gender inequalities could be clearly illustrated in discussions of economic empowerment and educational opportunities, it is not very obvious in discussions of HIV/AIDS policies (particularly in high institutions of learning). It is therefore necessary to devote a bigger section (within this toolkit) to show how women are not getting more attention when it comes to care, support or HIV prevention (in institutions of learning). Before planning for a separate toolkit exclusively for gender and HIV/AIDS, it is imperative to describe the real relationship between HIV/AIDS and gender differences. In this way, the policy issues would be given an appropriate contextual background. At the moment, it may look to be more academic or theoretical.

For instance, the following references could be used to showcase;

- I. Women in high institutions in Uganda, Kenya, Ethiopia and Zambia are more vulnerable to HIV infection (Ashebir, 2007; Katahoire and Kirumira, 2007; Nzioka, 2006; Ramos, 2006).
- II. Students particularly privately sponsored students, are under pressure to pay higher fees, women are pressured into transactional sex to bridge their fee gaps (Ochanda, Njima and Schneegans, 2006) and therefore stand greater risks of HIV/AIDS infection than their male counterparts.

What does gender mainstreaming entail?

- I. Assessment of HIV and AIDS action, policy and implications in light of male/female specifications
- II. Taking gender concerns and experiences to be an integral dimension of the design, implementation, monitoring and evaluation of institutional HIV and AIDS.
- III. Ensuring that women and men benefit optimally from the policies and programmes regardless of their gender differences
- IV. Acknowledgement that in higher education institutions women are possibly at higher risk of acquiring and transmitting the virus. There could be indicators of such in various institutions.

What could be done?

- a. Collecting, analysing, and using gender-disaggregated data on HIV and AIDS in the institution, colleges, faculties, departments and other units?
- b. Recognizing the right of all men and women, boys and girls; and their protection from exposure to the possible risk of HIV infection
- c. Promoting legal, civil and human rights of men/women, boys /girls affected and infected, and giving them access to treatment, counselling and support on an equal footing
- d. Monitoring the impact of HIV and AIDS on both men and women

### 6.7Activity

Review the case study below and prioritize the issues and actions that are relevant to your institution.

## 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. Anti-AIDS clubs have been 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 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 labour 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 demeaning activities such as prostitution or commercial sex work to raise income for livelihood. The 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 Counselling Centre in conjunction with KARA Counselling 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 popular beliefs among different study groups (4,12,14,15) and 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

Sexual behaviour among UNZA students tended to agree with other surveys where men state that 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 behaviour amongst University students is quite permissive. 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 Counselling Centre instituted a programme of HIV/AIDS information and education to students in 1994. A confidential HIV counselling and testing facility was also introduced at campus through a USAID funded project coordinated by Kara Counselling 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 submitting to the test, though a larger number attended the counselling alone. Apparently this seems to be a common finding in other projects in the country where people frequently express interest in HIV counselling and testing but seldom take the test even when it is made accessible, convenient and cheap for them to do so. The low utilization demand for HIV counselling and testing led to its discontinuation toward the end of 1994, although there is need to evaluate better avenues for providing voluntary HIV counselling and testing in the existing health care delivery system.

The information, education and communication (IEC) strategy involves social skills training in peer counselling and education for HIV/AIDS, assertiveness and negotiation for safe sex practise, condom promotion and use, and sustainable social behaviour change. This strategy aims to empower 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 fora 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 addressed 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 Counselling Council and the National AIDS Programme, participated and facilitated the development of a national policy on HIV/AIDS counselling. The Policy provides guidelines and a framework for counselling service provision, including voluntary HIV counselling and testing. The document is currently receiving ministerial attention prior to its ratification and adoption for implementation by the Government. An 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 across levels calls for the adequate provision of resources of financial, human, logistical and technical resources. It is apparent that there are inadequate resources mobilised for the implementation and management of HIV/AIDS programmes at higher education establishments not only in Zambia, but also in other countries worldwide. Efforts should be advanced to mobilise 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

## **Module 7**

### **Curriculum Reform and HIV/AIDS**

#### **OBJECTIVES**

Trainers and academic staff are informed of the motivations for including HIV and AIDS in academic programmes.

Academic staff recognize the impacts of HIV and AIDS on teaching and learning and the skills required by graduates.

Academic staff are skilled in the practical and theoretical dimensions of integrating HIV and AIDS into academic programmes.

#### 7.0 Curriculum Reform and HIV/AIDS

*What does integration mean in the higher education context?*

There is now a strong and growing consensus that curriculum reform must take place in higher education if institutions are to keep pace with the needs of society and the need for high skill professionals equipped to deal with an AIDS affected world of work. Much of the debate in higher education has revolved around what it means to integrate HIV and AIDS into curricula.

From the perspective developed in this Toolkit, it requires project leaders to refer back to the three areas of core business around which higher education revolves: teaching, research and community engagement. The questions that arise in the case of HIV and AIDS might be along the following lines:

- Is responding to HIV and AIDS part of the institution's academic mission?
- How is it relevant to the core business of the institution and where does it fit?
- Have HIV and AIDS, in any way, affected or changed teaching and learning in the institution?
- How does the institution see curriculum reform in relation to a comprehensive response?

Overall, the responses by African higher education institutions to HIV and AIDS are positive in many respects (COREVIP, 2003). A few examples would include the University of Namibia which has successfully adapted and implemented a programme titled 'My Future is my Choice'; the University of Rwanda which introduced HIV and AIDS related content in 1999 for entering students; and curriculum changes are proposed in a number of West African francophone institutions in collaboration with the UNDP. UNDP's major concern is the need to develop a larger number of professionals in the public service with the necessary policy and planning expertise in the area of HIV and AIDS.

More systematic information curriculum reform will be available from the AAU's survey of institutions in 2003. There is undoubtedly room for improvement but major advances have been made in terms of curriculum reform and teaching alongside their contributions in the areas of

policy development, leadership, advocacy and other programmes.

There are critical questions that may have to be addressed in undertaking curriculum reform for HIV/AIDS. These include the following;

1. What direction should the curriculum development take? Should HIV/AIDS courses be treated like other courses that are taught in class and which require taking written examinations? *Integrating HIV activities with other courses entail that this approach is taken.*
2. The majority of courses taken at the higher institutions of learning are taught using conventional pedagogical approaches. They are taught and evaluated using approaches that fall in the cognitive domains of learning. *Is it practical and feasible to achieve behavioral change objectives (in affective domain of learning) using cognitive approaches?* Assessment and evaluations used in other courses are conventional written examination. How will the achievement of *affective objectives* in the HIV/AIDS related learning be evaluated?
3. Are the academic staffs appropriately equipped to undertake HIV/AIDS related activities (in teaching and other interventional activities)? If not, are there plans to undertake Trainers of Trainers orientation courses?
4. There is certainly need for specialized skills on part of the leader, lecturers.
5. There is also need for production of learning facilities and resources (which may not be abundant in many institutions). These could include among others, audio-visual aids. Are there plans to produce such materials locally at the institution? The materials could be context-specific (tailored to meet needs of a specific institution and may not be directly applied in another institution). This could make the process expensive.
6. It is imperative to determine the diverse group targeted for by the curriculum and the learning resources. These are certainly group-specific. It is either targeting student, staff (academic, non-academic, other institution members such as wives of the staff who stay at campus, nearby communities? Each of the groups will be addressed by a different approach and different resources.

### 7.1 Critical co-factors

Reform of academic programmes requires careful consideration of a number of cofactors which will affect the direction taken by an institution and the likely success of the reform process.

- Choices - a reform process will be predicated on choices about priorities, time available, resources and what capacity is available.
- Comprehensive response - curriculum change will be most effective when it is located within a comprehensive response that is backed by policy commitments and management support. To put the issue bluntly, funding for a new course or an adapted course will only come as a result of Senate level approval. That approval can be more easily secured if the course is backed by institutional and academic policy.
- Ad hoc responses - there are good reasons for supporting and consolidating ad hoc responses to curriculum reform because they have value. For example, if a committed teacher in the education faculty has introduced HIV and AIDS as a module into the pre-service teacher education programme independently of any official decision, it should be supported.
- Institutional type - higher education institutions vary widely across Africa in the way they

are organised, managed and governed. The range includes universities (both public and private), technical institutes, nursing colleges, teacher training colleges or even theological colleges. There is no single template for curriculum reform across all these institutional types. Each of them has a specific mission, institutional arrangements and student profile which influence their programme offerings.

- Models of intervention - the form and content of curriculum interventions must be consistent with academic programme structures, the needs of students, the capabilities of teachers and the opportunities available within the curriculum
- Entry points and duration - current practice encourages the use of as many entry points as possible in the curriculum. So, for example, entry-level courses aimed at 1st year students should be complemented by non-formal programmes and content and skills that are integrated into their professional programmes. (This issue is illustrated in the diagram below). There is evidence to suggest that formally certificated and evaluated programmes achieve better results. As yet there are no standards that are common in terms of the duration of courses since this depends heavily on the content and structure of the academic timetable.
- High and low prevalence environments - there is sufficient cause to argue that HIV and AIDS should be part of the curriculum regardless of the extent to which the disease is a threat to students and the institution. So for example, all trainee health professionals should be required to have competence in dealing with HIV and AIDS. On the other hand, working in low prevalence environments may require differing approaches. Can the same arguments be made about other disciplines such as the humanities, social sciences etc. in a low prevalence context? A key factor in this debate is what the motivation is for including HIV and AIDS in the curriculum.

## 7.2 Strategy -who is our target audience?

In practical terms, trainers will need to equip academic staff to answer a number of strategic questions if they want to embark on a path of curriculum reform: who, why, how, what and where. The first of these is 'who?'

- Target -our target audience includes teaching staff, researchers, students and trainers elsewhere in the institution. Ideally they should include the 'unconverted'.
- Academic leaders - the target should be considered as a group of academic leaders as HIV and AIDS requires academic leadership.
- Academic leadership in practice - what does it mean? Assume your students and faculty are at risk; inform your students/staff; support those affected and infected; manage HIV and AIDS in the classroom; keep your students and staff HIV free; keep those living with the epidemic healthy and productive for as long as possible.

## 7.3 Activity

As a trainer or project leader, speaking to academic staff, you are likely to encounter a host of questions and concerns at this point in the process. Focus the discussion around the following questions and attempt to resolve them.

1. Is this my responsibility?
2. Do I have the capacity and inclination?
3. What other resources/support are available within the institution or externally?

#### 7.4 Why integrate HIV/AIDS into teaching and learning?

This question must be answered in the first instance with reference to the mission of the institution. What role does the institution see for itself in the fight against HIV and AIDS? Are its graduates expected to be both socially responsible about HIV/ AIDS and professionally equipped to deal with the epidemic?

The motivations for integrating HIV and AIDS into the curriculum can be categorised along the following lines:

- Personal
- Professional
- Institutional

This Toolkit provides a framework which allows you to work across this spectrum of needs and allows us to put both prevention-oriented content/messages as well as professionally oriented skills into the curriculum. What do these mean in practice?

- Personal motivations - life skills, behaviour change, core values (non-racism, non sexism, equality, the rule of law).
- Professional motivations -responding to HIV and AIDS as a professional competence in the world of work (e.g. clinical skills in the health sciences, policy development, planning, research, analysis, programme development, implementation and management).
- Institutional - new leadership, investment/efficiency, skills development/HRD for students and faculty (re-tooling faculty).

#### 7.5 How best can we integrate HIV/AIDS into teaching and learning?

There are choices to be made at this point in the reform process which include using formal, non-formal or both options simultaneously. There are advantages and disadvantages in each of these cases. Before opting for any of these paths it is important to ask a few questions which should orient us towards making the appropriate choice.

- What knowledge base do students/faculty already have about HIV/AIDS?
- How do we build on that base?
- Have we established what types of knowledge and skills would be most relevant to their personal interests and professional aspirations?
- Is there space in the curriculum for HIV/AIDS?
- How do we determine the existing knowledge (that the students and other target beneficiaries have) about HIV/AIDS?
- Do we have the tools to determine both the knowledge-base on HIV/AIDS and the type of knowledge and skills that they need? If no, can we develop them?
- What are the sources of knowledge that students/faculty use to know about HIV/AIDS? (In light of the various myths and misconceptions that surround the epidemic)
- How do we correct the myths and misconceptions?

- In case there is no space in the curriculum for HIV/AIDS (assuming space mean time in the formal academic schedules), can it be created outside the curriculum? If yes how appropriately can this be done?

Let us examine each of the options in terms of advantages and disadvantages:

- Formal model (advantages): assures greater integration, is credit bearing and possible to evaluate through conventional means (tests, assignments and exams).

Benchmarking: Best practices can be shared and tried out in various institutions with minimal modifications; The challenges can also be comparatively analysed.

Formal model (disadvantages):

- Can be slow to develop, is costly and has rigid requirements.
- Competes for time and space with the more formal academic activities in the institutions
- There is a big likelihood that students and even staff will treat the programmes like other university courses which are occasionally passed for purposes of completing the course for certification and not for immediate application.

Examples of formal models: core courses, electives, foundation courses required for the completion of a degree programme.

- Non-formal model (advantages): is flexible, has possibilities for social mobilisation and overall low cost implications.

When professionally organised, informal activities could diversify the monotonous and rigorous academic activities; they could create relaxation alongside learning (the edutainment model).

- Non-formal model (disadvantages): tends to be ad hoc, is seen as a 'soft option' by students and staff, has no guarantee of continuity and it is not integrated into the 'regular' academic programme.

The typical institutional academic staff may not be well versed with the structural processes of organising informal learning activities, particularly in the affective domains (which HIV/AIDS programmes entail). They are more familiar with the structured cognitive and perhaps psychomotor domains of learning.

Examples of non-formal models: peer education projects, life skills workshops, awareness training for new students, AIDS clubs etc.

### **Recommendations**

Some generic recommendations are discernable in current attempts at curriculum reform.

- Use a range of different entry points in the curriculum (foundation year, core courses, specialised modules, extra curricula activity).
- Choose what is appropriate and relevant to the needs of students.
- Consider what is possible for your institution: adopt a short term and long term view.

- Expect a lag of up to 24 months to get a new course passed through Senate.
- Whatever the choice, there are cost implications in terms of time, personnel, research, materials etc.
- Objectives related to introducing HIV and AIDS content in existing or new courses should be framed in a way that translates easily into indicators and allows for measurement/evaluation.
- AIDS fatigue' amongst students is a reality and has the potential to undermine strategies that rely too heavily on simply transmitting information.
- Choose what is appropriate and relevant to the needs of the various categories of staff

*AIDS fatigue*: one of the factors contributing to the fatigue is the use of non-changing messaging, materials, modes and media. It is imperative to diversify presentation and delivery modes. It may be advisable to engage students (or other people) in content generation and development; and in the design of presentation formats and media.

### **Pedagogy**

In pedagogical terms, the strategies which have been deployed in teaching HIV and AIDS show high levels of innovation and flexibility. They include: performance, ICT, workshops, projects, research, case studies, exams and service learning. HIV and AIDS have also turned the spotlight on traditional classroom practice where teachers are seen as, or indeed see themselves as, the best-equipped and most knowledgeable person in the room. It is becoming more evident that students themselves are an untapped source of knowledge about the epidemic and the ways in which it has affected institutions and individuals.

One of the preliminary activities towards developing an effective pedagogy is organising orientation workshops for academics such that they;

Appreciate the fact that knowledge on HIV/AIDS could come from a number of sources, one source being young people themselves. Acquire skills in conducting participatory learning activities to tap knowledge and insights from a variety of sources/people. Put emphasis on teaching students (and other people) how to look for knowledge and information (*process-focused learning*) other than giving packages of facts, knowledge and information (content-based learning). Competently balance up the domains of learning (cognitive, psychomotor and affective) as they deal with HIV/AIDS programmes. Get familiar with modern tools of information transfer, particularly those that are popular to young people. These include the social network sites SNS such as facebook, twitter, MySpace and YouTube.

Get the basics of applying educational entertainment (edutainment) for conveying messages and igniting debate on HIV/AIDS

An example of the use of multimedia and social network sites in the HIV/AIDS campaigns is found in appendix 3

### 7.6 What curriculum interventions are most appropriate, manageable and effective for the institution?

It may not be visible but it is quite possible that academic staffs are already including content on HIV and AIDS in their teaching. A quick institutional scan will establish the extent to which this is happening. Course developers should be encouraged to build on what exists wherever possible, to adapt programmes used by other institutions and to share their knowledge as widely as

possible.

The extent to which lecturers are willing to co-operate and the pace at which the changes take place are hard to predict. One factor stands out and that is the level of expertise which staff themselves have in handling HIV and AIDS. There may also be personal and cultural barriers to them participating fully in the change process.

### **Programme design**

Debates about programme design will never be conclusive in higher education because the reasons why a core course works well in one institutional setting and less so in another is hard to elucidate. No single model of programme design is either appropriate or relevant. There is also a danger in course developers leaping ahead to a choice about programme design before exploring the questions that precede decisions about design -hence the emphasis in this Toolkit on an overall framework within which curriculum reform should take place. The options are not limited to but include those listed below:

- core course;
- foundation course;
- stand alone course;
- elective module;
- research projects;
- projects and workshops.

Curriculum interventions, like peer education projects, have gained popularity very rapidly because of their proven acceptability to students. As a result they tend to be seen as quick solution to a far more complex problem of curriculum reform. In the context of the choices we make about programme design, we need also to ask who do we want to reach; at what points in their academic programme; what level of frequency is necessary to make the programme cohere and what types of skill or behaviour change is our intervention aimed at? If interventions are non-formal, they typically aim at behaviour change. The challenge in a comprehensive response is to strike a balance between the urgency behind the need to change behaviours on the one hand, and on the other hand the need to create a new generation of professionals with AIDS related skills. Organisations like UNDP are now pursuing the integration of HIV and AIDS in professional disciplines with African university partners.

### **Disciplinary boundaries**

Disciplinary boundaries can be another stumbling block. It is relatively easy to make an argument that disciplines in the health sciences, social sciences and basic sciences must include content and skills related to HIV and AIDS. It is less so when confronted with engineering and the applied sciences. One strategy that has broken through in these disciplines is to de-link HIV and AIDS from its personal dimensions and to integrate it primarily as a professional competence. What does this mean in practical terms? 'AIDS competence refers to a theoretical and practical understanding of the epidemic, appropriate to the programme of study being undertaken and its implications for the future careers of participating students' (Jelly, 2003).

#### Disciplinary boundaries and the challenge of integration

One of the challenges in transcending disciplinary boundaries towards curriculum integration could be the lack of expertise and skill in the art of integration. Each of the various academics and professions could have mastery only in the content of one or two particular discipline areas. Integration entails that there are people with competences in correlation of disciplines. The task involves

1. Breaking down barriers between disciplines

2. Identifying and developing conceptual clusters between diverse disciplines
3. Identifying integrating threads between disciplines to form broad fields

In particular, those involved in discipline integration need to be in position to undertake one or several of the following approaches

- a. *Problem centered approach*
- b. *Process-based approach* (such a “problem-solving,” “decision-making,”)
- c. *Situation-based approach*
- d. *Content-based approach*

### **Content**

Content is also likely to be specific to the context and the emphases which lecturers want to develop. There are various ways of handling this from a management perspective.

- Use opportunities to integrate content into existing courses or minimise the investment in developing new content through partnerships (i.e. use what is already in existence).
- Leave decisions on content to the faculty concerned.
- Ensure that they have the necessary skills/capacity.
- Ensure that the content is culturally and gender sensitive.
- Integrate theory and practice wherever possible.

### **Institutional type**

Considerations about the type of institution in which the curriculum reforms are proposed have a particular importance in two cases: distance education institutions and teacher education institutions.

### **Distance Education**

Distance education institutions use learning technologies and instructional techniques which differ fundamentally from 'face to face', residential models of instruction. The critical advantage which can be exploited in distance education is the potential of reaching and researching a far larger number of students. Distance education also has the capability of linking a community of students across a far greater geographical and cultural spread. Through distance education technologies, support and some services can be provided without the student being on a campus. One of the most developed examples is a programme focused on HIV and AIDS in the workplace offered jointly by the Medical University of Southern Africa and the University of Stellenbosch. Over two years, roughly 340 students have been enrolled from 35 countries on the continent with content and support delivered through the Internet.

The challenge is in services which require personal interactions which are less easy to mediate through technology. The range of content available to students through the Internet far outweighs what any institutional library can contain and therefore offers significant opportunities for research, resource based learning and advocacy.

### **Teacher Education**

Teacher education institutions have a specific role in the education sector in that they train

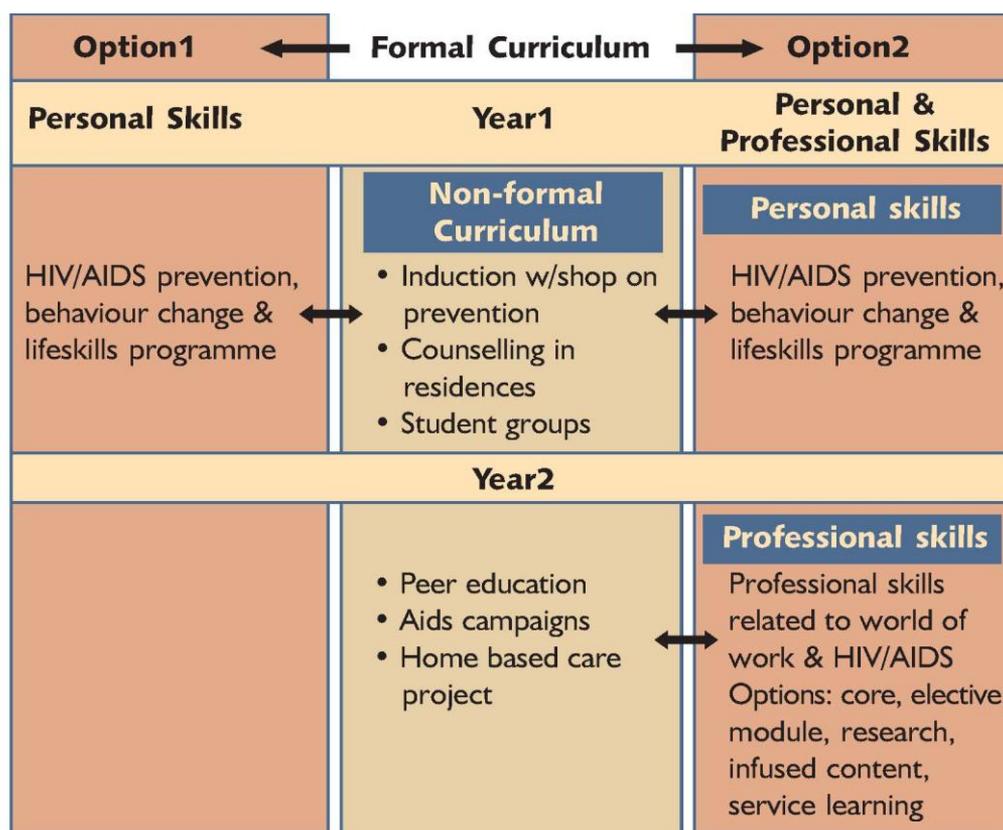
professionals who reach into every school and classroom in the country. The extent to which initial teacher education has embraced HIV and AIDS is still uneven. In high prevalence contexts where children with HIV, orphans and AIDS affected families are a reality, teachers have to be informed and skilled in a host of new ways. For example, Uganda's PIASCY programme (launched by the Ministry of Education in 2003) comprises assembly messages, peer education and life skills for primary and secondary schools. An integral part of the implementation of this initiative involves the training of teacher educators and teachers developers based at district level.

Given the scale of the challenge in training hundreds of new teachers and reaching thousands of teachers already in service, there are strong arguments, especially from ministries of education, that curriculum reform in teacher education needs to be prioritised in the short-term. UNESCO's regional offices in lenya and Harare have, to some extent, focused on teacher education in the area of HIV/AIDS and are useful regional resources.

#### HIV/AIDS in the Higher Education Curriculum\*

General: *Resource centres*

Curriculum development in individual institutions could be constrained by a number of factors including among others;



- Inadequate technical/human resources
- Inadequate financial resources
- Inadequate physical/material resources

It may be practical and feasible for various institutions (assisted by governmental and non-governmental organisations) to pool resources and develop joint resource centres. Generic drafts

of technical approaches, curricula, materials and media could be developed at the resource centres and made available for use by individual institutions. Naturally, many of these resources may need to be modified and adapted to the needs of the individual institutions.

This initiative may not be completely new in the context of African Universities. There are innovative models that have been developed, and others are still in the pipeline (though in different fields). An example is PASGR (Partnership for African Social Research and Governance Research). One of the objectives is to develop expertise, curricula and facilities that could be jointly applied across institutions in East, South, west and Central Africa (cognizant of the fact that there are regional diversities and interests).

A similar initiative is the sub-Saharan African regional Network (subsidiary of the Child-watch International Research Network)

#### 7.7 Where is the most appropriate place to initiate, develop and monitor these curriculum interventions?

Higher education is based on diffuse authority structures where every discipline has its own codes and ways of working as well as a level of independence in terms of what to teach and how to teach it. These are important principles which make higher education institutions the leaders and change agents we expect them to be.

Within this context, where do you need to build consensus around the need to respond to HIV/AIDS through the curriculum? It means you have to negotiate changes of policy through a hierarchy of stakeholders in the institution. A quick list would include the following:

- Senior management.
- Senate.
- Faculty Boards.
- Academic Planning Unit.
- Deans (executive).
- Academic staff (tenured and part-time).

In this negotiating process, there is an inclination to overlook the value of allies like professional boards. As the accrediting authorities for professional qualifications and regulators of entry to occupations, they have enormous influence which can be beneficial to advocates of curriculum change in response to HIV and AIDS. They are at their most influential in medicine, dentistry, social work, nursing, psychology, engineering and law.

*Supplement:* in addition to the listed levels, and in light of the above observation (on resource centres), it could be rational to add on other levels (beyond an individual institution)

- National bodies of higher education
- Regional bodies of higher education

In making this suggestion, it is acknowledged that individual institutions ought to have autonomy in the type and number of programmes that they should pursue. Nonetheless, the following observations could also be made

- a. Given the opportunity, many of the institutions (particularly the private ones) may not consider taking extra burdens of taking on activities that may be considered costly (but with no direct and no concrete financial/material benefits to the institution). On the other hand, they have an obligation to respond to the urgent and critical needs of the communities that they serve. This obligation could be reinforced from the governing bodies.
- b. The national/regional bodies could provide the much needed coordinating functions if common resources (such as resource centres) are to be of essence in the development of HIV/AIDS programmes. Without their facilities, it would be difficult for individual institutions to coordinate each other.

### Observation

A comprehensive HIV/AIDS curriculum is one that addresses the cognitive, psychomotor and the affective domains of learning

#### *Summary of the taxonomy of educational objectives*

	Cognitive	Psychomotor	Affective
Focus	Deals with the 'head', the intellect	Deals with the 'hands' skills, and the practical aspects of knowledge	Deals with the 'mind'; behaviors, attitudes, and values
Application	Academic fields, use of formulae, theories and principles	Practical application of the knowledge in physical performance tasks	Demonstration of good values during the applications of the knowledge
Effective methods of imparting knowledge	Conventional teacher-talk-learner-listens, discussions, discovery methods,	Demonstrations, fieldwork, practical work.	Edutainment, role-modeling, plays, skits, songs, poems, reading, preaching.
Performance levels			
Level 1	Memorizing	Observing	Receiving
Level 2	Comprehension	Imitating	Responding
Level 3	Application	Practicing	Valuing
Level 4	Analysis	Adopting	organization
Level 5	Synthesis	Perfecting	Characterization by value
Level 6	Evaluation	**	**

The above table demonstrates the processes through which a comprehensive curriculum for HIV/AIDS programmes can be made. The same processes need to be followed in the assessment of achievement.

#### Activity for programme managers

Try to analyse the HIV/AIDS programmes in your Institutions to determine whether your programmes and activities follow the above taxonomy.

#### Behavioral change objectives

While information and general knowledge on HIV/AIDS are important aspects of the programmes, the dominant dimensions of the programmes are those that address behavioral change among individuals and communities. It is therefore important that the affective domains of learning are emphasized in the programmes. This is elaborated below;

The taxonomy of the Affective Domain: The emphasis of the affective domain is on values, beliefs, attitudes, and behavioral aspects of knowledge. The affective domain is based upon behavioral aspects and may be labeled as beliefs.

#### *The Taxonomy of the affective Domain (Anderson & Krathwol 2001<sup>3</sup>)*

Level	Involves	Example
Receiving	Being aware; receiving information or attending to information or new knowledge	Person would listen to a presentation on HIV/AIDS or a film, drama or a talk show that relates to behavioral change
Responding	Showing some new behaviors as a result of experience	The individual would participate in discussions or ask questions about the presentation. He/she may also write notes or make.
Valuing	Showing some definite involvement or commitment	The individual might begin to think seriously about the presentation; think of how the presentation relates to real life situations, or determining the worth of the new information in regard to existing situations; may generate new insights based on the concepts presented.
Organization	Integrating a new value into one's general set of values, giving it some ranking among one's	The person begins to make long-range commitments based on the insights generated; related to the presentations

<sup>3</sup> **Anderson, L. & Krathwohl, D (2001).** A Taxonomy for Learning, Teaching and Assessing: A Revision of Bloom's Taxonomy of Educational Objectives. New York: Longman,

	general priorities	
Characterization by Value	Acting consistently with the new value	At this highest level, a person is firmly committed to the newly attained values and demonstrates behaviors attesting to the newly acquired values

### Edutainment, old and new media in HIV/AIDS programmes

Given that some of the constraints facing HIV/AIDS awareness initiatives are engrained in culture, social norms and beliefs; the mode of education entertainment (*edutainment*) could be instrumental in illustrating options and possibilities. The approach enables entertainment and education to be seamlessly woven together in such a way that there is no clear dividing line between the two (De Fossard 2004). It is used to capture attention of young people that are unlikely to pay attention to conventional messages. Based on the *Social Cognitive Theory* (Bandura 2002), edutainment enables the application of social marketing techniques for HIV/AIDS awareness programmes. The approach exposes both positive and negative behavior/practices and illustrates desirable targets.

As Bruner (1990) points out, an endangered society is one where alternative narratives cannot be scripted and whose members can no longer change the stories they tell themselves. In a context of many African settings, people are held hostage by a sense of fatalism. In edutainment, role models could be used to demystify incapacitating beliefs and attitudes related to HIV/AIDS. Edutainment could offer alternative remedies to HIV/AIDS scenarios that are hitherto considered unalterable. Role modeling demystifies incapacitating beliefs and empowers people to explore the various options available. It also offers alternative narratives in which peoples control over HIV/AIDS is demonstrated. Models are portrayed as positive, negative, and transitional (Bandura 1997; Sabido 2004; Poindexter 2004). The positive characters depict healthy values and behavior and they are rewarded, the negative characters model unhealthy behavior and antisocial values and they suffer as a result. Transitional characters represent the audience: they tend to be uncertain at first about which behavior to adopt. They gradually become convinced and begin to practice the healthy behavior and get rewarded (Cody & Sabido 2008). In order to make informed decisions, the audience is given the opportunity to watch several characters, rather than just one.

*Trigger video vignettes*; it is proposed that media that is popular with young generations are used in the HIV/AIDS prevention programmes. Such media include trigger videos vignettes. They could be made up of skits that convey various messages on HIV/AIDS. These videos, which could be about 5-10 minutes, could be uploaded on YouTube and other Social Media Networks. The purpose of these vignettes is to ignite debate and discussion among various target audiences on controversial topics of HIV/AIDS. The uploaded vignettes could be useful in the following respects

1. *Help youths*, particularly those with access to the internet to view the materials and initiate face-book or twitter dialogue
2. *Help instructors*: instructors could download the materials on flash disks or CDs and use them as instructional aids in teaching and group discussions

New media such as the Social Network sites (Face book, MySpace, YouTube, Twitter, etc) offer opportunities for engaging university students and staff in various dimensions of HIV/AIDS dialogues and debate. Social network sites could be central in the institution-based HIV/AIDS programmes<sup>4</sup>. At the same time, the realignment and convergence of the old media (mobile phone, radio and television) in form of call-in interactions provide a platform for interactivity.

*Interactive call-in radio programmes:* 5-10 minutes (audio) skits could precede interactive call-in programmes on radio and Television and could be the focus of the interactive debates and discussions. The convergence of radio and mobile telephony is positioned to support the sharing of insights among various audiences. It is particularly handy for spouses and relatives of institutions staff who are confined to household chores and cannot afford the mainstream awareness activities that are programmed for the students and staff. This arrangement is also likely to attract participation of communities outside the institution. In effect the institution would be getting insights from the non-academic communities. It also offers the institution an opportunity to contribute to the communities struggle against HIV/AIDS (this can only be effective if the dialogue is in languages used by the majority of the people in the catchment areas). Interactive call-in radio programmes are afforded by the rich and poor, literates and illiterates and could be accessed in the remotest parts of the country. The arrangement fits well in the African oral cultures where there are high levels of illiteracy and poor reading cultures. It also fits well in settings where technologies are less sophisticated. Existence of numerous local FM radio stations in many African countries is an opportunity for this approach to social marketing. Some universities operate FM radio stations. However, even those that do not have the facility could collaborate with available FM stations within their vicinity.

*Rationale for using multimedia:* systems, tools and technologies that support interactive communication need to be developed alongside existing cultural resources (Balkin 2004). By telling their stories, various communities can be initiated into new ways of seeing, hearing, feeling and discovering the power of their voices (Greene 2001). Theoretical perspectives such as *Symbolic Interactionism* (SI) may help to illustrate innovative media use. The SI perspective sees society as consisting of organized and patterned interactions among individuals (Blumer 1969). Being creative, dynamic and pragmatic actors, the youths construct their social world not as passive or conforming objects of socialization. They adjust their behavior in accordance with the actions of other players and events in their environment. Social media is therefore used for functional and cultural creation (Cheliotis 2009). The SI perspective focuses on symbols, negotiated reality and the social construction of society and illustrates the audience engagement with the interactive media on various media. It is suggested that messages are generated, transmitted and received by audiences in ways that are meaningful to them. Information is drawn from different sources into the audiences' own spaces and is creatively reused by the audience in their network (Lessig 2008). To be affective, the communication has to be in a form that is appropriate to the audiences' sub-cultures. For instance, the quasi-modern youth culture has unique symbols, choices, fashion, styles, interests, slang; music and film genres (UNESCO HIV 2002; Hebdige 1979). It also has distinctive forms of recreation, socializing, coping, unique role-models and expressions (slang).

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<sup>4</sup> See Nkosinotando Mpofu & Abiodun Salawu (2012); Investigating the use of social networking sites and their implications for HIV/Aids communication amongst Rhodes University students; *Communicatio: South African Journal for Communication Theory and Research* Volume 38, Issue 1, 2012 (Available online)

## 7.8 Institutional drivers

There is a way of attaching a more concrete value to institutional drivers of curriculum change than the conventional arguments about long-term human resources development needs and the economic role of higher education. A number of institutions have discovered a new niche market in HIV and AIDS. The results are evident in that new students are attracted to programmes which have relevance to their work and are often packaged as short courses or professional development courses. Teachers and researchers working in areas such as human resource management, population studies, health economics and a range of other disciplines have also realised that their skills have a value well beyond the institution and provide the springboard for them to work as advisors, technical assistants and consultants to government and other agencies.

## 7.9 Activity

1. Review the example of the course developed by the University of Botswana which is provided below in the light of the issues raised in this chapter.
2. Draft a proposal as to why your institution should consider a curriculum based response to HIV/AIDS and what form the response should take.

### Activity for lecturers

Each institution has peculiar contexts which make it either easy or difficult to integrate HIV/AIDS into academic and non-academic programmes. Examine the structure of your institution and examine the strengths and limitations of carrying out the following

- I. Handling HIV/AIDS as 'separate subject' or course
- II. Handling HIV/AIDS as a compulsory subject or topic across all degrees or diploma courses in the institution
- III. Setting compulsory questions on HIV/AIDS in their examinations
- IV. Integrating HIV and AIDS into existing subjects
- V. Infusing HIV and AIDS across the curriculum
- VI. Training and motivating staff to offer HIV/AIDS course, to teach well and to evaluate the students
- VII. Integrating HIV and AIDS into extra-curricular activities such as sports, or creative arts like drama and music subjects, going to see plays and concerts, and debates.
- VIII. Combination of different approaches

## 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 behaviour. 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 behavioural 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 behavioural 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 behaviour.

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 behaviours.

### **Key commitments**

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

**Change:**Our behaviour 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.

## **Module 8 Research and HIV/AIDS**

### **OBJECTIVES**

- Trainers are equipped to motivate why higher education institutions should be involved in research on HIV and AIDS.
- Academic teaching staff and members of the research community are better informed of their role in a response to HIV and AIDS.
- Academic teaching staff and researchers work towards the closer integration of research and teaching about HIV and AIDS.
- Researchers are aware of the policy and strategy issues that surround research on HIV and AIDS.
- Trainers, researchers and academic staff develop awareness of the scope and magnitude of research requirements and activities on HIV/AIDS; stretching beyond the institutional boundaries.

### **8.1 Motivations**

Why should higher education institutions be committed to research on HIV and AIDS? The ACU's most recent deliberations on this issue propose the following motivations and strategy issues (CACU, 2002):

- There can be no doubt that HIV and AIDS constitute a major problem for our societies as a global emergency which threatens gains in economic development and human dignity.
- New knowledge is critical to our efforts at combating and managing the epidemic.
- New knowledge promotes human development, strengthens the higher education institution's engagement with the society it serves, strengthens teaching and can support the development of better and more informed policies.
- Many of the problems generated by the disease and the epidemic are interdisciplinary and therefore provide opportunities for working across disciplines, institutions and geographical boundaries.
- New opportunities for funding are constantly emerging.
- Higher education institutions particularly have a major stake in the global search for improved bio-medical, social and economic understanding of HIV and AIDS. As institutions founded with a mandate to generate new knowledge, the ultimate aim must be that research efforts should contribute to a better understanding of the epidemic and improvements in the technologies needed for prevention, treatment, care and support.
- HIV/AIDS is a moving target and its face is constantly changing; Establishing sustainable coping strategies call for ongoing research

### **8.2 Institutional Context**

- What is your current research strategy and does it refer to HIV and AIDS?

- Has your institution attempted any research into HIV and AIDS?
- Are there institutional barriers to getting involved in research on HIV and AIDS?
- In which areas or disciplines is HIV and AIDS research mainly concentrated?
- What incentives does your research strategy use to encourage new research?
- Does your ethics policy sufficiently cover the rights of people living with HIV and AIDS and researchers who may be involved in projects?
- Is there a mechanism which tracks research outputs in specific areas?
- What resources are available within the institution to support research on HIV and AIDS?
- What additional resources can be mobilised locally?
- What partnership/collaboration opportunities have you explored which involve research on HIV and AIDS?
- Does a culture of inter-disciplinary research exist at your institution, and if not, what would facilitate its development?
- Does your institution give any priority to HIV and AIDS research in terms of funding or other support?
- Are research findings easily disseminated within the institution?
- What opportunities (besides the facilities) do exist in your institution to promote research in HIV/AIDS?

How is it possible to generate and improve research outputs around HIV and AIDS?

- Research on HIV/AIDS attracts funding.
- Research on HIV/AIDS lends itself to collaborative partnerships which leverage additional resources.
- Networking through the AAU offers the possibility of reaching nearly 270 partner institutions.
- Health science faculties provide a strong node for growing research.
- Research in the social sciences and humanities is less costly and easier to initiate. What co-factors will stimulate and support research on HIV and AIDS?
- Existing leadership in the research community.
- A research policy that prioritises engagement with major social and health problems.
- A health research culture.
- A sound ethics policy which covers the rights of research subjects in relation to information, confidentiality, non-discrimination etc.

### 8.3 Trends

Since the late 1990's the pace of change in new research on HIV and AIDS and education has

picked up rapidly. Much of the available information has been generated by and for international agencies such as UNAIDS, the World Bank and development co-operation agencies. A quick scan in 2003 indicates that much of the focus continues to be on the African scenario which remains the most pressing in terms of the impact of HIV and AIDS.

In early 2001, the South African Universities Vice Chancellors Association (CSAUVCA) published its own analysis of institutional responses to HIV/AIDS in the South African university system which comprises 21 universities providing for roughly 330 000 students. The report argued strongly for the development of institutionally defined responses predicated on a set of minimum standards for prevention, treatment and care, towards which every institution should work and strive to maintain.

In March 2001, the Association for the Development of Education in Africa (CADEA) published a synthesis of the findings of seven case studies of higher education institutions in Africa (Clelly 2001). These included: the University of Namibia, the University of Zambia, the University of Ghana, the Jomo Kenyatta University of Agriculture and Technology (Kenya), the University of the Western Cape (South Africa), the University of Benin and the University of Nairobi. The findings have set important benchmarks with respect to the current impact of HIV/AIDS on African universities and the responses they have made. It also argues for and elaborates the elements of an institutional response to the epidemic.

A corpus of institutional profiles now exists which includes those commissioned by the ADEA (Anarfi, Seclonde, Magambo, Nzioka, Otaala, Barnes, Mwape and Iathuria, 2000). In addition, a similar study has been completed on the University of Botswana

(Chilisa and Bennell, 2000). One issue that created difficulty in nearly all the studies was the availability of reliable data upon which the researchers could base their analysis. Student and staff records do not traditionally provide high levels of detail on issues such as illness and causes of death. Even if they did, there are other issues of protocol surrounding the use and handling of private and understandably sensitive information. On another level it is important to encourage the development of databases which track research output and allow for greater co-ordination and mobilisation of new resources.

There are changes and developments in the transmission dynamics of HIV and AIDS which call for vigorous research

- Target populations: while in most of the early years the most vulnerable populations were the youths between 15-25, the married groups (up to 45 years) are more vulnerable to HIV infections
- The improved treatment of HIV and AIDS (typified by ARVs, among other things, has led to complacency to HIV. People no longer fear the imminent death that traditionally followed the infection.
- There is media saturation with regard to HIV/AIDS. The same prevention messages have featured on and on and they do not seem to make more appeal to the audience any longer.
- There also seem to be general prevention fatigue both among the practitioners and the various target groups.

In view of the above, it is imperative to undertake audience research to come up with new approaches, innovative communication strategies, messaging, tools and media.

There is also need to develop structures and processes through which universities and research stations could establish joint data based for sharing notes and experiences and findings on HIV/AIDS. This is based on the reality that individual institutions may have different niches in areas of research; ranging from bio-medical to behavioral and socio-economic research.

## Reflections

Should research on HIV/AIDS in institutions of learning be theoretical or applied research, or both?

## 8.4 Activity

1. Review the example provided below and comment on the issues facing researchers wanting to become involved in HIV/AIDS related work at your institution.
2. Draft a proposal aimed at establishing a research partnerships between your institution and a partner that focuses on HIV/AIDS.

### **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 endeavor. 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 non-profit 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.

*Source: [http://www.av.org/events\\_z\\_press.asp](http://www.av.org/events_z_press.asp)*

## **Module 9**

### **Community engagement**

#### **OBJECTIVES**

- Trainers and project leaders are equipped to motivate members of the institutional community (staff, students and management) to be more engaged in their associative communities.
- Students, staff and management are more aware of the different ways in which higher education institutions can be involved in a response to HIV and AIDS through community engagement.
- HIV and AIDS are integrated into institutional commitments to community outreach and accredited and connected to teaching.
- Trainers and project leaders are aware of the interrelatedness between communities and Universities (or other institutions of learning) on matters of HIV/AIDS
- Trainers and project leaders have competences and skills to engage communities in dialogue, research and interventions on HIV/AIDS

#### Community Engagement and HIV/AIDS in Higher Education

##### 9.1 Strategy

A successful community engagement strategy has a way of bringing benefits to the institution and to the communities served by the institution. The ACU has elaborated, in detail, the motivations behind such a strategy for universities (CACU, 2002).

- Universities cannot operate without being located in communities and engaging them in the life of the institution.
- Community engagement initiatives provide excellent opportunities for students and staff to provide badly needed services to communities, to engage their expertise in a realistic setting and to build a stronger basis for the mission of the university.
- Engagement with communities not only facilitates the identification of problems facing communities but also creates opportunities for working together towards solving them.
- The research community benefits especially from community engagement activities when opportunities arise from working with schools, clinics, hospitals, care projects, government, international agencies and NGOs.
- Engagement need not necessarily be on a voluntary basis either - universities can provide training and knowledge to youth and adults who may be willing and able to pay for such access.
- Community involvement ensures that the university is sensitive to the realities of social life within a regional context.

Community engagement offers the opportunity for a range of other interventions in a response to HIV and AIDS:

- The opportunity for students and staff to extend the boundaries of learning into the realities of how communities are practically facing HIV and AIDS (Learning).
- An opportunity to develop new knowledge based on practical and socially relevant issues

Cresearch).

- Opportunities to promote or challenge policies, practices and attitudes which either hinder or enhance the fight against HIV and AIDS (Advocacy).
- A way of making a meaningful role for people living with HIV in the life and work of the institution. This principle is usually entitled GIPA (Greater Involvement of People with AIDS) and has applications across all the areas addressed in this Toolkit.

## Recommendations

- Despite the need for much stronger engagement by African institutions in their communities, there is a perception that community engagement has been far more successfully promoted and realised in the developed world. This is not to suggest that the motivation is absent amongst the institutions. African institutions need to show decisively that HIV/AIDS is an instance where they can contribute in meaningful ways by extending the boundaries and efficacy of higher education.
- Community engagement is weakened when it is accorded a lower value than the more formalised activities of higher education institutions. Typically it will attract no subsidies, as is the case with formally recognised courses. Service learning, a strategy which makes learning in the community an integral part of the academic experience is growing in popularity as a way of strengthening commitments to community engagement and as a way of taking teaching and learning closer to an applied context. In the most advanced cases, institutions have established academic policy that requires schools and faculties to make service learning a requirement in the structure of academic programmes.
- Higher education institutions should be committed to finding all possible means of engaging with and learning from People Living with HIV and AIDS (PLWHAs). Community engagement is an ideal opportunity to pursue this objective in the communities and organisations where PLWHAs are based.

The following could be examples of proposed competencies

1. Upgrading (or introducing to) the trainers and project leader's skills and approaches needed to dialogue with community members (many of whom are illiterate and may not fully understand abstract concepts and language).
2. Trainers and project leaders could be introduced to the skills and competences needed to use modern communication tool/media as they engage the communities. These include, among others, the following;
  - Interactive radio/TV (particularly based on the convergence of old and new media (cell phones and radio/TV)
  - Social Network sites such as Face book, MySpace, Twitter, YouTube, etc. for a long time, there has been a general belief that these tools are for the young ones. Making adults embrace them entails changing the mindset of teachers, counselors, and trainers. The new social media is particularly attractive to the young generations particularly students in higher institutions of learning.
3. Initiating and streamlining students-led organizations that could (when trained and facilitated) reach out to communities and help out with the HIV/AIDS initiatives
4. Using the universities facilities (such as sports and MDD) to attract communities to attend HIV campaigns. For instance, talking about HIV during the half time sessions, or gearing MDD activities in line of HIV messaging (*educational entertainment*)

## 9.2 Activity

Review the example below and evaluate ways in which your institution can engage more with communities in the area of HIV/AIDS.

### Activity for all

- I. Is your university involved in the development of HIV/AIDS community outreach projects?
- II. If yes, which aspects of HIV/AIDS does your institution focus on HIV/AIDS?
  - Care,
  - Counselling
  - Impact-mitigation projects
  - Prevention (awareness campaigns and peer-education activities)
- III. Are students working hand in hand with staff in these outreach projects? Does each of the categories work on their projects?
- IV. Are the outreach programmes used as opportunities for the students to gain professional experience?

### **"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 antiretrovirals, maternal to child transmission and the relationship between HIV infection and tropical diseases. As well as provision of comprehensive HIV and AIDS care in prisons.

Unprotected male to male sex, sharing of razor blades, tattooing and sharing needles have been recognised as risk factors for HIV transmission at Kamfinsa Prison in Zambia. Beginning in 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 counselling 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 of 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 recognised 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 their 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 seroprevalance and risk behaviours 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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*Source: [www.procaare.org/index.php](http://www.procaare.org/index.php)*

## Module 10

### Monitoring and Evaluation

#### OBJECTIVES

- To provide the institution and programme managers with ways of assessing what interventions work, under what conditions and why the interventions are successful (impact).
- To enable institutional managers and funders to judge the effectiveness of an intervention in terms of the resources available (efficacy and cost effectiveness)
- To provide programme designers (staff, students or management) with some of the tools necessary for monitoring and evaluation (skills and process)
- To establish strong policy and practice in the area of monitoring and evaluation.
- To enable institutions managers to develop participatory processes of designing and developing monitoring and evaluation tools (alongside key stakeholders).

#### 10.1 The Importance of Monitoring and Evaluation

There is always good reason to stress the importance of monitoring and evaluation or M&E as it is known in practice. Despite the many arguments in favour of good policy and practice, both are often dealt with as an afterthought. There are countless examples of innovative projects in the education sector for which no verifiable impact indicators are available. In the case of HIV/AIDS, the value of impact data is doubly important because of the urgency of preventing the spread of the epidemic and information which can be used to mitigate and better manage the impacts of the epidemic.

M&E in the area of HIV/AIDS has been the subject of intensive scrutiny and subsequent development. This module does not have sufficient space to provide all the detail necessary for a fully developed M&E strategy. The approach used in this Toolkit is based, to a large extent, on two sources: (a) a monitoring and evaluation framework developed for an existing capacity building programme on HIV/AIDS in higher education which operates in South Africa; and (b) a framework developed for the evaluation of HIV/AIDS education programmes (SAUVCA, 2003 and the South African Department of Health, 2003). Both these sources are recommended as resource documents and can be obtained from the South African Universities Vice Chancellors

Association, <http://www.heaids.ac.za>. International development agencies working in the education sector such as UNESCO, the World Bank and UNAIDS have invested major effort in developing indicators for the sector and should be the first resort when looking for guidelines. However, to date, few well established examples exist for HIV/ AIDS in the higher education context.

Most higher education institutions operate with reasonably well-developed management information systems. These systems are geared to monitoring the internal workings of the organisation. The purpose behind this collection of data is to provide managers with decision support information and an 'early warning system'. The mass of data generated through this regular process is the basis upon which any evaluation will rely.

Evaluations are designed differently depending on what they intended to do. As we know, formative evaluations shape the process you are engaged in, whereas summative evaluations are more of an assessment at the end of a process.

It is crucially important that the manager commissioning the evaluation and the evaluators are in agreement about responsibilities, the terms of reference and the information required. The credibility of the judgements that come from an evaluation are directly related to how coherently the evaluation is designed. These design issues are reflected in the attention to indicators in the case study provided for this module.

Some of these are captured below and can be applied generically.

### **Responsibilities**

- Will it be an internal or external evaluation?
- Will the responsibility rest with the programme manager, a small team or a supervisor?
- What roles are assigned to the evaluator or members of the team?

### **Terms of Reference**

- What is being evaluated?
- Why is the evaluation being done?
- What are the key issues you wish to explore?
- Is the evaluation focused on process or outcomes - or both?
- 

What time frame have you set for the evaluation?

- What are the cost implications?

### **Information requirements**

- What baseline data has already been collected or needs to be collected?
- Where will the information come from?
- Is there time, money and capacity to collect the information?
- What skills are needed to collect the information?
- What data collection tools will be used (surveys, tests etc.)?

### **Recommendations**

- The key indicator on which programme managers, institutional heads and partners inevitably focus is the impact of behaviour change interventions. What may get lost in the process are those indicators which tell us about the credibility of the model we are using. The point is that both monitoring and evaluation should be given enough attention to enable us to distinguish clearly between the three: theory, process and impact.

- Prevalence monitoring, through whatever means, has proved difficult and contentious. There are ways in which to circumvent these difficulties by using the best available proxies of risk that are available through routine functions of the institution such as STI screening by the campus health service.
- If at all possible, ensure that community engagement programmes are also linked to sound indicators. This adds to their credibility and sustainability.

## 10.2 Activity

Review this list of indicators\* and discuss whether they are appropriate to your institution and country context.

1. Risk Assessments Conducted.
2. Non-discrimination Policy.
3. Institutional Council committed to address HIV and AIDS.
4. Institutional financial commitment for implementing HIV/AIDS programmes within the institution.
5. Effective marketing or advocacy of HIV and AIDS programmes and services at higher education institutions.
6. Policies that encourage infusion of HIV and AIDS into the curriculum.
7. Condom Distribution.
8. Existence of quality HIV and AIDS prevention services for higher education staff and students.
9. Use of HIV and AIDS prevention services.
10. Partner notification/referral rate.
11. Medical personnel trained in the care of HIV-related conditions.
12. Existence of Treatment, Care, and Support Services .
13. Use of Treatment, Care, and Support Services.
14. Promotion of Lecturer involvement in HIV and AIDS teaching.
15. Infusion of HIV and AIDS into the curriculum.
16. Health professions students trained in the care of HIV-related conditions.
17. Ethics Policies appropriate for HIV and AIDS research activities.
18. Increase in the number of ethical and appropriate HIV and AIDS research projects.
19. Networking and information sharing events.
20. Number of Programme-related Publications.
21. Utilization of Programme Website.
22. Involvement of diverse stakeholders in designing/developing/modifying the M&E tools

\* *Adapted from SAUVCA/CTP/ HIGHER EDUCATION HIV/AIDS Programme/ Indicators For Measuring OUTPUTS/OUTCOMES of the Programme/ February 2003.*

General

Alongside the standard protocols of M&E, it may be useful to consider involving key stakeholder in designing, developing and evaluations of HIV/AIDS initiatives. The key stakeholders could also be involved in modifying the tools and make technical contributions, and also to be involved in the practical aspects of the M&E. The importance of a joint ventures is that it reflects the values, expectations and visions of various stakeholders with regard to what various interventions should focus on.

Activity for all

Examine the factors in your institution that hamper the monitoring and evaluating of HIV/AIDS programme's activities. Are the factors related ?

- I. Lack of baseline information
- II. Lack of clear indicators
- III. Lack of well kept data?

Do the strategies to reduce the barriers include developing?

- A checklist of critical issues to be dealt with during M & E;
- Clear and measurable indicators;
- Appropriate evaluation methodologies
- Understanding of how to gather different data sets using these methodologies and how to use the different data sets;

**Use the following checklist in evaluating aspects of your institutional HIV/AIDS policy**

		Yes	No	Not sure
1	Evaluation is comprehensive; deals with			
	Reflective evaluation			
	Formative evaluation			
	Summative evaluation			
	implementation consistent with initial design and plan			
2	Monitoring is comprehensive; over time and looks at;			
	inputs,			
	processes,			
	outputs			
3	Quantitative indicators involves specifying			
	number of student programmes and activities			
	number of participants per activity			
	number of counselors available			
	number of counselling sessions held			
	number of times a promotional radio spot was aired			

	number of posters distributed			
	condom uptake			
	programme elements carried out their frequency			
4	Qualitative indicators			
	Are staff and student attitudes on stigma and discrimination changing			
	how are programme activities influencing behaviour change			
	what do the outcomes mean/ do they make a difference			
	General evaluation questions			
	Is the institution developing new sources of knowledge and understanding of HIV/AIDS			
	Are there new explanatory frameworks that challenge the status quo			
	Is the institution developing new social formations and new ways of coping with complex social, economic and political issues			
	Are research findings channeled to appropriate audiences			
	Are the activities likely to influence policy-makers in both the public and the private sector on HIV and AIDS			
	Is the institution acting as role models for other institutions			

#### WAY FORWARD

Working with HIV/AIDS in a higher 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 operating. 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 within government's overall strategy and programme.

## Practical advice

Taken as a whole, this project is large and complex. Not every institution will be able to mount a comprehensive response to HIV and AIDS and that may be for justifiable reasons (lack of capacity, resources etc.). In these cases, there are good reasons to develop and sustain a smaller response such as focusing on high quality research in the area of HIV and 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 a role that fits best with the department(s) 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 and 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 within the work place.

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

- Break the silence.
- Recognise 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 determined response to an HIV/AIDS affected world and ensure that this forms an integral part of the institutional mission.

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