

Uganda Martyrs University

HIV and AIDS & ANTI- SEXUAL HARASSMENT POLICY

JANUARY 2010

**Published by
Uganda Martyrs University**

First Edition, January 2010

Printed by Marianum Press Limited
P.O. Box 11, Kisubi
Entebbe

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Foreword

The acquired immunodeficiency syndrome (AIDS) due to infection from the immunodeficiency virus (HIV) first surfaced in or around 1980. Within two decades HIV infection and AIDS was the fourth leading cause of death globally. The HIV and AIDS pandemic continues to ravage sub-Saharan Africa, which has the highest prevalence on record. This sub-region remains most heavily affected by HIV, accounting for 67% of all people living with HIV and for 72% of AIDS deaths in 2007 (UNAID/WHO, 2008).

In Africa, AIDS and its complications are killing people at the prime of their lives. It is wiping out the productive sector and undermining investments in education and human capital. The life expectancy in most African countries has been reduced by one to two decades. AIDS has created a population of orphans and the previously resilient Africa social network can no longer cope. In some instances, a septuagenarian grandmother is left to care for 7 to 10 orphans; and in other situations 7-8 year olds are left to fend for themselves in Uganda. The estimated prevalence is 6,300/ 100,000 population with slightly more women than men. For the 15-24 year age group the estimated prevalence is 4,300/ 100,000 population. The number of living orphans is estimated to be 1.8 million (13% of the population). The numbers receiving anti-retroviral therapy is about 115,000. (UNAIDS/WHO, 2008).

In Uganda, and this is true of most sub-Saharan Africa, the epidemic has decreased. According to UNAIDS /WHO Report 2008, the epidemic in most sub-Saharan Africa, has stabilized or begun to decline. In actual fact, both the estimated adult prevalence and the number of people living with HIV has fallen consistently over the years. According to the report, increasing access to anti-retroviral therapy is starting to have a major impact on the AIDS epidemic, and prevention is also having an important impact on new infections although some decline in new infections is due to the natural course of epidemic.

Despite the gains made recently Sub-Saharan Africa remains the region most heavily affected by HIV, for a variety of reasons including:

- 1) Lack of adequate knowledge about the disease and its consequences.
- 2) Lack of trained leadership and commitment;
- 3) Lack of adequate resources;
- 4) Mismanagement of donor funds earmarked to counter this epidemic and other diseases, notably malaria and tuberculosis;
- 5) Conflict with cultural and religious practices and values;
- 6) Stigma associated with the disease which has led to those infected remaining silent for a long time. In addition, there is an attitude engrained in some cultures summarized best by saying, "I don't die alone". This attitude has led many to deliberately infect as many persons as they can encounter.
- 7) Due to a number of factors including physiological, socio-cultural and economic reasons, HIV and AIDS affects women and girls more adversely. In this era of HIV and AIDS, there should be zero tolerance to sexual harassment in the educational settings. "Any discrimination and or action that may put an employee or student of either sex at risk because of sex, strictly violates the basic principles of this policy and may be sanctioned in accordance with the relevant disciplinary policies" (Ministry of Education & Sports, undated, p.4).

Efforts by the Government and non-governmental organizations, as well as parastatal and civil society have seen a remarkable reduction in the both prevalence and the number of people living with HIV in Uganda in the last ten years.

The UNAIDS/WHO report concludes that although a lot has been done, much still remains to be done. The report concludes that HIV remains one of the world's most serious public health challenges and that responding to it is a "moral imperative".

In developing a policy on HIV and AIDS and Anti-Sexual Harassment, Uganda Martyrs' University (UMU) has embarked on a continuum stretching from prevention, treatment, care and support

of those affected and infected by HIV and AIDS; to mitigating the impact of the disease on individuals, institutions, and community of which they are a part. The activities generated and developed at the end of the policy development exercise are aimed at:

- 1) providing sustained tertiary education on HIV and AIDS whose course content and curriculum will systematically be geared to responding to the pandemic;
- 2) making our graduates understand the impact of HIV and AIDS in their personal, family and professional lives;
- 3) exercising zero tolerance to sexual harassment;
- 4) inculcating both theoretical and practical understanding of the pandemic and its implications in their future lives and professional careers;
- 5) engaging academic staff to mainstream HIV and AIDS in University life by integrating HIV and AIDS in core teaching programmes;
- 6) protecting staff and students by adequate training and continued sensitization;
- 7) protecting staff and students from sexual harassment.

We are most grateful to the Association of African Universities (AAU) for the grant that has enabled UMU to develop this policy. We are equally grateful to the UMU Task Force, a cross disciplinary, and UMU community-wide group that brought the task of policy development to a successful end. We believe that with this policy we will truly **“make a difference”**.

Charles L.M. Olweny, MD, FRACP
Vice Chancellor
Uganda Martyrs’ University

1. Uganda: The country situation and response

Uganda was at one time one of the most challenged countries in sub-Saharan Africa, in terms of the HIV and AIDS epidemic, registering as it did prevalence of 40% (UNAIDS/WHO, 2008). This was later reduced to 18% and most recently the prevalence has reduced to 5.4%. The success of the country in reducing the prevalence has been attributed to a variety of reasons, but including, most significantly, the leadership provided by Government and multi-institution and multi-strategy adopted in the fight against the disease.

The prevalence rate though stabilizing overall at 6.4% has, however, gone up in some regions. In 2005, about one million people were living with HIV. The reasons for this increase include:

(i) Sex with multiple partners. (ii) non-marital sex; (iii) non-consensual sex; (iv) commercial sex; (v) transactional sex; (vi) intergenerational sex; (vii) sex for survival, and (viii) alcohol consumption and drug abuse before sex. Uganda needs not only treatment, care and support of the infected and affected, but much aggressive preventive education through information, education and communication (IEC). (UNAIDS, 2007).

2.1 The Situation and Response in Higher Education Institutions in Uganda

The National Council for Higher Education (NCHE) issued guidelines (NCHE, 2007) requiring higher education institutions to develop HIV and AIDS Policies and other measures to manage the HIV and AIDS epidemic, but very few institutions have responded to date. Uganda Martyrs' University (UMU) has taken a decision to develop an HIV/AIDS and anti-Sexual Harassment Policy. A word about Uganda Martyrs' University.

2.2 a) Uganda Martyrs University

Uganda Martyrs University (UMU) is a private, Catholic-founded university whose main campus is located in the quiet rural setting of

Nkozi, 82km South- West of Kampala. The well-kept campus, which is located on the Equator, is ideal for learning, study and reflection.

UMU opened its doors on 18th October, 1993 and gained its Charter on 2nd April, 2005. Currently, the university's enrolment has approximately 1322 full-time and 601 part-time students pursuing various courses of study in its seven faculties: Faculty of Agriculture; Faculty of Business Administration and Management; Faculty of the Built Environment; Faculty of Education; Faculty of Health Science; Faculty of Humanities and Social Sciences; Faculty of Science and Institute Ethics and Development Studies. In addition, the university has over 2525 students enrolled in Distance Learning programmes. Programmes are offered at Diploma, Bachelors Degree, Masters and PhD. Plans are at an advanced stage to establish a school of Diplomacy and a Post Graduate Medical School.

VISION

The university's vision is the development of individual persons through education, laying emphasis on the creation of an environment where intellectual and moral values are priorities. It is committed to promoting justice, respect, solidarity, human rights, equality and environment protection, in its own community and in society in general. Its main target is to provide quality education which develops professional people who combine career competence with a strong sense of moral responsibility and social values needed to cope with the challenges of the world today.

MISSION

The university's mission is derived from the Christian understanding of the person. It is committed to developing an integral person by providing high quality education within a conducive environment. This is intended to produce professionals of varying academic competences with critical and creative abilities who are expected to contribute positively to the nation and the world at large.

The university vision is guided by the principles of: Transparency, Accountability, Reliability, and Action, based on institutional ethos and quality.

2.3 b) The University's Focus Areas include:

- a) Service to the nation and the Church through education and training of leaders;
- b) Studying the impact of HIV and AIDS on society and searching for appropriate solutions;
- c) Promoting Peace and Justice;
- d) Poverty Alleviation;
- e) Promotion of Food Security;
- f) Focus on Millennium Development Goals(MDGs);
- g) Issues of Human Rights;
- h) Issues on Education for Sustainable Development (ESD);
- i) Issues of Girl Child Education; and
- j) Issues of Violence against Girls, Women and Children.

2.4 Standing Committee on HIV/ AIDS and Sexual Harassment Policy

Uganda Martyrs University (UMU) recognizes the impact of HIV and AIDS on the UMU community and the community in which it is located and the need to coordinate all efforts at institutional level to avoid both duplication and gaps in the total response to the HIV and AIDS pandemic. It is with this in mind that the Policy contained herein was developed.

2.5 The following values guided policy development

The development of the policy took into account the link between HIV and AIDS and human rights. Human rights are fundamental and have been well documented in various human rights documents. The right to the highest attainable standard of physical and mental health; the right to information and education; the right to privacy; and the right to share in scientific advances and their

benefits, are all axiomatic (UNAIDS Report on the global Epidemic, Barcelona, 2002). Therefore the following values guide and underlie the policy formulation:

- Students, members of staff and their dependants have the right to dignity, respect, autonomy and privacy concerning their HIV and AIDS status; stigma and prejudice will be actively countered.
- Students, members of staff and their dependants who are living with HIV and AIDS will not be discriminated against in accessing education and/ or employment at the University.
- HIV and AIDS concern all of us; the full range of stakeholders, including people living with HIV, should be involved in defining and implementing the response to HIV and AIDS.
- HIV and AIDS have to be understood and addressed in its social and cultural context; this includes power relations between men and women; and sexual violence against women; changing values and meanings around sexuality.
- HIV and AIDS concern the entire UMU Community; an appropriate response to the epidemic can be achieved only by ensuring emphasis in the various programmes and activities of the University. All stakeholders should be involved in defining and implementing the response to HIV and AIDS at the University.
- HIV and AIDS can affect anyone; the policy should in no way perpetuate stereotypes of HIV and AIDS as belonging to any sex, age, ethnic group, sexual preference, student or member of staff, but it should recognize specific vulnerabilities and risk factors such as cases of sexual harassment.
- Appropriate strategies for caring and treatment of persons living with HIV (PLWHIV) are essential.
- The need for more attention to improve adherence to Greater Involvement of People Living with HIV (GIPA) principles

2.6 Goals and objectives of the policy

i. **Prevention and Education**

- To prevent the transmission of HIV through the provision of Information, Education and Communication (IEC) outlets;
- To raise the level of knowledge and understanding of all members of the university community regarding the impact of HIV and AIDS on the institution;
- To identify and disseminate the available resources to be used in the fight against the pandemic; and
- To empower both women and men to take responsible sexual decisions.

ii. **Care and support**

- To help those who are uninfected to remain free from infection;
- To provide HIV and AIDS counselling;
- To create an environment where people living with HIV and AIDS are safe to reveal their status and seek appropriate support and counselling;
- To equip the university community with skills that will enable them to live and work in societies with increasing rates of HIV infection; and
- To provide care for those infected and affected by HIV and AIDS.

iii. **Sexual harassment**

- To create an enabling learning and working environment devoid of sexual harassment

- To institutionalize the prevention of sexual harassment and establish mechanisms for dealing with cases of sexual harassment.
- To ensure that HIV and AIDS are addressed in the core business of the university: teaching, research and publication, and community outreach.

3. POLICY COMPONENTS

The policy has five principal components:

1. Rights and responsibilities of staff and students affected and infected by HIV and AIDS;
2. Integrating HIV and AIDS into teaching; research and publication; service activities of all University faculties, centres and units;
3. Providing preventive, care and support services on campus;
4. Institutionalising the prevention of sexual harassment and establishing mechanisms for dealing with cases of sexual harassment.
5. Implementation of policy: structures, procedures and monitoring and review.

3.1.1 Rights of Staff

1. No employee or applicant for employment at the UMU shall be required to undergo an HIV test, or disclose his/her HIV status.
2. The University shall not use the HIV status to deny employment contract or refuse to renew a contract.
3. HIV 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 status. HIV status shall not be used to influence retrenchment or retirement decisions on grounds of ill health, unless a member of staff has been medically proven to be or is no longer physically or mentally fit to continue his/her work.

5. HIV status shall not be reflected in the personal files of employees.
6. The HIV 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 status, it recognizes 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 shall, however, 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 and AIDS are accepted and are not stigmatized.
9. Employees have a right to know of possible risks of occupational exposure to HIV in their working environments.
10. The University endeavours to provide a working environment in which the occupational exposure of HIV is minimized; in addition to providing the necessary protective equipment, staff will be taught on usage and educated in general on the use of universal precautions (see Appendix 2).
11. Staff have a right to protection against sexual harassment. The University shall provide advice related to sexual harassment, sexually transmitted diseases and infections, and medication to all staff.
12. The University is committed to act against all forms of violence by punishing offenders according to legal procedures and University disciplinary procedures.

3.1.2 Rights of Students

1. No prospective student at the University shall be required to undergo an HIV test, or disclose his/her HIV status prior to admission.
2. No student at the University shall be required to undergo an involuntary HIV test, or disclose his /her HIV status.

3. The University shall not use HIV status in considering the granting of bursaries, scholarships and loans. The University shall actively promote greater involvement of people living with HIV (PLWHIV) as enunciated by UNAIDS.
4. The University shall not use HIV status in determining admission to residence on campus.
5. Students' registration shall not be terminated on the grounds of their HIV 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 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 environment in which persons with HIV and AIDS are accepted and are not stigmatized.
9. The University endeavours to provide a working environment in which the occupational exposure to HIV is minimised, and will provide the necessary equipment (see Appendix 2).
10. Students have a right to be protected against sexual harassment. The University shall provide advice related to sexual harassment, sexually transmitted diseases or infections, pregnancy and HIV infection, and medication, to all students.
11. The University is committed to act against all forms of violence by punishing offenders according to legal procedures and University disciplinary procedures..

3.1.3 Responsibilities of staff and students

1. Everyone has an individual responsibility to protect himself/herself against Infection. Students and staff living with HIV and 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 and AIDS have an obligation to choose professional

paths that eliminate the risk of transmission to their patients or colleagues.

3. Staff and students have a responsibility not to discriminate and stigmatize members of the University community living with HIV and AIDS.
4. Staff and students have a responsibility to respect the zero tolerance and sexual harassment policy of the University as embedded herein.

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

3.2.1 Teaching

UMU will encourage and support efforts made by faculties to incorporate aspects of HIV / AIDS and human rights into their curricula.

The University will provide a compulsory core curriculum on HIV and AIDS for all undergraduate students. The curriculum will include historical, epidemiological, health, legal, prevention and home-based care and support aspects of HIV and AIDS. The University will offer several short courses/seminars on HIV and AIDS for senior, mid-level and academic and administrative management staff, as well as for student leaders. One such course will focus on HIV and AIDS in the work place, including protection, performance management, and legal issues. Other short courses/seminars will be offered to the community, as appropriate.

3.2.2 Research

UMU will provide leadership on HIV and AIDS through research. Research will be used to inform policy, teaching and community service. Both staff and students of Faculties would be encouraged to develop research projects related to HIV and AIDS. The Research Directorate will consider such proposals for funding. The University commits itself to providing human and financial resources in support of HIV and AIDS research.

Reports from funded projects would be peer reviewed and published.

3.2.3 Community Service

The University commits itself to collaborate with the community in training and research on HIV and AIDS. It is essential to have full community participation and involvement in HIV and AIDS programmes and ensure that there is a flow of support between the University and various communities and community structures.

3.3 Provision of Prevention and Support Services

3.3.1 Awareness and Prevention

The University has a duty to educate and inform its members about HIV and AIDS. Relevant and appropriate information and care will be made accessible to staff and students at all times. In addition to teaching and research activities, strategies to prevent the spread of HIV and AIDS would include:

- Information, education, communication (IEC);
- Encouraging responsible behaviour;
- Sponsoring public fora (dramas, discussions, debates);
- Training HIV and AIDS Peer Educators (both staff and students);
- Increasing awareness about Sexually Transmitted Diseases (STDs) and Sexually Transmitted Infections (STIs) and their treatment;
- Acting against sexual harassment of women and girls, and, child abuse.

3.3.2 Counselling, Care and Support

Staff and students will have access to confidential services on campus; WHO Guidelines on Counselling apply (see Appendix 1). Peer counsellors and support groups will be available for students and staff affected and infected by HIV and AIDS.

Accidental/ occupational exposure to HIV is covered under the guidelines for dealing with accidental exposure (Appendix 2).

4. SEXUAL HARASSMENT

The University will exercise zero tolerance to sexual harassment

What is sexual harassment? Sexual harassment is defined as follows:-

Sexual harassment is any unwanted attention or behaviour of a sexual nature from someone in the workplace or classroom that causes discomfort or interferes with work or academic performance. Unwelcome sexual advances, sexual remarks, touching and requests for sexual favours are examples of behaviours that are considered as sexual harassment.

Sexual harassment is a form of behaviour which fundamentally undermines the integrity of academic and employment relationships. It is of particular concern within educational institutions where all members of the University community are connected by strong bonds of intellectual interdependence and trust.

Uganda Martyrs University prohibits any member of the University community, male or female, from sexually harassing another employee, student or other person having dealings with this institution. The University is committed to providing a working, living and learning environment that is free from all forms of sexual abuse, harassment or coercive conduct. This policy seeks to protect the rights of all members of the university and other persons having dealings with the institution, and to assure that all are treated with respect and dignity.

Accusations against persons engaged in any form of sexual harassment at UMU shall be officially investigated and when found culpable, the culprits shall be reprimanded, censured, or punished within the ambit of the rules governing conduct at the University and/or the laws of the land. Moreover, the university will not tolerate reprisals against victims of sexual harassment, and any

reprisal by the accused and/or others shall result in disciplinary action being taken.

Students, administration and staff are entitled by law to a workplace and learning environment that is free from unwelcome sexual behaviours. Every member of the university community is encouraged to seek information and guidance at any time from the University Counselling Centre to be established, the Director of Human Resources or Dean of Students.

In the event of an incident of sexual harassment, a victim has the following options:

- If possible, resolve the issue with the individual whose action is being questioned. In many cases, the "harasser" may not even realize that his or her actions are offensive. Be assertive and firm about your own rights. It is advisable to take a friend along as an advocate, or for support. This person can be asked later to serve as a witness, if needed. Keep a carefully written record of the meeting.
- If the offensive behaviour is not corrected, the incident(s) should be reported. It is recommended that the victim resorts to the above-mentioned options for guidelines and policy information for processing a complaint.

The university environment is a place for learning and growing – sexual harassment interferes with that process. When sexual harassment exists on the university campus, both the integrity and the learning environment are threatened. UMU strives to create and maintain a safe environment where everyone can enjoy freedom from sexual harassment and intimidation.

No employee or student, either in the workplace or in the academic environment, should therefore be subject to unwelcome verbal or physical conduct that is sexual in nature. It is expected that students and staff will treat one another with respect.

A. Policy Applicability and Sanctions

All students, faculty, staff, and other members of the university community are subject to this policy. Anyone who violates this policy is subject to discipline up to and including termination and/or expulsion.

All employees shall be given a copy of this policy and the Director Human Resources Office shall maintain a signed copy of each employee. New employees shall be given a copy of this policy at the time of appointment and the Director Human Resources Office shall maintain a signed copy of each employee.

B. Sexual Harassment Defined

Under this policy, unwelcome sexual advances, requests for sexual favours, and other visual, verbal or physical conduct of a sexual nature constitute sexual harassment when:

1. submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic status;
2. submission to or rejection of the conduct is used as a basis for academic or employment decisions or evaluations, or permission to participate in an activity; or
3. the conduct has the purpose or effect of substantially interfering with an individual's academic or work performance, or of creating an intimidating, hostile or offensive environment in which to work or learn.

Sexual harassment may take many forms - subtle and indirect, or blatant and overt. For example,

- It may occur between individuals of the opposite sex or of the same sex.

- It may occur between students, between peers and/or co-workers, or between individuals in an unequal power relationship.
- It may be aimed at coercing an individual to participate in an unwanted sexual relationship, or it may have the effect of causing an individual to change behaviour or work performance.
- It may consist of repeated actions or may even arise from a single incident if sufficiently severe.
- It may also rise to the level of a criminal offence such as battery or sexual assault.

Determining what constitutes sexual harassment under this policy will be accomplished on a case by case basis and depends upon the specific facts and the context in which the conduct occurs. Some conduct may be inappropriate, unprofessional, and/or subject to disciplinary action, but would not fall under the definition of sexual harassment. The specific action taken, if any, in particular instance depends on the nature and gravity of the conduct reported, and may include disciplinary processes as stated / provided for in the University disciplinary rules.

Examples of unwelcome conduct of a sexual nature that may constitute sexual harassment may, but do not necessarily, include, and are not limited to:

- physical assault;
- sexually explicit statements, comments, questions, jokes, or gestures;
- unnecessary touching, patting, hugging, or brushing against a person's body or other inappropriate touching of an individual's body;
- remarks of a sexual nature about a person's clothing or body;
- use of electronic mail or computer dissemination of sexually oriented, sex-based communications;

- sexual advances, whether or not they involve physical touching;
- requests for sexual favours in exchange for actual or promised job or educational benefits, such as favourable reviews, salary increases, promotions, increased benefits, continued employment, grades, favourable assignments, letters of recommendation;
- displaying sexually suggestive objects, pictures, magazines, cartoons, or screen savers;
- inquiries, remarks, or discussions about an individual's sexual experiences or activities and other written or oral references to sexual conduct.

Even one incident, if it is sufficiently serious, may constitute sexual harassment. One incident, however, does not usually constitute sexual harassment.

C. Procedure

The administrators designated to receive the complaints may include the following: (1) the Director Human Resources (2) Faculty Deans, immediate supervisors (3) The Dean of Students, and other persons designated by the Vice Chancellor.

An individual filing a complaint of alleged sexual harassment shall have the opportunity to select an independent advisor for assistance, support, and advice and shall be notified of this opportunity by the Human Resources Officer or the Dean of Students, or by their designee. It shall be the choice of the individual filing the complaint to utilize or not utilize the independent advisor. The independent advisor may be brought into the process at any time at the request of the alleged victim. Each faculty/department/centre or unit shall determine the means and manner by which an independent advisor shall be made available.

Supervisors' Responsibilities: Every supervisor has responsibility to take reasonable steps intended to prevent acts of sexual harassment, which include, but are not limited to:

- Monitoring the work and campus environment for signs that harassment may be occurring;
- Refraining from participation in, or encouragement of actions that could be perceived as harassment (verbal or otherwise);
- Stopping any observed acts that may be considered harassment, and taking appropriate steps to intervene, whether or not the involved individuals are within his/her line of supervision; and
- Taking immediate action to minimize or eliminate the work and/or school contact between the two individuals where there has been a complaint of harassment, pending investigation.

If a supervisor receives a complaint of alleged sexual harassment, or observes or becomes aware of conduct that may constitute sexual harassment, the supervisor must immediately contact one of the individuals identified above to forward the complaint to discuss it and/or to report the action taken.

Failure to take the above action to prevent the occurrence of or stop known harassment may be grounds for disciplinary action against the victim or alleged perpetrator.

Complaints of sexual harassment must be filed within sixty days after the discovery of the alleged act of sexual harassment with the supervisor, department head, dean, or one of the administrators listed above.

1. Employees

- a. An employee who believes that he or she has been subjected to sexual harassment by anyone is encouraged—but it is neither necessary nor required—to promptly tell the person that the conduct is unwelcome and ask the person to stop the conduct. A person who receives such a request must immediately

comply with it and must not retaliate against the complainant for rejecting the conduct.

- b. The employee may also choose to inform his or her immediate supervisor, who will in turn contact one of the officials listed above.
- c. If the employee feels uncomfortable about discussing the incident with the immediate supervisor, the employee is free to bypass the supervisor and present his or her grievances to any other listed officials or any other supervisor.
- d. After receiving any employee's complaint of alleged sexual harassment, be it in writing or otherwise, the supervisor will immediately contact any of the individuals listed above, to discuss it and/or to report the action taken. The supervisor has a responsibility to act even if the individuals involved are not supervised by that supervisor.

2. Students

- a. A student who believes that he or she has been subjected to sexual harassment by anyone is encouraged—but it is neither necessary nor required—to promptly tell the person that the conduct is unwelcome and ask for a halt of that conduct. A person who receives such a request must immediately comply with it and must not retaliate against the student for rejecting the conduct.
- b. The student may also choose to complain to his or her major Departmental Head, who will in turn contact one of the officials listed above.
- c. If the student feels uncomfortable about discussing the incident with the Departmental Head, the student is free to bypass the Head and complain to one of the above officials or to any Head or Dean, who will in turn immediately contact one of the officials listed above to forward the complaint, whether or not

the complaint is in writing, to discuss it and/or to report the action taken. The Head or dean has a responsibility to act even if the individuals are not supervised by that Head or dean.

3. Investigation and Resolution

- a. After receiving a complaint of the incident or behaviour, an investigation by one of the above listed officials will be initiated to gather information about the incident. Each section or unit may set guidelines for the manner in which an investigation shall be conducted.
- b. At the completion of the investigation, a recommendation will be made to the appropriate management regarding the resolution of the matter. The recommendation is advisory only.
- c. After the recommendation has been made, a determination will be made by management regarding the resolution of the matter.

D. Prompt Attention

Complaints of sexual harassment are taken seriously and will be dealt with promptly.

E. Confidentiality

UMU recognizes that confidentiality is important. However, confidentiality cannot be guaranteed in the case of sexual harassment. The administrators responsible for implementing this policy will respect the privacy of individuals reporting or accused of sexual harassment to the extent reasonably possible and will maintain confidentiality to the extent possible.

F. Retaliation

Retaliation against an individual who in good faith complains of alleged sexual harassment or provides information in an investigation about behaviour that may violate this policy is against

the University disciplinary guidelines, will not be tolerated, and may be grounds for disciplinary action. Retaliation in violation of this policy may result in discipline up to and including termination and/or expulsion. Any employee or student bringing a sexual harassment complaint or assisting in the investigation of such a complaint will not be adversely affected in terms and conditions of employment and/or academic standing, nor discriminated against, terminated, or expelled because of the complaint. Intentionally providing false information is also grounds for discipline.

“Retaliation” may include, but is not limited to, such conduct as:

- the denial of adequate personnel to perform duties;
- frequent replacement of members of the staff;
- frequent and undesirable changes in the location of an office;
- the refusal to assign meaningful work;
- unwarranted disciplinary action;
- unfair work performance evaluations;
- a reduction in pay;
- the denial of a promotion;
- a dismissal;
- a transfer;
- frequent changes in working hours or workdays;
- an unfair grade;
- an unfavourable reference letter;
- Refusal to counsel a student or to assist him/her in work;
- Making unfavourable comments on a student.

G. Relationship to Freedom of Expression

UMU is committed to the principles of free inquiry and free expression. Vigorous discussion and debate are fundamental rights and this policy is not intended to stifle teaching methods or freedom of expression. Sexual harassment, however, is neither legally protected expression nor the proper exercise of academic freedom; it compromises the integrity of institutions, the tradition of intellectual freedom and the trust placed in the institutions by their members.**

5. POLICY IMPLEMENTATION

The overall responsibility for implementing this HIV and AIDS and Anti-Sexual Harassment policy lies with the senior management of UMU, including the Vice Chancellor; the two Deputy Vice Chancellors, members of the Management Team, Deans of Faculties, Dean of Students, Centre Directors, Heads of Departments and the Uganda Martyrs' Students' Union (UMUSU).

The University will appoint an officer at the level of Director who will be responsible for policy coordination and oversight. The Director will chair an implementation committee, comprising of staff and students and the Dean of Students and Director of Human Resources, and will report directly to the Vice Chancellor. The Committee's functions, among others, will include:

- Disseminating and coordinating the HIV and AIDS and Sexual Harassment policy in the University and surrounding community;
- Organizing regular consultative meetings with the University community about matters related to HIV and AIDS, and sexual harassment;

* *Uganda Martyrs' University recognizes that not all acts of sexual harassment will lead to HIV infection.*

+ *Any member of the University who believes that he or she has been subjected to sexual harassment has the right to report the incident to the designated personnel. Any such complaints shall be dealt with as specified in the conduct of students and members of staff.*

- Establishing and implementing a system of policy monitoring and evaluation;
- Collaborating with community and other tertiary institutions and stakeholders.

The University will establish an appropriate budget for the implementation of this policy, and source additional funding from other stakeholders. A strategic work plan will guide the implementation of this policy. The policy will be subjected to regular review and appraisal every two-three years.

References

- DFID/USAID/UNFPA/UBOS/UNICEF (2007) 2006 Uganda Demographic and Health Survey: Fact Sheet.
- Du Pisani, A and Otaala, B. (2000). *UNAM HIV/AIDS Policy*. Printech: Windhoek.
- GOU- Ministry of Education and Sport (2006). *Guidelines on roles and responsibilities of stakeholders in the implementation of Guidance and Counselling in educational Institutions*. Entebbe, Government Printer.
- GOU- Ministry of Education and Sports (2006). *National Policy Guidelines on HIV and AIDS (Abridged Version)*. Kampala, GOU
- GOU-Ministry of Education and Sport (2006). *Persons with Disabilities Act*. Entebbe, Government Printer
- GOU-Ministry of Education and Sport (undated) *The Education sector HIV and AIDS Workplace Policy*. Kampala, GOU.
- GOU-Ministry of Education and Sports (2006). *National Policy Guidelines on HIV and AIDS*. Kampala, GOU.
- GOU-Ministry of Gender, Labour, and Social Development (2007) *The Uganda Gender Policy*. Entebbe, Government Printer
- Katohire, A. R. & Kirumira, E. K. (2008). *The Impact of HIV and AIDS on Higher Education Institutions in Uganda*. IIEP, Paris.
- Kenyatta University (2006). *HIV/AIDS Policy*. Nairobi, Kenyatta University.
- Kenyatta University (2007). ***Gender Policy***.
- Kenyatta University (2007). *Policy on Gender based violence and sexual Harassment*.

Khanyola. J. (2009). *Drivers of the HIV Epidemic and the Need of Behaviour Change*. Paper delivered on 27th February 2009 at the Uganda Martyrs University Seminar.

Ministry of education and Sports (2007). *The Education Sector HIV and AIDS Workplace Policy*. Entebbe: Government Printer.

National University of Rwanda (2007). *HIV/AIDS Control Policy*. Butare, National University of Rwanda.

National University of Rwanda (2009). *HIV and AIDS Control Policy*.

Nkumba University (2002). *Nkumba HIV/AIDS Policy- Entebbe, Nkumba University*.

UNAIDS and WHO (2008). *AIDS Epidemic Update*. aidsmap.com report (2008).

UNAIDS and World Health Organization (2007). *AIDS epidemic update*, Geneva, UNAIDS; WHO

UNICEF (2007). *Annual Report 2006: UNICEF, Uganda*. Kampala, UNICEF,

UNICEF, (2008). *The state of Africa's Children 2008*. Geneva, UNICEF

UNICEF, (2008). *The State of the World's Children 2008*. Geneva, UNICEF

University of Botswana (2002). *University of Botswana: HIV/AIDS Policy*. Gaborone, University of Botswana.

Various Institutional Policies can be downloaded for references from the AAU website by opening the link: <<http://www.aau.org/aur-hiv-aids/pubs.htm>>

APPENDIX 1

W.H.O. COUNSELLING GUIDELINES FOR HIV TESTING

COUNSELLING BEFORE HIV TESTING OR SCREENING

Undergoing a test for HIV infection is likely to be an important step in a person's life, and should always be accompanied by pre-test and post-test counselling.

THE AIM OF PRE-TEST COUNSELLING

- Counselling before the test should provide individuals who are considering being tested with information on the technical aspects of screening and the possible personal, medical, social, psychological, and legal implications of being diagnosed as either HIV-positive or HIV-negative. The information should be given in a manner that is easy to understand and should be up to date. Testing should be discussed as a positive act that is linked to changes in risk behaviour.
- A decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result. In some countries, the law requires explicit informed consent before testing can take place: in others, implicit consent is assumed whenever people seek health care. There must be a clear understanding of the policy on consent in every instance, and anyone considering being tested should understand the limits and potential consequences of testing.
- Testing for HIV infection should be organized in a way that minimizes the possibility of disclosure of information or of the discrimination. In screening, the rights of the individual must also be recognized and respected. Counselling should actively endorse and encourage those rights, both for those being tested and for those with access to the records and results. Confidentiality should be ensured in every instance.

ISSUES IN PRE-TEST COUNSELLING

- Pre-test counselling should focus on two main topics: first, the client's personal history and risk of being or having been exposed to HIV; secondly, assessment of the client's understanding of HIV/AIDS and previous experience in dealing with crisis situations.

ASSESSMENT OF RISK

In assessing the likelihood that the person has been exposed to HIV, the following aspects of his or her life since about 1986 should be taken into account:

- Frequency and type of sexual behaviour: specific sexual practices, in particular, high risk practices such as vaginal and anal intercourse without use of condoms, unprotected sexual relations with prostitutes;
- Being part of a group with known high prevalence of HIV infection or with known high-risk life-styles, for example, users of injecting drugs, male and female prostitutes and their clients, prisoners, and homosexual and bisexual men;
- Having received a blood transfusion, organ transplant, or blood or body product;
- Having been exposed to possibly non-sterile invasive procedures, such as tattooing and scarification.

ASSESSMENT OF PSYCHOSOCIAL FACTORS AND KNOWLEDGE

The following questions should be asked in assessing the need for HIV testing:

- Why is the test being requested?
- What particular behaviour or symptoms are of concern to the client?
- What does the client know about the test and its uses?
- Has the client considered what to do or how he/she would react if the result is positive, or if it is negative?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?

- Who could provide (and is currently providing) emotional and social support (family, friends, others)?
- Has the client sought testing before and if so, when, from whom, for what reason, and with what result?

The initial counselling should include a discussion and an assessment of the client's understanding of (a) the meaning and potential consequences of a positive or a negative result, and (b) how a change in behaviour can reduce the likelihood of infection or transmission to others.

Pre-test counselling should include a careful consideration of the person's ability to cope with the diagnosis and the changes that may need to be made in response to it. It should also encourage the person being counselled to consider why he or she wishes to be tested and what purpose the test will serve. When asking about personal history, it is important to remember that the client:

- May be too anxious to absorb fully what the counsellor says;
- May have unrealistic expectations about the test; and
- May not realize why questions are being asked about private behaviour and therefore be reluctant to answer.

During pre-test counselling, it is also important that the client be told that current testing procedures are not infallible. Both false-positive and false-negative results occur occasionally, although supplementary (confirmatory) tests are very reliable if an initial test is positive. These facts must be clearly explained, together with information about the "window" period during which the test may be unable to assess the true infection status of the person.

IF TESTING IS NOT AVAILABLE

There may be locations where reliable facilities for testing are not readily available. Where this is so, every effort should be made to emphasize prevention counselling, especially the need for changes in behaviour among people who have engaged in high-risk activities, and the reinforcement of appropriate behavioural changes.

Counselling, education, information and support are the crux of behaviour change.

COUNSELLING AFTER HIV TESTING OR SCREENING

Counselling after testing will depend on the outcome of the test, which may be a negative result, a positive result, or an equivocal result.

COUNSELLING AFTER A NEGATIVE RESULT

It is very important to discuss carefully the meaning of a negative result (whether this was anticipated or not). The news of being uninfected is likely to produce a feeling of relief or euphoria, but the following points should be emphasized:

- Following a possible exposure to HIV, there is a “window” period during which a negative test result cannot be considered reliable. This means that, in most cases, at least three months must have elapsed from the time of possible exposure before a negative test can be considered to mean that infection did not occur. A negative test result carries greatest certainty if at least six months have elapsed since the last possible exposure.
- Further exposure to HIV infection can be prevented only by avoiding high-risk behaviour. Safer sex and avoidance of needle-sharing must be fully explained in a way that is understood and permits appropriate choices to be made.
- Other information on control and avoidance of HIV infection, including the development of positive health behaviour, should be provided. It may be necessary to repeat explanations and for the counsellor and the person being counselled to practice methods of negotiating with others in order to assist the client in introducing and maintaining new behaviour.

COUNSELLING AFTER A POSITIVE RESULT

People diagnosed as having HIV infection or disease should be told as soon as possible. The first discussion should be private and confidential, and then the client should be given time to absorb the news. After a period of preliminary adjustment, the client should be

given a clear, factual explanation of what the news means. This is a time for acknowledging shock of the diagnosis and for offering and providing support.

It is also a time for encouraging hope for achievable solutions to the personal and practical problems that may result. Where resources are available, it may also be justifiable to talk of possible treatments for some symptoms of HIV infection and about the efficacy of anti-viral treatments.

How the news of HIV infection is accepted or incorporated often depends on the following:

1. The person's physical health at the time. People who are ill may have a delayed reaction. Their true response may appear only when they have grown physically stronger.
2. How well prepared the person was for the news. People who are completely unprepared may react very differently from those who were prepared and perhaps expecting the result. However, even those who are well prepared may experience the reactions described in the following pages.
3. How well supported the person is in the community and how easily he or she can call on friends. Factors such as job satisfaction, family life and cohesion, and opportunities for recreation and sexual contact may all make a difference in the way a person responds. The reaction to the news of HIV infection may be much worse in people who are socially isolated and have little money, poor work prospects, little family support, and inadequate housing.
4. The person's pre-test personality and psychological condition. Where psychological distress existed before the test result was known, the reactions may be either more or less complicated and require different management strategies than those found in persons without such difficulties. Post-result management should take account of the person's psychological and/or psychiatric history, particularly as the stress of living with HIV may act as catalyst for the reappearance of earlier disturbance.

In some cases, news of infection can bring out previously unresolved fears and problems. These can often complicate the process of acceptance and adjustment and will need to be handled sensitively, carefully, and soon as possible.

5. The cultural and spiritual values attached to AIDS, illness, and death. In some communities with a strong belief in life after death, or with a fatalistic attitude towards life, personal knowledge of HIV infection may be received more calmly than in others. On the other hand, there may be communities in which AIDS is seen as evidence of antisocial or blasphemous behaviour and is thus associated with feelings of guilt and rejection.

Counselling and support are most needed when reactions to the news of HIV infection and disease appear. Some reactions may initially be very intensive. It is important to remember that such responses are usually a normal reaction to life-threatening news and as such should be anticipated.

PSYCHOLOGICAL ISSUES

The psychological issues faced by most people with HIV infection or diseases revolve around uncertainty and adjustment.

With HIV infection, uncertainty emerges with regard to hopes and expectations about life in general, but it may focus on family and job. An even more fundamental uncertainty may concern the quality and length of life, the effect of treatment, and the response of society. All these are relatively unpredictable in terms of their long-term outcome. They need to be discussed openly and frankly, but care should always be taken to encourage hope and a positive outlook.

In response to uncertainty, the person with HIV must make a variety of adjustments. Even the apparent absence of a response may, in itself, be an adjustment through denial. People start to adjust to news of their infection or disease from the time they are first told.

Their day-to-day lives will reflect the tension between uncertainty and adjustment. It is this tension that causes other psychosocial issues to assume more or less prominence and intensity from time to time.

FEAR

People with HIV infection or disease have many fears. The fear of dying alone, and particularly, for dying alone and in pain is often very evident. Fear may be based on the experiences of loved ones, friends or colleagues who have been ill with, or died of, AIDS. It may also be due to not knowing enough about what is involved and how the problems can be handled. As with most psychological concerns fear and the pressures such fear creates can often be managed by bringing them clearly and sensitively into the open. They should be discussed in the context of managing the difficulties, including with the help of friends and family or with the counsellor.

LOSS

People with HIV-related disease experience feelings of loss about their lives and ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial stability, and independence. As the need for care increases, a sense of loss of privacy and control over life will also be experienced. Perhaps the most common loss that is felt is the loss of confidence. Confidence can be undermined by many aspects of life with HIV, including fear for the future, anxiety about the coping abilities of loved ones and caregivers, by the negative and/or stigmatizing actions of others. For many people, recognition of HIV infection will be the first occasion that forces them to acknowledge their own mortality and physical vulnerability.

GRIEF

People with HIV infection often have profound feelings of grief about the losses they have experienced or are anticipating. They may also suffer the grief that is projected on to them by close family members, lovers, and friends. Often these same people are

supporting and taking care of them on a day-to-day basis, and watching their health decline.

GUILT

A diagnosis of HIV infection often provokes a feeling of guilt over the possibility of having infected others, or over the behaviour that may have resulted in the infection. There is also guilt about the sadness the illness will cause loved ones and families, especially children. Previous events that may have caused pain or sadness to others and remain unresolved will often be remembered at this time and may cause even greater feelings of guilt.

DEPRESSION

Depression may arise for a number of reasons. The absence of a cure and the resulting feeling of powerlessness, the loss of personal control that may be associated with frequent medical examinations, and the knowledge that a virus has taken over one's body are all important factors. Similarly, knowing others or about others who have died or are ill with HIV-related disease, and experiencing such things as the loss of potential for procreating and for long-term planning may contribute to depression.

DENIAL

Some people may respond to news of their infection or disease by denying it. For some people, initial denial can be a constructive way of handling the shock of diagnosis. However, if it persists, denial can become counter-productive, since people may refuse to accept the social responsibilities that go with being HIV positive

ANXIETY

Anxiety can quickly become a fixture in the life of the person with HIV, reflecting the chronic uncertainty associated with the infection. Many of the reasons for anxiety reflect the issues discussed above and concern the following:

- Prognosis in the short and long term
- Risk of infection with other diseases
- Risk of infecting others with HIV

- Social, occupational, domestic, and sexual hostility and rejection.
- Abandonment, isolation, and physical pain
- Fear of dying in pain or without dignity
- Inability to alter circumstances and consequences of HIV infection
- How to ensure the best possible health in the future
- Ability of loved ones and family to cope
- Loss of privacy and concern over confidentiality
- Future social and sexual unacceptability
- Declining ability to function efficiently
- Loss of physical and financial independence.

ANGER

Some people become outwardly angry because they feel they have been unlucky to catch the infection. They often feel that they have been, or information about them has been badly or insensitively managed. Anger can sometimes be directed inwardly in the form of self-blame for acquiring HIV, or in the form of self-destructive (suicidal) behaviour.

SUICIDAL ACTIVITY OR THINKING

People who are HIV infected have a significantly increased risk of suicide. Suicide may be seen as a way of avoiding pain and discomfort or of lessening the shame and grief of loved ones. Suicide may be active (i.e., deliberate self injury resulting in death) or passive (i.e., concealing or disregarding the onset of a possibly fatal complication HIV infection or disease).

SELF-ESTEEM

Self-esteem is often threatened early in the process of living with HIV.

Rejection by colleagues, acquaintances, and loved ones can quickly lead to loss of confidence and social identity, and thus to reduced feelings of self-worth. This can be compounded by the physical impact of HIV-related disease that cause, for example, facial

disfigurement, physical wasting, and loss of strength or bodily control.

HYPOCHONDRIA AND OBSESSIVE STATES

Preoccupation with health and even the smallest physical changes or sensations can result in hypochondria. This may be transient and limited to the time immediately after the diagnosis, or it may persist in people who find difficulty in adjusting to the disease.

SPIRITUAL CONCERNS

Concern about impending death, loneliness, and loss of control may give rise to an interest in spiritual matters and a search for religious support. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may appear in the context of religious and spiritual discussions.

Many of these and other concerns will appear or become more pronounced when a diagnosis of AIDS is made. The appearance of new infections, cancers, and periods of severe fatigue all have a significant emotional and psychological impact. The effect is likely to be even greater if the person with AIDS has been rejected by family or friends and has withdrawn from normal social relationships.

OTHER COUNSELLING ISSUES

HIV infection often highlights other issues critical to quality of life.

SOCIAL ISSUES

Environmental and social pressures, such as loss of income, discrimination, social stigma (if the diagnosis becomes commonly known), relationship changes, and changing requirements for sexual expression, may contribute to post-diagnosis psychosocial problems. The patient's perception of the level and adequacy of social support is of vital concern and may become a source of pressure or frustration.

MEDICAL MANAGEMENT

The type of counselling support usually required and requested is often influenced by the person's experiences with other forms of health care related to the infection. Where the patient or loved ones feel that medical management has been insensitive or has been conducted without sufficient regard for privacy, counselling may be all the more necessary in order to persuade the patient to comply with recommended treatment programmes.

Counselling may also involve helping the person gain access to appropriate medical care and participate more fully in decisions about treatment. If there is any evidence of neurological disease, day-to-day management of the patient may be complicated, and special emphasis will have to be given to counselling of family, loved ones and care-givers.

At this stage, counsellors may need to co-ordinate a range of health and social services. Many people with HIV will also seek care from traditional or complementary healers: this may first be revealed in the context of supportive counselling. Where this is the case, counselling can help patients talk about their perceived needs and their satisfaction with these caregivers.

COUNSELLING AFTER AN EQUIVOCAL TEST RESULT

If the result of the HIV test is equivocal, the counsellor has particular responsibilities to provide information. In particular, there are two main issues to cover:

1. The person should be given a clear explanation of what such a test result means. The first test most commonly used on all samples is the enzyme-linked immunosorbent assay (ELISA). The ELISA has levels of sensitivity and specificity approaching 99.5%, meaning that a non-reactive result with this technique can be regarded as a definite indicator that the person is not infected, except for test during the "window period". However, a reactive result suggests the possibility of HIV infection. The usual procedure in that case is to perform a second test using the ELISA; if the second ELISA test is also

positive, supplementary testing is required, for example using the Western blot test. The results of such supplementary testing may be positive (indicating HIV infection), negative (indicating no infection), or indeterminate (giving an equivocal result). Where the result of supplementary testing is indeterminate (which may be the case in up to 10% of samples in some areas), the reason may be one of the following:

- The test is cross-reacting with a non- HIV protein (usually, the protein reaction is simulating the reaction associated with p24 core protein).
 - There has been insufficient time for full seroconversion to occur since the person was exposed to HIV. When presented with an indeterminate result, the options are to:
 - Use other methods to try to achieve a reliable result. Combinations of laboratory techniques may be needed to exclude false-positive results.
 - Refrain from further testing for the moment. If the result is indeterminate and further testing is not possible, the person cannot reliably be considered HIV- infected. The counsellor should advise the person to come for repeat testing in three months. It is important to remember that the risk of finding a false-positive result in the ELISA is higher in areas with a low level of HIV infection than where the background rates of HIV infection are high. Thus, in places where there are many people with AIDS in the community, it is more likely that a reactive or positive resulting in the ELISA is accurate.
2. Prevention and support while waiting for an unequivocal result. The period of uncertainty following an equivocal test result may be three months or longer. It is important for counsellors to stress essential messages related to prevention of transmission, regarding sexual activity, drug use, donation of body fluids or tissues, and breast-feeding. Just as importantly, however, the uncertainties associated with this period may lead to acute and severe psychosocial difficulties, and the

counsellor must be prepared to assess and manage such issues or to make appropriate referrals, if possible.

SELF-HELP GROUPS

In some places, the counsellor can call on peer-support or self-help groups, part of a growing network of non-governmental AIDS service organizations (ASOs). These can provide a type of personal care and peer-based psychosocial support that may not be available elsewhere. If no such groups exist, the counsellor may be able to encourage clients to form one. Where this is not possible, the counsellor may be able to put clients in touch with each other on an individual basis, at the discretion of the counsellor and with the express consent of the individuals and on a confidential basis. Matters that are often best dealt with through self-help groups, but which need to be raised by the counsellor in any event, include the following:

1. Learning to live with HIV infection. Self-help groups are often in a good position to address this because many of the people involved may have already gone through the process. They can describe the medical and psychological problems they have experienced and the interventions they have found most useful.
2. Helping care-givers and loved ones handle the pressures of living with sick or distressed people on a daily basis, especially where this involves managing bleeding, vomiting, incontinence, disposal of dressings, etc and advice regarding sexual relations.
3. Reducing stress and avoiding conflict. The need to overcome anxiety, depression and other possible challenges to sustained health has to be handled on a practical, "I did this..." basis.
4. Deciding how best to talk about HIV/AIDS. Fear of disclosing a diagnosis of HIV or AIDS to loved ones, family, friends, and colleagues needs to be examined and solutions sought, including what to say, to whom, when, and how.
5. Dealing with feelings of loneliness, depression, and powerlessness. Self-help or peer support groups can provide help and mutual support. Advice from people who have

themselves gone through such feelings may be more meaningful than advice provided on a second-hand or theoretical basis.

6. Managing the implications of adopting and maintaining safer sex behaviour. Peer support groups can organize discussions and training that can be far more relevant than advice provided through formal health care programmes. Peer commitment to safer sex also helps make these practices socially acceptable, attractive and thus sustainable.

The essence of peer-support group activity is a feeling of group cohesion, a sharing of experiences and mutually supportive activities. At times, such groups may need help in getting started and in maintaining regular activities. They will all look to the counsellor for help in identifying medical services and caregivers. Providing legal advice and in some cases, financial support may also become issues in establishing such groups and giving them operational legitimacy.

APPENDIX II

Guidelines for dealing with spillage of blood and other body fluids

The University adheres to universal precautions in the form of three infection control guidelines. These are: personal protective equipment (PPE), Engineering controls and work practice controls.

Personal Protective Equipment (PPE), includes gloves, lab coats, gowns, shoe covers, goggles, glasses with side shields, masks and resuscitation bags. The purpose of PPE is to prevent blood and body fluids from reaching a persons skin, mucous membrane, or personal clothing.

Engineering Controls; refer to methods of isolating or removing hazards from the workplace. Examples of engineering controls include: sharps disposal containers, laser scalpels, and ventilation including the use of ventilated biological cabinets (laboratory fume hoods)

Work Practice Controls; refer to practical techniques that reduce the likelihood of exposure by changing the way a task is performed. Examples of such techniques include: hand washing, handling of used needles and other sharp and contaminated reusable sharps, collecting and transporting fluids and tissues according to approved safe practices.

(Taken from the web-page of the Canadian Centre for occupational Health and Safety).

Blood and other body fluid specimens which are known or suspected to be infected with HIV should be handled in accordance with guidelines produced by the Ministry of Health and Social Services. A higher level of risk may arise from work with concentrated HIV solutions.

Staff undertaking higher risk work should undergo pre-placement screening by a qualified medical practitioner. Certain disorders may

make an individual susceptible to infection if accidental exposure occurs; the general suitability of an individual for this type of work must be considered. Prospective laboratory technicians and health workers will be counselled confidentially by a qualified physician/counsellor so that they are aware of the risks involved and know what to do in the event of an accident.

Before any member of staff embarks on higher risk work, a blood sample will be taken; this will be stored frozen and kept until destruction is ordered with the agreement of the individual. The sample will be coded and will not be tested without the consent of the person concerned. There is no need for pre-employment or routine HIV testing. An annual health review will be required to record occupational incidents and to monitor the individual's health. HIV testing may be performed at the request of the individual after appropriate counselling.

Accidental exposure to HIV in the laboratory may occur from splashes to the skin and eyes or through inoculation injury; aerosols of high titre material can also be a hazard. Splashes to the eyes or mucous membranes should be washed with soap and water and made to bleed freely. The University will not allow the use of human blood in laboratories or for experiments at undergraduate level.

The accident must be reported to the University Safety Officer and the Occupational Health Unit as soon as possible. The Occupational Health Unit will consider the desirability of administering prophylactic Zidovudine, and will arrange counselling and further follow-up.

APPENDIX III

Universal precautions and checklist of precautions to prevent HIV transmission

Universal precautions

(extract from the ILO code of practice, Appendix II)

a. Universal blood and body- fluid precautions

Universal blood and body- fluid precautions (known as “Universal Precautions” or “Standard Precautions”) were originally devised by the United States Centres for Disease Control and Prevention (CDC) in 1985, largely due to the HIV/ AIDS epidemic and an urgent need for new strategies to protect hospital personnel from blood- borne infections. The new approach placed emphasis for the first time on applying blood and body- fluid precautions universally to all persons regardless of their presumed infectious status. Universal Precautions are a simple standard of infection control practice to be used in the care of all patients at all times to minimize the risk of blood- borne pathogens. Universal Precautions consist of:

- i. Careful handling and disposal of sharps (needles or other sharp objects);
- ii. Hand- washing before and after a procedure;
- iii. Use of protective barriers- such as gloves, gowns, masks- for direct contact with blood and other body fluids;
- iv. Safe disposal of waste contaminated with body fluids and blood;
- v. Proper disinfection of instruments and other contaminated equipment; and
- vi. Proper handling of soiled linen.

APPENDIX IV

DEFINITIONS

Abstinence: not engaging in sexual intercourse or delaying sexual debut

AIDS: the Acquired Immune Deficiency Syndrome, is a range of medical conditions that occurs when a person's immune system is seriously weakened by infection with the Human Immunodeficiency Virus (HIV). HIV weakness cells in the immune system. This impairs the body's ability to respond to other infections. People living with AIDS are susceptible to a wide range of unusual and potential life-threatening diseases and infections. Through most of these can be treated, there is no successful treatment for the underlying immune deficiency caused by the virus to date.

Care, treatment and support: The care, treatment and support available to employees and students living with HIV, according to national legislation, education service regulations or institutional policy.

Commercial sex: being paid money for offering sex or sexual services.

Community: Local institutions outside the education institution which provide leadership or support on social, economic and political issues relevant to citizens, such as private employers or business, non- governmental social welfare organizations, health care providers, faith based organizations (FBOs), cultural institutions, etc.

Discrimination: any distinction, exclusion or preference made on the basis of HIV status or perceived HIV status, including discrimination on the grounds of sexual orientation, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation, or training, in accordance with the

definition and principles of the Discrimination (Employment and occupation) Convention, 1958 (no. 111).

Extra-marital sex: having sex outside marriage or a committed relationship.

HIV: Human Immunodeficiency Virus, a virus that weakens the body's immune system and (if remained untreated) may result in AIDS. Even though there is no cure to an HIV infection, antiretroviral (ARV) medication treatment reduces the possibility of developing AIDS.

Multiple partners: having more than one sexual partner.

Non-consensual sex: having sex against your will - normally in rape, defilement, assault, also in marital rape, date rape, child abuse.

Non-marital sex: having sex with someone to whom you are not married to or in a committed relationship with.

Peer educator: the trained employee or student who develops or implements a developmental counselling programme to meet the personal, psychosocial, social, and educational or training needs of employees or students in relation to HIV and AIDS.

Post-exposure prophylaxis (PEP): measures to be instituted after possible accidental exposure to HIV infection, e.g. rape, sports injuries and exposure to sharp instruments etc.

Screening: assessing the level of actual risk of exposure to HIV and/ or providing access to HIV testing. HIV screening should be done within the framework of the HIV/ AIDS Workplace Policy.

Sex and gender: there are both biological and social differences between males and females. The term 'sex' refers to biological determined differences, while the term 'gender' refers to differences in social roles and relations between males and females. Gender roles are learned through socialization and vary widely within and

between cultures. Gender roles are affected by age, class, race, ethnicity and religion, and by the geographical, economic and political environment.

Sex for survival: being given survival materials e.g. food, shelter in exchange for sex.

Sharp/ sharp instrument: an object such as a needle or other instrument used in school health care or in the education setting (e.g. tools in woodwork) that is able to penetrate the skin and potentially cause infection.

Transactional sex: being given something in return for sex e.g. promotion at work, a car, high grades in school (marks) etc.

APPENDIX V

LIST OF ACRONYMS/ ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral (drug)
ART	Antiretroviral therapy
CDC	Centres for Disease Control (USA)
EMIS	Education Management and information system
FBO	Faith Based Organization
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
PEP	Post- exposure prophylaxis: Prevention of disease or preventive treatment
PTA	Parent- teacher association
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
V(C)CT	Voluntary (and Confidential) Counselling and Testing
WHO	World Health Organization
UMU	Uganda Martyrs' University
UMUSU	Uganda Martyrs' University Students' Union
PLWHA	People Living with HIV and AIDS
GOU	Government of Uganda
DFID	Department for International Development
USAID	United States Agency for International Development
AAU	Association of African Universities

APPENDIX VI

TERMS OF REFERENCE FOR THE TASK FORCE ON HIV AND AIDS AND SEXUAL HARASSMENT POLICY OF UMU

1. To formulate the HIV and AIDS and Sexual Harassment policy and guidelines for implementation at Uganda Martyrs' University (as per agreement with the Association of African Universities (AAU)).
2. To examine the relevant documents on HIV and AIDS and Sexual Harassment; and other Organizations to ensure that the policy content and recommendations are in line with the latest knowledge on HIV and AIDS.
3. To undertake wide consultations with all University stakeholders: University Management; students, members of staff, and other stakeholders.
4. To review and support existing HIV and AIDS programmes at Uganda Martyrs' University.
5. To advise the University Management in matters pertaining to appropriate interventions for HIV and AIDS prevention, treatment, care and support at Uganda Martyrs' University.
6. To Coordinate and monitor the implementation of HIV and Sexual Harassment programmes within Uganda Martyrs' University.
7. To promote operational research on HIV and AIDS to enhance effectiveness and focused response to HIV and AIDS programming at Uganda Martyrs' University.
8. To establish a database on HIV and AIDS at Uganda Martyrs' University.
9. To solicit financial support- for HIV and AIDS programmes from both the national and international community.

APPENDIX VII

MEMBERS OF THE HIV & AIDS ANTI-SEXUAL HARASSMENT POLICY TASK FORCE, UMU

Professor Charles L.M. Olweny	Vice Chancellor	(Ex- officio)
Professor Barnabas Otaala		Chairperson
Mrs. Christine Kizito	Dean of Students	(Ex-officio)
Mr. Euzebio Akiiki Katorogo	Director of Human Resources	(Ex-officio)
Naume Constance Awino	Estates Department	Member
Wilfred Adioma	Security	Member
Godfrey Bwogi	Agriculture	Member
Richard Awichi	Science	Member
Dr. Harriet Mutonyi	Education	Member
Belinda Alice Nakibuule	Dean of Students' Office	Member
Dr. Stella R. Nakiwala	Health Sciences	Member
Ass. Prof. Laura Ariko Otaala	Humanities	Member
Sister Cecilia Draru	Institute of Ethics & Dev't Studies	Member
Edward Segawa	Business Administration	Member
Anthony Ogah	Built Environment	Member
Leonard Kawuki	Research Directorate	Member
Khellen E. Musiime	Infirmery	Member
Job Ondonga	UMUSU	Member
Kigenyi Rajab	UMUSU	Member
Mbahweza Gad	UMUSU	Member
Dr. Alfred Lumala	Nkozi Hospital	Member

APPENDIX VIII

University of Zambia--Sexual Harassment

University of Zambia

Sexual Harassment*

Sexual harassment is unwelcome sexual advances, requests for sexual favours, and other verbal or physical conducts of a sexual nature, when submission to or rejection of this conduct explicitly or implicitly affects a person's employment or education, unreasonably interferes with a person's work or educational performance, or creates an intimidating, hostile or offensive working or learning environment.

Sexual harassment may involve individuals of either sex, and be between members of the same or opposite sex. Sexual harassment typically involves a person in a position of power as the initiator. However, it may occur in a number of ways, e.g. harassment of student by student, staff member by staff member, staff member by student or student by staff member, where there is an element of threat or coercion in the behaviour.

Sexual harassment may be, but is not limited to:

- Explicit or implicit propositions to engage in sexual activity;
- Gratuitous comments of a sexual nature such as explicit statements, questions, jokes, or anecdotes, remarks of a sexual nature about a person's clothing or body whether made orally, in writing, or through electronic media;
- Deliberate, repeated humiliation or intimidation based upon the sex of the individual;
- Remarks about sexual activities or speculation about sexual experiences;
- Exposure to gratuitous sexually suggestive visual displays such as photographs, graffiti, posters, calendars, or other materials;
- Persistent, unwanted sexual or romantic attention;
- Deliberate physical interference with or restriction of an individual's movements;
- Subtle or overt pressure for sexual favours;

- Intentional touching and physical assault.

Complaints Regarding Sexual Harassment:

Any member of the University who believes that he or she has been subjected to sexual harassment has the right to report the incident to the designated personnel. Any such complaints shall be dealt with as specified in the Code of Conduct of students and members of staff.