

**Institutional Policies
for
Managing HIV/AIDS in Africa**

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Institutional Policies for Managing HIV/AIDS in Africa

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INTRODUCTION¹

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

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

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

The statistics make grim reading. HIV/AIDS is the deadliest scourge on the African continent. For those who are unable to contemplate the scope of the disaster, these numbers will shock. An estimated 28 million people are currently living with AIDS in Sub-Saharan Africa. This number represents nearly two thirds of all AIDS cases reported globally. In 2001 there were 3.4 million new infections and 2.3 million deaths. The continent harbours 21 countries with the highest prevalence of HIV in the world. In at least 10 countries, prevalence rates among adults exceed 10 percent. To bring the matter down to the individual level, 44 percent of pregnant urban women in Botswana were HIV positive in 2001. One in four adults in Zimbabwe and Botswana carries the virus. Of the 13 million AIDS orphans world-wide, 10 million of them live in Sub-Saharan Africa (Africa Today, Vol. 9, No. 5, May 2003, p. 19). Calisto Madavo, the World Bank Vice-President for Africa, emphasizes this tragic situation differently. He states: "Let us not get caught up only in numbers – HIV infection rates, HIV prevalence rates, mortality rates. Behind these numbers there is flesh and blood. Behind these numbers there are husbands, wives, parents, children, farmers, teachers, doctors. It's the wellspring of African knowledge and wisdom being drained before our eyes. According to a West African proverb, "Every time an elder dies, it's as if a library has burned down..."²

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

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

¹ I acknowledge with gratitude the help I received from the following colleagues who provided information used in this paper: Mary Crewe, University of Pretoria; Wendy Orr, University of Witwatersrand; Barbara Michel of the South African Vice Chancellors' Association; Mandy Govender, University of Cape Town; Mary Kabanyama-Zigira, Kigali Institute of Science and Technology; Philip Owino, Kenyatta University; Mosarwa Segwabe, University of Botswana,;and Mark Winiarski, University of Namibia.

² Calisto Madavo, Vice President for Africa, World Bank, at an address to a gathering of German development officials in Berlin, March 29, 2001).

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

WHY SHOULD TERTIARY INSTITUTIONS BE CONCERNED WITH HIV/AIDS?

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

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

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

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

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

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

It is an educationally **purposeful** community, a place where staff and students share academic goals and work together to strengthen teaching and learning on campus. It is an **open** community, a place where freedom of expression is uncompromisingly protected and where civility is powerfully affirmed. It is a **just** community, a place where the sacredness of the person is honoured. It is a **disciplined** community, a place where individuals accept their obligations to the group and where well-defined governance procedures guide behaviour for the common good. It is a **caring** community, a place where the well-being of each member is sensitively supported and where service to others is encouraged. And it is a **celebrative** community, one in which the heritage of the institution is remembered and where rituals affirming both tradition and change are widely shared. Given such a community, one would expect it to rise to the occasion, by “challenging the challenger” - - HIV/AIDS.

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

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

POLICY DEVELOPMENT

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

At the University of Namibia (UNAM), our experience goes back to 1997 when we developed HIV/AIDS guidelines for the University which were approved by the University Senate. But it was not until our visits to other sister institutions in the SADC region (University of Botswana; University of Natal; University of Pretoria) and numerous exchanges on HIV/AIDS issues with several universities which fall under the South African Vice Chancellors’ Association (SAUVCA), that UNAM began to actively develop its own policy – drawing heavily on its 1997 guidelines; and drawing liberally from other HIV/AIDS policies which had been adopted then or which were in draft form.

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

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

MANAGEMENT

The University ensures that all members of staff are familiar with the HIV/AIDS policy and the legislation that governs HIV/AIDS in the workplace. Most of the universities and technikons in South Africa have HIV/AIDS policies. The few that do not have them are in the process of developing them, often with financial support from DfID. In other Anglophone countries, many tertiary institutions do not yet have HIV/AIDS policies. More recently, however, with the ADEA-WGHE support, a number have either developed or are in the process of developing such policies. These include the Mombasa Polytechnic and Highridge Teachers Training College, in Kenya; Nkumba University in Uganda; and the University of Botswana, Gaborone, Botswana.³

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

In addition to policies, some tertiary institutions have actually set up separate structures charged with carrying out these policies. Some institutions (University of Botswana; University of Cape Town; University of Natal; Kenyatta University; and University of Namibia) have established HIV/AIDS Units to coordinate activities across the institutions and to combat “ad hocism” or the temptation to leave it to a few people with “a fire in their belly.” The University of Pretoria supports a Centre for the Study of AIDS in Africa whose primary purpose is to mainstream HIV/AIDS through all activities of the university to ensure that it is able to plan for and cope with the impact of HIV/AIDS on the whole tertiary education sector in South Africa.⁴

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

PEER COUNSELING, TUTORING AND MENTORING

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

Youth Radio Station

The University of Namibia established a radio station in 2001 (under the auspices of the United Nations and currently in partnership with Johns Hopkins University), which uses music, jingles, drama and talk

³ Alice Lamptey, personal communication, 2003.

⁴ See page 18 for the websites containing HIV/AIDS policies of selected institutions.

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

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

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

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

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

My Future is My Choice (MFMC) is a University of Namibia initiative that aims to empower learners by giving them information and skills that will enable them to make the personal choice to change their behaviour. The training provided covers ten sessions and covers topics such as reproductive health and HIV/AIDS, decision-making skills, saying “NO”; relationships and values, and alcohol and drug use and abuse.

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

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

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

CURRICULUM INTEGRATION

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

University of Cape Town

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

University of Namibia

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

Kenyatta University

Kenyatta University offers a wide variety of HIV/AIDS-related courses at the certificate, diploma and post-graduate levels, as well as a compulsory core unit for all students. At the last graduation, 85 students received certificates for one or other of these HIV/AIDS courses. These courses are proving to be increasingly popular because of their reputation for helping graduates to secure good jobs (ACU, 2001).

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

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

VOLUNTARY COUNSELING AND TESTING

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

Voluntary counseling and testing (VCT) has proven to be one of the early factors in behavioural change in countries such as Uganda, Senegal, Kenya, Tanzania, and Trinidad and Tobago. It is also efficacious and cost-effective. It can be assumed that people who want to know about their HIV status are willing to

change their behaviour. In Namibia, the number of persons demanding VCT is growing steadily. Private industry, in particular the mining industry, has played a decisive role in this regard, showing positive results in condom use and infection rate. VCT is in high demand in rural areas. However, VCT facilities have still to be made available throughout the country.

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

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

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

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

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

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

THREE EFFECTIVE THINGS MANAGERS CAN DO

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

Within tertiary institutions, capacity development is an immediate need. Key personnel require training to deal with AIDS in the workplace as well as staff to ensure that there is peer education and

program support. Members of the Dean of Student's Office and other student support services, the campus clinic, the library, and the key members of the Unions should all have some basic training on how to handle issues related to HIV/AIDS in the workplace.

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

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

For tertiary institutions in existence for ten years, it would be instructive to undertake tracer studies of past students. Information from such studies would, among other things, assist institutions to plan intakes more realistically, taking into account losses inflicted by the HIV/AIDS epidemic.

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

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

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

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

"Each year, more and more people die from the [HIV] disease and it is the stigma and misinformation around HIV that is killing people," Juan Manuel Suarez del Toro, president of the International

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

Federation of Red Cross and Red Crescent Societies, said in a recent World Red Cross Day message. “People place themselves at high risk from infection or refuse to seek treatment rather than face the consequences of social stigma, such as losing their homes, businesses and even their families,” he said (Olafsdottir, 2003).

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

Some scholarship regarding shame and stigma suggest the topic is approachable. Kaufman (1996) has studied these factors in terms of Western psychological factors, but little Third World research is documented. Parker, Aggleton and collaborators (2002) have addressed stigmatization and discrimination regarding HIV disease and have articulated a research agenda, including studies of social processes and aspects across cultural boundaries. Others have reviewed 21 interventions that explicitly attempted to decrease stigma associated with other diseases (Brown, Trujillo, & Macintyre, 2002). They concluded that the reviewed studies indicate something can be done about stigma through interventions such as information, counseling, coping skills acquisition, and contact. Underlining the scarcity of SDS interventions, the authors found only two national level efforts to combat stigma and no documented studies on the effects of mass media campaigns.

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

We then need to move to the issues of interventions regarding SDS. Funders need to support more scientifically based intervention studies. Researchers and communities will require encouragement for large- and small-scale interventions. Perhaps researchers will need to start with neighborhood or ethnic-group level interventions. In this regard our African researchers may also need to note that the Ford Foundation recently awarded the Centre on AIDS and Community Health of the Academy for Educational Development (AED) a grant to implement its HIV/AIDS Anti-Stigma Initiative. AED will examine the impact of HIV/AIDS related stigma and will work with community-based organisations to create strategies to combat it.⁵ This suggested research agenda may be a “tall order” but is a direct challenge to tertiary institutions, particularly in Africa, because their role is critical in resolving some of Africa's problems.

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

⁵ The Academy News, Spring 2003, p.6

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

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

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

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

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

Encouraging Public Debates on HIV/AIDS Issues

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

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

Discussions such as these encouraged for participants in the *My Future is My Choice* programme can be extended to public debate on HIV/AIDS issues. To undertake such debate, it would be crucially important to understand the political and social context within which one is working; the varying target and audiences' capacities to participate, and key ethical issues, such as informed consent; confidentiality, and the use of information.

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

A FEW SUGGESTIONS

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

1. Collaboration and Partnership

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

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

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

1. Advocacy to sensitize participants on the actual and potential impacts of HIV on the operations of their institutions.
2. Clarification of needs and responsibilities in the four domains of knowledge and understanding of the epidemic, teaching and preparation of students, research and dissemination of knowledge and service to or engagement with society.
3. Reaching agreement on the need for institutional response and what this implies in terms of a way forward at the institutional and group level.

4. Considering a new mechanism that ties all the institutions together to fight the HIV/AIDS epidemic, with a view to institutionalising the response throughout the respective institutions (in country or cross-border).

2. Learning from exchanging visits with other institutions

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

3. Doing activities at zero-budget

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

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

CONCLUDING REMARKS

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

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

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

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

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

They say:

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

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

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

The Author

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UNIVERSITY HIV/AIDS POLICIES WEBSITES

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