Commonwealth Universities in the age of HIV/AIDS: what every senior executive needs to know

Association of Commonwealth Universities
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Contents **Page**

Preface

Objectives of this document

Universities are in a unique position to shape debate, action, policy and practice in the fight against an epidemic which will have profound consequences not only for the societies we live in but for our institutions as well.

This document is intended to act as a means of mobilising university leaders in our community against HIV/AIDS. ACU also hopes it will have relevance and usefulness for researchers, activists, policy makers and the men and women across the Commonwealth who share a belief in universities as agents of change in the struggle against HIV/AIDS.

The ACU membership comprises nearly 500 universities in 36 countries. It is a diverse community and our task is therefore to speak to a range of different audiences and to ensure that the ACU's approach to the problem is informed, realistic and meets the needs of institutions operating in widely differing contexts.

This document is designed to pose some key questions for institutional leaders and, we hope, provide some answers:

- why is HIV/AIDS an issue for universities in the Commonwealth?
- what role can the university play?
- where do we begin to address the issue?
- what impacts will the epidemic have on the university?
- how will it affect our teaching, research, outreach and operations?
- are we responding sufficiently?
- what should our priorities be?
- how can we define an institutional response?

ACU is especially concerned that institutions use this document, and the process it supports, to sensitise key actors at institutional level, to think ahead, to anticipate the possible impacts of the epidemic and to think carefully through the responses – or lack thereof – which have been made in terms of the core business of a university.

There are suggestions on how to take a role of social leadership in the fight against HIV/AIDS and how to tackle aspects of the epidemic from an institutional perspective. Lastly, this is a means to assist us in mapping our way forward and defining a vision for Commonwealth universities in an age where HIV/AIDS has become a primary factor.

Structure

The document is organised into two parts**.** **Part I** begins by reflecting on the key question of why universities should be concerned about HIV/AIDS and continues by discussing the particular role of the ACU, other higher education agencies, and the global scale of the problem. This section concludes by outlining what issues universities need to consider in formulating their responses to the epidemic.

Part II provides an in-depth analysis of the four core functions of the university (teaching, research, management and outreach) and analyses how they may be affected by the epidemic. It then suggests responses which can be developed in each area as part of an institutional response. Each section ends with a set of questions for discussion.

Additional information and data are provided in a set of tables reflecting key indicators of the epidemic in Commonwealth member countries (Appendix A).

Process

This document has its origins in a consultation process convened by the ACU in Geneva in March 2001. The consultation involved representatives from a number of ACU member institutions and was focused on developing the next steps in a programme of capacity building activities around HIV/AIDS. It was agreed that a process of sensitising, informing and intensive advocacy needed to be developed around core groups of vice chancellors based in Africa and Asia. This discussion document would be used as a resource document for a series of workshops in which the many dimensions of the HIV/AIDS epidemic will be dealt with – all ultimately aimed at developing and improving our capacities to prevent, mitigate and manage the impact of HIV/AIDS on universities. At the conclusion of the workshops, our hope is to refine this document sufficiently for it to be used by other agencies as a good practice guide in developing policy and programmes that concern higher education and HIV/AIDS.

The current version of this document indicates sections where new information on good practice examples from around the Commonwealth are still to be included. It is expected that these will be drawn from the African and Asian workshops and inform the final form of the document.

Acknowledgements

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Members of the Geneva Consultation in March 2001, including Prof Brendan Bain, University of the West Indies, David Clarke-Patel, DFID, Dr D G Dongaonkar, Maharashtra University of Health Sciences, Dr Adeeba Kamarulzaman, University of Malaya, Prof Michael Kelly, University of Zambia, Dr Jaisy Mathai, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Prof Barnabas Otaala, University of Namibia, Dr R S Rao, Manipal Academy of Higher Education, Dr Paolo dos Santos Rodrigues, Universidade Federal Fluminense (Brazil) , Prof John Tarrant, University of Huddersfield, Ms Marie Paule Roudil, UNESCO and the above three ACU staff – all contributed towards framing the central questions in this document and provided a range of critical perspectives from across the Commonwealth.

Support from DFID has been instrumental in the development of this project and DFID's participation in the Geneva Consultation helped define the way forward.

A number of colleagues in Southern Africa and Asia have generously shared documents, data, ideas and their time.

Biographical Note

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Abbreviations and Acronyms

AAU	Association of African Universities
ACU	Association of Commonwealth Universities
ADEA	Association for the Development of Education in Africa
AIDS	Acquired Immune Deficiency Syndrome
ASO	AIDS Service Organisation
CARICOM	Caribbean Community
DFID	Department for International Development (UK)
EU	European Union
GIPA	Greater Involvement of People with HIV/AIDS
HIV	Human Immunodeficiency Virus
NACO	National Aids Control Organisation (India)
NGO	Non Government Organisation
PLWHA	Person/s Living with HIV/AIDS
SAUVCA	South Africa Universities Vice-Chancellors Association
SADC	Southern African Development Community
STI	Sexually Transmitted Infection
UTA	Universities Talk AIDS (India)
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing

Definitions

- HIV is a retrovirus that spreads through unprotected sexual intercourse, transfusion of unscreened blood contaminated with HIV, needles contaminated with HIV, and from infected women to their children during pregnancy, childbirth or breastfeeding.
- HIV is a slow acting virus but spreads fast
- The majority of HIV infected individuals look healthy and feel well for many years after infection.
- A laboratory test or a saliva test is the only certain way to determine whether an individual is HIV positive.
- Once an individual is infected, he or she is infected for life. HIV progressively weakens a person's immune system.
- Once an HIV infected person's immune system is severely damaged, he or she becomes vulnerable to life threatening opportunistic infections (e.g. pneumonia, tuberculosis) and is diagnosed as having AIDS.
- Most patients succumb to opportunistic infections within two years after the onset of AIDS. (Adapted from UNAIDS, 1999)

Part I

Introduction

I.0 Why HIV/AIDS concerns universities

The ACU would argue that there are essentially five primary reasons why members of the higher education community should be interested and involved in the struggle against AIDS – wherever you are and whatever the impact might be on your institution.

1. **HIV/AIDS is a development issue, not just a health issue.** HIV/AIDS affects not just the health status, but also the social, economic and psychological well being of individuals and communities. It has the capacity to weaken economies by diminishing the supply of educated, skilled and professionally qualified people and reducing the pool of leaders in critical areas of society, the economy and government. Responding to HIV/AIDS requires that we think about a range of mechanisms to prevent its spread and mitigate its consequences.

2. **HIV/AIDS affects not just individuals but institutions and systems**. University communities comprise students, academic staff, support staff and members of the communities in which they are based. They are also a national resource in many countries. The impact of HIV/AIDS affects the performance of institutions and their role in society at the very core of their operations as institutions dedicated to teaching, research and outreach.

3. **HIV/AIDS affects human resource development**. Universities play a critical role in the education and training of the highest skilled people in most economies. This is especially so in developing world economies where university level education is available only to a small minority. Students, who are the life-blood of universities, are particularly vulnerable to HIV infection by virtue of a range of factors which make institutional environments a focal point of social and sexual interaction.

4. **The struggle against HIV/AIDS requires knowledge resources**. In a world dominated by knowledge-based economies, universities occupy a highly strategic place as developers of new knowledge both in the public interest and for use by industry and commerce. Whether it is in the form of developing new models of peer education or vaccines, universities have a vested interest in the generation and dissemination of knowledge resources. Preventing the spread of HIV/AIDS, managing its impacts and supporting those infected with HIV/AIDS requires constant attention to research and development. This access to knowledge enables universities to influence the course of decision-making by major social and political institutions, to influence policy, and to set new standards.

5. **Successful institutional and societal responses to HIV/AIDS require leadership**. Advocacy, research and institutional change all require leadership. Commonwealth universities have all been part of the huge social changes, which have taken place over the past 40 years. The newest leadership challenge in many parts of the Commonwealth is the struggle against HIV/AIDS. Universities are called upon to reassert their role as leaders by promoting open and honest debate, freedom of expression, the value of knowledge and a belief in the value of social and economic progress.

2.0 Why is ACU involved?

ACU's first substantive involvement with HIV/AIDS began in 1999, immediately before the Commonwealth Heads of Government meeting in Durban. In collaboration with the University of Natal in South Africa, ACU held a symposium which focused on the need for coherent policies and strategies (ACU, 1999) and which led (in conjunction with a parallel meeting of the Commonwealth Medical Association) to the inclusion, in paragraph 55 of the official CHOGM Communiqué**,** of a statement recognising the urgency of the pandemic and a call to action on HIV/AIDS by governments and organisations. A Commonwealth Grouping now exists under the title Para 55, to which ACU belongs, and which continues to work on HIV/AIDS issues.

Support from DFID has enabled the ACU to continue working on a programme, which took a step further in a consultation with Asian, African, Caribbean and other role-players in Geneva in March 2001. At the same time, the ACU was able to release the results of a survey based on responses from 100 universities assessing whether institutional policy existed on HIV/AIDS and the form and content of such policy. The survey also looked at the provision of training, education and awareness raising for staff and students, access to resources like condoms and other services. Where policies do exist (42% of responding institutions with the highest concentration in Canada and Australia) they typically cover:

- A statement of the problem
- Safety procedures
- Commitment to non-discrimination
- Legal aspects of HIV/AIDS
- Issues related to teaching and research
- A commitment to community action

One of ACU's primary aims is to encourage and support every member institution to develop and implement a university specific policy on HIV/AIDS. It may well be asked whether other organisations in the international community are not better placed to tackle the epidemic. ACU's belief is that it has unique strategic advantages which must be exploited in the interests of the higher education community**:**

- ACU has global reach and is specifically concerned with issues in higher education

- ACU has direct access to the executive heads of member universities enabling it to impact directly on decision-making processes and opinion makers

- ACU has access to plentiful knowledge resources across a range of institutions in the developed and the developing world and is able to marshall them collectively.

The weight of international opinion is building steadily in the Commonwealth on the urgency of responding to the epidemic through every means possible and from every institutional vantage point. The latest of these commitments have come from the OAU in the form of the Abuja Declaration (April 2000) and the UN General Assembly (June 2001).

In this context, all signs points to a few critical factors which will determine our success in responding to the epidemic. Our vision must embrace the following elements:

- *Leadership*: The university plays a progressive and proactive role in society and gives leadership through research and role modelling in solving social problems. In our time, HIV/AIDS is undoubtedly one of the biggest and most immediate of these social problems.
- *Role-modelling*: The university is an example of society which works against the stigma, denial and discrimination that affects people with HIV/AIDS, their families and friends.
- *Capacity*: The university must have the capacity to manage and mitigate the impact of HIV/AIDS as a work place issue.
- *Planning*: Universities must be able to plan for and respond to the impact which HIV/AIDS related illnesses and deaths may have on the management, operations and financing of institutions.
- *Awareness*: HIV/AIDS literacy has to be an essential competence for managers and curricula changes must ensure that all undergraduates are at least aware of HIV/AIDS in their fields of study and in the world of work.
- *Knowledge generation*: An emphasis on HIV/AIDS related research is required in every discipline – not only those which contribute to institutional responses and controlling the disease but also those which add, for instance, to the body of knowledge about the demographic, economic**,** legal and development aspects of HIV/AIDS.

Across the Commonwealth, the space which universities create and maintain for critical open thinking must be used towards advocacy, towards creating a public platform for people with HIV/AIDS, towards making the sexual and social behaviours of young adults better understood and making behaviour more responsible. Part of this struggle has been won in Africa, but there, too, denial has restricted the public discussion of these critical issues.

There can be no denying the need for urgency if one simply keeps in mind the simplest problem statement of why HIV is unique and demands a response (World Bank 2000):

- HIV spreads very fast
- People who contract HIV may remain infectious for many years without knowing they have the virus or showing any symptoms. The potential for spread is high.
- It reduces life expectancy, which is positively related to education and productivity
- HIV/AIDS primarily affects people aged 15-49, who are in their prime as students, teachers, parents and workers.
- People with AIDS suffer repeated and prolonged illnesses, imposing great costs on households and health systems
- AIDS breaks down social cohesion, challenges value systems and raises questions about sexual behaviour and gender relations
- As yet, there is no vaccine and no cure.

2.1 Beyond Prevention

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

Strategies focused on prevention are important and need constant re-enforcement because of the vagaries of communication and the knowledge that the availability of information by itself is not sufficient to cause behavioural changes. Sustaining and building on positive behaviour changes is an even greater challenge.

But while prevention strategies must continue and be built upon, ACU argues that we need to think beyond prevention in a context where universities in many parts of the world have students and staff who have died, are ill, or whose families are seriously affected by the epidemic. Prevention alone will not address the gravity of their needs – it is insufficient. In this context, powerful arguments are emerging in wider society and within universities that any response to HIV/AIDS has to work across a continuum that includes: prevention, treatment, care and support (Cameron, 2000).

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

2.2 Equity issues

Because of its effects on social relations and the economic livelihoods of families and individuals, HIV/AIDS has the capacity to radically undermine equity in the life chances of students and staff. A student infected with HIV/AIDS before entering university or whilst at university is likely to bear huge costs in terms of their health, the possibility that they may not be able to repay loans and may not be able to contribute effectively to their families after completing their studies. Furthermore, HIV affects poor sectors of communities more acutely, because of diminished access to drug therapy, nutritional support and medical care.

Equity is at stake in this divide between the infected and the non –infected. It is also at stake in the case of those families who are affected by illness or death. In societies characterised by high levels of poverty and inequality, and where gaining access to university education is often a hard won battle often enjoyed by one individual in a family, the stakes are that much higher. Universities must be especially vigilant about these dynamics of the epidemic if they are to ensure equality of opportunity and more importantly, equity in the outcomes of higher education.

2.3 Funding

How can we afford to prioritise HIV/AIDS when our budgets are barely sufficient to play salaries and provide essential resources?

This is a common and very valid response to any suggestion that new priorities need to be addressed within already constrained budgets. This document argues that we need to think about the financial implications of HIV/AIDS in a different way for two reasons:

- first, investing even minimal time and effort in prevention strategies and policy development now will ultimately help in the long-term;
- second, a commitment to addressing HIV/AIDS is a positive signal to those outside the university community and may be a way of leveraging additional resources.

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

Our proposal of minimum standards is a way of resolving this dilemma. Minimum standards entail putting in place policy and programmes which address *at least the minimum* of what is required in a response to HIV/AIDS. No institution is bound to keep to the minimum but it is encouraged to maintain the *minimum* as a threshold. So, at the very minimum in terms of *policy*, a university should undertake to protect the human rights of HIV infected people and protect their privacy, confidentiality and job security.

When it comes to *programmes*, it may only be able to offer limited care and support within the institution, but it should make an undertaking to link students and staff with the necessary services outside the university. These are just two simple examples of what is possible: other sections of the document provide suggestions on other areas in which universities need to consider minimum standards.

3.0 What Can Universities do in Response to the Epidemic?

At its heart this document is designed to *sensitise, to inform and to compel* leaders in the university community to engage in a process of *self-reflection* about whether they have responded to the epidemic and how they may choose to respond in the near future.

As with any issue that has potentially fundamental implications for the mission of the organisation, its core business, its operations and its public mandate, the HIV/AIDS epidemic needs to be addressed through a process of inquiry.

There is already considerable debate in the education community about the extent to which education institutions should take responsibility for prevention, mitigation and management of the epidemic. Is it feasible to expect overstretched teachers (in both schools and universities) to assume responsibility for the care and support of students who are infected or affected? Should universities take on the burden of providing treatment and care for students and staff in conditions of constrained financial resources? Can a university change sexual behaviours? These questions are neither simple nor easy, but the process of inquiry must bring them to the surface and senior executives need to be equipped to handle them. The end point of this process of inquiry should be about *building capacity* across the university as an organisation to respond to the epidemic.

The process of inquiry might proceed along the following lines. Each of the following steps is proposed in a sequence which leads towards defining an institutional response. The steps focus on the role of senior executives in securing commitments, asking the right questions, mobilizing support and leadership through decision-making.

Prior to embarking on this process, it is worth asking: where should the process be initiated? It is envisaged that this process should be initiated both at the apex of the organisation (governing council, senate and senior management team) and at the level of a union meeting with manual workers.

Step 1: As a leader with a critical role to play in this process, you commit the organisation to a process of self-reflection by mobilising the key stakeholders in the university community.

Step 2: This step involves reflecting on what this epidemic may mean for the core business of the university, summarised under the following headings:

- Teaching
- Research
- Management
- Outreach

Step 3: Next, within each of these four areas of activity the following questions might be asked: what role in the struggle against HIV/AIDS does the university see for itself

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

Step 4: To what extent has the epidemic already affected the work of the university and the community it supports?

Step 5: Has the university responded in any way to the reality of the epidemic as an organisation or through the work of individuals? Are the responses adequate and appropriate?

Step 6: Where does HIV/AIDS rank in terms of your priorities?

Step 7: What form should your response to the epidemic take?

Step 8: Who will lead the process of defining your response?

Step 9: What structure will be put in place to drive the process of developing and implementing the response? To whom will it be accountable?

Step 10: What resources can be mobilised within and outside the university to support the response?

Step 11: How will you measure the success/efficacy of the response?

It should be evident just from these questions that a host of co-factors come into play once the process is underway – all of which have a critical bearing on the integrity of the response. They include:

- the will to act
- leadership

- commitment
- setting priorities
- institutional culture
- management structures
- decision making processes
- capacity to implement
- sustainability
- resources.

4.0 Leadership

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

Leadership can come from a number of places within the university community. All the available evidence points to the critical role of vice chancellors and senior managers in creating the right climate, in setting a precedent and in mobilising key constituencies within the institutional context. Executives also have substantial powers in affecting the flow of resources. The role of executive leaders is significantly enhanced when there is a sense of synergy with national ministries and government agencies that look to the universities as partners and for intellectual guidance. Student leaders can play a vital role in formulating strategy, in mobilisation and in articulating the concerns of their constituencies. If the issue has not already been raised by organised labour then senior executives have the responsibility to put HIV/AIDS into collective bargaining discussions and processes. Lastly, inter university bodies, which cover most parts of the Commonwealth, have a critical point of leverage in the fight against this epidemic. Like the ACU they have the advantages of *reach*, *a mandate to act on behalf of the collective* and *a spread of knowledge resources* within their community.

5.0 Other Resources for Capacity Building

There is a range of programmes concerned with HIV/AIDS already in progress across the international higher education community, which complement the work of the ACU. A common thread runs through all of them in their focus on 3 strengths in the university sector: research, capacity building and advocacy.

The Working Group on Higher Education (WGHE) under the ADEA has formulated a programme which is already in operation and will cover the period 2001-2002. Some additional research has been proposed on non-higher education institutions and the documenting of best practice cases. In terms of capacity building, the programme will probably involve a series of workshops and the development of training materials.

The International Institute of Education Planning (IIEP/UNESCO) in Paris has proposed a project which is likely to impact mostly on the school sector but will include training for education managers, research and a focus on planning issues with respect to HIV/AIDS. As part of this initiative the IIEP has established a clearinghouse of information on education and HIV/AIDS that has already gathered a substantial body of research and reports which are available on request (IIEP, 2001).

The Southern African Development Community's Human Resources Division has been active in the sub-regional context and has developed a set of protocols (SADC, 2001) which include the higher education sector. The organisation is about to develop a plan and is collaborating with other agencies on training and capacity building in the region.

Following recent conferences in 2001, members of the African Association of Universities (AAU) have initiated discussion on how to tackle HIV/AIDS programmatically. The Universities of Namibia and Botswana, have taken on the responsibility of developing a response within the AAU. The AAU's senior management development programme (SUMA) now includes components on the management of HIV/AIDS in higher education.

Lastly, again in Southern Africa, the South African Universities Vice Chancellors Association and the Committee of Technikon Principals have joined forces in a programme aimed at capacity building in 36 higher education institutions in South Africa and within SADC.

Part II

This section of the document analyses the four focal areas of the university's activities and suggests ways in which a response can be developed in each of them. It presents competing positions on many issues as well as examples of strategies which have been used with particular success. In engaging with a range of different perspectives and approaches, our concern is to provide the space for a range of different and institution specific pathways to develop – which ultimately work towards the common goals of preventing, mitigating and managing the impacts of the epidemic on higher education institutions and their communities. Simply put, there can be no simple formula or template which takes sufficient account of widely differing institutional cultures, variations in managing capacity, financial and human resources, the differing impacts of the epidemic and the different geographical locations of the Commonwealth.

Each section concludes with questions posed to senior executives which are intended to assist in shaping the process undertaken at institutional level.

6.0 Teaching

Why the need to change teaching and learning? Because living in a world affected by HIV/AIDS means that the needs of students and graduates and societies' requirements of them are being fundamentally changed.

6.1 Curriculum change: Though there is widespread agreement that university curricula should in some way reflect the impact of AIDS on our understandings of all disciplines, the mechanics of changing what is taught and how it is taught are far less straightforward.

In higher education, there is no uniformity of curriculum change even in the health sciences, which are the most immediately and obviously affected by HIV/AIDS. In the case of other disciplines the debate has included the following options:

- provide education on HIV/AIDS through non-formal means (workshops, peer education programmes)
- infuse issues of HIV/AIDS across the curriculum
- devise core compulsory courses across all disciplines
- implement compulsory courses which include HIV/AIDS issues within a life skills curriculum.

The latter most closely parallels the route taken by governments in school level curricula in African and some Asian countries.

6.2 Formal or non-formal HIV/AIDS education programmes: The larger debate is between formal and non-formal approaches to dealing with HIV/AIDS in the curriculum. It also involves considerations of time, resources

and scale. Depending on institutional processes, a change process can take up to 18 months and invariably involves some costs.

If one follows the formal route, a series of questions arise for any curriculum planner and educator:

- Is it the university's responsibility to enforce compulsory HIV/AIDS education?
- University education is not compulsory and students have choices- how do we reconcile this with a compulsory curriculum approach?
- What do you give up to make space for HIV/AIDS?
- How will you counteract poor quality teaching of a course which is treated as an extra burden by educators?
- How will you avoid the possibility that students simply learn the content by rote?
- How do you support the lecturers who are doing the work? What if any additional resources are available to them to develop new curricula?
- In terms of scale, should your approach reach across the institution from a central point or be driven by individual faculties?

In pursuing the non-formal option, the question arises as to whether university students are already too old for conventional sexuality education. These are young adults who may already be affected to an extent by 'AIDS fatigue'. The value of skills gained through extra curricular education is also undermined because it receives no recognition and is not often linked to a qualification or career path. Its voluntary nature puts the onus on students and the consistency of the programmes cannot be guaranteed.

Various options are now being tried in a number of institutions and it is still too early to determine which is the most appropriate or successful. Three working models using differing approaches are worth noting.

Example 1: *An Integrated Model* - places the onus on every faculty to ensure that students and teachers are AIDS literate and that HIV/AIDS is integrated into their degree structures. It is based on the proposition that HIV/AIDS must be made relevant to the life and career prospects of every student. Skills related to preventing and managing HIV/AIDS are developed in relation to career paths and marketability (Crewe, 2001). Engineering students, for example, have developed working models of home-based care kits, and human resource management students are ready to handle the reality of preventing and managing HIV/AIDS in the workplace immediately. These students represent the university as an institution producing socially responsible, flexible and professional graduates with skills that can be deployed immediately in the work environment. In the final analysis, this is an approach that depends heavily on executive leadership from the vice chancellor, AIDS specialists and executive deans.

Example 2: *Compulsory Model* - involves a foundation level course for all incoming students in which HIV/AIDS is part of a credit bearing life skills programme (UDW, 2001). The life skills approach challenges both educators and students to work with a range of issues, which are much wider than the biomedical aspects of the epidemic, and is targeted at providing students with the skills to make better choices in their relationships. The requirement that students treat the subject as a conventional academic topic involving research, assignments and tests, has yielded very important feedback to the university on their levels of knowledge, their attitudes and skills to deal with HIV/AIDS. It also provides a conduit through which students can approach the network of services (such as counselling, testing and care) which are otherwise treated with some scepticism.

Example 3 – *Non Formal Model* – involves recruiting and training a yearly cohort of students as peer educators who are prepared with the skills to educate their peers on HIV/AIDS. The programmes are typically voluntary, unpaid and target more senior students to work with new incoming students. Peer education has numerous advantages. It has been used in institutional settings for many years to tackle substance abuse and other risky behaviours and can therefore be easily adapted to focus on HIV/AIDS. Experience proves that students learn more readily from their peers. Peer education strategies are low cost, flexible and can reach substantial numbers with little infrastructure. Non-formal peer education programmes run alongside a formal model but moves are being made to set formalised standards of practice, credentials and to define a career path based on the skills students gain in non-formal programmes (SAUVCA, 2001).

6.3 Distance Education: What opportunities does distance education offer in your HIV/AIDS strategy? New distance education technologies and pedagogies now enable universities to reach a massively expanded number and range of students. Existing distance education infrastructure using print materials or electronic media can be adapted so that the same technology and the pedagogical power of distance education can also be harnessed against HIV/AIDS: to provide information and education on HIV/AIDS, to provide support services, to link distance learners to networks and to reach new communities where learners are located. There are, however, important difficulties which distance also creates. Providing services and support to students at a distance remains a challenge. For research, training and advocacy, electronic fora such as the one run by the International Institute of Education Planning (IIEP) are invaluable. Sites maintained by the ACU, the World Bank and a number of other organisations are increasingly carrying policy related information and research on HIV/AIDS aimed at a higher education audience.

6.4 Teacher Education: Universities play an important role in training teachers in many countries. However**,** the extent to which teacher education programmes reflect a world in which children and parents with HIV/AIDS are a

reality is still a matter of concern. Teachers obviously play a critical role in reaching hundreds of young children on a daily basis and have the power to shape positive attitudes to HIV/AIDS. Growing numbers of orphans, the loss of teachers and increasing social instability in poverty-affected communities has placed new burdens on schools which are already fragile structures. In this context too, debate has developed about the role of the school and the role of the teacher.

- How feasible is it to expect teachers to take on the role of care-givers for orphans?
- Can teachers realistically implement a life skills curriculum with minimal preparation and equally inadequate support?
- Can universities be expected to prepare teachers for these realities when they themselves lack the skills to analyse and respond to the epidemic?

Exemplar

6.5 Teaching as advocacy: Academic freedom is a powerful tool when coupled with the need to provide public information and to counter public denial, the need to promote the rights of people living with HIV/AIDS and to overcome public reluctance to testing. Students are willing and able to communicate these messages to a range of different audiences outside the institution through their work, research and community outreach. The classroom is in many ways an ideal place to encourage debate, innovation and action around HIV/AIDS.

6.6 Issues for discussion

- *Does the university's academic policy reflect a commitment to teaching and discovering new knowledge about HIV/AIDS?*
- *Has there ever been a discussion about HIV/AIDS as an academic matter in Senate or elsewhere in the university?*
- *Has Senate or any other body taken any decisions on how the university will respond to HIV/AIDS?*
- *How, if at all, has teaching changed at your institution in response to HIV/AIDS?*
- *In which disciplines have curricula changed?*
- *Was the process voluntary or led by senior management?*
- *What is the response thus far from students and staff to the change in curricula?*
- *Do you consider curriculum change a priority?*
- *What would you consider a feasible approach to change in your institution?*
- *How is it possible to get people living with HIV/AIDS more involved in designing new programmes and delivering them?*

7.0 Research

7.1 Research strategies: Research strategies can have both an external orientation (collaboration, publications, commissioned projects) and an internal focus on the needs of the institution itself.

The first question one confronts in this area has to be - why focus on HIV/AIDS? The answer is multifaceted:

- There can be no doubt that HIV/AIDS constitutes a major problem for our societies
- New knowledge is critical to our efforts at combating and managing the epidemic
- New knowledge has its greatest utility in affecting policy decisions
- Many of the problems generated by the disease and the epidemic are interdisciplinary and therefore provide opportunities for working across disciplines, institutions and geographical boundaries
- There are constantly new opportunities for funding emerging.

Research into HIV/AIDS is now a global industry in which universities have a major investment. Because of the costs of high-level scientific research, historical patterns and the economic difficulties faced by many institutions in the Commonwealth, there are major disparities in the output of research. What re-enforces the disparities is the lack of an intellectual culture and leadership in some institutions when it comes to driving research programmes. Funding is not a simple solution to the problem. Trying to generate an ethos of curiosity about HIV/AIDS is not something that can be enforced – it needs to grow from a process of intellectual engagement with the meaning and manifestations of the epidemic. So powerful is the stigma that some institutions have reported a reluctance to engage with HIV/AIDS even amongst researchers.

Aside from the biomedical research in which many universities have made massive investments, there is a need for well-conceived and up to date research on a host of social, legal, ethical, economic and other aspects of HIV/AIDS. Where the research does exist it is of high quality, but few means exist for sharing the information and its practical applications.

In the social and behavioural sciences, many universities can make a valuable contribution without having to contend with major start up costs and highly developed research infrastructure. In any field, existing research programmes can be augmented or refocused to include work on HIV/AIDS, thus obviating the need to establish completely new units dedicated only to AIDS research. Stand-alone units have a number of advantages but they can become isolated from the larger research culture of the university and connections to teaching.

7.2 Internal Intelligence: The dimensions of the epidemic as an internal phenomenon are equally important areas of research. A quick glance at

research issues, which have immediate relevance *within* individual institutions might include the following:

- what knowledge do young adults have about HIV/AIDS on arrival at university?
- to what extent have they already been involved in unsafe sexual behaviour?
- what forms of awareness and education against HIV/AIDS have they been exposed to?
- do students/staff hold religious, cultural or social beliefs that will impede or facilitate efforts at prevention?
- what types of sexuality education or life skills training works best for young adults between the ages of 18-25 and older students and staff?
- what factors affect women - specifically in societies where women are socially and economically subordinate and cannot negotiate sexual behaviour?
- how is it possible to engage young adults about sexuality in cultural and social contexts where sex and sexuality are taboo and poorly understood?
- how receptive are local communities to the idea of universities advocating non-discrimination and public discussion of sexuality?

More social and behavioural research is now emerging in India (and some in other parts of South Asia) on the ways in which HIV/AIDS is understood and acted upon by university students and school students particularly. (Lal et al, 2000; Mathai, R et al 2000; Sabherwal, 1995; Mawar et al, 1997, Singh,1997; Asthana et al, 2001; Kumar et al, 1999; Agrawal et al, 1999; Sachdev, 1998; Verma,1997). The research indicates some gaps in the students' knowledge and their misconceptions, their anxieties, the extent to which the believe they are unsusceptible to infection, the unease of teachers in dealing with sexuality, and most importantly, the receptiveness of students to information on HIV/AIDS and prevention strategies.

7.3 Collaboration: Collaborative research is a powerful tool that helps to overcome some of the constraints of geography and funding. With a network of nearly 500 institutions, the Commonwealth is in a unique position to foster and facilitate such collaborations. Such partnerships are already well established in some areas but there is room for growth. The challenge of disseminating research on HIV/AIDS in the education sector has been boosted by collaborative ventures such as the International Institute of Education Planning's (IIEP) information clearing -house on HIV/AIDS. Inter-university bodies and the Commonwealth Knowledge Network should be exploited as a means of strengthening institutional research capacity, attracting additional resources and disseminating information.

Biomedical research into HIV/AIDS is well developed in Indian universities and universities in regions like Chennai have established significant reputations as research centres (Desmond, 2001). Madras University in Chennai is partnered by the Scottish Institute for Infectious Diseases and the Tamil Nadu MGR Medical University is engaged in research into injecting drug use and HIV/AIDS. The Indian AIDS Research and Control Centre, ARCON, was established in 1994 as a collaboration between the Government of Maharashtra and the University of Texas system. Maharashtra is the epicentre of the epidemic in India. Two teaching hospitals, Grant Medical College and Sir JJ Hospital are the key centres of research in the state.

7.4 NGO partnerships: In addition to the expertise developed by universities in the Commonwealth – much of which remains undocumented at this point – there is a huge reservoir of expertise in dealing with AIDS that is based in the NGO community, AIDS Service Organisations (ASOs) and international development agencies. In fact, one of the most commendable contributions universities have made is in helping to establish, support and defend NGO organisations working in the field of HIV/AIDS. A number of regional bodies like AFRICASO, in the African region, provide an umbrella structure for service organisations. Australian community based organisations belong to the Australian Federation of AIDS Organisations (AFASO), and the other regional umbrella bodies include APCASO (Asia/Pacific), LACASO (Latin America and the Caribbean), NACASO (North America) and EuroCASO in (Europe). Programmes are plentiful and easily accessible. UNAIDS has developed a widely used database of best practice cases and materials. Regrettably, at this stage, there is little in the way of best practice information that focuses specifically on higher education. ACU's efforts in this programme focused on HIV/AIDS are aimed at filling this gap.

7.5 Opportunities: Universities must begin to see research into the HIV/AIDS epidemic as an opportunity to have a primary impact on the most pressing social, health and economic issue in recent history. This is especially so in an area like HIV/AIDS where stigma and ignorance are so powerful and research is the key to generating new knowledge in the fight against the epidemic. New approaches to prevention, treatment, care or any other dimension of the epidemic provide a platform for advocacy and setting new standards. A research strategy that identifies and supports work on HIV/AIDS will assist in attracting interest and highlighting the profile of AIDS research. The availability of concentrated high level skills within universities also makes them important partners in programmes driven by government or other multi-lateral agencies. Their role in shaping policy as a result of these partnerships is highly strategic. For example, the University of the West Indies has begun to play a major role in regional strategies to address the epidemic in the Caribbean.

A new programme of assistance by the EU to CARICOM, the regional development structure, was recently announced. It is entitled Strengthening the Institutional Response to HIV/AIDS in the Caribbean Project and involves the University of the West Indies as a key agency. The University of the West Indies held intensive discussions in March 2001 on its role in the region. It acknowledges that although institutional policy on HIV/AIDS had been in place since 1995, its implementation was still weak. Within the CARICOM led initiative the University will focus on long-term capacity building through research and training particularly in the areas of health, economic and communication aspects of HIV/AIDS. Curriculum development will also be a major responsibility of the University in the fields of health, social studies, health economics and media/communications. Furthermore, it will have to address the needs of all the region's language groups. With specific reference to research, the University is likely to concentrate on: behavioural change of individuals as it relates to risk factors for HIV/AIDS, aberrant or unusual clinical manifestation of HIV, the direct and indirect costs of the epidemic, evaluation of preventative measures and ethical aspects of HIV/AIDS. At institutional level, the University will conduct a situation and response analysis to assess the university's responses to date (or lack thereof) and the ways in which it can respond as a teaching institution, an employer, a research institution and a provider of medical and other services (Bain, 2001).

7.6 Trends: Since the late 1990's the pace of change in new research on HIV/AIDS and education has picked up rapidly. Much of the available information has been generated by and for international agencies such as UNAIDS, the World Bank and development co-operation agencies. A quick scan in 2001 indicates that much of the focus continues to be on the African scenario which remains the most pressing in terms of the impact of HIV/AIDS, with a predominant focus on school level education.

A few studies have broken new ground more recently. Coombe (2000) has written persuasively on the planning and management issues in the education sector. The arguments could easily be adapted to a number of other contexts in the Commonwealth.

The analysis pointed to the factors which have impeded a coherent and effective response to the epidemic. They include:

- a lack of political commitment
- lack of understanding of the social – as opposed to health – impacts
- lack of management capacity at national and sub-national levels
- lack of trust amongst potential partners
- lack of focus and concentration

Writing again from an African perspective on higher education, Kelly (2000) has argued the case for the need to universities to respond. The analysis pointed to key shortcomings in their responses to date. Institutional responses, even in countries which have been hardest hit and most visibly affected by the epidemic, are characterised by:

- silence, stigma, denial and discrimination
- a reluctance to treat HIV/AIDS as more than a health problem
- imperfect knowledge of the disease
- a focus on prevention rather than pro-active control
- few, if any, attempts at integrating responses to HIV/AIDS into the core functions of universities.

There are differences across the continent but it nevertheless paints a somewhat dispiriting picture.

In early 2001, the South African Universities Vice Chancellors Association (SAUVCA) published its own analysis of institutional responses to HIV/AIDS in the South African university system which comprises 21 universities providing for roughly 330 000 students. Many of the arguments made by Kelly were confirmed but the report also reflected a range of important, often small, and innovative approaches to the epidemic which have been made since the early 1990s (Chetty, 2000). The report argued strongly for the development of institutionally defined responses predicated on a set of minimum standards for prevention treatment, and care, towards which every institution should work and strive to maintain.

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

A corpus of institutional profiles now exists which includes those commissioned by the ADEA (Anarfi, Seclonde, Magambo, Nzioka, Otaala, Barnes, Mwape and Kathuria, 2000). In addition, a similar study has been completed on the University of Botswana (Chilisa and Bennell, 2000). It is worth noting that no such exercise is known to have been done in the case of a Caribbean, Asian, European or Australian university.

7.7 Issues for discussion:

- What is your current research strategy and does it refer to HIV/AIDS?
- Are there barriers to getting involved in research on HIV/AIDS?
- What incentives does your research strategy use to encourage new research?
- Does your ethics policy sufficiently cover the rights of people living with HIV/AIDS and researchers who may be involved in projects?
- Has your institution attempted any research into HIV/AIDS?

- Is there a mechanism which tracks research outputs in specific areas?
- What resources are available within the university to support research on HIV/AIDS?
- What additional resources can be mobilised locally?
- What partnership/collaboration opportunities have you explored which involve research on HIV/AIDS?

8.0 Management

Why should your institution be concerned about HIV/AIDS as a management issue? Consider the following:

- All evidence from the African context signals that HIV/AIDS affects more than just individuals and that it has profound impacts on organisations and institutions like universities.
- If the teaching and research issues are not tackled, university education may become increasingly irrelevant to the needs of students and society.
- Coping strategies are vital in avoiding and managing threats to the health of the organisation.
- The university has a responsibility to its staff and students for prevention and care
- The university should be a leader for change in society.

The task of managing universities in the age of HIV/AIDS has to be re-visited. At the very least, HIV/AIDS requires some careful analysis and thinking about how the work of the university is planned, managed and delivered. Whereas research and teaching are primarily focused on students and academic staff, in this section institutional policy and responses must provide for non-academic staff as well.

The range of issues that need to be covered under management is perhaps the most complex and substantive. They include:

- Finance
- Human resources policy and procedures
- Institutional Policy
- Programmes (prevention, treatment, care)
- Student and Staff Welfare
- Gender
- Health and Safety
- Employee Benefits
- Minimum Standards
- HIV/AIDS and the Workplace

8.1 Financial issues: HIV/AIDS has direct and indirect costs to institutions. Direct costs will be evident in the financial liabilities which universities will have to meet in terms of:

- Health insurance contributions
- Life assurance benefits
- Pension and disability benefits
- Funeral benefits
- Housing benefits (possibly)

Indirect costs are most often in the form of:

- Lost productivity due to illness and death
- Loss of staff
- Loss of expertise
- Recruitment costs
- Retraining costs
- Lost loan repayments

These are outlined in Appendix B (excerpted from Challenging the Challenger, Kelly 2001). Financial managers, institutional planners and human resources managers have a vested interest in understanding and being able to respond to the ways in which these costs will affect the viability of the organisation and the extent to which it is able to support students and staff who are effected by the epidemic. There is substantial evidence that health benefits, welfare benefits and pensions are amongst the first to be affected.

8.2 HIV/AIDS and the Workplace: As HIV/AIDS has a bearing on health and safety, productivity and equity issues in the workplace, managers need the skills to make informed, appropriate and responsible decisions to prepare themselves and to respond to HIV/AIDS in the workplace. One way of seeing this form of capacity building is that our aim should be to make managers and staff AIDS literate - at the very least. It is possible to define some basic minima in some of these areas since various types of pre-existing legislation governing labour practices, shops and offices, etc, cover many of them. Policy and procedures need to be put in place which ensure that all staff and students have the following information:

- a basic understanding of HIV/AIDS, how it is transmitted and what its effects are on the body
- the relationship between HIV/AIDS and other sexually transmitted infections
- how HIV/AIDS affects the workplace and how to respond appropriately
- what legal frameworks regulate the workplace with respect to HIV/AIDS
- why and how infected and affected persons should be protected from unfair labour practices, social and economic discrimination
- why confidentiality must be protected
- what services for prevention, treatment, care and support are available at the university or elsewhere and how to access the services
- what health and safety precautions need to be applied in the case of any workplace accident (universal precautions)
- what benefits staff are entitled to in the event of their becoming infected or if their families are affected.

One example of best practice outlines a way of understanding the *concerns and responsibilities of both employers and employees* (South Africa Department of Health, 1998) and is based on the value of a collaborative approach.

Employees will be *concerned* about:

- avoiding infection with HIV
- ensuring that the people living with HIV are treated fairly by all
- ensuring that confidentiality is maintained
- having a safe working environment
- protection from discrimination
- protection of employee benefits
- protection of promotion and training opportunities

In turn, employers will be *concerned* about:

- recruitment of employees who are capable of performing the tasks they are required to perform
- provision of equitable and sustainable employee benefits (including health care cover)
- performance management in relation to, amongst others, productivity loses and absenteeism
- retaining experienced and trained staff
- fair and sustainable approach to training, promotion and benefits
- the risk of becoming HIV infected at work (mainly in health care facilities)
- the issue of employing people with HIV in high risk or unhealthy environments

In terms of their *responsibilities* managers are expected to:

- ensure that the process of consultation takes place
- help develop an HIV/AIDS policy and programme
- show commitment to the HIV/AIDS programme
- allow time for employees to take part in the HIV/AIDS programme
- formalise the job description of anyone who is involved in implementing the programme to facilitate their work and increase their credibility
- feed comments down from management
- ensure that resources are made available to the programme
- participate in collaborative partnerships

Employees bear the *responsibilities* of:

- taking responsibility for their own health
- participating in the programme
- owning the programme
- respecting the privacy and confidentiality of those living with HIV
- respecting the rights of those who are not HIV positive
- taking lessons learnt at work into their homes and community life.

8.3 Human Resource Development: A number of African institutions have had to confront the profound implications of losing staff with decades of experience; people who are difficult and costly to replace. This is the human

resources development dimension of HIV/AIDS at its sharpest. Recruiting new staff is costly and time consuming. Training younger staff to act as replacements takes years and fast tracking new recruits through development programmes may have to be considered. In cases where universities are losing between 2-3 people a month to illness and death – the effort, cost and stress of replacing staff can be crippling. Institutional level HRD policies need to anticipate and provide for this possibility especially in high priority areas of expertise.

Building capacity as a HRD function should be both an internal and externally focused set of processes. The internal capacity to understand, respond to and manage HIV/AIDS is proving to be a key strength. This is a special challenge in contexts where the average government run health service cannot provide the bare minimum of services or health resources. There are simple, effective measures which can be put in place at key points in the organisation of the university. Health centre managers need access to training, accurate information, up to date clinical practices and the freedom to spread their message. Student counsellors need to be able to supply accurate information, motivate changes in behaviour and provide the essential support to infected and affected students and their families. In short, all of these require skills, resources and authority – the ingredients of strong institutional capacity.

8.4 Minimum standards: Alongside policy development, minimum standards for prevention, treatment and care have been proposed as a way of tying institutions to a commitment in responding to HIV/AIDS. These standards could be specific to an institution or to a group of institutions. They can be based on existing regulatory requirements such as, for example, those which typically cover occupational health and safety, or adapted to suit the particular context in which the university operates. In the health sector, these standards are sometimes incorporated in the form of a patients' charter that defines the rights and responsibilities of patients and the health service agencies providing their services. As with all policy development processes, the question of resource allocations to support the policy commitments remains a critical obstacle to action. The standards also reflect public commitments on the part of universities to recognise the importance of HIV/AIDS and the role that universities can play in the epidemic. More importantly, they provide a concrete and visible alternative to lofty statements of policy which are often too difficult to implement.

Example 1: This example is built around the idea that organisations must focus on doing the *simple things* that prevent the spread of HIV and mitigate its impacts. Two obvious examples come to mind: effective services for contraception and the treatment of sexually transmitted infections (STIs) – both of which are commonplace, cheap and available even in very rudimentary public health systems. The presence of STIs are known to increase the risk HIV infection. A programme within the university that effectively prevents and treats sexually transmitted infections will have an immediate impact in reducing the transmission of HIV and the possibility of

infection. Contraceptive and STI treatment services should therefore be a *minimum* requirement of the health services at any institution.

8.5 Institutional Policy: Why is it necessary to have policy on HIV/AIDS? This is a question worth asking particularly if staff or students or management do not yet see themselves as affected by the epidemic.

Policy development has been highlighted in the work of the ACU since 1999. At its best, policy informs, supports and drives decision-making processes that affect the lives of people affected by and living with HIV/AIDS. This thrust should not however presume too much about the power of policy. At worst, policy making can become a sterile, bureaucratic exercise that has little value. More especially in the case of HIV/AIDS, where so much remains unspoken, the process needs to develop in a way which is meaningful and carries commitment.

But, policy by itself is not a solution to organisational weaknesses such as a lack of leadership, critical resource gaps or inertia. Whilst the process of developing policy should be pursued vigorously, the absence of policy should not be allowed to stifle initiative and effort. In some cases, institutions are reluctant to work on policy or programmes unless they see what they consider to be proof of the effects of HIV/AIDS. Given the window period between infection and illness, denial has huge cost to individuals and institutions already in much of the world where HIV/AIDS is rampant.

8.6 Gender: Why should a sexually transmitted disease affect women more than men?

Women are physiologically, socially and economically more vulnerable to the impacts of HIV/AIDS than men. The transmission modes of HIV make women more vulnerable and their ability to negotiate safer sexual practices remains constrained by culture and social practices. There are many parts of the Commonwealth where unsafe behaviour by men is condoned and where women remain victims of sexual violence and rape. Sexual violence heightens the threat of HIV infection and increases the vulnerability of women.

Gender imbalances appear to manifest as early as the first sexual experiences amongst young teenagers. Younger women – especially those who are poor or without access to services – are being pressured into relationships with men who believe they are avoiding the risk of infection or even curing themselves of infection. Women – even in the university context - are under pressure to provide sexual services to sustain themselves, a practice that has taken on the colloquial expression of 'sugar daddyism.' In all of these ways, HIV/AIDS influences the dynamics between men and women and has the potential to cause profound imbalances in gender relations.

Many analyses of public health services find that women are at a disadvantage in their access to health services and that HIV/AIDS will exacerbate that disadvantage. Likewise, their jobs prospects are likely to be

severely compromised by their HIV status. In the domain of legal relationships, there are concerns about their continued ability to exercise their rights to property, employment, marital status and security (Matlin and Spence, 2000). If they are HIV infected, pregnant women bear the brunt of the epidemic in the threat to their own health and that of their unborn children.

There is substantial evidence that HIV/AIDS has a differential impact on young women. In institutional and social contexts where women remain at a disadvantage, universities will have to guard against the gendered nature of HIV/AIDS. Knowing these trends, it is imperative that prevention, treatment and care-focused interventions are sensitive to the way in which HIV/AIDS will affect gender dynamics and the status of women. Despite our beliefs that universities are liberal and supportive environments, women often have to contend with sexual violence, harassment and rape. On the basis of these arguments it should be clear that policy, programmes and institutional practices dealing with HIV/AIDS need to be attuned to the differential impacts on women and their specific needs. This is an issue that goes well beyond just management issues and needs to be reflected in teaching and research as well.

8.7 Programmes (prevention, treatment and care): In this millennium, universities will have to acknowledge that their staff, students and communities include people living with HIV/AIDS who need access to treatment, support and care if they are to continue working and studying productively.

Treatment and support/care services are now a necessity as part of an institutional response. Access to treatment has become a major political and health issue in the developing world. It is a complex challenge for most governments because of the costs involved and the infrastructure that is needed to support treatment programmes.

In the context of universities, there are calls for institutions to take a stand on treatment and equally strong arguments about whether it is feasible and appropriate for universities to take on such responsibility. University policy should reflect its stand on treatment so that unfounded expectations are not created. Even without going the route of costly anti-retroviral drugs, small interventions such as initiating and improving a service to treat sexually transmitted infections (STIs) and providing contraceptive services will go a long way towards improving the chances of prevention. The better the standard of health services the more likely people will be to test voluntarily (VCT) and to believe in the university's commitment to protecting their confidentiality and dignity. If the silence and denial, which surrounds so much of the epidemic, has to be broken, voluntary testing has to be encouraged and the service has to be provided.

Making condoms easily available is a strategy that can be done at negligible cost and that can have a direct impact on the sexual behaviours of men and women. If provided regularly, with accurate information and with a support mechanism, condoms provide a means of introducing prevention strategies –

but they are not a solution by themselves. There is nevertheless considerable evidence that providing condoms publicly in some contexts will be contested and that getting men to take the responsibility for using them is often difficult.

Denial is a serious obstacle in societies where sexual relationships between men are denied and stigmatised, but the existence of these relationships will play a major role in the transmission of HIV between men and between men and women. This pattern is referred to as men who have sex with men (MSM) – although not exclusively – and therefore needs to be factored into the way programmes are designed and targeted.

The range of interventions being tried in response to the epidemic is growing daily. They include peer education, needle exchange, counselling, life skills education, home based care, sexuality education and many more. What is apparent is that our thinking about how to prevent and respond to the impacts of HIV/AIDS will have to change as the epidemic unfolds.

- Prevention must be a sustained process, not a one off activity.
- Programmes will have to be differentiated to ensure that the core messages are well received by the many smaller populations that make up a university community.
- Universities also need to be more concerned about what interventions work, under what conditions, at what cost and why the interventions work.

Exemplars

8.8 Student and Staff Welfare: The African case studies (ADEA 2000) make it clear that many aspects of university life are already being affected by the impacts of the HIV/AIDS epidemic. Numbers of staff have become ill and have died – in a pattern that signals the impact of HIV/AIDS - though few cases have actually been recorded of publicly acknowledged deaths due to AIDS. Typically, deaths are attributed to the opportunistic infections which signal the advent of AIDS. Trauma is therefore a reality in student and staff social life.

The dynamics of social life also sharpen around the issue of disclosure – making public one's HIV status, the cause of an illness or the cause of death being due to an AIDS related illness– requires careful and sensitive treatment. Students, staff and their families are rarely willing to make these disclosures and their choices must be respected. The drawback in this case is that their behaviour compounds the secrecy, shame and stigma attached to the disease. The retreat to privacy means that their needs as infected or affected people cannot be accurately identified and supported.

Disclosure, when handled sensitively, has been a powerful weapon in overcoming stigma and isolation. However, promoting disclosure has to be backed by policies and services that safeguard the welfare of the infected person. Welfare services in the form of counselling, referral mechanisms, support groups, faith based organisations and public sector health and mental health resources all need to be marshalled around this critical need.

8.9 Issues for discussion

- Does your institution consider HIV/AIDS a threat from a management perspective?
- Where does HIV/AIDS rank in relation to your other priorities?
- Have you, your management team or the institution made any specific responses to the HIV/AIDS epidemic?
- Is there any evidence that your institution has already been affected by HIV/AIDS directly or indirectly?
- In your capacity as an institutional leader, what form of response do you consider appropriate and necessary?
- What resources are there within and outside the university community which you can draw on to formulate a response?
- How do you define your responsibilities and those of students and employees?
- If you have made a commitment in terms of policy, to what extent have you succeeded in implementing the policy?
- What proportion of your management, staff and students can you reasonably describe as AIDS literate?

9.0 Outreach

9.1 Outreach strategy: How can a university's outreach strategy focused on HIV/AIDS bring substantial benefits to the institution and the communities it serves?

- Universities cannot operate without being located in communities and engaging them in the life of the institution.
- Outreach initiatives provide excellent opportunities for students and staff to provide badly needed services to communities, to engage their expertise in a realistic setting and to build a stronger basis for the mission of the university.
- The research community benefits especially from outreach activities when opportunities arise from working with schools, clinics, hospitals, care projects.
- Outreach need not necessarily be on a voluntary basis either – universities can provide training and knowledge to youth and adults who may be willing and able to pay for such access.

9.2 Experiential learning: Students who have little or no experience of the workplace or of being an adult responsible for the lives of others, are a major source of goodwill that can be made available to people living with HIV/AIDS. In the same way, outreach can provide opportunities for people living with HIV/AIDS to take advantage of the resources and support which universities may be able to offer.

9.3 Outreach as advocacy: Outreach is not a soft option when it comes to HIV/AIDS – it is about engaging with the hard realities of the destructive power in this epidemic. A commitment from universities to work with students, their families, communities and vulnerable populations will send a powerful signal to decision makers and ordinary people that universities care; that they are prepared to lead in the fight against HIV/AIDS and that they will use their intellectual resources and authority in order to prevent the spread of the epidemic. Advocacy around HIV/AIDS has in some instances pitted academics and intellectuals against government policies, business practices in the health care industry and against one another in scientific and philosophical debates about the epidemic. Where the debates have highlighted the plight of marginal and vulnerable members of society, academics have served an important purpose. Similarly, where the debates have focused on government policies or business practices, universities can and have made important contributions through critique and advocacy of new ideas. In this way, outreach has the potential to extend academic freedom beyond the confines of the university and serve a wider mission.

9.4 GIPA- Greater Involvement of People Living with HIV/AIDS: Universities can and do set precedents that influence opinion makers and decision makers. Popular opinion and prejudice – as in the stigma attached to people with HIV/AIDS – often militates against intellectual argument but universities have the capacity to show that preventing the spread of HIV/AIDS is essential; that living with HIV/AIDS with dignity and without fear is possible;

and that universities are places of compassion and care. People living with HIV/AIDS (PLWHA's) who are supported by universities in their public disclosure are powerful beacons and need to be brought into the thinking and decision making process of institutional responses to HIV/AIDS.

In communities where ignorance, fear, prejudice are strong and respect for human rights is a privilege, living with HIV/AIDS, getting access to health care, finding and keeping a job, ensuring that children remain in school and many other basic entitlements in society can be threatened as social cohesion weakens and poverty takes its toll. The majority of the world's population infected with and affected by HIV/AIDS is poor and they will bear they bear the brunt of the epidemic. Through advocacy, access to media, access to information technologies and institutional power, universities can affect the life chances of generations in this epidemic.

Exemplars

9.5 Questions for discussion:

- *How effectively does the university engage with communities?*
- *What strategies have been tried in attempts to improve community involvement?*
- *What is your university's current policy on outreach?*
- *Are there ways in which people living with HIV/AIDS can become more central to outreach initiatives?*
- *What incentives does the university provide for students and staff to pursue outreach opportunities?*
- *What value does 'service to communities' hold in the curriculum and professional training programmes?*
- *Are there ways of developing outreach initiatives as opportunities for 'service learning' for students and new career paths?*

10.0 Way Forward

This document will be read differently by senior executives, depending very much:

- on where you are geographically
- on whether HIV/AIDS has yet had an impact on your society and its institutions
- on the sense of urgency with which the disease is being addressed
- and perhaps most importantly, on whether the epidemic is a reality for you, your colleagues, your family, friends - and the organisation you lead.

In North America and Western Europe the epidemic can be managed as a chronic illness thanks to the availability of high quality treatment and support services in the public and private health sectors. In Africa the epidemic has

been responsible for more fatalities than any other cause except armed conflict.

Though India has an estimated 4 million HIV infected people, it is difficult to gauge whether a generalised epidemic will develop in south and south east Asia and what the immediate consequences might be for higher education institutions. In the Caribbean, an epidemic is developing that is still contained by geographical boundaries but poses a major threat to small fragile economies.

We have no ready-made answers. However, it is essential that the process of self-reflection within the ACU must lead us to some measure of consensus about the urgency of this epidemic, our resolve to act on it and the commitments we need to make in policy, resources and effort – if our universities are to respond with integrity and remain healthy organisations. In some quarters it will take courage to speak openly and the will to act will be elusive and dissipated – even whilst an epidemic rages. This is the challenge to our leadership.

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Useful Websites

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

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

AEGIS www.aegis.org

AVERT, www.avert.org

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

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

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

PubMed, National Library of Medicine, **www.ncbi.nlm.nih.gov**

KIT, Royal Tropical Institute, **www.kit.nl**

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

Aids Research Council (India), **www.arcon.8m.com**

Appendix A – The Scale of the Problem

Selected data on HIV/AIDS in Commonwealth Countries
(excerpted from UNAIDS, 2000)

Appendix B – Economic Impact on Workforce of HIV/AIDS
(excerpted from Kelly, M, Challenging the Challenger, ADEA, 2001)