

**AFRICAN HIGHER EDUCATION INSTITUTIONS RESPONDING
TO THE HIV/AIDS PANDEMIC**

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ACRONYMS AND/OR ABBREVIATIONS

AAU	–	Association of African Universities
ACU	–	Association of Commonwealth Universities
ADEA	–	Association for the Development of Education in Africa
COL	–	Commonwealth of Learning
COSDEC	–	Community Skills Development Centre
FAWE	–	Forum for African Women Educators
FAO	–	Food and Agricultural Organisation
IRBs	–	Institutional Review Boards
LAC	–	Legal Assistance Centre
MATS	–	Media and Technology Studies
MSM	–	Men having Sex with Men
SAUVCA	–	Southern African Universities' Vice-Chancellors' Association
SSA	–	Sub-Saharan Africa
STDs	–	Sexually Transmitted Diseases
UNAM	–	University of Namibia
UNESCO	–	United Nations Educational, Scientific and Cultural Organisation
US	–	United States
USAID	–	United States Agency for International Development
VCT	–	Voluntary Counseling and Testing
WAD	–	Women's Action for Development
WGHE	–	Working Group on Higher Education

EXECUTIVE SUMMARY

The paper examines the situation of HIV/AIDS globally, and in Africa. The observation is that contrary to what was expected in the early nineties the number of people who have died from AIDS and those who have been infected has almost tripled. The worst hit nations are in Africa, with India and Caribbean following in “hot pursuit”. In Africa the epicentre of the pandemic is in Southern African countries.

Up to recently higher education institutions had done very little in terms of response to the pandemic. The Kelly report (Kelly 2001) as well as reports from workshops sponsored by the Association of Commonwealth Universities (ACU) and the South African Vice Chancellors’ Association (SAUVCA) indicate the serious impact of the pandemic in terms of the fiscal situation, and in terms of the negative social impacts on university communities. At the same time the reports indicate some good examples of what has been done by individuals or groups within the Universities “with a fire in their belly”. The examples cover a range of areas including what has been done in teaching, research, as well as among communities of which the institutions are a part.

The central message of the paper is that higher education institutions must develop a comprehensive HIV prevention programme which runs through and drives each of the following:

- HIV/AIDS policy and strategy development
- Developing culturally appropriate prevention messages
- Tackling socio-economic factors
- Establishing partnerships
- Sustaining awareness and education
- Challenging denial and stigma
- Situating prevention in a community context
- Linking care to prevention
- Rigorous scientific reflection

With the active partnership and collaboration of governments, NGOs’, bilateral and multilateral organisations, and invigorated by the pronouncements of **Audience Africa** (1995) higher education institutions will succeed in **“Challenging the Challenger”**

INTRODUCTION

“HIV/AIDS is unequivocally the most devastating disease we have faced, and it will get worse before it gets better”, Dr. Peter Piot, Executive Director (UNAIDS) November 2001.

“Education is at the core of one of the great challenges facing humanity: winning the fight against AIDS. Education is life-sustaining. It furnishes the tools with which children and young people carve out their lives, and is a life-long source of comfort, renewal and strength. The world’s goals in promoting education for all and in turning back the AIDS epidemic are mutually dependent. Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach.”

Peter Piot, Executive Director of UNAIDS in the Foreword to the Inter Agency strategy paper “HIV/AIDS and Education: A Strategic Approach”

This paper will provide an overview of the HIV/AIDS situation globally and in Africa. It will then provide the present status of HIV/AIDS in higher education institutions in Africa, including examples of good practice with respect to teaching, research and community service, and present barriers and challenges.

The section entitled “where do we go from here?” deals with how higher education institutions might dramatically increase their efforts to comprehensively “Challenge the Challenger”, the HIV/AIDS pandemic. The paper ends with concluding remarks reiterating the position of the AAU adopted at their Nairobi meeting in February 2001. References as well as appendices are provided.

OVERVIEW OF THE HIV/AIDS SITUATION GLOBALLY AND IN AFRICA

AIDS is turning back the clock on development. In too many countries the gains in life expectancy won are being wiped out. In too many countries more teachers are dying each week than can be trained. We will mainstream AIDS in all World Bank work....

*The President of the World Bank, James D. Wolfensohn,
address to the U.N. Security Council, January, 2000*

The first news of a sudden rise of infections among young gay men appeared in 1981, stemming from the reports of the US Centre for Disease Control.

Out of this grew the awareness of a new syndrome and the beginning of the history of a disease that has taken hold of the public imagination like no other. Two years after the “gay plague”, it was becoming clear that this disease was not limited to gay men, and was spreading fast. By 1986 it was apparent the infection spread mainly through sex and could target anyone. Today, the epidemic is looking at the face of heterosexual men, women and children who

are dying in their thousands around the world. This segment of the world's population represents entire generation who are not aware that they are involved in this crisis.

Table1: The HIV/AIDS Epidemic Globally and in Sub-Saharan Africa at the end of 2001			
	Globally	All Countries of Sub-Saharan Africa	World, Excluding Sub-Saharan African
Adult Population	3,198,252,000	291,310,000	2,906,942,000
Adults Infected	37,100,000	26,000,000	11,100,000
Children Infected	3,000,000	2,600,000	400,000
Adult Infection Rate	1.16%	8.93%	0.38%
AIDS Deaths in 2001	3,000,000	2,200,000	800,000
AIDS Orphans	14,000,000	11,000,000	3,000,000
Proportion of Total World Population	100%	10.4%	89.6%
Proportion of Adult Infections	100%	70.1%	29.9%
Proportion of Child Infections	100%	86.7%	13.3%
Proportion of Female Infections	100%	81.1%	18.9%
Proportion of AIDS Deaths	100%	73.3%	26.7%
Proportion of AIDS Orphans	100%	78.6%	21.4%

Source: *Derived from Report on the Global HIV/AIDS Epidemic, UNAIDS, July 2002*

The HIV/AIDS epidemic has turned out to be much more extensive than predicted, with almost every passing year seeing a revision upwards of estimates and projections. In 1991, the World Health Organisation expectation was that, world-wide, the year 2000 would see some 20 million individuals infected with the human immuno-deficiency virus, HIV. The prediction was almost three times short of the mark. By the end of 2001, almost 22 million persons had already died of the disease, more than 40 million adults and children were living with HIV/AIDS, and five million individuals became newly infected with HIV during the course of 2001.

Currently Sub-Saharan Africa (SSA) is the most severely affected region in the world, with the epicentre of the disease lying in the countries of Southern Africa. At the end of 2001, the infection rate for adults in their productive years, those aged between 15 and 49, was 8.9% for SSA as a whole, and 0.4% for the rest of the world (outside of Sub-Saharan Africa) (Table 1). Tables 2, shows the same grimstory as do tables 3,4,5. This means that on average one in every eleven adults living in SSA is HIV-positive. Although they account for only 10.4% of the world's population, SSA countries experience almost three times as many AIDS deaths in 2001 as the rest of the world combined and are home to more than three-quarters of the children orphaned by the disease. Table 2 shows the same grim story, as do tables 3,4, and 5.

Table 2: HIV prevalence rate in Adults 15-49(%), in Sub-Saharan Africa at the end of 2001			
Sub-Saharan Africa			
Angola	5.5	Lesotho	31.0
Benin	3.6	Liberia	...
Botswana	38.8	Madagascar	0.3
Burkina Faso	6.5	Malawi	15.0
Burundi	8.3	Mali	1.7
Cameroon	11.8	Mauritania	...
Central African Republic	12.9	Mauritius	0.1
Chad	3.6	Mozambique	13.0
Comoros	...	Namibia	22.5
Congo	7.2	Niger	...
Cote d'Ivoire	9.7	Nigeria	5.8
Dem. Republic of Congo	4.9	Rwanda	8.9
Djibouti	Senegal	0.5
Equatorial Guinea	3.4	Sierra Leone	7.0
Eritrea	2.8	Somalia	1.0
Ethiopia	6.4	South Africa	20.1
Gabon	...	Swaziland	33.4
Gambia	1.6	Togo	6.0
Ghana	3.0	Uganda	5.0
Guinea	...	United Rep. Of Tanzania	7.8
Guinea-Bissau	2.8	Zambia	21.5
Kenya	15.0	Zimbabwe	33.7

Source: WHO/UNAIDS, 2002

Table 3: Adult HIV-prevalence rates (%) in continental SADC states, 1997 – 2001				
	Dec. 1997	Dec. 1999	Dec. 2001	% change in HIV-prevalence rate, 1997 – 2001
Angola	2.1	2.8	5.5	+162
Botswana	25.1	35.8	38.8	+55
DRC	4.4	5.1	4.9	+11
Lesotho	8.4	23.6	31.0	+269
Malawi	14.9	16.0	15.0	+1
Mozambique	14.2	13.2	13.0	-9
Namibia	19.9	19.5	22.5	+13
South Africa	12.9	19.9	20.1	+56
Swaziland	18.5	25.3	33.4	+81
Tanzania	9.4	8.1	7.8	-17
Zambia	19.1	20.0	21.5	+13
Zimbabwe	25.8	25.1	33.7	+31

Source: UNAIDS 1998, 2002 and 2002

Global HIV rank ⁱ :	Country	%adults (15-49 years) HIV-positive	Adults and children HIV-positive
1	Botswana	38.8	330,000
2	Zimbabwe	33.7	2,300,000
3	Swaziland	33.4	170,000
4	Lesotho	31.0	360,000
5	Namibia	22.5	230,000
6	Zambia	21.5	1,200,000
7	South Africa	20.1	5,000,000
9	Malawi	15.0	850,000
10	Mozambique	13.0	1,100,000
17	Tanzania	7.8	1,500,000
25	Angola	5.5	350,000
27	DRC	4.9	1,300,000
			Total: 14,690,000

Source: UNAIDS 2002, UNDP Human Development Report 2002

Country	2000			2010		
	Without HIV/AIDS	With HIV/AIDS	Net difference	Without HIV/AIDS	With HIV/AIDS	Net difference
Angola ⁱⁱ	-	-	-	-	-	-
Botswana	39	136	+97	27	170	+143
DRC	139	154	+15	108	126	+18
Lesotho	86	133	+47	62	145	+83
Malawi	176	220	+44	137	203	+66
Mozambique	175	226	+51	140	225	+85
Namibia	63	139	+76	45	165	+120
South Africa	66	120	+54	48	147	+99
Swaziland	118	183	+65	89	204	+115
Tanzania	101	128	+27	73	109	+36
Zambia	107	169	+62	80	146	+66
Zimbabwe	41	133	+92	29	153	+124

Source: US Census Bureau, Population Reference Bureau, WHO from: US Census Bureau's country HIV/AIDS profiles.

The situation for South Africa, as confirmed by some of the writers there, and its juxtaposition to other SADC countries where the prevalence rates are high, make the fact that the epicentre of the pandemic is within its own borders even worse (Kelly, 2000).

AIDS is causing social and economic crises, which in turn threaten political stability. The two key economic impacts of HIV/AIDS are:

- The loss of productive labour through increased absenteeism, early retirements, increased morbidity and mortality; and
- A rise in costs associated with increased pension and medical aid payouts, and training and recruitment spending (Whiteside, 2000).

In education the loss of teachers has been staggering:-

ⁱ 9Countries ranked by adult HIV-prevalence rates (excluding non-SADC states)

ⁱⁱ No projections available

- In the Central African Republic, 85 percent of teachers who died between 1996 and 1998 were HIV-positive, dying on average 10 years before they were due to retire.
- In Zambia, more teachers died of HIV/AIDS in 1996 than were produced by the country's colleges that year. And 1300 teachers died in the first 10 months of 1998 compared with 680 teachers in 1996.
- In Kenya, teacher deaths rose from 450 in 1995 to 1 500 in 1999.
- HIV-positive teachers are estimated at over 30 percent in parts of Malawi and Uganda, 20 percent in Zambia, and 12 percent in South Africa. (HIV/AIDS: A Strategic Approach, 2001).

HIV/AIDS is not just numbers, staggering and frightening though these are. It is our lives.

Those who have died through AIDS were fathers, and mothers, and brothers and sisters, dear friends; they were doctors and nurses; primary school teachers, electrical engineers; community leaders; finance managers; entrepreneurs, researchers, and communal farmers trying to lift their families out of poverty (World Bank, 2000). They were our students in higher education institutions. They were our members of academic staff. They were our workers.

HIV/AIDS therefore goes beyond statistics. It is at the heart of our lives, touching things we touch and affecting people we love. As Mungai (2001) put it "They (statistics) do not describe the processes of the lives, the illnesses and deaths of people tested. It is the lives of whole generations of AIDS orphans who will miss education, including the lives of those who end up in the streets, in prostitution and in deeper poverty unless they are cared for. It is the overwhelming problems experienced by relatives due to the sheer numbers of AIDS orphans under their care.

It is the agony of children who watch their lonely parents die in pain. In other families the parents are unable to earn a living yet in others the extended family has broken down.

It is the economic problem of orphans managing households as well as the nutritional problems involved and the efforts made by AIDS orphans to grow food. It is concerned with the poor health care that AIDS orphans get.

It is the sexuality, especially the process of adolescent development, which underlies sexual maturation, marriage and family development. It is the patterns of sexual activities which lead to HIV infection. Of particular interest are the lives of commercial and forced sexual activities." (p. 261 – 62)

As long as there is no cure for HIV/AIDS, one of the most important lines against of battle against the epidemic is effective HIV/AIDS education. Awareness has so far been created of the activities that increase risk and transmission. However, it is now necessary to be much more effective in

promoting prevention of STDs and HIV/AIDS through a structured education which people can internalize. (Mangai, 2001 p. 239).

The challenge posed by the HIV/AIDS pandemic is threefold: stopping the further spread of the disease; providing care and support for those infected and affected, and offsetting the negative impacts of the disease on individuals, institutions, and society's social systems.

Many Governments in Africa have developed and are developing responses to the pandemic. Michael Kelly in his paper, "**African Universities and HIV/AIDS**" identifies three reasons why any responsible academic should be centrally concerned about HIV/AIDS. Kelly argues that "First, AIDS has changed the world as we know it. Second, AIDS makes it imperative that a university takes the special steps needed to maintain itself as a functioning institutions. Third, AIDS calls on a university to exercise certain responsibilities to the society within which it operates". (Kelly, 2000)

What have higher education institutions done in this respect? First we turn to a consideration of what the situation is with respect to HIV/AIDS in higher education institutions.

HIGHER EDUCATION INSTITUTIONS AND HIV/AIDS: PRESENT STATUS

The dangers of HIV/AIDS to all peoples around the world, but particularly to people in Africa are now a matter of public record. So are the dangers posed to institutions such as Universities which are vulnerable to many adverse effects of HIV/AIDS. In recognition of this situation the Working Group on Higher Education (WGHE) of the Association for the Development of Education in Africa (ADEA) decided to undertake case studies on the way HIV/AIDS affects some individual universities in Africa, and to document the responses and coping mechanisms that these institutions had developed. The purpose of the studies was described as to "generate understanding of the way that HIV/AIDS is affecting universities and to identify responses of staff, students, and management that might profitably be shared with sister institutions in similar circumstances." (Anarfi, J.H. 2000; Barnes, T. 2000; Magambu, J.K. 2000; Mwape, G. & Kathuria, R. 2000; Nzioka, C. 2000; Otaala, B. 2000; Seclonde, H. 2000).

The terms of reference were inter alia to respond to the following questions:

1. In what ways have the universities concerned been affected by HIV/AIDS?
2. How have the universities reacted to these impacts?
3. What steps are the universities taking to control and limit the further spread of the disease on their campuses?
4. What HIV/AIDS-related teaching, research, publication and advisory services have the universities undertaken?

5. How do the universities propose to anticipate and address the larger impact of HIV/AIDS on the national labour market for university graduates?

Out of the case studies Professor Michael Kelly of the University of Zambia made a synthesis entitled **“Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV/AIDS.”** (Kelly, 2001)

The report paints a disquieting picture, as it indicates that many of the institutions studied remain in the dark concerning the HIV/AIDS situation on their own campuses: **“A thick cloak of ignorance surrounds the presence of the disease in the Universities. This cloak is amply lined with layers of secrecy, silence, denial, and fear of stigmatization and discrimination”**.

In spite of difference in details, the studies show that HIV/AIDS is having a serious impact on the fiscal situation of the universities in much the same way as it does on other institutions. The disease increases operating costs, reduces productivity (especially through high absenteeism), diverts resources, and threatens sources of income. Although the case studies provide limited evidence in these areas (university record-keeping does not enable it), they make it clear that universities are experiencing all four effects.

Evidence from the case studies suggests that the university in Africa is a high risk institution for the transmission of HIV. **“Sugar-daddy” practices, sexual experimentation, prostitution on campus, unprotected casual sex, gender violence, multiple partners, and similar high-risk activities are all manifested to a greater or lesser degree.** Therefore, the report recommends, the entire university community – but in particular the university management – needs to face this threat squarely. “In the HIV/AIDS context of university life today the university culture is in danger of affirming risk more than safety. It is in danger of affirming death more than life”.

One unsettling finding that emerges from the report concerns the social life of students on campus and the extreme vulnerability of female students, workers, and those in precarious circumstances. **Kelly says the case studies “are shot through with concern about the subordinate status of female students and, in particular, their inability to negotiate for either no sex or safer sexual practices.”** He speaks about “consensual rape”, whereby, because of her lack of empowerment, the female partner consents under duress to intercourse in order to preserve a relationship, avoid a beating, ensure financial support, or repay favours. The case studies **suggest the prevailing climate on university campuses may encourage such violence and thereby facilitate the spread of HIV/AIDS.**

In 1999 The Association of Commonwealth Universities (ACU) organized jointly with the University of Natal a symposium entitled **“The Social Demographic Impact of HIV/AIDS: Commonwealth Universities**

response". Two years later the symposium was followed by a workshop attended by senior representatives from ten universities in southern and eastern Africa. (Botswana, Cape Town, Copperbelt, Eduardo Mondlane, Kenyatta, Malawi, Namibia, Natal, Zambia, and Zimbabwe (ACU, 2001).

The workshop participants unanimously agreed that in the crisis situation arising from HIV/AIDS universities have two key roles to play. **They must contribute effectively to preventing the further spread of the epidemic and in managing its impacts; and this they must do both within their own institutions and within the society they serve.**

The workshop participating universities indicated that they attached the highest priority to the achievement of these objectives. As responsible educators and researchers in their respective communities they recognized their responsibility to commit their intellectual resources and energies to reducing the spread of HIV infection, caring for the infected and affected, and providing support. They indicated their intention to develop policies and management structures that would take adequate account of HIV/AIDS; to mainstream HIV/AIDS perspectives into the professional training of all students at all levels; to engage in dialogue and outreach activities in their AIDS - affected communities and societies.

In 2000, the Commonwealth of Learning (COL) in partnership with the Association of Commonwealth Universities (ACU) the University of Dundee, Abertay, Scotland and the Association of African Universities initiated an annual institute for African Vice Chancellors. Entitled "**Managing Change: A strategic development programme for leaders of universities in Commonwealth Africa**". In this institute issues pertaining to HIV/AIDS have featured prominently.

The Chetty (2001) report on the situation in South African Universities documents responses in four areas: management, planning, programmes, and policy. It analyses key strategy issues including leadership, capacity, resources and the system-level impacts that HIV/AIDS will have on higher education.

Finally, one of the latest initiatives involves UNDP and the University of Natal which are proposing to train, in a **Training of Trainers Course (TOT)** three individuals from each of 31 African universities identified on HIV/AIDS and Development.

Aims of the course include:

a) Overall aim:

To contribute to prevention of HIV/AIDS amongst students and staff within a broader vision/framework of addressing the issues of Prevention, Care and Mitigation of the pandemic

b) Primary objectives:

- 1) To enable participants to design and implement and/or elaborate a life skills teaching programme for first year students at their own universities in order to provide students with the means to prevent being infected, and to be socially responsible;
- 2) To enable participants to design and implement discipline-based courses that lead to the production of graduates that have competency to apply knowledge about HIV/AIDS in their professional work

c) Specific aims:

- 1) Train academic staff in methodology and methods of curriculum development and teaching HIV/AIDS;
- 2) Empower university teachers to integrate HIV/AIDS into their own teaching and to provide similar training to their university staff;
- 3) Enhance research related to HIV/AIDS within the university and among other related stakeholders

From the various activities described in the previous section it would be helpful to provide examples of some **good practice** and well as indicating some constraints or barriers to change.

EXAMPLES OF GOOD PRACTICE

From the Kelly report (2001) and the ACU workshop held in Lusaka (ACU 2001) as well as some recent developments it is possible to cite illustrative examples of **good practice** in HIV/AIDS Policy development in universities, community engagement; and establishment of HIV/AIDS Unit, and research being undertaken.

HIV/AIDS Policy Development

A number of Universities in South Africa have had HIV/AIDS policies for some time now (Chetty, 2000). More recently other universities in Africa have developed policies, including Kenyatta University, and the University of Namibia.

The University of Namibia (UNAM) has a Policy on HIV/AIDS. This Policy grew out of policy guidelines on HIV/AIDS originally drafted in 1997. 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) and 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*

At its last meeting in November 2002 the Senate of the University approved the HIV/AIDS Five Year Strategic Plan: 2003-2007, for implementation of its policy.

Other universities which have not yet developed HIV/AIDS Policies were invited by the Working Group on Higher Education (WGHE) of the Association for the Development of Education in Africa (ADEA) to bid for some modest funding to assist them develop their HIV/AIDS policies. To date four awards have been made to the Mombasa Polytechnic; University of Botswana; Highridge Teachers Training College, Nairobi, and Nkumba University, Entebbe, Uganda (Lamptey, 2003). On Nkumba University William Saint had this to say:

Prompted by Professor Kelly's report, "**Challenge the Challenger**", stimulated by the example of the University of Namibia AIDS Policy, and financed by a small grant from the ADEA Working Group on Higher Education, the Nkumba University in Uganda has just completed the publication of its policy statement on HIV/AIDS. The policy was approved by Senate on December 13, 2002. (Saint, 2003 personal communication)

Community Engagement

Home-Based Care Programme: a lecturer at the University of Botswana set up a home-based care programme for HIV/AIDS infected and affected members of the community; and the programme proved so effective that the Government has taken it up as a model.

Youth Radio Station: the University of Namibia established a radio station in 2001 (under the auspices of UNESCO), which uses music, jingles, drama and talk shows as a means of mainstreaming HIV/AIDS issues among youth. It aims both to entertain and educate; and a survey revealed that it is the most popular radio programme for young people. 78% of young people in the 16-24 age bracket and 98% of the students on campus listen to it. Incidentally, it promotes and enhances the image of the university and provides a range of practical training, skills and experience that are of value to graduates wanting to work in the broadcasting and communications industries.

House to house counseling: the University of Namibia has started a pilot project whereby school leavers in areas where prevalence is determined to be high are trained to equip them for house to house counseling. Their brief is to go from door to door collecting information about the incidence of STDs and HIV-related sickness and death, and to report back to the clinic, which then takes appropriate action to provide the necessary services.

My Future is my Choice is a University of Namibia initiative which aims to empower students in the 15-18 year old age bracket by giving them the information and skills that will enable them to make the personal choice to change their behaviour. It is firmly based on the concept of Child-to-Child transfer of knowledge (i.e. the older child passes information to the younger) – a system which is culturally acceptable and common in Africa; and the government is now interested in adopting the programme for lower grade school children.

Introducing certificate courses and/or modules: Kenyatta University is offering a wide variety of HIV/AIDS-related courses at the certificate, diploma (mainly in the holidays, for teachers) and post-graduate levels, as well as a compulsory core unit for all students. At their last graduation, there were 85 recipients of certificates for one or other of these HIV/AIDS courses; and they are proving increasingly popular because of their reputation for helping graduates to secure really good jobs. What is particularly interesting is that full-time programmes are being offered in the evenings by demand and on a “paid for” basis – and it is not only working people from the community but also students who are opting to register for and pay for these programmes; such is their perceived value and relevance. The fee structure also means that the university can afford to pay for well-qualified and able teachers, thereby perpetuating the success of the programmes.

Training community leaders in HIV/AIDS: Kenyatta University is also involved through these programmes in spearheading the training of community leaders so that they are sufficiently informed about the issues and can play their part in minimizing the spread of the pandemic.

Involvement in community improvement projects: Another aspect of Kenyatta’s involvement with the community is the development of an outreach project called OKUO. This involves students and staff in various community projects such as cleaning the environment, advising on mother-to-child transmission, helping to plan home and family care (including advice on nutrition), providing counseling on HIV/AIDS and assisting with the care of orphans. (ACU, 2001 pp 10 – 11).

The University of Namibia in collaboration with the University of Tampere, Finland, will run a training workshop for Regional Governors, Senior Administrative Officers and Mayors and Town Clerks from all over Namibia. Entitled “**The Role of Leaders in the Prevention of HIV/AIDS**” the workshop is designed to sensitize these leaders to various issues on HIV/AIDS and to assist the care of the infected and affected, and the mitigation of the pandemic on individuals and institutions.

HIV/AIDS Units and Centres for the study of AIDS

The workshop was informed that some Universities had established HIV/AIDS Units or Centres for the study of AIDS in Africa. Examples of Units include Kenyatta University, University of Botswana, and the University of Cape Town. The University of Namibia is in the process of setting a Unit and already has two people on board - - a Fulbright scholar and a medical doctor

from Inter-team, an NGO in Switzerland. The University of Pretoria is an example of the Centre for the Study of AIDS in Africa.

Examples of Current Research and Teaching Activities

“Seroprevalance of HIV/AIDS in surgical and medical patients at Queen Elizabeth Hospital”: the University of Malawi reported a study which sought to make at least a small indentation on the paucity of data that is available on the prevalence of HIV in the general population of Malawi. Over a two week period in October 1999 and January 2000, all new admissions were invited to participate in the study and were offered pre- and post-test counseling. Of 769 medical admissions (of whom 11 refused to be tested) 70% were HIV+ (the highest percentage ever recorded in Africa); and of 457 surgical admissions (of whom 10 refused to be tested), 35% were HIV+. A further breakdown of the statistics revealed a higher incidence of infection in women than in men in every category.

It is hoped that these data may be useful in the development of clinical algorithms for in-patient management and optimal use of limited resources. Although a very small study, it provides an example of the value of “starting small” and of doing something rather than nothing.

“In but Free” (HIV/AIDS Prevention in Prisons) is a community based programme of the Copperbelt University and the Zambia Prison Service. It grew out of two base line surveys, conducted in 1994 and 1998/99, of risk behaviour in prisons in Zambia and aims to promote HIV/AIDS prevention in Zambian prisons using inmates and officers as the key players in the intervention. It is a well recognized fact that prisoners world-wide are paid less attention to *vis-à-vis* HIV/AIDS than any other group in society, yet the very circumstances which render them especially vulnerable (men having sex with men (MSM), intravenous drug use, initiation practices such as tattooing, insufficient supplies, and hence sharing, of razors) have led to a prevalence rate among prisoners of 27% (*cf* 19% nationally). The *“In but Free”* project has already trained 450 inmates and 65 prison officers as counselors; has been instrumental in introducing regular health checks; and is pressing for home-based care for the terminally ill. Interestingly, condoms may not be issued to prisoners as MSM is illegal in Zambia and carries a jail sentence of five years.

HIVAN (HIV/AidsNetworking) is a new initiative of the University of Natal. Founded in 2001 at the instigation of the Vice-Chancellor. Its fundamental purpose is to facilitate such networking between academia and society as will mobilize and coordinate a cohesive critical mass of expertise, resources and strategies (for teaching, research and intervention) initially within KwaZulu-Natal and ultimately, it is hoped, nationally and perhaps also internationally. It is essentially multi-disciplinary and multi-sectoral in its approach; and one of its key components is the development of a data base with linked websites of information resources and networking tools. It is also a focus for HIV/AIDS graduate research and training; it provides a campus HIV/AIDS support unit;

and organizes fellowship and job-swap programmes that facilitate exchange of experience and expertise. Of particular relevance is the fact that HIVAN offers support to lecturers who are endeavouring to integrate HIV/AIDS into their courses. (ACU, 2001 page 15)

HIV/AIDS – Life Styles, Knowledge, Attitudes and Practices: a Baseline Survey of Greater Windhoek Youth in Namibia

The majority of Namibian youth believe that they will ultimately get the virus that causes AIDS. This is despite high levels of knowledge and awareness about HIV and AIDS and other health issues, according to a University of Namibia (UNAM/USAID) research report released recently.

The survey of 15-25 year olds in Greater Windhoek found that 60% believed it was possible that they would be infected with HIV during the next 12 months. Though youth felt fairly confident that they could refuse sex without condoms, the majority also believed that they still could get HIV if they were monogamous (51%) and about one-third of the respondents believed they could still get HIV even if they were abstinent.

In response to these findings, UNAM/USAID has launched an innovative, community-driven, radio magazine programme to address lifestyle issues raised by the youth. “**The Suzie and Shafa Show**” is developed in Namibia for youth, by youth, in partnership with The University of Namibia and Johns Hopkins University Centre for Communication Programmes, the Media and Technology Studies (MATS) of the Ministry of Basic Education, Sports and Culture and supported by USAID.

The show will be broadcast in Windhoek over a local community station, UNAM Radio 97.4FM. The programme addresses the key factors Namibian youth are confronted with today, such as perceptions of risk toward HIV infection and HIV testing. For example, while two-thirds of the youth surveyed said they wanted to be tested for HIV, only about a quarter had ever actually been tested. **The Suzie and Shafa Show** addresses practical issues such as where to go for HIV testing as well as lifestyle issues related to alcohol and drug use, relationship problems, and sexual habits.

“The survey findings suggest an extraordinary need for programmes that provide youth with the skills and support needed to make healthy choices on lifestyle and behaviour as well as providing hope that it is possible to avoid HIV infection. **The Suzie and Shafa Show** is a pioneering effort that has young people in partnership, with support from a wide range of community organizations, creating entertaining, provocative and insightful programmes that truly reach youth,”

Teaching of a Compulsory Module

The Senate of the University of Namibia approved at its last meeting held in November 2002 the teaching of a compulsory module on HIV/AIDS for **all** first year students, starting in the academic year 2003. Entitled “**Contemporary**

Issues” the course will cover three topics (themes) of equal length: **Introduction to Social Ethics; Introduction to Gender Issues; and HIV/AIDS.**

The foregoing experiences provide a strong indication that gains and successes are being achieved in the fight against HIV/AIDS. It has become clear, however, that it is necessary to have a structured programme on HIV/AIDS education aimed at bringing about long-term behaviour change in sexual lifestyles. In order to achieve this goal, the HIV/AIDS programme would need to be integrated with both formal and continuing education, with adolescent development being the central topic, in order for it to be stable and sustainable (Mungai, 2001, p. 250).

The approach must be multi-sectoral and multi-disciplinary. And this must be reflected in all the activities, including the HIV/AIDS education programmes.

We turn to a brief consideration of barriers or constraints encountered by higher education institutions.

Barriers or Constraints and Challenges

The ACU (2001) Lusaka report identifies the following as barriers to change:

- Lack of high level commitment
- Lack of necessary structures for implementation
- Lack of empirical evidence of the scope and scale of the problem
- Lack of resources (human and financial)
- Lack of buy-in from the campus community
- Limited access into the academic curriculum

Kelly (2001) indicates as a challenge the need for a comprehensive HIV Prevention Programme the first requirement of which is total management **commitment** which runs through and drives each of the following:-

- HIV/AIDS policy and strategy development
- Developing culturally appropriate prevention messages
- Tackling socio-economic factors
- Establishing partnerships
- Sustaining awareness and education
- Challenging denial and stigma
- Situating prevention in a community context
- Linking care to prevention
- Rigorous scientific reflection

Additional challenges have come from the EFA goals (2000); the Millennium Development Goals (2001); and the UGASS Declaration of Commitment on HIV/AIDS as indicated in boxes **3** to **5**.

Box 1. EFA Goals (2000)

- expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children;
- ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory primary education of good quality;
- ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes;
- achieving a 50 per cent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults;
- eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality; and
- improving all aspects of the quality of education and ensuring excellence of all so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

Box 2. Millennium Development Goals (2001)

Agreed upon goals include:

- | | |
|---------------|--|
| Goal 2 | To achieve universal primary education. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling; |
| Goal 3 | To promote gender equality and empower women. Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015; |
| Goal 6 | To combat HIV/AIDS, malaria and other diseases. Have halted by 2015 and begun to reverse the spread of HIV/AIDS. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. |

Box 3. UNGASS Declaration of Commitment on HIV/AIDS (2001)

Agreed upon targets include:

- reducing HIV infection among 15-24-year-olds by 25 per cent in the most affected countries by 2005 and, globally, by 2010;
- developing by 2003, and implementing by 2005, national strategies to provide supportive environment for orphans and children infected and affected by HIV/AIDS;
- ensuring that by 2005 at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; and
- having in place strategies by 2003, to address vulnerability to HIV infection, including under-development, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys.

Given the above-named constraints/barriers and challenges, one can ask “where do we go from here”? What can higher education institutions do, to respond to the HIV/AIDS pandemic? We briefly deal with this question in the following paragraphs.

WHERE DO WE GO FROM HERE?

In order to respond successfully to challenges, and risks implied above and the vulnerability to which all of us are susceptible, the call is for commitment at personal, moral, political and social levels. Some points in this respect are quite clear, for institutions of higher education.

1. Prevention has to be the main priority, especially in countries where the prevalence rates are higher. Prevention has to extend to care and to the mitigation of the impact of the pandemic on individuals and institutions.

As Graca Machel Mandela puts it:

There is need to design and implement strategies that are as comprehensive as the virus itself. We must have prevention, and a continuum of care and treatment within one paradigm.

2. Top-down commitment and support is essential: from the political, through the institutional, to the local level.

3. Collaboration - - between national and international agencies, between the private and public sectors and religious groups, between disciplines and between different levels of authority - - is a critical factor if the best possible use is to be made of all available human and financial resources.

The exchange of experience between African countries is important. So is the sharing of facilities in order to optimize the use of available resources. The process of political and economic liberalization through which Africa is now going requires broad-based participation, for which education is essential.

Partnership with funding agencies should be based on shared and agreed framework and objectives. Funding agencies have often been interested in particular projects only, especially when they have involved capital investment rather than recurrent costs. What is needed is a commitment from the funding agencies to be involved over a longer period, until the government is able to absorb the recurrent costs. Funding agencies can also play a useful role in providing analytical support to define options, formulate policy, and facilitate the transfer of ideas and experience.

There is need to improve documentation distribution channels for wider and timely dissemination in various African languages. There is also need to involve institutions and African expertise more closely in studies and other activities so as to build endogenous capacities.

Finally we refer to the importance of research in tertiary institutions and provide illustrative examples of the kind of research that could be undertaken. We also provide the kinds of partnering that higher education institutions could develop with other bilateral and multilateral bodies.

Academic Excellence through research

One of the major roles of the universities (and other higher education institutions) is that of maintaining academic excellence. In this regard it is perhaps appropriate to quote Allan Bullock, former Vice Chancellor of Oxford University, who has written of the three great academic traditions – namely, scholarship, teaching and research: “by scholarship I mean the preservation and transmission of accumulated knowledge, and the training of a succession of apprentices in the necessary and often rare skills these require. By teaching I mean educating those who are going to hold responsible jobs in private and public sectors of the economy, in government, and the professions – and educating them not by rote, but by continual turning – over; a critical re-examination, or re-interpretation of what has been inherited from the past, in the light of a new generation of teachers’ and students’ experiences. That forms a part also of the third tradition, research, at least in the humanities and social studies, where the ideas of earlier periods are not discarded, as in the sciences but constantly re-evaluated, often with the recovery of lost insights. Research in the other sense; that is, the discovery of new knowledge, is of course the essential activity of scientists and of many scholars. It’s of double value when it is pursued, not in isolation, but in

combination with teaching and the preservation and transmission of knowledge, both of which it can enliven”.

We briefly refer to illustrative examples of research that could be undertaken in biomedical ethics; nutritional health; and seroprevalence studies, by institutions of higher learning.

Research in biomedical ethics

Few in many African countries with high prevalence rates have antiretroviral therapies for HIV disease and advocates for increased access frame it as a human rights issue (LAC, 2002). Discussions that fall into the realm of ethics are now arising about the cost and value of education, scholarships, and work training for HIV-infected persons without access to antiretroviral medications.

Funders and agencies that provide health care and research, such as the Global Fund for AIDS, Tuberculosis, and Malaria and the U.S. Centres for Disease Control and Prevention, are expressing increased interest in African countries, particularly as the HIV epidemic accelerates. It is likely that research efforts will burgeon in the next decade.

With the increasing interest in research and access to care come crucial questions to be deliberated by nations in Africa:

- Is access to medication a basic human right?
- In a country with limited resources, what are the ethical issues when research programmes provide scarce healthcare only to enrolled subjects?
- Should there be national policies or laws involving the conduct of research and requiring constitution of Institutional Review Boards (IRBs) and their review and approval of protocols?
- In dealing with children affected and infected by diseases, including HIV/AIDS, how will we ensure the protections enshrined in the UN's Convention on Rights of the Child (1989) and African Charter on the Rights and Welfare of the Child, by the Organisation of African Unity?
- What specifically African considerations must be included in the development of access to care policies and human subjects protection?
- Do any of the vicissitudes of developing countries serve to mitigate aspects of protection that are articulated in Western documents?
- Who will fund the mechanisms that ensure rights in medical care and research?
- What entity will be responsible for constituting and administering an IRB, investigating alleged breaches and enforcing penalties for confirmed breaches of protocols, especially involving projects funded across international boundaries?

Research on biomedical ethics is therefore axiomatic.

Nutritional Health

HIV/AIDS is devastating the agricultural economies and rural communities in the high prevalence countries in Africa. The cost of caring for household members with AIDS, coupled with the loss of productive capacity associated with the disease, underscores the need for effective life span of those individuals who are HIV positive. At the same time, it highlights the need for maintaining the nutritional health of children, the elderly and those who have not been infected and therefore must bear the added burden of supporting affected family members. Institutional strategies are needed to systematically address the economics as well as the social situation faced by households and communities ravaged by HIV/AIDS. The proposed **Healthful Harvest** project being submitted under the USAID strategic interest area of Agriculture and Environment is an example of the types of study envisaged here. It is an interactive programme of education and institutional capacity building that promotes the role of rural women as environmentally-aware farmers, processors of nutritious, value-added foods made from locally grown crops and marketers and distributors of such products. Through this proposed project, Pennsylvania State University, a land grant institution with a long history of community outreach and training, will partner with University of Namibia to enhance educational and entrepreneurial opportunities for women agriculturalists in Northern Namibia. Project activities will also be coordinated with Women's Action for Development, a non-governmental organization active in Namibia and the Ondangwa Community Skills Development Centre (CSDEC), a training centre established by the Namibian Ministry of Higher Education to provide skills training in a number of areas, including food processing. An independent Technical Cooperation Project will be initiated by FAO that will promote the sustainability of the **Healthful Harvest** initiative. Upon the completion of this project we will have developed educational and training materials related to the areas of agricultural productivity, organizations of a cooperative, nutrition and HIV/AIDS and processing of cereals-based foods. Furthermore, a women's cooperative will have been established in the northern region of Namibia that will supply locally grown crops for processing at the COSDEC processing facility. We will also have prepared a group of trainers to use the **Healthful Harvest** materials in other areas of Namibia.

Seroprevalence Studies/VCT

Many higher education institutions in Africa do not seem to have accurate prevalence rates among their populations. It seems critical for higher education institutions to be able to better estimate the prevalence of HIV/AIDS in their populations. In some institutions, some studies point to a higher prevalence among better educated compared to the general population due to their affluence, mobility, and desire to push sexual boundaries. After a period of time, other evidence suggests that the prevalence for the better educated is lower than for the general population due to the impact of learning more about HIV/AIDS. So what are some possible approaches? If some testing were to be done on campus on a voluntary basis (VCT), that would at least provide more information than exists now. If coupled with a campaign to promote

testing, the prevalence figures would likely gain credibility. In the case of the University of Namibia the situation is eased by the observation that the Government of Namibia regards HIV Voluntary Counselling and Testing (VCT) as a potentially powerful intervention to reduce high-risk behaviour and thus an important complement to other on-going AIDS prevention strategies. The Government has agreed that initially, there will be five 'franchise' VCT centres implementing VCT services in Namibia. The VCT centres are members of a national VCT network that is distinguished by a common logo and name – "New Start Voluntary Counselling and Testing Centre". We expect one of the Centres to be at UNAM, with USAID support. We turn to a brief examination of possible partnerships / collaborations.

Partnering to prevent youth infection

The World Bank is a member of the U.N. Interagency Working Group on schools and education, a partnership that facilitates countries development of strategic plans for HIV/AIDS prevention and impact management in education systems. How best can higher education institutions partner with it in matching teacher supply and demand and in providing quality skills-based prevention programmes and in enabling all children and youth to receive good quality education?

Collaboration with Commonwealth of Learning (COL)

The Commonwealth of Learning (COL) is already collaborating with UNESCO on a number areas, including distance education. It would be feasible to explore ways that it and UNESCO could support higher education institutions in the use of distance education to train rural communities as well as teachers on various aspects of HIV/AIDS.

Collaboration with UNESCO

Under the UNESCO/UNITWIN Network for Southern Africa, UNESCO "twins" three Universities in Southern Africa (Namibia, Eduardo Mondlane, University of Western Cape) with Universities in the north (Bochum, Lund, Utrecht). UNESCO Chairs have been created for Mathematics and Science Education, Human Rights and Democracy, and Environment. This arrangement has worked extremely well over a number of years and important documentation has been produced, capacity built through training and various programmes addressing these issues developed.

UNESCO could assist in the creation of chairs on HIV/AIDS in a number of institutions, particularly in those countries which have high prevalence rates. It could also assist in developing curricula for schools, tertiary institutions and colleges of education, on HIV/AIDS education, as well as assist in training of counseling for HIV/AIDS, since both the Guidance Unit in UNESCO Headquarters and the Regional Guidance and Training Centre in Malawi fall under its remit. In this last regard an initiative has been taken by us in consultation with Professor Babatunde Ipaye (University of Ilorin) to develop modules for HIV/AIDS Counselling (Appendix I)

Collaboration with Forum for African Women Educators (FAWE)

The Forum for African Women Educationalists (FAWE) with Headquarters in Nairobi, Kenya, and with country chapters in many African countries has done extremely commendable work in promoting girls' education and promoting the notion that girls, given support and encouragement, have the potential to succeed in science and science-oriented subjects, including those that have been the preserve of the males, as well as anybody. FAWE has particularly been successful in their work through the Female Education in Mathematics and Science in Africa (FEMSA) Project which is linked to UNESCO's Special Project: **"Scientific, Technical and Vocational Education of Girls in Africa"**. Launched in 1996, it covers activities in twelve African countries, including eight LDCs (Burkina Faso, Cameroon, Ghana, Kenya, Malawi, Mali, Mozambique, Senegal, Swaziland, United Republic of Tanzania, Uganda, Zambia). The overall Objective of the project is to assist in improving girls participation in scientific, technical and vocational education (STVE), so as to give them the impetus necessary to launch into science careers. Specific objectives aim to include more girls in secondary school, notably by improving the quality and effectiveness of STVE, to make an impact on the attitudes and stereotypes which prevent girls from taking advantage of current opportunities in science and technology, and to promote a positive image of women in scientific and technical areas, as well as in social circles.

Higher education institutions could work collaboratively in the achievement of the various goals including the EFA goals (2000); the Millennium goals (2001) and the UGASS Declaration of Commitment on HIV/AIDS (2001).

Collaboration with the Association of African Universities (AAU) and Association of Commonwealth Universities (ACU)

The Working Group on Higher Education (WGHE) of the Association for Development of Education in Africa (ADEA) has already taken initiatives supporting HIV/AIDS work in higher education institutions. It commissioned the study for instance, of seven universities referred to earlier. This role has been passed on to the AAU headquarters. It would be ideal to extend this work to other higher education institutions. The AAU has supported HIV/AIDS policy development in higher education institutions, as witness by the recent awards for this purpose. This commendable support should continue. In addition support for the development of strategic plans to implement HIV/AIDS policies should be initiated, as should tracer studies of past students of tertiary institutions. The Association of Commonwealth University should work hard-in-glove with the AAU in these endeavours.

CONCLUDING REMARKS

One of the most devastating criticisms of Universities and academics in Africa is that they do not play a role in addressing some of the most critical problems in Africa, and hence do not make a contribution to development efforts. The most critical problems in Africa include the HIV/AIDS pandemic. But some good progress has been made. Also at a meeting in Nairobi, the Association of African Universities passed a declaration. In that declaration was an important resolution dealing with the issue of HIV/AIDS.

“To a greater degree than ever before, African Universities must renew their commitment to helping Africa find effective solutions to its perennial problems of hunger, poverty and disease. They must, by their research and teaching, strengthen their contribution to improvements in food production and distribution, disease control and health service delivery, and the general well-being of their people. In particular, the HIV/AIDS crisis poses a serious threat to African societies within which Universities are situated. African Universities must be in the forefront of research, education and action in this area. We recognize that the solution to this problem might well reside in.”

I am sure at this conference we wish to reaffirm that declaration. We are optimists by nature, and we believe in the three WWW's, that we were introduced to in Nairobi, last year. That is, We Will Win!, especially if we take to heart the challenges posed to us by Audience Africa (1995) indicated in Appendix II.

A favourite quote:

*“In a time of drastic change it is the learners who survive;
the “learned” find themselves fully equipped
to live in a world that no longer exists”*

APPENDIX I: A MODULAR APPROACH TO THE TRAINING OF HIV/AIDS COUNSELORS IN AFRICA

Introduction:

Module 1: An overview of Counseling

1. Counseling as a helping profession
2. Counseling in Africa: Participants talk of the perceptions and place of counseling in their countries
3. Culture and Counseling
 - Socio-cultural premises of counseling
 - Culture as a facilitator in counseling
 - Inhibiting aspects of culture in counseling
 - Cultural variation in non-verbal communications and body language
 - Cultural silence on sex, and sexuality issues in Africa
4. Religion and Counseling: facilitating, inhibiting; meditative.
5. Assessment/Evaluation of Counseling: does counseling work?

Module 2: Introduction to Health Counseling

1. The concept of health and wellness as they relate to psychology and Counseling.
2. Meaning and Purpose of health Counseling.
3. Enhancing and applying counseling skills to HIV/AIDS prevention work.
4. Psychosomatic aspects of health.

Module 3: HIV/AIDS: Basic Information for Counselors

1. Basic introduction to the Clinical manifestations of HIV infections and the AIDS disease. Methods of transmitting HIV.
2. Basic introduction to HIV antibody testing: concepts of sensitivity and specificity; types of tests available; concepts of sero-conversion and problems of false positive and false negative etc. the crisis of the “worried well”.
3. Transmission of HIV.

4. Prevention of HIV.
5. Pre-screening and post-screening counseling.
6. Mobilizing people for voluntary testing and counseling.
7. The Social Sequeale of HIV.

Module 4: HIV/AIDS Counseling

1. Theories and models in HIV counseling
 - i) The Health Belief Model (HBM)
 - ii) The Theory of Reasoned Action
 - iii) Social Learning and Cognitive Theories
 - iv) The AIDS risk reduction model
 - v) Stages of Change model
 - vi) Hierarchy of Effects model
 - vii) Diffusion of Innovations
 - viii) Social Marketing
 - ix) Handling the case of the worried well
 - x) Hopelessness, Helplessness and the existential self: the Biblical book of Job.
2. The psychology and culture of the major risk groups: adolescents; commercial sex workers; men who have sex with men; drug users and drug injectors; compulsive sex seekers, etc.
3. Patterns of communications with high-risk groups.
4. Reactions to HIV-positive results and counseling approaches in handling them.

Module 5: Systemic HIV-counseling

1. Meaning of systemic counseling in HIV/AIDS.
2. Theory and practice of systemic counseling in HIV.
3. Tasks in systemic counseling.
4. Reframing: Handling issues of spirituality and the client's belief system; helping to attain balance.

Module 6: Psychological healing and the major counseling theories

applied to HIV/AIDS counseling:

1. Rational Emotive Theory
2. Personal Construct Theory
3. Reality Therapy
4. Crisis Theory and Intervention
5. Logo Therapy
6. Therapeutic treatment of existential neurosis
7. Problem solving therapy
8. Management of anxiety, depression, and stress related disorders.

Module 7: Crisis Counseling

1. Conceptual issues in crisis counseling
2. The philosophical vocabulary of the African in crisis situations and their application in HIV/AIDS Counseling.
3. The Psychology of HIV/AIDS; Crisis and crisis intervention; death, fatality and the African culture.
4. Palliative counseling.

Module 8: Home care and Support Networks

1. The concept of caring in the African culture.
2. Support networks: purpose, functions and roles.
3. Mobilizing/forming support networks.

Module 9: Ancillary issues in HIV/AIDS Counseling

1. Stigmatization and the counselor's role.
2. Nutritional therapy in HIV/AIDS.
3. Confidentiality and ethical issues in HIV counseling.
4. The legal aspects of HIV/AIDS.

Module 10: Practical Work/Project/Field work.

APPENDIX II: AUDIENCE AFRICA – UNESCO PARIS, 1995

13. We are all in varying degrees responsible, and we must all make a firm and resolute commitment to reverse this trend, by breaking with the past and formulating a completely new endogenous development policy. We can do so provided that we share a number of convictions: the first is that, contrary to the general view, our continent is not poor. We all have to realize that, of all the continents, Africa has the greatest natural wealth, which means that with competent and serious men, capital and know-how, it could catch up with other parts of the world very quickly, as Latin America and Asia are now doing.
14. The second fact of which we must be convinced is that independence is not an end in itself but a means to the end of national liberation; in other words taking oneself in hand.
15. The third is that Africa will never be built by foreigners, whatever emotional, cultural and personal bonds they have formed with the continent, and whatever the terms of the moral contract that might lay the basis for a new type of partnership between our continent and the international community. Incidentally, the end purpose of assistance is to make it possible for assistance to be phased out.
16. The fourth is that only Africa can decide its destiny. Africans – and they above all – must take the initiative in solving their own problems. Africa is neither a 'lost continent' nor a 'continent in distress' inhabited by people incapable of raising themselves to the level of other peoples.
17. The fifth is that as long as Africans have no confidence in themselves, in their brothers and sisters, in their culture, in their abilities or in their values, they will never make full use of the resources of creativity and inventiveness that lie dormant within them.
18. The sixth is that the three decades of difficulties, mistakes, hesitant experimentation, set-backs and partial successes that have brought discredit on our continent will not have been in vain if we have the courage to carry out a critical assessment of the situation, examine our own consciences, recognize our inadequacies and weaknesses and draw, with humility, all the appropriate lessons from it with a view to a new start.
19. The seventh is that, notwithstanding the need for structural adjustment plans, they should rapidly give way to genuine development programmes based on growth, full employment and justice, devised and carried out by the citizens of the countries themselves for the benefit, in particular, of the most disadvantaged sections of society.

20. The eighth is that any centralization of power or seizure of power by a minority operating through a single party or a State-party is harmful. It is contrary to the process of development and represents a form of dictatorship. It must be opposed. Africa needs democracy because it is the missing link between development and peace, democracy being understood not as a model to be copied but as an objective to be attained.
21. The ninth is that as long as the idea of peace is mistreated in Africa, efforts to promote development will never live up to expectations. Armed conflicts, civil wars, border disputes, tribalism and ethnic rivalries, political disputes and the exploitation of religion for partisan ends make it only realistic to regard political instability and war not as epiphenomena but as a serious and ongoing trend. We can reverse this trend, which has gone on for 50 years, but we shall need an inflexible political will.
22. Finally, as compared with Europe, the Americas, and the countries of the Indian Ocean and the Pacific, which are forming economic blocs engaged in cut-throat competition, micro-States have no chance of becoming significant and credible forces unless they unite. With its present population of 640 million people, who will number more than 1.2 thousand million consumers in 23 years' time, we can be sure that Africa, with the wealth of its soil, its subsoil, its seas, its forests and its tourists and cultural potential, will never be marginalized if its people have the necessary negotiating skills to turn such undoubted benefits to commercial advantage" (Audience Africa, pp 3-4).

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