Challenging the Challenger

Understanding and Expanding the Response of Universities in Africa to HIV/AIDS

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The Working Group on Higher Education (WGHE) was founded in 1989 to strengthen collaboration between African governments, development agencies, and higher education institutions. Its goals are to improve the effectiveness of development assistance and, more broadly, to support the revitalization of African universities. The lead agency of the WGHE is the World Bank, which works closely with the Association of African Universities (AAU) in carrying out the WGHE's activities.

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ACRONYMS AND ABBREVIATIONS

ACU Association of Commonwealth Universities

ADEA Association for the Development of Education in Africa

ADF Africa Development Forum

AIDS Acquired Immune Deficiency Syndrome

CICE Current Issues in Comparative Education

DVC Deputy Vice-Chancellor

GDP Gross Domestic Product

HDI Human Development Index

HIVHIV Human Immuno-Deficiency Virus

ICASA International Conference on AIDS and STDs in Africa

ICPD International Conference on Population and Development

ILO International Labour Organisation

IPAA International Partnership against AIDS in Africa

JKUAT Jomo Kenyatta University of Agriculture and Technology

MTCT Mother-to-Child-Transmission

PLA Person(s) Living with HIV/AIDS

PLWHA Person(s) Living with HIV/AIDS

SAUVCA South African Universities' Vice-Chancellors' Association

STD Sexually Transmitted Disease

TB Tuberculosis

UNAIDS Joint United Nations Programme on HIV/AIDS

UNECA United Nations Economic Commission for Africa

UNICEF United Nations Children's Fund

UNZA University of Zambia

UWC University of Western Cape

VC Vice-Chancellor

VCT Voluntary Counseling and Testing

WGHE Working Group on Higher Education

EXECUTIVE SUMMARY

INTRODUCTION

In response to concerns expressed by the Association for the Development of Education in Africa (ADEAADEA) at its Johannesburg Biennale in December 1999, the ADEA Working Group on Higher Education (WGHEWGHE) commissioned a number of case studies on the impact of HIV/AIDSHIV/AIDS on universities in Africa. The purpose was to generate understanding of the way the disease is affecting African universities and to identify responses and coping mechanisms that might profitably be shared with sister institutions in similar circumstances. This report draws upon case study reports commissioned by the WGHE at seven universities in six countries—Benin, Ghana, Kenya (2), Namibia, South Africa and Zambia. It compares, analyzes and summarizes these findings, and presents them for general reference.

THE HIV/AIDSHIV/AIDS CONTEXT

HIV/AIDSHIV/AIDS continues to pose a major threat to people in Africa. Although the number of new infections across the continent was 5 percent less in 2000 than it had been in 1999, the number who died of AIDS was 9 percent more than in the preceding year. The overall infection rate for Africa at the end of 1999 was 8.7 percent, with 23.5 million out of an adult population of 268.9 million being infected. Over two million AIDS-related deaths occurred in 1999 in the countries of Africa with infection rates of 5 percent or more. As a result of those deaths, these countries confront the demanding challenge of responding to the needs of a burgeoning number of orphans.

HIV/AIDSHIV/AIDS is unraveling hard-won development gains in Africa and will have a crippling effect on its future prospects. For this reason, many African universities find that they must operate in a worsening socio-economic environment. Areas of special concern to universities are the way the disease impacts on households, on the demographic structure of society, on the various sectors with which universities have traditionally interacted, and on the economy

in general.

HIV/AIDSHIV/AIDS AT THE CASE STUDY UNIVERSITIES

The seven case studies generally agreed that no one knows exactly what the HIV/AIDSHIV/AIDS situation is at their respective universities. A thick cloak of ignorance surrounds the presence of the disease on campus. This cloak is amply lined with layers of secrecy, silence, denial, and fear of stigmatisation and discrimination. Records that name the disease are not held in any of the administrative or academic offices, while those available in university health-centres are inadequate and incomplete. Even information on staff and student mortality is vague and full of shortcomings. Apart from a few exceptional cases, it is not possible to affirm unambiguously that death was due to AIDS. Nevertheless, university executives state that their institutions are experiencing an increasing number of AIDS-related deaths. For example, an average of three deaths occurred each month at the University of Zambia throughout the 1990s; currently the University of Nairobi is experiencing 4 - 6 deaths a month. In all institutions, the death rate is presently higher among the lower cadre staff than among academics.

Although AIDS-related student deaths are reported, it seems likely that the real impact of AIDSAIDS on students will not unfold until students have graduated from university and entered the world of work. It is notably more difficult to track student than staff deaths, since student deaths may occur during a vacation or following withdrawal from studies. Such withdrawal could be due to personal sickness or to AIDSAIDS-related family difficulties in paying fees.

Although university students display shortcomings in their basic knowledge about both HIV/AIDSHIV/AIDS and sexually transmitted diseases (STDsSTDs), they seem to be generally aware of the existence of HIV/AIDSHIV/AIDS and to know the basic facts about its transmission. Yet students do not generally regard themselves as being seriously at risk of HIVHIV infection. Their dominant attitudes towards AIDSAIDS are denial, fatalism and an air of invulnerability. Nevertheless, students tend to acknowledge that HIV/AIDSHIV/AIDS is a problem on campus. In fact, the majority allege that they know of fellow-students who are HIVHIV-positive and of students or staff who have died of the disease

Students tend to associate strong stigma with HIV/AIDSHIV/AIDS. Even where there may be no overt discrimination against them, HIVHIV-positive individuals may experience subtle forms of prejudice and ostracisation. One consequence of this is that it is difficult for those who are willing to do so to come out publicly about their HIVHIV status. This has contributed to the absence of clearly identified Persons-Living-with-AIDS groups on university campuses.

UNIVERSITY HIV/AIDS ARRANGEMENTS

HIV/AIDSHIV/AIDS-related services in universities focus mostly on students. Moreover, they are essentially health-centred. They provide mainly public information, together with a modicum of prevention, some health treatment, and some counseling. They do not appear to be very comprehensive in either scope or coverage. Although not formally restricted to students, they do not seem to extend adequately to academic and non-academic staff.

The main thrust of university information, education and communication efforts in relation to HIV/AIDS HIV/AIDS tends to occur in the brief period of student orientation at the beginning of the academic year. Incoming students are given some factual information about the disease, STDs, and the avoidance of unwanted pregnancies. Information is also provided about available university health services, counseling, and condom availability. In almost all cases, however,

these are one-off presentations with little or no follow-through.

The principal university response to HIV/AIDS HIV/AIDS takes place through university health services and clinics. These have been giving increased medical attention to the needs of students and staff, undertaking condom distribution, promoting awareness-raising through posters and other educational materials and, in conjunction with other student service units, extending their capacity to offer counseling. The demand pressures on university medical centres, which tend to be seriously understaffed and under-resourced, have greatly increased in recent years. More cases of STDs and of tuberculosis are being treated than in the past, even though it is acknowledged that many in the university community seek treatment elsewhere for these complaints. Financial constraints, aggravated by increased demand, lead to an uncertain and erratic supply of drugs and reagents in clinics, thereby rendering their services less effective.

University clinics supply condoms, either directly on request or through outlet points in student halls of residence or counseling centres. In some cases, members of anti-AIDSAIDS clubs or AIDSAIDS societies may distribute condoms directly to students in their rooms. Available figures suggest that condom distribution has increased in recent years.

Some universities have seen the formation of Student Welfare Societies, AIDSAIDS Societies, or Anti-AIDSAIDS Clubs, designed to sensitise students on HIV/AIDS HIV/AIDS issues, provide peer support, and promote HIV/AIDSHIV/AIDS awareness in nearby secondary schools. No investigations have been conducted to evaluate the impact that these non-formal associations may be having. The fortunes of these groups fluctuate greatly, with much depending on the dynamism of a few individuals and support from a "patron."

FINANCE-RELATED IMPACTS OF HIV/AIDSHIV/AIDS

Despite its potential for substantial adverse financial impact, university financial budgets and financial planning make almost no allowance for HIV/AIDSHIV/AIDS.

HIV/AIDS HIV/AIDS makes an impact on the fiscal situation of a university by increasing costs, reducing productivity, causing the diversion of resources, and threatening sources of income. The cost increases arise from direct costs (those that involve increased financial outlay), indirect costs (those that reflect reduced workforce productivity, whether by the infected worker or by others whom HIV/AIDS HIV/AIDS concerns deflect to other activities), and systemic costs (those arising from the way the disease reduces the overall skills and experience in the workforce, affects morale, etc.). Absenteeism accounts for the largest share of the costs arising from HIV/AIDSHIV/AIDS. Significant costs are also incurred in providing for funerals, while the deaths death of trainee members of staff represent a threefold loss for a university: the loss of well qualified and carefully selected individuals, the loss of training investments, and the costs of repatriating the remains of the deceased.

University provisions for sick leave tend to be generous. A person infected with HIVHIV will normally continue to receive full benefits throughout the series of comparatively short illnesses that precede the development of full-blown AIDSAIDS. When a more extended period of leave is required because of the progression of the disease, this may cover several months, or even a year or more. Humanitarian considerations frequently deter block university administrators from adhering to strict contractual provisions and terminating the benefits of an individual who will clearly pass away in the very near future. No

evidence is available from universities in seriously affected countries regarding the proportions of their budgets that are tied down by salaries and benefits for sick members of staff. Companies that operate for a profit can usually generate this information, but universities, other educational institutions, governmental, and non-profit organisations generally tend to deal with such losses in a less business-like mannerstringent fashion.

Although the evidence is patchy, HIV/AIDS HIV/AIDS is also appears to have an adverse impact on staff morale, the ability of an academic or non-academic group to continue to work together as a team, and the maintenance of routines. Clearly the disease is eroding the human and social capital of educational institutions, undermining their capacity to offer academic and support services. Staff find that in addition to their normal responsibilities they may have to cover for sick or deceased colleagues, sometimes in areas where they are less suitably qualified or experienced. In several institutions, morale and motivation are at a low ebb, although this may have less to do with HIV/AIDSHIV/AIDS-related reasons than with financial considerations (e.g., dissatisfaction with income levels and conditions of service, inadequate resources to support teaching and research, insufficient medical supplies, poor state of facilities).

Because of its macro-economic and household impacts, HIV/AIDS HIV/AIDS also constrains the public and private resources available for university education. The various impacts of AIDSAIDS on families produces a substantial number of students who are unable to pay fees. A sinister outcome of this situation is the way it has driven some students into illicit activities such as prostitution.

HIV/AIDS AND UNIVERSITY TEACHING AND RESEARCH FUNCTIONS

The case studies provide some evidence that, because of sickness or death, a number of teaching programmes have had to be taken over by more junior and less experienced staff. There are no reports that HIV/AIDS HIV/AIDS has led directly to any teaching programmes being abandoned. But clearly teaching activities often proceedare often operating under less than satisfactory conditions, especially in departments that have a large number of registered students. Some cases are also reported where course attendance and submission of student work have been affected by student illness. This is not yet seen to be a major problem, since lecturers have been able to use their discretion to give the affected students extra time in which to submit their work. However, an untold number of students experience severe emotional problems when they learn that somebody in their family is suffering from HIV/AIDSHIV/AIDS. This knowledge makes it difficult for them to study and to concentrate on their academic work.

University research and consultancy activities seem to have been affected in much the same way as teaching. There have been no reports of a decline in such activities due to the sickness or death of staff. But evidence indicates that less qualified staff have had to assume responsibilities and that more senior staff have had their workloads increased. On a more positive note, evidence shows that an increasing volume of research in AIDSAIDS-related areas is being produced by the universities.

HIV/AIDSHIV/AIDS AND UNIVERSITY SOCIAL LIFE

The case studies provide rich information on norms and practices pertaining to social and sexual life on university campuses in Africa. They show that the culture of campus life appears to be ambivalent about - or even open to - "sugar daddy" practices, sexual experimentation, prostitution on campus, unprotected casual sex, gender violence, multiple partners, and similar high-risk

activities. In the context of HIV/AIDSHIV/AIDS, student communities with such a culture are in danger of encouraging risk more than safety, thereby abetting death more than life. As a result, a residential university must be regarded as a high-risk environment for the transmission of HIVHIV.

The reports of the social life of students on campus are also rife with concerns about the subordinate status of female students and, in particular, their inability to negotiate for either for no sex or for safer sexual practices. The case studies also suggest that the climate on university campuses tends to be such that consensual rape frequently occurs.

UNIVERSITY RESPONSES TO HIV/AIDSHIV/AIDS

The most striking feature of the university response to HIV/AIDSHIV/AIDS is what can only be described as the awe-inspiring silence that surrounds the disease atthe institutional, academic and personal levels. Notwithstanding some qualifications, for all practical purposes both individuals and institutions conduct themselves as if the disease did not exist.

In their response to HIV/AIDSHIV/AIDS, universities display characteristics similar to those shown by general education systems: considerable disarray, inadequate understanding, piecemeal response, lack of coordination, absence of well-developed action plans, minimal policy framework, and heavy reliance on the initiative of a few interested and committed members of staff. Responding to Efforts to mobilize to respond to the HIV/AIDS HIV/AIDS situation in universities and in society has has not generated the passionate commitment that universities and university students have historically manifested in other struggles dedicated to university advancement, national liberation, and social causes.

Success in overcoming HIV/AIDS HIV/AIDS within the university demands exceptional personal, moral, political and social commitment on the part of the top university executives. Where such leadership has been forthcoming, successes are visible. In general, however, manifestations of such top-level commitment are rare.

University-wide structures for coordinating and implementing the institution's response to the disease are the exception rather than the rule. Budgetary provision for the implementation of any AIDSAIDS-related plans also tends to be unusual.

In spite of the risks of academic and non-academic staff run of contracting contacting HIVHIV/AIDS among academic and non-academic staff, workplace education programmes for the protection of such staff or workplace provision for their HIV/AIDS HIV/AIDS needs (such as VCT, worker-friendly health services, condom supply, rest rooms) do not yet exist.

UNIVERSITY RESPONSE IN ACADEMIC AREAS TO HIV/AIDSHIV/AIDS

No substantive changes in university academic policies or practices have yet occurred in response to the disease. Although some institutions have made provision for attention to HIV/AIDSHIV/AIDS at some points of the curriculum, evidence that HIV/AIDSHIV/AIDS has been mainstreamed into the teaching programmes of universities is lacking.

In the absence of university policies to this end, the inclusion of HIV/AIDSHIV/AIDS within teaching programmes depends greatly on initiatives arising from individuals or departments. In the university setting, however, it would be

more productive to integrate relevant HIV/AIDSHIV/AIDS concerns into all teaching programmes and courses, underlining their relevance to subsequent professional life, rather than to focus concern on information and sensitisation programmes directed towards knowledge as a motivator for behavioural change. In their undergraduate programmes, universities should ensure that students master the skills of learning — in the jargon, that they learn how to learn — so that they will be flexible, adaptable and innovative in response to the needs of the fast-changing and unpredictable AIDSAIDS world.

No university appears to be giving any thought to its responsibility to build up the professional skills and capacities that are being run down in society as a result of AIDSAIDS. For example, there is no evidence that any institution has increased its graduate numbers to meet the increased AIDSAIDS-occasioned demands in certain professional areas (in particular for more health, counseling and education personnel), or to teach in new areas cast up by the epidemic. Neither is there any evidence that universities are aware of their "intellectual leadership" responsibility to react to the new and special knowledge needs of a society living with AIDSAIDS.

Universities have generated a steady output of research that has added considerably to the international understanding of HIV/AIDSHIV/AIDS. The research covers all areas — scientific, medical, social and communication — and frequently extends to include community outreach and advisory/consultancy activities. Although some research is institutional, most is individual. Even though these research findings have been extensively disseminated internationally, information on AIDSAIDS research and related services is not well shared within or among universities.

Virtually every area with which a university deals represents a legitimate fieldarea for investigation about HIV/AIDSHIV/AIDS and its impacts. The cross-cutting and multidimensional nature of the HIV/AIDSHIV/AIDS epidemic needs a broad and multi-disciplinary response. Elements of this approach must also characterise university HIV/AIDSHIV/AIDS research. While each discipline must respect its own research canons, the university must ensure that some element of multi-disciplinarity and cross-sector collaboration characterises its HIV/AIDSHIV/AIDS research.

In dealing with HIV/AIDSHIV/AIDS issues, university research might do well to adopt a pro-active approach, with Africa's best minds investigating how they can circumvent the disease and its impacts, out-flanking it on every front. The mind-set of research cadres in universities needs to enshrine a determination to research their way ahead of the disease. They should not allow HIV/AIDSHIV/AIDS to dictate the pace of events or the scope of their investigations.

A common complaint from many institutions is that the university does not receive adequate funding for research. But in the area of HIV/AIDSHIV/AIDS this is likely to be different, with resources becoming available through national HIV/AIDSHIV/AIDS governing councils and the International Partnership against AIDS in Africa (IPAA). The need is for the institutions to develop a research action plan for HIV/AIDSHIV/AIDS, for use by university leadership as it seeks they seek to mobilise the necessary research funds.

TOWARDS A COMPREHENSIVE UNIVERSITY RESPONSE TO HIV/AIDS

The results of the case studies suggest that universities need to make more concrete arrangements for the management and control of HIV/AIDSHIV/AIDS on their campuses. In addition, the policy direction should be forward-looking, propelling the institution to be several steps ahead of the disease. Gaps identified by the case studies, and weaknesses within systems already established, point to three

features that could usefully characterise the university response to the epidemic:

- *Committed leadership*. Combating HIV/AIDSHIV/AIDS requires even more commitment, vision and leadership than fighting a war of independence. The case studies make it very clear that university leadership does make a difference. Where strong, sustained leadership is provided, success follows. In the absence of such leadership, efforts flag and little of value is accomplished.

- *Clear targets*. Targets for university action should reflect those for national and international action. This means that university policy must be informed by national policy and be consistent with it. Universities should also ensure that their policies incorporate the first ICPD+5 target: that by 2005 at least 90 percent of those between the ages of 15 and 24 will have access to the information, education and services required to reduce their vulnerability to HIV HIV infection.

- *A strategic approach*. Basically this comprises sixfive steps: a situation analysis; a response analysis; formulation of broad guiding principles; identification of priority areas and strategic goals; elaboration of steps for reaching the priority objectives within an action plan; and determination of the institutional framework and structures needed for implementation.

Implementing an institution-wide HIV/AIDSHIV/AIDS programme will require commitment, people, skills, materials and funds. The university's senior executives, in conjunction with university governing bodies and senates, have the responsibility to ensure the availability of these resources. In many respects, assuring resources can be the best indicator of the depth of university commitment to confronting the HIV/AIDSHIV/AIDS crisis.

The development of a policy and strategic framework is only the beginning of the process of managing HIV/AIDSHIV/AIDS at the university. In the final analysis what is needed is sustained action and not just plans. Moreover, the process of policy or plan development should not become bogged down in the traditionally cumbersome processes of a university. HIV/AIDSHIV/AIDS is a matter of life and death - for individuals, for institutions and for systems. Dealing with it will always require a sense of urgency.

Like their respective countries, universities are getting some things right in relation to HIV/AIDSHIV/AIDS. But they are also getting many things wrong. What they are getting right is the mounting concern they show about the disease and the actions they are beginning to take. Their strength is the commitment of individuals, the preparedness of many to be involved if they are given direction, and the wealth of knowledge and expertise in all institutions that is already engaged in responding to the epidemic. The essential weakness of the university response to the disease is that a coordinated strategy seems to be conspicuously absent, with the result that the actors are running off in all directions.

A comprehensive university response to HIV/AIDSHIV/AIDS requires close attention by universities to their essential mission: to serve the real needs of their AIDSAIDS-affected societies through the generation, selection, adaptation, transmission and preservation of knowledge, and the stimulation of intellectual life and cultural development.

Attention to this mission leads ultimately to two basic strategies for university action, one inward-looking, the other outward-looking. The inward-looking strategy is concerned with self-preservation and seeks to protect the functioning

of the university as an AIDS AIDS affected institution. The outward-looking strategy focuses on human welfare and seeks to serve the needs of society in an AIDS-AIDS-affected world.

This two-pronged strategy must be implemented within the context of certain fundamental principles that were reflected in the case studies, as they are in virtually every attempt to set the stage for coping with HIV/AIDSHIV/AIDS:

1. Openness and acceptance that break the silence.
2. Promotion of gender equity and empowerment.
3. Adoption of a strong human rights approach.
4. Inclusion at all levels of People Living with AIDS.
5. Cohesion with national policies and strategies.

CONCLUSION

One of the most pernicious aspect of HIV/AIDSHIV/AIDS is fear — fear of those who are infected, fear by those who are infected, but above all, fear that the disease cannot be overcome. The case studies show that this fear is not well-grounded. Through the activities of their members, the universities in Africa have shown that they have it within them to respond to the challenge the disease poses for them. They have also shown that they can contribute to solving the problems that it creates for society. Universities have the expertise to control the HIV/AIDSHIV/AIDS they confront from within. They also have the expertise to assist society in managing and gaining control over the epidemic and its impacts. With strong and visible leadership from the senior university management, they can fuse their currently disparate efforts into one coherent united onslaught on the HIV/AIDSHIV/AIDS enemy. The outcome will be that promised by Zambia's former President, Dr. K. D. Kaunda, when addressing the Africa Development Forum in December 2000: "WE WILL WIN!"

Chapter 1

HIV/AIDS and Development in Africa

The Scale of the HIV/AIDS Epidemic in Africa

HIV/AIDS HIV/AIDS continues to pose a major threat to Africa. During the year 2000, an estimated 2.4 million Africans died of HIV-related illnesses, while a further 3.8 million adults and children became infected with HIV (UNAIDS December 2000). About 80 percent of the global total of AIDSAIDS deaths during 2000 occurred in Africa and almost 72 percent of the new HIVHIV infections. However, although the number who died of AIDSAIDS in Africa in 2000 was 9 percent more than in 1999, the number of new infections was 5 percent less. UNAIDS tentatively attributes the decline in new infections to two factors:

1. Infection rates have stabilised or even fallen in some countries; and

2. "The epidemic has gone on for so long that it has already affected many people in the sexually active population, leaving a smaller pool of people still able to acquire the infection" (UNAIDS December 2000:4).

But the agency warns that if the number of new infections in a heavily populated country such as Nigeria expands rapidly, the slight improvement of 2000 will be quickly erased.

The highest rates of HIVHIV infection occur in the countries of Eastern and Southern Africa. But the threat from the disease is not confined to these sub-regions. More than half of the countries in Sub-Saharan Africa (24 out of 43 for which data are available) are experiencing a generalised epidemic, with the adult HIVHIV infection rates (i.e., the rates for those aged 15-49) exceeding 5 percent at the end of 1999 (see Table 1). The countries experiencing a generalised epidemic include countries with large populations, such as Nigeria, Ethiopia, South Africa, and the Democratic Republic of Congo. Taken all together, the heavily infected countries account for 80 percent of the adults in the sub-continent - 215 million out of a total of 269 million. Their average infection rate is 10.38 10.38 percent, with an estimated 22.3 million out of a total adult population of 214.9 being HIVHIV-positive at the end of 1999 (Table 1).

On the other hand, the 19 countries with lower infection rates tend to be less populous—only four have populations above 10 million and none has a population that exceeds 20 million. The average infection rate for these countries is 2.2 percent, with 1.2 million adults out of 54 million being HIVHIV positive at the end of 1999. For Africa as a whole, the average infection rate at the end of 1999 was 8.74 percent, with 23.5 million out of an adult population of 268.9 million being infected.

In 1999, over two million AIDSAIDS-related deaths occurred in the countries of Africa with infection rates of 5 percent or more (Table 1). This was about three-quarters of the global total. As a result of so many deaths, these countries confront the demanding challenge of responding to the needs of a burgeoning number of orphans. In each of four of these countries — Ethiopia, Uganda, Tanzania and Nigeria — the number of AIDSAIDS orphans exceeds one million, while in each of four others — Zimbabwe, Kenya, Zambia and the Democratic Republic of Congo — it exceeds half a million (other estimates give much higher figures for all countries, with orphan numbers standing close to or in excess of a million in each of Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe). The social and economic implications of deaths on this scale from just one disease, the prolonged periods of extensive illness that precede them, the intractable challenge posed by the huge number of orphans, and the disruptions that the disease and its consequences are bringing to household, employment, health, education and other systems, constitute a disaster of mind-boggling proportions.

Table 1. HIV Estimates, Sub-Saharan Africa, 1999

	ADULTS (15 - 49 years)				
	Number	HIV infected	Infection Rate	AIDS Orphans	AIDS Deaths
Countries with infection rate above 5%	214.944 m.	22.312 m.	10.38%	11,424,200	2,091,800

(24 countries)					
Countries with infection rate below 5% (19 countries)	54.003 m.	1.194 m.	2.21%	619,760	113,000
All countries (43 countries)	268.947 m.	23.506 m.	8.74%	12,043,960	2,204,800

Source: Derived from *UNAIDS Report on the Global HIV/AIDS Epidemic, June 2000*, page 124.

The Impact on Development

It has almost become a truism that HIVHIV/AIDSAIDS is unraveling hard-won development gains and exertingexertomg a crippling effect on future development prospects. The repercussions of the epidemic are such that the worst affected countries are already experiencing major development reversals. If the epidemic goes into a more rapid expansion phase in less severely affected countries, the trend will be the same. This means that already many African universities find that they must operate in a substantially changed (and worsened) socio-economic environment. In the future, others may face similar prospects.

In order to appreciate the turbulent ambience that HIV/AIDS is creating for African universities, iit is necessary to understand some of the social and economic consequences of the epidemic. The areas of greatest concern are the way the disease impacts on households, on the demographic structure of society, on the various sectors with which universities have traditionally interacted, and on the economy in general.

Household Impacts and Orphans

The most immediate effects of HIV/AIDS are experienced at the individual and household levels. The effects have many facets: illness, physical and psychological pain and suffering, health care and costs, income loss, reduced household productivity, death, funeral costs, mourning and grief, increased poverty, increased vulnerability of women, growth in the number of orphans, the social dislocation of those who survive, and the ultimate disappearance of households. To illustrate, consider the following:

- Following an AIDS death, average household consumption in Côte d’ Ivoire fellfalls 44 percent on the previous year and households with an AIDSAIDS patient spentspend twice as much on medical expenses as those without such a patient (Béchu 1998).

- In Ethiopia, AIDS-affected households were found to spend between 11.6 and 16.4 hours per week in agriculture, compared with a mean of 33.6 hours for non-AIDSAIDS-affected households (UNAIDS-UNECA 2000).

- In Tanzania, a case study survey found that in households where one person was sick because of AIDSAIDS, 29 percent of labour was spent on AIDSAIDS-

related matters; if two household members were devoted to nursing duties, the average household loss from agricultural activities was 43 percent (UNAIDS-UNECA 2000).

- In Zimbabwe, a bed-ridden AIDS patient was estimated to cost the affected household an additional US$23 – 34 per month. In a survey carried out in 2000 to assess the impact of adult female mortality in two districts, it was found that 65 percent of the households where the deceased female had lived were no longer in existence (UNAIDS-UNECA 2000).

The reduction in household income, the increase in privately-borne medical expenditures, and the reduction in time devoted to agricultural activities signals a dramatic deepening of poverty for affected households. Given the largely rural background from which the majority of African universities draw their students, it is probable that the epidemic is reducing potential future student intakes. It is also clear that universities must take cognizance in their teaching, research and service activities of the way the disease is changing the structure of households and their ability to produce what they require to meet their own needs.

Data on orphans has already been presented in Table 1 (and is given for each country in Annex Table 1). The challenge posed by the increase in orphans is already being encountered on a massive scale across the continent. Equally, the problem seems set to expand almost without limit, with no end in sight. As with AIDS itself, nothing of such all-encompassing magnitude has ever before been experienced by humanity. No well-elaborated paradigms exist for guidance in coping with it. There is no real understanding of how best to support children who have no caregivers in their households, or how to enable extended families and communities respond to the care, nutrition, health, education and other needs of children who have lost one or both parents to AIDS.

Concerns are expressed that the increase in the number of orphaned juveniles as a proportion of the general population will lead to a sustained increase in crime levels in the short to medium term (Schönteich 2000). Questions are asked about how orphans in rural areas can learn to be productive when there is nobody to pass the relevant knowledge on to them (UNAIDS, December 2000:13 – 14). Questions are also raised about how today's orphans will become tomorrow's parents when they will never have known the formative years of a normal childhood, being parented in a normal family with father, mother, brothers and sisters (Kelly 2000).

Universities throughout Africa exist in a milieu where AIDS has magnified the orphans question beyond previously imaginable boundaries. Apart from the impact on potential future student numbers and quality qualities, this is an area that urgently cries out for concentrated and concerted university action. It might be necessary for some universities, at least, to think about developing centres for orphan studies or incorporating such studies more expressly into the other research activities that are being conducted. Responding to a problem as large as that posed by orphans will require skills and understandings that as yet can scarcely be identified, but which will surely entail imaginative, innovative responses from the best minds that universities possess.

Demographic Impacts of HIV/AIDS

The most significant demographic impacts of HIV/AIDS are on population growth rates (and in consequence, on size) and structure. The United States Census Bureau estimates that in 26 countries the population growth rate in 2000 is already lower than it would have been in a no-AIDSAIDS scenario, with the difference being very substantial for some countries (see Annex Table 2). It further projects that, apart from Uganda, the growth rate in each of these countries will continue to decline during the coming decade. For the first time, it is now being projected that AIDS will lead to negative population growth, with Botswana, South Africa and Zimbabwe experiencing population decline by 2003. Other countries, such as Lesotho, Mozambique, Namibia and Swaziland, will be experiencing a growth rate of nearly zero, whereas in the absence of AIDS they would have been growing at the rate of their growth rate would be two percent or more (Stanecki 2000).

One outcome of this AIDS mortality will be a reduction in the numbers of persons to be educated. Recent World Bank projections for four countries document the kind of reduction in student numbers that AIDS is expected to cause (see Table 2). The smaller number of primary school candidates will work its way through the system to generate an even smaller number of candidates for admission to universities. This could have two effects: a potentially smaller number of applicants would reduce pressures for admissions and/or expansions; at the same time, the smaller pool of candidates might also display a smaller range of ability.

Table 2. Impact of AIDS on the Size of the School-aged Population in Selected Countries

	Projected Population of Children of Primary School Age in 2010	
	Without-AIDS Scenario	With-AIDS Scenario
Kenya	8.2 million	7.1 million
Uganda	6.8 million	6.0 million
Zambia	2.7 million	2.2 million
Zimbabwe	3.0 million	2.3 million

Source: World Bank, August 2000

A further effect of the AIDS mortality will be the emergence of population structures that have never been experienced before. Because AIDS impacts most severely on those in the productive age group (women aged 20 - 30 and men aged 30 - 40), dependency ratios will increase, with larger numbers of young and elderly persons depending on the productive capacity of a smaller proportion of those in their economically (and biologically) most productive years. For biological and socio-cultural reasons, significantly more African women than men are HIV-positive and women are infected at younger ages than men.

This is trend is producing more men than women in the various age-cohorts, a factor that "may push men to seek partners in younger and younger age cohorts" (Stanecki, 2000, p. 2). Since sexual "age-mixing", typically between older

men and younger women, is one of the many factors that play a role in kick-starting and maintaining a sexually transmitted HIVHIV epidemic (UNAIDS December 2000), the changing population structure could lead to more older men infecting younger women, who then transmit the disease to their partners or children, thereby establishing a vicious cycle of infection and disease. As will be seen in later pages, sexual age-mixing is a phenomenon that is regularly encountered in African universities.

The effect of the epidemic on life expectancy is devastating. epidemic is producing a devastating effect on life expectancy. In each of the countries appearing in Annex Table 2, life expectancy is lower in the AIDS situation than if there had been no AIDS, while 19 of the 26 countries have seen the indicator lose ten years or more. In all countries, apart from Ghana, life expectancy is currently estimated as being below 55 years, while by the year 2010 it will have fallen to 50 or less — in some countries it will fall to around 30 years of age, a level not seen since the beginning of the 20th century (Stanecki 2000:4).

Fuelling this decline in life expectancy will be an increase in death rates. In Botswana and Zimbabwe these are already more than 300 percent higher than they would have been in the absence of AIDSAIDS. But in all countries affected by AIDS the death rate is higher than in a no-AIDS situation. These death rates will continue to increase, even though mortality due to non-AIDS causes will continue to decline. Contributing to these expanded death rates are increases in infant and child mortality. The latter sensitive index of development showed a downturn during the 1990s, largely because of AIDS, in such countries as Angola, Botswana, Cameroon, Côte d'Ivoire, Kenya, Rwanda, South Africa, Zambia and Zimbabwe (UNICEF 2001, Table 8).

One further perspective is relevant for university administrators. According to models developed for UNAIDS, in any country where 15 percent or more of adults are currently infected, at least 35 percent of boys now aged 15 will die of AIDS (UNAIDS, June 2000:25). Even bleaker is the prospect for young people in more heavily infected countries. In 1997, half of the 15-year-old boys in Zimbabwe could expect to die before the age of 50, while the likelihood of a 15-year-old girl dying before the end of her reproductive years increased from 11 percent in the early 1980s to over 40 percent in 1997. Where such circumstances obtain, they raise serious issues relating to training, employment and replacement policies for a university's own staff. They also raise major questions about the duration and nature of training as well as the numbers that should be trained in response to currently estimated needs.

The Sectoral Impact of HIV/AIDS

HEALTH SECTOR

"Not only is Africa the worst HIV/AIDS affected region, it is also the world's poorest region with the lowest access to and quality of health care" (Botchwey 2000:9). Although HIV/AIDS is more than a health problem, it makes one of its most significant impacts on the health sector. This sector must deal with an increasing number of AIDS-related illnesses, diverting its already scarce resources to caring for such illnesses. Studies repeatedly return to three issues in this area:

- the way hospital beds and services are being increasingly given over to AIDS patients;
- the way high levels of morbidity and mortality among health-care staff are reducing capacities to provide care and treatment; and
- the prohibitive costs of scaling up HIV/AIDS health programmes to adequate levels of acceptability.

In response to these pressures governments are finding themselves faced with difficult choices. In particular they are finding it necessary to make trade-offs between treating AIDS as against preventing new HIV infections; between treating AIDS as against treating other illnesses; and between spending on health as against spending on other sectors (Botchwey 2000).

A further consideration is that the growth of AIDS-related illnesses is expanding the demand for health care and consequently the demand for health-service personnel. One estimate for South Africa is that the demand for health services in 2010 could be more than 11 percent higher than in a no-AIDS scenario (Quattek 2000:41). In addition to ensuring that their health-care graduates will have the flexibility to cope with the ever-increasing demands of the AIDS epidemic, universities must be prepared to adjust so that they can also respond to demands for an increase in the number of such graduates.

EDUCATION SECTOR

The impact of HIV/AIDS on the education sector is not altogether straightforward. At one level, evidence is emerging that education remains virtually the only "vaccine" currently available for warding off HIV infection. Beyond the early stages of the AIDS pandemic, education reduces the risk of HIV, with better educated persons exposing themselves less to the risk of infection. The positive side of this is that providing more extensive and better quality education — even if not dealing directly with reproductive health and AIDS education — is likely to make a population less vulnerable to HIV infection. The negative side is that "new HIV infections will gradually become concentrated among illiterate and poor people as the epidemic spreads among the population" (Vandemoortele and Delamonica 2000). Both aspects, positive and negative, highlight the importance of universalising education of good quality so that this "social vaccine" is available to all persons. The relevance for universities is that they must see the education sector in its totality, with themselves as one of its parts, with higher education having needs that may need to be subordinated to the good of the whole.

At another level, AIDS is playing havoc with education systems. It is reducing the number of children in school, not merely because it leads to fewer children in need of education (cf. Table 2 above), but also because sick parents are taking their children (especially girls) out of school, orphans are not attending school, households are becoming more reliant on children's labour and the economic contribution they can make, and AIDS-costs are reducing family ability to meet even modest educational expenses. On the supply side, the disease is constraining the ability to provide educational services, with high levels of morbidity and mortality among teachers. UNICEF has estimated that in 1999 alone 860,000 children in Sub-Saharan Africa lost their teachers to AIDS (UNICEF 2000:8).

In addition, the quality of education is also being eroded by such factors as frequent teacher absenteeism; intermittent student attendance; low teacher morale; considerable student and teacher trauma; repeated occasions for grief and mourning in the school, in families and in the community; a widespread sense of insecurity and anxiety among young learners, especially orphans; unhappiness and fear of stigmatisation and ostracisation on the part of both teachers and students who have been affected by HIV/AIDS; and teacher uncertainty about personal HIV status (UNECA 2000). Compounding these problems are those of reduced resources, rather generalised poverty, a sense of unreality about the curriculum's relationship to real life, a disconnect between the world of the school and the world of work, and a pervasive doubt about the need for school education when it seems certain that many will die young because of AIDS.

THE PRIVATE AND INDUSTRIAL SECTOR

HIV/AIDS impacts on the private and industrial sector by reducing productivity, increasing costs, diverting productive resources, and affecting the market for business products. The first three effects arise from the various consequences that follow when the disease is present in the workforce: increased absenteeism, reduced performance levels of infected workers, additional burdens on healthy workers, inexperience of replacement workers, increased medical and insurance costs, extensive recruitment and training costs, increased size of workforce to cover for possible sickness, absenteeism and death, payment of funeral and other benefits. The extensive household impacts of the disease, and the increasing private costs of medical care, reduce the market demand for products of all types. There is also a market effect when individuals die before they have finished paying for goods they have purchased (Whiteside and Sunter 2000).

Most of these factors affect universities, since they are expected to organise their affairs according to sound business principles. Therefore, universities need to learn from what AIDS is doing to the business world and how the business community is responding to the disease. Although data are limited, the following examples are illustrative:

- In three firms in Abidjan, the average annual costs per employee due to HIV ranged from 0.8 to 3.2 percent of the 1997 wage bill (UNAIDS-UNECA 2000).
- On a tea and coffee estate in Malawi, production loss in 1995/96 to illness was 3.4 percent of gross profit (UNAIDS-UNECA 2000).
- Swaziland estimates that it will have to train more than twice as many teachers as usual over the next 17 years just to keep services at their 1997 level (Swaziland Ministry of Education 1999).
- Between 1993 and 1997, medical costs per employee for 6 firms in Dar es Salaam increased five-fold and funeral costs increased six-fold (UNAIDS-UNECA 2000).
- In 1997, the cost of AIDS to the National Railways of Zimbabwe was the equivalent of 20 percent of company profits (UNAIDS-UNECA 2000).

In a study carried out across a number of countries, it was found that absenteeism, funeral attendance and employee burial costs, taken collectively, accounted for almost three-quarters of the increased labour costs due to HIV/AIDS, with labour turnover, health care, recruitment and training costs accounting for the balance of 26 percent (Table 3). It is clear that absenteeism, due at first to illnesses during the period of HIV infection and subsequently to the full-blown AIDS condition, is responsible for the greater part of the increased costs. As will be seen, universities in Africa generally do not maintain good records on such absenteeism or other HIV/AIDS-related costs. That business companies find it necessary to do so should provide the universities with a lesson.

Table 3. Distribution of Increased Labour Costs Due to HIV/AIDS

Cost Area	Percent of Total Increased Costs
Absenteeism due to HIV	37
Absenteeism due to AIDS	15
Burial & funeral benefits of an employee	16
Funeral attendance by employees	6
Health care	5

Labour turnover	5
Recruitment	9
Training	7

Source: Whiteside and Sunter 2000:101 (drawn from Roberts and Rau, n.d.)

MACROECONOMIC EFFECTS

HIV/AIDS relentlessly undermines three of the main determinants of economic growth, namely human, physical and social capital:

- The disease reduces the stock of human capital because it affects mainly adults in the age range 15 - 49 who are in their most productive years. Because in the early years of its occurrence information about the disease was inadequate, heavily infected countries have already lost a large proportion of a generation of educated persons. Since significant development of human capital takes place at the household level, sickness and death of a household member, especially a parent, may leave the younger generation with nobody to pass on to them the necessary knowledge and skills, while the readiness with which AIDS-affected families take children out of school causes further disruptions in basic human capital formation (see above p. 3).

- HIV/AIDSIt reduces physical capital because it undermines savings, at both household and public levels, and affects the incentive to save at household level (Botchwey 2000). Extensive medical costs reduce the ability of households to save and oblige many to dispose of capital assets. Earlier than planned-for pension payments and terminal benefits steadily eat into private sector and national investments. Government ability to save is constrained by increased expenditures, arising from efforts to provide treatment and care for AIDS-related illnesses, and to recruit and train additional personnel (civil servants, teachers, health workers) to replace those lost to the disease.

- HIV/AIDS reduces social capital — the "features of social organization, such as trust, norms and networks, that can improve the efficiency of society by facilitating coordinated actions" (Whiteside and Sunter 2000:94) — because it is "tearing away at social institutions. At the local level, AIDS is destroying the social fabric of communities. At the national level, AIDS is undermining the capacity of governments to provide basic social services and efficient economic management, regulation and legal framework" (Bonnel 2000:3).

Because of the long period between initial HIV infection and the development of full-blown AIDS (and subsequent death) these impacts are still in process of making themselves felt. Nevertheless, cross-country regressions for the period 1990 - 1997 show that HIV/AIDS has already reduced the rate of growth of Africa's GDP per capita by 0.7 percentage points a year (Bonnel 2000:17). In the absence of the disease, Africa's income per capita would have grown at 1.1 percent per year, which is nearly three times the growth of 0.4 percent actually achieved in 1990 - 97. In terms of GDP the future impact of HIV/AIDS will be even more substantial:

> *In the case of a typical African country with a prevalence rate of 20*

> *percent, the rate of growth of GDP would be some 2.6 percentage points less each year. At the end of a twenty year period GDP would be 67 percent less than otherwise* (Bonnel 2000:17).

These effects are directly relevant to universities in Africa in the following ways:

- The reduced GDP and the growth of competing claims could lead to fewer public resources being available for the education sector as a whole, and for higher education in particular.
- The extensive impact AIDS makes on household economies means that families and individuals tend to have fewer cash resources at their disposal, whether for education or for other purposes. As a result, universities will be constrained in their efforts to generate income through student fees.
- "As the expectation of a lower life-span takes hold" (Botchwey 2000:7), families may become less inclined to invest in education or training programmes where the returns lie in the distant future.
- Families and individuals may also become less inclined to invest in training for teachers, health workers, and other professions which historically have been associated with high levels of HIV infection.

The ADEA WGHE Case Studies

It is frequently said that "with AIDS it cannot be business as usual." The points made throughout this chapter suggest areas where university practice and university policy must adjust to the imperatives of HIV/AIDS. These and other points will be further elaborated upon in the following chapters which synthesise case studies from the following institutions:

- The University of Benin
- The University of Ghana
- The Jomo Kenyatta University of Agriculture and Technology, Kenya
- The University of Nairobi, Kenya
- The University of Namibia
- The University of Western Cape, South Africa
- The University of Zambia

In response to concerns expressed by the Association for the Development of Education in Africa (ADEA), at its Johannesburg Biennale in December 1999, the ADEA Working Group on Higher Education (WGHE) commissioned these case studies on the ways that HIV/AIDS affects some individual universities in Africa. The purpose was to generate understanding of how the disease is affecting African universities and to identify responses and coping mechanisms that might profitably be shared with sister institutions in similar circumstances.

Each study addressed six questions:

1. In what ways have the universities concerned been affected by HIV/AIDS?
2. How have the universities responded to these impacts?
3. What steps are the universities taking to control and limit the further spread of the disease in their communities?
4. What HIV/AIDS-related teaching, research, publication and advisory services have the universities undertaken?
5. How do universities propose to anticipate and address the larger impact of HIV/AIDS on the national labour market for university graduates?
6. Should university access, including via distance education, be

consciously increased to compensate for expected national losses in skilled professional personnel?

Almost at the same time as these institutional studies were being conducted, an independent investigation on the same topic was taking place in South Africa under the auspices of the South African Universities' Vice-Chancellors' Association (SAUVCA). The SAUVCA project was concerned with assessing the impact of HIV/AIDS on teaching, research, management, planning, policy and practice in each of the 21 universities in South Africa. The preliminary findings of the SAUVCA investigation (see Appendix 1) have been drawn upon to enrich the present report.

The immediate purpose of this report is to empower university self-expression around HIV/AIDS in Africa. In this way, it seeks to help bring HIV/AIDS issues to the fore in each university's thinking about itself. The ultimate goal is to prompt African universities to integrate HIV/AIDS fully into all aspects of their planning and operations. If this is accomplished, African universities will proactively address HIV/AIDS on campus and among their communities while at the same time helping their societies to cope with, manage and surmount the epidemic.

Chapter 2

HIV/AIDS: Case Study Country Situations

The availability of qualified academics willing to undertake case studies in their own universities, together with the approval of senior management, determined the choice of the seven universities and six countries that serve as the basis for this report. The universities and countries were not chosen at random. Neither were they chosen so as to cover the university world of Africa in any systematic way. Nevertheless, a common thread of institutional experience with HIV/AIDS provides a focus for the synthesis to which the reports give rise. A certain unity arises from commonalties in the ways that institutions experience the disease and from the similarities in institutional responses.

The countries involved vary in population, wealth, educational attainment, and development status (Annex Table 3). In four of them, per capita income is close to US$1 a day, while in the other two (Namibia and South Africa) it is six or more times greater. All countries rank below the world median for the human development index (HDI), with two (Benin and Zambia) being close to the bottom of this scale. Life expectancy at birth is highest in Ghana, at 60 years, but is six

to nine years less than this in four of the other countries and 20 years less in Zambia. Educational levels, as indicated by adult literacy rates, are relatively high in South Africa, Kenya, Zambia and Ghana, but low in Benin.

The two wealthiest countries in the survey, Namibia and South Africa, have very high HIV prevalence rates. Because of differences in their population sizes, the number of infected persons varies greatly between these two countries (Annex Table 4). With an estimated 4.2 million infected individuals, South Africa is believed to have the largest number of HIV positive persons in the world. In Zambia, the crude death rate due to AIDS alone was more than 11 per 1,000 of population in 1999, while in Namibia it was close to 11. In Kenya and South Africa it was 6, in Ghana 2, and in Benin less than one.

The countries vary in their national response to the HIV/AIDS crisis (Annex Table 6). All except Benin have established some form of high-level structure in support of the national response — a national AIDS committee or commission, an inter-ministerial committee, or a presidential-level body dealing with HIV/AIDS. Namibia and Zambia do not have an overall national HIV/AIDS policy in place, although each country has HIV/AIDS policy statements in specific sectors, such as education. National strategic HIV/AIDS plans exist, or are under development, in almost all countries. Since these are not always supported by a budget, their implementation remains problematic.

The priorities targeted for attention in national strategic plans differ widely among countries. In Kenya, priority components focus on advocacy and the promotion of behaviour change; blood safety; providing a continuum of care and support; treatment and control of STDs; epidemiology and research; prevention of mother-to-child transmission (MTCT) of HIV; and mitigation of the socioeconomic impact. For South Africa, four priority areas have been chosen:

1. *Prevention*: promote safe and healthy sexual behaviour; improve management of STDs; reduce MTCT; ensure blood safety; provide post-exposure services; improve access to voluntary testing and counseling (VCT).

2. *Treatment*: care in health facilities, in communities, and for children/orphans.

3. *Research*: monitoring and surveillance (AIDS vaccine development; investigation of treatment and care options; policy research; regular surveillance).
4. *Human rights*: create appropriate social, legal and policy environment (UNAIDS-UNECA 2000).

The Zambia National Strategic Framework identifies priority geographical areas: provinces with the highest prevalence rates, districts adjoining main trucking routes, areas with seasonal workers, refugee populations or frequent cross-border traffic. Sub-populations targeted for attention are: people living with HIV/AIDS, orphans, youth in and out of school, commercial sex workers, private sector workers, men. The Framework It also defines priority interventions: promotion of a multisectoral response, promotion of behaviour change, improved STD control, destigmatisation of HIV/AIDS, increased VCT, reduced MTCT, home-based care and support for persons living with HIV/AIDS, community-based support for orphans and vulnerable children, and improved hospital care (Zambia National AIDS Council 1999).

The socio-economic impacts of the disease in the various countries are in keeping with those outlined in the previous chapter. Additional details and summaries of research findings are presented in Annex Table 5. The table brings out that even in Benin and Ghana, where a generalised epidemic has not yet materialised and where adult prevalence rates are below five percent, HIV/AIDS is causing major

disruptions in social and economic areas. Disruptive impacts in the more seriously infected countries are even more considerable and widespread.

Although differences in the details can be observed, the AIDS situation will be broadly similar in other African countries. Its consequences comprise development delayed or reversed; increasing sickness, absenteeism and death among productive workers; household and national budgets under pressure; subsistence and commercial agriculture both at risk; erosion of profits; increase in the number of orphans and vulnerable children; and sluggish national responses. This is the environment in which higher education institutions throughout Africa now find themselves. This is the context within which they must survive. These are the circumstances with which they must contend - dynamically, proactively, and confidently.

Chapter 3

The HIV/AIDS Situation in the Case Study Universities

The over-riding message emerging from the case study institutions is that they lack good information about the HIV/AIDS situation on their campuses (see Box 1). A thick cloak of ignorance surrounds the presence of the disease within the universities. This cloak is amply lined with layers of secrecy, silence, denial, and fear of stigmatisation and discrimination.

Box 1. Denial and Lack of Information in Participating Universities

The question of AIDS has never been officially or unofficially mentioned during any of the student or other university assemblies (BENIN).

The response of the University to HIV/AIDS is one of virtual denial, manifested in the near absence of any omnibus activity or programme on the disease on campus, overtly managed and supported from the top. …. The general belief in the University (is) that the disease is out there and not yet on campus (GHANA).

At the early stages of the epidemic there is more of denial and lack of appreciation of the dangers of the problem. This may be the position at JKUAT. In this university the failure to recognise that HIV/AIDS poses major threats to the society has led to failure to respond adequately and in good time (JOMO KENYATTA UNIVERSITY).

There has not been any systematic attempt to assemble data on HIV prevalence rates at the University …. This could be due to the stigma associated with HIV/AIDS which inhibits discussion about the disease among both the infected and

affected (NAIROBI).

A questionnaire on (the) impact of HIV/AIDS …. was sent to all academic and administrative staff, including the top administration of the University. Of the over 400 questionnaires sent out, only four were received, for whatever the reason! Apathy? Perhaps! Of the four academics who responded, there was a clear indication that they did not know what the university was doing in this area (NAMIBIA).

There is a deep and broad, official and unofficial, personal and institutional silence about HIV/AIDS on campus (WESTERN CAPE).

It is impossible to determine the prevalence of HIV/AIDS in the university community because …. nobody to date has come out in the open to acknowledge being HIVHIV-positive in the University (and) death certificates do not state whether one died of an AIDS-related illness or not (ZAMBIA).

The lack of university information on the disease is attributed to inadequate records. The researchers most commonly sought such records in university clinics and health centres. Available records were found to be inadequate for two principal reasons:

1. They make almost no mention of AIDS;

2. They are incomplete to the extent that they do not capture the situation of university personnel who attend outside clinics and health centres, either because the under-resourced university clinics are unable to offer the necessary care and treatment, or because of a widespread concern that clinic records will not remain confidential.

In fact, records that might throw light on the prevalence of HIV/AIDS on campus did not appear to be held by any of the central administration or university management departments (registrar, personnel officer, bursar, etc.). No evidence emerged that the governing university body, as the employer, or Senates/Academic Boards as the stewards of an institution's academic work, were being provided with information on the occurrence of AIDS-related illnesses, absenteeism or deaths among academic or non-academic staff, or among students. Neither were such records being maintained in academic departments, faculties or schools. "When asked to provide figures for absenteeism due to illness/attending funerals, one Head of Department said: *'You do not keep a record of such cases or things. Funerals are not something to be enjoyed and when one is already going through trauma due to the death of someone you cannot be so inhumane as to ask the person to fill in the form and get the leave approved'.*"

Although from a management perspective it would be desirable to have the campus HIV/AIDS situation clearly documented, efforts to do so would likely encounter insoluble problems. Chief among them would be the human rights issue. It is generally acknowledged that testing for HIV status, either as a condition for admission as a student or for appointment to staff, is unacceptable. The United Nations International Guidelines on HIV/AIDS and Human Rights have already called for legislation that would, among other things, guarantee "freedom from HIV screening for employment, promotion, training or benefits" (United Nations 1998:19). The human rights of the affected students/staff would also be violated if they were required to reveal their HIV status either prior to admission/employment or during the course of their study/employment. Regardless of what problems this might create for the institution, students and staff retain the right to confidentiality about their personal HIV status and about the existence of HIV/AIDS in their families. Universities must seek to affirm these rights, even though in doing so they find that they are not equipped with the detailed

information they would wish for in order to manage the AIDS epidemic on campus.

"To be blunt, no one knows what the HIV/AIDS situation is at the University of the Western Cape" or indeed, at other universities on the sub-continent. An estimate for the University of Nairobi is that 10 to 20 percent of staff and students are HIV-infected. But in general, the absence of adequate information means that the HIV/AIDS prevalence rate on university campuses must be surmised to be similar to that obtaining for comparable groups in the general population:

- "It was acknowledged by most of the interviewees that like the rest of Zambian society the university has been affected by HIV/AIDSHIV/AIDS."
- "The virus that causes AIDS already infects many Kenyans in all walks of life. At JKUAT, some 11.7 - 13.5 percent of members of staff are infected (130 - 150 staff). Elsewhere in the country, for every 18 adults, one is infected. In urban areas, one of every 9 adults is infected."
- "In the absence of hard data, therefore, it would be reasonable to assume that perhaps 20 percent of UWC students are HIVHIV positive."

It is relevant here to note that new evidence suggests that the relationship between HIVHIV prevalence and level of education is changing. In the 1980s and early 1990s, when the pandemic was in its initial phases and transmission mechanisms were not well understood, most studies found that this relationship was direct and positive — higher prevalence rates were likely to be encountered among those with higher levels of education. This may no longer be the case. Some recent studies are finding a negative correlation between level of education and HIVHIV prevalence (Vandemoortele and Delamonica 2000). The point in relation to prevalence levels on university campuses is that, for members of staff who received their education prior to the mid-1990s, prevalence levels could well be higher than those found in the general population. On the other handLikewise, for students who received their education during the 1990s, and much of it since the middle of the decade, their prevalence levels could be lower.

Campus Morbidity and Mortality

Because of its more definite character, university campuses generally can provide better information about mortality than morbidity. But even this information is not complete. Apart from some exceptional cases, it is not possible to affirm positively that death was due to AIDS. One of these exceptional cases was Jomo Kenyatta University where an annual average of four AIDS deaths occurred among staff in the period 1995 - 1999. The University of Nairobi reports the number of deaths (from all causes) in the university community rising from 0 - 3 a month in 1991 to a current 4 - 6 a month, while the University Vice-Chancellor is quoted as saying that the University loses on average two persons (from among teaching and non-teaching staff and students) in AIDS-related deaths each week.

The University of Zambia reports total staff deaths of 352 in the period 1990 - 1999, two-thirds being male and one-third female. One-eighth of these were academic members of staff, while the remainder were non-academic. The crude death rate for staff in 1999 was 22/1,000 deaths, which is somewhat higher than the Zambian rate even under the with-AIDS scenario (see Annex Table 3). That the majority of these deaths were due to AIDS can be deduced from the ages at which they occurred: 53 percent were in the age-range 20 - 34, and 44 percent in the range 34 - 49. At these ages, there should be almost no deaths other than those due to major accidents and exceptional illnesses.

The death rate in these, and very likely other, universities is higher among the lower cadre staff than among academics. The poor housing conditions and areas

where the lower cadre staff tend to live is seen as one factor contributing to this difference. It is also noted that certain categories of workers may be at high risk of HIVHIV infection. These include drivers, who share the HIVHIV hazards experienced by long-distance truckers; security personnel who may use their position to abuse commercial sex workers found loitering on campus when abandoned by their male clients; and cleaners who are taken advantage of by senior staff and students alike.

AIDS-related student deaths are reported from Benin, while other universities describe some tendency for an increase in annual student deaths (although only 7 percent of staff interviewed at the University of the Western Cape knew of students who had died of AIDS, while 62 percent did not know of any). Two of the largest schools at the University of Zambia experienced more than 20 student deaths in the first semester of 2000. These losses translate into an annualised death rate of more than 20/1000, which is an exceptionally high rate for individuals who are clustered in the 20 - 30 age range.

One report makes the valid point that, given the long period that intervenes between HIVHIV infection and the emergence of full-blown AIDS, the full extent of student HIVHIV infection will not unfold until students have graduated from the university and entered the world of work. Whether they were infected before entering the university or whether they become infected during the course of their studies, the majority of HIVHIV-positive students will not succumb to AIDS until after they have completed their studies and left the institution. As evidence for this, the University of Zambia noted that four students from a relatively small diploma programme died within a year after their graduation.

The reports also note that it can be more difficult to track student than staff deaths, since student deaths may not occur when students are on campus, but during a vacation or following withdrawal from studies. In the same vein, the University of Nairobi has observed some tendency for students suffering from prolonged sickness to relocate from university residences to living off-campus with nearby friends and relatives. Similarly, approximately 1,500 students (16 percent of the total) drop out of the University of the Western Cape each year. The majority do so on financial grounds, but some do so for personal reasons. "It is only possible to guess what role HIV/AIDSHIV/AIDS played in the decision-making of these former students." Were they infected? Were they hard-pressed financially because AIDS had struck in their families? No one knows.

Although clinics and health services exist on all university campuses, information on possible HIV-occasioned student and staff morbidity is very sparse. It has already been noted that members of the university community may avail themselves of other medical facilities, when these are within easy reach, fearing that information on their HIVHIV status might not remain confidential at the university facility. However, a common observation in the case study reports is that the level of morbidity within the university community has increased, and in consequence the strains on the university health services have intensifiedincreased. "Many students and staff are to be found lining up for medical attention in the various university clinics and speculations are rife that most of the diseases are HIV/AIDSHIV/AIDS-related" (University of Nairobi). In particular, the number of cases of tuberculosis (a disease frequently associated with HIV infection) being reported in universities is said to have increased substantially.

Awareness among Students of HIV/AIDS

University students seem to be generally aware of the existence of HIV/AIDSHIV/AIDS and to know the basic facts about its transmission. Earlier misconceptions, such as that HIVHIV could be transmitted through saliva or

mosquito bites, are no longer very common. They also possess good knowledge about STDSTD symptoms. But not all students seek treatment for these, partly because university health services may not have the necessary reagents or drugs, partly because students fear that their STDSTD status might not remain confidential.

Important shortcomings in students' basic knowledge about both HIV/AIDSHIV/AIDS and STDSTDs still remain, e.g., that oral contraceptives prevent HIVHIV infection or that the HIV virus can pass through an undamaged condom. Encouragingly, the University of the Western Cape found that what students learned had an influence on their behaviour. Almost two-thirds of students surveyed stated that they had changed their behaviour because of what they had learned about HIV/AIDSHIV/AIDS, with significant proportions saying that their changed behaviour now allowed for condom use or for abstinence.

Yet there is widespread evidence that students do not generally regard themselves as being seriously at risk of HIVHIV infection. A survey at the University of Ghana found that only 45 percent considered themselves at risk of contracting the disease. The SAUVCA investigation found a similar situation in South Africa universities, with student attitudes manifesting denial, fatalism and an air of invulnerability.

In almost all universities, new students are provided with information on the disease as part of their orientation programme when first they arrive on campus. The orientation may also include information on the availability, location and resources of university counseling and health services. In many instances, Vice-Chancellors personally address incoming students on this issue. However, cases are also documented where HIV/AIDSHIV/AIDS plays a very insignificant role in student orientation and where it may be omitted entirely, particularly if the designated trainer is not available.

In general, students tend to acknowledge that HIV/AIDSHIV/AIDS is a problem on campus. The majority know of students who are HIVHIV-positive and of students or staff who have died of the disease. It is not clear how they come by such definite knowledge, given that so much silence and denial enshroud the existence of infection. The University of Nairobi suggests that these diagnoses are based more on 'social' than 'clinical' evidence: "You could just observe his physical appearance to know that he had got it" or "she was such a loose woman, we knew it was a question of time and it (AIDS) would catch on with her."

Acceptance of HIV/AIDSHIV/AIDS on Campus

In a questionnaire to students, the University of the Western Cape asked: "Is it considered to be a stigma (bad or shameful) to be HIVHIV positive or to be a person living with AIDS?" Excluding the non-committal responses (don't know, n/a), students who associated a stigma with HIV/AIDSHIV/AIDS were almost twice as many as those who did not. An independent investigation at the University of Botswana found significant negative attitudes toward the disease and towards those affected: "There were fears expressed regarding eating and working with infected students although it was generally believed that infected students should be allowed to continue with their education" (Odirile 2000).

Even where no overt discrimination is manifested against them, HIVHIV-positive individuals experience subtle forms of prejudice. Those who are suspected of being HIVHIV-positive frequently sense that they are isolated. They may be taunted. Students may just keep as much as possible to their rooms. Workers may experience humiliation, as when they are forbidden to use departmental crockery. Some fear that knowledge that they are HIVHIV positive will lead to their being condemned as promiscuous (see Box 2).

Box 2. Student Fears (especially among Females) of Acknowledging that One is HIV-Positive

- I would be afraid of losing friends.
- According to my understanding there is no one on campus who would support me.
- I trust no one. People would treat me differently.
- Women are badly treated and regarded as sluts.
- A man is tolerated whilst a woman is seen as promiscuous.
- It is difficult or impossible for a woman to have a relationship if she is HIV-positive publicly.
- Women are treated badly but guys nicely (University of the Western Cape).

This fear of stigmatisation, together with the failure of universities to get the HIV/AIDSHIV/AIDS problem out into the open and to promote its acceptance as a feature, however undesirable, of modern life, contribute greatly to the suffering of members of the university community who experience the disease. These circumstances also make it even more difficult for those who are willing to do so to come out publicly about their HIVHIV status. This has contributed to the absence of clearly identified Persons-Living-with-AIDS (PLA/PLWHA) groups on university campuses. "PLWHA have never come out into the open to express their wish to be involved in the university management of the epidemic. This may not necessarily be due to victimisation and discrimination on the part of the university administration, but to the anticipated response of the other members of the university community who may not have open acceptance of the disease" (University of Ghana). The Africa Development Forum has highlighted the losses that universities, in common with other communities, experience when they cannot call upon the services of such groups:

> *People living with HIV/AIDS stand at the centre of any community efforts to overcome the pandemic, and to change attitudes to overcome denial, stigmatisation and discrimination. Their rights must be respected in full and their leadership potential recognised* (ADF 2000, §2.3).

Failure to create a climate of acceptance within which it would be relatively easy to be open about one's HIV status also contributes very significantly to the further spread of the disease, since it denies to individuals the protection that knowledge of a potential partner's HIVHIV status could bring.

University HIV/AIDS Arrangements

The case studies draw attention to areas where universities have made special HIV/AIDSHIV/AIDS arrangements or have stepped up services because of the disease. As will become apparent from the discussion below, HIV/AIDSHIV/AIDS-related services in universities are almost entirely student-centred. In addition, they are predominately health-centred. They look mostly to information, a modicum of prevention, some health treatment, and some counseling. They do not seem to be very comprehensive in either scope or coverage. Although not formally confined to students, they do not seem to extend to staff. The care they provide does not encompass AIDS patients in their homes, but is either campus- or hospital-based. Overall, campus services appear to find themselves in a situation that greatly exceeds their capacities to respond. In the process, dedicated health and counseling personnel are being frustrated and demoralised in their work and HIV/AIDSHIV/AIDS is settling in for a long stay.

- **STUDENT ORIENTATION AND AWARENESS-RAISING**

The main thrust of university information, education and communication efforts in

relation to HIV/AIDSHIV/AIDS seems to be concentrated into the brief period of orientation undergone by new students. Universities in Africa have a long tradition of dedicating a week or so to orienting incoming students to the complexities of university academic and social life. HIV/AIDSHIV/AIDS is tending to feature ever more prominently among the topics for this orientation programme. Students receive some factual information about the disease, STDSTDs, and the avoidance of unwanted pregnancies. Information is also given about available university health and counseling services and condom availability.

It is critical that new students are alerted from the outset to be HIV/AIDSHIV/AIDS-vigilant, especially when the warning bells are sounded by senior university administrators. But in the absence of continuous follow-up activities, these one-off communications are likely to have very little impact where it is most urgently needed, on student behaviour.

There seems to be clear need at almost all institutions to establish on-going HIV/AIDSHIV/AIDS education programmes that provide students with training in psycho-social life-skills such as assertiveness, effective communication, and decision-making. These are needed in order to equip students to resist peer pressures in such high risk areas as alcohol abuse, drug-taking, and casual sex. It must also be remembered that the majority of students profess that they already know a great deal about HIV/AIDSHIV/AIDS when first they arrive on campus. Many see the orientation presentation of the topic as being little more than a formality. The majority probably learn something about the provision of clinical, counseling and condom services, but little that will stimulate them to adopt or maintain more responsible sexual behaviour.

The University of Namibia appears to be unique in sponsoring a systematic follow-though on student orientation through an annual university-wide HIV/AIDSHIV/AIDS awareness week. During this week, debates, discussions and guest speakers provide ample opportunity for deepening knowledge and awareness of the disease on campus and in society. The week also forms part of university outreach to the community on HIV/AIDSHIV/AIDS, through radio broadcasts, theatre presentations, and awareness-raising meetings for secondary school students. The latter, being youth to youth, are of particular value for both university and school students.

Some universities report the formation of Student Welfare Societies, AIDS Societies, or Anti-AIDS Clubs designed to sensitise students on HIV/AIDSHIV/AIDS issues, provide peer support, and promote HIV/AIDSHIV/AIDS awareness in nearby secondary schools. At the University of Zambia, the Anti-AIDS Club has put up a large road-side billboard which reads:

GRADUATE WITH POSITIVE A's

NOT WITH AIDS

GET A POSITIVE UNZA DEGREE

NOT A POSITIVE HIV CERTIFICATE

ZAMBIA NEEDS YOUR DEGREE

The Club has also produced a calendar bearing the same message.

Evaluations of the impact of these non-formal associations have yet to be undertaken. Evidence from secondary schools is that they can be powerful channels for the best kind of HIV/AIDSHIV/AIDS education because young people themselves are involved in programme design and delivery. They use participatory and

experiential learning techniques, and the programmes take adequate account of the youth culture, speaking a language that young people understand (Kelly 2000). Significantly, students at the University of the Western Cape, who generally welcomed the University's interesting awareness programmes, criticised them because "students are not directly involved in the programmes designed to assist them." A similar point is made in the SAUVCA report. But in universities as in secondary schools, the fortunes of such clubs fluctuate greatly. Their achievements often depend on the dynamism of a few individuals and support from a "patron."

- **HEALTH AND COUNSELING SERVICES**

Many of the participating universities suggest that the principal response to HIV/AIDSHIV/AIDS on their campuses is being carried out through their health services and clinics. These have increased medical attention to the needs of students and staff, initiated condom distribution, promoted awareness-raising through posters and other educational materials (for instance, articles in university newsletters and newspapers, or broadcasts on campus radio), and augmented their capacities to provide counseling. At the comparatively better resourced University of the Western Cape, the campus health services are also able to provide free HIV/AIDSHIV/AIDS testing. An early effort to provide for voluntary AIDS counseling and testing at the University of Zambia came to an end in 1994, partly because of poor take-up and partly because of lack of funds. This service has recently been re-established for all members of the university community, but as yet no information exists on the extent to which it is being used.

The demand pressures on university medical centres, which tend to be seriously understaffed and under-resourced, has greatly increased in recent years. More cases of STDSTDs and of tuberculosis are being treated than in the past, even though it is acknowledged that many in the university community seek treatment elsewhere for these complaints. Financial constraints, aggravated by increased demand, lead to uncertain and erratic supply of drugs and reagents in clinics, thereby rendering their services less effective. Jomo Kenyatta University adds a further perspective: responding to HIV/AIDSHIV/AIDS imperatives is absorbing so much of the university's health and general budgets that this is creating serious challenges for other programmes, which find themselves with fewer resources than would otherwise be the case.

University clinics supply condoms, either directly upon request or through outlet points in student halls of residence or counseling centres. In some cases, members of anti-AIDS clubs or AIDS societies may distribute condoms directly to students in their rooms. Available figures suggest that condom distribution has increased in recent years. At least one institution, Jomo Kenyatta University, has witnessed a concomitant decrease in STDSTDs and student pregnancies. None of the case studies speak of femidoms being made available, so the assumption is that the supply and distribution has been confined to male condoms.

Universities usually ensure, through their student welfare offices, that counseling services are available for students. In addition to customary psycho-social, academic and health-related problems, these services are now being asked increasingly to deal with HIV/AIDSHIV/AIDS-related issues. Usually these follow two different lines: some students seek counseling because of concern about their HIV status; others seek assistance from the counseling office in coping with financial pressures which they or their families are experiencing because of AIDS sickness or death. The increase in AIDS morbidity and mortality among university community members and their families suggests the need for expanded and more professionally qualified counseling services. This need will become more severe as universities seek to introduce or expand the provision of voluntary counseling

and HIV/AIDSHIV/AIDS testing.

Chapter 4

The Impact of HIV/AIDS on University Operations

The Impact on a University's Fiscal Situation

Basically, HIV/AIDSHIV/AIDS impacts on the fiscal situation of a university in much the same way as on any other enterprise. It tends to increase operating costs, reduce productivity, divert resources from planned activities, and threaten sources of income. Although the case studies have been able to provide little hard evidence in these areas, they make it clear that all four effects are being experienced by universities in Africa, with the first three making their greatest impact through the way they affect the university workforce.

Whiteside and Sunter (2000:109 ff.) provide useful schemas for analysing the financial impact of HIV/AIDSHIV/AIDS on a company's workforce. The analysis can be applied equally well to universities and can guide them in collecting data that would enable them to monitor one of the principal ways through which HIV/AIDSHIV/AIDS would affect their costs (see Table 4). Essentially, they propose that the costs involved be analysed as *direct costs* (those that involve increased financial outlay), *indirect costs* (those that reflect reduced workforce productivity, whether by the infected worker or by others whom HIV/AIDSHIV/AIDS concerns deflect to other activities), and *systemic costs* (those arising from the way the disease reduces the overall skills and experience in the workforce, affects morale, etc.)

Table 4. *The Economic Impacts of HIV/AIDSHIV/AIDS on an Institution's Workforce*

Direct Costs	*Indirect Costs*	*Systemic Costs*
Benefits package	Absenteeism	Loss of workplace cohesion
Recruitment	Morbidity on the job	Loss of productivity

Training	Management resources	Loss of skills and experience
HIV/AIDS Programmes		

Source: Derived from Whiteside and Sunter 2000:112 (full details provided by the authors appear in Appendix Chart 1)

- **DIRECT COSTS**

The case studies indicate that universities are already bearing increased costs for the maintenance of regular medical services through their clinics and health centres. These must be kept supplied with rising amounts of materials for testing and treating an increasing number of STDSTD cases, with drugs for tuberculosis and other AIDS-related illnesses, and with disposabledisposible materials and special equipment that will protect health workers against possible infection. Additional calls, and therefore costs, are involved in providing some form of hospital care for staff or students who may become severely ill.

As is the case with other large employers, universities are being called upon to make terminal benefits available to employees earlier than expected. Further, some universities (such as the University of the Western Cape) contract with private medical insurance companies to provide medical coverage for their employees. The tendency has been for the premiums for these schemes, and for pension and life benefits, to increase rapidly as HIV/AIDSHIV/AIDS spreads. For South Africa, Metropolitan Life has estimated that the cost of an average set of insurance benefits could double for many schemes by 2005 and triple by 2010 (Quattek 2000:38). Few universities will be able to avoid similar cost increases.

Universities also face ever larger and more frequent expenses for funerals. The conditions of service at almost all institutions oblige the university to provide a funeral grant when a member of staff, spouse, or child passes away. They also require the university to provide funeral transportation (or cash in lieu) for the carrying of the dead to their place of origin. These payments place a heavy burden on university budgets. In mid-1999, for example, the University of Zambia estimated that it was spending close to US$1,500 each month on funeral grants and expenses. At the University of Nairobi, funeral-related vehicle use jumped from 7 percent of total transport requests in 1991 to 22 percent in 1999.

The universities have not yet begun to deal with the replacement and training costs of those who have died or left active university service because of HIV/AIDSHIV/AIDS. This is largely because the majority of staff severances have occurred among the cadre of general workers, where replacement is not costly (or may not take place, because of pressures on the university to retrench workers). But increasingly, universities are coming to recognise that considerable costs are involved in the recruitment and training of replacement academic, administrative and technical staff. Particularly costly are the losses that many of the institutions have experienced of trainee members of staff studying abroad. The death of such individuals represents a three-fold loss for a university: the loss of well qualified and carefully selected individuals, the loss of professional development investments, and the costs of repatriating the remains of the deceased.

The case studies contain no evidence that any of the universities has begun to put in place HIV/AIDSHIV/AIDS awareness education programmes for their staff. By not sponsoring such programmes, universities are out of line with current practice in financial and industrial firms and in government ministries. For

example, the education and health ministries in Zambia run workplace HIV/AIDSHIV/AIDS programmes for their staff at various levels. Protecting employment as well as employees through education and training programmes at the workplace is among the strategic objectives adopted by the International Labour Organisation (ILO) in its response to the challenge of HIV/AIDSHIV/AIDS (ILO 2000:24). Universities can expect that they will be shortly come under pressure to provide for such programmes and to budget for the resulting material and human costs.

- **INDIRECT COSTS**

As shown in Table 3 above, absenteeism accounts for the largest share of the costs arising from HIV/AIDSHIV/AIDS. Employee absenteeism stemming from HIV/AIDSHIV/AIDS has two aspects: the absences that occur as the immune system progressively breaks down during the almost invisible HIVHIV stage of the disease, and the absences that occur when the disease has progressed to full-blown AIDS. The former tend to be of short duration, but increase in frequency and duration as time progresses. The latter may be quite extended and almost inevitably lead to permanent absence from duties.

> *…. the immune system can be breaking down for a long period of time, and the infected person can be beset by a series of illnesses long before diagnosis of full-blown AIDS. A conservative assumption might be that, on average, each infected teacher loses six months of professional time before developing full-blown AIDS and then 12 months thereafter* (World Bank 2000:23).

While both forms of absenteeism lead to loss of productivity, the costs of sporadic absences caused by intermittent illness during the HIVHIV stage can be more troublesome to manage because they are so unpredictable and because the situation is at too early a stage to justify a replacement for the individual in question. These unscheduled absences can be very disruptive of teaching and general administrative activities, with individuals having to cover for colleagues at short notice or with the work being left undone. Repeated experiences of this type tend to lower the morale even of healthy staff, leading to further declines in productivity.

A further aspect of absenteeism is the way this has increased in order to facilitate funeral attendance. In some countries, funerals occur mostly at weekends so that they cause minimal disruption of normal operations. But in others they occur throughout the week. In such circumstances, teaching and other departments may be deprived of a member of staff for several days at a time. In the case of a death of a staff member, the impact is even more severe because of the university tradition that other members of staff, and representatives of the university management, participate in the funeral. The increase in the number of staff funerals is also becoming burdensome to the members of some university communities where there is a strong expectation that they will contribute financially to the costs associated with the period of mourning and burial.

University provisions for sick leave tend to be generous. A person infected with HIVHIV will normally continue to receive full benefits throughout the series of comparatively short illnesses that precede the diagnosis of full-blown AIDS. When a more extended period of leave is required because of the progression of the disease, this may cover several months, a year or more. Humanitarian considerations frequently deter block university administrators from adhering to

the strict contractual provisions regarding sick leave and terminating the benefits of an individual who will clearly pass away in the very near future. Moreover, as one of the studies noted, responsible officers may not report absence due to prolonged illness, precisely so that the affected individual may not lose salary or other benefits that have assumed greater importance than ever because of the illness.

No evidence is available from universities in seriously affected countries regarding the proportions of their budgets that are committed to salaries and benefits for sick members of staff. Companies that operate for a profit can usually generate this information, but universities, other educational institutions, government and non-profit organisations generally tend to deal with such losses in a less business-like manner.

Shoring up various areas of the university's operations, so that it can function in an HIV/AIDSHIV/AIDS environment, necessarily requires diverting resources from one purpose to another. This may entail the reallocation of financial resources (as when more must be spent on staff recruitment and training or on medical services), or of human resources (as when individuals are called upon, informally or officially, to help cover for an absent colleague). Each diversion of resources that has not been planned for means that finances or personnel must be depleted in some other area, with a consequent impact on the institution's efficiency. The reports speak consistently about the need to devote more resources to medical care on campus, but equally consistently about the inadequacy of any increases there may have been in this area.

- **SYSTEMIC COSTS**

Because much of their concern is with the impact of HIV/AIDSHIV/AIDS on students and university core operations, the case studies make only glancing references to issues such as staff morale, the ability of an academic or non-academic group to continue to work together as a team, AIDS-occasioned breakdown in routines, or reduced experience in the workforce. The University of Ghana refers to the possibility of HIV/AIDSHIV/AIDS "wiping out the reservoir of knowledge and expertise created over time." The University of Benin is concerned that "the virus could decimate the human resources of the institution." Other reports make reference to junior academics having to stand in for their sick or incapacitated seniors in both teaching and research areas. More frequently, however, it is the senior staff who must cover for courses or research undertakings that, because of morbidity or mortality, can no longer be undertaken by junior staff.

In most institutions, morale and motivation are at a low ebb. This is more for finance-related than for HIV/AIDSHIV/AIDS-related reasons (i.e., dissatisfaction with conditions of service, inadequate resources for teaching and research, insufficient medical supplies, poor state of facilities).

Impacts on Sources of Funding for Universities

Universities derive their income from government subventions, student support schemes, income-generating activities, private payments for fees, research and consultancy, donor agency funding, and investments. The HIV/AIDSHIV/AIDS pandemic threatens these sources of income. Public resources are under the double threat of not growing as rapidly as they otherwise would, and of being diverted to AIDS care. Financial allocations to the health sector need to be scaled up several times over if the resource requirements for AIDS care are to be met. For example, UNAIDS estimates that the additional investments needed to respond to the disease could consume 1.7 percent of GDP in Rwanda, 0.5 percent in Swaziland, and 1.4 percent in Zimbabwe (UNAIDS-UNECA 2000). In effect, the AIDS crisis means that, in their quest for public funds, universities will face even more constraints than

in the past.

The disease is also constraining income from private funds, with both families and industry controlling fewer disposable resources. The case studies brought out some ways in which this is already affecting universities. The very large student drop in enrollments that the University of the Western Cape experienced in 1999 on financial grounds (1,500 out of 9,000 students dropped out, 86.5 percent for financial reasons) may be indicative of the difficulties HIV/AIDSHIV/AIDS creates for families to pay fees. Other universities also refer to students who are unable to pay their fees because of AIDS in the family. In the 1999 academic year, 70 students requested financial assistance from the University of Zambia Students Union because they were orphaned (management tried to accommodate such students by allowing them to pay their fees in installments). At the University of Nairobi, at least 60 percent of the problem cases with which Student Advisors must deal are AIDS-related. Most of these are AIDS orphans who are not able to pay fees. A sinister outcome of this situation is the way it can drive some students into prostitution (heterosexual and homosexual), as they explore every avenue in search offor alternative means of financial support.

Many universities in Africa sustain a massive edifice of loan schemes and procedures —loans to staff for a variety of purposes, formal loan schemes to enable students meet their fees and costs, and more informal credit arrangements that allow for deferred payments. In the absence of suitable life insurance policies on which the university would have a claim, these various arrangements place an institution at high risk of loss through the premature death of the person benefiting from the loan or credit. Student loan schemes have always been difficult to manage and questions continue to be raised about their financial viability. With the possibility that 20 percent or more of students may die within a few years of graduating from university, these questions deserve ever more serious attention. The question of staff loans received passing attention in one of the case studies, but in general the likelihood of increased loan defaults due to AIDS was not considered.

The Impact on Teaching, Research and Service Activities

In universities, a larger incidence of morbidity and mortality occurs among the lower cadres of staff than among academic staff. This reflects the pattern across society. In South Africa, for instance, it is forecast that the HIVHIV infection rate will peak at 13.1 percent for highly skilled (including professional) workers, compared with 22.8 percent for the skilled and 32.8 percent for the semi-skilled and unskilled (Quattek 2000:.34). Annual AIDS-deaths are forecast to peak at 1.2 per 100 highly skilled workers, at 2.0 per 100 skilled workers, and 3.4 per 100 semi-skilled and unskilled workers.

Because of this pattern, one might think that HIV/AIDSHIV/AIDS is not disrupting actual university teaching to the same extent as it is disrupting other areas of university operations. However, it must be remembered that replacement of academic staff with post-graduate degrees is much more difficult and protracted than replacement of staff in lower cadres. Also, university teaching involves many highly specialised areas. It may be possible for other staff to move over and cover for a sick or deceased colleague in some general field. But they cannot easily do so when the loss is in an area where the affected member of staff is the only specialist. Such a loss affects present and future generations of students, because of the lengthy academic training that a replacement may need.

The case studies provide some evidence that, because of sickness or death, teaching programmes have had to be taken over by more junior and less experienced staff. There are no reports that HIV/AIDSHIV/AIDS has caused any teaching programmes to be abandoned. But clearly teaching activities are less than

satisfactory, especially in departments that have a large number of registered students. The complex situation faced by students whose lecturers are sick is well articulated by a female student from the University of Zambia (see Box 3).

Box 3. *Experience in a Course Taught by an Ailing Lecturer*

"The course really suffered and we couldn't blame him. We knew what was happening. He had lost a lot of weight and used to get infections and he wasn't motivated and it wasn't really his fault. So the course that he was teaching really suffered because we were left to our own resources. A lot of times he wouldn't come for lectures. We would feel really sorry for him and also that hindered us when we didn't agree with something he said in lectures. We couldn't bring ourselves to tell him because we knew he had personal depression. So we just left him. It was very depressing for us as well."

In many academic programmes, it is normal for students to undertake field trips or gather field experience, either during term or vacation periods. The demands that AIDS deaths and funerals have placed on limited university transport facilities have seriously affected universities' ability to provide field trips. For example, the University of Nairobi has found that the annual number of field trips decreased by half in the period 1995 - 2000.

Cases are reported where course attendance and submission of student work have been affected by student illness. This is not seen to be a major problem, since lecturers have been able to use their discretion to give the affected students extra time in which to submit their work. However, an untold number of students experience severe emotional problems when they learn that somebody in their family is suffering from HIV/AIDSHIV/AIDS. This knowledge makes it difficult for them to concentrate on their academic work.

Addressing this problem, the Association of Commonwealth Universities proposed in 1999 a set of policy guidelines for universities in Commonwealth countries. Among other provisions, these guidelines state "No student shall use his or her HIVHIV infection as a reason for failing to perform work, complete assignments, attend lectures or field trips or write examinations. Exceptions shall be considered only on professional medical and legal advice" (ACU 1999, D.8). This guideline may need to be revisited. It does not seem to take adequate account of the enormous emotional and psychological stress experienced by students personally infected by HIVHIV or affected by its presence in their families.

Research and consultancy activities appear to have been affected in much the same way as teaching. No instances have been reported of such activities being declined because of the sickness or death of staff have been reported. But evidence exists that less qualified staff have had to assume responsibilities, or that the more senior staff have had their workloads increased. On a more positive note, an increasing volume of research in AIDS-related areas seems to be coming to the universities, including the seminal work being undertaken jointly by the University of Nairobi and Oxford University on the development of a vaccine that would boost the body's immune system.

The Impact on the Social Life of Universities

The ACU draft policy guidelines make a discrete reference to the realities of social life on university campuses in their sections on rape, sexual abuse, drug use and violence, and again in the section on personal responsibility. These

policy statements are presented separately, although in almost the same form, for staff and students. For students, the guidelines read:

> *The university recognises the existence of rape, sexual abuse, drug use and violence on its campus(es) and makes every possible effort to curb these practices and to provide students with access, where relevant, to appropriate counseling and support. Particular attention is paid to providing advice about issues (medical, behavioural and legal) related to sexual harassment, sexually transmitted diseases, pregnancy and HIV infection and medication (ACU 1999, D.4, ii).*

The section on personal responsibility for students states:

> *Students shall be encouraged to recognise that they have a responsibility to play a role in responding to the HIV/AIDS epidemic and to develop a personal lifestyle in which they will not put themselves or others at risk of infection (ACU 1999, D.7, ii).*

The ADEA case studies paid considerable attention to this topic, but focused almost exclusively on the sexual behaviour of students. For understandable reasons (including time constraints), they did not address, other than in an incidental way, the sexual behaviour of staff. It is clear from the case studies that opening up this area leads to an enormous field of inquiry which they could deal with in only a limited fashion. Universities should be encouraged to undertake more concerted research in this area and to share their findings. This might lead to some consensus on how universities could help their student and staff members to "develop a personal lifestyle in which they will not put themselves or others at risk of infection."

On the basis of survey questionnaires and earlier research, the case studies characterised the campus situations as follows:

- The majority of campus students are sexually active, with a higher proportion of male than female students acknowledging that they are so. "To have a sexual partner is considered a prestige symbol among students" (University of Zambia).
- Students who are not sexually active made their decision to abstain long ago (before they arrived on campus?) and some of these decisions were informed by their religious beliefs.
- Because they encounter fewer restrictions, students who live on campus are more likely to be engaged in sexual activity than those who live off campus with relatives or friends.
- Sexual activity occurs steadily throughout a term/semester, but seems to increase with the approach of examinations, possibly because of closer student interactions at this time (University of Ghana).
- Sexual activity increases according to the academic year, being at its lowest for first year students and at its highest for final year students, but always with a higher proportion among male than among female students (University of Namibia).
- "The female students felt that about 10 percent of the female student population engages in sexual relationships because of poverty, peer pressures, or the need for emotional support and a sense of security" (Jomo Kenyatta University).

- Although there is extensive unprotected sexual behaviour (at times resulting in unwanted pregnancies), the use of condoms appears to be on the increase.

- Having more than one sexual partner is a status symbol—it is "cool" (University of Namibia).

- On campus, sexual relationships are generally neither steady nor monogamous. "Guys play a 'taste and go' approach" (University of the Western Cape). "Student relationships form and break up easily, with an average relationship lasting three to five months" (University of Benin). "… affairs are very common and the change in partners is very frequent within the small university community. Some call these 'seasonal friendships'" (University of Zambia).

- Senior male students find that it is easier and even "safer" for them to have relationships with junior female students. This is because they perceive their senior female counterparts as having been long enough at the university to have had other male partners (possibly from outside the university community) who put them at greater risk of HIVHIV infection (University of Nairobi).

- Senior male students no longer have enough money to spare on prostitutes and hence they divert their energies to less experienced and unsuspecting junior female students (University of Nairobi). On the other hand, "young females do not enjoy relationships with their age-mates because they consider them immature" (Jomo Kenyatta University).

In addition to these activities, which are nearly all "in-house," university students engage in considerable sexual activity with outsiders:

- The "sugar daddy" syndrome, in which comparatively well-off older men from off-campus pay special attention to female students, occurs universally. The "sugar mummy" syndrome, in which older women pay attention to younger male students, also occurs but does not seem to be very widespread.

- Male students patronise off-campus commercial sex workers and sometimes bring them into student residences (in student language, they introduce a "collection" or an "import").

- Some female students engage in commercial sex work. For some, the motivation is to raise money to pay for their fees or support their families. For others, it is to live in a good lifestyle and display symbols of status (such as a cell-phone).

The reports on the social life of students on campus 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. These concerns have been well articulated in research conducted at the University of Botswana:

> *The female students pointed out that females do not have as much power over sexual issues as men and they struggle in efforts to convince their men about what is right. Females repeated their concern with the pressures placed on them by parents and society to marry and bear children, and the acceptable cultural practice which encourages older men to have sexual relations with younger women. They felt that women need empowerment and legal protection due to the abuses that they often suffer* (Odirile 2000).

Gender violence was addressed by only one report, that from the University of the Western Cape. Violence against women is endemic in South African society, with a rape case occurring on average every 23 seconds. In other countries the problem exists, but not on so large a scale. Much more common is "consensual rape" where, because of her lack of empowerment, the female partner unwillingly consents to intercourse in order to preserve a relationship, avoid a beating, ensure financial support, or repay favours. Unfortunately, violence of this nature occurs in every society and hence at every university. The case studies suggest that the climate on university campuses tends to be such that consensual rape frequently occurs. Female students, workers, and members of staff risk being treated more as commodities than as persons. They may have experienced in their own lives what was well expressed by a student (male) from the University of the Western Cape:

> *There are many guys who force women to have sex with them. Women tend to refuse but finally let guys sleep with them and never report these cases.*

Universities as High-Risk Institutions

UNAIDS has listed the behavioural and social factors which play a role in kick-starting a sexually-transmitted HIVHIV epidemic or driving it to higher levels:

- Large proportion of the adult population with multiple partners
- Overlapping, as opposed to serial, sexual partnerships
- Large sexual networks
- "Age mixing", typically between older men and younger women
- Little or no condom use
- Women's economic dependence on marriage or prostitution, robbing them of control over the circumstances or safety of sex (UNAIDS December 2000:8).

Evidence from the case studies indicates that almost every one of these factors manifests itself to a greater or lesser degree in the sexual behaviour of students on university campuses. The prevailing "culture" of university campuses — the unspoken assumption that "this is the way things happen here, these patterns of behaviour are acceptable in our circumstances" — appears to be ambivalent about, or even open to, sugar daddy practices, sexual experimentation, prostitution on campus, unprotected casual sex, gender violence, multiple partners, and similar high-risk activities. But in the context of HIV/AIDS within student communities today, such a culture may well be become a culture of death. In a setting of HIV/AIDS prevalence, the university culture stands in danger of affirming risk more than safety. It is in danger of affirming death more than life.

In other words, a university is a high-risk institution for the transmission of HIVHIV. "The assumption we have to work from is that residential university students are a high-risk population"(Chetty 2000:3). The entire university community - but especially the university management - needs to face this squarely. They should also recognise that certain other practices may heighten the risk of HIVHIV infection. For instance, the requirement that students undertake field trips or gather field experience, either during term or vacation periods, generally results in their being away from their normal surroundings, being required to make their own accommodation arrangements, and having some money readily available — a combination of factors that increase the likelihood that an individual will engage in sexual activity, possibly with lethal consequences.

Universities need to consider all these factors and be willing to make necessary changes. Modifying a university culture and social behaviour so that they affirm

life more strongly than death, safety more than risk, is not easy. It cannot be done from the top alone, but needs the involvement of individuals all down the line, including the very important constituency formed by the students and their union. But without some leadership, inspiration and guidance from the top it is unlikely that other parties will initiate efforts for a change in this direction. In the present situation, what is really needed is a shared inner awareness, deriving from personal realisation, that with AIDS it can no longer be "business as usual." Circumstances are now so different that there is need, even in a university, to tighten up cultural and behavioural norms, and to re-examine certain practices, which in AIDS-free circumstances would not give rise to such concern.

Chapter 5

University Responses to the HIV/AIDS Crisis

Evidence from the wider education scene in Eastern and Southern Africa suggests that the education sector faces considerable disarray, inadequate understanding and piecemeal response in its attempts to manage the impacts of HIV/AIDSHIV/AIDS. The sector appears to be responding to the demands of the disease almost randomly. It has some projects, but few programmes. It is going in all directions at once (UNECA 2000: iii).

The messages coming from the case studies are very much along the same lines. At some risk of simplification, it can be said that the studies point to the following response dimensions (some of these have already been touched on and some will be further elaborated upon in the following chapter):

General Characteristics

- The most striking feature of the university response to HIV/AIDSHIV/AIDS is what can only be described as an awe-inspiring silence that surrounds the disease atthe institutional, academic and personal levels. Notwithstanding a

few isolated initiatives, individuals, the institutions and their groupings carry on, for all practical purposes, as if the disease did not exist.

- In their response to HIV/AIDSHIV/AIDS, universities display characteristics similar to those shown by their parent education systems: considerable uncertainty, limited understanding, failure to attend to systemic impacts, lack of coordination, absence of well-developed action plans, minimal policy framework, and heavy reliance on the initiative of a few interested and committed members of staff.

- Responding to the HIV/AIDSHIV/AIDS situation in universities and in society has not generated the passionate commitment that universities and university students have historically manifested in other struggles dedicated to university, liberation, and social causes.

Policy Development and Leadership

- Universities are notionally aware that they should be concerned about HIV/AIDSHIV/AIDS and its impacts, but they are not translating this notional awareness into any form of meaningful action plan.

- Only one institution has developed formal policy guidelines on HIV/AIDSHIV/AIDS and one other has set itself seriously to work on the development of an institutional policy. To date, none of the others appears to have made progress in adapting the policy framework proposed by the ACU or in developing their own policy statement.

- Success in overcoming HIV/AIDSHIV/AIDS in a university demands exceptional personal, moral, political and social commitment on the part of the top university executives. Where such leadership has been provided, there has been success. In general, however, manifestations of such top-level commitment have been limited.

- University leadership needs to galvanise staff and students to look beyond individual concerns and to articulate and act upon systemic HIV/AIDSHIV/AIDS-related issues.

- University leadership tends to be confined to isolated expressions of concern about HIV/AIDSHIV/AIDS, during student orientation and at other times, but does not sufficiently extend to follow-through action by accountable individuals.

- The prime responsibility for mainstreaming HIV/AIDSHIV/AIDS into all of the university's operations, but in particular into its teaching, research and service functions, rests with the senior university executives and their officers. In the absence of such stimulation and leadership, the efforts of staff and students remain uncoordinated and — usually — un-resourced. Moreover, because they are vested in individuals, such efforts lack sustainability.

Organisational Structures, Planning and Programming

- Considerable passing of responsibility — from university councils to senates, to faculties or schools, to departments — takes place, but no concerted university action or strategy emerges from this cycle. HIV/AIDSHIV/AIDS is appears to be everybody's responsibility, but nobody's concern.

- The supreme university bodies tend to remain satisfied with appropriate statements about HIV/AIDSHIV/AIDS, but do not follow these with steps that convert these statements into action.

- University-wide structures for coordinating and implementing the institution's response to the disease are the exception rather than the rule.

- With one exemplary exception, no budget for the implementation of any AIDS-related plans has been provided within the universities studied.

- Specific information on AIDS impact on the university is almost completely lacking. Records are poor and are poorly maintained. Almost none of them (even in health clinics) mention HIV/AIDSHIV/AIDS.

The Institutional Response

- Although they show considerable concern for the needs of individuals, universities have undertaken virtually no institutional response to HIV/AIDSHIV/AIDS. Even within the few institutions that have begun to consider more systematic initiatives, there is generally no recognition that the response must be as wide as the university itself and must include all its members and all its departments.

- Universities tend to leave responsibility for HIV/AIDSHIV/AIDS initiatives to interested individuals and groups, but seldom seek to build these into a coordinated institutional response. This results in piecemeal, fragmentary interventions that can be sustained only as long as the interest or presence of the individual or group is assured. It also produces patchy coverage of the problem.

- In so far as they take action, universities seem to focus their concern almost entirely on prevention of HIVHIV infection and on the immediate treatment of illnesses. Occasionally they give some, but not much, attention to counseling. But they do little to address the growing needs for care (in the workplace, in clinics, in homes—especially homes located on campus) or for anti-retroviral therapy. They have yet to discover the need for impact management, or for developing the capacity to manage the disease through proactive, forward-looking measures.

- The majority of university responses seem limited to medical issues that can be dealt with at the level of their clinics and health centres.

- Current provisions for the counseling required in an HIVHIV situation are grossly inadequate, with few if any staff receiving the professional preparation needed to effectively provide this kind of counseling.

- Much of university attention focuses on HIV/AIDSHIV/AIDS within the student population.

- Notwithstanding severe impacts on academic and non-academic staff, workplace education programmes for the protection of these staff or workplace provision for their HIV/AIDSHIV/AIDS needs (such as VCT, worker-friendly health services, condom supply, rest rooms) have yet to be developed.

- Despite the potential for AIDS to exert a substantial negative financial impact on the university, this risk does not seem to be taken into account in the course of financial management or financial planning.

- Considerable AIDS-related disturbance or turbulence is taking place in some of the universities, with high levels of staff morbidity, absenteeism and mortality. But the institution's governing bodies have not recognised that this could be a growing phenomenon that may eventually undermine the university's ability to provide its mandated services.

- Attention to HIV/AIDSHIV/AIDS has not yet been mainstreamed into university management. Specifically, there is no indication of any change in what may constitute high-risk management arrangements, such as assignments that may entail substantial periods of separation from a spouse or virtually unsupervised student hostel arrangements.

- No evidence has been found that every university is universities are taking steps to reduce the infection risks experienced by personnel in medical and dental departments, or to establish procedures for dealing with post-exposure situations.

The Teaching and Research Response

- Although AIDS has been prevalent in the region for more than a decade, no substantive changes in university academic policies or practices have been introduced in response to the disease.

- Although some institutions have made provision for the inclusion of HIV/AIDSHIV/AIDS in some aspects of the curriculum, HIV/AIDSHIV/AIDS concerns and content have not yet been mainstreamed into the teaching programmes of universities.

- Good HIV/AIDSHIV/AIDS-related research work and publications are emerging from some institutions, but this is not always well-disseminated, even within institutions.

- Universities could capitalise even more on the potential HIV/AIDSHIV/AIDS provides for research that is significant for the well-being of society. They could also be less fatalistic in their AIDS-related research.

- No university appears to be giving thought to its responsibility to build up the professional expertise and skills which are being run down in society because of AIDS, that is, to increase its graduate numbers to meet the growing demands in certain professional areas (in particular for more health, counseling and education personnel), or to teach in new areas cast up by the epidemic. There is no evidence that universities recognise a responsibility to respond to the new and special knowledge needs of an AIDS-controlled society.

- Knowledge about HIV/AIDSHIV/AIDS is far from perfect, even among academic staff, some of whom say they do not know enough to be able to incorporate the topic into their courses.

The Institutional Climate

- Persons who are believed to have AIDS may experience a considerable amount of stigma and discrimination. Sometimes this is these are overt, but most often it takes they take subtle and veiled forms. However, as the disease progresses, compassion and understanding tend to replace stigma and discrimination.

- Concern about ostracisation and the belief that the university will do

little to help them have impeded persons living with HIV/AIDSHIV/AIDS from coming out into the open about their status and forming associations that would promote their interests and contribute to stemming the disease.

- Students appear to have reasonable levels of knowledge about the disease. Most of this knowledge has come from the media or was obtained while at secondary school, but some learned much of what they know about HIV/AIDSHIV/AIDS from university sources.

- Student knowledge about the disease is not leading, on the scale that is required, to desirable behaviour change.

- High risk sexual behaviour is an accepted feature in the life and culture of students on university campuses. Personal knowledge about the risks of such behaviour is not yet leading to changes in the cultures that support this behaviour.

- The climate on university campuses tends to be such that consensual rape frequently occurs. Female students, workers, and members of staff risk being treated more as commodities than as persons.

- Although there are sporadic efforts at student activism (through clubs and societies) aimed at preventing the spread of HIVHIV, the initiatives tend to be half-hearted and may not be sustained.

- As with students, so with institutions: institutional knowledge about HIV/AIDSHIV/AIDS is not leading to institutional change.

The Costs of Delay

- Universities are in danger of repeating the mistakes that their respective countries have also made in dealing with HIV/AIDSHIV/AIDS:

    - under-estimating its potential to destroy systems;

    - being lulled into complacency and inaction by the external signs of apparently healthy individuals and currently functioning systems;

    - treating the disease as essentially a health issue;

    - not showing the requisite sense of urgency;

    - giving urgent, but short-term, financial problems higher priority than dealing with a disease situation that has potential to undermine everything that the institution strives to accomplish;

    - failing to build up the necessary capacity for managing the impacts of the disease;

    - acting as if enough were being done when individuals or groups initiate responses and activities, but without seeking to establish these on a coordinated institutional basis or to build them into an institutional framework.

- Universities are also in danger of allowing HIV/AIDSHIV/AIDS on campus to remain enshrouded in a cloak of silence, secrecy and shame that constrains efforts to limit its further spread and respond to its challenges.

- Above all, universities are in danger of failing to show the wholehearted and exceptional personal, moral, political and social leadership commitment that is needed for overcoming HIV/AIDSHIV/AIDS.
- The costs of these shortcomings will be manifested in time wasted and lives lost.

Chapter 6

HIV/AIDS in Relation to Curriculum, Research, and Policy Development within a University

Adapting the University Curriculum in Response to HIV/AIDS

In the absence of university policies, the inclusion of HIV/AIDSHIV/AIDS in teaching programmes depends greatly on the initiatives coming from individuals or departments. For the greater part, this work is being undertaken at the grassroots, without any particular support from the top. As a result, it tends to have a piecemeal quality and to be inadequate in coverage (in relation both to content and to student participation). An general exception occurs in medical and health-science programmes. These usually require that all students participate in courses that cover all aspects of the disease, though the focus may be largely on its medical and clinical aspects.

Other departments may integrate relevant aspects of the problem at appropriate points in their programmes. The case studies report that this is being done in

such areas as Administration, Biological Sciences, Education, Ethics, Geography, Gender Studies, Law, Microbiology, Psychology and Sociology. The strength of these efforts is the way they amalgamate AIDS-relevant issues with strictly professional concerns. HIV/AIDSHIV/AIDS is presented as a professional matter within the relevant disciplinary area. The purpose is to prepare participating students to address the HIV/AIDSHIV/AIDS issues that they will encounter in their professional lives after graduation. The goal is to develop AIDS-educated and AIDS-competent graduates who will be adequately qualified to carry AIDS concerns into their subsequent life, to address AIDS issues in their professions, and to bring AIDS into the open within their societies soceities.

This purpose differs significantly from that of information and orientation programmes that seek to inform students about HIV/AIDSHIV/AIDS, largely with a view to promoting the understanding that will bring about personal behaviour change. Although some of the case studies suggest the existence of such AIDS-awareness programmes in universities, these may have minimum value (a point that the information about student social life on campus seems to confirm). HIV/AIDSHIV/AIDS orientation courses for large numbers of students may have some value in communicating factual information and/or correcting misconceptions. However, the determinants of human behaviour are too complex and are too closely intertwined with affective issues for such courses (which tend to be mainly cognitive and factual) to result in large-scale behaviour change. A problem of 'AIDS fatigue' is also appearing. The majority of new entrants to universities already know a great deal about the disease. Many will tend to resist what they might consider as over-kill or even indoctrination.

In a university setting, a more appropriate development course would seem to be to follow the emerging example of some of the case study universities, namely to integrate relevant HIV/AIDSHIV/AIDS concerns into all teaching programmes and courses, underlining their relevance to subsequent professional life. This mainstreaming should not be confined to the formal learning situations of lecture halls and laboratories, but should extend to all aspects of university programmes, including the field-work, practical attachments, and research investigations that are integral to most of them. So that these efforts will not degenerate into a series of uncoordinated and department- or person-specific initiatives, it will be necessary for university senates to mandate this mainstreaming, to monitor its implementation and to ensure accountability in its regard.

Responding to AIDS-Created Professional Needs in Society

The case studies concerned themselves almost entirely with integrating HIV/AIDSHIV/AIDS into university teaching programmes. They did not address issues of enlarging student intake into these programmes or establishing new ones. Both strategies are important for universities in Africa.

Universities are duty-bound to respond to the needs of their societies. Because of AIDS, societies in Africa are losing skilled and professional individuals whom they have spent years in developing. Because of the way the epidemic has developed, a positive relationship often exists between prevalence rates and level of education or training. Although this situation may be changing (Vandemoortele and Delamonica 2000), it remains true that considerable losses are occurring among teachers, college lecturers, doctors, other health-care workers, engineers, business managers, and senior civil servants.

Universities in seriously affected countries need to keep their finger on the national pulse, to assess what is happening in these and similar areas and to adjust their student numbers accordingly. While the essential mandate of a university extends beyond the task of developing skilled human resources, the

responsibility remains to do something about replenishing the national stocks of skilled and qualified individuals whose numbers are being depleted by AIDS. The mining industry in South Africa, which now trains four drillers for every post available, has faced up to this challenge. The education policy for Swaziland also seems to be coming to grips with a similar problem as the education ministry steels itself to train twice as many teachers as usual over the coming two decades, just to keep services at their current levels (Swaziland 1999:50). Responding to such a situation requires a massive adjustment by teacher education institutions, not only in the size of their programmes, but also in the way these are timed and very likely in the manner in which they are structured and offered. Universities should be adopting similar approaches.

Universities will also have to adjust to the way that HIV/AIDSHIV/AIDS will change the demand for certain services. It has already been noted that by 2010 the demand for health services in South Africa could be more than 11 percent higher than in a no-AIDS scenario (Quattek 2000:41). This implies an almost immediate start on enlarging enrolments so that programmes can gradually get up to speed. No other work seems to have been done in this area, but that in itself suggests what constitutes a legitimate contribution for universities in Africa should be doing. They could devote some of their expertise to investigating the human resource needs which AIDS will create in the medical, counseling and other areas in their countries and then ensure that their programmes are adequate to respond to these needs.

Two other aspects of a university's curriculum and training response to HIV/AIDSHIV/AIDS imperatives are important. One is the way the loss of qualified personnel throughout society is making it necessary for others to move over sideways and take over the responsibilities of departed colleagues. There is no guarantee, though, that they possess the skills or expertise needed to do so. This points to the desirability of ensuring greater flexibility in graduates so that they can more readily assume responsibilities at the margins of their strictly professional areas. The narrow academic preparation of graduates was never a good thing, but it is even less so in an AIDS-dominated society. This is very easily seen in the teaching profession. A secondary school teacher competent in only one teaching subject is of much less value to an AIDS-stricken school community than one who in addition to the major subject possesses one or more minors. Perhaps, more then ever before, universities should concentrate in their undergraduate programmes on ensuring that students master the skills of learning — in the jargon, that they learn how to learn — so that they will be flexible, adaptable and, hopefully, innovative in response to today's fast-changing and unpredictable AIDS world.

The second point concerns the introduction of new areas of study and research. The growth of the AIDS epidemic will surely demand professionals in areas not yet adequately covered in universities. One thinks, for instance, of the sciences of death (thanatology) and suffering, micro-credit, sexuality, risk-taking, theology, and the abiding need for an expanded integration of the human rights and ethical dimensions into almost every teaching and research programme. University executivesadministrators in Africa may protest that they have a hard enough time just to keep their institutions running, without having to consider innovations and developments along these lines. But unless some of these matters are considered, the universities may find that they are not running along the right track. It cannot be stressed too often that with AIDS it cannot be business as usual. The relevance and survival of universities in Africa depends very heavily on their being able to adjust to the imperatives of the disease in all facets of their operations.

AIDS-Related Research, Publications and Public Service

Since the publication in 1982 by the School of Medicine, University of Zambia, of

some of the first documented cases of AIDS in Africa, the case study universities have maintained quite a steady output of research on HIV/AIDSHIV/AIDS. This has added considerably to the international understanding of the disease. The research covers all areas — scientific, medical, social and communication — and frequently extends to include community outreach and advisory/consultancy activities. Much of it is institutionalised, as exemplified by the Public Health Programme at the University of the Western Cape, the Noguchi Memorial Institute for Medical Research at the University of Ghana, and the Institute for Economic and Social Research at the University of Zambia. Some has received international acclaim, as for instance, the international cooperation between the University of Nairobi and Oxford University in the development of an AIDS vaccine.

In many of the universities, postgraduate students are increasingly investigating HIV/AIDSHIV/AIDS-related issues as part of their Masters and Doctoral programmes, while undergraduate students are encouraged to conduct mini-research and write short term papers in these areas as part of their academic programmes.

Findings from the research and consultancy services that have been undertaken have been shared at various in-country meetings and at numerous regional and international conferences. Personnel from universities in Africa, including several from the case study universities, played a prominent role at the XIth International Conference on AIDS in Africa (ICASA) held in Lusaka in September 1999, at the XIIIth International AIDS Conference held in Durban in July 2000, and at the Africa Development Forum 2000, held in Addis Ababa in December 2000. This is as it should be: African researchers bringing to the international community the findings of African research on a problem that haunts Africa.

A further outcome of university research has been staff involvement in the development of strategic frameworks and national policies, the conduct of workshops and training programmes for government departments, and the provision of support for non-governmental organisations. This involvement has led to rueful remarks from some university personnel about the contrast between the extensive assistance they provide to help various organisations to launch their HIV/AIDSHIV/AIDS programmes and the limited requests for similar assistance they receive from their own institutions.

It is clear from the case studies that impressive and significant HIV/AIDSHIV/AIDS-related research is already being conducted and that important professional advisory services are being provided. But it is equally clear that information on such research and services is not well shared within or between universities. The University of the Western Cape has recently established a data-base covering its AIDS-related teaching, research and publications. It would be valuable if something similar were developed at every institution. This would enable staff to know about institutional activities in this area, but even more importantly, to enable the universities to draw upon this storehouse of information for the development of programmes, strategies and activities that would mainstream HIV/AIDSHIV/AIDS into every aspect of their operations.

Subsequent sharing of this data-base with other institutions in the region should logically follow. This could be effected through the Commonwealth Knowledge Network which the ACU is establishing or through a purposeful initiative either of the Association of African Universities or of the ADEA Working Group on Higher Education.

The University of Namibia has established a special fund for research related to HIV/AIDSHIV/AIDS. This is something that could be emulated by other universities in the region. A common complaint from many institutions is that the university does not provide adequate funding for research. But in the area of HIV/AIDSHIV/AIDS it is likely to be different, with resources becoming available

through national HIV/AIDSHIV/AIDS governing councils and the International Partnership against AIDS in Africa (IPAA). The need is for the institutions to develop a research and action plan for HIV/AIDSHIV/AIDS, armed with which the university leadership must seek to mobilise the necessary funds.

Governments and the international community recognise that the cross-cutting and multidimensional nature of the HIV/AIDSHIV/AIDS epidemic needs a broad and multisectoral response. Elements of this approach must likewise characterise university HIV/AIDSHIV/AIDS research. While each discipline must respect its own research canons, the university should seek to ensure that some element of multidisciplinarity and collaboration characterise the research. HIV/AIDSHIV/AIDS is not just a medical problem. Neither is it just a scientific problem. It is a multidimensional human problem that cannot be adequately addressed unless it is put under the combined spotlights of several disciplines. The University of Ghana has recognised the need for closer collaboration between medical and social scientists and the importance of moving research closer to the community and the public. A university that is guided by such principles would seem to be on the right track. In addition, such a university would very likely find it easier to attract external resources for its HIV/AIDSHIV/AIDS research.

But something more is required of universities. Clearly they must confront the major challenge of extending knowledge about the scientific, physiological and bio-medical aspects of HIV and the course of infection. Equally they must respond to the need for extensive new insights in all the human and social sciences. Indeed, virtually every area of the university lends itself to investigations about HIV/AIDSHIV/AIDS and its impacts. But it would be limiting if research in Africa, the continent worst affected by the epidemic, were simply to be driven by the disease, reacting to it and seeking to understand its impacts subsequent to their occurrence. A more pro-active approach is necessary. Africa's best minds must be brought to bear on how the disease and its impacts can be circumvented, on how to get ahead of it on every front — from vaccine development through therapy to forestalling social and economic impacts, to developing institutions so that they become intrinsically immune, to positive incorporation of the realities of healthy sexuality, death and the symbolism of blood into people's lives, thinking and language.

The mind-set of research cadres in universities needs to enshrine a determination to research their way ahead of the disease. They should not allow HIV/AIDSHIV/AIDS to dictate the pace of events or the scope of their investigations. Instead, the approach should be to lay down the law to the disease.

University Frameworks for Coping with HIV/AIDS

The quotations in Box 4 demonstrate considerable variation among universities in their preparedness to deal with HIV/AIDSHIV/AIDS. Although several of the institutions recognise the desirability of developing institutional policies or frameworks, the majority have not

yet done much about this. The picture is somewhat less bleak in South Africa where four universities had put institutional policies in place by October 2000, and ten had them in draft form - although seven more had not progressed this far (Chetty 2000:cf. Appendix 1).

Box 4. *Variations in University State of Readiness*

"The response of the university to HIV/AIDSHIV/AIDS is one of denial, manifested in the near absence of any omnibus activity or programme on the disease on campus overtly managed and supported from the top" (University of Ghana).

"I think HIV/AIDSHIV/AIDS will be devastating. But the campus is completely unprepared" (Academic Vice-Rector, University of the Western Cape).

"The University of Zambia has not integrated HIV/AIDSHIV/AIDS into its plans" (University of Zambia).

"Despite the potential (of its human resources), the University has given no place to HIV/AIDSHIV/AIDS in its strategic or institutional planning" (University of Benin).

"The University of Namibia developed policy guidelines on HIV/AIDSHIV/AIDS which were approved by Senate and Council in 1997. The thrust of the guidelines is directed at prevention of HIVHIV transmission and the needs of those persons who have HIVHIV or AIDS" (University of Namibia).

The consensus reached at the ACU meeting in November 1999 brought out clearly that universities should make more concrete arrangements for the management and control of HIV/AIDSHIV/AIDS. In addition, the policy direction should be forward-looking, propelling the institution to be several steps ahead of the disease. It should look beyond containing and controlling HIV/AIDSHIV/AIDS to overcoming and vanquishing it. A policy that confines itself to little more than a "status quo" response, directed primarily at prevention, counseling and information dissemination, may meet with only limited success, leaving the university involved in an interminable rearguard action against the disease.

The gaps identified by the case studies, and the weaknesses with systems already established, point to three features that should characterise the university response to the epidemic:

- committed leadership;
- clear targets; and
- a strategic approach.

- **LEADERSHIP**

The important role of leadership cannot be over-emphasised. It is relevant that the theme for the recently concluded Africa Development Forum 2000 was "AIDS: The Greatest Leadership Challenge." The Forum recognised that combating HIV/AIDSHIV/AIDS requires even more commitment, vision and leadership than fighting a war of independence. The case studies make it very clear that university leadership does make a difference. Where strong, sustained leadership is provided, success follows. In the absence of such leadership, efforts flag.

Thus, the first needs for a university's response to HIV/AIDSHIV/AIDS are for:

- dynamic, sustained, publicly manifested, resource-backed and action-backed leadership from the university's most senior executives at the highest level;

- a widespread diffusion of this leadership function, expressed in the involvement, support, backing and commitment of senior university personnel at every level —academic, professional, administrative, technical, and support services (including student leadership and units providing student services);

- openness about the disease, its prevalence and its impacts in all

departments and at every level of university operations;

- a sense of urgency and crisis that judiciously combines the development of strategic understanding and planning with the need to take immediate action to reduce prevention, provide care for the infected and affected, and mitigate impacts — and thereby to save lives.

Universities must also take note of the universally accepted position that no campaign to address the challenge of HIV/AIDSHIV/AIDS can possibly succeed without the full participation of those who experience the disease and must live with it (PLAs). Consequently, university leadership must make a special effort to enable PLAs on their campuses to be open about their status, to establish their own groups and networks, and to participate fully in the development and implementation of AIDS-related university policies.

- **TARGETS**

Since universities are at the service of the wider society, targets for university action should reflect those for national and international action. At the national level, these targets must be derived from the guidelines proposed by the supreme HIV/AIDSHIV/AIDS authority in a country. In other words, university policy must be informed by national policy and be consistent with it. Some universities are fortunate in that members of their staff are also members of such national authorities. In these cases, the institutions can draw upon this dual role to ensure that university and national policies are well aligned. In other situations, university staff can make a similar contribution through their membership in technical committees that service national HIV/AIDSHIV/AIDS bodies.

In formulating its HIV/AIDSHIV/AIDS policy, a university should also be guided by the international development targets set by the United Nations. Because these targets were formulated at the United Nations General Assembly Special Session held in June 1999 to assess progress five years after the International Conference on Population and Development (ICPD) held in Cairo in1994, they are known as the ICPD+5 targets. They are of particular relevance to a university (and also to school systems) because they relate to persons between the ages of 15 and 24. They state:

> *Governments with the assistance from UNAIDS and donors should, by 2005, ensure that at least 90 percent, and by 2010 at least 95 percent, of young men and women aged 15-24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as male and female condoms, voluntary testing, counseling and follow-up.*
>
> *Governments should use, as a benchmark indicator, HIV infection rates in persons 15-24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 percent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 percent* (UNAIDS May 2000).

Universities should ensure that their policies incorporate the first ICPD+5 target, relating as it does to information, education and services necessary to reduce disease transmission. This will require an expanded response across institutions, but without neglect of either workplace provisions for those who are older or management actions to control, mitigate and pre-empt the impacts of the disease. The virtual absence of AIDS testing and the need to preserve confidentiality make provision for the second ICPD+5 target difficult for universities. But at the very least they should be aware of this target when

formulating their policies and drawing up their plans.

- **STRATEGIC APPROACH**

Although universities have long been committed to the development of strategic plans, they are not all conversant with the process for developing a strategic framework for responding to HIV/AIDSHIV/AIDS on campus. Basically this comprises six steps:

1. Produce an An analysis that develops the context and causes for the HIV/AIDSHIV/AIDS situation at the university. This would be similar to the analysis presented in some of the case studies.

2. Develop an An analysis of the response the university is making to the disease within its own social, cultural and economic framework. The case studies have also addressed this area.

3. Formulate broad principles that will guide the university's response during the planning period — such as respect for human rights, university-wide ownership of strategies and solutions, the ICPD+5 principle that all students have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, the promotion of female empowerment, the involvement of persons living with HIV/AIDS, or the need for an implementation team.

4. Decide on priority areas and strategic goals for the university response, e.g., promoting behaviour change, preventing and controlling STDs, increasing voluntary counseling and testing, reducing casual sexual activity on campus.

5. Develop a series of steps or strategies for reaching the priority objectives, e.g., find ways of promoting peer-to-peer HIV/AIDSHIV/AIDS education, work towards more student-friendly and better resourced STD-related health services, design workplace HIV/AIDSHIV/AIDS education and support systems. This stage also includes some identification of the human, financial and material resources needed for taking the identified steps.

6. Determine the institutional framework (committee, special unit, etc.) best suited to ensure the implementation of the strategies and to establish the evaluation procedures that will monitor whether the plan is being implemented and goals are being attained.

Implementing an institution-wide HIV/AIDSHIV/AIDS programme will require commitment, people, skills, materials and funds. The university's senior executives, in conjunction with university governing bodies and senates, have the responsibility to ensure the availability of these. In many respects, assuring resources can be the best index of university commitment to responding dynamically to the HIV/AIDSHIV/AIDS crisis.

Two words of caution should be registered here. One is that the development of a policy and strategic framework is only the beginning, not the end of the process of managing HIV/AIDSHIV/AIDS at the university. In the final analysis what is needed is action and not just plans. The second is that the process of policy or plan development should not become bogged down in the traditionally cumbersome processes of university decision-making. HIV/AIDSHIV/AIDS is a matter of life and death - for individuals, for institutions and for systems. Dealing with it will always require a sense of urgency.

Chapter 7

Towards a Comprehensive University Response to HIV/AIDS

The case studies brought together in the preceding pages have outlined the critical HIV/AIDSHIV/AIDS situation within a number of universities in Africa. They show that, though muted, the situation is bad. They suggest that, by and large, universities have not responded adequately to the challenges posed by the disease. The studies recognise that in countries with low overall adult prevalence rates, the full impacts of the disease may not yet have been felt. In such countries, universities may be only experiencing just the iceberg tip of an epidemic-in-the-making (e.g., University of Benin). But the reports stress that in every country and in every institution there is need for energetic measures, for more self-assessment that will prevent some institutions from going off course and will bring others back on track.

The reports would be in essential agreement with the University of the Western Cape's view that with their cumbersome bureaucracies, storm-in-a-teapot internal misunderstandings, and difficulties in communications, universities tend to be a microcosm of the society in which they are embedded and which they serve. Stated in other words, a university's lack of single-minded engagement with the challenge of HIV/AIDSHIV/AIDS is a reflection of a similar lack within the country. Like their respective countries, universities are getting some things right in relation to HIV/AIDSHIV/AIDS. But equally they are getting many things wrong.

What they are getting right is the mounting concern they show about the disease and the actions they are beginning to take. The majority have begun to take steps in the right direction. But for the most part these are the steps of individuals within the institutions and, as such, do not yet constitute an institutional

response. Nevertheless they are positive steps. But to elaborate on a metaphor used by the University of the Western Cape, while some universities have left the starting blocks in terms of their response to the epidemic, others are still positioning themselves for take-off, and still others have not yet got themselves lined up. But for all of them, a coordinated strategy seems to be conspicuously absent, with the result that the actors are running off in all directions. This seems to be the essential weakness of the university response to the disease.

The strength of the university response is the commitment of individuals, the preparedness of many to be involved if they are given direction, and the wealth of knowledge and expertise in all institutions that is already engaged in responding to the epidemic.

A Lesson from Industry

Universities have much to learn from industry's response to the HIV/AIDSHIV/AIDS crisis. Figure 1 sets out the essential ingredients of a comprehensive HIV-prevention programme that was designed by the giant South African industrial group from Southern Africa, Anglo-American. The group's operations are regularly monitored to evaluate progress in adhering to this programme. In similar vein, universities should ensure that they have a comprehensive HIV/AIDSHIV/AIDS programme in place and that, on a regular basis, they monitor adherence to it.

Figure 1

Key Elements Essential to a Comprehensive HIV-Prevention Programme

The first requirement is Total Management Commitment

This 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

Source: Derived from Whiteside and Sunter 2000:104.

This programme stresses the vital role that top executives play in providing the necessary leadership. The university's senior management must unceasingly inspire the programme and ensure that it does not falter. The message from the case studies is clear: leadership counts. Where it is present, something worthwhile occurs. Where it is absent, responses are piecemeal, uncoordinated, and often not sustained.

Universities should find almost all of the elements in Figure 1 relevant

appropriate to their situation. Special note should be taken of the second item, developing culturally appropriate prevention messages. What is at stake here is being responsive to the interaction of the many cultures that are to be found on a university campus — national cultures, traditional cultures, academic cultures, youth cultures, university student cultures. Many educational programmes fail because they are too simplistically cognitive and neglect the world outlook, paradigms, and pressures that arise from these various cultures.

The Way Forward

But even more is needed for a comprehensive university response. The Anglo-American programme provides useful guidelines for preventative preventive initiatives. Universities must go further than this. Universities exist to serve the real needs of their societies through the generation, selection, adaptation, transmission and preservation of knowledge, and the stimulation of intellectual life and cultural development. They must be conscious of this mission in their approach to HIV/AIDSHIV/AIDS.

The HIV/AIDSHIV/AIDS interventions of universities that remain alert to this mission must comprise both inward-looking and outward-looking dimensions. The Commonwealth Deputy Secretary General, Dame Veronica Sutherland, highlighted these two aspects in November 1999 when she posed two questions for consideration by the ACU Symposium:

1. How can Commonwealth universities develop policies and practices that will help reduce the transmission of HIV/AIDSHIV/AIDS among students and staff?

2. What contributions can the Commonwealth universities make that will help their communities and countries reduce transmission rates, and cope with those already infected by the virus?

The inward-looking dimension reflects the concern a university should have to sustain itself as a functioning institution when it is already experiencing an HIV/AIDSHIV/AIDS crisis within its own community. If the epidemic prevents a university from functioning properly, then it also impedes it in the discharge of its core functions of teaching, research and service. To prevent this from occurring, the university, in common with other major systems, has a binding duty to keep itself in good working order. Most of the basic elements of this self-preserving concern have already been proposed in Figure Chart 1. What needs to be added more explicitly is gaining control of the disease in relation to the university's own workforce, academic and non-academic, and coping with its fiscal consequences. The former implies strategies and procedures for minimising the possibility of HIVHIV infection among university personnel (including post-exposure procedures), university-wide provision for workplace education, and fast-track staff appointment measures. The latter implies better record-keeping, more explicit tracking of direct and indirect costs, and explicit budget-lines for HIV/AIDSHIV/AIDS interventions.

The outward-looking dimension relates to the university's core functions of teaching, research and service. If it is to respond to the needs of an AIDS-affected society and world, the university must seek to produce quality graduates who are competent to manage and control HIV/AIDSHIV/AIDS within their respective professions. This calls for the mainstreaming of professional aspects of HIV/AIDSHIV/AIDS into every programme; the qualification of graduates in the numbers which the AIDS-circumstances of society dictate; and the development of new fields of study that are needed for understanding and managing the AIDS crisis. It also calls for more attention to a quality that is increasingly important in its own right: the flexibility that equips students to quickly assimilate new skills and information when AIDS-related circumstances necessitate

this.

This dimension also places a high premium on the "rigorous scientific reflection" of the Anglo-American agenda. Developing the knowledge that will enable society to manage and control HIV/AIDSHIV/AIDS demands research that should be both rigorous and vigorous. As noted earlier, this research should be characterised as much as possible by a multidisciplinary approach so that scientific and social areas, both broadly understood, draw upon and stimulate the work of one another. In its concern to serve real needs, the university should also place its expertise at the service of society, both within a country and outside its borders. Finally, as an institution whose core business is knowledge, the university must play its role in the knowledge economy to which HIV/AIDSHIV/AIDS has given rise, sharing and receiving knowledge related to the disease, and developing its own expertise to generate and manage greatly increased quantities of information.

This two-pronged strategy must be supported by certain fundamental principles that were reflected in the case studies, as they are in virtually every attempt to set the stage for coping with HIV/AIDSHIV/AIDS:

1. Get HIV/AIDSHIV/AIDS out into the open and break every form of silence, secrecy and shame that enshrouds it.

2. Recognise the extent to which HIV/AIDSHIV/AIDS has been feminised. Work to change the subordinate status and subjugation of women. To this end, act urgently to promote greater gender equity, to overcome the social and other constraints to enhanced female participation, and to lead by word and example in transferring power and responsibility to women.

3. Ensure that the entire university culture is enlightened by human rights principles so that, by deliberate and conscientious adherence to these, vulnerability to HIV/AIDSHIV/AIDS may be reduced, those infected or affected by the disease may live in dignity, and no form of stigma or discrimination may find a haven within the institution.

4. Recognise that persons living with HIV/AIDSHIV/AIDS are among the most important actors in any programme to contain and control the disease. Without in any way using or manipulating them, the university should draw upon their unique expertise and insights, and fully involve them in every aspect of its HIV/AIDSHIV/AIDS campaign.

5. Coordinate university plans and programmes with those at national level so as to ensure greater synergy, unity of direction, complimentarity of activities, access to resources, and more efficient resource use.

Over and above all of these interventions, strategies and pillars, the case studies insist that there must be one overarching principle: *totally dedicated, committed leadership from the university's top management*. The whole edifice stands or falls by this. This is what holds everything together. For this reason, it will be necessary for the university's chief executives to throw their full weight behind the institution's struggle with HIV/AIDSHIV/AIDS, use the best available human resources in the strategic areas of prevention, care and impact control, and demonstrate through sustained and public communications that until it has been overcome HIV/AIDSHIV/AIDS will stand at the heart of the university's business. Such leadership will have to be courageous — the impacts of HIV/AIDSHIV/AIDS are adverse. It will have to be innovative and resourceful — the impacts of HIV/AIDSHIV/AIDS are complex and surprising. It will have to be sustained. The impacts of HIV/AIDSHIV/AIDS are likely to be long-term.

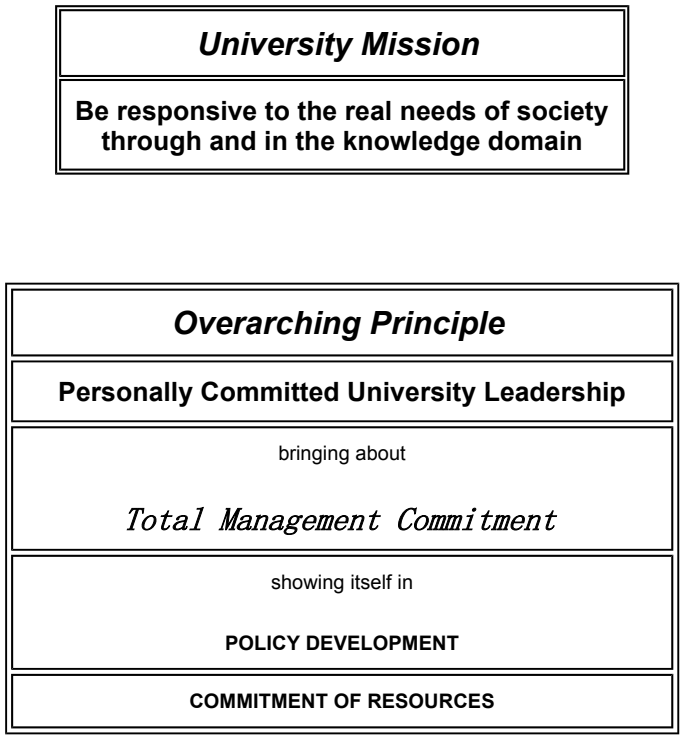
University executives must also provide leadership that is leaders must also be action-backed and resource-backed. The principal actions to be taken will be to ensure the development of appropriate university policies and strategies and to establish suitable monitoring and evaluation frameworks to ensure that these are being implemented. The resources required are human, financial and material. The ability of the institution to continue to function smoothly smoothly and to carry out its teaching, research and service functions may well depend upon adequate resource allocation for the struggle with HIV/AIDSHIV/AIDS.

Figure 2 brings all of these ideas together in the form of a conceptual framework for a comprehensive response to HIV/AIDSHIV/AIDS in a university in Africa.

Figure 2

Conceptual Framework for a Comprehensive

University Response to HIV/AIDS



○ Cohesion with national policies and strategies.

Basic Strategies	
Inward-looking	***Outward-looking***
Protect its own functioning as an AIDS-affected institution.	Serve the needs of an AIDS-affected society.

Interventions	
INWARD-LOOKING	**OUTWARD-LOOKING**
Link prevention to care: ● Establish partnerships with staff and students. ● Sustain awareness. ● Challenge denial and stigma. ● Engage all campus cultures (student, traditional, faith). ● Provide VCT, counseling, guidance. ● Provide adequately resourced HIV/AIDS-friendly health services. ● Address values and practices in campus life ● Provide workplace education for staff. ● Establish or strengthen occupational safety systems and procedures.	***Produce highly flexible, top quality, AIDS-competent graduates:*** ● Mainstream professional HIV/AIDS issues in the curriculum of all fields. ● Readjust programmes to promote more flexible graduate preparedness for a fast-changing AIDS-world. ● Introduce new fields of study in response to HIV/AIDS imperatives. ● Adjust student intake and numbers in programmes to match projected professional needs in an AIDS-affected society.
Tackle management-related factors: ● Establish AIDS-related management and financial information systems. ● Provide for direct costs of HIV/AIDS. ● Provide for indirect costs of HIV/AIDS. ● Establish dedicated HIV/AIDS budget. ● Keep loan systems under constant review. ● Establish procedures for speedy recruitment and training of replacement staff.	***Reflect vigorously on the needs and challenges of an AIDS-affected society:*** ● Conduct AIDS-relevant pure, applied and action research. ● Conduct AIDS-relevant research in scientific, medical, social, ethical and cultural areas. ● Encourage cross-fertilising and/or multidisciplinary research. ● Establish high-level AIDS-related cross-discipline seminars.

(continued)

	Place expertise at the service of an AIDS-

	affected society: • Disseminate and communicate research and study findings. • Share knowledge, experience and expertise. • Provide service, advice, consultancy, training.
	Further develop AIDS-relevant expertise: • Train staff and build capacity. • Establish local, regional and international partnerships. • Develop information-sharing and networks.

Conclusion

In his famous radio address at the time of the economic depression in the early 1930s, President Franklin D. Roosevelt assured his fellow Americans that *"the only thing we have to fear is fear itself."* In their different ways, the authors of the case studies echo this view. One of the most pernicious aspect of HIV/AIDSHIV/AIDS is fear — fear of those who are infected, fear by those who are infected, but above all, fear that the disease cannot be overcome. The case studies show that this fear is not well-grounded. Through the activities of their members, the universities in Africa have shown that they can respond to the challenge the disease poses for them. They have also shown that they can contribute to solving the problems that it creates for society.

Now is the time for these largely uncoordinated individual initiatives responses to be re-focused as a strong institutional response project. If this is done along the lines set forth in the preceding pages, and in the context of strong and visible leadership, then the message will not be "all bleak, for *the future does not have to be like the past*" (Whiteside and Sunter 2000:xi; italics added). Universities possess the expertise to control the HIV/AIDSHIV/AIDS they confront from within. They also possess the expertise to assist society in managing and gaining control over the epidemic and its impacts. With strong and visible leadership from the senior university management, they can fuse their currently disparate efforts into one coherent united onslaught on the HIV/AIDSHIV/AIDS enemy. The outcome will be that promised by Zambia's former President, Dr. K. D. Kaunda, when addressing the Africa Development Forum in December 2000:

> *In this age of information technology, we are used to seeing the three letters WWW. ….Let WWW be our driving force, our inspiration in this war with AIDS: WWW — WE WILL WIN!*

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APPENDIX 1

HIV/AIDS and South African Universities: Current Issues and Future Challenges

By D. Chetty*

Findings from interviews with 21 institutions in the South African university sector conducted under the auspices of SAUVCA (South African Universities' Vice-Chancellors' Association) in September and October 2000.

Assumptions

Dealing with HIV/AIDS in higher education has involved making some assumptions.

Firstly, even if AIDS is not a visible reality on our campuses yet, in the next five years it will be visible and unavoidable according to all available

evidence. South Africa has a rate of 1500 new infections every day. By mid-1999, 3.6 million South Africans were estimated to be living with HIV.

Secondly, it is about the way in which higher education should be responding to the problem. Institutions of higher education are the loci of teaching, knowledge generation, debate, innovation and progress. The disease has in many ways called into question what the role of universities will be in a world where AIDS is an everyday reality.

Thirdly, it would be reasonable to assume that most students are educated, aspirational, have access to information and would act on the information they receive about HIV/AIDS—in effect, a low-risk population. This project and existing research suggests that the opposite appears to be the case. Even when the information is available the chances of changing behaviours in this population are not predictable. The assumption we therefore have to work from is that residential university students are a high-risk population.

Fourthly, the assumption might be that because the South African epidemic is ten years behind the epidemic elsewhere in Africa we have less experience to work from but we can learn from other interventions. Whilst this is true, the findings of this project by SAUVCA are cause for cautious optimism. Our institutions are more prepared and engaged than is often acknowledged.

Lastly, the integrity of our responses to the pandemic now will affect our chances of success in dealing with HIV/AIDS in five years time.

Findings

Uneven and ad hoc Responses:

1. The current scenario is characterised by high levels of effort, often by individuals and small groups, and a growing level of sophistication in the approach being adopted in dealing with the pandemic.
2. However, at the same time, responses are often unplanned, once-off and without a framework at institutional level.
3. The context in which the work is being done is weakened by the absence of any formally agreed national policy or guidelines.
4. There is often no pressure at institutional level or from national government.
5. No support is yet publicly available from national government.
6. There are no incentives to make HIV/AIDS a priority and keep it a priority.
7. There are few models available to those institutions which are struggling to engage with the issue.

Climate:

1. The national debate in recent times has not been helpful. It has caused confusion, a loss of momentum and a dilution of awareness.
2. Institutions report that their dealings with foreign partners have been particularly affected by government's position.

Leadership:

1. Dealing with HIV/AIDS requires leadership at the national government level, from SAUVCA, and from institutional leaders.
2. At institutional level, where leadership is at senior level (VC/DVC), the

impact has been immediate.
3. Where institutions have invested time and effort in establishing and sustaining a structure (forum, committee, task groups), there too the responses are stronger.

Where to Start—Policy?

1. Significant effort has been put into developing institutional policy. At this stage, four institutions have developed and adopted policy, and ten institutions have policy in draft form.
2. In seven cases no draft exists at this time and it is difficult to say how much substantive work has been done on policy.
3. The key weakness of an institutional response, which focuses too heavily on policy, is that policy by itself is not necessarily the first priority or a pre-condition for success. Programmes can be launched and delivered successfully without a fully developed policy framework. Where policy does exist it strengthens the response.
4. Policy development processes are also prone to being bogged down in lengthy institutional processes. The development process takes time.

Defining an Institutional Response:

1. SAUVCA makes a critical assumption in its approach to HIV/AIDS. An institutional response must be defined more broadly than a 'health problem'.
2. The other typical alternative is to see HIV/AIDS as simply a student matter.
3. Either of these narrow responses will have consequences in the ability of institutions to deal with a range of as yet unimagined impacts of HIV/AIDS.

Size and Shape:

1. Most institutions demonstrate only a theoretical understanding of the possible linkages between the impacts of HIV/AIDS and the future dimensions of the system.
2. No instruments exist yet to capture critical information.
3. Little is known about the costs to the system which HIV/AIDS will bring.
4. There are clear signs of stress already at some institutions. Students are dropping out in 2nd and 3rd year in significant numbers without any plausible explanation. Are we tracking changes in enrolment and progression adequately?

Programmes and Interventions:

1. The range and scale of programmes is impressive and growing daily but remains uneven in coverage across the sector. Programmes include prevention, treatment, care, support, policy, research, media, curriculum, community outreach, etc.
2. However, many interventions continue to operate at the level of awareness campaigns and prevention through health services. Many remain in the 'once-off' mode with no sustainable plan or process of institutional change.

Distance Education:

1. With more than one-third of all enrolments in higher education being in distance education, a re-think is required about the range of opportunities, constraints and different modalities which distance mode institutions might present.
2. In effect, distance education may require a significantly different strategy.

Capacity:

1. Few people are designated with full-time responsibility for dealing with HIV/AIDS but this is a growing trend. The longer it remains an add-on function, the lower the profile of HIV/AIDS and chances of success in addressing the problem.
2. It is new field and requires expertise. A real danger exists in putting more pressure on already inadequate services such as health-centres.

Risk:

1. It is important to note that institutions are making assessments of risk to students and to staff. Group life policies have become mandatory for health-science students at most institutions with medical and dental faculties. A debate has arisen in this context about debt recovery by institutions where student debt is the larger and more pressing concern. In a similar vein another debate is developing on the possibility of pre-testing students in particular fields of study.
2. Some discussion has taken place about liabilities with respect to pension funds and medical aid benefits but these are not well developed. Burial insurance is being used by students' families.
3. The risk carried by health-science students where they train in state health facilities is not well understood. State institutions indemnify themselves against liability and provide some form of post exposure prophylaxis (PEP). Thereafter institutional policies are often unclear.
4. In their policy statements and in their practices, institutions will need to take account of a range of ethical and legal responsibilities, which are now arising, that concern risk and the support systems needed to mitigate and manage the consequences of those risks.

Data/Information Management:

1. Data is a critical requirement for any form of intervention. However, the ability which institutions have to gather and use data is severely limited. Self-disclosure is a rare occurrence and confidentiality has to be protected at all times. With these two constraints in place, institutions are asking how they can possibly obtain and use data on levels of incidence and prevalence.
2. There is widespread agreement that, were the data available, it would be the ideal stimulus to act on the problem.

Gender:

1. That women are more vulnerable to HIV/AIDS is well accepted. Ways of radically reducing the level of threat to women are still not well developed. Campus residences remain spaces where both men and women put themselves at risk.
2. The connections between the threat of HIV/AIDS infection and that of rape and sexual violence also require attention.
3. Sex work has been reported on a small number of campuses and poses a significant threat to women who are compelled to sustain themselves through such means.
4. HIV/AIDS plays into the most complex of behaviours which derive from cultural and social notions of masculinity and femininity. Our approach to dealing with HIV/AIDS in widely differing contexts will have to take account of these differences.
5. Male bisexuality and homosexuality need to be targeted for specific attention even if heterosexual transmission remains the major focus.

Research:

1. In a few cases, institutions have been tracking the types and volume of research they produce related to HIV/AIDS.
2. Research output in higher education is low and has been declining in recent times. It is clear from this project that many institutions are not yet alive to the research contributions they could be making or the opportunities available for research on HIV/AIDS.
3. Research requires leadership, a supportive climate and resources. In too many cases, none of these pre-conditions is readily available.

Institutional Culture:

1. Health and sexuality are private matters for some communities in our society and this is reflected in institutional cultures.
2. How do we make an essentially private practice a matter of public debate and action whilst being sensitive to the cultures in which our institutions are rooted?
3. Student attitudes and responses can vary between high levels of engagement on a professional or personal level and the converse—denial, fatalism and an air of invulnerability.

Equity:

1. A debate is emerging about the way in which HIV/AIDS will play into the dynamics of student life and welfare at historically black campuses. Historically, these campuses have been isolated from towns/cities (and) transport and have few on-campus recreational facilities. The use of recreational drugs and sex are a threat in this context.
2. A few institutions report that residences have become living spaces for students twelve months a year. What will we do if students are unable to return to their families and they are ill?

Student Participation:

1. The accepted wisdom is that for interventions to succeed, students need to be involved in the decisions about design, delivery and implementation of any interventions which target them. The extent to which this is happening varies widely.
2. A critical weakness in programme responses to date is that monitoring and evaluation are either non-existent or very poorly developed. Line managers and implementers concede that although they can attest to high levels of awareness amongst students, there is little evidence or certainty about the extent to which awareness is translating into behaviour changes.

Networks and Partnerships:

1. With a few exceptions, these (regional and local networks) are poorly developed.
2. Most institutions concentrate on their external partners. With one or two exceptions, the idea of internal partnerships is still in its infancy. Internal partnerships across faculties may well be more effective in defining an institutional approach.
3. Partnerships require initiative and must be sustained by more than a flow of money.
4. The response from the international donor community has been poor and needs a re-think.

5. Local AIDS service organisations are important partners and are often thought to have a more creative, flexible and credible approach to the pandemic.
6. Partnerships need structure, clear expectations, an agreed framework and the capacity to deliver. In the context of current imbalances, what should the response be from development agencies, the Department (of Education) and institutions?

Resources:

1. Human, material, financial and intellectual resources are undoubtedly important in dealing with HIV/AIDS. No institution is adequately prepared and the threat of competing priorities is constant.
2. Some institutions have for the first time allocated dedicated financial resources to HIV/AIDS at an institutional level.

Sectoral Approach:

1. Though some institutions welcome the need for a sectoral approach others see it as unnecessary or inappropriate. Universities have an important tradition of institutional autonomy and self-regulation. In the current context of dealing with HIV/AIDS, a laissez-faire stance will work well for institutions that have already taken the lead (and) are well resourced and where HIV/AIDS is recognised as a priority. In the case of institutions which are visibly more vulnerable because of poor capacity, lower resource levels, management instability and declining public confidence, HIV/AIDS has potential to wreak havoc in five years time. SAUVCA's assessment is that we cannot afford the consequences of an approach that relies simply on voluntarism and our best intentions. A coordinated response across the sector that, at a very minimum, will allow the sector to say "we have policy and programmes in place for prevention, care and support at all universities" will send a much needed public signal to everyone with a stake in the sector.
2. The obvious question remains, why is there no joint strategy for higher education?

Conclusion

From this brief overview, it is possible that higher education institutions may well have to review their mission statements in the near future. A revised mission ought to take account of the following:

"[We] prepare our students and staff to live with HIV/AIDS within ourselves, amongst our friends, our families, our communities and in our workplaces."

Are we prepared for this world?

Appendix

Chart 1

Economic Impact on Workforce of HIV/AIDS

Total Costs of HIV/AIDSHIV/AIDS in the Workforce = Direct Costs + Indirect Costs + Systemic Costs

DIRECT COSTS	INDIRECT COSTS	
Benefits package:	*Absenteeism:*	*Loss of*
• University health clinics	• Sick leave	• Red mot
• Medical aid/health insurance	• Other leave taken by sick employee	• Dis wor
• Disability insurance	• Bereavement and funeral leave	• Bre dis una etc
• Pension fund	• Leave to care for dependents with AIDS	
• Death benefits/life insurance payout	• Late-coming, stopping-off early because of sickness or attending to the sick	
• Funeral expenses	• Time off to attend clinic or bring sick dependents to clinic	
• Subsidised loans		
Recruitment	*Morbidity on the job*	*Workforc experien*
• Recruitment expenses (advertising, interviewing, etc.)	• Reduced performance due to HIV/AIDS sickness	• Reduct skill, p memory,
• Cost of having positions vacant (profit the employee would have produced)		

Chart 1 (continued)

DIRECT COSTS	INDIRECT COSTS	
Training:	*Management resources:*	
• Pre-employment education and training costs	• Managers' time and effort for responding to workforce impacts, planning prevention and care programmes, etc.	
• In-service and on-the-job training costs	• Legal and human resource staff time for HIV-related policy development and problem solving	
• Salary while new employee comes up to		

speed		
HIV/AIDS programmes		
• Direct costs of prevention programmes (materials, staff, etc.)		
• Time employees spend in prevention programmes		
• Studies., surveys, and other planning activities		

Source: Whiteside and Sunter, 2000:112 (with minor additions)

Annex Table 1

HIV Estimates - 1999

COUNTRIES WITH INFECTION RATES ABOVE 5 PERCENT				
	Population (Thousands)	HIV-infection Adult Rate (%)	AIDS Orphans	AIDS Deaths
Botswana	1,592	35.80	66,000	24,000
Swaziland	981	25.25	12,000	7,100
Zimbabwe	11,509	25.06	900,000	160,000
Lesotho	2,108	23.57	35,000	16,000
Zambia	8,974	19.95	650,000	99,000
South Africa	39,796	19.94	420,000	250,000
Namibia	1,689	19.54	67,000	18,000
Malawi	10,674	15.96	390,000	70,000
Kenya	29,507	13.95	730,000	180,000
C. A. R.	3,550	13.84	99,000	23,000

Mozambique	19,222	13.22	310,000	98,000
Djibouti	631	11,75	7,200	3,100
Burundi	6,587	11.32	230,000	39,000
Rwanda	7,238	11.21	270,000	40,000
Côte d'Ivoire	14,534	10.76	420,000	72,000
Ethiopia	61,123	10.63	1,200,000	280,000
Uganda	21,209	8.30	1,700,000	110,000
Tanzania	32,799	8.09	1,100,000	140,000
Cameroon	14,704	7.73	270,000	52,000
Burkina Faso	11,633	6.44	320,000	43,000
Congo	2,867	6.43	53,000	8,600
Togo	4,515	5.98	95,000	14,000
Dem.Rep.Congo	50,407	5.07	680,000	95,000
Nigeria	108,995	5.06	1,400,000	250,000
Total	466,844	10.38 10.35	11,424,200	2,091,800
COUNTRIES WITH INFECTION RATES BELOW 5 FIVE PERCENT				
Gabon	1,196	4.16	8,600	2,000
Ghana	19,699	3.60	170,000	33,000
Sierra Leone	4,721	2.99	56,000	8,200
Eritrea	3,717	2.87		
Liberia	2,941	2.80	31,000	4,500
Angola	12,497	2.78	98,000	15,000
Chad	7,462	2.69	68,000	10,000
Guinea-Bissau	1,188	2.50	6,100	1,300
Benin	5,945	2.45	22,000	5,600
Mali	10,976	2.03	45,000	9,900

Annex Table 1 (continued)

	Population (Thousands)	HIV-infection Adult Rate (%)	AIDS Orphans	AIDS Deaths
Gambia	1,266	1.95	8,600	2,000
Senegal	9,251	1.77	42,000	7,800
Guinea	7,375	1.54	30,000	5,600
Niger	10,414	1.35	31,000	6,500
Mauritania	2,602	0.52		610
Equatorial Guinea	442	0.51	860	120
Madagascar	15,502	0.15	2,600	870
Comoros	676	0.12		
Mauritius	1,149	0.08		
Total	54,003	2.21	619,760	113,000
Total, All Countries	520,847	8.74 10.35	12,043,960	2,204,800

Source: Derived from *UNAIDS Report on the Global HIV/AIDS Epidemic, June 2000*, page 124.

Annex Table 2

Population Growth Rates With and Without AIDS, 2000 and 2010

	GROWTH RATE, 2000		GROWTH RATE, 2010	
	With AIDS	No AIDS	With AIDS	No AIDS
Benin	3.0	3.2	2.5	2.9

Burkina Faso	2.7	3.2	2.4	3.1
Burundi	3.1	3.7	2.3	3.0
Cameroon	2.5	2.8	1.9	2.5
Central African Republic	1.8	2.5	1.4	2.3
Congo	2.2	2.8	1.9	2.5
Côte d' Ivoire	2.2	2.9	1.9	2.8
Dem. Republic of Congo	3.2	3.5	2.9	3.2
Ethiopia	2.8	3.4	2.3	3.3
Gabon	1.1	1.4	0.5	1.3
Ghana	1.9	2.1	1.1	1.6
Kenya	1.5	2.3	0.4	1.6
Lesotho	1.7	2.3	0.2	2.0
Malawi	1.6	2.6	0.8	2.1
Madagascar	1.5	2.4	0.1	2.0
Namibia	1.6	2.9	0.2	2.7
Nigeria	2.7	3.0	2.0	2.7
Rwanda	1.1	2.1	0.4	1.8
South Africa	0.5	1.2	-1.3	1.0
Swaziland	2.0	3.1	0.5	3.0
Tanzania	2.6	3.1	2.1	2.9
Togo	2.7	3.0	1.7	2.3
Uganda	2.7	3.4	3.0	3.5
Zambia	1.9	3.2	1.7	2.8
Zimbabwe	0.3	2.2	-0.9	1.9

Source: Stanecki, July 2000, Tables 1 and 2

Annex Table 3:

Case Study Countries — Selected Socio-Economic Indicators

	Population (millions)		GNP per capita (US$)	HDI[1] Rank	Adult Literacy Rate (percent)			Life Expectancy at Birth	C D R
	Total	Aged 15–49			Total	Male	Female		
Benin	5.937	2.681	380	157	37	49	26	53	
Ghana	16.678	9.150	390	129	65	76	54	60	
Kenya	29.549	14.261	340	138	78	86	70	52	
Namibia	1.695	0.795	2,110	115	n.a.	n.a.	n.a.	51	
South Africa	39.900	20.962	3,210	103	82	82	82	54	
Zambia	8.976	4.102	370	153	78	86	71	40	

Source: UNAIDS-UNECA 2000 (This document gives details on information sources)

Notes:

1. Human Development Index, 2000

2. Deaths per 1,000 population

3. Deaths per 100,000 live births

4. Deaths per 1,000 live births

Annex Table 4

Case Study Countries — HIV/AIDS Indicators

	People living with HIV/AIDS	Adult Rate (percent)	Estimated AIDS Deaths	Measured

	Adults (15–49)	Children (0–14)			Women i ante-nata clinics, major urb centres (median percent)
Benin	67,000	3,000	2.45	2,613	3
Ghana	330,000	14,000	3.60	33,000	3
Kenya	2,000,000	78,000	13.95	180,000	15
Namibia	150,000	6,600	19.54	18,000	25
South Africa	4,100,000	95,000	19.94	250,000	19
Zambia	830,000	40,000	19.95	99,000	27

Source: UNAIDS-UNECA 2000 (This document gives details on information sources)

Annex Table 5

Case Study Countries — Socio-Economic Impacts of HIV/AIDS

	MACROECONOMIC	HOUSEHOLD	AGRICULTURE	FIRMS & COMPANIES	E
BENIN	Not available	84% of 68 families affected by an AIDS experienced a reduction in hours of work or bankruptcy	Not available	AIDS increased costs in 6 out of 14 firms surveyed and reduced profits for remaining 8	Of a prir pup have teac in
GHANA	Not available	Not available	Not available	Not available	Of a mil sch 11,(

					lost AIDS
KENYA	A 1996 study predicted a reduction of 14.5% in GDP by 2005. A 2000 model predicts annual loss of 1.3% in GDP growth per capita as a result of AIDS	Households estimated to lose 49% - 78% of their income when one person dies from AIDS (not including funeral costs)	In one province, costs due to AIDS-related funerals tripled between 1992/93 and 1998/99	In a study of 4 firms, the annual cost per employee with AIDS was between US$17 and US$49. In a study of six firms, the AIDS-related loss in profits averaged 1.7% in 1994 and was projected to rise to an average of 4% in 2005	Of a mil sch 95,(lost AIDS

	MACROECONOMIC	HOUSEHOLD	AGRICULTURE	FIRMS & COMPANIES	E
NAMIBIA	Annual loss in GDP growth per capita as a result of AIDS projected to be 1.5% by 2005.	In 12 of 18 AIDS-affected house-holds, there was a reduction in livestock numbers (and hence in household savings).	Mourning may lead to up top 25% loss of production time during short critical production periods (e.g., sowing and weeding).	Not available	Of pri pup hav tea in
SOUTH AFRICA	Real GDP growth is forecast to be 0.3% lower in 2005 than it would have been without AIDS. The AIDS-induced decline by 2010 in the annual GDP growth rate per capita is estimated to be 1%.	Not available	Not available	Due to AIDS, total costs of benefits will rise from 7% of salaries in 1996 to 19% by 2005. The remuneration costs paid by firms as a result of AIDS will increase by 15%. AIDS costs to the mining industry will be more than 13 times higher in 2010 than in 1996.	Of mil sch 10(los AII
ZAMBIA	As a result of AIDS, the annual loss of GDP growth per capita is projected to be 1.15% by 2010.	AIDS-affected households report annual income levels of 30 - 35% less than unaffected households. 59.8% of 116	Not available	At the Indeni National refinery, AIDS-related medical and funeral costs in the early 1990s exceeded the	Of mil sch 56, los AII res 55%

		families of AIDS patients reported food shortages.		total profits of US$24,500.	in wer mee chi edu

Source: UNAIDS-UNECA, 2000 (This document gives details on information sources)

Annex Table 6

Case Study Countries — Management and Implementation of the National Response to HIV/AIDS

	National HIV/AIDS policy exists	Specific legislation exists against HIV/AIDS discrimination	High level AIDS national structure (Council, Commission, Committee, etc.) exists	National Strategic Plan on HIV/AIDS		
				A Plan exists	The Plan identifies clear priorities	Plan is supporte by a budget
BENIN	Yes	No	No	No	Not applicable	Not applicab
GHANA	Yes	No	Yes	Yes	Yes	No

KENYA	Yes	No	Yes	Yes	Yes	Yes
NAMIBIA	No	No	Yes	Yes	Yes	Yes
SOUTH AFRICA	Yes	No	Yes	Yes	Yes	Yes
ZAMBIA	No	No	Yes	Yes	Yes	No

Source: UNAIDS-UNECA 2000 (This document gives details on information sources)