

1. HIV/AIDS and Development in Africa

The scale of the HIV/AIDS epidemic in Africa: in 2000, an estimated 2.4 million Africans died of HIV-related illnesses and a further 3.8 million adults and children became infected. In 2000, 80% of the total AIDS deaths occurred in Africa and 72% of new HIV infections. The highest rates of infection occur in the countries of Eastern and Southern Africa, although the disease is not confined to these sub-regions. More than half the countries in SSA are experiencing a generalised epidemic, with adult (15-49) infection rates exceeding 5% at the end of 1999. The 19 countries with lower infection rates also tend to be less populous; none has a population exceeding 20 million. The average infection rate for these countries is 2.2%, with 1.2 million adults out of 54 million being HIV positive at the end of 1999. For Africa as a whole the average infection rate at the end of 1999 was 8.74%, with 23.5 million out of an adult population of 268.9 million being infected.

The impact on development: hard won development gains are being lost in the worst affected countries. Many African universities are operating in a changed socio-economic environment. Other areas for concern are the disease's impact on households, the demographic structure of society, the economy etc.

Household impacts and orphans: the most immediate effects of HIV/AIDS on individual households are suffering, reduced productivity and income, increased vulnerability, the growing number of orphans etc. As many students to African universities come from hard hit rural areas, it is probable that student intakes will decrease due to this increased poverty.

Demographic impacts of HIV/AIDS: the US Census Bureau estimates that in 26 countries the population growth rate in 2000 is already lower than it would have been in an HIV/AIDS free world. It also projects that this trend will continue (except Uganda) in the coming decade. Moreover, AIDS mortality will affect the number of people to be educated. At university level, this could mean fewer admissions and possibly a smaller range of skills. A further effect of AIDS mortality will be the emergence of hereto unknown population structures e.g. larger numbers of young and elderly people or more men than women (women are more susceptible to the disease than men). Finally, as death rates increase life expectancy will decline, in 19 out of the 26 countries studied, life expectancy has fallen by around 10 years. This will also affect universities' staffing requirements and replacement policies.

Health sector: HIV/AIDS impacts significantly on this sector by diverting already scarce resources to deal with the ever increasing number of AIDS-related illnesses. Governments are faced with the dilemma of allocating resources for the treatment of AIDS or its prevention.

Education sector: evidence suggests that education is virtually the only way to ward off the infection. However, on the demand side, AIDS is reducing the number of children in school as households are becoming more reliant on children's economic and labour contributions or parents are unable to meet school fees. On the supply side, high levels of morbidity and mortality in teaching staff are affecting the ability to provide educational services. Compounding these problems are teacher absenteeism, sporadic student attendance and considerable student and teacher trauma brought about by the disease.

The private and industrial sector has seen reduced productivity and increasing costs due the epidemic. When the disease is present in the workforce, there is increased absenteeism, increased medical and insurance costs, as well as the need for a larger workforce to cover for sick colleagues. These additional health costs reduce market demand for all products. A multi-country study found that absenteeism, funeral attendance and employee burial costs represent $\frac{3}{4}$ of the increased labour costs due to HIV/AIDS.

Macroeconomic effects: HIV/AIDS undermines the main determinants of economic growth i.e. human, physical and social capital. Human capital because the disease mainly affects people in their most productive years (15-49). Physical capital because it undermines savings at both household and public levels. Finally, HIV/AIDS reduces the features of social organisation such as trust, norms and networks that can improve the efficiency of a society.

2. HIV/AIDS: Case Study Country Situations

Seven universities in six countries (Benin, Ghana, Kenya, Namibia, South Africa and Zambia) served as a basis for this report. The countries involved vary in population, wealth, educational attainment and development status.

- All countries rank below the HDI with Benin and Zambia close to the bottom of this scale.
- Life expectancy is highest in Ghana at 60 years but 6-9 years less in 4 of the other countries and 20 years less in Zambia.
- Namibia and South Africa (the wealthiest countries) have very high HIV prevalence rates
- All the countries have some form of national response to the HIV/AIDS crisis (except Benin)
- Strategic plans differ widely. In Kenya, priority focuses on advocacy, behaviour change, blood safety, care and support, treatment and control of STD's, prevention of MTCT and mitigation of the socio-economic impact. In South Africa, four areas have been chosen: prevention, treatment, research/monitoring and human rights.

3. The HIV/AIDS Situation in the Case Study Universities

Campus morbidity and mortality: campuses can usually provide some information on this, although it is often incomplete with the exception of Jomo Kenyatta University, where an average of four AIDS deaths occurred among staff between 1995 and 1999. Crude death rates for staff have risen in other universities and AIDS-related deaths can be deduced from the ages at which they occurred. Death rates are higher among lower cadre staff probably due to poor housing and where they live. AIDS-related student deaths are reported from Benin and other universities describe a tendency for an increase in annual student deaths. Two of the largest schools at the University of Zambia saw over 20 student deaths in the first semester of 2000. Annually, this means a death rate of more than 20/1000, which is exceptionally high for the 20-30 age range. Tracking student deaths is difficult due to the long period between infection and full-blown AIDS i.e. the infection may not unfold until students have graduated. Furthermore, student deaths may occur off campus. The University of Nairobi has noticed that students with prolonged illness often live off campus with friends/relatives.

Awareness among students of HIV/AIDS is fairly widespread and most seem to know the basic facts about transmission, although some misconceptions persist e.g. oral contraceptives prevent HIV/AIDS. There is some evidence that students do not regard themselves as being at risk of HIV, in the University of Ghana only 45% of students considered themselves so. In most universities, new students are given HIV/AIDS information as part of their orientation programme when they arrive on campus.

Acceptance of HIV/AIDS on campus varies. In the University of the Western Cape a survey revealed that twice as many students considered it to be a stigma to be HIV-positive as those who did not. The fear of discrimination makes it difficult for individuals to be open about their HIV status and may significantly contribute to the spread of the disease by denying the protection that knowledge of a potential partner's HIV status could bring.

Student orientation and awareness-raising tends to be directed at new students entering the university. There is a clear need for universities to provide **ongoing HIV/AIDS education programmes** to equip students with the skills to resist peer pressure in such areas as drug-taking, casual sex etc. Only the University of Namibia has a systematic follow-through on student orientation through an annual university-wide HIV/AIDS awareness week, which aims not only to deepen awareness on campus but also forms part of university outreach to the community. Some universities have set up Anti-AIDS clubs, although their success depends on the dynamism and support of a few individuals.

Health and counselling services are often cited by universities as being the principal response to HIV/AIDS. Many have initiated condom distribution, promoted awareness-raising and at the better resourced University of the Western Cape, campus health services provide VCT. Pressures on already under-resourced university medical centres have increased in recent years owing to the rising number of STDs and TB cases. For example in the Jomo Kenyatta University, responding to HIV/AIDS absorbs much of the university's health and general budgets. Student welfare offices are being increasingly asked to deal with HIV/AIDS-related issues: some students seek counselling on their HIV status, some are concerned about the financial pressures which they or their families are experiencing because of AIDS sickness or death.

4. The Impact of HIV/AIDS on University Operations

Direct costs: the case studies indicate that universities are bearing increased costs for the maintenance of medical services due to rising amounts of testing and treatment materials and the special equipment required to protect health workers against possible infection. Funeral benefits also place a heavy burden on universities e.g. in 1999, the University of Zambia estimated spending 1,500 USD per month on funeral grants. Moreover, universities have not started to deal with the replacement and training costs of those leaving the university

because of HIV/AIDS. Finally, there is no evidence that the case study universities have put in place any kind of staff HIV/AIDS awareness programmes.

Indirect costs: absenteeism (during the HIV stage and in the full-blown AIDS stage) accounts for the largest share of costs arising from HIV/AIDS and leads to loss of productivity and can disrupt teaching and administration activities. University benefits for sick leave tend to be generous and a person infected with HIV/AIDS will continue to receive benefits prior to the diagnosis of full blown AIDS. Universities are often loathe to adhere to the strict rules regarding benefits when an individual will clearly die in the near future and some officers may not report absences so that the affected individual can continue to receive financial aid.

Systemic Costs: in most universities staff morale and motivation are low, although this tends to be more finance-related than HIV/AIDS-related. Universities' funding (government subventions, fees, income-generating activities etc.) is being threatened as resources are diverted elsewhere to cope with the HIV/AIDS pandemic. For example, UNAIDS estimates the additional investments needed to respond to the disease could consume 1.7% of the GDP of Rwanda, 0.5% in Swaziland and 1.4% in Zimbabwe. The disease also affects student enrolments; in 1999, the University of the Western Cape experienced a sharp drop in student intakes for financial reasons as many students are unable to pay fees when AIDS is present in the family.

The impact on teaching, research and service activities: in universities, a larger incidence of morbidity and mortality occurs among the lower cadre staff. In South Africa, it is forecast that HIV infection will peak at 13.1% for highly-skilled workers, 22.8% for the skilled and 32.8% for the semi-skilled and unskilled. However, HIV/AIDS does disrupt teaching, since it is more difficult to replace academic staff than lower cadre staff. Sometimes it is possible for other staff members to cover for a deceased colleague in a general field but this is not so when the affected teacher is the only specialist. HIV/AIDS-related sickness and death has led to teaching programmes being taken over by less experienced staff, cancelled field trips etc. Student illness can affect course work and attendance although many lecturers give affected students extra time to submit work.

The impact on the social life of universities: based on questionnaires and earlier research, the case studies characterised the campus situation as follows:

- The majority of campus students are sexually active with a higher proportion of female students
- Due to fewer restrictions, on-campus students are more likely to engage in sexual activity than those who live out
- Sexual activity increases with the approach of examinations
- Sexual activity is lower in first year students than final year students (higher proportion of women students)
- The use of condoms appears to be increasing
- Having several sexual partners is considered "cool"
- Senior male students often prey on inexperienced junior female students

Off-campus:

- The "sugar daddy" syndrome in which older wealthier men court junior female students is widespread
- Male students often patronise sex workers
- Some female students engage in commercial sex work often to pay for fees or to support their families

Female students are particularly at risk owing to their inability to negotiate sex or safe sex. Gender violence is endemic in South African society, with a rape occurring every 23 seconds. "Consensual rape" when a female unwillingly consents to intercourse (to avoid a beating, to preserve a relationship etc.) is also widespread.

Universities as high-risk institutions: UNAIDS lists the following social and behavioural factors that play a role in starting a sexually transmitted HIV epidemic:

- Large proportion of the adult population with multiple partners
- Overlapping as opposed to serial sexual relationships
- Large sexual networks
- Age-mixing (typically older men with younger women)
- Little or no condom use
- Women's economic dependence on marriage or commercial sex work

All of these factors exist to a greater or lesser degree in the sexual behaviour of students on campuses.

5. University Responses to the HIV/AIDS Crisis

For the most part universities have responded to the HIV/AIDS epidemic with silence. There is much uncertainty, limited understanding, a lack of co-ordinated actions and too much reliance on a few committed individuals.

Policy development: only one university has developed formal policy guidelines on HIV/AIDS. Senior university executives need to mainstream HIV/AIDS into all aspects of the university's operations and in particular into teaching, research and service functions.

Organisational structures, planning and programming: universities (with one notable exception) have no budget for the implementation of any AIDS-related plans. Records that could help assess the impact of the epidemic on the university are poorly maintained and almost none mentions AIDS.

The institutional response: although, universities show concern for the needs of individuals, virtually no institutional response to HIV/AIDS has been undertaken, leaving the task to interested individuals. This results in piecemeal interventions that last only as long as the interest or presence of the individual is assured. When universities do take action they focus on prevention of HIV and on the treatment of illnesses, with little thought to the provision of counselling for students or staff.

The teaching and research response: there have been no substantive changes in university academic policies or practices in response to the disease. HIV/AIDS has not been mainstreamed into teaching programmes and many teachers would be ill-equipped to incorporate the topic into their courses if ever it were.

The institutional climate: those believed to have AIDS may experience discrimination, although as the disease progresses this is often replaced by compassion. Although, students have reasonable knowledge about the disease (from the media, secondary school etc.), many are involved in high risk sexual behaviour.

The costs of delay: universities risk making the same mistakes as their respective countries in dealing with the HIV/AIDS crisis by:

- Underestimating its potential to destroy systems
- Treating the disease as a health issue
- Failing to build the necessary capacity to manage the impacts of the disease
- Not coordinating responses and activities on an institutional basis
- Failing to show the personal, moral, political and social leadership commitment needed to overcome HIV/AIDS

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/AIDS in teaching programmes depends largely on individuals/departments (except for medical and health science programmes), and therefore tends to have a piecemeal quality. Some departments integrate HIV/AIDS at relevant points in their programmes as a strictly professional matter within the discipline; the aim being to prepare students to address HIV/AIDS issues that they will encounter later in their professional lives. Large scale HIV/AIDS orientation courses give factual information about the disease but do not seem to result in large scale behaviour change. There is also the risk of "AIDS fatigue" i.e. overkill.

Responding to AIDS-created professional needs in society: the case studies were mainly concerned with integrating HIV/AIDS into teaching programmes and did not address the issues of increasing student intake into these programmes or establishing new ones. AIDS is responsible for the loss of skilled individuals whom the universities have spent years developing. Universities need to adjust to the way that HIV/AIDS changes the demand for certain services e.g. health services, by expanding enrolment in these areas as well as introducing new areas of research such as thanatology, micro-credit, sexuality, risk-taking and so on.

AIDS-related research, publications and public service: the case studies have produced a regular output of research on AIDS, which has contributed to the international understanding of the disease. In many universities, postgraduate students investigate HIV/AIDS-related issues as part of their Masters and Doctoral programmes. Findings from research have been shared at conferences, although information on such research is not well shared between universities. The University of the Western Cape has created a database of AIDS-related teaching and research publications, which should enable other universities to develop strategies and programmes to mainstream HIV/AIDS into every aspect of their operations. The University of Ghana has recognised the importance of collaboration between medical and social scientists and of moving research closer to the public.

University frameworks for coping with HIV/AIDS: not all of the institutions have recognised the need for developing institutional policies. In South Africa, four universities had put policies in place by October 2000 and ten had them in draft form. Universities need to look beyond controlling the disease to overcoming it through committed and sustained leadership, clear targets that reflect those developed at national and international levels and a strategic approach.

7. Towards a Comprehensive University Response to HIV/AIDS

It is clear that the HIV/AIDS situation is critical in a number of African universities and that many have not responded adequately. Although the majority have begun to take steps, a coordinated strategy is absent.

A lesson from industry: universities can learn much from industry. The big South African industrial group Anglo-American designed a comprehensive HIV-prevention programme, which is regularly monitored. This programme stresses the vital role top executives play and universities would do well to heed the message. The programme also highlights the need for developing culturally appropriate messages.

The way forward: universities must go further than the Anglo-American programme by designing both inward-looking (keeping itself in good working order) and outward looking (producing quality graduates able to manage HIV/AIDS within their respective professions) interventions. This two-pronged strategy must be supported by certain principles:

- Recognising the extent to which HIV/AIDS has been feminised
- Ensuring that human rights are adhered to and that discrimination is not tolerated
- Recognising the importance of involving PLHA to contain and control the disease
- Coordinating university plans with those at national level

Conclusion: African universities have demonstrated through their activities that they can respond to the challenges posed by the disease. However, these largely uncoordinated activities now need to be refocused as a strong institutional response project as set out in the previous pages.