UNESCO REVIEW OF HIGHER EDUCATION INSTITUTIONS' RESPONSES TO HIV AND AIDS

THE WEST INDES– THE CASE OF THE UNIVERSITY OF THE WEST INDIES

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HIV and AIDS represent a major health tragedy in the Caribbean. It is vital that all partners and stakeholders are fully aware and part of the fight against HIV and AIDS. UWI is positioned to play a central role in educating those sectors in our community… and to fight HIV and AIDS. My vision is to expand and enhance our contributions in the effort to the community and we obviously need to have the same effort within the university and perhaps we need to do that first or at the same time.

Professor Nigel Harris 2005.

UWI's mission is to unlock West Indian potential for economic and cultural growth by high quality teaching and research aimed at meeting critical regional needs, by providing West Indian society with an active intellectual centre and by linking the West Indian community with distinguished centres of research and teaching in the Caribbean and overseas

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LIST OF ABBREVIATIONS USED

AAU		Association of African Universities
ACU		Association of Commonwealth Universities
AIDS	-	Acquired Immune Deficiency Syndrome
CAREC	-	Caribbean Epidemiology Centre
CARICOM	-	Caribbean Community
CRN+		Caribbean Regional Network of people living with HIV and AIDS
HAART	-	Highly Active Anti-Retroviral Therapy
HDI	-	Human Development Index
HIV	-	Human Immuno-deficiency Virus
IEC	-	Information, Education and Communication
ILO	-	International Labour Organisation
KAP	-	Knowledge, Attitudes and Practices
MSM	-	Men who have Sex with Men
NAC	-	National AIDS Commission
NIH	-	National Institute of Health
NSP	-	National Strategic Plan
PAHO	-	Pan-American Health Organisation
PEP	-	Post-Exposure Prophylaxis
PLHA	-	People Living with HIV and AIDS
SIRHASC	-	Strengthening the Institutional Response to HIV/AIDS/STI in the Caribbean
TOT	-	Training of Trainers
UNAIDS	-	Joint United Nations Programme on AIDS
UNDP	-	United Nations Development Programme
UNICA	-	Organisation of Caribbean Universities and Research Institutes
UWI	-	University of the West Indies
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation
WIGUT		West Indies Group of confirmed University Teachers

1. GENERAL OVERVIEW OF THE IMPACT OF HIV/AIDS ON THE HIGHER EDUCATION SECTOR

The notion of universities, worldwide, responding to the crisis generated in society by HIV and AIDS, is a relatively new one. For a long time, AIDS has been recognised as something that could be incorporated into the traditional services offered on campuses through the campus health clinics and student support services. This response was often one of counselling and care, coupled with sporadic attempts at education and awareness through safer sex campaigns, World AIDS Day events, dramas, marches and through the distribution of condoms and informational pamphlets.

This is essentially a conscience driven, largely passive, response. It assumes that students will be concerned about HIV and AIDS and will need support to address these concerns. It recognises that they will also be at risk of being infected with HIV and will need support and condoms to minimise this risk[1].

This has been the response to date of most universities – passive and relying on the philanthropy and good will of staff members to add this work onto their existing workloads. Programmes have tended to stagnate or flounder as a result.

The idea of an HIV/AIDS response being fully institutionalised in universities is a relatively new, and often poorly understood one. Consequently there are few examples where it has happened in an effective and sustained way. There are some HIV/AIDS research programmes that aim to foster multidisciplinary research, or to generate research in the field. There are some general prevention and awareness campaigns, some counselling and support interventions and condom distribution.

These do not completely answer the question of how best to address HIV and AIDS on campus; rather they are a classic status quo response. There is a problem, needing a standardised response often through "tool kits" and a set of complex issues and the solution to universities is to research them. Generally, asking status quo questions will give status quo answers, and with HIV and AIDS taking steps to defend the status quo against AIDS is inadequate. What is needed is oppositional questions – giving oppositional answers and new understandings and solutions.

Universities need to ask and to answer the question – ***why have an AIDS programme at all?*** Is it because there is a belief that universities will be able to stem the epidemic, at least among their students and help to mitigate the impact of the epidemic? Is it because of a possible (though as yet unproven) staff and student attrition rate that will destroy the fabric of the university? If this is the case, how can the university stem what is a far wider social, political and economic issue?

The answers lies potentially in the recognition that the history, the nature and the shape of the epidemic – its swathe through society being the greatest social representation of our time – reveals itself as an intellectual challenge and therefore absolutely part of the core function of the institution and all faculties. Intellectual fascination with the epidemic and a complex understanding of what it is about

[1] Crewe, M. They roam the landscape like a pack of leaderless dogs. 1999; Heads of Commonwealth Universities; Durban.

should fuel the response and all the other aspects – staff and student support and outreach are spin offs from this engagement.

Institutionalising HIV and AIDS as a university response is far more complex than offering counselling services or establishing research programmes or indeed protecting "what is" against "what might be". It involves turning the whole University around to recognise both the threat of HIV and AIDS[2] and its possibilities for a transformed institution and society, and to respond to it in a holistic and complete way. It involves addressing the essence, culture and power of the institution and it challenges the relationship between the institution and the society in profound and fundamental ways.

In the past, many universities have been able to respond effectively, creatively and with rigour and energy to social and political injustices. Some South African universities for example, have a rich history of their opposition to Apartheid and the political repression of the previous regime; in other countries, universities have developed strong schools of postcolonial studies. French universities were a ferment of challenge and debate and new ways of thinking and being, and some Latin American universities offered a comprehensive challenge to political ideologies and control. This active engagement and critique and challenge by academics, the tertiary sector and by social and political theorists is largely missing in terms of HIV and AIDS.

Universities can offer intellectual leadership in the HIV and AIDS epidemic and challenge many of the taken for granted assumptions about the epidemic, about society, about sexualities and identity. They can also foster new understandings and explanations of the epidemic and the societies in which it is developing and how to address them through a range of interventions that are both internal to the university, as well as being external in the communities from which the staff and students are drawn and which are served by the university and the wider society. The role of the tertiary sector in this epidemic is to ask questions – to ask the difficult questions and to challenge the existing assumptions about young people, social and sexual behaviour, political responses, and to create imagined futures into which the students and the rest of society can project and a society post-AIDS to which they can all strive.

For this to happen, HIV and AIDS work must be seen as a process that can transform the institutions in how they address many of the seemingly social problems. HIV and AIDS offer a new critical lens through which long standing, seemingly intractable social issues such as race and racism, class, gender, power, poverty and social change can be viewed, understood and challenged. It allows for a fresh look at how societies operate and how the education system in one way or another colludes in this oppression and gives a new way of seeing how the status quo and all its ramifications can be challenged. HIV and AIDS radically alter the core function and rationale of any university.

Because tertiary education, unlike primary and secondary education, is not compulsory and students are free to choose their university, many institutions believe that they have not had any obligation to provide HIV and AIDS education.

[2] In most of the literature HIV and AIDS is posed as a threat, a danger and very seldom compellingly as a possibility, a challenge.

Because HIV and AIDS education is often compulsory in the school system, many universities have taken the approach that students have already been informed with basic information. In addition, because most students are legally adults when entering the system, universities have not believed that they have a particular responsibility to address the issue. Likewise, the nature of public campaigns and the education provided in schools is very likely to have made the students bored and disaffected with and from AIDS education and they are very resistant to having to expand their HIV and AIDS knowledge, no matter how precarious is their grasp of the basic facts. It is also not the case that students, their families or their donors pay large sums of money to have safer sex programmes as part of the formal curriculum, and finding ways to get students to engage with HIV and AIDS as a non formal aspect of the curriculum is a challenge that few institutions have adequately met.

The Association of Commonwealth Universities (ACU) has however addressed the issue and encouraged universities to develop a comprehensive HIV and AIDS response.[3] They produced a comprehensive discussion paper in 2001,[4] which detailed the main issues for tertiary institutions to take heed of when developing an AIDS response. The Association of African Universities[5] has made HIV and AIDS education a priority for its members and has produced a comprehensive tool kit for use in African Universities. Their response operates off the premise that ***African tertiary institutions – are increasingly aware that their communities by reason of the age groups (19–49 years) of the majority of members, and the dominant lifestyles, are especially vulnerable to the human immune-deficiency virus (HIV)***[6]. The AAU recognised that the higher education sector was highly vulnerable to the HIV and AIDS epidemics but also had the potential to act as a unique resource for the development and application of country and community specific knowledge and solutions. Kelly (2000)[7] in his research has argued that where institutions have responded, it has been through reactive responses characterised by:

- notional awareness but lack of concrete action;
- lack of information and hard data;
- silence at institutional and individual level;
- stigma and discrimination;
- the fact that HIV and AIDS are not mainstreamed into the management of the institutions;
- little replenishment of societies' AIDS-depleted skills;
- the treatment of HIV and AIDS as health problems;
- imperfect knowledge of the disease and its impact;
- little sign of behaviour change in institutions and individuals; and
- focus on prevention and not pro-active control.

These early responses are what can be termed "status quo" responses. They do not challenge any of the assumptions that had been made about the epidemic and its likely impact on the sector. They ask conventional questions rather than seeing how AIDS could be a transformative process.

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[3] See Crewe M An HIV/AIDS Policy for Commonwealth Universities

[4] Commonwealth Universities in the age of HIV/AIDS: What Every Senior Executive Needs to Know November 2001 at http://www2.ncsu.edu/ncsu/aern/comonka.html

[5] The AAU is and recently held a meeting in Pretoria

[6] An HIV/AIDS Toolkit fir Higher Education Institutions in Africa, Module one, p3 Association of African Universities 2004

[7] Kelly M. Planning for education in the context of HIV/AIDS 2000 UNESCO

Whilst many might argue that the situation as outlined by Kelly and others has since changed, many of the challenges described are still relevant today. Indeed, one could question what Kelly had in mind were the institutions to respond – this is still the model of passive engagement and obligation. Literature searches reveal that while many HIV/AIDS 'tool kits' and briefs exist for the higher education sector, few, if any, impact studies supported by hard data and sound methodology exist. There are almost no intellectual or academic discussions, coming from the sector, of the impact of HIV and AIDS on the sector or indeed and more significantly on the role of the sector in offering intellectual, workplace and policy leadership. Indeed, the AAU operating from the epicentre of the epidemic, found the "virtual absence of institution specific targeting and action" and sought to develop a situation where universities could take a lead in developing a response that looked both at how the institutions would be affected but also at how the society could be influenced.[8] However, tool kits in whatever guise are again a static and formulaic response, which homogenises the sector rather than seeking the strength that lies in diversity and difference.

Kelly and Bain (2003)[9] in *HIV/AIDS and Education in the Caribbean* highlight again several reasons why every tertiary level education institutions must engage dynamically and proactively with the epidemic:

- no institution is immune against the disease and no institution is an AIDS free enclave;
- every institution has a responsibility for the wellbeing of its members (students and staff);
- the disease has the potential to impair institutional functioning;
- the long lead-time between initial HIV infection and the development of AIDS has major implications for institutions as some students might already be HIV positive when they enrol and they might fall ill during their studies;
- the mandate of service to society demands the engagement of every tertiary education institution with HIV and AIDS;
- tertiary institutions have a special responsibility for the development of human resources, as they are responsible for the preparation of a large segment of the professional and skilled personnel that society needs; and
- tertiary institutions are crucial agents of change and providers of leadership directions for society.

In the absence of any formal impact or risk assessment one can repeat the speculations about the potential impact of HIV and AIDS on the tertiary sector. It is generally agreed now that HIV and AIDS is likely to have an impact on:

- policy development and the wider functioning of the university;
- curricula, research and educational issues;
- psycho social services for student and staff;
- managerial and human resource management, staff recruitment and retention and student enrolments;
- finance; and

[8] See in particular the work of the University of Pretoria through the Centre for the Study of AIDS – www.csa.za.org and their unique conceptualisation of the interplay between the University and the communities from which the students are drawn and the state.
[9] Kelly, M and Bain, B. Education and HIV/AIDS in the Caribbean. 2003; UNESCO.

- legal issues.

No country has yet lived through this epidemic and there are as yet no successful interventions in the tertiary sector upon which others can be modelled – but there are some best or promising practices, which can be assessed and adapted. There is no simple formulaic model that responds to the challenge that HIV and AIDS pose to each institution and while some of the fundamental issues may be similar; each institution will have its own particular institutional culture and tradition that will affect how best to shape a response.

Universities have to find the answers to two questions –

- how will HIV and AIDS affect the day to day operations of the university – the teaching and learning environment, exams, staff and student wellbeing, the structure of degrees and the sustainability of the institution?
- how is it possible to create a climate of critique and intellectual engagement with this most fascinating of all social issues that will see the epidemic in a positive light and not fulfil the gloom and doom predictions?

While linked – these allow for different responses – the practical, logistical response which is to address the issues raised by Kelly and Bain, the AAU and ACU and to do this well –

- information;
- awareness;
- training;
- impact assessments;
- treatment and care; and
- some teaching in the formal and non formal programmes.

In addition the response can reside in the research questions and the promotion of research. Experience has shown that this research is usually overly determined by the bio medical model and projects a notion of behaviour change that is informed by that model. This is the route most institutions have followed.

There is another way to answer these questions and that answer is eluding most of the tertiary institutions that are grappling with AIDS. The answer lies in seeing AIDS as the most fundamental, most exciting challenge that universities have had to face to date – if this is true, AIDS becomes the rationale for their existence. In this response, the University takes its mission statement and reads it through AIDS and formulates a response that incorporates the day to day issues of AIDS into its existing health and wellbeing programme and that it also seeks to find ways to create the image of a new society.

Is it possible to create a society that will live through and beyond this epidemic and emerge a stronger society with new social understanding, new social formations, stronger and new families, new understanding of who citizens are in the age of AIDS and to generate in young people a critical engagement with the issues that drive this epidemic – race, class, gender and culture and with the underpinning issues of governance, accountability, citizenship and democracy.

Universities have two imperatives for response – the ***economic imperative*** and the ***moral imperative***. The economic imperative seeks to answer how the institution will survive the epidemic with all the economic demands that it will make and be able to expand and provide all the services that are needed and promote research and attract good staff. The companion to this is how will the university train and develop good graduates who understand, intellectually and professionally how to ensure that their countries and societies can survive the epidemic and understand what kinds of social, political and economic decisions need to be made so that the society will be able to develop through the epidemic rather than being dragged down by it.

The moral imperative requires that universities revise their operations to find the most effective ways to incorporate and include high numbers of staff and students living with HIV into the smooth functioning of the institution. Universities should further ensure that support services are provided and that universities are environments in which staff and students feel secure to disclose their status, knowing that they will get the support and dignity they deserve. The companion to this is that universities are positioned in society in ways that allow them to challenge the widespread social stigma and discrimination that exists against people living with or affected by HIV and AIDS, and can do this through strong intellectual vision and leadership and publicly acting in ways that challenge this deeply rooted stigma and discrimination.

Universities have as their core function the generation of knowledge through teaching and research and creating a core of new intellectual leaders. The epidemic offers a rich environment for expanded curricula and research. It allows for an intellectual curiosity and engagement with society, history, the present and the future as do few other issues that can embrace all faculties and programmes. Through its institutional response to HIV and AIDS, universities need to generate a **culture of critique.** This is the role universities can play in providing intellectual leadership that develops an understanding of the epidemic and why it is that internationally, regionally and locally the epidemic seems to be expanding rather than retreating and one which we still do not understand how best to address.

Universities need to engage with HIV and AIDS through what Stuart Hall referred to as Metaphors of Transformation.[10] Metaphors of transformation must do at least two things.

First: they must allow us to imagine what it would be like when prevailing cultural, social and political values are challenged and transformed, when the old social hierarchies are overthrown, old standards and norms disappear and new meanings and values, social and cultural configurations begin to appear.

Second: such metaphors must also have an analytic value. They must provide for us new ways of thinking about the social and symbolic domains in this process of transformation – show us how to think in a non-reductionist way. The question is what alternative metaphors do we have for imagining a new social cultural and economic politics – how do we upturn the symbolic order and from it create a new understanding of a radically transformed society and our role and position within it?

[10] Stuart.Hall Allon White Metaphors of transformation **in** D.Morley and K Chen (eds) Stuart Hall: Critical Dialogues and Cultural Studies 1996 p286ff Routledge

What are the metaphors we are confronting in AIDS, and the response by Universities?

Critical theory is about people's lives. As Stuart Hall has said our inability to understand and to end this epidemic humbles us as intellectuals; but at the same time the epidemic demands our attention:

AIDS is one of the questions which urgently brings before us our marginality as critical intellectuals in making real effects in the world – anyone who is seriously into intellectual practice must feel... its ephemerality, its insubstantiality, how little it registers, how little we have been able of change anything or get anybody to do anything.

But at the same time Hall writes

AIDS is indeed a more complex and displaced question than just people dying out there. The question of AIDS is an extremely important terrain of struggle and contestation. In addition to the people we know who are dying, or have died, or will, there are many people dying who are never spoken of. How could we say that the question of AIDS is not also a question of who gets represented and who does not? AIDS is the site at which the advance of sexual politics is being rolled back. It's a site at which not only will people die, but desire and pleasure will also die if certain metaphors do not survive, or survive in the wrong way.

Camus[11] called the plague itself a kind of abstraction – ***still*** he wrote ***when abstraction sets to killing you, you've got to get busy with it.***

Being an intellectual said Said[12], does ***not mean opposition for oppositions sake – but it does mean asking questions, making distinctions, restoring to memory all those things that tend to be overlooked or walked past in the rush to collective judgment and action***. With regard to the consensus on group or national identity, it is the intellectual's task, he argues, to show how the group is not a natural or god given entity but is a constructed, manufactured, even in some cases invented object, with a history of struggle and conquest behind it.

When the intellectual begins to speak there is always a structure of power and influence, a massed history of already articulated values and ideas, and - also most important for the intellectual, an underside to them, different ideas and other values.

The major issue faced by the intellectual is whether to be allied with the stability of the victors and rulers or – the more difficult path – to consider that stability as a state of emergency threatening the less fortunate with the danger of complete extinction. The sociologist, Shils, argued that intellectuals stand at two extremes – they are either against the prevailing norms or, in some basically accommodating way, they exist to provide "order and continuity in public life".[13]

[11] Said, E. Representations of the Intellectual: Reith Lectures
[12] *Ibid.*
[13] *Ibid.*

In the world of AIDS and the university response, only the first of these two possibilities is truly the modern university intellectual's role (that of disputing prevailing norms) precisely because the dominant norms are today so intimately connected to the dominant hegemony, which always exacts loyalty and subservience rather than intellectual investigation and re examination.

And because the critical imagination that AIDS and democracy require will get lost if we opt for the path or order and continuity.

In times of crisis, such as the AIDS epidemic, an intellectual is very often looked upon to represent, speak out for and testify to the sufferings of others. As Said reminds us, prominent intellectuals are always in a symbolic relationship with their time – in the public consciousness they represent achievement, fame and reputation which can be mobilized on behalf of an ongoing struggle or embattled community (such as People Living with HIV or AIDS (PLHAS)).

Inversely, prominent intellectuals are very often made to bear the brunt of their communities' opprobrium, either when factions within it associate the intellectual with the wrong side or when other groups mobilize for an attack. To this very important task of representing the collective suffering (the impact of infection with HIV, the toll of death, the social stigma), testifying to the travails there must be added something else, the task to universalize the crisis (AIDS affects the whole society not just designated and singled out groups), to give greater human scope to what a particular race or nation suffers (the reality of living in the new epicentre of the epidemic) and to associate that experience with the sufferings of others (recognizing now that there can be no academic work that ignores AIDS).

This point is of course illuminated by the work of Gramsci,[14] and while there are now many more fashionable theorists, to use his work on intellectuals remains pivotal. Gramsci's thinking in relation to intellectual work captures the power of the University and a transformed and transforming institution. For Gramsci, the organic intellectual must work on two fronts at one and the same time.

On the one hand, we must be at the forefront of intellectual theoretical work because it is the job of organic intellectuals to know more than the traditional intellectuals – really know and not just pretend to know, not just to have the facility of knowledge but to know deeply and profoundly. And, if we are in the game of creating a counter-hegemony we have to be smarter than them.

The second point is that the organic intellectual cannot be absolved from the responsibility of transmitting these ideas, that knowledge, through the intellectual function, to those who do not belong professionally, in the intellectual class.

In this epidemic, intellectual work is deadly serious. It is a practice, which always thinks about its interventions in a world in which it would make some difference, in which it would have some effect.

The University can and must become the forum for active research, for vocal and critical public debate – it must act in the classic function of a university to challenge all of our comfortable taken for granted assumptions, to foster a critical imagination,

[14] See Gramsci's discussion of the importance of organic and traditional intellectuals.

to create new meanings, to generate excitement for intellectual engagement with the challenges of our time – not defensively but actively seeking to create a new society, a firm democracy and one in which the AIDS epidemic is both understood and halted.

This leadership will also operate to inform and educate the wider public in terms of the issues at large and the facts and values that go with them. Part of the failure to address AIDS universally has been that much of the response is based on populism rather than on a rigorous and theoretically informed social understanding of our society. We need to challenge this through a ferment of new ideas, the creation of a new social consciousness and explanation and through the ways in which we understand, explain and change the world.

It will and should generate a new re-contextualized language of AIDS – one which is inclusive of the whole society and one which allows people affected, though not necessarily infected to feel part of a shared programme of action, debate, discourse and action.

An extensive research programme is essential. This will generate research not only at each institution, but also in collaboration with other institutions. This research will be part of the culture of critique and will have to address the role of the state, private sector, NGOs and the ways in which the activities of these (despite their individual successes) have often, unintentionally, undermined the development of a coherent, united, informed and successful programme. The Universities are ideally placed to be part of the new language and context of AIDS that is needed for a successful response.

Unless staff and students have a very clear professional understanding of this epidemic and what it is likely to mean in terms of their future careers, as well as their personal and imagined futures; the sector will have failed both the students and the wider society. In this professional understanding, much of the critique and theoretical understanding generated will be incorporated into student curricula. The students will grapple with AIDS as a professional intellectual issue in the same way that they do with many other issues pertinent to not only their discipline but to the wider society.

This professional understanding will have another component, which is that as many graduating students as possible will have been fully trained in the management, political, social, economic and legal aspects of AIDS in the workplace. They will be able to generate workplace programmes that include peer education and counselling; as well as an understanding of the relevant legislation, and the effects of large numbers of sick and dying colleagues.

Through this major change in attitude in the society will occur and it will be possible to end the prejudice and discrimination and the social hostility. However, this can only be achieved when people with AIDS are seen to be, and see themselves to be part of the society and not outside of it or a special category.

HIV/AIDS has reached the proportion of a pandemic for the simple reason that human rights are being violated. The virus can thrive and create the adverse social, economic and political conditions that are increasingly seen, only if the conditions for its existence and spread are ideal. These conditions are the continual and

widespread violations of human rights – something that occurs in most countries. As hard a reality as it might be to accept, the widespread and continuing violation of fundamental human rights has worked in tandem with the AIDS pandemic and the hold it has taken in the world.[15] The underlying social and economic factors which contribute to HIV infection are vast. They include the lack of economic power and widespread access to treatment or prevention measures such as condoms; the lack of social power to make responsible sexual decisions, or to opt for early diagnosis and a healthy and open approach to living with HIV or AIDS; the lack of political power to change oppressive myths, cultural values and practices that perpetuate and exacerbate the powerlessness in the face of the epidemic; the lack of a voice to effectively influence decision makers and policy makers.

The role of a university based HIV and AIDS programme is to provide that voice – the voice that can effectively influence decision makes and policy makers as well as educate the wider society about the rights to which they are entitled, and how to ensure they are respected. The university based response needs to be firmly located within a rights based culture.

The impact of HIV and AIDS manifests itself within universities in a similar way to any major enterprise or in the case of the University of the West Indies a multinational company; a brief discussion of the financial issues is pertinent. The costs of HIV and AIDS on the tertiary sector are of ongoing concern to financial managers. To date, very little research has been done on cost issues relating to staff and student populations and HIV infection. Engaging in HIV prevention efforts and making treatments available will have some cost attached to it and it will be difficult for any institution to show a direct saving as a result. But the initial costs of establishing prevention and treatment programmes will be more cost effective than doing too little and bearing the costs of high levels of infection and morbidity in later years.

Prevention efforts and treatment can be strongly argued for from a cost perspective:

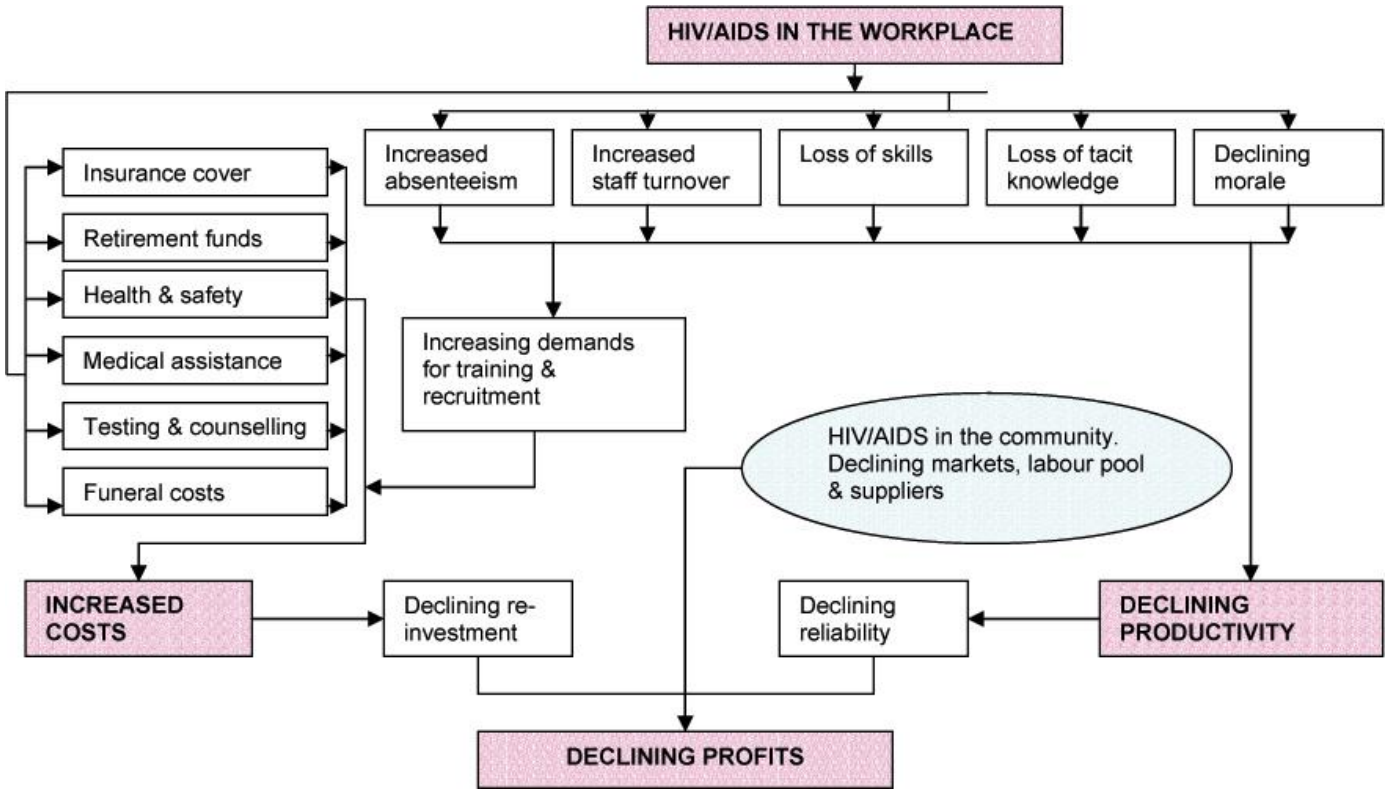
- one of the goals of universities is to provide skilled, educated, thinking individuals for a wider society. Individuals infected with HIV (and who die prematurely due to lack of antiretroviral (ARV) treatment) are likely either to make a far smaller social contribution, or make none at all as a result of premature death;
- a great deal of effort is expended on improving and maintaining the quality of teaching and research at universities. The effects of HIV (increased deaths, sickness and disability) will reduce the effectiveness of teaching by creating more trauma an disruption and by demotivating students about their future prospects; and
- defaults on fees may rise as students divert spending to the health care needs that arise out of HIV infection.[16]

The financial impact is felt in an increase in operating costs, reduced productivity, diversion of resources from planned activities and threatened sources of income. According to Kelly the first three will have the greatest impact on the university workforce. Another impact, which can affect a university adversely, is the loss of

[15] AIDS Review 2002 ***Whose right?*** Centre for the Study of AIDS, University of Pretoria 2002 p. 12ff
[16] Stephen Kramer 2004 University of Pretoria – HIV Risk Study p19 aids intelligence.

skills and institutional knowledge. This can make replacement of staff very difficult, even with the presence of a large labour pool.

Figure 1: The impact of HIV/AIDS on an enterprise[17]



Whiteside and Sunter (2000) look at the economic impact of HIV and AIDS on an organisation in three categories: direct, indirect and systematic costs summarised as follows:

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		

University campus health services face increased financial burdens as they meet the needs to provide HIV testing, counselling, treatment for opportunistic infections and sexually transmitted infections, and ideally ARV treatment as well. A further direct cost for the health services will be increased expenditure on disposable materials and equipment to protect health workers from possible infection.

Benefit packages for staff members can also be severely affected and the demand for the payout of these packages occurs much sooner than expected in the context

[17] *LISK, F. Labour market and employment implications of HIV/AIDS. Geneva: ILO Programme on the World of Work; 2002.*

of HIV and AIDS. The payment of funeral benefits places a large burden on institutions and there are sometimes various company costs associated with funerals, which include but are not limited to transport costs to funerals, transport of the dead to their place of origin and absenteeism of staff and students to attend funerals.

The deaths of skilled staff members have not yet affected many universities' ability to supply quality education as most deaths have occurred in the general non-academic categories where replacement is not that costly; because a growing tendency amongst universities around the world is to subcontract these categories and staff severances are not always captured in university records. Many institutions are however starting to experience the costs of recruiting and training skilled staff members (academic, technical and support staff). Anecdotal evidence at this stage suggests that many university staff members do not feel that they are at risk of HIV infection and some senior administrators might agree with this notion.

Epidemiological data suggests that 50% of HIV cases diagnosed in the Caribbean occur in the 25 – 34 year age group.[18] University staff members in this age bracket are very often still trainee staff members who might be studying abroad and Kelly suggests that the replacement costs of these staff members might be three times as much as other staff members: loss of well qualified and carefully selected individuals, loss of professional development investments and the costs of repatriating the remains of the deceased.

Research has shown a significant lack of workplace programmes for university staff members and universities as employers have operated in a vacuum in comparison to other employers for a very long time. This despite the fact that the International Labour Organisation (ILO) in its *Code of good practice on HIV/AIDS in the world of work 2001* recommends that employers should initiate and support programmes at their workplaces to inform, educate and train workers on HIV/AIDS prevention, care an support and the enterprise's policy on HIV/AIDS. There are not many well-documented university workplace programmes, although in areas like Africa where the epidemic is taking its toll at all staff levels, some promising practices are coming to the fore.

Most of the indirect costs of HIV and AIDS to universities can be attributed to absenteeism and it can manifest in several ways:

- intermittent absences as staff members' immune systems progressively being broken down by HIV.
- longer absences as HIV progresses into the final stage of illness, AIDS.
- absences owing to family responsibilities to look after sick family members.
- absences because of funeral attendance.

All of these absences result in a loss of productivity and affects an institution's teaching and administrative abilities. The responsibilities of absent staff members are delegated to other staff members and some activities are left undone. In the long term this can affect overall productivity further as it affects healthy staff members' morale.

[18] *Status and Trends: Analysis of the Caribbean HIV/AIDS Epidemic1982 - 2002*

Most universities make generous provisions for sick leave of staff, even for prolonged illness. One cost factor that needs to be taken into account however is the costs of temporary replacement staff for these individuals.

The HIV and AIDS epidemic is also threatening the funding sources of universities around the world. HIV and AIDS require substantial amounts of funding to be prevented and managed. This creates competing priorities for funding as more funding is diverted for HIV/AIDS management and care. In a similar way, family money set aside for university tuition is now being spent on medical expenses and fewer students can afford to study or complete their studies. At the University of the Western Cape in South Africa 1,500 students dropped out of university in 1999, 86.5% of these students did it on financial grounds, which could be indicative of the financial burden placed on families by HIV/AIDS. The National Student Financial Aid Scheme (NSFAS) in South Africa is also increasingly writing off student loans as graduates are dying from AIDS-related illnesses.[19]

The three UWI campuses have different student fee and payment structures. At the Cave Hill campus, Barbadian nationals pay no tuition fee, at the St. Augustine campus nationals from Trinidad and Tobago get government assistance for 50% of their tuition, while at Mona students need to pay the full tuition fee. If the epidemic impacts on student fees, it will have a disproportionate effect on the three campuses, and this should be taken into account.

Developing and maintaining a good, comprehensive HIV and AIDS programme will require dedicated and sustained funding. As with other core functions of the University, it is essential that such funding be found from within the general university budgets and projects supported through donor funding. The essential funding is for full time core staff, support infrastructure and media development as well as for the provision of counselling, ARV treatment and care through an expanded wellness programme. However, experience has shown that a great deal of money has been spent on programmes and projects whose success is dubious,[20] while there are a number of programmes and projects that have managed to do excellent work on very modest budgets. It is something of a fallacy that AIDS work requires a great deal of money – programmes that are well planned and executed and which draw on all the available skill and expertise available in the institution through the Faculties and international partnerships.

2. HIV AND AIDS IN THE REGIONAL AND NATIONAL CONTEXT OF THE WEST INDIES

The Caribbean is the second most affected region in the world, and HIV and AIDS is seen as a major developmental problem.[21] In severity it is second only to the Sub-Saharan epidemic. The first cases of AIDS in the region were reported in Bermuda and Jamaica in 1982 and currently it is estimated that more than 440,000 people are living with HIV in the Caribbean. This figure includes 53,000 people who were newly infected in 2004. It is estimated that about 36 000 people died of AIDS-related conditions in 2004. In the Caribbean Community (CARICOM) region, within which the

[19] NSFAS presentation at the Higher Education AIDS Programme, South Africa. 27 June 2005.
[20] See e.g. the incredibly expensive Lovelife programme in South Africa funded to the tune of ZAR 80 million and with little proven efficacy
[21] UNAIDS, AIDS Epidemic Update: December 2004

three main UWI campuses are situated, it is estimated that 370,000 people are living with HIV; this figure includes the 48,000 people who were newly infected in 2004. An estimated 29,000 people died of AIDS-related conditions in the same year.[22]

The Caribbean currently has an average adult (aged 15-49) HIV prevalence rate of 2.3%. Amongst young people (aged 15–24) 3.1% of women and 1.7% of men are living with HIV.[23] In five countries (Bahamas, Belize, Guyana, Haiti and Trinidad and Tobago), the overall adult HIV prevalence rate now exceeds 2%. Amongst adult men aged 15-44 years AIDS has become the leading cause of death.[24] About two thirds of all HIV infections are attributed to heterosexual transmission, while homosexual and men who have sex with men (MSM) accounts for a significant, but neglected part of the epidemic.

The current and potential impacts of HIV and AIDS are ensuring that the Caribbean region is becoming a bigger donor priority with donor funds increasing from US$ 20 million in 2000 to US$90 million in 2003. At the end of 2004 this amount exceeded the US$ 300 million mark.

Table 1: HIV/AIDS Unit Project Database, 52 projects as to December 2004 (PAHO).

Source of Funding	Funds Available (US$)
The World Bank	136,780,000.00
The Global Fund	111,553,832.00
USAID	7,067,608.00
UNAIDS	1,538,466.00
The Clinton Foundation	51,000,000.00
CIDA	28,500,000.00
CDC	250,000.00
CAREC	9,182,778.41
UNDP	683,400.00
Merck	40,000.00
Total:	**346,596,084.41**

For the purposes of this review only the national context of the three countries in which UWI campuses are based; Barbados, Jamaica and Trinidad and Tobago, will be discussed.

2.1 National Context: Barbados

Barbados has a population of 271,000 and this is projected to reach 300,000 by 2015; with an annual growth rate of 0.4%.[25] It is ranked 29th of 177 countries in the 2004 United Nations Development Programme (UNDP) Human Development Index (HDI), which measures a county's achievements in terms of life expectancy, educational attainment and adjusted real income. Barbados is considered by the UNDP to be the highest ranked developing country in the world on the HDI. Barbados has a Gross Domestic Product (GDP) of US$ 15,290 per capita of which

[22] UNAIDS, AIDS Epidemic Update: December 2004
[23] UNAIDS, AIDS Epidemic Update: December 2004
[24] *Ibid.*
[25] CAMARA, B. et al. Status and Trends – Analysis of the Caribbean HIV/AIDS Epidemic 1982 – 2002. CAREC/PAHO/WHO; 2004.

US$ 940 is spent on health. Life expectancy at birth is 77.1 years and adult literacy is at 99.7%.

Barbados is one of the countries with the highest HIV prevalence, currently 1.5%, in the region and the Joint United Nations Programme on HIV/AIDS (UNAIDS) highlights the fact that is vital to alleviate the social and economic impacts of HIV and AIDS for the containment of the disease on a regional and global level. The first AIDS case was diagnosed in 1984 and an estimated 2,500 adults (15-49 years of age) were living with HIV at the end of 2004. 800 of the people who were living with HIV are women. Less than 200 deaths attributable to AIDS were recorded in 2003.

Interestingly, HIV prevalence in Barbados mirrors that of industrialised countries where prevalence amongst men exceeds that of women 3:1, which could indicate that currently men who have sex with men may fuel the epidemic. The epidemic showed a 34% decrease in AIDS in both men and women between 1998 and 2001. According to UNAIDS,[26] this reduction could be attributed to greater access to ARV drugs on the island.

In 2000, the government approved a ***Comprehensive Plan for Management and Control of HIV/AIDS 2001 – 2005*** which has the following key areas:

- prevention and control;
- treatment;
- care and support; and
- management and institutional strengthening.

In 2001, the Prime Minister established a National AIDS Commission (NAC), chaired by the Special Envoy on HIV/AIDS, to advise on policy and coordinate the implementation of the national programme. The government pledged US$ 50 million over five years for the implementation of the plan in the 2001. It negotiated a further US$ 15.1 million from the World Bank to strengthen the plan.

Barbados was the first country in the world to negotiate a loan for the funding of a multi-sectoral HIV/AIDS Prevention and Control Project that included ARV treatment. This has resulted in a 40.8% decrease in inpatient costs post highly active antiretroviral treatment (HAART) and a 59.4% decrease in annual hospital days.[27]

2.2 National Context: Jamaica

Jamaica is the third largest island in the Caribbean and had a total population of 2,676,000 in 2004 and is the most populous Caribbean Epidemiology Centre (CAREC) Member Country. With an annual growth rate of 0.9%, the population is expected to rise to 300,000,000 by 2015. HIV prevalence in 2004 was estimated to be 1.2%. It is ranked 79th on the UNDP HDI and it has a GDP per capita of US$ 3,980.[28] One of the

[26] UNAIDS Country HIV and AIDS estimates:
[27] UNAIDS. Barbados Country HIV and AIDS Estimates, end 2003. Available from: http://www.unaids.org/EN/Geographical+Area/by+country/barbados.asp [accessed 17 June 2005]
[28] UNDP. Human Development Index.

main sources of income is the tourist industry. Life expectancy at birth is 75.6 years and the adult literacy rate is 87.6%.[29]

Jamaica has the third largest population of people living with HIV and AIDS (PLHA) in the Caribbean, after Haiti and the Dominican Republic. The first AIDS case in the Caribbean was reported in Jamaica in 1982. Since then 7,036 AIDS cases were reported to the Epidemiology Division, with 990 being in 2002 alone. It has a generalised HIV and AIDS epidemic with an adult HIV prevalence rate of 1.2% and an estimated 22,000 people were living with HIV/AIDS at the end of 2003.

The AIDS situation in Jamaica seems to be worsening as the cumulative AIDS rate has increased from 63 per 100,000 population in 1995 to 199 per 100,000 population in 2000 and to 290 per 100,000 population in 2002.[30] The annual AIDS incidence has increased from 24 to 38 per 100,000 population between 1997 and 2002. AIDS has become the leading cause of death in the 24 – 25 age group and the second leading cause of death in the 0 – 4 age group.[31] Heterosexual transmission accounts for 61% of new infections and the male female ratio amongst AIDS cases is 2:1. The MSM category of infection is however seen to be underreported by epidemiologists.[32]

A general lack of access to HAART, exacerbated by poor nutrition and unsystematic access to treatment of opportunistic infections has resulted in a high annual mortality rate (900 in 2003).[33]

Jamaica established a National AIDS Committee in 1988 as a private non-governmental organisation. Today it functions as an umbrella body for non-governmental, community and faith-based organisations. In 2002 the parliament unanimously approved the ***National HIV/AIDS Strategic Plan (NSP) 2002 – 2006*** which follows the Medium Term Plan (1997-2001). The NSP encourages the broadest participation of all sectors of society – including young people, people living with or affected by HIV and AIDS, women's groups and service clubs. In 2002 a World Bank loan for US$ 15 million was approved to facilitate the implementation of the NSP 2002–2006.

The Jamaican submission to the Global Fund to fight AIDS, Tuberculosis and Malaria was successful for the amount of US$ 23 million of which US$ 7,560,365 was approved for the first two years (2004-2005)[34]. The submission addresses: stigma, discrimination, prevention, provision of HAART and improved care and treatment facilities.[35]

2.3 National Context: Trinidad and Tobago

[29] *Ibid.*
[30] CAMARA, B. et al. Status and Trends – Analysis of the Caribbean HIV/AIDS Epidemic 1982 – 2002. CAREC/PAHO/WHO; 2004.
[31] *Ibid.*
[32] *Ibid.*
[33] UNAIDS. Jamaica Country HIV and AIDS Estimates, end 2003. Available from: http://www.unaids.org/EN/Geographical+Area/by+country/jamaica.asp [accessed 17 June 2005]
[34] Global Fund Press Release: 18 May 2004. http://www.theglobalfund.org/en/media_center/press/pr_040518.asp
[35] UNAIDS. Jamaica Country HIV and AIDS Estimates, end 2003. Available from: http://www.unaids.org/EN/Geographical+Area/by+country/jamaica.asp [accessed 17 June 2005]

The Republic of Trinidad and Tobago had a population of 1,307,000 in 2004 and it is estimated to have the same population by 2015 even though it does have a population growth rate of 0.5% with a current HIV prevalence rate of 3.2%.[36] It is ranked 54th on the UNDP HDI and it has a GDP per capita of US$ 9,430. Life expectancy at birth is 71.4 years and the adult literacy rate is 98.5%.[37]

Trinidad and Tobago is struggling with a steadily rising HIV epidemic in all regions of the country. At the end of 2003, 11,000 people were living with HIV/AIDS. A total of 6,100 AIDS death were recorded in 2003. It is possible that the prevalence is underreported as a 1997 review of the surveillance system found that only about 50% of the AIDS cases get reported.[38] The first reported cases were amongst homosexual men in 1983 but extended to the general population in 1985. The 25 – 49 age group accounts for 57% of the reported HIV cases.[39] Trinidad and Tobago has a generalised epidemic with heterosexual transmission accounting for most new infections.[40] The epidemic is deeply rooted amongst youth and reports confirm that women are becoming more adversely affected with the male to female ratio in infections changing from 6:1 in 1985 to 1.3:1 in 1999.[41] The HIV epidemic is fuelled by multiple sexual partners, substance abuse (crack and cocaine), gender inequalities and migration.

UNAIDS reports that the economic impact of HIV and AIDS includes loss of savings, investment, labour supply, employment and a rise in health expenditure could amount to 5% of Trinidad and Tobago's GDP by 2007.[42]

In 2003, the Prime Minister committed US$ 80 million toward the execution of the National Strategic Plan. In March 2004, the National AIDS Coordinating Committee, located in the office of the Prime Minister, was launched. The ***National Strategic Plan (NSP) on HIV/AIDS 2004 – 2008*** was adopted at a total cost of US$ 90.33 million over five years.

3. UWI INSTITUTIONAL RESPONSE

UNESCO has undertaken a study of the response of Universities to the HIV/AIDS epidemic and the University of The West Indies (UWI) was selected as one of these. The Centre for the Study of AIDS, located at the University of Pretoria, South Africa was asked to undertake the study of the UWI HIV/AIDS response. Mary Crewe was appointed as the consultant, and Johan Maritz did the research in the West Indies. He visited the UWI from the 6th – 10th June 2005, giving a tight time frame for the research and write up.

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[36] UNAIDS Epidemiological Fact Sheet: Trinidad and Tobago. 2004 Update.
[37] UNDP. Human Development Index.
[38] UNAIDS Epidemiological Fact Sheet: Trinidad and Tobago. 2004 Update.
[39] CAMARA, B. et al. Status and Trends – Analysis of the Caribbean HIV/AIDS Epidemic 1982 – 2002. CAREC/PAHO/WHO; 2004.
[40] *Ibid.*
[41] UNAIDS Epidemiological Fact Sheet: Trinidad and Tobago. 2004 Update.
[42] World Bank press release: World Bank Approves $20 Million for HIV/AIDS Prevention and Control in Trinidad and Tobago. 27 June 2003. http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/TRINIDADANDTOBAGOEXTN/0,,contentMDK:20117058~menuPK:331458~pagePK:141137~piPK:141127~theSitePK:331452,00.html

There were a couple of limitations to the site visits. The research was done on the Mona campus and he was not able to visit either St Augustine or Cave Hill, very few students were available for interviews and no Deans of faculty were interviewed.

A total of 24 UWI staff members from all three campuses were interviewed, either through face-to-face interviews and or teleconferences[43]. The UNESCO terms of reference were used as an interview guide in semi-structured interviews.

The Institutional Context: The University of the West Indies

> *'To propel the economic, social, political, and cultural development of West Indian society through teaching, research, innovation, advisory and community services, and intellectual leadership'*[44]

The University of the West Indies (UWI), established in 1948, is an autonomous regional institution serving fifteen countries in the Caribbean. These countries are Anguilla, Antigua & Bermuda, Bahamas, Barbados, Belize, British Virgin Islands, Cayman Islands, Dominica, Grenada, Jamaica, Montserrat, St. Kitts/Nevis, St. Lucia, St. Vincent & The Grenadines and the Republic of Trinidad and Tobago.

Founded in 1948 at the Mona Campus in Jamaica, as a University College in a relationship with the University of London, it achieved independent status in 1962. The St. Augustine Campus in Trinidad and Tobago was established in 1960 and the Cave Hill Campus was established in 1963. Central Administration of the institution is based at the Mona Campus. All campuses are quasi autonomous but are integrated through centrally administrated functions and operations. A strong presence is maintained on the twelve non-campus Caribbean countries through centres run by the School for Continuing Studies. A Resident Representative runs each centre and performs administrative, teaching, registrarial and public relations functions.

The current student enrolment stands at 31,000 students of which 25,500 are enrolled on-campus. UWI awards approximately 5,000 degrees per annum of which about 1,100 are postgraduate degrees and diplomas. About 70% of enrolled students are women.

The Executive Management Committee consists of the Vice Chancellor, eight Pro Vice Chancellors, three Deputy Principles, the Registrar and the Director of Finance.

UWI has the following faculties – Engineering, Humanities and Education, Law, Medical Sciences, Science and Social Sciences.

When reviewed against the general overview of the response of the tertiary sector internationally, the UWI shows a strong commitment to HIV and AIDS management and to the development of a comprehensive and innovative programme. The existing UWI response is summarised below followed by some of the interesting observations and lessons learned and some suggestions for expanding the programme and the development of new initiatives.

[43] For a list of interviewees please refer to Appendix 1.
[44] Mission of the University of the West Indies in its Strategic Plan 2002 - 2007

3.1 UWI HIV and AIDS Policy

The University of the West Indies developed its first policy on HIV and AIDS in 1995. Although the policy was not very comprehensive it was perceived to be adequate at that time. The policy was redrafted in 2004 to address a greater variety of issues. Through both policy-drafting phases many stakeholders participated in the process, the work however, was mostly done by academic staff members. Students at master's level from the social sciences completed small studies on HIV/AIDS policies on campus and it is felt that their work did impact the final policy. No people living with HIV and AIDS participated in this process however, nor did individuals from marginalised groups (e.g. sexual minorities or drug using communities).

The university submitted the original HIV/AIDS policy, formulated in 1995, to the West Indies Group of confirmed University Teachers (WIGUT) for comment before promulgation. WIGUT is one of the staff unions at UWI. Outside of this process there has been little direct involvement from WIGUT as a body in the HIV and AIDS programmes on campus. Members of WIGUT have been involved in private and academic capacity however and some members of the union are members of the UWI HIV/AIDS Response Programme as well.

The policy[45] covers the following areas:

- rights of affected persons;
- confidentiality;
- managing HIV and AIDS within the University
    - treatment of affected persons,
    - education and counselling,
    - employee guidelines,
    - medical/Laboratory environments,
    - accidental exposure HIV,
- staff and student responsibilities;
- gender-related issues;
- research;
- the community.

The policy does not cover issues pertaining to the financial management of HIV and AIDS in the institution such as: employee benefits, inability of students to repay student loans or skills replacement and training costs. The policy does, however, make provision for staff and student welfare and for ARV treatment and access to post-exposure prophylaxis (PEP) in the event of accidental exposure to blood products in laboratory settings and sexual assault.

A separate policy on sexual harassment and assault exists; but these two policies exist in isolation from each other with no formal links between the two.

Even though an HIV and AIDS policy has been in existence for 10 years, the general feeling from many informants during this review process was that the policy is not well enough known amongst staff and students. Nor could any informant recall if

[45] See Annexure 2 for the complete policy

there was ever a need to enforce the policy where an individual's rights had been infringed.

The policy has been reviewed once and stakeholders are committed to keep it up to date and relevant to current challenges.

3.2 Leadership on HIV and AIDS

Leadership at UWI has always showed committed support to effective participation in the regional HIV and AIDS epidemic. The Chancellor, Sir George Alleyne, a very distinguished medical professional, was previously a member of the Pan-American Health Organisation (PAHO). He currently still carries special responsibility for HIV and AIDS in the region. He has indicated that he is more than willing to put his expertise at the institution's disposal.

The University's HIV and AIDS Response Programme (HARP) was established and supported by the previous Vice-Chancellor, Professor Rex Nettleford. He was very supportive of HIV and AIDS initiatives at the institution. Professor Nigel Harris, who himself is also a distinguished medical professional, succeeded him in 2004.

He seems, and is perceived, to be central to HARP and during a recent interview said:

> *HIV and AIDS represent a major health tragedy in the Caribbean. It is vital that all partners and stakeholders are fully aware and part of the fight against HIV and AIDS. UWI is positioned to play a central role in educating those sectors in our community… and to fight HIV and AIDS. My vision is to expand and enhance our contributions in the effort to the community and we obviously need to have the same effort within the university and perhaps we need to do that first or at the same time.*[46]

To date, HIV and AIDS issues are not reported as a separate entry in the institution's annual report, outside the scope of what UWI HARP is doing. To date there has been no reporting on the impact or perceived impact of the epidemic on the University campuses.

A gap in the UWI HIV and AIDS response is the lack of student leadership. Access to students is one of the limitations of this review, as the study visit took place during a student holiday. Some students were approached informally, but were not interested in participating in the review. Student leadership is not evident from a desktop review perspective, excluding the students who are peer educators within UWI HARP.

There is no overt leadership or involvement from People Living with HIV and AIDS (PLHAs) or sexual minority groups in the planning and implementation of the HIV and AIDS activities in the university response. The CEO of the Caribbean Regional Network of people living with HIV and AIDS (CRN+) does have an ad hoc relationship with UWI HARP, but she does claim to have a more proactive relationship with the St. Augustine Campus, based in Trinidad. References were also

[46] Interview at UWI Mona Campus on 5 June 2005. He was appointed as the new Vice-Chancellor eight months ago at the time of the interview.

made at the Mona Campus of their relationship with Jamaica AIDS Support, a similar organisation to CRN+.

3.2.1 UWI HARP

The lead agency responsible for the University response is UWI HARP and is headed by Prof Brendan Bain who is also the head of the Department for Community Health at UWI (Prof Bain is also the focal person for HIV/AIDS in the institution). UWI HARP was established in August 2001; to ensure and more organised response within the university and to develop and monitor HIV/AIDS policies, but the work really started gaining momentum in 2002 when UWI collaborated in the 'Strengthening the Institutional Response to HIV/AIDS/STI in the Caribbean (SIRHASC) initiative[47].

This initiative was funded by the European Commission had five project outputs and UWI was one of the lead agencies for outputs one and five of the project:[48]

- An increased pool of appropriately skilled personnel to contribute to effective policy development, planning and implementation of STI/HIV/AIDS programmes.
- More comprehensive and accurate information on the course, consequences and costs of the epidemic through improved surveillance, monitoring and evaluation of national control programmes through operational research.

The mission of UWI HARP is to help build and use capacities of the University in order to add an interdisciplinary understanding of HIV/AIDS, to contribute substantially to HIV/AIDS prevention and care, and to mitigate the impact of the HIV/AIDS epidemic and to partner with Government and NGOs. It has the following aims:

- to accelerate action by UWI in response to the growing HIV/AIDS epidemic through research, education, training and strategic engagement with the wider society;
- the development and monitoring of policies;
- to generate, attract and manage resources to sustain the response to HIV/AIDS; and
- to serve as a clearinghouse for HIV/AIDS information, working in collaboration with and complementing national, regional and international agencies.

There is a notion within the institution that UWI HARP falls within the Medical Faculty, but its mandate to look at the entire University's response. According to a senior project officer it is placed within the Medical faculty in terms of office but not vision.[49]

[47] CARICOM SECRETARIAT Strengthening the institutional response to HIV/AIDS/STI in the Caribbean (SIRHASC) December 2003 p26ff

[48] The SIRHASC project completed and external review of the project in December 2003 by CREDES Public Health Consulting. For a list of the five project outputs see Annexure 3

[49] The positioning of UWI HARP is very important – the perception of a bio medical bias due to its location needs to be seriously addressed

UWI HARP is almost entirely donor funded, with the exception of two staff members' salaries that are carried by the institutions; and the provision of office space and infrastructure. The Director of UWI HARP cites accessing continued donor funding as a challenging priority. Senior management at UWI feels that few departments in the institution are adequately funded, but that there is a lot of donor funding in the sector and the onus should be on the heads of departments to access as much of this funding as possible. There is a feeling that HARP is quite successful in generating project funding but the question remains as to whether this fundraising should be the function of HARP and if so whom within HARP or whether it shouldn't be an aspect of wider university fundraising.

3.3 Education relating to HIV/AIDS

3.3.1 Pre- and in-service training on HIV/AIDS for university staff

The notion of pre- and in-service training of university staff generated mixed responses from interviewees during the review process. There is currently no formal training programme to provide all staff levels with training on HIV and AIDS prevention and mitigation and the some of the interviewees felt that there is no need to have an institutional training programme to transfer these skills. Some senior administrators were content with some of the staff members receiving this training but not all staff members. The other interviewees, mostly at practitioner level, felt that a pre- and in-service training programme for all staff in the institution is needed and would strengthen the institutional response.

UWI HARP has provided regular training sessions on basic information on HIV and AIDS for non-academic staff members of one of the staff unions. These members have indicated that they have family members who were infected or were infected themselves and did not know where to turn for support and guidance.

3.3.2 Formal HIV/AIDS Education

A curriculum development committee was constituted by HARP in 2002 and membership to this committee was voluntary and not mandated by the university. The committee identified courses across disciplines which showed opportunity for integration of HIV/AIDS and those which already had HIV/AIDS content. The committee also identified opportunities for stand-alone courses. A needs assessment was done and a matrix of the courses were completed to show those with the strongest opportunity. Meetings were conducted with the lecturers of the selected courses to obtain their buy in. The curriculum development process was consultative and cooperative in nature.

Under the SIRHASC initiative, UWI successfully facilitated two two-day Training of Trainers (TOT) workshops in July and August 2003. A total of 60 academic staff members attended these workshops. These workshops intended to prepare staff members to understand the

- virology;
- serology;
- biology of HIV;
- its social, political and economic dimensions;

- teaching of sensitive material in the classroom;
- understanding the sexual mores of their students; and
- issues related to care and treatment.

23 of the 40 courses that were targeted for integration at the Mona campus in the 2003/2004 academic year were successfully integrated with HIV content and 17 new courses were developed. A total of 30 (15 existing 17 new) of the courses were delivered and a total of 973 students were exposed to these courses.

At the St Augustine campus two new courses were developed: Health and Social Counselling and Social Epidemiology and 149 courses were identified for integration of HIV/AIDS issues.

The Cave Hill campus developed six new courses:

- health policy and planning;
- investigating health and services research project;
- health and social challenges of HIV/AIDS;
- human sexuality;
- health psychology;
- leadership in service.

A total of 37 courses were identified at the Cave Hill campus and 27 of these were proposed for integration of HIV-related themes/content. During the 2003/2004 academic year 14 courses were delivered with HIV/AIDS content.

There are currently no compulsory courses on HIV/AIDS in the institution. The Vice-Chancellor supports both infusion and standalone models of curriculum development.

The SIRHASC initiative also enabled UWI to recruit six new lecturers to strengthen its HIV/AIDS teaching ability, these are as follow for the three campuses:

- Mona: a health communication specialist and a public health and health promotion specialist;
- St Augustine: two health economists; and
- Cave Hill: one health economist and one health planning and behavioural sciences specialist.

The initiative also enabled the UWI to award 36 postgraduate scholarships at master's degree level and also to award six fellowships during the project period.[50]

UWI HARP supports the teaching and development of HIV and AIDS curriculum on an ongoing basis and developed an HIV/AIDS Teaching Resource Manual, which contains multi-disciplinary teaching support material for lecturers. This manual was piloted and updated and is now also available in CD-ROM format.[51] HARP further procured 64 new publications for the University libraries and distributed 170 HIV/AIDS videotapes to academic departments of the University.

[50] See SIORHASC interim report ibid 26 for the placement of the scholarships and fellowships
[51] 500 copies of the CD-ROM were produced for distribution on all three campuses.

The Mona Campus also hosts the Caribbean Institute of Mass Communication (CARIMAC). This Institute is very active teaching and conducting research on a variety of topics pertaining to HIV and AIDS. CARIMAC also facilitates the Master's Programme in Communication for Social and Behaviour Change.

UWI recently collaborated with the Commonwealth Secretariat and UNESCO to appoint the first UNESCO Chair for HIV/AIDS and Education. The recruitment process has been completed and a candidate with a background in medicine and education has been appointed. It is hoped that the Chair will strengthen the marriage between the medical and social sciences in the UWI response to AIDS. The Chair will be based at the Faculty of Humanities and Education at the St. Augustine campus.

3.3.3 Non-formal HIV/AIDS education

UWI HARP has established a peer education programme at all three campuses and currently has about 100 peer educators. The UWI peer educator programme is funded by the SIRHASC initiative and facing some uncertainty as the initiative and budget concludes in September 2005, but efforts are currently underway to source funding for the continuation of activities. There is currently not a not a dedicated peer education coordinator – on the St. Augustine campus the peer educators are supervised by the curriculum coordinator, on the Mona campus they are supervised by the Student Counselling Unit and at the Cave Hill campus this duty falls on the Student Services Unit.

The different campuses implemented different models of peer education and sometimes more than one model per campus. There is a general feeling that peer education entails building a strong peer network and these peers can make an impact on other students through a leadership and advocacy role. Role modelling is intrinsic to this approach and it relies on the ***each one teach one*** approach, a cascade model of diffusion of knowledge and information within a target group.

Even though peer education generally forms part of the informal curriculum, peer educators have also been used by UWI in the formal curriculum, where they have been used as assistant lecturers in a module on health and security. The peer educators in this case did formal lecturing and then facilitated the discussions afterwards.

One of the challenges cited by an interviewee is the fact that it is very difficult to justify the value of peer education to donors and CARICOM. The project implementation unit of the SIRHASC initiative wanted to see peer education as a product of curriculum development and wants it to be part of a structured curriculum. The interviewee goes on further to say that donors want to see projects with a predictable and guaranteed output and the UWI peer education programmes was not structured in this manner.

UWI HARP, the Campus Health Service and the Campus Counselling have been engaged with Information, Education and communication (IEC) activities on campus from time to time. These campaigns are sometimes sporadic in nature and generally happen around key dates like World AIDS Day, orientation and other exhibitions on campus. Most materials distributed at these IEC campaigns come from the Ministry of Health and form part of the national programme. UWI HARP has produced limited

promotional material in the past and most campus stakeholders complain about a lack of fiscal resources to produce UWI focussed IEC materials.

UWI HARP has had one successful Voluntary Counselling and Testing (VCT) drive at the Mona Campus in 2005 so far where students were encouraged to be tested for HIV. Currently no formal VCT service exists on any of the campuses, but dialogue and proposals are currently being initiated to establish a VCT service on the Mona Campus.

3.3.4 Impact of educational activities

No formal Knowledge, Attitudes and Practices (KAP) survey has been conducted at UWI but there is a National KAP survey that has been running for three years, since 2003, which is being used as a reference point.

On World AIDS Day 2004 UWI HARP conducted a small HIV/AIDS Risk Assessment Survey with 173 respondents. The survey had some limitations and cannot be extrapolated to the entire student population, but some of the findings indicated significant risk activity:[52]

- 79.7% reported that they had sex before;
- 55% were currently sexually active;
- 43.4% had more than one sexual partner in their lifetimes;
- 50% of respondents had not used a condom at their last sexual encounter with their regular partner;
- 36.5% of the sexually active group has had an HIV test before;
- 40% of the sexually active respondents did not know the status of their regular partners;
- 27% of them did not know the status of their non-regular sexual partners.

Even within the limitations of the survey it is clear that there is a need for both formal and informal curriculum interventions to promote prevention.

3.4 Research on HIV/AIDS

The University has made a significant contribution to the regional body of knowledge on HIV/AIDS and several academic departments on all three campuses are engaged in HIV/AIDS research. The Vice-Chancellor also highlighted the importance of HIV/AIDS in the institutional research framework. Some current projects include, but are not limited to:

- National Institute of Health (NIH) funded vaccine research and clinical trials;
- paediatric AIDS;
- communication for social and behaviour change;
- gender and the position of women;
- health economics;
- community health and psychiatry;
- education

[52] MULLINS, J. Report on HIV/AIDS Risk Assessment Survey. Kingston: UWI HARP; 2004.

Through the SIRHASC initiative three studies have been funded: one study on the psychosocial needs of women living with HIV/AIDS and two HIV/AIDS impact assessments, one in Haiti and the other in Suriname (which are currently being finalised).

Initially informal networks motivated by common interest existed where researchers met to discuss their HIV/AIDS research. The Annual UWI HARP Scientific and Business Conferences forms a platform where researchers can share and discuss their research and highlight new research priorities. These conferences help the different HARP committees to get agreement on HIV/AIDS issues and have their findings validated by outsiders.

The University does not however have a good monitoring system to gauge the various new and ongoing research initiatives. There is no central database to monitor the different research initiatives. The question of 'who is doing what?' can sometimes be a challenge and this becomes evident in ethical review committees for the approval of new research.

The UWI HARP core group also highlighted the need for either dedicated HIV/AIDS sections in the libraries or dedicated resource libraries to make UWI and other research more accessible.

Various UWI researchers and departments have forged partnerships with other institutions, these include but are not limited to the Jamaican Ministry of Health, the NIH, Jamaica University of Technology, UNESCO, PAHO and others.

3.5 Partnerships and networks

UWI has forged partnerships with faith-based organisations, the private sector, Jamaican Dental Association, Jamaican Medical Association, NIH, the Ministries of Health in Jamaica, Trinidad and Barbados, Jamaica AIDS support, CRN+, UNESCO, the Commonwealth Secretariat amongst others in its response so far.

The University works closely with the Organisation of Caribbean Universities and Research Institutes (UNICA) and the Secretary General of UNICA facilitated some of the logistics of this review.

3.6 Programmes and services

3.6.1 Prevention

The University prevention programme includes the dissemination of government IEC media at key dates throughout the year and on an ongoing basis at the halls of residence and the Campus Health Centre.

Male condoms are freely available on campus and are distributed to halls of residence and the Campus Health Centre. Additional condoms are distributed on key dates like condom week and on Valentines Day. UWI has also partnered with condom companies in the past to do promotions on campus. The Health Centre has collaborated with the Ministry of Health to try and introduce the female condom on

campus but this was not very successful, they will however try to reintroduce them in the future.

STIs are diagnosed at the Health Centre and treatment is available to students, but STIs are generally only diagnosed as a part of general medical investigations. The head of the unit sites the most common STI diagnosed on campus as gonorrhoea. The Health Centre is available to students' partners only if they are UWI students. However, services are also available to staff members, and their immediate dependants can access these and other services as well, but after a private health insurance was introduced for staff members the Health Centre is no longer accessed that widely by staff.

HIV testing is available at the Health Centre but not as accessible as VCT. Testing for HIV generally occurs when it is requested as part of an overall medical investigation. Statistics on HIV are not readily available, but funding is being sought to establish a formal VCT programme and to improve data collection and reporting. The prevalence for the region is known and student HIV prevalence should be more or less in line with the regional estimates. The students are engaged in high-risk practices and anecdotal evidence according to clinic staff suggests an increase in the STI prevalence and unwanted pregnancy in the institution, especially following student.

In the absence of a VCT programme, an event was hosted in the 2004/2005 academic year in collaboration with the Ministry of Health on the Mona campus. The event, called 'Sex in the City' was an expo but VCT was also offered on the day.

There is a very low reported incidence of alcohol and substance abuse in the institution and this is not yet seen as a major problem.

Pos-Exposure Prophylaxis (PEP) is available to staff and students in the event of sexual assault, needle stick injuries and to individuals working with patients and blood products in the University hospital and laboratories. The standard universal precautions are also included in the HIV/AIDS policy. As cited earlier, there is no link between the HIV/AIDS policy and the sexual harassment policy.

3.6.2 Treatment and care

The University offers a comprehensive treatment programme at the institution and these services are available to staff and students at the Health Centre or the University teaching hospital which is on the Mona campus. Confidentiality is assured and HIV/AIDS services are integrated into all services.

Staff at the Health Centre are adequately prepared to diagnose and treat opportunistic infections and free antiretroviral treatment is available onsite. Currently four students are on treatment and are reported to be showing good adherence. Full blood monitoring is also available and all of the bloods are drawn and handled onsite and sent for pathology testing at the University hospital. Where necessary, referrals can be made to other external service providers as well.

3.6.3 Support

The majority of counselling services are available through the Campus Counselling Unit based within the Campus Health Service and thus becomes a one-stop centre for both mental and physical wellbeing.

Pre- and post-test counselling is provided to all individuals undergoing HIV testing and ongoing counselling is available to people who test positive and require further psychosocial care. Adherence counselling is also offered to the students who are on antiretroviral treatment. Loss, grief and bereavement counselling is also offered at the Counselling Unit.

Currently there are no HIV/AIDS support groups available but it was indicated by respondents that this would form part of the VCT programme, once it becomes available.

3.6.4 Community outreach

The outreach activities of the University response are mostly unstructured and limited by capacity and lack of fiscal and human resources. One exception however is the UWI Centre for Gender and Development Studies that is engaged in several outreach activities, which include but is not limited to the Homework Centre, Women in Micro Enterprise, gender analysis and policy planning for the Office of the Jamaican Prime Minister, Caribbean Feminist Activism and public lectures and seminars.

UWI HARP has undertaken small activities, but larger scale programmes have been undertaken where HARP collaborated with academic departments. One such example is the 'Educate Today – Save Lives Tomorrow' programme done in collaboration with a group of second year social work students at the Cave Hill Campus.

The programme formed part of a practical component of the students' academic programme. The Haynesville community in Barbados, a community with several social problems and at high-risk of HIV infection, was identified for the programme. Students had to plan, design and execute an HIV awareness intervention. Follow up afterwards showed positive experiences from both community members and students.

3.6.5 Monitoring and evaluation of response

The SIRHASC[53] initiative underwent an external review at the end of 2003 and it was found that UWI reached the major targets under objectives under output 1 (an appropriate pool of appropriately skilled personnel) whilst under output 5 it says that the partners did not speak to the intention of the output but stills says the establishment of UWI HARP has solidified UWI's involvement in HIV/AIDS efforts in the region.

[53] Refer to Appendix 3 for a summary of the outputs of the SIRHASC initiative.

No formal evaluation of the impact and efficacy of the UWI HIV/AIDS response has so far been conducted. Small-scale process evaluations have so far, however, showed promise.

The Annual Scientific and Business Conference does however enable UWI to share its best practices internally and with others as it is not only attended by members from UWI. The main conference objectives were to:

- provide an update on current research related to HIV/AIDS in the Caribbean;
- to identify gaps which represent opportunities for new research; and
- work towards agreement on a strategic framework for research on HIV/AIDS and related themes in the Caribbean, with an emphasis on research geared to influencing policy and practice

4. LESSONS LEARNED

The overall response of UWI and specifically the activities of UWI HARP have made significant strides in mainstreaming HIV and AIDS into the life of the University. UWI HARP enjoys a good awareness and high profile amongst UWI staff members, but owing to the lack of student participation in this review it would be highly speculative to make the same assumption about students.

The strongest component and potential best practice of UWI HARP is probably the structured participative approach to curriculum development. Curriculum development is at the centre of university responses in Africa but is also one of the most challenging components of their responses, as little consensus exists on the ideal model for the process. The participative UWI model could be a good benchmark for other institutions to follow.

Respondents also indicated that the infusion model could add greater sustainability to the curriculum development process, as it does not require the same expenditure as the development of new courses. When courses are infused into the existing courses, it is easier to absorb into faculty budgets and this is very true in light of the volatility and/or lack of donor funding.

The UWI approaches to informal education have not been as effective as anticipated. Peer education is deemed by most stakeholders in the institution as an effective approach to mobilise students and to raise awareness and influence behaviour. UWI HARP has faced challenges in raising the profile and justifying peer education to donors, as donors want to see it as part of the formal curriculum. One of the common challenges faced with peer education around the world is the lack of accepted minimum standards and weak monitoring and evaluation strategies of peer education programmes.

Peer educators can make a difference in resource constraint settings, specifically within universities, where the skills, creativity and sense of community can be used to offset human resource constraints.

The assumption exists that the new UNESCO Chair will be part of UWI HARP but there seems to be disagreement from some of the core UWI HARP members with the terms of reference of the Chair. Some members feel that there is too great a focus on formal curriculum and that the Chair should be engaged with issues of informal curriculum as well. A senior administrator also alluded to the possibility of two initiatives running in isolation from each other and competition for University resources.

During a group meeting with UWI HARP it was agreed that distance education is an under utilised medium to reach students with information on HIV/AIDS, and that more this medium should be further explored as an additional conduit for HIV/AIDS education.

The placement of UWI HARP elicited mixed responses during the review process. Even though it is only placed within the Medical Faculty in terms of office and not vision, it is felt that the medical sciences benefit disproportionately from its placement and that it is in danger of portraying HIV and AIDS as a purely medical issue.

The majority of the respondents felt that there is a justified need for a pre- and in-service training programme for all staff members of the institution and that this should be prioritised.

Moving away from so called AIDS research exclusivism and highlighting the relevance of HIV/AIDS in all research and promoting multidisciplinary research the overall research framework of UWI could be strengthened, and more potential research grants could be accessed.

There is also a feeling that the involvement of UWI in the SIRHASC initiative should have been planned better, as there is a feeling that UWI could have benefited more from its involvement in the programme. It is also felt that a lot have lessons have been learned from the process up to date and that these lessons will guide their involvement in future initiatives.

5. RECOMMENDATIONS FOR ACTION

The crucial question to be answered is how can the UWI best develop a mechanism to ensure AIDS competence among all staff and students?[54]

What the staff and students at UWI need is not only a mechanism that will develop HIV and AIDS competence among staff and students – but also an expanded vision of what such competence would involve – knowledge about HIV and AIDS on a personal level and being able to think about and effect behaviour change is one aspect. HIV and AIDS competence, however, also means a critical engagement with the epidemic as an intellectual activity that creates new understanding about the Caribbean epidemic and the ways in which leadership at all levels can be exercised.

[54] Morrissey M 2005 Response of the education sector in the Commonwealth Caribbean to the HIV/AIDS epidemic: A Preliminary Overview accessed at www.ilo.org/public/english/dialogue/sector/sector/papers/sn-educat1.pdf

UWI has an impressive record in tackling the HIV and AIDS epidemic on a variety of fronts and the University has clearly taken very seriously all the information about the importance of establishing a comprehensive response to the epidemic. However, like so many other initiatives in the sector the question is where to from here? A comprehensive policy, UWI HARP, curriculum change and debate and research form the basis of a comprehensive response – but it seems clear from the review, as well as from assessing the various discussion documents at hand as well as on the internet, that a new infusion of energy and vision is needed.

There are two fundamental recommendations from which all others will stem.

i) the UWI HIV and AIDS programme should have core funding from the University budget and not be dependant on donor funding. Donor funding can be accessed for other projects and programmes but the core programme must be part of the University expenditure. This is because it is a core function of the university and must be planned for and budgeted for.

ii) The UWI HIV and AIDS response must be located as a separate and focused responsibility of one of the pro Vice Chancellors. HIV and AIDS must become a core function of this management portfolio.

UWI HARP

This is an impressive initiative and has the power and the potential to become a role model – a best practice – for other institutions in the region and other parts of the world. However, it needs a formalised status as a centre with a full time director, or regional coordinator supported by at least six core staff members. These seven staff members need to have dedicated appointments to the work of UWI HARP and cannot have the work as an "add on" to their existing teaching and administrative functions. UWI HARP needs to operate as and be seen to operate as a full fledged HIV and AIDS Centre.

The Director of UWI HARP will need to report directly to the Pro Vice Chancellor. The work of UWI HARP would cover:

- student support and outreach;
- staff training and development;
- media development;
- counselling and treatment;
- community outreach;
- university management and legal issues;
- curriculum change and innovation;
- research and publications;
- gender programmes and human rights.

The physical location of UWI HARP is very important. It needs to be taken out of the medical school and into the main section of the University and would have a presence on each of the three campuses. Even if the work is not overtly medical and does cover other areas – the perception is that UWI HARP is predominantly dealing with medical issues –and the research even in behavioural sciences influenced by the bio medical paradigm. It is worth keeping existing expertise and institutional

memory and there need to be discussions with Dr Brendan Bain about his position in relation to a full time dedicated Director position as well as with the current two full time staff. Staff positions would need to be advertised and staff would need to have the same conditions and benefits as other University staff and be regarded as part of the academic staff of the institution.

Student support and outreach

UWI HARP needs to develop an extensive student based volunteer service. These students would be recruited from the general student body, with an attempt to have a good representation across all faculties. These students would be involved in a range of activities and would need specialised training in each of the activities. The work that the volunteer students would include

- peer education and training;
- counselling and "befriending" students;
- treatment and adherence work in the health services;
- library based work to support staff and student research;
- community outreach and support;
- media development and distribution;
- workplace, human rights and development issues;
- supervision and support.

Young people at universities, the potential leaders of the future, in high AIDS prevalence countries must have the tools to imagine or think about their futures, and to use these descriptions to inform the ongoing development of university students' leadership skills in responding to AIDS in their countries and local communities. Hence, the direct target group is university students with an indirect target group being their peers and other members of their communities. As leaders of the future, the student volunteers will be instrumental in the long-term national, regional and local development in the three countries. The effects of a comprehensive volunteer project are to help develop youth/student-based programmes and leaders that look and act beyond the current status quo, to re-think and reposition themselves as citizens living in a region that is grappling with the impact of HIV/AIDS.

The HIV/AIDS epidemic is dynamic in nature and requires dynamic leadership to curb the further spread of AIDS as well as to develop university environments and communities where students who are HIV positive can feel safe to disclose their status and receive the necessary support.

Staff training and development

UWI HARP will need to take the AIDS policy and address a comprehensive AIDS in the workplace programme that ranges from the education and training of various categories of staff to investigating the rights and obligations of staff, employment contracts, medical aid and pension provisions for staff living with HIV and AIDS, redeployment of staff and recruitment of new staff.

Media Development

UWI HARP would need to develop a "corporate image" and develop a range of media and support materials. These can be developed through the use of students in art

courses and graphic design and produced for specific events, different campuses, and to address particular social and political issues and events – rights, poverty, development, VCT and treatments, sexuality and sexual issues and basic facts. The fact is that a great deal of AIDS media is unimaginative and dull and boring and it is essential that there is a vibrant and challenging media campaign.

Counselling and treatment

Developing a VCT roll out and ensuring that the UWI is fully able to fulfil its obligations requires a comprehensive counselling and support programme. This will be done through the clinic and student health services but UWI HARP can also develop a counselling, treatment adherence and support service. Trained student volunteers can also offer a counselling service located in all faculties and operated from faculty facilities.

Community Outreach

HIV and AIDS will have a direct impact on the communities from which the staff and students are drawn and into which students will graduate to work and live. Working in and with communities would cover HIV and AIDS and its impact on the social fabric, the question of orphans, poverty and nutrition, AIDS related stigma and discrimination, gender issues, and human rights. UWI HARP would exercise a leadership position in terms of understanding these issues and developing responses and new ways of thinking through community based solutions.

University management and legal issues

The role of UWI HARP would be to act in an advisory capacity to the HR division about how the epidemic will impact on staff recruitment, contracts, pension and medical aid payments, treatments and employment issues. It is important to ensure that the policy is located within a rights framework and that the UWI is seen to be actively promoting the rights of People living HIV and AIDS as well as actively employing people who are living with HIV and AIDS. The policy needs to address the rights issues of all staff and students.

Curriculum change and innovation

UWI HARP should operate in conjunction with an **Interfaculty Committee.** Each Dean should be involved in the selection and choice of the person to represent the various faculties on this committee. Ideally there should be two representatives on this committee – one for curriculum and one for research. The issues to be addressed in the curriculum would cover the continuation of the work on how HIV and AIDS can be incorporated into the curriculum as a professional field of study of all students and where in the degree structure it makes the most intellectual sense to have HIV and AIDS as a core component. The personal and sexual issues of HIV and AIDS transmission – i.e. the basic facts should not as a rule be in the curriculum. Students will access that information from other services. The point of HIV and AIDS being infused into the curriculum is to increase the students and staff intellectual understanding of the epidemic. As far as research is concerned it is important that all faculties see that HIV and AIDS is a serious field of research and study and that this should be promoted in all faculties. In addition, through the interfaculty committee various faculties could be required to take the lead in developing various

responses – the Faculty of Law e.g. could take the lead in developing a rights-based approach and ethical issues, the Social Sciences could take the lead in developing a critical social theoretical approach.

Research and Publishing

To develop a truly intellectual response to the epidemic requires that a serious research and publishing ethos be promoted on all campuses. This can be done through commissioned research,[55]which is published under the auspices of UWI HARP so that the Centre gains international intellectual recognition. UWI through its HIV and AIDS programme should take the lead in developing a critical mass of research, opinion, policy direction and programme evaluation that can guide and shape the response of the Caribbean to the epidemic. In addition, the research has to become part of the institutional culture. Monthly AIDS research forums[56] should be established where research of UWI Staff and other people is presented and debated, there needs to be on each campus a critical public forum for debate, dissent and development of the culture of critique. The role of the **UNESCO Chair in AIDS and Education** is of particular importance here and should be the lead agency for promoting the research agenda.

Gender programmes and human rights

There are some other aspects of UWI which make it very interesting in terms of the potential for HIV and AIDS work. The gender ratio between men and women indicates that there is a need for the work of UWI HARP to become more closely aligned with the work of the Centre for Gender and Development Studies. UWI HARP should become a companion centre with a unit on all three campuses. The Gender Centre should have representation on the interfaculty committee.

UWI HARP would need to take the lead in ensuring that the implications of having HIV and AIDS located within a human rights approach are fully understood.

The existing model of UWI HARP could be formalised into a Centre or the UWI could look to the ways in which other dedicated HIV and AIDS Centres on Universities in other parts of the world are constructed. However, the strength of any response is one that draws together robust, critical and rigorous research with student programmes that give students access to formal and informal activities and enhances their area if study.

In addition, the University needs to prioritise its data collection and impact assessment activities at various levels within the institution:

- it needs to calculate the current and potential financial impact of HIV and AIDS in the institution;
- structures need to be designed to measure the staff and student losses within the institution and how it affects the supply and demand chain;

[55] See e.g. the AIDS Reviews produced annually by the Centre for the Study of AIDS and the research output of the National Centre in HIV Social Research at the University of New South Wales and the HIV Social, Behavioural and Epidemiological Studies Unit at the University of Toronto.
[56] Many universities have had success in using monthly forums to create a platform for debate and research dissemination.

- the potential impact of HIV and AIDS on the quality of education needs to be assessed;
- statistics on the utilisation of services will strengthen institutional ability to access donor funding.

UWI HARP serves the entire multi-country university community but mostly collaborates and works with the governments of the three campus-based countries. Greater collaboration with all constituencies could mean a greater influx of resources within the programme.

Greater engagement with the community that UWI serves will enable it to promote community ownership of HIV and AIDS initiatives and will help it to protect the future students of the University.

Donor funding should be sought and accessed for related projects and other initiatives and across the campuses and in specialised areas and faculties, but the programme should not rely on such funding – there needs to be a dedicated core budget which is sufficient to ensure the full working of an expanded HIV and AIDS programme throughout the campuses. Donor funding is by its nature fickle and precarious and the importance and success of an AIDS programme cannot be affected by the withdrawal of funding or the programme being tailored to donor agendas.

These recommendations do not wish to suggest that in one form of another these activities are not happening or have not been thought of – rather it is to suggest a structure or mechanism through which they can be strengthened and developed. The HIV and AIDS programme needs to become a formalised part of the institution with the status and power of a fully fledged Centre, accountable in the first instance to a pro Vice Chancellor and to the University community at large. HIV and AIDS needs to be a regular item on the management committee meetings and the response of the UWI to the epidemic needs to be strengthened from being a very good programme to a programme of excellence. The foundations exist for this to happen.

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APPENDIX 1: Interview list

Dr Weaver	UWI School of nursing
Dorothy Palmer	Librarian - School of Education, Secretary of West Indies Group of confirmed University Teachers
Prof Nigel Harris	UWI Vice-Chancellor
Ms Maxine Ruddock-Small	Project Officer – UWI HARP
Prof Marlene Hamilton	Pro Vice-Chancellor
Dr Blossom Anglin-Brown	Director: Campus Health Centre
Prof Brendan Bain	Director: UWI HARP
Ms Yolanda Simon	CEO: Caribbean Regional Network of People Living with HIV/AIDS
Mr Joseph Pereira	Deputy Campus Principal: Mona Campus
Dr Marjan de Bruin	CARIMAC
Ms Hope Ramsay	UWI HARP Mona / CHART / Community Health
Ms Phyllis McPherson Russell	Mona
Ms Pauline Russel Brown	Mona
Ms Althea Bailey	Mona
Lorna Parkins	Secretary General UNICA
Mike Morrissey	UNESCO
Ms Jasneth Mullins	Mona
Ms Thelma Henry	Cave Hill
Prof Zulaika Ali	St Augustine & NAC
Prof Prabhu	St Augustine
Dr Roger Mclean	St Augustine & NAC
Prof Reddock	St Augustine & NAC
Dr Peter Weller	Counselling Init and UWI HARP
Ms Nancy Muturi	UWI HARP / CARIMAC

APPENDIX 2: Institutional policy

UNIVERSITY OF THE WEST INDIES

Policy

HIV/AIDS

August 2004

INTRODUCTION

The Human Immunodeficiency Virus (HIV) is the infectious agent of Acquired Immunodeficiency Syndrome (AIDS). After approximately 20 years since the first diagnosed case of AIDS, HIV/AIDS is currently present in every country in the world. In 2002, approximately 40 million individuals were living with HIV/AIDS, with the projection of 45 million newly HIV infected persons by 2010.

The Caribbean Region is second in the world in terms of HIV prevalence and incidence, next to Sub-Saharan Africa, with estimates of 500,000 infected persons in the Region. In the Western Hemisphere, the Caribbean is the region most affected by HIV/AIDS and is taking its toll among young adults, women, and children, putting the region's economic, social and human development at risk. Persons infected with HIV often appear well and continue to function productively despite the fact that their immune system is gradually being weakened. The social, economic, and developmental implications of the rapid spread of this disease are many, and demand an urgent response.

HIV infection is spread primarily by sexual intercourse, infecting mostly young adults, often as they begin to engage in sexual activity. AIDS represents the late clinical stage of infection with HIV. It is a severe, life-threatening clinical condition, which most often results in progressive damage to the immune and other organ systems, especially the central nervous system.

As with other communities, those in higher education must respond effectively to the epidemic of HIV infection. The University of the West Indies (UWI) accepts that HIV infection and AIDS can happen on any campus and is accountable to its community to do everything possible to prevent people from being infected and to limit the consequences of established infection.

The UWI is guided in its development and implementation of these policies by currently available scientific and medical information, and notes that there are effective preventive and clinical strategies for controlling the disease.

THE POLICY

1. General

1.1 The UWI subscribes to the view that education should be the primary institutional response to HIV infection and commits itself to on-going HIV/AIDS education within the university and in the community it serves.

1.2 The University believes that adequate and appropriate information and assistance will help guarantee fair and adequate treatment of the people

affected by HIV and encourage responsible behaviour by all persons, infected or not.

1.3 The policy aims to encourage people who suspect that they may be infected to be diagnosed and get attention at the earliest opportunity. This will help prevent the spread of the disease, reduce fear and ignorance, and increase the chances of survival of individuals who access available means of treatment.

1.4 The University aims to prevent the spread of HIV in its community through the provision of appropriate education and counselling within the institution and by ensuring there is easy access to prophylactics such as condoms.

1.5 All students and staff members will be informed of the University's HIV/AIDS policy, as the University is committed to disseminate this policy to all members of the university community.

1.6 This policy must be updated and renewed periodically by the body responsible for the UWI's response to HIV/AIDS.

2. Rights of Affected Persons

2.1 The University insists that all persons shall be treated with respect and consideration for their intrinsic and fundamental rights and privileges as human beings.

The University policy is based on the protection and safeguarding of the human rights of all people infected with or affected by HIV.

2.2 HIV tests are not required of applicants for admission to or candidates for employment at, the University of the West Indies. Consideration for admission or employment cannot be denied individuals on the basis of a positive HIV test.

2.3 Persons who have tested positive for HIV shall be entitled to the same level of respect and consideration as anyone with any other illness or disability. People who have tested positive for HIV will be entitled to work, study and pursue other normal university activities as long as their current medical status is such that their continuing to do so will not pose a health hazard either to themselves or others.

2.4 HIV infected persons will be entitled to have any problem that arises addressed in a humane fashion and, like any other person, they will be protected from arbitrary termination of their employment or student status.

3. Confidentiality

3.1 University Health Services will provide information and counselling in strict confidence. No information about the HIV status of any person will be shared with the university administration or anyone else, without the explicit written permission of the affected person or where required by law. This policy applies to any information obtained about family members or other associates of students or staff in the course of consultation or counselling in the health services or elsewhere within the university.

3.2 Members of the administrative or academic staff and staff of laboratories, who have access to private and confidential information about students or staff, shall be required to handle such information in strict confidence. If information is divulged without specific authority, the affected person has the right to legal redress.

4. Managing HIV/AIDS within the University

4.1 Treatment of Affected Persons

4.1.1 The University aims to achieve, within the resources available, a best practice standard in all HIV/AIDS interventions. Its personnel will work with national, regional, and international authorities in its quest to achieve this end.

4.1.2 The UWI, through the University Health Services and in collaboration with relevant agencies and organizations, will facilitate and support access of persons living with HIV/AIDS in its community to appropriate care and treatment, including the procurement of antiretroviral therapy, where indicated.

4.1.3 Students with HIV/AIDS who are capable of vigorous sports activity will not be restricted from recreational sports or competitive athletic participation. Students are encouraged to consult with their clinician for advice in regard to participation in sports of any kind.

4.2 Education and Counselling

4.2.1 All members of the university community are entitled to, and shall have, access to comprehensive information about HIV/AIDS and related issues to enable them to deal rationally, effectively, humanely, and with empathy towards persons affected by HIV/AIDS in the university community or outside of it. Information and advice will be

available to the university community from the University Health Services or any other source designated by the University.

4.2.2 The University's Health Services are responsible for organizing and/or conducting AIDS education programmes, and staff and students have a responsibility to avail themselves of such programmes in order to have a clear understanding of the potential impact of HIV/AIDS on their own lives, the university and the community. These programmes will equip staff and students to be able to live and function in societies with significant rates of HIV infection and AIDS.

4.2.3 Counselling on HIV/AIDS and related issues will be available to all students and staff. Support and referral services for staff and students living with HIV/AIDS will be provided within the resource capability of the counselling and general health services of the UWI. These services will include voluntary HIV testing with appropriate pre-and post-test counselling.

4.2.4 The University will ensure that all records connected with the counselling and support services are kept confidential.

4.2.5 The body responsible for the University's response to HIV/AIDS will ensure that appropriate training courses are conducted and that staff in supervisory positions are trained in the management of HIV/AIDS.

4.3 Employee Guidelines

4.3.1 No member of staff has the right to refuse to work with or alongside anyone else on the grounds that the other has HIV or AIDS. Any allegation and/or action intended to induce or commit an act of discrimination against a person affected by HIV/AIDS will be subject to investigation and disciplinary measures under the terms of the contract of employment.

4.3.2 Should an employee or student believe that he/she has been discriminated against on the basis of HIV status, such a grievance should be addressed through the appropriate grievance procedures of the University.

4.3.3 Continued employment, including promotion and training opportunities, will not be affected by a staff member's HIV status, provided that the staff member is able to perform his/her duties satisfactorily. Should a staff member become too ill to perform the duties as set out in his/her conditions of employment, suitable alternative work may be offered, if available.

4.3.4 Staff members with HIV/AIDS are entitled to the standard allocations of sick leave as contained in their conditions of service. As with other illnesses, requests for additional sick leave would be applied for through the officer responsible for human resources.

4.3.5 Staff members with AIDS shall be treated and accorded the same privileges and courtesies as any other staff with a serious illness. Being affected with HIV/AIDS should neither prejudice nor give preference to anyone's entitlement to sick leave or other benefits. HIV/AIDS shall not be used more than any other illness as justification for non-performance. Should a staff member living with HIV/AIDS be performing below expectations, the normal assessment and disciplinary procedures shall be followed.

4.3.6 In the event that HIV positive employees become medically incapacitated and are advised to stop working, general university rules and relevant legislation governing retirement because of ill health will apply. Any decision regarding termination of employment of a member of staff who is ill will be made in full consultation with the staff member concerned and his/her medical practitioner, and with appropriate legal advice.

4.3.7 The University is committed to a policy in which sexual exploitation of staff and students is not tolerated and respect is given to the equality of all human beings, without consideration of gender, race, religion, or social status. By upholding these principles and practice of mutual respect, staff and students are exhorted to play their part in the effort to prevent the spread of sexually transmitted disease, including HIV.

4.3.8 There is no justification (medical or otherwise) to deny or restrict access of persons with HIV infection or AIDS to classrooms, office buildings, residence halls, facilities, swimming pools, recreational facilities or other common areas within the University.

4.4 Medical/Laboratory Environments

4.4.1 Units whose academic, research, clinical and work programmes involve risk of exposure to HIV-contaminated blood, body fluids or viral preparations are required to follow the strict policies and procedures for safety as these relate to the specific areas involved. The director of each unit will be responsible for providing relevant safety information and equipment, continuing education, and supplies for members of staff and students working in or visiting the unit. (See Appendix 1)

4.4.2 All staff and students in university-affiliated medical facilities shall receive specific training on the handling and disposal of sharps and other ways of preventing infection with HIV. Training for staff will be arranged by the body responsible for the University's response to HIV/AIDS at set intervals and will be done in collaboration with appropriate university personnel or units.

4.4.3 The following vaccines are highly recommended for students and staff working in University-affiliated medical institutions

- Hepatitis B
- Diphtheria, Pertussis and Tetanus combination
- Booster doses of tetanus toxoid (every 10 years)
- Polio
- Measles, Mumps and Rubella combinations
- Chicken Pox (for persons who have not had the disease)

4.5 Accidental Exposure to HIV

4.5.1 Most injuries can be prevented by using techniques such as not recapping needles by hand and by always disposing of used needles in the sharps' disposal containers provided in work areas. Many exposures to the eyes, nose, mouth or skin can be prevented by using appropriate barriers (e.g. gloves, eye and face protection and gowns) when contact with blood or body fluids is expected. There is no evidence that exposure by a stick with a solid needle delivers enough of a viral load to become infected.

4.5.2 Where prophylactic anti-retroviral treatment is available, this should be started within hours of the exposure following the protocol of counselling and testing laid out by the institution.

4.5.3 Staff or students who visit and work in medical/laboratory facilities outside of the University should be trained and counselled before such visits and should be assisted in obtaining emergency medication to take with them in case of accidental exposure to HIV. See Appendix 1.

5. Staff and Student Responsibilities

5.1 Each individual has a responsibility to himself or herself to minimize his/her risk of HIV infection and transmission by taking appropriate precautions. Persons who know, or suspect, that they are infected with HIV are urged to seek medical advice in order to avail themselves of the available care.

5.2 Members of the University Community have a responsibility to obtain education and to conduct themselves in accordance with the knowledge of the transmission of the disease so that they protect their partners in intimacy and where appropriate other members of the community. For example, they should not donate blood.

5.3 Members of the University Community are expected to respect the rights of other staff and students at all times and to refrain from words or deeds that demonstrate prejudicial or discriminatory attitudes

towards people with HIV/AIDS. University staff should set the example in challenging manifestations of prejudice and discrimination within the university. All requests for information regarding the university's response to a given "incident" regarding HIV/AIDS should be directed to the designated University department or unit. This department or unit will be assisted in providing such information by the University's Legal Counsel and the appropriate University members.

6. Gender-related Issues

6.1 The University is committed to providing an environment in which the equality of men and women is respected, where neither sexist behaviour nor gender-based discrimination is countenanced, and in which pro-active attention is given to protecting all students from coercive sex.

6.2 The University also recognizes its responsibility to provide its male and female students and staff with such gender-sensitive programmes as will ensure that they are aware not only of the rights and vulnerabilities of others, but also of the HIV/AIDS related implications of sexual abuse and violence, which affect women predominantly.

6.3 The University will seek to access appropriate medical and other therapy for any of its members who are subject to sexual violence.

6.4 The University will allow no barriers to men or women being able to obtain protection against the spread of HIV; this includes condoms and other related material.

7. Research

7.1 The University will continue to foster medical, social and economic research intended to expand the pool of knowledge on the impact of the epidemic and to treat, plan for, and ameliorate its effects.

7.2 It will encourage research into stigma, discrimination, and homophobia, which inhibit the ability of individuals and the community to deal with HIV/AIDS in a rational and effective manner.

7.3 The University will use various methods and media to disseminate the results of the research and undertake and support appropriate interventions to influence the reduction of stigma and discrimination and the social and economic impact of the epidemic.

8. The Community

8.1 The University will make available to the community that it serves appropriate courses related to the control and amelioration of the impact of HIV/AIDS.

8.2 The University will encourage its staff to continue to contribute to the efforts to control the epidemic through participation in the medical, education, social and economic sectors in the communities it serves.

UNIVERSAL PRECAUTIONS

1.1 The basis for advocating the consistent application of universal precautions lies in the assumption that in situations of likely exposure to HIV, all persons are potentially infected and all blood should be treated as such. All blood, open wounds, sores, breaks in the skin, grazes and open skin lesions, as well as all body fluids and excretions which could be stained or contaminated with blood (for example tears, saliva, mucus, phlegm, urine, vomit, faeces, and pus) should therefore be treated as potentially infectious.

a. Blood, especially in large spills such as from nosebleeds, and old blood or bloodstains, should be handled with extreme caution.
b. Skin exposed accidentally to blood should be washed immediately with soap and running water.
c. All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with running water and/or antiseptics.
d. If there is a biting or scratching incident where the skin is broken, the wound should be washed and cleansed under running water, dried, treated with antiseptic and covered with a waterproof dressing.
e. Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be flushed with running water for at least three minutes.
f. Proper facilities should be made available for the disposal of infected waste.

1.2 All open wounds, sores, breaks in the skin, grazes and open skin lesions, should at all times be covered completely and securely with a non-porous or waterproof dressing or plaster so that there is no risk of exposure to blood.

1.3 Cleansing and washing should always be done with running water; the water should not be poured over the area to be cleansed. Areas without running water should keep a supply on hand specifically for use in emergencies, e.g., in a 25-litre drum. This water can be kept fresh for a long period of time by adding bleach.

1.4 All persons attending to blood spills, open wounds, sores, breaks in the skin, grazes and open skin lesions, body fluids and excretions should wear protective latex gloves or plastic bags over their hands to eliminate the risk of HIV transmission effectively. Bleeding can be managed by compression with material that will absorb the blood, e.g., a towel.

1.5 If a surface has been contaminated with body fluids and excretions which could be stained or contaminated with blood, for instance, tears,

saliva, mucus, phlegm, urine, vomit, faeces and pus), that surface should be cleaned with running water and fresh, clean household bleach (1.10 solution), paper, or disposable cloths. The person doing the cleaning must wear protective gloves or plastic bags.

1.6 Blood-contaminated material should be sealed in a plastic bag and incinerated. Tissues and toilet paper can readily be flushed down a toilet.

1.7 If instruments (for instance scissors) become contaminated with blood or other body fluids, they should be washed and placed in a strong household bleach solution for at least one hour before drying and re-using.

1.8 Needles and syringes should not be re-used, but should be safely destroyed.

Training in first aid for students and staff should be provided. First aid kits should be maintained at strategic locations and made available when necessary. Gloves should be taken to every sporting event by the person in charge, as well as a fully equipped first aid kit on each vehicle transporting students.

APPENDIX 3: Summary of outputs under the SIRHASC initiative

1 – An increased pool of appropriately skilled personnel able to contribute to effective development, planning and implementation of STI/HIV/AIDS programmes.

2 – Increased regional awareness of the benefits, costs and operational feasibility of interventions to reduce mother-to-child transmission.

3 – An expanded and effective regional network of people living with HIV/AIDS in six countries advocating for improved care and support and contributing to national policy development

4 – Improved regional capacity to design, implement and evaluate interventions to reduce high-risk behaviour related to the spread STI/HIV infection.

5 – More comprehensive and accurate information on the course, consequences and costs of the epidemic through improved surveillance, monitoring and evaluation of national control programmes and through operational research.