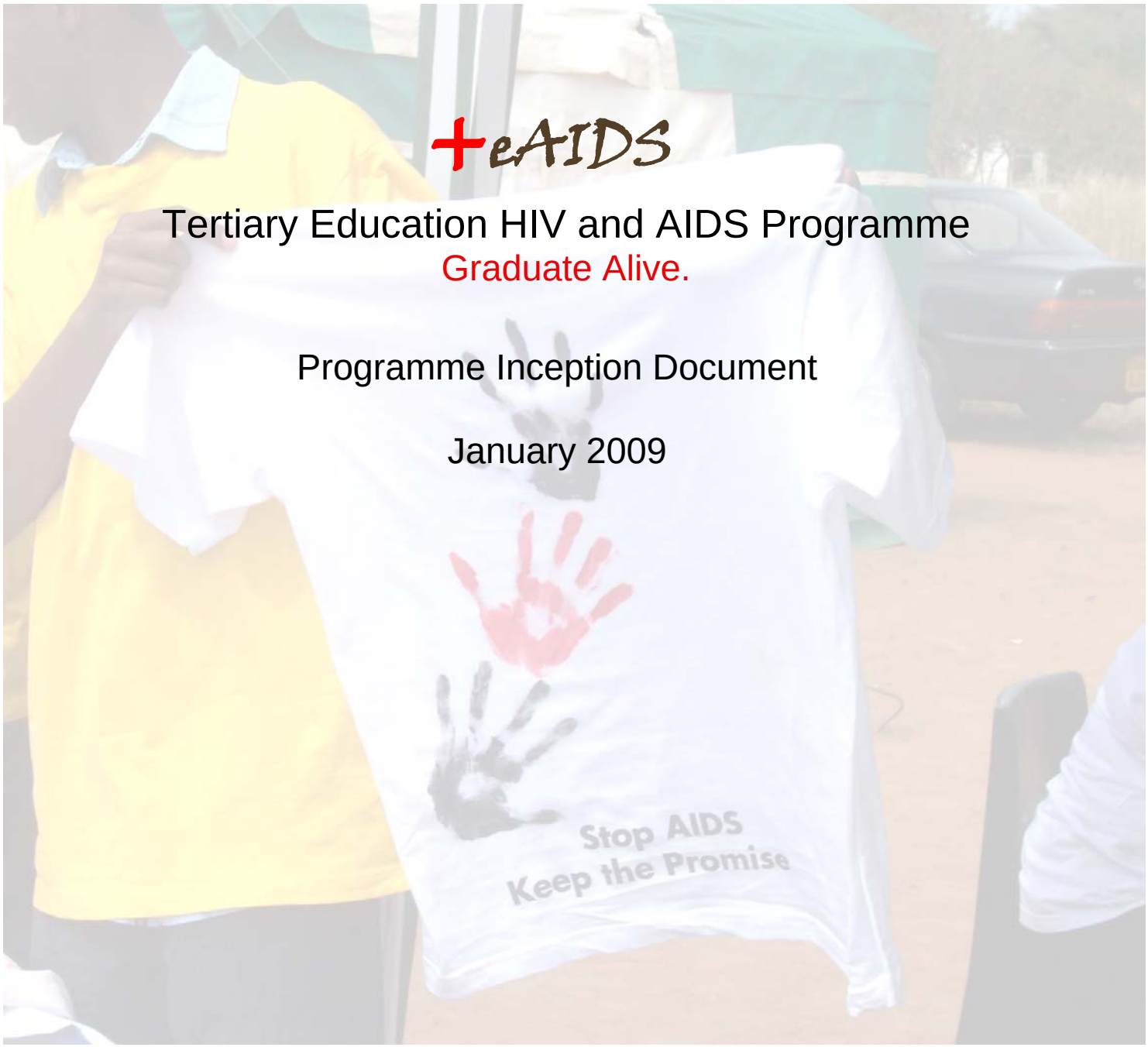


+eAIDS

Tertiary Education HIV and AIDS Programme

Graduate Alive.

Programme Inception Document

January 2009

TERTIARY EDUCATION COUNCIL

Transforming Tertiary Education in Botswana

TABLE OF CONTENTS

GLOSSARY OF ABBREVIATIONS

ABC	Abstinence, Be faithful, Condomise
ACHAP	African Comprehensive HIV and AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretrovirals
AZT	Zidovudine
BOTA	Botswana Training Authority
CDC	Centres for Disease Control and Prevention
GIPA	Greater Involvement of people living with HIV Principles
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IPT	Isoniazid TB Preventative Therapy
KRA	Key Result Area
MASA	Botswana ARV Programme (MASA – meaning New Dawn)
M&E	Monitoring and Evaluation
MM&E	Motivation, Monitoring and Evaluation
MOE	Ministry of Education
MOH	Ministry of Health
MLG	Ministry of Local Government
NACA	National AIDS Coordinating Agency
NACP	National AIDS Control Programme
NHRDS	National Human Resource Development Strategy
NSF	National Strategic Framework
PMTCT	Prevention of Mother to Child Transmission of HIV
RHT	Routine opt-out HIV Testing
SADC	Southern African Development Community
SRC	Student Representative Councils
STI	Sexually Transmitted Infection
SRH	Sexual Reproductive Health
T.E.C	Tertiary Education Council
ToR	Terms of Reference
UB	University of Botswana
UNAIDS	United Nations AIDS Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session (on HIV and AIDS)
VAT	Value Added Tax
WHO	World Health Organization

EXECUTIVE SUMMARY

With over 32,000 young adults enrolled by 2004, Botswana's tertiary education sector has a critical role to play in confronting the challenges of HIV and AIDS. Young adults represent a high risk group for the transmission of HIV and they are also the generation that has been most impacted by HIV through the loss of loved ones and the loss of essential services.

Tertiary education students (youth and mature students) represent a key component in the future triumph over HIV as they form the forthcoming skills set for the country, the doctors, nurses, entrepreneurs, social workers and other high level workers who will drive and develop the economy and the future response.

Tertiary institutions must begin to provide students and staff with the entire gamut of HIV services – psycho-social support, prevention interventions, support for students whose families have lost breadwinners, counselling and testing etc. In addition, tertiary institutions need to scale up their response to the human resources gap that has been left by HIV and AIDS. But to add to these mammoth challenges, the sector is more than 20 years delinquent in its response. The sector needs to work efficiently and effectively to catch up and succeed in contributing to the intellectual capital needed in our national response.

The Tertiary Education HIV and AIDS Programme (teAIDS) seeks to go beyond awareness to coordinate fragmented efforts in order to construct a comprehensive sector-wide response to HIV and AIDS that is coherent in terms of strategic direction, co-ordinated in terms of management and better linked to the national policies and programmes. The teAIDS strategy will involve three transitions for all tertiary institutions that will help initiate or scale up their response and their ability to provide services for students and staff. The three transitions (Filling the Gap, Support and Research) will embrace seven interconnected thematic pillars:

1. Leadership, motivation and commitment
2. Prevention and testing
3. Support and treatment literacy
4. Expertise and best practices
5. Motivation and community engagement
6. HIV and Me
7. By Us, For Us (Research)

Because the programme is stakeholder-driven, input and commitment is needed from institutions, staff and students and the Tertiary Education Council must assist institutions in preparing for the transitions that lie ahead. The strategic plan must be guided by a Baseline Audit of institutions which will include focus groups, site visits, self administered questionnaires and other measurement tools. The programme will also benefit from the ongoing strategic and technical support of a multi-sectoral Advisory Team comprised of professionals from the tertiary, youth and HIV sectors.

"When HIV is present in the human body, it inhibits the ability of the immune system to respond to what would, in normal circumstances, be manageable illness. When the virus is present in education, it inhibits the ability of the system to deliver what, in normal circumstances, would be achievable outcomes," (UNESCO 2007)

1.0 PROGRAMME JUSTIFICATION

1.1 Global Overview

The Human Immunodeficiency Virus (HIV) has caused the deaths of more than 25 million people and infected a further 33.2 million people worldwide. Everyday, more than 6800 people are newly infected with HIV and more than 5700 people die from AIDS (Acquired Immune Deficiency Syndrome). By the year 2020, projections estimate that more than 100 million preventable deaths will have resulted from HIV related illnesses (UNAIDS 2007).

1.2 The context of HIV and AIDS in Botswana – "Highest Prevalence, Highest Response"[1]

Botswana has been one of the countries hardest hit by the HIV pandemic, since the first case was reported in December 1985. Over the last two decades the extent of infection has progressed rapidly, re-shaping sectors of society, individuals and institutions alike. As a consequence, HIV has weakened the immune system of the country by undermining the impressive development gains made in Botswana since independence. Notwithstanding the formidable challenge, the response has been nothing less than impressive. Through a combination of political leadership, the provision of considerable national financial resources and the support of the international community, Botswana has showed signs of achieving some measure of management and control of this epidemic. The key instruments through which the response has been driven are as follows:

[1] Former President Festus Mogae, Speaking at the 2006 International AIDS Conference (Toronto, Canada)

Table 1.1 Botswana Government Responses by Year (Policies, Strategies and Programmes)

Instrument	Year	Objective
Policies and Strategic Frameworks		
Short Term Plan	1987 – 1989	To guide the mobilization of the nation to respond to HIV and AIDS.
Medium Term Plan I	1989 – 1993	To guide the governance and the coordination of HIV and AIDS programmes in Botswana.
National Development Plan (7)	1991 – 1997	To provide a guide and framework for a multi-sectoral response to the HIV and AIDS epidemic
Botswana National Policy on HIV and AIDS	1993 (revised 2004)	To guide the governance and the coordination of the HIV and AIDS Programmes in Botswana.
Botswana National Youth Policy	1996	To provide the Government of Botswana with the opportunity to promote the four national principles amongst young people; outlines needs and risks that young people face.
National Population Policy	1997	To address major concerns and issues critical to the growth, structure and characteristics of our population and provides strategies to influence them in a manner conducive to the attainment of sustainable human development.
Medium Term Plan II	1997 – 2002	To provide strategic guidance in the national response focusing on preventing the spread of HIV and mitigating the impact of HIV and AIDS at all levels of society through a multi-sectoral and participatory approaches.
Public Service Code of Conduct	2001	To provide a foundation for sustainable HIV and AIDS programmes and services in the workplace.
Botswana National Strategic Framework	2003 – 2009	To provide strategic guidance on the national response with reference to goals, objectives, targets, indicators and strategies.

National Response Structures		
National AIDS Control Programme (NACP)	1987	To coordinate the National AIDS Programme and Sexually Transmitted Diseases.
AIDS/STD Division (MOH)	1992	NACP and STD programme merged.
National AIDS Coordinating Agency	1999	Responsible for mobilizing and coordinating a multi-sectoral national response to HIV and AIDS.
Department of HIV and AIDS Prevention and Care	1999	To provide leadership in the delivery of HIV and STI preventative, care and support services through policy development, implementation, guidance and coordination of health sector responses.
Programmes		
Information, Education and Communication (IEC)	Late 1980s	To create awareness through advocacy for prevention of HIV; to mobilize different partners and stakeholders to get involved and actively participate in the national response.
Screening of Blood and Blood Products	1986	To contribute to the reduction of the spread of HIV and other blood borne infections by screening blood and blood products.
AIDS at the Workplace Programme	1990	To mitigate the impact of HIV and AIDS among the workforce in different workplaces.
Sexually Transmitted Infections Control Programme	Early 1990s	To contribute to the reduction of HIV transmission through the reduction of other sexually transmitted infections.
Community Home Based Care (HBC)	1995	Ensuring quality of care at all levels from health facilities to home level for the terminally ill.
Prevention of Mother to Child Transmission (PMTCT)	1999	To reduce morbidity and mortality, and improve child survival through prevention of HIV (vertical) transmission from mother-to-child.
Isoniazid TB Preventive	2000	To prevent TB among people living with

Therapy (IPT)		HIV.
Voluntary Counselling and Testing (VCT)	2000	To provide opportunities and emotional support for HIV testing in the whole country.
Masa/HAART Programme	2002	To reduce morbidity and mortality from HIV and AIDS through the provision of free antiretroviral treatment.
Routine opt-out HIV testing (RHT)	2004	To increase the uptake of HIV testing, and provide early referral for HIV treatment, care and support services.

According to the Botswana AIDS Impact Survey (BAIS II 2004), there are an estimated 300,000 people living with HIV in Botswana, which gives Botswana a national prevalence rate of 17.1% (for all citizens aged 18 months – age 64). The estimated life expectancy is 55.6 years.

The adjusted HIV prevalence among pregnant women aged 15-49 in Botswana is 33.7%. Three districts had a prevalence over 40% (Selebi-Phikwe 49.0%, Chobe 45.6%, and Bobirwa 42.9%) (Botswana 2007 Sentinel Surveillance Survey).

Recent epidemiological models conducted by the National AIDS Coordinating Agency (NACA) indicate that the number of new infections for the 15-49 age group (both males and females) is approximately 18,000/year, giving Botswana an incidence rate of 2.4% in 2007. In real numbers that means we still have close to 50 people becoming newly infected on a daily basis in Botswana alone (NACA 2008).

Estimates from 2008 also show that approximately 19,600 children are living with HIV (NACA 2008). Due to Botswana's free antiretroviral (ARV) programme, many of these children are living healthy lives, having grown up positive from birth they are now continuing through the education system with their age-mates. Children progress through HIV at different stages than adults and as treatment improves, more and more children living with HIV will have the opportunity to continue to tertiary education. In addition, tertiary institutions are already experiencing the effects of large numbers of orphans and will increasingly need to provide socio-economic and emotional support to children who have lost one or more parents due to HIV, in addition to providing better services for students who are HIV positive, and also preventing new infections.

The prevention approach in Botswana has, until recently, largely focused on the behaviour change principles of the ABC Model – Abstain, Be Faithful and Condomise and VCT (Voluntary Counselling and Testing). In 2003, more than 10,000 condom dispensers were procured and installed for free. Today, however,

Empty Condom Dispenser, Gaborone Botswana

many of these dispensers across the country sit empty. However, the government and other supporting organizations distribute millions of condoms per year. Research and monitoring strategies are needed to evaluate the successes of such interventions to understand these seemingly incongruous trends.

Since the early 1990s. the Sexually Transmitted Infections Control Programme has contributed to the reduction of HIV transmission through the syndromic management of sexually transmitted infections, including the nationwide Acyclovir roll-out strategy to control genital ulcer disease. Strong evidence supports several biological mechanisms through which STIs facilitate HIV transmission by increasing both infectiousness and HIV susceptibility. Thus, detection and early treatment of individuals with STIs and prevention are important components of an HIV control strategy. Measures for strengthening partner tracing are ongoing. Promoting male circumcision is being recognized as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men. Plans to re-introduce it at a larger scale are ongoing.

Where there are no interventions, approximately one third of all babies born to HIV positive mothers will become infected during pregnancy, birth or breastfeeding. The Prevention of Mother to Child Transmission of HIV (PMTCT) programme in Botswana was the first national programme to distribute antiretroviral drugs (1999). The PMTCT programme includes not only preventative medications and counselling but also a one year supply of infant formula for mothers who choose not to breastfeed. To date, the programme uptake is 89%, with 96% of babies born from PMTCT mothers being HIV negative, indicating a reduction in HIV transmission from 40% to 4% (NACA 2008).

Since its inception in 2000, Voluntary Counselling and Testing (VCT) plays a critical role in both HIV prevention and treatment. By 2005 over 300,000 people (of a total population of 1.8 million) had undergone voluntary testing.

Mortality rates have started to decline mainly due to a free ARV programme for all citizens, initiated in 2002. Funded by Government and with substantial donor assistance from the Merck Company Foundation and the Bill and Melinda Gates Foundation (known together as ACHAP or the African Comprehensive HIV/AIDS Partnerships), the programme commenced in 2002 and within three years 54,378 people were on ARV medication. According to the World Health Organization (WHO) this was about 85% of those who were in need of treatment and even more encouraging was the fact that they were adhering to the drug regime. By April 2008, more than 100, 517 people were taking antiretroviral treatment, more than 95% of those who need it (NACA 2008).

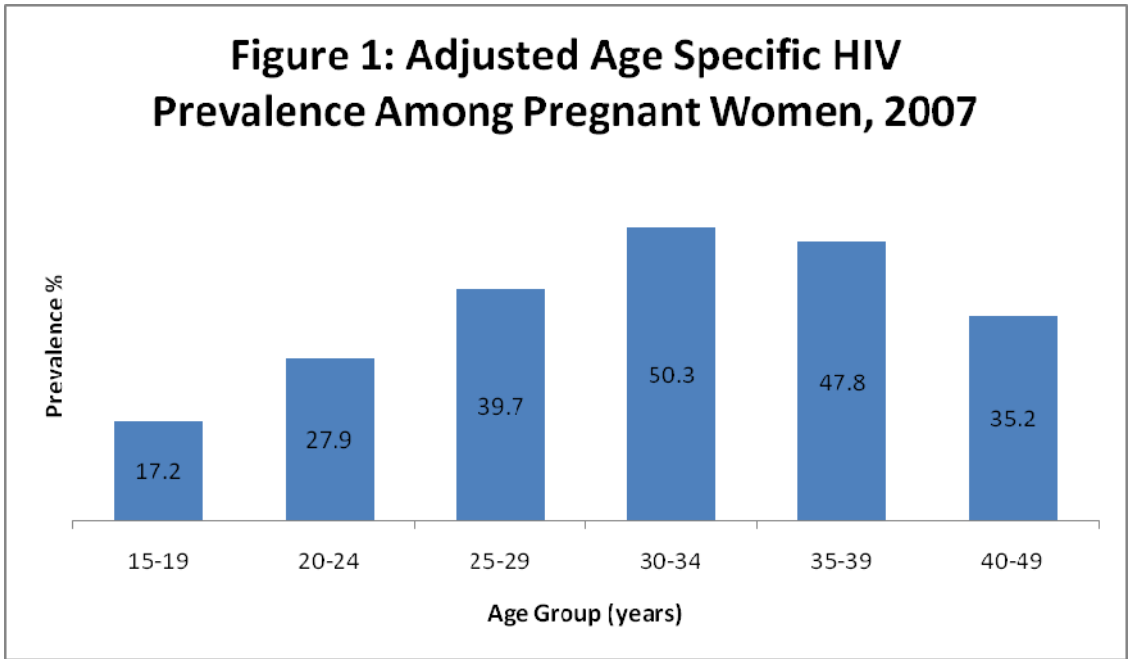
In January 2004, Botswana became the first country in the world to introduce Routine Opt-Out HIV Testing (RHT). HIV tests are now offered as a routine part of health checkups and appointments in public and private clinics. People who do not wish to test have the choice to “opt-out” if they wish. This approach was initiated not only to destigmatize HIV and treat the test just like any other procedure, but also to help Botswana understand the extent of the epidemic and to facilitate early diagnosis and treatment.

The roll-out of Antiretroviral Therapy (ART) has drastically reduced the number of AIDS deaths, averting approximately 50,000 adult deaths through to the end of 2007. If we can assume that the coverage and commitment of ART remains high and medications are taken properly by individuals, then we can expect ART will avert approximately 130,000 AIDS-related deaths through to 2016 (NACA 2008).

1.3 The Challenges Persist

With no cure in the pipeline, however, major challenges remain. If treatment has progressed in leaps and bounds, prevention still seems to be making only baby steps. Botswana’s estimated incidence rate (the number of new infections – roughly 18,000 per year, or 49 per day) is not falling fast enough (NACA 2008). Recently, residents of smaller villages have complained publicly, expressing concern that many people still view HIV as an ‘urban’ disease because there is still very little education on HIV and other health issues that reach the rural areas. Residents of Marapong village reported that “rural areas are miles behind the rest of the country when it comes to HIV and AIDS issues” (Daily News, July 2008).

In a recent report on Botswana’s progress to UNGASS, NACA said the following: “Although the provision of ART and the PMTCT programmes on a national scale have significantly reduced the number of deaths in recent years, this is expected to reverse in the not-so-distant future with the number of deaths again increasing year-on-year.” (2008 Progress Report to UNGASS, NACA). There is no time to rest.



Source: 2007 Botswana Second Generation HIV and AIDS Sentinel Surveillance Survey Results, Ministry of Health, Botswana.

The most recent HIV Sentinel Surveillance Survey (2007) reports that 33.7% of pregnant women aged 15-49 years are living with HIV. As seen in Figure 1.1, the most affected age groups fall between the ages of 20-50 – which make up the bulk of tertiary student and staff populations.

Stigma is proving hard to break down, likewise a significant breakthrough in behavioural change has yet to be witnessed, skills and capacity erosion across all sectors of society has to be dealt with, and the costs of treatment (US$ 1 million/1000 people per year) are not sustainable unless new infections are reduced to zero. In addition, ignorance around HIV and AIDS issues still persists, staffing the healthcare programmes is a major problem due to an ongoing shortage of healthcare workers, and extending counselling and treatment throughout Botswana's vast rural expanse has yet to be achieved. This requires a multifaceted response to the challenges that the virus poses and in a manner that brings the various role players together through a co-ordinated and systemic approach.

The literature abounds with detailed discussions and ghastly predictions about the effects that HIV has had and will have on the economies of highly-affected countries. Box 1.1 highlights some of these impacts and the deterioration of the human, physical and social capital that results here as well.

Box 1.1: HIV and Economic Growth

The HIV epidemic has a negative impact on economic growth because it deteriorates the necessary human, physical and social capital.
Human Capital – HIV affects adults in their most productive years. Household expenses increase, younger generations suffer because of less money and fewer trained professionals are there to pass on the skills. Also, financially constrained households tend to remove children from school to help support the family.
Physical Capital – families who have a loved one that is sick tend to draw on savings and ultimately do save even less. Government is also unable to save due to costs of ARV treatment and other health-related costs.
Social Capital – people who are of age to pass knowledge such as norms, understandings, networks etc are sick or dying. This changes society and government must struggle to address the side effects such as basic social services, regulatory and legal frameworks, ensuring security etc.

Source: UNESCO 2007

An HIV-free future can only be achieved through HIV-free youth. Because tertiary institutions are made up of so many young people, T.E.C has a national responsibility to work towards this goal in an extraordinary way.

1.4 The Challenge for Tertiary Education

The impacts on the education sector have been well documented and some of the impacts are summarized in Box 1.2.

Box 1.2: The Impacts of HIV on Education Content, Function and Expectations

HIV and AIDS impact:

A. The context for education:
- Economic
- Social
- Cultural
- Health

B. The functioning of an education system:
- Demand
- Supply and costs
- Management and process
- Quality

C. Expectations for education:
- Contribute to preventing the spread of HIV
- Greater community involvement
- Attainment of equity goals
- Renewed stress on the acquisition of productive skills
- Improved information about the system

Source: UNESCO 2007

HIV is not just affecting individuals and families but it is also affecting organizations and systems. Illness, care-giving and death all affect one's capacity to work and study – affecting students and staff. Absenteeism due to illness, depression, stigma and death have clear impacts on productivity. Skills and knowledge that help companies and governments flourish and grow are literally disappearing and can ultimately have huge impacts on the economy. The entire educational sector is affected by HIV and AIDS.

Students at any level of education are impacted by HIV. Below is a short list compiled by a group of African institutions who came together in 2007 to discuss the impacts HIV with the United Nations Educational, Scientific and Cultural Organization (UNESCO). These are just some of the impacts on classrooms that UNESCO has been able to measure from highly affected countries around the continent:

- Frequent teacher absenteeism, with classes being left for days, even weeks to learn on their own;
- Shortages of teachers in specialized areas such as mathematics or science;
- Increased reliance on less qualified teachers;
- Learners are frequently absent, participate intermittently or drop out;
- A concern for the sick at home takes attention away from teaching and learning;
- Frequent periods of grief and mourning in schools, families and communities;
- Unhappiness and fear of stigmatization and ostracism on the part of both teachers and learners who have been affected by the epidemic;
- Uncertainty and anxiety in the relations between learners and teachers (who may be caricatured by the community as those responsible for the introduction of HIV);
- Teachers' uneasiness, fear or ostracism experienced due to their personal HIV status

One of the tragedies of having such a high HIV prevalence is that much of *what* impacts individuals and *how* it impacts individuals cannot be measured and counted in an easy way. It is not really possible, for example, to quantify the trauma that a person experiences who is either infected or affected. The loss of a loved one, or the difficulty of illness, or the tensions of care-related multitasking are not easily calculable. Although they cannot be measured, they certainly do impact the education systems, teachers and learners and their families alike.

In Botswana, similar to other countries around the region, the dual context of migration and HIV has had negative consequences for the education sector. Migration for purposes of employment has globally been identified as one of the factors that increases one's vulnerability to HIV. Although education has not generally been categorized as "migratory", teachers, students and other

personnel may share some of the same experiences as migratory workers as they are often reassigned to locations where their services are most needed. This can result in a lack of access to certain programmes, including those related to their health and HIV status. In particular the following situations may put teachers and students at increased risk:

- Full-time boarding programmes for students
- Trainee teachers who have to make their own accommodation arrangements
- Teachers who cannot be accompanied by their families
- Teachers who attend long training courses and are separated from families
- Students from rural areas who relocate to urban centres to gain access to certain skills/courses
- Students on external placement for tertiary education

According to UNAIDS, young people between the age of 15-24 are considered to be the most at risk for HIV. Of the 33.2 million people living with HIV, it is estimated that more than 10 million are in this age group. Equally frightening is that almost half of all new infections (more than 6000 total per day) occur amongst young people (UNESCO 2006).

Some studies show that tertiary education is characterized by a vast landscape of sexual experience (Epstein 2001, Chilisa 2001, Saint 2004, Chetty 2004, Katahoire 2004, UNESCO 2006, AAU 2007). Students in tertiary institutions are generally a mix of sexually inexperienced and sexually mature – a phenomenon which often leads to intergenerational sex, power-laden relationships and gender-based violence. Many students are also leaving home for the first time to live independently in the socially charged atmosphere that characterises life in tertiary education institutions. Box 1.3 illustrates some of the other pressures that put students at risk. This is a potent recipe for facilitating HIV transmission.

Box 1.3: Characteristics of University/College Life That May Put Students at Risk:

- Enhanced personal freedom
- Attractions of city/urban life
- Peer pressure
- The commonplace of casual sex
- The commonplace of multiple sex partners
- Reports of “sexually transmitted grades/degrees”
- Reports of transactional sex
- Reports of intergenerational sex

Source: UNESCO 2007

It has been said that it is at university that sex ceases to be taboo and enters the realm of the expected (Epstein 2001). Studies in both South Africa and Zimbabwe have indicated that males (and increasingly females) often use their University and College years to acquire as much sexual experience as they can. Studies also indicate that unplanned pregnancies are common and a lot of pressure exists to be in a relationship. Tertiary education brings together youth who are in their peek years of sexual activity and

experimentation and puts them in close proximity of one another with no systematic supervision. In addition, it brings together youth and mature students from different regions, different socio-economic backgrounds and can also be a space where gender dynamics and economic disparities begin to shape peer pressures. Box 1.4 shows some examples of behaviours that are frequently

Box 1.4: Behaviours That May Put Tertiary Students at Increased Risk

Studies show that the following behaviours are common in tertiary institutions around the region:

- Unplanned sexual encounters (alcohol influence)
- Peer Pressure
- Increase in alcohol consumption and drug use
- Instances of rape
- Societal pressures on males and females to have first child
- Transactional sex
- Intergenerational sex
- Sexually transmitted degrees/grades
- Increase in adventure/experimental activities involving alcohol, drugs and sex

Source: UNESCO 2007

reported at tertiary institutions from around the region. Tertiary education is often reflected on as a liminal space and time – it represents a moment "in and out of time" – no longer a youth, but not yet a full adult. Liminal spaces are generally associated with special and extraordinary experiences, less restrictions, more peer pressure and a suspension of what is considered normal (Turner 1967).

Tertiary education institutions need specific, custom-made responses. Although many of the students may be part of the same age continuum as secondary students, tertiary institutions are unique in that they are providing training to young adults, most of whom are already sexually active and living independently. Furthermore, tertiary institutions enrol not only youth but also large numbers of mature students returning to school to upgrade skills or access new courses. Historically, the HIV response in education has often been centred around "teaching HIV and AIDS" – mainstreaming HIV content into the curriculum and giving students some general knowledge about the epidemic. However, tertiary education is structurally difficult because students are not required to come together in any kind of formal way, nor are they required to take a few core classes as they are in secondary school, which presents challenges for a curriculum approach, even through simple awareness.

AIDS mortality has an immediate impact on the numbers of persons to be educated. Less candidates enrolling in primary education, consequently filters up to the tertiary level where it will eventually translate to less graduates. Smaller numbers of graduates means smaller numbers of professionals which can translate to less innovation, less national potential and a decrease in global competitiveness. Tertiary institutions depend on new intake of students each

year – this is what helps tertiary institutions to survive. This same group of youth that has so much potential to grow and prosper is also the group that has been most affected and infected with HIV. The current statistics imply that it is certainly possible that a percentage of our students arrive at tertiary school already living with HIV. Many of our students have suffered a lifetime of loss over the last decade. And without universal access to prevention coupled with individual responsibility, some will also become infected while they are at school.

Virtually all of the global health organizations that deal with HIV (WHO, UNAIDS, World Bank, CDC etc) have, at one time or another, called youth the "window of hope". Optimistic governments and HIV and AIDS service organizations have also coined youth "the HIV-free Generation". This statement could not be farther from the truth. In fact, youth of today cannot be the HIV-free Generation – they are already the generation *most impacted* by HIV. Young people under the age of 30 have grown up with HIV – they have **never** known a world without AIDS. In fact, they bear the full brunt of the epidemic – they suffer from it by loss of family and friends, they are orphaned by AIDS and today they are the people most likely to become infected. HIV is the leading cause of illness and death amongst young people. They account for more than half of all new infections (UNAIDS 2007).

Despite the challenges they face, youth still **can** be the "window of hope" … **if** they can do what previous generations have not been able to do in the last 30 years….

1. Develop and practice consistent safer sexual behaviour
2. Openly and confidently address shame, stigma and discrimination
3. Create an environment for discussion and debate
4. Treasure and manage safer sexual relationships

To accomplish these goals, youth need an extraordinary intervention. The education sector owes it to them to go beyond awareness.

1.5 Tertiary education at the Centre of a Solution

Tertiary institutions exist in inherent leadership and knowledge skills building and shaping environments. Their core responsibilities are to disseminate knowledge, build skill sets, and to nurture future leaders. Tertiary education institutions are the epicentres of excellence and should be standing at the forefront in research, addressing social taboos and fighting stigma and gender inequalities. Instead, many of these institutions have been strangely silent. The traditional autonomy of tertiary institutions perhaps combined with an expectation that they are capable of handling their own affairs may contribute to the silence. For the most part, tertiary institutions enjoy a tradition of autonomy that surpasses that of primary and secondary institutions. Unfortunately, with regard to HIV, this autonomy can

actually become a liability, as it often leaves tertiary institutions outside the field of action taken by ministries at a national level.

With over 32,000 young adults enrolled by 2004, a number that is set to substantially increase over the next two decades, Botswana's tertiary education system has a critical role to play in confronting the challenge of HIV and AIDS. As previously demonstrated, students (both youth and mature students) represent the group that is most at risk. However, students also represent a key component in the future triumph over HIV as they form the forthcoming skills set for the country, the doctors, nurses, entrepreneurs, social workers, in sum the high level workers who will drive and develop the economy. The considerable amount of investment that is currently being made in their future (and that of the nation) cannot be wasted. Without them and the future contribution they will make to society, the current efforts in responding to the HIV and AIDS challenge will come to nothing. It is the current generation of students that will be the future leaders and decision makers who will shape what will hopefully be an HIV and AIDS free destiny for Botswana. Their future livelihood and contribution to that destiny is of such fundamental importance that it cannot be left to chance. Of equal importance are the lecturing staffs that teach the students and are central to Botswana's research, knowledge and innovation system as well as the support staff who provide the services which are essential to the operations of each tertiary education institutions.

In addition, due to the macroeconomic impact that HIV is making on Botswana's economy (1.5% annual fall of GDP and by 2021 the GDP will be 25% - 35% less than it would have been without HIV), we need students to make a future contribution toward the growth of the economy and the country as a whole – now more than ever (NACA and UNDP 2007). If students are not in school because of illness or because of caring for someone who is sick, or because they need to work to replace breadwinner income, we will see an overall decline in productivity, skilled economic growth, labour and ultimately a reduction in national competitiveness – not to mention an increase in costs and dependence on government for social amenities.

While there have been some commendable responses from some individual tertiary institutions and coordinating bodies to raise HIV and AIDS awareness and promoting models such as ABC (Abstinence, Be Faithful and Condomise), these have largely been uncoordinated and little evaluation of their success has been undertaken at a national level. The lesson that is being learned is that awareness campaigns and other activities are not enough to motivate behaviour change.

Therefore, this project proposal seeks to go beyond awareness and also to bring the existing fragmented efforts together and to build a comprehensive system-wide response to HIV and AIDS that is coherent in terms of strategic direction,

coordination, implementation and monitoring and one that has improved linkages to the national policies and programmes.

Tertiary institutions are in a position to make a significant contribution within the multi-sectoral response framework by using their comparative advantage of advanced study and research. They also transmit an accumulated body of knowledge to learners, they create new knowledge and they expand the boundaries of existing knowledge. In addition, they are almost solely responsible for the preparation of a large segment of the professional and skilled population. Tertiary institutions are capable and have the capacity, through medical and social research, to generate new knowledge that can have a huge impact on this epidemic. The latter can facilitate evidence based programming and cost-effective interventions that address expressed needs. Yet, a culture of silence still abounds.

1.6 A Brief Scan of Best Practices in Tertiary Institutions

"Notwithstanding the few isolated initiatives, the institutions and their groupings carry on, for all practical purposes, as if the disease does not exist." (Michael Kelly, after completing a review of tertiary responses to HIV in Sub-Saharan Africa in 2001)

A brief regional scan of the literature relating to HIV in tertiary settings yielded a paper trail of activity showing that there have been improvements since 2001. Best Practice Box 1.1 illustrates one of the exemplar pockets of significant responses from the University of Pretoria.

Best Practice Box 1.1 Centre for the Study of AIDS, University of Pretoria (South Africa)

The Centre for the Study of AIDS (CSA) is located on campus at the University of Pretoria. It is a "stand alone" centre that is self-funded with more than 50 staff members and more than 500 volunteers. The centre alone is responsible for the development and coordination of a comprehensive University-wide response to HIV. The centre cooperates with top management of the institution and also the umbrella organization for tertiary institutions in South Africa – HEAIDS (Higher Education HIV and AIDS Programme).

The CSA meets regularly with faculty committees to ensure they have a professional and personal understanding of the epidemic – the faculties themselves responded with programme-specific curriculum interventions.

Support for staff and students is provided through peer education, counselling, VCT, support groups, awareness activities, condom distribution, educational workshops etc.

In addition, the CSA has created a climate of debate and critique through its widely publicized AIDS Forums and Seminars. They regularly bring speakers to provide fresh ideas and perspectives. They have also joined forces with the Centre for Human Rights to create an HIV and Human Rights Research Unit, and they annually publish an AIDS Review.

The University of Botswana (UB) has also modelled a youth friendly Health and Wellness Centre aimed at promoting healthy lifestyles among students and staff through a variety of programs. Programs include HIV Voluntary Counselling and Testing, blood donation campaigns, Student Centred lunch hour (topics have included depression, self esteem, relationships, grief etc), health promotion assistants, wellness days, health related training to students, and an information resource area for students. The Health and Wellness Centre at UB is an excellent model for other tertiary institutions to consider, especially with the assistance of youth-friendly stakeholders around the country. In addition, UB will soon launch its own Centre for the Study of HIV and AIDS in early 2009.

Other studies from the region speak in a murmur about awareness activities and pockets of innovation (UNESCO 2007). Where a response has been initiated it is usually characterized by the following trends:

- A health response, rather than a holistic one
- A non-research culture
- Notional awareness rather than concrete actions or activities
- Focus on prevention, not proactive control
- Initiatives from individuals or departments as opposed to efforts to mainstream HIV and AIDS across the whole institution
- Limited effort to replenish societies' AIDS-depleted skills
- Concentration on awareness-raising at the expense of behaviour change.

In Botswana, the following general observations have been noted:

- Lack of individual responsibility and commitment to curb the spread of HIV – instead there is an over-reliance on government to curb the spread
- High reliance on collective efforts for behaviour change as opposed to individual efforts
- Lack of understanding of mainstreaming of HIV and AIDS across the sectors – e.g. tertiary institutions using their comparative advantage to do research on HIV and AIDS in order to guide programming
- Delays in alignment of curriculum with emerging epidemiological trends such as HIV and AIDS
- Delays in training professionals in skills most depleted by the impacts of HIV and AIDS – e.g. healthcare, education sectors
- Delays in training and employing people in service areas that emanate from the impact of HIV and AIDS such as psychology, child and adolescent counselling and community development

Some of the best practices from the continent are summarized in Table 1.2. When this programme is launched, tertiary institutions in Botswana can look to some of these practices (and the ones from UB and the University of Pretoria above) as examples of projects that institutions can benchmark from.

Table 1.2 Best Practices from Continental Scan of HIV Initiatives in Tertiary Institutions	
Country	**Initiative**
Burkina Faso	In 2004, the University of Ouagadougon launched a five year Institutional Plan (2005-2009) to respond to HIV. Part of the five year approach is a University Strategic Plan for HIV and AIDS Control through training and research. The strategy aims to raise awareness, conduct research on Opportunistic Infections and nutrition and to develop modules to be included in all student training.
Kenya	The Kenyatta University in Nairobi has launched an AIDS Control Unit to promote activities that will lead to the promotion of a healthy and productive resource for the nation. The programme includes peer education, annual bulletin, orientation package, compulsory core unit on HIV, condom distribution, counselling, VCT, training in lifeskills and HIV research.
Namibia	The University of Namibia has created a special fund for research related to HIV.
Nigeria	Ahmadu Bello University has developed a Youth Friendly Centre on campus funded by Nigeria's National Coordinating Agency and one of the National Banks. Inside the Youth Friendly Centre is an internet café, ATM, VCT, access to materials, media resources and counsellors. The centre also generates funds through the internet café.
South Africa	In September 2008 Vaal University Technology launched a new "fun and funky" HIV prevention campaign called the "Scrutinize HIV and AIDS Campaign". The campaign is linked to a series of new nationally aired television advertisements aims to empower young people with knowledge that will help youth reduce behaviours which put them at high risk for HIV. The campaign uses humour, animation and a funky graphic style to deliver its messages, personifying the virus itself as a ninja.

In addition to an increased response in terms of support and prevention, the sector needs to respond to the human resources gaps that are created by this pandemic. Regionally, there needs to be more evidence that institutions have increased their graduate or undergraduate numbers to meet the increased AIDS-related demands in certain professional areas (e.g. health, counselling, and education). Similarly, the sector (through tertiary institutions themselves) needs to demonstrate evidence of significant response to the in-country research needs. A research agenda is needed not only for the tertiary sector but also nationally – an clear research agenda which addresses not only academic research but applied research as well.

From the earlier and immediate "awareness" responses from the early 2000s (before antiretrovirals), it almost seems like HIV has silently retreated back to the realm of silence and shame. In this post-treatment era, few individuals or organizations in countries with universal access are engaged in activism. Yet, stigma persists. New infections are still occurring. All of the youth passing through tertiary institutions today have been heavily impacted by HIV. What is interesting is that virtually every arena in which tertiary education deals with

represents a legitimate field of interest and investigation for HIV and the impacts it is having on society – and yet these institutions, the intellectual epicentres of our countries, where youth who are impacted and infected reside – are stunningly silent.

2.0 PROGRAMME OUTLINE

2.1 Purpose

Tertiary education is at the core of developing Botswana's human resource and knowledge capabilities and has a critical role to play in actively responding to the HIV and AIDS pandemic. The Tertiary Education HIV and AIDS Programme (**teAIDS**) intends to establish a national system-wide, comprehensive, integrated and strategic HIV and AIDS programme that embraces the entire tertiary education system and focuses on interventions that will generate maximum impact. **teAIDS** will be the first co-ordinated approach to HIV and AIDS that incorporates all tertiary education institutions in Botswana which currently serve an annual enrolment of approximately 32,000 students and employs a corps of highly educated staff. **teAIDS** aims to harness the collective expertise and knowledge that resides within individual tertiary education institutions to provide a cohesive sector wide response to the challenges of HIV and AIDS. **teAIDS** supports Botswana's ambition to developing a nationally relevant and globally competitive tertiary education system by 2015 through the provision of high level human resources and beneficial knowledge and innovation which is a vital component of improving the quality of life and success of its entire people.

Because we are dealing with staff and students who are mostly sexually active and who are also responding to new contexts and pressures at their institutions, we must aim to go beyond prevention and awareness. As leaders in the intellectual realm, we also have a responsibility to feature more prominently in *leading* the response to this epidemic – that means we have to feature more prominently in research, innovation and steering the response.

The overarching goal of teAIDS is for all stakeholders in the tertiary sector to be: **HIV Aware, HIV Competent, HIV Safe** and **HIV Healthy**.

2.2 Baseline Audit

This project must be stakeholder-driven. Globally, there is a well-documented history of imposed projects that have, albeit with good intentions, failed. Before a sector-wide strategy is developed, we must consult our stakeholders. The first step will be regional consultative and informative workshops with all institutions. These workshops will invite three representatives from each institution (Institutional Leaders, HIV Coordinators and student Health Representatives) to come together to review the Programme's inception and intentions, to work in focus groups to discuss challenges, successes and ideas and to map the way forward. These workshops will be followed by the Baseline Audit.

The Baseline Audit of our institutions aims to answer three general questions:

- What is currently happening in our institutions in relation to HIV and AIDS?

- What is the current package being offered at institutions and how does it compare with the package outlined in the NSF?
- Does the current response meet the needs of our stakeholders?

The stakeholders of this project are teachers, students and staff of tertiary institutions in Botswana. They are also future professionals and leaders of the country and therefore a key part of T.E.C's mandate needs to address any major health crisis that threatens the future of our stakeholders, including the socio-cultural issues that may fuel the spread. HIV is threatening our staff and students. T.E.C must find out why, how much, and what can be done to mitigate the negative effects of this epidemic.

To answer those two vital questions, we must go to the institutions themselves. The Baseline Audit will be conducted over a four month period in 30 institutions between 2008 – 2009. The audit will be both quantitative and qualitative, knowledge based and also experiential. The audit will consist of:

- Site Visit (what do institutions have in terms of HIV services, programmes, IEC, physical space, counselling areas, resources etc)
- Knowledge Questionnaires (distributed to a sample of students to assess their own knowledge of HIV and how it works – this gives us an idea of what they have learned previously)
- Institutional HIV Responses (what the institution is doing, what is missing, what are the challenges, what structures are in place that contribute to the national response, is HIV part of the core business)
- HIV & Me Focus Groups (open ended questions and impact assessments of how HIV has affected students in their personal lives, discussions of behaviour change etc)

The Methodology for the Audit is still a work in progress. We are developing the measurement tools and will review them with stakeholders and the Health Research Unit at the Ministry of Health when necessary.

When the Baseline Audit is complete, the data will be entered, analyzed and a report on the findings will be developed and distributed. This report will feed the Key Result Areas to be developed for the Strategic Framework.

2.3 Strategic Framework

The **teAIDS** strategy and objectives will embrace 7 interconnected thematic pillars:

1. Leadership, Motivation, Commitment
2. Prevention and Testing
3. Support and Treatment Literacy
4. Expertise and Best Practices

5. Motivation and Community Engagement
6. HIV and Me
7. By Us, For Us

The seven pillars are an outline for now, but will be fed by the results of the Baseline Audit. After the Baseline Audit is complete, these pillars, as summarized below, will create the Transitions or Key Result Areas (KRAs) of the project. The seven pillars will be grouped together to form the strategy for intervention – which will take place in 3 Transitions/KRAs. Each transition has a list of 'priorities' for now – which will later become KRA 'Objectives' when the strategy is complete – we cannot draw conclusions about what is needed in tertiary institutions until we have the feedback from our stakeholders. As an institution we have to be cognizant of emergent strategies during the implementation stages.

Note: We have used the word "transition" rather than "phase" because "phase" implies something brand new. For some institutions, they are already engaged in an active HIV response – so this will not be a new addition – but rather a "transition" into a more holistic, coordinated and strategic approach that is relevant to the whole sector.

Transition 1: Filling the Gap

Depending on the results of the Baseline Audit, some institutions may already be well underway in accomplishing some of the objectives that will be created under this transition. The first essential pillar is leadership at the highest level of each institution by management and students, evidenced in the form of strategy, policy, advocacy, resources and a firm commitment to achieving tangible results. Leadership must be at the top otherwise the huge freight which rests upon it and all of the future efforts to be undertaken will topple.

Prevention, treatment, care and support programmes which go beyond awareness and the distribution of condoms (which characterises the current approach of many institutions) to include counselling, testing, treatment, care and support services as well as peer education must be included under this Transition. These include specific services to both students and staff including work-based programmes for the latter that will inter alia provide employee based training on all aspects (legal, prevention, and management) of HIV and AIDS. This transition will require a financial commitment from T.E.C and all institutions, as well as a Minimum List of Requirements for institutions which is aligned with the NSF.

Thematic Pillars:

Leadership, Motivation, Commitment
Prevention and Testing
Support and Treatment Literacy

Critical areas of this transition that must feed the objectives will be:

- leadership, literacy and commitment
- defining roles and responsibilities for all players
- defining minimum requirements for institutions
- link institutions together and set schedule so they can meet and share
- health services for prevention and support for all stakeholders
- monitoring and evaluation

Transition 2: Support

A recent survey in Botswana indicated that 40% of new patients being treated with ARVs said they delayed seeking treatment because of stigma (Wolfe 2006). Stigma – like lack of committed leadership – can be a significant barrier to any interventions. Stigma must be addressed in a relevant and significant way. Institutions must create Institutional Policies and put the GIPA Principles into practice.

A commitment to MM&E (Motivation, Monitoring and Evaluation) is essential. T.E.C and institutions should work together to create sustainability plans and to strengthen networks between institutions to share best practices and motivate volunteers.

Thematic Pillars:

Expertise and Best Practices
Motivation and Community Engagement

Critical areas of this transition that must feed the objectives will be:

- strategies and activities to fight stigma
- strengthen district and institutional networks
- strategies for ensuring sustainability of programmes at institutions
- define and share best practices between institutions and in SADC region
- MM&E

Transition 3: Research

HIV does to tertiary institutions what it does to the body – it undermines the systems that should be there to protect us. The only sustainable and long term solution to the HIV and AIDS crisis is the development of a knowledge base that will for the moment inform us how to manage the disease and over the long term lead us to a cure, or a vaccine at the very least. Tertiary education institutions have an important role to play in these twin endeavours and their individual efforts need to be supported so as to ensure a co-ordinated approach which maximises the resources (human and financial) available and promotes the sharing of knowledge and understanding.

"By Us, For Us" (BUFU) denotes an active effort to do research on HIV in Botswana from within Botswana. We have the capacity and the ability to do both clinical and social research. Institutions from surrounding countries have engaged both undergraduate and graduate students in research and host annual student-driven research forums. See Best Practice Box 2.1 which highlights the annual "Imagined Futures" Conference held through the Centre for the Study of AIDS at the University of Pretoria.

HIV and Me will address issues of Behaviour Change. This incorporates all of the Thematic Pillars but becomes especially important with research – in order to document behaviour change, we must seek and record input from our stakeholders who are impacted by HIV. Each institution should be actively engaging students in research on behaviour change. In particular it is important to research on factors that contribute to an apparent lack of behaviour change, despite the high knowledge level that prevails. We can't make assumptions based on statistics. We must gather qualitative data.

Best Practice Box 2.1 Imagined Futures Annual Conference (University of Pretoria, South Africa)

"Imagined Futures" is an annual conference hosted by the University of Pretoria. The conference is volunteer and student driven with much of the content coming from University students and staff from around the region.

Conference topics have previously included:

- **Studying and stigma**
- **Living positively on campus**
- **Male sexuality and peer education**
- **ARVs and Adherence on Campus**

Conference attendees include students, teachers, leaders in the field, researchers and programme managers.

The conference seeks to create a platform for students and practitioners/programme managers to interact with each other in order to facilitate horizontal learning. The conference further seeks to:

- **Discuss the challenges face by HIV positive students**
- **Assess whether current programmes are meeting the needs of HIV positive students**
- **Find potential solutions to these challenges**
- **Identify priorities for future research and programme development**

Thematic Pillars:

HIV and Me
By Us, For Us

Critical areas of this transition that must feed the objectives will be:

- support and strengthen knowledge generation
- communicate and disseminate new knowledge and best practices through various media
- coordinate and archive new and prior knowledge through appropriate vehicles
- increase collaboration with community service providers to facilitate research on the impact of current interventions
- undertake costing studies to adopt interventions with maximum impact and minimum costs

3.0 PROGRAMME MANAGEMENT

3.1 The pivotal role of the Tertiary Education Council

This project is informed by four documents – the Botswana National Policy on HIV and AIDS, the Botswana National Strategic Framework I, the Tertiary Education White Paper and the National Human Resource Development Strategy. The Tertiary Education Council was established by Act of Parliament Cap 57:04 of 1999 to be responsible for "…promotion and coordination of tertiary education and for the determination and maintenance of standards of teaching, examination and research in tertiary institutions (Section 5(1)). The Act defined tertiary education as all the education and training taking place in "a post secondary training institution including [the] University". See Appendix A for a list of all tertiary institutions that the Council currently supports.

Other specific functions of the T.E.C as stipulated by the Act are:

a) Formulate policy on tertiary education and advise Government accordingly;
b) Coordinate the long term planning and overall development of tertiary education;
c) Liaise with both the public and private sectors of the economy on all matters relating to human resources development and requirements;
d) Plan for the funding of tertiary education and research, including the recurrent and development needs of public tertiary institutions; etc.

The members of the Council were appointed in 2002 and the Executive Secretary in 2003 who immediately engaged with four high level strategic tasks namely:

(1) Setting strategic direction for the system through the development of a proposal for a tertiary education policy for Botswana.
(2) Developing system funding strategy and model for tertiary education institutions to facilitate system level steering to ensure the tertiary education policy goals are met.
(3) Develop standards and instruments to ensure a quality education, quality driven tertiary education system and to ensure adherence in terms of policy direction.
(4) Managing on behalf of the Government the development of a National Human Resource Development Strategy for Botswana.

The Tertiary Education Council is thus in a strategic position to play an important role to lead, direct, co-ordinate and monitor a range of interventions and overtime to create an integrated enabling environment that will assist in curtailing the HIV epidemic. This will be a nationally co-ordinated large scale effort targeted at what is a very vulnerable and strategic section of the population. It aims to strengthen

the capacity of individual tertiary education institutions in responding to the causes and consequences of HIV and AIDS as well as facilitate the leadership role that the tertiary education system must play in a comprehensive and integrated manner. A similar umbrella programme exists in South Africa – the Higher Education HIV and AIDS Programme (HEAIDS). Best Practice Box 3.1 outlines the HEAIDS programme and how it reached out to all institutions in South Africa using a "phased" approach to assist institutions in their HIV response and also to advocate for an institutionalized HIV response. As the HEAIDS programme is wrapping up its final year, T.E.C will utilize its lessons-learnt when creating the strategic framework for the tertiary sector in Botswana.

Best Practice Box 3.1: Higher Education HIV and AIDS Programme (HEAIDS)

The Higher Education HIV and AIDS Programme (HEAIDS) is an initiative based on a partnership between the South African Universities Vice-Chancellors Association and the Committee of Technikon Principals and the national Department of Education. It is an umbrella body that serves to coordinate a national effort aimed at improving the capacity of higher education institutions in the prevention and management of HIV and AIDS.

The programme is a donor-funded initiative designed in two phases. Phase One succeeded in implementing a number of prevention and HIV control mechanisms needed to launch a response at each institution. Phase One was accompanied by small seed grants for institutions to 'kick start' their programmes. Phase Two has concentrated on creating and strengthening networks between institutions and also with communities, advocacy to institutionalize HIV responses such as teaching, training, research, community engagement and service.

HEAIDS also distributes small grants to institutions, disseminates information about best practices and builds knowledge through surveys and assessments. Currently, HEAIDS has initiative a nation-wide HIV Prevalence Study across Higher Education Institutes in the country.

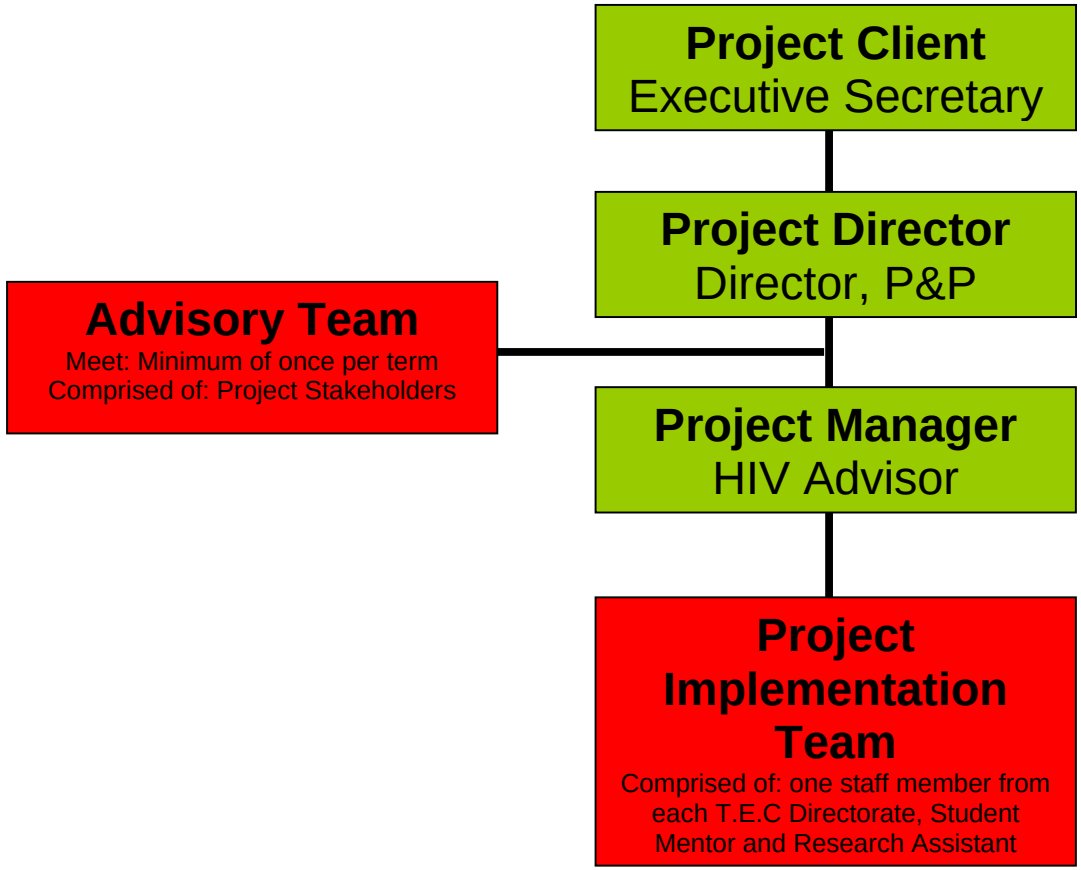
As the leading institutions of Botswana's intellectual capital and human resource development, tertiary institutions must play a significant role in responding to HIV. Botswana's tertiary institutions are concurrently vulnerable and filled with potential, just as their new students are in the face of HIV. T.E.C recognizes both their vulnerability and their potential as a social and technical resource and is therefore launching this programme to both assist with and motivate a more significant response.

The most powerful asset that tertiary institutions have at their disposal is their intellectual capital. Up until now, the collective response from the tertiary sector has largely been a whispered bellow. Outside of a few strong efforts from one or two institutions, the tertiary sector has, in effect, ignored something that has killed millions globally and thousands of us locally. Both T.E.C and tertiary institutions themselves aim to give students education that will enhance their well-being and direct them to a prosperous future. How are we responding to their well-being if we are not using the full potential of the nation's intellectual resources to respond to this epidemic?

3.2 Programme Structure

The leadership, management and implementation of the **teAIDS** project will comprise three levels. The first will be responsible for the overall Governance and policy direction of the Project. This will be represented by the Tertiary Education Council but will be expanded as additional project partners are identified. The project will be supported by the **teAIDS** Advisory Team whose role will be to provide strategic management and technical advice. Detailed project development, implementation and programme delivery support will be undertaken and co-ordinated through a Project Implementation Team comprising a small professional team of staff made up of one staff person from each T.E.C Directorate, the HIV Advisor, Research Assistant and Student Mentor. The Project Implementation Team will work directly under the supervision of T.E.C Management and in close collaboration with a **teAIDS** Working Group comprised of an officer identified by each institution who will be responsible for programme delivery and the student representative responsible for health from each institution. The overall governance and management structure is outlined below, followed by a project map and timeline.

Programme Governance and Management



teAIDS Programme Map

1. Background Research:

1. Collect and review published material on higher education responses to HIV in the region.
2. Contact Secondary Dept – find out what students learn before they come to us
3. Benchmarking visit to HEAIDS

AUGUST/SEPTEMBER

2. Revise Project Scoping Document

1. Branding, logo etc
2. Send draft to Directorate – Oct 3rd
3. Present findings to directorate – Oct 8th
4. Submit final copy to senior mgt of T.E.C – October 10th

SEPTEMBER/OCTOBER

3. Set up teAIDS Advisory Committee:

1. TOR
2. Prelim Task List
3. Recruitment

OCTOBER

4. Institutional Leadership Commitment

1. All institutional heads should be HIV literate
2. All institutional heads should understand their roles as leaders, support the scoping document and green light the way forward for the Baseline Audit
3. Two-day Educative Workshop to be held last week of October in each region.

NOVEMBER

5. Preparing for Institutional Change

1. In preparation for the Baseline Audit, invite each institution to regional WS to prepare them for the audit and introduce the scoping document and way forward.

NOVEMBER

6. Baseline Audit - should ask 2 main questions: What are institutions currently doing? Why aren't they doing more?

1. create specifications, submit research proposal
2. create and review measurement tools
3. Interview students, teachers, admin, senior management, HIV committees
4. focus groups, site visits

NOVEMBER/DECEMBER/JANUARY/FEBRUARY/MARCH

7. Compile Results

1. Compilation and Analysis
2. Report Writing

APRIL

8. Draft National Strategy Objectives – Should focus on these 7 Pillars:

1. Leadership, Motivation, Commitment
2. Prevention and Testing
3. Support & Treatment Literacy
4. Building Expertise and Best Practices
5. Motivation and Community Engagement
6. HIV & Me
7. By Us, For Us – Research

MAY/JUNE

9. Structures

Systems

Transition Plan

JULY/AUGUST

10. Launch National teAIDS Strategy

- Concert - DJ Fresh (for e.g)
- Institutional Presentations
- Future: Annual Conferences

SEPTEMBER

4.0 CONCLUSION

4.1 A Higher Response

In 2002 when Michael Kelly was researching tertiary responses in the region, he observed the following about leadership: “where it is present, something worthwhile occurs. Where it is absent, responses are piecemeal, uncoordinated and often not sustained,” (Kelly 2001). Currently, the virus is dictating the direction of our movements and responses. We are, in fact, largely reactionary. If we want to dictate the direction of our response, then we need good drivers – we need totally dedicated leadership.

As a sector, we must confront HIV head on. How unfortunate will it be if Botswana, one of the highest affected countries in the world, is simply driven by this epidemic, in effect, merely just reacting to it? Rather, would it not be beneficial for everyone in Botswana, if the tertiary sector used its insights and intellectual capital to respond to the major challenges of this epidemic that in fact require new insights, knowledge management and knowledge extension? Could not the tertiary sector lead us to the point where we have the ability to get ahead of this epidemic once and for all?

We tend to think that HIV is the worst epidemic we will ever face. This optimism has a single flaw. Because we treat this pandemic as a “one time” issue, we have not taken steps to create an epidemiological history of our experiences – we are not making a knowledge bank or resource archive of our achievements, failures, experiences and best practices. It is more like we are holding our breath through this epidemic – we are being reactionary rather than revolutionary. We have been holding our breath – waiting for the free ARVs and behaviour change to work. The ugly reality is that HIV has made a home with us – just like it does in our bodies. And it’s not going away as quickly as we had hoped. Behaviour change doesn’t just happen with some good Information, Education and Communication (IEC) messages – it has to be appropriate to context and it has to be nourished. And free ARVs are not a cure – we do have another wave of sickness on the horizon – and we are still dredging our feet through treatment literacy and the fight against stigma.

It is not all bad news, however. HIV forces the education sector to re-think some of the issues that have plagued our sector for decades, such as:

- Linking education to the supply and demand of human resources
- Greater focus on the acquiring of productive skills
- Greater involvement of the community
- More student centred learning
- Equity (poverty, gender, accessibility for rural and special needs)
- Stronger and more effective partnerships
- Knowledge management at institutions

These issues are also highlighted in the new National Human Resources Development Strategy (recently submitted for consideration and approval by His Excellency the President in August 2008).

The aim of the National Human Resources Development Strategy is to transition Botswana from an albeit successful resource based-economy to an economy that is more characterized by high level skills, technology transfer, productivity and innovation.

To move Botswana in this direction, four key sectors were identified as national priorities related to their strategic importance and rapid growth. The sectors are: Mining and Resources, Health, Financial Services and Tourism. The fact that health is now recognized as a key sector means that we have now become aware that HIV and AIDS, amongst other critical concerns, has made an enduring foothold in the country

Botswana is facing a serious health care worker shortage – we need to increase numbers in certain areas (nurses, doctors, epidemiology, teaching, medical support staff) and we also need professionals skilled in bereavement, child counselling, as well as the science and management of HIV.

If there is any upside to the devastating effects that HIV has cast upon Botswana it would be found in our lessons learned – essentially our epidemiological memory. As the pandemic rips through sub-Saharan Africa and other challenged countries around the globe, Botswana – with its commitment from the current government, from the former President Festus Mogae and the free anti-retroviral programme and from its determination to roll-out routine testing – has become a diamond in the rough. Botswana has the potential to be the exemplar of HIV prevention, treatment, care and support – to be the best practice and the knowledge managers of this epidemic in the region.

To move us toward a higher response and simultaneously position Botswana as the country with the highest response and management, two important priorities must be cemented in our national approach:

1. Research and innovation
2. Deliberate human resource development in the field of HIV and AIDS

Tertiary Institutions are not only responsible for the welfare of their staff and students but they also have a special responsibility for the development of human resources and preparing the coming generations of professionals and skilled workforce that the whole economy depends on. Tertiary education is the connection between education and the economy – thus making HIV a socio-economic development issue.

In Botswana, national plans demonstrate political commitment, a multi-sectoral approach and extensive funding for national programmes. As a sector, we have the support of the national government behind us. As institutions, we have the support of the Tertiary Education Council and the support of our communities. Our communities wait for our responses. To be the agents of change that our communities expect us to be, we must exhibit leadership, be socially active, engage our communities and engage one another as institutions. Institutional responses have to be revolutionary, not reactionary; they have to be systematic, not ad hoc.

Tertiary education is the critical pillar of human development worldwide. It provides the highly-skilled individuals needed in every labour market. It provides the skilled labour to sustain our health, education, entrepreneurship, civil society and even our political leadership. Youth who finish tertiary education literally become the future of all of our industries.

At the end of the day, if we can't keep students alive for more than a decade after they graduate, then we are ultimately failing them and the country as a whole. Education is not just about gaining skills for a trade. It has never been just about learning how to do a job. Education has always been about learning how to live and function in society – and that means giving our students the tools they need to Graduate Alive and to live happy, healthy and productive lives.

SOURCES USED

Association of African Universities
2007 HIV and AIDS and Higher Education in Africa: a Review of Best Practice Models and Trends. Association of African Universities: Accra, Ghana.

Botswana Press Agency
2008 "Rural Areas Lack HIV and AIDS Education" Daily News Archive. July 15, 2008. BOPA: Gaborone.

Central Statistics Office
2004 Botswana AIDS Impact Survey II 2004. CSO: Gaborone, Botswana.

Chetty, Dhianaraj
2004 An HIV and AIDS Toolkit for Higher Education Institutions in Africa. Association of African Universities. Accra, Ghana.

Chilisa, Bagele
2001 "Addressing the Impact of HIV and AIDS on the University of Botswana" Pula: Botswana Journal of African Studies, 15(2).

Economic Commission for Africa
2000 The Leadership Challenge and the Way Forward: HIV and AIDS and Education in Eastern and Southern Africa. Economic Commission for Africa: Addis Ababa.

Epstein et al.
2001 "Othering" Education: Sexualities, Silences and Schooling" Review of Research in Education. Vol. 24: 127-179.

Katahoire, Anne R.
2004 A Review of Key Themes and Issues Emerging from Literature on HIV and AIDS in Higher Education in Africa and Uganda in Particular. UNESCO: France.

Kelly, Michael
2001 Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV and AIDS. The World Bank for the Working Group on Higher Education: Washington DC.

National AIDS Coordinating Agency (NACA)
2008 HIV and AIDS in Botswana: Estimated Trends and Implications Based on Surveillance and Modelling. NACA: Gaborone Botswana.

NACA and UNDP
2007 The Economic Impact of HIV and AIDS in Botswana. Econsult Botswana Ltd: Gaborone Botswana

Republic of Botswana, Ministry of State President
2008 Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV and AIDS. Ministry of State President: Gaborone.

Saint, William
2004 Crafting Institutional Responses to HIV and AIDS: Guidelines and Resources for Tertiary Institutions in Sub-Saharan Africa. World Bank: African Region.

Turner, Victor
1967 "Betwixt and Between: The Liminal Period in Rites de Passage" in *The Forest of Symbols*. Cornell University Press: New York.

UNAIDS
2007 UNAIDS Annual Report: Knowing Your Epidemic. UNAIDS: Geneva.

UNESCO
2004 Developing Policies and Practices for Mainstreaming HIV and AIDS in Institutions of Higher Learning – Workshop Summary of Presentations and Recommendations. UNESCO: Nairobi.

UNESCO
2006 Expanding the Field of Inquiry: A Cross Country Study of Higher Education Institutions' Responses to HIV and AIDS. UNESCO Division of Higher Education: France.

UNESCO
2007 Educational Planning and Management in a World with AIDS. Volumes One – Four. UNESCO EduSector AIDS Response Trust: France.

Wolfe, W., et al.
2006 "Effects of HIV-Related Stigma Among An Early Sample of Patients Receiving Antiretroviral Therapy in Botswana." AIDS Care, 18(8): 931-933.

Appendix A

Official List of Tertiary Education Council Registered Institutions

ABM University College
Assembly Bible College (Letter of Interim Authority)
Ba Isago University College
Bamalete School of Nursing
Botswana Accountancy College
Botswana College of Agriculture
Botswana College of Distance and Open Learning (Letter of Interim Authority)
Botswana Institute of Administration and Commerce
Botswana International University of Science and Technology (Letter of Interim Authority)
Botswana Wildlife Training Institute
Deborah Retief Memorial School of Nursing
Francistown College of Education
Francistown College of Technical and Vocational Education (Letter of Interim Authority)
Francistown Institute of Health Sciences
Gaborone Institute for Professional Studies
Gaborone Institute of Health Sciences
Institute of Development Management
Limkokwing University (Letter of Interim Authority)
Lobatse College of Education
Lobatse Institute of Health Sciences
Molepolole College of Education
Molepolole Institute of Health Sciences
National Institute of Information Technology
New Era College of Arts, Science and Technology (Letter of Interim Authority)
Serowe College of Education
Serowe Institute of Health Sciences
Seventh Day Adventist School of Nursing
Tlokweng College of Education
Tonota College of Education
University of Botswana