



# ASSOCIATION OF AFRICAN UNIVERSITIES

## HIV & AIDS and Higher Education in Africa: A Review of Best Practice Models and Trends

OCTOBER 2007



**HIV and AIDS and Higher Education in Africa:  
A Review of Best Practice Models and Trends**

Association of African Universities

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Association of African Universities  
Accra

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## Abbreviations

AAU	Association of African Universities
ACU	Association of Commonwealth Universities
ADEA	Association for the Development of Education in Africa
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AWSE	African Women in Science and Engineering
DfID	Department for International Development (UK)
EU	European Union
GIPA	Greater Involvement of People Living with HIV
HESA	Higher Education South Africa
HIV	Human Immunodeficiency Virus
IIEP	International Institute of Education Planning
IA	Irish Aid
MAP	Multi-country AIDS Programme
MTT	Mobile Task Team on the Impact of HIV and AIDS on the Education Sector
NGO	Non Government Organisation
OI's	Opportunistic Infections
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern African Development Co-operation Community
SAREC	SIDA Department for Research Co-operation
SARUA	Southern African Regional Universities Association
SIDA	Swedish International Development Agency
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNESCO	United Nations Education Scientific and Cultural Organization
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WGHE	Working Group on Higher Education
WB	World Bank

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The research for this report was carried out in late 2006 and early 2007 by Dhianaraj Chetty, a specialist consultant on HIV and AIDS in the education sector. Dhianaraj Chetty has been involved in research, writing and capacity building on HIV and AIDS in higher education over the past seven years and is the author of the AAU's HIV and AIDS Toolkit for Higher Education Institutions in Africa and other publications. For more information, contact [dhianaraj@yahoo.co.uk](mailto:dhianaraj@yahoo.co.uk) Professor Michael Kelly, another eminent specialist on HIV and AIDS in the education sector, provided advice in the design of the project and editorial guidance in the final compilation of this study.

## Foreword

As Africa's premier institutions of human resource development, universities must play a critical role in training professionals to fight against and mitigate the effects of HIV and AIDS. However, their capacity to contribute effectively is limited by resource constraints, financial and human, as well as by policy deficiencies. As the HIV and AIDS pandemic threatens the continent, its institutions of higher learning are faced with the challenge not only of increasing their contribution to the continental fight, but also of working collaboratively to address the threat of HIV and AIDS to their individual institutions.

Recognizing both their vulnerability and their potential as a unique social resource for the development and application of country- and community-specific knowledge and solutions to the fight against the HIV pandemic, the Association of African Universities (AAU) is collaborating with several of its partners to document the role and contribution of its members in the fight against the pandemic.

The first step in helping Africa's universities individually and collectively is to identify their strengths, constraints and opportunities for addressing the human resource and policy challenges occasioned by the HIV and AIDS pandemic. That is the aim of this survey, commissioned by the Association of African Universities (AAU) with funding from the Swedish International Development Agency (SIDA), namely, to identify, document and share best practices observed within its membership. The survey assessed the capacity of African universities to contribute to solutions, not only through the professionals and experts they produce, but also through their impact on policy and the communities that they serve. To that end, information was collected about how universities are responding to the HIV and AIDS pandemic through their human resource development strategies, as well as their educational and outreach programmes.

The Terms of Reference for this study called for the identification a sample of between 12 and 15 institutions which exemplified best practices in the response to HIV and AIDS in Africa, in the following areas (though not exclusively):

- Education and prevention
- Institutional policies
- Curriculum integration
- Research
- Care and support for persons living positively with HIV.

The survey results show that, by and large, African universities are making great strides in their efforts to address the threat that the HIV pandemic poses to their institutions and to those who study, work and live in them, but that they need more support to play an even greater role in the fight against the global pandemic.

The Association of African Universities and partners will present the completed study to a focus group of African university leaders and higher education policy makers at the AAU Conference of Rectors, Vice Chancellors and Presidents of African Universities (COREVIP) scheduled to be held in October 2007 in Tripoli in Libya. The discussion, feedback and recommendations from the conference will be incorporated in a publication that will be shared widely.



Akilagpa Sawyerr  
Secretary General  
Association of African Universities (AAU)



## Executive Summary

### 1.0 Background

The Association of African Universities (AAU) represents institutions across the continent with a membership of 199 institutions (2006 data). The Terms of Reference for this study called for the identification a sample of between 12-15 institutions which exemplified best practice in the response to HIV and AIDS in Africa in the following areas (though not exclusively):

- Education and prevention
- Institutional policies
- Curriculum integration
- Research
- Care and support for persons living positively with HIV and AIDS
- Others

### 2.0 Methodology

The research design for this study sought to maintain a balance between the four sub regions in which HIV and AIDS is a pressing issue: west, central, east and southern Africa. It did not include inputs from the North African and Arabic speaking countries because these are primarily low prevalence countries. The sample also tried to ensure appropriate representation from Anglophone, Francophone and Lusophone institutions. Some university systems are small and consist primarily of a single national university. Others, like Nigeria, Kenya and South Africa are large, complex and require more than one case study to capture the degree of diversity and differentiation.

The target institutions included:

West Africa	University of Ghana, Legon, Ghana
	University of Ibadan, Nigeria
	Ahmadu Bello University, Zaria, Nigeria
	Université de Cocody, Abidjan, Côte d'Ivoire
East Africa	University of Dar es Salaam, Tanzania
	Kenyatta University, Nairobi, Kenya
	Maseno University, Kisumu, Kenya
Central Africa	National University of Rwanda, Butare, Rwanda
Southern Africa	Copperbelt University, Kitwe, Zambia
	University of the Western Cape, south Africa
	Universidade Eduardo Mondlane, Mozambique
	University of Namibia, Windhoek, Namibia

### 3.0 Best Practice

What is meant by best practice and why should we document them? Most institutions working in the field of HIV and AIDS rely on the UNAIDS criteria for best practice. Identifying best practices in the response to HIV and AIDS is essentially about looking for what works, why and how. Furthermore, it's about 'lessons learned and the continuing process of learning, feedback, reflection and analysis'<sup>1</sup>.

UNAIDS uses a set of five criteria as a guide: *effectiveness, efficiency, relevance, ethical soundness and sustainability*. The formal objectives of best practice are further defined as:

- To strengthen capacity to identify, document, exchange, promote, use and adapt best practice as lessons learned within a country and inter-country as a means to expand the national response to HIV and AIDS
- To promote the application of best practice process for policy and strategy definition and formulation.
- To collect, produce, disseminate and promote best practice.

This report presents an analysis and synthesis of examples of best practice in the higher education response to HIV and AIDS based on the application of these criteria through in-depth case studies. Using case studies, the report relies partly on the value of description in order to document practices which have hitherto not been captured and to promote sharing and replication. Each case study is then reviewed using best practice criteria and referenced in analytical sections focused on trends and recommendations.

In terms of structure, the report critically evaluates and periodises the process through which higher education responses to HIV and AIDS has evolved. It argues that the responses which have taken shape since the late 1990s up until about 2005 can be characterised as the *1<sup>st</sup> generation responses*. These were driven both by internal innovation and external pressures from government and the international community which called on higher education to take a stronger and more active stance on HIV and AIDS as an internal institutional priority. In other words, prevention, treatment, care, treatment and support were all equally important if students and employees were to be adequately prepared to live in and engage with a world affected by HIV and AIDS. Up until this point, many of the leading responses were focused externally, often in the area of bio-medical research.

These pressures for change resulted in international and regional programmes which promoted an emphasis in key areas: strong leadership, policy and management commitment, effective prevention and education programmes, care and support programmes, curriculum change to develop new skills,

<sup>1</sup> UNAIDS Summary Booklet of Best Practices, Issue 1, p5, June 1999

research/knowledge generation and community engagement. A host of reports have documented the progress (or lack thereof) in each of these areas. Using evidence from a selected group of best practice examples, this report is aimed at taking the analysis of higher education responses to HIV and AIDS a step further by outlining a set of imperatives which will need to inform the *2<sup>nd</sup> generation responses*. So, for example, what is the *2<sup>nd</sup> generation response* to Voluntary Counselling and Testing (VCT) if it is clear that students are still reluctant to test for HIV (after years of social mobilisation) because of stigma?

#### 4.0 Recommendations and the way forward

1. The *1<sup>st</sup> generation of responses* to HIV and AIDS by higher education institutions was led by key actors in government, the development agencies and an influential group of institutional leaders starting in the late 1990s. Many of these responses have now matured or reached a stage of development which requires careful review involving the same actors, but also practitioners and stakeholders.
2. Despite some weaknesses in the work which continues, this report details increasing evidence of change, examples of best practice and a *growing community of practice on HIV and AIDS* in African higher education. This community of practice represents a critical mass of experience and expertise in the sector which needs to be recognised for its commitment and innovation. The vibrancy of this community is evident from the strength and proliferation of networks across the continent and internationally which are focused on higher education responses to the epidemic.
3. At this juncture the AAU, other international agencies and institutions themselves have the opportunity to define a new agenda in the response to HIV and AIDS by asking the *2<sup>nd</sup> generation questions*. The response to those questions must directly address the gaps and weaknesses which have been identified.
4. In programmatic terms, the new agenda should build on the foundations laid over the recent past and signal a *renewal of the response to HIV and AIDS*. This renewal must address the following:
  - Repositioning HIV and AIDS in terms of integrated Sexual and Reproductive Health Services.
  - Urgent attention to improve adherence to GIPA principles.
  - Uptake and utilization of existing services.
  - Closer collaboration with the public health sector and greater support to communities.
  - Improved peer education, linked to the promotion and uptake of VCT.
  - Expansion of treatment literacy and access.

- Stronger focus on skills development in formal courses on HIV and AIDS.
5. It needs to be acknowledged that the HIV and AIDS response in higher education must take more account of malaria and tuberculosis (TB) as equally important health risks for most students and communities in the African context. Multi Drug Resistant (MDR) TB and Extreme Drug Resistant (XDR) TB have recently emerged as major threats in Southern Africa. As this report makes clear, co-infection with malaria and HIV is an area that needs more clinical attention, especially given that most patients using university health centres are concerned about malaria.
  6. Despite the greater focus on abstinence in peer education and other programmes, students are often unclear as to the real alternatives to being sexually active. Abstinence has been generally equated with a religious affiliation within a campus context. However, it should be possible to articulate an abstinence strategy without being tied to a faith-based approach. There are significant tensions at some campuses about the extent to which faith based groupings limit opportunities for more open discussion of sexuality and may even be encouraging covert risk-taking behaviour.
  7. Part of the renewal strategy must be about *re-inventing* or perhaps *re-conceptualising* existing practices and programmes. For example, just as health care practitioners are constantly looking for new and more effective models of delivering HIV and AIDS services, universities need to rethink their role and the models on which their responses are based. Good examples of this are evident in programmes such as 'I Choose Life' in Kenya which has mobilised students around behaviour change using widely different leisure and social activities including dance classes and other groups.
  8. In terms of *curriculum reform*, some of the best higher education responses are still restricted by uncertainty among managers and academics about their role in the epidemic. This is often evident in their inability and unwillingness to take on the role of providing students with both the *professional and personal skills* to cope with an AIDS affected world. Too often it's a 'convert' who is willing to contemplate HIV and AIDS in the economics or law curriculum, not the Dean or Head of the Department who should be instrumental in the decision. The picture is much the same, if not worse, in the natural sciences and engineering. This picture has to change fundamentally if a renewal is to occur at the level of curriculum integration.
  9. *Anti-retroviral (ARV) treatment access* has fundamentally shifted the dynamics of the epidemic and has had implications in higher education. Two issues are worth noting. Firstly, despite the availability of ARV treatment, uptake at higher education based treatment centres is still low. The reasons

for this trend are complex and need further attention. Secondly, there is a view that every university HIV and AIDS programme should be expected to act as a testing and treatment site. Despite major increases in the numbers of people accessing treatment in the developing world, access remains limited and universities can make an impact on that front with their resources and expertise. To start with, they can play a greater role in servicing the communities in which they are based.

10. Over the past five years or so, the 1<sup>st</sup> generation of responses has made universities a *safer space for affected and infected people* in many respects. Universities provide better access to education, services, care and support programmes and an environment which protects human rights particularly of people living with HIV. Despite the truth in this assertion, universities remain places where students and employees are also still extremely reluctant to disclose their HIV status. Why? Stigma is alive and well on many campuses. The persistence of this problem, as in the case of some many others, must compel universities to critically revisit their role in defining citizenship in an AIDS affected world. If PLHIV remain reluctant to disclose their status because of stigma, prevention, care and support programmes and services will never completely fulfil their core mandate.
11. The challenge of expanding the *output and quality of research* in African higher education is far broader than simply putting HIV and AIDS on the research agenda. Despite some institutions being repositories of very high calibre skills and capacity on HIV and AIDS, the skill of high level researchers is often more likely to find its way into private consulting assignments for development agencies rather than publishing in academic journals. This is not a problem peculiar to research on HIV and AIDS and is more reflective of a broader problem in African higher education. In this view, universities run the risk of being seen as little better than co-opted NGOs who have no accountability to their constituency. A renewal strategy needs to shift that balance of power by re-valuing the task of research, its rewards and its applications.
12. Higher education's *intellectual capital* is its most powerful asset. In the response to HIV and AIDS this asset has immediate applications and is far more valuable when it is deployed as research in support of policy, programme development or capacity building. Professional development programmes for health professionals or managers in the public and private sectors is a huge and growing market, especially given the pace at which the epidemic changes and the need for new skills. Despite the potential of this opportunity, too few attempts have yet been made to capitalise on, or to use, higher education's expertise as an asset for the good of the institution and for the public good. Training programmes and contract research can generate income, create new linkages, build new expertise and leverage change within the public and private sectors.

13. Some of the institutions profiled in this report have traditionally operated in a service culture in which '*user fees*' are the norm. In other words, at the health centre everything *except the consultation* has a private cost. There is enough evidence to support the view that however small, user fees pose a barrier to access and uptake of key services. In the case of HIV and AIDS, higher education institutions should always be working towards reducing barriers to access and increasing the uptake of prevention, care and support services. The case is even stronger at university health centres and hospitals where the cost of a CD4 test is prohibitively high for most ordinary people in the surrounding community. Clinical care is expensive but there are ways of reducing these barriers and institutions should be encouraged to find ways of garnering support through both the public and private sectors.
14. With the exception of the South African example, programmes at higher education institutions are either silent or avoid the issue of prevention, care and support for *sexual minorities* men who have sex with men (MSM), gay men and lesbians. Gay and lesbian communities now exist in many African cities, in some cases organized and visible, in others less so. The situation is not made easier by the existence of repressive legislation and state supported homophobia in many countries with respect to MSM and same sex relationships. Higher education has a responsibility to improve the popular understanding of this issue as both a human rights concern and public health challenge. That challenge is to find ways of ensuring that sexual minorities are more encouraged to make use of services, rather than driving risk-taking behaviour underground. If higher education takes sexual and reproductive health rights seriously in the years to come, these communities must be recognised and supported.
15. It is very encouraging to note that more institutions are using their own modest financial resources in support of their HIV and AIDS programmes to leverage additional support from external sources. Country level public sector and NGO programmes have experienced exponential growth since the advent of the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM), President's Emergency Plan for AIDS Relief (PEPFAR) and the expansion of the World Bank's Multi-country AIDS Programme (MAP). More institutions should be encouraged to pursue these opportunities by linking with national programmes, international research collaborations and areas in which they can add value.
16. As the international response to the epidemic has matured institutionally, there is increasing consensus around the *Three One's*:
  - One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners.

- One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate.
- One agreed country-level Monitoring and Evaluation System.

The Three One's were designed to increase accountability, improve coordination and strengthen the response to the epidemic. However, the importance of this shift does not appear to have made an impact on the practice of planning and service delivery in higher education responses to the epidemic. The discourse of programme management at institutional level is often disconnected from any sense of a broader national framework this has to change. The exceptions which are slowly growing in number are those institutions which are accredited testing and treatment centres and those which have strong linkages with National AIDS Control Programmes

17. Those universities which have responded to HIV and AIDS as more than a 'social obligation' or a way of mitigating a risk, have seized on a very different strategy *one that sees HIV and AIDS as an opportunity to reinvigorate the life of the university*. It is an opportunity to rethink the kind of graduates we aim to produce in a world which requires cognitive, creative and vocational skills that are able to respond with equal strength to globalisation, climate change, new technologies or HIV and AIDS.

## **Part I Higher Education and HIV And AIDS : A Rapid Appraisal**

### **1.0 Background**

The Association of African Universities (AAU) represents higher education institutions across the continent with approximately 199 members<sup>2</sup>. The AAU's programme on HIV and AIDS, based at the Secretariat, has been in existence since 2002 and is focused on research, capacity building and the mobilisation of higher education leaders in the response to the epidemic. The AAU has been instrumental, along with other national, bi-lateral and multilateral organisations in the mobilisation of key decision makers in the higher education sector's response over the past few years. This report reviews the efforts which have been made by higher education institutions on the continent with the purpose of identifying lessons learned and best practices. In documenting and disseminating these examples, it is hoped that other institutions will benefit from the sharing of new knowledge and contribute to the overall strengthening of the response to the epidemic.

### **1.1 Terms of Reference**

The Terms of Reference for the study called for the identification of a sample of between 12-15 institutions which exemplified best practice in the response to HIV and AIDS in Africa in the following (though not exclusively) areas:

- Education and prevention
- Institutional policies
- Curriculum integration
- Research
- Care and support for persons living positively with HIV
- Others

### **1.2 Methodology**

#### *Best Practice*

What is meant by best practice and why should we document them? Most institutions working in the field of HIV and AIDS rely on the UNAIDS criteria for best practice. Identifying best practices in the response to HIV and AIDS is essentially about looking for what works, why and how. Furthermore, it is about 'lessons learned and the continuing process of learning, feedback, reflection and analysis'<sup>3</sup>.

A more comprehensive definition could be developed along the following lines<sup>4</sup>:

<sup>2</sup> Denotes 'members in good standing' only.

<sup>3</sup> UNAIDS Summary Booklet of Best Practices, Issue 1, p5, June 1999

<sup>4</sup> The Good Practices of the National AIDS Control Commission (CNLS Rwanda), p8.  
<http://129.194.252.80/catfiles/4166.pdf> n.d



*'A good practice is one, which through experiment and attributions, proves beyond doubt, that it yielded tangible results and can be used beneficially by others. It has to possess unique element[s] in order to be distinct from common ones. It is the one that others can regard as a model.'*

Best practice is inevitably based on judgements that occur at either one or two levels of analysis. At the first level, the practice's accomplishments are described. However, at the second level, analysis is based on criteria that look at strengths and weaknesses as well as successes and failures. UNAIDS uses a set of five criteria as a guide: *effectiveness, efficiency, relevance, ethical soundness and sustainability*. The formal objectives of best practice are further defined as:

- To strengthen capacity to identify, document, exchange, promote, use and adapt best practice as lessons learned within a country and inter-country as a means to expand the national response to HIV and AIDS.
- To promote the application of best practice process for policy and strategy definition and formulation.
- To collect, produce, disseminate and promote best practice.

### **1.3 Scope**

Within the criteria set by the Terms of Reference, the research design sought to maintain a balance between the four sub-regions in which HIV and AIDS is a pressing issue: west, central, east and southern Africa. It did not include any inputs from the North African and Arabic speaking countries because these are primarily low prevalence countries. The sample also tried to ensure appropriate representation from Anglophone, Francophone and Lusophone institutions. Some university systems are small and consist primarily of a single national university. Others, like Nigeria, Kenya and South Africa are large, complex and require more than one case study to capture the degree of diversity and differentiation.

The target institutions included:

**Selected Institutions by Region**

West Africa	University of Ghana
	University of Ibadan
	Ahmadu Bello University
	Université de Cocody
East Africa	University of Dar es Saalam
	Kenyatta University
	Maseno University
Central Africa	National University of Rwanda
Southern Africa	Copperbelt University of Ibadan
	University of the Western Cape
	Universidade Eduardo Mondlane
	University of Namibia

Why was this sample of 12 institutions selected and not others? They were selected in large part because of their regional and national reputations as innovators and leaders in the response to HIV and AIDS. Secondly, they were accessible in the time frame available for this study. Thirdly, they were deemed appropriate given the resources available for the study.

**1.4 Structure of the report**

Part I of the report is largely focused on a rapid appraisal of progress to date in the higher education response to HIV and AIDS in Africa. It reviews recent initiatives at national and international level across Africa, especially those institutions that have yielded major changes in the pace of policy development, capacity building, curriculum integration, community outreach and prevention services.

Part II analyses and interprets the shifts that taken place since 2000/2001 when the international higher education community, government leaders and major policy advocates began mobilising the higher education response to HIV and AIDS. In particular, it describes the transition from 1<sup>st</sup> generation responses to a 2<sup>nd</sup> generation.

Part III is a series of best practice profiles of 12 institutions across 4 sub-regions in Africa. Evaluation of the institutions involved a general assessment of progress in a range of standard categories that are the basis of most higher education responses: management of the response to HIV and AIDS, prevention services, access to treatment, policy development, community outreach, curriculum integration, research, student involvement and the involvement of people living with HIV . A best practice area was selected in each of the twelve profiled institutions:

### Best Practice Areas

	<b>Institution</b>	<b>Best practice area</b>
1.	University of Ghana, Ghana	Distance education
2.	University of Ibadan, Nigeria	Social science research on HIV and AIDS
3.	Ahmadu Bello University, Nigeria	Prevention services
4.	Kenyatta University, Kenya	Peer education
5.	Maseno University, Kenya	VCT
6.	University of Dar es Salaam, Tanzania	Clinical care and support
7.	Université de Cocody, Côte d'Ivoire	Student involvement
8.	Copperbelt University, Zambia	Community outreach
9.	National University of Rwanda Rwanda	Access to treatment and care
10.	University of the Western Cape, South Africa	Involvement of people living with HIV
11.	Universidade Eduardo Mondlane, Mozambique	Policy development and advocacy
12.	University of Namibia, Namibia	Curriculum reform

Given the range of activities which make up the institutional programme at each of these institutions it was not always easy to select only one best practice. The institutions were asked to put forward suggestions and these were evaluated as part of the research process.

Part IV examines the gaps and weaknesses in higher education responses to HIV and AIDS with a particular focus on risk assessments and emerging trends. The 'Way Forward' section concludes the report with a synthesis of major findings and recommendations.

The conceptual framework for this report is based in part on a recent review commissioned by the Ford Foundation on HIV and AIDS and African Higher Education in which a number of the analytical advances were initially outlined<sup>5</sup>.

<sup>5</sup> Chetty, D. 'Briefing Paper on the Higher Education Sector's Response to the HIV and AIDS Epidemic in Africa with special reference to the Ford Foundation, March 2007 (unpublished).

## 1.5 Rapid Appraisal

In the late 1990s, the international higher education community began to formulate a response to calls for stronger leadership and a more proactive stance on the HIV and AIDS epidemic. Those calls emanated from governments, development agencies and small group of influential leaders within higher education. They urged institutions and their apex organizations to put forward a position on their approach to the HIV and AIDS pandemic, to take stock of how they were responding or to outline ways in which they should be responding in the years ahead. The epidemic was at its peak in many high prevalence countries and it was all too apparent that universities were absent or invisible in the institutional leadership of the global response.

In the discourse of HIV and AIDS and development, that moment coincided with a heightened increase in political and social mobilization around the social sector response to HIV and AIDS. Multi-sectoral responses to the epidemic had moved the response to HIV and AIDS away from a *health dominated model* and compelled authorities in areas like education, social welfare, local government and various others to develop *sector specific responses*. It was a watershed moment that galvanized the energies and resources of social sectors which had a wider reach and better access to target audiences when it came to preventing new infections and providing urgently needed support for infected and affected groups.

Education institutions recognized their strategic importance in that they reached millions of children, youth and adult learners every day on a systematic basis and through that interaction also had access to families and communities. At the same time, education authorities had to define their approach to the challenge of HIV and AIDS. The dominant idea underpinning most responses that emerged in government and in the development community were variations on a theme: *use the school curriculum to teach HIV and AIDS and life skills*.

Since education's biggest contribution was in the realm of prevention, education became the *social vaccine* against HIV and AIDS. Education programmes had the potential to transmit the knowledge, skills and values to prevent infections, prepare children to cope with an AIDS affected world and instil the basis of a tolerant, compassionate response towards affected and infected people in society. Teachers were critical intermediaries in this approach and therefore had to be trained to teach HIV and AIDS in ways that were appropriate to the age, culture and context, as well as having the skills to identify children and communities needing care and support. A wide range of interventions proliferated across the developing world, often driven by donor agencies. Whilst schools and the curriculum presented a major opportunity to reach children and communities, the constraints were equally challenging. Teachers were not necessarily willing or able to teach aspects of HIV and AIDS

education (e.g. sexuality, relationships, risky behaviour) that made them uncomfortable and for which they were often poorly prepared. Classroom resources were few and integrating HIV and AIDS into already overburdened curricula was difficult.

In some respects, the response was woefully late. In high prevalence countries, the impact of the epidemic on families and communities had already created a generation of orphans and vulnerable children and schools and welfare agencies were inadequately prepared to handle these impacts. A parallel stream of thinking, research and advocacy developed from around 2001 and focused on the planning, management and financing implications of HIV and AIDS for the education sector<sup>6</sup>. It was necessary to rethink the overall supply and demand factors in the education sector if the projected demographic impacts of the epidemic materialized. The reality was that teachers were becoming ill in more significant numbers, child-headed households were increasing in number and the managers of the education sector needed to think more carefully about impact mitigation and the long-term institutional impacts of the epidemic. Losing a teacher to chronic illness or death or having children leave the education system due to increased poverty and a lack of family support posed a real threat to education systems. Many countries in southern and eastern Africa (especially Kenya and Uganda) had only recently made major new strides towards free and compulsory basic education in response to the call for *Education for All*. Enrolments grew rapidly, often masking the growing population of orphaned and vulnerable children in the system.

At this initial stage it was as important for higher education to define its role *as part of the education sector*. It is fair to say that in the push to strengthen and intensify the education sector response to HIV and AIDS, basic education was the priority and rightly so. Basic education was where the bulk of learners in the system were accommodated and it predictably consumed the bulk of any new resources that became available. In contrast, higher education had small numbers of students and employees in relatively high cost institutions. However, what became clearer was a profile of behaviours and risk factors in higher education that differed significantly to other education institutions. Because higher education targets a different age group who were already sexually active and responding to specific institutional pressures and opportunities, strategies in the sub sector needed to engage with more than just prevention.

<sup>6</sup> *This stream of thinking gave rise to the Mobile Task Team on the Impact of HIV and AIDS in Education (MTT), a project based at the Health Economics and AIDS Research Division at the University of Kwa-Zulu Natal. The project consisted of a multidisciplinary team of education specialists funded by USAID to service ministries of education and education institutions in approximately 12 Sub Saharan African countries.*

Starting in 2000, a range of research reports at national and international level, began to interrogate the actual and potential impacts of the epidemic on higher education, the responses which higher education had made to date, why it was necessary to strengthen the response and how to manage and mitigate the impacts of the epidemic in future years<sup>7</sup>. The initial reports also formulated a response to another subset of questions which aimed at making the case for action to university leaders and managers in their own terms.

It was relatively easy to argue, at the level of theory, about the 'development challenge' posed by HIV and AIDS. It was a rather different task to elaborate that challenge in the functional and institutional context of university management and operations. There was evidence of a range of work already being carried out, mostly in the realm of research, prevention education and social mobilization. However, a picture emerged through the surveys which found that the higher education community was lacking on many fronts, including:

- Ad hoc responses and reactive responses rather than proactive and systemic.
- Uneven responses (often a strong research focus at the expense of internal programmes and services).
- Silence/denial.
- Stigma.
- Focus only on prevention and education.
- Poor co-ordination within institutions.
- Persistence of risky social and sexual behaviour.
- Lack of a relationship to government and non-government organizations in terms of policy, plans and programmes.
- Poverty as the root cause of vulnerability.
- Constraints on operations and resources leading to a 'short-term' mentality.
- Low priority of the response to HIV and AIDS.
- Absence of risk and impact assessments.

<sup>7</sup> *'Institutionalizing the Response to HIV and AIDS in the South African University Sector, South African Universities Vice-Chancellors Association (2000); 'Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV and AIDS', World Bank/ADEA (2001); 'Commonwealth Universities in the Age of HIV and AIDS: Guidelines towards a strategic response and good practice', Association of Commonwealth Universities (2002); 'Commonwealth Universities in Age of HIV and AIDS: what every senior manager needs to know', Association of Commonwealth Universities (2002); 'A Toolkit for Higher Education Institutions in Africa Mitigating the Impact of HIV and AIDS', Association of African Universities/Working Group on Higher Education (2003/04); 'African Universities Response to HIV and AIDS in the Global AIDS Initiative Countries', Association of African Universities (2004); Directory of Higher Education Institutions in Africa responding to HIV and AIDS (2004); 'Widening the Field of Inquiry: A Cross Country Study of Higher Education Institutions' Responses to HIV and AIDS', UNESCO (2006).*

Though it does not apply only to African higher education, the most recent of these surveys in 2006<sup>8</sup> re-iterated many of the criticisms that were first articulated in 2000. Despite these criticisms, it would be wrong to paint an overall picture of stasis and inaction.

To varying degrees, the process of change within higher education reflects the way in which HIV and AIDS has affected the mission of social institutions in a world affected by HIV and AIDS. Firstly, the external and internal pressures generated a *community of ideas*. A new language took root in higher education which articulated HIV and AIDS as more than a health problem and more than just an abstract threat to their mission in society. Institutional leaders were compelled to learn and respond to issues which were previously marginal to their core tasks of teaching, research and community engagement. Secondly, as the response has grown, *networks* have flourished which represent a *community of interest*. The AAU and Association of Commonwealth Universities (ACU) supported this thrust through their membership. Eastern Africa now has a network of institutions supported through Kenyatta University. In Southern Africa, the national association of higher education institutions in South Africa HESA (previously the South Africa University Vice-Chancellors Association - SAUVCA) is the hub for another major network. Thirdly, at institutional level - in health centres, peer education programmes, student activist groups and employee welfare societies a *community of practice* has emerged which deserves recognition for its increasing sophistication, innovation and commitment. Amongst these are examples which fully merit recognition as models of best practice. A few examples are listed below to illustrate the pace and scale of change.

#### *Policy development*

In terms of *institutional policy development on HIV and AIDS*, South Africa's HEAIDS programme reported in 2005 that 86% of the country's universities had developed *institutional policy on HIV and AIDS* and equally high levels of service provision in areas such as prevention and VCT<sup>9</sup>. The programme was unique in its sector-wide reach covering all universities in the country and was initiated in 2001 with support from the UK's Department for International Development (DfID) and Irish Aid.

AAU has used small grants (\$5,000) over the past two years to promote policy development and curriculum integration. Institutions working on HIV and AIDS and curriculum integration received \$3,300<sup>10</sup>.

<sup>8</sup> *Widening the Field of Inquiry: A Cross Country Study of Higher Education Institutions' Responses to HIV and AIDS*, UNESCO, 2006

<sup>9</sup> *Turning the Tide: a strategic response to HIV and AIDS in South African Higher Education*, SAUVCA, Pretoria, 2005.

<sup>10</sup> *Personal communication from AAU, January 2007.*

### Institutions receiving grants in 2004 for HIV and AIDS policy development

2004	Mombasa Polytechnic	Kenya
	University of Botswana	Botswana
	Highbridge Teachers Training College	Kenya
	Nkumba University	Uganda
	Kigali Institute of Science and Technology (KIST)	Rwanda
	La Chancellerie des Universités du Togo	Togo
	Ho Polytechnic	Ghana

### Institutions receiving grants in 2005/ 2006 for HIV and AIDS policy development

2005	Université d'Antsiranana	Madagascar
	University of Dar es Salaam	Tanzania
	University of Ilorin	Nigeria
	Université de Cocody	Côte d'Ivoire
2006	University of Agriculture, Abeokuta	Nigeria
	National University of Science and Technology, Bulawayo	Zimbabwe
	Université de Ouagadougou	Burkina Faso
	Université Nationale du Rwanda	Rwanda

### Capacity building

*Capacity building* initiatives have helped to sustain the momentum of change. Early on, the AAU initiated the development of a *Toolkit on HIV and AIDS for Higher Education Institutions in Africa* that has been rolled out since 2006 in East Africa and Central Africa, with plans for Southern and West Africa in the pipeline<sup>11</sup>. This programme is supplemented by the AAU's interventions through its annual Senior University Managers in Africa (SUMA) Programme and activities integrated into the bi-annual Conference of Rectors Vice-Chancellors and Presidents (COREVIP) since 2003. The AAU's newly launched Leadership Development Programme (LEDEV) will also include components on HIV and AIDS. The ACU and the World Bank have also invested in efforts to sensitise and mobilize African higher education leaders since 2001.

<sup>11</sup> The East African Sub Regional Workshop was hosted by Kenyatta University in Nairobi in July 2006, followed by a Central African Sub Regional workshop hosted by the National University of Rwanda and the Kigali Institute of Science and Technology (KIST) in Kigali in December 2006. Overall, these two capacity building workshops brought together representatives from more than 25 institutions.



Capacity building has grown significantly in recent years with a number of organisations now programming regional and sub regional activities on a yearly basis. Since 2005, UNESCO (Nairobi) and African Women in Science and Engineering (AWSE) have focused on capacity building for executive deans in science and engineering. Its first East African initiative, in late 2005, involved 25 mostly Kenyan institutions. A second similar activity at Kwame Nkrumah University of Science and Technology, Ghana involved a further seven Ghanaian institutions.

Capacity building for *curriculum integration* of HIV and AIDS outside of the biomedical sciences was recognized early on as one of the weakest and most complex areas in the response by universities. The United Nations Development Programme (UNDP) prioritised this issue in capacity building in selected universities starting in 2003<sup>12</sup>. UNDP began its own capacity building programme with a 'training of trainers' (TOT) phase. The TOT was designed to provide participants with opportunities to<sup>13</sup>:

- familiarize themselves with a seminal, current and comprehensive corpus of knowledge on HIV and AIDS as a cross cutting social and economic issue;
- meet and engage with academics and specialists involved with multiple facets of the HIV and AIDS pandemic;
- engage in academic conversation and debate with peers;
- develop HIV and AIDS related research proposals; develop lateral and critical thinking skills in relation to HIV and AIDS as a cross cutting social issue; and
- develop co-operative research relationships with academics from their own and other African countries.

Altogether, thirty institutions across the continent were involved in this first phase. In February 2007, the UNDP launched the next phase of its work (in co-operation with AAU) in the form of a curriculum for mainstreaming HIV and AIDS. The initiative will focus on developing capacity for mainstreaming HIV and AIDS in targeted countries by using higher education based professionals as a resource.

AAU's own initiative in curriculum integration has been through small grants to institutions since 2005. Recipients of AAU support are indicated in the table below.

<sup>12</sup> The UNDP programme is managed by the Regional Services Centre based in Johannesburg, South Africa.

<sup>13</sup> *Training of Trainers in integrating HIV and AIDS as a social issue into tertiary level curricula, Task Completion Report, UNDP, 2004.*

**Institutions receiving grants for HIV and AIDS and curriculum integration  
2005, 2006**

2005	University of Ibadan	Nigeria
	University of Botswana	Botswana
	Kenyatta University	Kenya
	University of Dar es Salaam	Tanzania
	National University of Rwanda	Rwanda
	University of Namibia	Namibia
2006	Université du Burundi	Burundi
	Université de Ouagadougou	Burkina Faso
	Université Gaston Berger	Senegal
	Université de Nouakchott	Mauritania

*Partnerships*

Innovative use of *partnerships* is critically important in leveraging new resources, expertise, linkages and creating a platform for change in resource-constrained environments. Using its partnership with the MacArthur Foundation, the University of Ibadan in Nigeria, has moved ahead rapidly in policy development, curriculum integration and training of academic staff on HIV and AIDS after participating in the UNDP's capacity building programme. Details of this process are discussed further in the best practice examples section of the report.

*Outreach*

In Zambia, the Copperbelt University's pioneering programme focused on HIV and AIDS prevention and peer education for prisoners and prison officials is an exemplar of *community outreach* between a university and its local communities. Initiated in 1995, the project has trained more than a 1,000 prisoners and over 200 as peer educators on HIV and AIDS and has scaled up to cover all Zambian prisons<sup>14</sup>. Prison officers have also been trained as psycho-social counsellors and home based carers. The strength and scale of this programme merit its inclusion in the survey of best practices later in this report.

*Programmes*

Starting in 2002, seven Kenyan universities (Nairobi, Kenyatta, Daystar, Egerton, Maseno, Moi University and the Co-operative College of Kenya) have partnered with the '*I Choose Life*' peer education programme which continues to grow<sup>15</sup>. Though

<sup>14</sup> '*In But Free*' Prisons Project a partnership between Copperbelt University, the Zambia Prisons Service and the National AIDS Council of Zambia.

<sup>15</sup> [www.ichooselife.or.ke](http://www.ichooselife.or.ke)

peer education is now a familiar focus in *programming* at many universities, this initiative is the largest collaborative programme involving a number of universities all implementing the same model. The model and its outcomes are discussed in further detail in the profile of Kenyatta University's best practices.

### *Prevention Services*

From a small rural base, Maseno University has established an HIV and AIDS programme which sets a benchmark. A high quality, well utilized VCT service is the key to its success. In a rural catchment area of 80,000 people, it received 1,653 clients in 2005 and a further 1,280 clients by October 2006. This is exceptional by most standards and highlights the issues of service delivery, utilization rates and accreditation from the health authorities. Details of the Maseno model are discussed later in the report.

An increasing number of institutions on the continent have responded positively to the need for essential services (e.g. HIV and AIDS education programmes, VCT, condom distribution, sexual and reproductive health services, etc). At another level, institutions are realizing the benefits of policy development and are responding to a growing pressure for graduates who are HIV and AIDS competent at both personal and professional levels. In the case of essential services, institutions have built on previously existing health services or developed stronger partnerships with external agencies (international NGOs or government) to leverage new resources and support.

## Part II From 1<sup>st</sup> to 2<sup>nd</sup> Generation Responses

### 2.1 1<sup>st</sup> Generation Responses

It is worthwhile to pause and reflect on why and how these advances in policy development, prevention programmes, curriculum and outreach came about. The response to HIV and AIDS in higher education is now sufficiently well developed to categorize these responses as *1<sup>st</sup> generation responses*. This 1<sup>st</sup> generation was driven by certain imperatives at the international level which were subsequently adopted by many countries and institutions. A consensus developed around the need for:

- Strong leadership, policy and management commitment.
- Putting in place effective prevention and education programmes.
- Care and support in an environment that recognized the needs of infected and affected people.
- Curriculum reform to develop the new skills needed by graduates in an AIDS affected society.
- Knowledge generation that would improve society's understanding of the epidemic, set new standards and contribute to better programming interventions.
- Community engagement that makes institutions responsive and accessible to the communities in which they work.

With that said, it is important to recognize significant regional, institutional and country level differentials. Institutions in Eastern and Southern Africa, two of the high prevalence sub-regions, have responded more rapidly than those in lower prevalence countries. In the higher prevalence sub-regions, universities in Namibia, Zambia, South Africa, Kenya, Tanzania and Botswana are leaders in the field. At country level, the larger more established universities with research and teaching capacity in the health sciences often lead. However, there are important exceptions, as in the case of Maseno University in Kenya, a small rural institution with limited resources but a high level of commitment and service delivery. In Nigeria, the large federal universities, all of which have high capacity in both teaching and research have taken the lead in the response. Overall, it is also noticeable that higher education institutions in Anglophone countries are more visible and proactive in the international response than their Francophone counterparts. At another level, private and faith based institutions are increasingly more common in higher education and as likely to be involved in the response to HIV and AIDS. Faith based and private institutions were not covered in the research for this report, though it is readily acknowledged that they play an important role both in the higher education community and in the response to the epidemic.

Though institutions may be supportive of quicker action and a more comprehensive response, constraints of scale, institutional frameworks, resources and competing priorities are still significant. Without access to donor funding, many universities have shied away from committing operating budgets to new programmes or services which have traditionally been provided by the public health sector. In some cases, national policies on student funding also make it difficult to raise much needed fee income which could be used to fund services and programmes internally. This refers particularly to education systems where public higher education has historically been virtually free of charge and where students are supported through state bursaries.

## 2.2 Mainstreaming

Since 2003, higher education responses to the epidemic have been influenced by the moves towards *mainstreaming HIV and AIDS* which took hold in the development community. What are the implications of mainstreaming for higher education? UNDP has defined the mainstreaming of HIV and AIDS in higher education using three questions<sup>16</sup>:

- Are any aspects of a university's policy or practice *favourable to the transmission of HIV* and therefore call for examination and change with a view to reducing risk?
- What aspects of a university's policy or practice *inhibit the transmission of HIV* and therefore should be strengthened and encouraged?
- In what ways is the AIDS epidemic likely to affect the university's operations and the attainment of its goals, and what should be done about this?

There are clearly elements of mainstreaming in the way many institutions have approached the comprehensive response to HIV and AIDS. The rationale behind mainstreaming should prompt us to begin thinking about how to define and elaborate a second phase of the higher education response to HIV and AIDS. *To put this issue more simply: do we continue doing more of the same or is there a need to shift the debate?*

## 2.3 2<sup>nd</sup> Generation Responses

However, doing more of the same should not imply that we simply scale-up the prevention, policy development, curriculum integration and outreach as the sum total of the response. That does not equal mainstreaming. Furthermore, increasing the supply of services will not by itself overcome the built-in weaknesses of existing services and programmes. Perhaps a *rethink or a re-conceptualisation* is needed of existing practices before moving ahead?

<sup>16</sup> Prof Kelly's presentation 'Mainstreaming HIV and AIDS in Institutions of Higher Learning' was organized around these key questions, to UNESCO/AWSE Workshop on Higher Education Science and Curricular Reforms: African Universities Responding to HIV and AIDS, Nairobi, 12<sup>th</sup> April 2006.

For example, how can we increase VCT uptake in a positive way that significantly reduces stigma. Perhaps a rethink if needed of peer education programmes as the mobilisation mechanism which delivers larger numbers of people willing to know their status?

If we opt instead to *shift the debate* whilst we scale up, what does that entail? It requires leadership in the higher education community to define a set of *2<sup>nd</sup> generation imperatives* as key ingredients to a *renewal of the response to HIV and AIDS*. Defining these imperatives is best done against the backdrop of current trends in the epidemic.

## 2.4 Trends in the epidemic

What do trends in the epidemic tell us at the moment<sup>17</sup>? Sub Saharan Africa continues to bear the brunt of the epidemic, with Southern Africa as the epicentre. Of people living with HIV in Sub Saharan Africa, 59% are women. Over the past two years, numbers of people living with HIV increased in all regions of the world. In the high prevalence countries, Zimbabwe is the only country showing declines in prevalence, whilst the epidemic continues to grow in South Africa, Mozambique and Swaziland. In Eastern Africa, HIV infection levels are stabilizing or declining whereas West Africa shows divergent trends. Some significant decreases have been reported in Ghana. In terms of new developments, UNAIDS notes the emergence of transmission through injection drug use in Kenya, Tanzania, South Africa, and Nigeria.

In South Africa, HIV prevalence is not yet at a plateau - prevalence amongst young people may be stabilizing, but larger numbers of people are now dying of AIDS. Despite this reality it is reported that a large proportion of South Africans still do not believe they are at risk of becoming infected. Approximately two million South Africans living with HIV do not know that they are infected and believe they face no danger of becoming infected. Recent outbreaks of extreme drug resistant tuberculosis (XDR TB) are also a major concern in the health sector.

In Mozambique the epidemic shows significant increases in HIV infection since 2000 (11% in 2000 to 16 % in 2004). Islands like Madagascar are experiencing much smaller epidemics with prevalence recorded at under 1% in 2005 and knowledge of HIV is poor and condom use is highly infrequent.

In Uganda overall stabilization has characterised trends since the 1990s. New trends are somewhat divergent, for example, recent increases in infection in some rural areas. Very high malaria rates are being found amongst HIV infected people and malaria occurs with increased frequency and severity in HIV infected adults.

Kenya still faces a serious epidemic but some significant changes have taken place in behaviour, including the delay in sexual debut, increased condom use rates and

<sup>17</sup> Excerpted from *AIDS epidemic update, UNAIDS, 2006*

the reduction in the number of partners. Tanzania shows significant increases in infection in rural areas and the possibility that injection drug use is contributing to the epidemic.

In Nigeria, 300,000 adults were newly infected with the virus in 2005. South Africa and India are the only other countries with larger numbers of people living with HIV. In contrast, Ghana shows signs that the epidemic could be in decline despite slight differentials between urban and rural areas. Interestingly, older men and women are more at risk and married women are reportedly at greater risk (three times more likely) of infection.

Though this provides only a glance at trends in the epidemic, many of the challenges are still part of the landscape in high prevalence countries. In this context, what best practice examples are discernable at institutional level and what lessons can they offer us for the way forward?

## Part III - Best Practice Examples

### 3.1 University of Ghana

Each profile in this section reviews the core components of the response to HIV and AIDS at each selected institution. In general, the analysis focused on the following areas:

- Management of the response
- Institutional Policy
- Sexual and Reproductive Health Services
- Student Involvement
- Prevention Services
- Curriculum integration
- Research
- Treatment Access
- Community Engagement

A highlighted section further describes and analyses an area of best practice at the institution

#### *Management of the response to HIV and AIDS*

Despite being a locus of major research outputs and various projects on HIV and AIDS over the years, it was in 2006 that the Vice-Chancellor established an HIV and AIDS Co-ordinating Body. Prof John Anarfi, a senior faculty member at the Institute of Statistical, Social and Economic Research leads the institutional response. In terms of scale, the university currently enrolls approximately 30,000 students at postgraduate and undergraduate levels.

At the institutional level most of the Co-ordinating Body's activities are being channelled through a World Bank funded project entitled TALIF the 'Teaching and Learning Innovation Fund'. The university's first priority is to establish an institutional policy as a way of addressing the lack of co-ordination, the absence of a plan of action and the absence of a monitoring mechanism. Its second objective was to set up a co-ordinating body to implement the policy.

A draft policy was developed in 2006 but was not finalised. It will be reintroduced for discussion by the senior management in early 2007. In terms of its other activities, the major focus will be in scaling up essential primary prevention services on campus. Three VCT sites are expected to be the focus of attention (one at the Noguchi Memorial Institute, one at the School of Nursing and another at the University Hospital. The first of these will be fully active by early 2007.



Secondly, the University plans to revitalize and formalize the peer education programme.

Thirdly, prevention programmes using multi-media are in the pipeline. Radio talk shows, a series of debates at halls of residence and a billboard campaign are also planned.

### *Sexual and Reproductive Health Services*

Working with Engender Health (an international NGO), the Faculty of Nursing set up a Community Based Centre for Partners in Health (COMBACEPH) in October 2004 - primarily as a means of providing sexual and reproductive health services to students and staff at the University. It assumed students would be keen to use the facility but the response, to date, has been poor. Since moving towards an outreach strategy focused on the halls of residence, the initiative has had a much better response. COMBACEPH also conducts outreach at local secondary schools and collaborates with a local radio station. Its recent intervention, entitled 'Sex and Sense' showed good responses from youth, especially on the issue of rape and sexual violence.

Students, staff and the surrounding community make use of the University Hospital, which effectively plays the role of a district hospital and is a 105-bed facility. Its services therefore include general practice, medical, surgery and emergencies. In the case of students, they first use a Student Clinic and may then be referred to the hospital. The clinics handle nearly 150 patients a day between two doctors. Student health services are free and are covered by fees paid to the institution. However, members of the public pay a fee, as is the case of all public hospitals, with the exception of a few services.

A VCT service at the hospital is planned for implementation in 2007. Contraception services are available through the antenatal clinic. Students use the general practice clinic for their needs which is sometimes a dis-incentive. No designated services are available for HIV or PMTCT as yet. Testing for pregnant women is only available at a cost of 40,000 Ghanaian Cedis, a substantial amount for an ordinary community member.

Another facility available to students and staff is the Noguchi Memorial Institute which is set to offer free VCT services in the near future. Though it is primarily a high level research and training centre, it's recently established health Support Centre will form a key component of the university's response in terms of services. Twenty employees have already made use of the facility within two weeks of its launch in October 2006. Its strategy is to embrace a wider range of health issues than HIV and AIDS; it will therefore handle family planning services, STI treatment services, PMTCT and condom distribution.

### *Student involvement*

The most effective intervention so far is in reaching students through the training of peer educators. They are trained by COMBACEPH in the Faculty of Nursing on a three-day programme and subsequently have monthly meetings. No specific roles or targets have been set for the peer educators. A total of 120 peer educators have been trained since 2004 and will be deployed as trainers in the new TALIF supported initiative. Since its inception, the programme has continued to generate major interest from students wanting to be trained. The target for 2007 is to have 2,000 more trained peer educators available.

### *Prevention services*

As VCT becomes more widely available through the new testing sites, the Coordinating Body will be assessing demand as well as its delivery strategy. The National AIDS programme supports all public VCT centres and if the Noguchi Memorial Institute is accredited, it too will form part of the network and enjoy some benefits from the linkage.

**COMMUNITY-BASED CENTRE  
FOR PARTNERS IN HEALTH**

*Our Services*

- ▶ **COUNSELLING** ▶ **FAMILY PLANNING**
- ▶ **HEALTH EDUCATION** ▶ **IMMUNIZATION**
- ▶ **PHYSICAL ASSESSMENT/SCREENING**
- ▶ **HOTLINE SERVICES/HELPLINE** ▶ **VCT**

➤ *Come let's talk!* ➤

Condom distribution is still *ad hoc* and occurs mostly through shops on the campus and through social marketing campaigns. A snack bar in the building housing COMBACEPH is encouraged to sell condoms where they retail for 500 Cedis each. Another initiative, using non-formal channels, distributed an estimated 150,000 condoms in the halls of residence in 2005.

Some commentators at the university note a social conservatism about sex amongst youth in Ghana in general, sex is silent. University teachers are concerned about

perceived levels of risk resulting from unsafe sexual behaviour amongst students and an unwillingness to accept the need for testing. Social conditions on campus may contribute to increased risk. For example, student accommodation is heavily oversubscribed and forces large numbers of students to use the inadequate facilities a factor which some commentators see as increasing risk.

### *Curriculum integration*

At institutional level, there are moves to develop and implement a course aimed at mainstreaming HIV and AIDS into the core curriculum in 2007/2008. Key decisions were in process in late 2006 as to where the course will be housed, delivery modalities and other curriculum management issues. The draft proposal for the course is based on 36 hours of instructional time and focused heavily on the biological and epidemiological aspects of HIV transmission, prevention measures and management of infection. Since Ghana is fortunate to show signs of a declining epidemic in a low prevalence country (3.6-2.7% prevalence), there is an interesting challenge in motivating departments to buy into the necessity of putting HIV and AIDS on the curriculum agenda. One option being explored is to use the compulsory year-long undergraduate course in African Studies as a platform for teaching HIV and AIDS.

There are departments already teaching HIV and AIDS related content (most likely what is termed 'infused content'), including:

- Law
- Geography
- Communications
- Public Health
- Nursing
- Social Work

### *Research*

Research on HIV and AIDS is very well developed in the health sciences while the Institute for Statistical, Social and Economic Research also acts as a locus for high level, high output socially directed research. Other outputs are often in the form of commissioned or contract research on a private basis.

### *Treatment access*

Access to ART is available through the university teaching hospital and private hospitals at this point in time. University authorities are concerned about students using pharmacies as treatment centres for a range of health issues because of the lack of regulation over dispensing.

### *Best Practice*

The university's Institute of Adult Education (in partnership with the United Nations Population Fund) has successfully delivered a *distance education programme* since 2003 in '**HIV and AIDS Counselling and Care-Giving**' to more than 2,000 students. Using distance education modalities, an open admissions policy and priced at \$50, the four month long course has reached nurses, teachers, community workers and a range of other constituencies.

The second component of the Institute's programme is based on a partnership agreement with the University of Stellenbosch in South Africa, and focuses on the delivery of another distance education format course on the '**Management of HIV and AIDS in the Workplace**'. This component will use satellite based internet access to reach students.

Thirdly, the University of Ghana, University of Cape Coast, University of Winneba and Canada's Simon Fraser University are the principal partners in a Canadian International Development Agency (CIDA) funded five-year programme on '**Reducing HIV Stigma by Education**'. The programme outputs will include:

- Increased capacity, knowledge and skills in the application of instructional methods.
- 126 university lecturers and tutors trained to teach HIV and AIDS to teachers enrolled in the education diploma programmes and to community youth workers.
- 15000 school teachers and 18000 community youth workers using participatory education techniques to educate girls and boys in HIV and AIDS awareness and prevention.
- 1.2 million school children and 72000 out of school youth with fundamental HIV and AIDS education.

Designed as a one semester credit-bearing course it will build on the Institute's experience in the delivery of the care-givers' course which also used a print-based delivery mode. It will go to full scale after a pilot phase at the University of Cape Coast ending in March 2007.

The Institute's programming is backed by evidence based feedback. Thus far, the response to its care-givers' course is very positive but has identified stigma as a major constraint. A survey among students, service providers and staff in 2004 revealed other important risk factors. While knowledge levels were high, behaviour change was weak. The survey confirmed opinions among HIV and AIDS specialists regarding the general reluctance to discuss sex and sexuality together with a range of cultural taboos. The feedback on condom usage is also complex. Whilst there was strong support for condom distribution, commentators acknowledge that women relent to pressure from men to stop condom use as a sign of 'trust'.

## *Analysis*

Though the overall response to the integration of HIV and AIDS in the University of Ghana's curriculum is as yet relatively undeveloped and lacking in a clear framework, the Institute of Education has successfully exploited the potential which *distance education* offers. Unlike face-to-face teaching, the *effectiveness* of distance education enables universities to reach far larger numbers of students (*efficiency*), in multiple locations, at lower cost (*sustainability*) and with greater flexibility. The success of its initial programme, which is closer to a non-formal/professional development course, has also provided a platform on which to build new formal credit bearing course offerings which are more integrated into the mainstream of teaching and qualifications structure. The partnership programme on HIV and AIDS in the workplace strengthens the *relevance* of the curriculum in an area which has received scant attention in most institutions.

Contact: For more information on the HIV and AIDS Programme at the University of Ghana, contact Prof J K Anarfi, [jkanarfi@isser.ug.edu.gh](mailto:jkanarfi@isser.ug.edu.gh)

### **3.2 University of Ibadan, Nigeria**

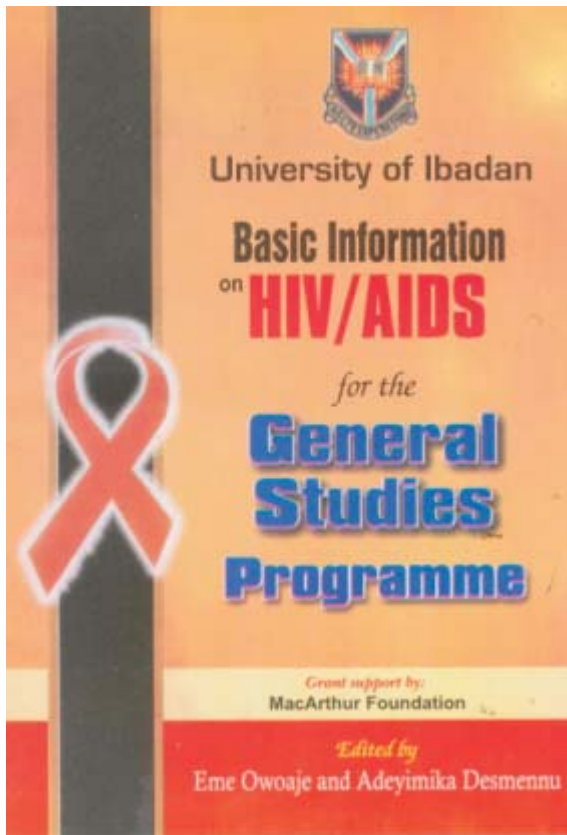
#### *Management of the response to HIV and AIDS*

The University of Ibadan is the oldest among Nigeria's federal universities and is one of the continent's most widely recognized. In 2006 its enrolment stood at 24,000 students with a strong emphasis on post-graduate education. This trend will be strengthened over the coming years to reach a 60/40 ratio between under-graduate and post-graduate. As a federal institution, its student body is drawn from across Nigeria as well as elsewhere in Africa.

The initial attempts at co-ordination of the response at Ibadan were focused on prevention and driven by the University of Ibadan's Committee on HIV and AIDS Prevention (UNICAP) based at the University's College of Medicine. The College of Medicine has anchored the university's response since its inception in 1998, mostly through its research and teaching activities in a range of disciplines in the health sciences. Similar committees were set up in each of the 13 faculties.

#### *Curriculum integration*

A University of Ibadan team participated in the UNDP's 2003 training programme which was aimed at mainstreaming HIV and AIDS in the curriculum. Subsequently, with the support of the MacArthur Foundation, a team took the process two levels further:



a. Capacity building sessions for academic staff interested in teaching HIV and AIDS related issues which involved 112 people, with one of the sessions funded by AAU itself.

b. Development of a general studies core course which is a requirement for all incoming students. The course involves four hours of contact time focused on HIV and AIDS-related content as part of a larger programme, including: the epidemiology of HIV, the natural history of HIV infection, transmission and predisposing factors to HIV infection, impact of HIV and AIDS on society, management of HIV infection and prevention. Three thousand copies of a resource booklet have been published and implementation of the course was planned for January 2007. The university is keenly pursuing opportunities to replicate the course elsewhere in higher education.

As a follow up to the UNDP course, Ibadan was allocated \$10000 which was used to fund seven research sub grants and a further \$3000 for books and materials.

There are other significant curriculum-based efforts at making students 'AIDS competent' in terms of personal and professional skills. For example, the Centre for Literacy, Training and Development Programme for Africa (CLTDPA) developed a 'Professional Diploma in HIV and AIDS/STIs Education'. Approved as a formal curriculum offering by Senate in early 2006, the course is a three year part-time programme aimed at community leaders, health workers, religious leaders, community-based organizations and non-government organizations. More generally in the Faculty of Education which caters for 4000 students, students receive some HIV and AIDS related content. Schools themselves have been required to teach family life and HIV and AIDS for the past four years. Another good example is the university's Guidance and Counselling Department which has been training HIV counsellors for at least six years but only at post-graduate level.

The inclusion of HIV and AIDS in the General Studies course marks significant progress over four years (2003-2006) during which academics and the institutional as a whole has become more receptive to the idea of an institution-wide response to HIV and AIDS.

### *Research*

The University of Ibadan is a major research institution in the region and its flagship programmes in HIV and AIDS include the REACH Programme (a partnership with Northwestern University (USA) discussed below). The University is also a major partner in the AIDS Prevention Initiative in Nigeria (APIN), a multi-institution initiative funded by the Bill and Melinda Gates Foundation that has a wide multi-disciplinary scope. Its major outputs to date include a seminal publication 'AIDS in Nigeria', available at: [http://www.apin.harvard.edu/AIDS\\_in\\_Nigeria.html](http://www.apin.harvard.edu/AIDS_in_Nigeria.html)

Though strong in terms of partnerships, the university is heavily dependent like many others on the continent for external support of its major research programmes. In terms of its approach to research, new initiatives are often driven by individual researchers or clusters, rather than an institution-wide strategy. Partnerships also exist at government level where government has primary responsibility for the delivery of health care but again at an individual level.

### *Prevention services*

The University Health Centre (Jaja Clinic) operates as a primary health care centre handling all prevention services and refers all secondary matters to the University Teaching Hospital. The hospital conducts all investigations and is a major treatment access facility. The clinic initiated counselling and testing services in 2002 for students and staff and by 2004, it had tested 305 people. A significant number of tested were positive (13%) but never returned to the centre for any follow up investigations, care or support<sup>18</sup>.

Students' perceptions of VCT testing and the delivery of the service are clearly a challenge, as is the case in other institutions profiled in this report. In the case of Ibadan, students are less than keen to test at campus-based facilities for a variety of reasons.

User fees are also the norm in most Nigerian health facilities and students are expected to cover the cost of all services except consultations. User fees are levied for:

- VCT
- Drugs (except malaria)
- Investigations
- STI treatment
- Contraception services
- Opportunistic infections

<sup>18</sup> Quoted in 'A situation analysis of the University of Ibadan HIV and AIDS Prevention Programmes', Dr R Ademoye, 2005.

There is significant debate at the university on the merits of condom distribution and no agreement has yet been reached on distribution at the student residences or the clinic. Condoms are typically available through vendors and shops operating on the campus.

#### *Student involvement*

Ibadan's primary platform for student involvement is through its peer education project under the umbrella of the Centre for HIV and AIDS Intervention in Nigeria (CEHAIN) programme. Most other projects under CEHAIN were focused on research and publications. Starting in 2001, the peer education project trained 40 students and continued over a three year period on internal resources. In 2005, using additional support from the MacArthur Foundation, the project expanded and has managed to train a total of 389 peer educators. Interestingly, the project managers note that a small percentage of peer educators are willing to test (30% estimated) and an even smaller number (10%) are likely to have tested in the past. A focus group conducted with peer educators in October 2006 at Ibadan for the purposes of this report delivered a high level of engagement by a very articulate and opinionated group of students. The dynamics within the group illustrated interesting fault lines: male students were more conscious of promoting 'Yoruba culture and tradition' in dealing with sex and sexuality, whereas female students were interested in a more emancipatory concept of female sexuality and gender in the context of HIV and AIDS. Half the group claimed to be abstinent, a practice which provoked vigorous debate about the role of faith-based groups in student life.



### Peer educators at University of Ibadan



The Action Group on Adolescent Health (AGAH), established in 1997, is another important student initiative, primarily because it is managed by students themselves. The group's plans are focused on the establishment of a Youth Friendly Centre along the same lines as the other pilot sites including Ahmadu Bello University. It is envisaged that the centre will offer services for: STI treatment and management, counselling including rights and sexual and reproductive health, essential drugs and VCT. It is instructive to note the response by students to student-led VCT campaigns. AGAH's campaign in June 2006, netted 200 students who tested. Student leaders attribute the high uptake to perceptions and anxieties about testing in a less user friendly environment. Marketing seems to play an important role in reducing negative factors.

Nigeria's National Youth Service Corps a year long post university training scheme in which young graduates are deployed across the country also includes a short course aimed at developing peer education skills for use in secondary schools with youth.

Nigerian student life is characterized by high levels of voluntarism and a belief in the value of being engaged in activity that is both socially valuable and personally fulfilling. This culture of voluntarism is a powerful basis on which to sustain the response to HIV and AIDS. Student responses to the curriculum reforms have been positive and are re-enforced by a strong sense of their value as future decision makers and leaders in the public and private sector after graduation.

#### *Institutional policy*

A draft policy was developed in 2006 and is scheduled for adoption in 2007.

*Best practice*



A recently initiated research collaborative programme at the University of Ibadan focused on generating evidence-based responses to policy and responses to HIV and AIDS. This programme highlights the potential and the value of investing in responses that generate new knowledge about the HIV and AIDS epidemic.

REACH Alliance to Combat HIV and AIDS is a collaborative programme of the University of Ibadan and Northwestern University in the United States. The programme grew out of a 2004 seminar at Northwestern entitled “HIV and AIDS Prevention in Nigerian Communities: Strengthening Institutional Responses” and was jointly organized by the Faculty of Social Sciences at Ibadan and Northwestern's Programme of African Studies.

Nigerian scholars, activists and policy makers attending the seminar raised an urgent call for detailed, well researched and systematically presented information on the dynamics of HIV in specific Nigerian contexts.

Launched in 2006 with support from the Bill and Melinda Gates Foundation in 2006, REACH is aimed at examining why prevention efforts fail and how they can be improved using social science expertise and community-based approaches. The outputs of the programme are directed at policy makers, practitioners, activists and those communities most in need of better HIV and AIDS programming.

The Faculty of Social Sciences at Ibadan comprises the departments of geography, political science, psychology and sociology. At least 60 of the faculty at Ibadan have

experience in working on HIV and AIDS issues, including training of NGOs in prevention and care as well as research on orphans, vulnerable children and other populations at risk.

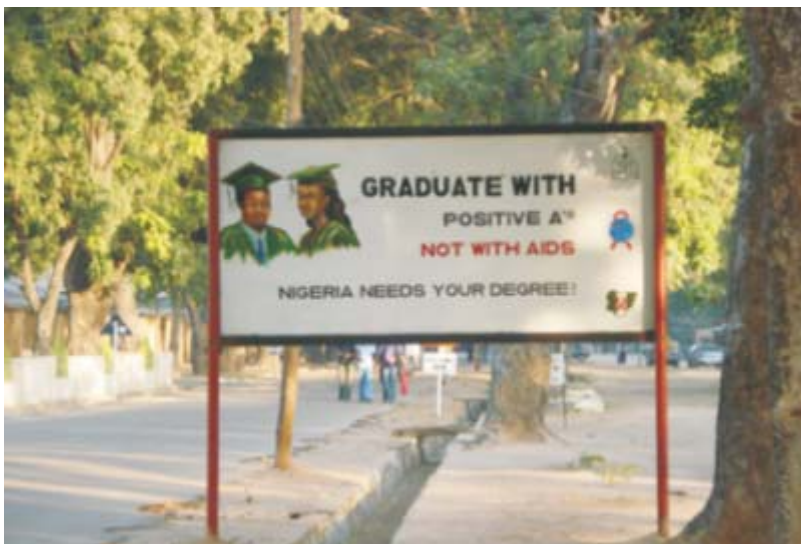
It is a faculty that handles 2,000 students a year and is committed to providing for their health and psycho-social needs. Starting in 2004 with its own Student Health Centre, the faculty provides psycho-social support and education to its own students with major involvement from students themselves.

### *Analysis*

The REACH programme is a new initiative but it merits best practice recognition on a number of counts. Firstly, it represents a major departure from the tradition of health and biomedical sciences being the leading edge of research on HIV and AIDS in higher education. This time it's the social sciences. Secondly, it is located within a faculty which has a demonstrated commitment to working on HIV and AIDS as both an academic pursuit and as part of an institutional response (*relevance*). Thirdly, the research agenda is aimed at using research to influence and support decision-making in policy the most *effective* use of social science research. Fourthly, this programme builds on the University's reputation for partnerships in high level research and contributes towards its strategy of becoming a premier post graduate teaching and research institution.

Contact: For more information on the HIV and AIDS Programme at the University of Ibadan, contact Dr Eme Owoaje, [emeowoaje@yahoo.com](mailto:emeowoaje@yahoo.com)

### **3.3 Ahmadu Bello University, Nigeria**



**Billboard at Ahmadu Bello University, Kongo Campus**

Ahmadu Bello University ('ABU'), located in the city of Zaria is a large comprehensive research and teaching institution with an enrolment of approximately 35000 students (2006 data). Founded in 1962, as one of Nigeria's federal universities, it is considered the premier higher education institution of Northern Nigeria. The city of Zaria has been a magnet for students for generations and is home to five other higher education and training institutions. Of more than 7,000 academic and support staff, fifty percent live on the main campus. This is a community large enough to support its own primary schools.

### *Management of the response to HIV and AIDS*

'ABU' is a major role player in medical and health sciences education in the region, focused around a 600 bed teaching hospital. In 1990 the university's Health Service began awareness campaigns and followed on with collaborative activities with AIDS NGOs in the local host communities. Between 1995-97, the first cases of people living with HIV in the university were diagnosed, an occurrence which further galvanized their response. By 2003/2004 sentinel survey data from ante natal sites was showing significant prevalence levels in the area. KAP study findings have also shown a range of sexual behaviours, risk-taking activity, a large number of students who were already sexually active and unprotected sex. In 2003, the United Nations Office on Drugs and Crime (UNODC)<sup>19</sup> sponsored a needs assessment which reported that most responses to HIV and AIDS in Nigerian higher education showed major weaknesses.

Against this backdrop in 2004, the University began to mobilize an institution-wide response and established a University Committee on HIV and AIDS under the office of the Vice-Chancellor.

### *Prevention services*

At the same time as the University Health Service was formed in 2004, the health service initiated its first prevention services aided by support from the Federal Ministry of Health and other agencies. Counselling, testing and screening commenced on a small scale. Testing was free but test kits had to be bought or were supplied by donors.

The first major round of testing in 2005 involved 257 clients and reported 70 positive cases. In the period January to June 2006 a further 408 clients tested and 38 positive cases were reported. Clients testing positive were referred to the ABU Teaching Hospital for management but treatment of OIs and syndromic management of STIs is carried out by the health service.

The University Health Service has used an innovative approach to mobilize clients for VCT which appears to be yielding results. VCT drives were conducted through outreach sessions at faculty level instead of mass mobilizations. In 2005, with the

<sup>19</sup> Quoted in 'A Five Year Proposal for HIV and AIDS Intervention Programme in Ahmadu Bello University and its neighbouring communities in Zaria metropol', Development Office, ABU, n.d.

assistance of the Killian Foundation, the health service tested 1127 students and staff over nine months. In the Faculty of Veterinary Medicine, 259 clients tested. A further 167 clients tested at the Faculty of Pharmacy.

With a 24 hour health service on both its campuses and 10 medical officers available, the university is able to offer students and staff a high level of care, even before referral to the teaching hospital. Most services at the health service are free for all students but small user charges are applied for staff and their dependants.

The University Health Service is an active member of the Committee of Directors of University Health Services, an umbrella body that has been in existence for 30 years and which plays an important role in setting policy and guiding the development of campus based services.

#### *Treatment access*

ART as well as a range of HIV care services are freely available through the teaching hospital but the university is still heavily dependent on donor support through PEPFAR. A small number of students are already on treatment but a general climate of stigma undermines the likelihood of disclosure. From a public health perspective, the treatment programme would appear to be in its early stages but it is growing in numbers. An estimated 1700 adult patients were registered at the Adult ARV clinic by late 2006. In contrast the paediatric clinic handles around 50 children's cases. ABU plays an important role as the 1<sup>st</sup> national PMTCT pilot site handling about 18-20 patients on a weekly basis. The ABU programme is expected to treat 7000 patients over the next 3 years.

#### *Student involvement*

Recent survey data shows an urgent need for increased education and skills development among students. Awareness of risk is poor, condom use is low and more than half of male students reported being involved in sexual relationships with multiple partners.

The Health Service focuses its advocacy drives on the induction period for freshmen, an orientation campaign following matriculation and faculty level orientation programmes. The Department of Theatre and Performing Arts uses its resources in community theatre around the same key points in the calendar in order to educate and mobilize students.

Abstinence is a major feature of campaigns and programming at ABU and is strongly supported by university management as the most culturally appropriate response in the context of northern Nigeria. Religious affiliation is an important aspect of social life and the university expects its community to respect the pre-dominantly Muslim values in its host community. It is now equally commonplace for churches in Nigeria to ask couples to take an HIV test before marriage. University management has

developed a dress code which it sees as an additional means of changing sexual and social behaviour at the institution. In keeping with this approach, the health service chooses not to make condoms freely available. Students have to ask for them from a nurse at the health services facility.

Like other examples documented in this report, from a practical point of view, health care practitioners readily concede the complexity of working with students who cannot admit to being sexually active because of the social taboo attached to pre-marital sex. At the same time, they need to ensure that if the students are sexually active, there are ways of ensuring that they make use of sexual and reproductive health services in a way that will not compromise them socially but will also reduce their vulnerability. The power of social taboo in contexts like these deserves more attention because of the likelihood that risk-taking behaviours, particularly unprotected sex, will be driven into secrecy and out of reach by peer educators, health workers or prevention service providers.

### *Partnerships*

The University has relied heavily on its partnerships to sustain the response to HIV and AIDS. The National AIDS Council (NACA) supplied billboards for the campus and is also a partner in the Youth Friendly Centre (discussed in detail below). From 2005 onwards PEPFAR has supported baseline research, advocacy campaigns and the supply of test kits. Another philanthropic foundation supported the provision of 1,700 more test kits. Other partnerships include the Youth Awareness Movement on HIV and AIDS in Africa (YAAMA), the Bill and Melinda Gates Foundation, the Global Fund and the State Action Committee on HIV and AIDS (SACA).

### *Community engagement*

The most sustained work engagement with external stakeholders arises from a partnership with the UNODC through which secondary schools are being trained to deliver HIV and AIDS education and advocacy campaigns.

On the internal front, various attempts have been made at training peer educators, the first of these being an intervention by the Society for Women and AIDS in Africa (SWAN). SWAN is active in 32 of Nigeria's 36 states and the University's counselling centre is a locus of co-ordination for their work at ABU. YAAMA's activities were an offshoot of the initial peer education project and it was from then onwards expected to act as the custodian of the HIV and AIDS programme amongst students. YAAMA's remit includes activities in local communities as well. The largest peer education activity to date was in 2005 when 120 peer educators were trained. The University Campus Choir trained another 40 students. Despite the level of commitment to peer education, the overall structure and management of peer education activities needs strengthening.

*Best practice*



Ahmadu Bello University is one of five pilot sites across Nigeria for a **Youth Friendly Centre**, initiated as a partnership with the Nigeria's National AIDS Council and EcoBank, a commercial bank. The Youth Friendly Centre's are a new structure combining on-campus banking facilities with a student-focused facility that incorporates education and media resources, space for gatherings and counselling services. Whilst focused on the task of minimizing the spread of HIV infection and providing education on HIV, the centre at ABU draws most of its 100 users a day by offering access to the internet and banking services. Since its opening in late 2006, about 100 students and employees have made use of the testing and counselling service. As the internet facility grows in popularity and usage, it is hoped that the Centre will generate its own revenue. It is a novel and innovative attempt at mainstreaming HIV education and prevention services using a commercial partnership and non-traditional health promotion strategies. In a context where sexuality and reproductive health issues are still highly contested, it presents an important alternative for youth who need a 'safe environment' which also does not compromise them socially.

## *Analysis*

As a very recent initiative, it still remains to be seen whether the Youth Friendly Centre's combination of service delivery, outreach and routine commercial activity is the best means of capturing the youth market on campuses. With that said, this initiative is *unique* in the African context. Even the idea of on-campus banking facilities is a novelty for many institutions and commercial operations such as banking relying on careful projections of *sustainability*. The involvement of the National AIDS Council is an added advantage in that it illustrates the potential of leveraging private sector resources for the public good. This model prompts the need for a re-think about a typical 1<sup>st</sup> generation response to the epidemic in the form of the 'HIV and AIDS Unit' or the 'HIV and AIDS Control Unit' or a 'Centre'. Often established as a single purpose, stand alone facility, these units and centres have had mixed responses. Staffing, costs, stigma and the quality of leadership have to varying degrees determined the success or failure of these focal points. In the years ahead, it may be more effective to reach students and employees through less traditional approaches. As the success of online 'social networking' has demonstrated, internet access is a powerful tool and that is already clear from the motivations of the Centre's users.

Contact: For more information on the HIV and AIDS Programme at the Ahmadu Bello University, contact Prof G Onyemelukwe, [gconyemlukwe@yahoo.com](mailto:gconyemlukwe@yahoo.com)

### **3.4 Kenyatta University, Kenya**

#### *Management of the response*

Kenyatta University is located a short distance from the city of Nairobi in Kenya and became a full-fledged University in 1985. With a population of 14,000 students and 2,317 members of staff, it is in the forefront among Kenyan Universities in higher education response to HIV and AIDS<sup>20</sup>.

In keeping with the Government of Kenya policy, its AIDS Control Unit (ACU) was established to develop and co-ordinate programmes for the management of the HIV and AIDS within the university and its immediate community. Training is a major area of work for the ACU and it provides life-skill training, training of community leaders and the youth on HIV and AIDS. The university also trains staff and students on how to care for infected and affected HIV and AIDS individuals.

In terms of its advocacy role, the Aids Control Unit mobilizes the university community, local communities and schools using drama, music and puppetry presentations on HIV and AIDS.

<sup>20</sup> Details in this section are based on Owino, P, 'HIV and Responses in the Kenya Universities sub sector', [http://educationclearinghouse.nairobi-unesco.org/docs/Kenya\\_University\\_Sector-description\\_of\\_response\\_to\\_HIV\\_AIDS.pdf](http://educationclearinghouse.nairobi-unesco.org/docs/Kenya_University_Sector-description_of_response_to_HIV_AIDS.pdf)



The Aids Control Unit also acts as a focal point for partnerships including the Government of Kenya, the AAU, the Association of American Universities and Colleges (AAU & C) and the Kenya Aids Vaccine Initiative (KAVI).

#### *Institutional policy*

Kenyatta was amongst the first in Kenya to develop policy on HIV and AIDS and it was adopted and implementation began shortly afterwards in 2001.

#### *Prevention services*

The university offers Health Services to all students, members of staff and their families and includes access to traditional medicine practitioners. Condoms are readily available for the students and staff who need them at the Health Centre and in the student hostels.

The Aids Control Unit normally has a special session with all new students on campus, to discuss issues related to HIV and AIDS. The Vice-Chancellor also does a public address to all 1<sup>st</sup> year students.

VCT is available to all students, staff and the local community. VCT promotion is focused around an annual HIV testing day which attracts students, staff and the local community. More general psycho-social support and counselling services are available to all students and these events are co-ordinated by the Dean of Students and the Aids Control Unit. Staff seminars and workshops are continually organized for mobilization.

### **HIV Testing Day at Kenyatta University, 2004**



### *Curriculum integration*

The university offers a wide variety of courses at certificate, diploma and post-graduate levels, as well as a compulsory core course unit. In addition, the school of pure and applied science offers a course on nutrition and HIV and AIDS. With the support of the AAU, Kenyatta University has partnered with the University of Namibia in the development of a curriculum geared towards the skills needs of teachers, nurses, students, social workers and civil servants working with HIV and AIDS. This initiative was in response to a request from government in Namibia in 2005 which urged the university to take the lead in establishing a teaching programme on HIV and AIDS with the requisite expertise. Thirty-one staff members were recruited into the project with technical support provided by Kenyatta University's ACU through a staff exchange<sup>21</sup>.

Research on HIV and AIDS is increasingly well developed at the university, particularly amongst post-graduate students at the level of the post-graduate diploma in HIV and AIDS where a research component is compulsory. The AIDS Control Unit also continually assesses the impact of HIV and AIDS on the university community through internally focused research.

### *Community outreach*

The university plays a key role in mobilizing communities through the AIDS Control Unit and the organization of Kenyatta University Outreach Project (OKUO). Through OKUO, students, staff and the local communities participate in HIV and AIDS activities and other self-help projects.

The university is in the process of establishing a community resource centre, which is meant to serve both the university and the local community and to provide a micro-finance programme to support people living with HIV and AIDS.

Kenyatta University Students AIDS Control Organization (KUSACO), the Kenyatta University peer counsellors, and the Kenyatta University staff Anti AIDS Group (KUSAAG) are students and staff organizations which are actively dealing with HIV and AIDS in the university and its environs. Students have formed linkages with their home community based responses to HIV and AIDS through District Associations.

### *Peer education*

Over 200 students and six members of staff are trained annually in a partnership with 'I Choose Life', the multi-institutional HIV and AIDS peer education training programme based at the University of Nairobi. A more detailed discussion of this programme is provided in the section on best practices (see below).

<sup>21</sup> Owino, P, Hangula, L and Otaala, B, *HIV and AIDS Capacity Building and Curriculum Development and Implementation at the University of Namibia (UNAM)*, April 2005.

The AIDS Control Unit also initiated part-time students' residential advisors to counsel students on alcoholism, drug abuse and issues related to HIV and AIDS. In addition, the university offers unique employment opportunities to two of the best Trainer of Trainers graduating from the HIV and AIDS Peer Education programme annually.

### *Best practice*

In June 2006, Kenyatta University hosted the 'East African Regional Workshop on HIV and AIDS' focused on capacity building. Organized jointly with the Association of African Universities, the workshop was designed to assist Kenyan and other East African institutions in the implementation of the AAU's 'HIV and AIDS Toolkit for Higher Education Institutions in Africa'. The workshop was also an opportunity to reflect on new research at Kenyatta University and on-going programmes in which the university has a major involvement.

Kenyatta University is a major partner in '*I Choose Life*', the leading behaviour change programme in Kenyan higher education<sup>22</sup>. Launched in 2002, it is a multi-institutional programme involving seven other universities. Its baseline findings indicated that 43% of students at Kenyatta were sexually active and not using condoms consistently. Thirty six percent were abstaining and 21% were sexually active and using condoms. The overall objectives of the intervention were:

- To improve HIV and AIDS related knowledge.
- Delaying sexual debut.
- Decreasing the number of sexual partners.
- Increasing condom use among sexually active students.
- Increasing VCT uptake.
- Decreasing stigmatisation against people living with HIV.
- Strengthening HIV and AIDS policy development and implementation with student participation.
- Community support for sustained behaviour change.
- HIV care and support for students.

Over 4 years, the programme has trained an estimated 2901 peer educators who are expected to have reached more than 40000 students. It has recorded nearly 4000 VCT test visits and established 210 post test clubs. Two post test clubs for students living with HIV are also in existence. By 2006, survey data from implementing institutions showed 86% students were using condoms and an increase of 25% in the number of students who have tested for HIV. Uptake of VCT was directly linked to exposure to the behaviour change programme and 78% of students involved in the programme reported having tested for HIV. Interestingly, the gaps in the programme showed that partner reduction and levels of stigma were taking far longer to overcome.

<sup>22</sup> Based on a presentation by Mike Muthungi, Programme Manager: *I Choose Life*, Eastern African Workshop on HIV and AIDS Toolkit, Kenyatta University, June 2006. [www.ichooselife.or.ke](http://www.ichooselife.or.ke)

## *Analysis*

The scale on which *I Choose Life* operates (across seven institutions) has already proven its potential for replication, though without significant external support it is not altogether clear it will be sustainable. Peer education is hugely popular but with highly variable outcomes in education. *I Choose Life* is significant in having established benchmarks and close monitoring and evaluation as part of its methodology. Its *relevance* to the needs and interests of students is well supported by the sheer numbers of students who have been recruited as peer educators. In a context where the uptake of VCT is highly variable, the *effectiveness* of this programme on one level is evidenced by the numbers of recruits who have tested for HIV. Finally, few other programmes have been innovative enough to spawn up to 20 behaviour change groups on a university campus based on a host of different interest groups the largest of which comprises 65 dance enthusiasts at one of the programme's partner institutions.

Contact: For more information on the HIV and AIDS Programme at Kenyatta University, contact, Dr Philip Owino, [philipowino@yahoo.com](mailto:philipowino@yahoo.com)

### **3.5 Maseno University, Kenya**

#### *Management of the response*

Maseno University has its origins in a teacher training college and a government training centre and was formally established in 2001. It is located about 25 kms outside of Kisumu, the capital of Nyanza province which borders on Lake Victoria. The area straddles the major transport route to Uganda and Rwanda, a factor which is known to be a major driver of the epidemic in an already high prevalence environment. By 2001, data from ante natal clinics showed prevalence levels as high as 22%, but has declined significantly since then. Typhoid is a serious health threat too and affects the local water supplies.

#### **Staff at Maseno University AIDS Control Unit**



## Maseno University Students



In the late 1990s, the university became increasingly concerned about the loss of staff to illness and death. It is estimated that eight employees per year were lost in this period, as the epidemic matured in the region. The initial response by management was to institute a medical levy for two purposes: a) support for the anti malarial programme, and b) create a supply of ARVs. Malaria is the dominant concern for most members of the 8,000 strong Maseno community who seek medical assistance on a daily basis. Buying its own ARVs in 1998 was an expensive undertaking and it took some effort to convince managers to invest in a levy. The early uptake of ARVs was low with only 10 people seeking access to the service and staff, too, were reluctant. Prior to this initiative, medical insurance for staff was entirely a private matter. The income from the levy effectively helped create the basis for a far more comprehensive health service than ever before.

Formalization of the university's response to the epidemic came in 2003 with the establishment of the Maseno University AIDS Coordinating Committee (MUACC), chaired by the Deputy Vice-Chancellor for Academic Affairs. MUACC comprises key stakeholders and fulfils a critical co-ordination and oversight response.

The HIV and AIDS Programme enjoys a high level of support from management and this is also reflected in terms of hard cash. The focal point of the response, the AIDS Control Unit has a dedicated budget of 500,000 Ksh (\$7,200) annually.

### *Prevention services*

Similar to most Kenyan universities, Maseno's AIDS Control Unit (ACU) was established in 2000 and is staffed by five full-time employees and is managed by the university's School of Public Health. The ACU is distinct from, though linked to, the University Health Centre. The ACU's remit specifically deals with HIV and AIDS-related matters, including VCT, rape counselling, PEP counselling, STI prevention and management, PMTCT, peer education, support groups, community outreach, training, HIV and AIDS policy issues and general prevention programming. The ACU provides services to students, staff and the surrounding community.

VCT testing, initially supported by the US Centres for Disease Control, is now funded by the university but is supported by the Ministry of Health. Access to VCT services is available at a local mission hospital but overall the Maseno ACU has a higher number of clients. Among students, there is parity in the numbers of male and female service users. In contrast, amongst staff, more men are inclined to make use of the service if indeed they use it. Service managers at Maseno concede that VCT and ARV uptake by staff is far from satisfactory. Stigma, denial and cultural practices based on concepts of witchcraft make public involvement with HIV a taboo for many. In the social codes of the community, HIV infection denotes 'an unacceptable behaviour' not befitting of a university lecturer or manager. These factors have severely constrained the development of a workplace response.

Maseno's testing and treatment services are significantly different not only because of their scale but also their linkages to the public health system. Being an accredited site means taking on the responsibility of reporting every month to the Ministry of Health as well as regular quality assurance and supervision. In exchange, the university benefits from access to supplies (test kits), training and recognition.

Condom distribution is free at the ACU and at student hostels, with the support of an international NGO. Students have become accustomed to buying condoms at about KSh 10 for a pack of three. In relative terms, a bottle of beer in a Local bar costs between 65-75 KSh. STI treatment and management services are readily available.



However, there is a challenge in getting students to seek medical attention and to access care as soon as they are aware of the problem. Many are often inclined to wait till they need acute care.

By 2007, the health centre will be functioning as a fully fledged hospital with 23 beds. Patients in the ART treatment programme are referred to the hospital pharmacy and to the home-based care programme. The health centre is a major community resource, often handling 130-140 patients on a daily basis.

#### *People living with HIV and AIDS*

Post-test clubs have been established on the campus for both positive and negative students. The Positive Support Group, comprising approximately 20 members, has been established and usually meets on a fortnightly basis. The negative support group has a larger membership.

University management is attuned to the upswing in the numbers of students coming from households which cannot support their education. Larger numbers of students are known to be orphaned and have to rely on work study placements to make ends meet. Roughly 200 students a year are given such placements. In the opinion of management, part of the pressure on these students comes from being part of AIDS affected families and households.

#### *Access to treatment*

In 2003, the university was designated as an accredited ARV treatment centre a major achievement in view of the lack of readiness in much of the public sector at the time. Prior to this accreditation and publicly funded ARV supply, Maseno had invested its own resources in drugs and was supplying ARVs to patients most in need. Access to treatment created a visible reduction in the number of deaths which reduced to two to three a year. By late 2006, a total of 78 patients had been registered in the treatment programme and 52 were already on ART. Service managers plan for the enrolment of three to four patients per month. About 50 patients are enrolled in the PMTCT programme.

#### *Institutional policy*

Institutional policy was developed in 2006 and is expected to be finalised in 2007. A thousand copies will be distributed once it is adopted. This will be followed by implementation planning.

#### *Student involvement*

Students have four representatives on the board of the ACU which assures them a role in key decisions. The work of the ACU is backed by its own monitoring and evaluation framework and the board's influence was instrumental in the development of the institutional policy on HIV and AIDS at Maseno. Unlike campuses in major urban areas, student life at the university is heavily concentrated on the campus because of its rural setting. As a result, students are motivated and involved. Despite this level of engagement and the high quality of services on campus, students are still some way off from being confident about disclosure and

living openly with HIV in this small community. Thus far, only one student has disclosed his/her HIV status and is participating in the treatment programme a situation which management and student leaders hope will change once the institutional policy becomes a reality.

Abstinence programming and activities have taken root at Maseno in the form of the Blue Ribbon Movement which started in mid-2006 with about 50 female members. Delayed sexual debut and an emphasis on 'secondary virginity' (choosing to abstain after becoming sexually active) are prominent in the group's activities. Abstinence also has a strong appeal amongst Muslim students.

One of the behaviour change groups on the campus entitled 'Al Mifta' - linked to the 'I Choose Life' peer education programme - specifically targets Muslim men and women and the home communities from which they come. Aside from these attempts to promote abstinence, according to VCT service managers there is a significant population of students who are sexually inactive when they take their first HIV test.

Peer education at Maseno falls under the umbrella of 'I Choose Life'. It targets 180 students per year who participate in a 32 hour training programme delivered through two hour long sessions after class. Students are mobilized through the work of twenty behaviour change communication groups (BCC) on the campus, each with a membership of 15 students. Only one BCC change group is an exception the dance group with 65 members. Within the programme, Maseno is unique for its range of behaviour change groups. Other institutions within the programme have developed differing emphases. For example, Moi University is strong on post-test care and support, while Egerton University has a reputation for working on gender issues.

Faith-based groups are a major focus of social life at Maseno. Four times a week, hundreds of students throng to meetings and services organized by their denominations. The strong religious culture at the institution does place limits on what is socially acceptable in public discourse. Promoting a vibrant and open discussion on sexuality, prevention and reproductive health issues is therefore a challenge for programme managers.

Risk behaviours continue to play a part in student life. A number of male students would concede to having an 'on campus' and an 'off campus' partner. 'PAPISM' *poverty attributed partners* a phenomenon affecting both men and women. Male students acknowledge that the 'Gold Rush' tradition still holds sway at the beginning of the academic year and women are concerned about levels of sexual violence. The responses from a very articulate and engaging focus group with peer educators on campus also illustrated the limitations of orientation programmes. Most were indifferent to the AIDS education they received which they characterized along the following lines: 'all the men have AIDS, stay away from them'.



### **A focus group of BCC group members at Maseno University**



#### *Curriculum integration*

Some significant attempts have been made at formal integration of HIV and AIDS into the curriculum. These courses range from compulsory infused content in education and economics and specialized modules on gender and HIV and AIDS in the department of planning. HIV and AIDS do not yet feature strongly in the science curricula.

From the perspective of students, many spoke of becoming AIDS competent through what they have acquired outside the classroom through peer education and behaviour change groups. Those involved in part-time vacation jobs were quick to point out that they are already seeing the benefits of being competent in handling HIV and AIDS professionally.

The HIV and AIDS Programme at Maseno has initiated some of its own research, primarily in the form of a baseline study in 2004 and a planned mid term study. All other research proposals are managed through the MUACC.

The location of the Aids Control Unit within an academic department (public health) at Maseno is an unusual arrangement that has created interesting possibilities for integration within the routine teaching and learning activities of the university.

*Community engagement*

Externally directed community engagement is best expressed at Maseno through its home-based care programme. By late 2006, 60 households, within a 20 km radius, were being supported and 35 trained voluntary home-based carers were active. Just under half of these carers are students and all of them are prepared for service on a two week training programme.

*Best Practice*

Maseno University is a small, rural institution with approximately 4,000 students. As such, it is unlike many of the larger, older comprehensive teaching and research institutions that are profiled in this report. Maseno's Aids Control Unit is integrated into the university's Department of Public Health and works closely with a 23 bed University Health Centre in the delivery of a range of public health services to students, staff, dependants and the surrounding community. On a busy day the out-patients facility at the Health Centre receives approximately 100-120 people. On any given day, malaria features strongly as the cause for seeking medical attention.

**MINISTRY OF HEALTH**  
**INTEGRATED MONITORING AND EVALUATION REPORT FORM MOH 726**

NASCOP

Facility MASENO UNIVERSITY District KISUMU Month AUGUST Year 2006

Indicate N/S where there is no service and N/D where there is service but no data

T. VCT code 61216 PMCT: PMCT Code Number

Sex	Measure			
	No of clients	No tested	No. +ve	%+ve
Males	32	32	4	12.5
Females	20	20	2	10.0
Totals	52	52	6	11.5

V. ARV Code Number

Measure	Children <12yrs		Adults >12yrs		Totals		Grand Totals
	M	F	M	F	M	F	
No. of HIV +ve patients receiving (clinical care)	New all		0	1	5	4	5
	Re-all		0	12	2	13	25
No. of patients on zidovudine	Zidovudine		0	1	3	4	5
	Fluconazole		0	0	0	0	0
No. of new attendees Previously on ARV	Total		0	1	3	4	5
No. of patients who commenced ARV's within the month	Pilot patients						
	Pilot spouses						
	Th patients						
	Health workers						

PMCT Measures:

Measure	Value
A No of new ANC clients	
B No. of Revisits	
C No. ANC counselled and tested	
D ANC HIV +ve	
E Mother NVP ANC	
F Infant NVP ANC	
G Maternity mothers counselled and tested	
H Maternity HIV +ve	
I Maternity NVP	
J Maternity Infant NVP	
K No of deliveries	
L Choice of infant feeding	Breastfeed Alternative feeding

STD's: STD Code Number

Syndrome	Type of visit
A Urethral discharge:	Initial visit
	Re-all
	Sub-total
	Referrals

**Monthly report to the Ministry of Health on VCT and ART Services**

The Centres for Disease Control helped with the initial establishment of the VCT service but it has since been funded internally. An estimated 12-14 students used the VCT service per day in 2006. General counselling is also available through the Dean of Students office. As an accredited HIV testing and treatment site since 2003, the university is integrated into the national HIV and AIDS programme. In a catchment area of 80000 people, it received 1,653 clients in 2005 and a further 1,280 clients by

October 2006. In a small university context, these are exceptionally high numbers of service users. Integration with the national programme allows for external quality assurance, sharing of data, access to resources and recognition. This example illustrates what is possible within a small institution with modest resources, strong leadership and innovation.

### *Analysis*

Maseno University's VCT service has demonstrated its success on a number of levels. Firstly, it is a service available to the university community and surrounding villages – a critical element of engagement with communities (*relevance*). Secondly, given the size of the university and its resources, this programme is a benchmark of *efficiency* in terms of the numbers using the service. Few other institutions have recorded similar utilisation levels in their VCT service. Thirdly, the University's strategy of integration with the public health sector ensures the *sustainability* of its programme by leveraging additional resources. Finally, the University has clearly been *effective* in generating demand for HIV testing. However, the larger question remains unanswered – has the uptake of testing reduced new infections or improved the uptake of treatment, care and support?

Contact: For more information on the HIV and AIDS Programme at Maseno University, contact Ms Doreen Othero, [doreenamo@yahoo.com](mailto:doreenamo@yahoo.com)

## **3.6 University of Dar es Salaam, Tanzania**

### *Management of the response to HIV and AIDS*

Around May 2000, the Government of Tanzania issued a directive that all public universities were expected to establish a committee structure to direct their response to HIV and AIDS. Ministries too were expected to establish in-house structures for the same purpose. By August 2000, the UDSM Committee was in place and was trying to define its role in the national response. The Ministry of Higher Education, Science and Technology played an important role in co-ordinating the education sector response but few new resources came with the added responsibility.

Like much of East and Southern Africa, there was a good deal of externally focused activity on HIV and AIDS before 2000 at UDSM, but no structured internal programming within the university. As Tanzania's oldest, largest and most experienced institution, UDSM was expected to take the lead in the higher education response.

In hindsight, the programme managers reflected on the inception of the programme as both a challenging and very positive experience. The first action plan was developed in October 2000 and academic staff and other employees participated

keenly. To begin with, the bulk of the programme's effort predictably went into education, advocacy and mobilization. A strong partnership with the Norwegian agency NORAD, from 2003 onwards, contributed to infrastructure development. The university's level of commitment has grown over time and its support is reflected in the dedicated \$10,000 annual budget for the programme (2006).

Other partners include the University of Toronto, the Ministry of Health, the Tanzania Aids Commission, SIDA/SAREC and the National Aids Control Programme.

### *Prevention services*



**UDSM Health Centre receiving a supply of drugs from the Ministry of Health**

The focal point of the response to HIV and AIDS is the University Health Centre, a large facility which handles up to 200 patients a day including students, staff, dependants and members of the public. With a staff of a 100 employees and under the supervision of the Ministry of Health, the Centre offers a wide range of services including out patients, in patient wards, PMTCT, TB clinic, reproductive health service, maternal and child health, eye clinic, chronic disease management, STI treatment and management, PEP, VCT, ART, skin clinic, infectious disease control and treatment and management of OIs.

From 2003, the Health Centre was able to offer counselling for testing but not testing itself. Testing had to be done at Muhimbili Hospital, a large national hospital which also acts as UDSM's teaching hospital for the health sciences. By April 2005, the

Health Centre was ready to offer free rapid testing as a government accredited site on campus. Other diagnostic tests including CD4 tests are done off campus with the university covering the bulk of the costs.

Despite the determination to make VCT available, the uptake of testing was low in the early stages. This picture has now reversed with students self-referring. Between 15-20 clients are tested per month and numbers are increasing slowly. Around 5% of test results were positive in late 2006. The VCT service was formalized by mid 2005 and its activities were consciously marketed through education materials and outreach activities. The programme managers are conscious of the need to determine levels of co-infection with TB amongst HIV patients. Overall, while only 14 cases of HIV infection were reported by the Health Centre between 2000-2004, in the same period the facility handled 207 cases of TB<sup>23</sup>.

As a new service, university management is keen to establish the acceptability of the service and to isolate areas needing improvement.

#### *HIV and AIDS in the workplace*

UDSM is a community of approximately 2,000 staff (800 academic and 1,200 support staff) and 17,000 students. Depending on their income levels, an estimated 85% of employees make use of the Health Centre. Every employee, their spouse and up to four dependants under 18 years old are entitled to medical benefits.

Management and trade union representatives are confident about having created a workforce that is more informed about HIV and AIDS since 2000 when the university's response was initiated. It's also clear that the primary needs of staff are in the areas of: education/prevention, good quality services e.g. VCT and psycho-social support. Supervisors themselves are also more AIDS component now and the recruitment process tests this issue. Stigma remains a problem but is decreasing.

A new programme planned for 2007-2011 will involve dissemination and implementation of the institutional policy as well as capacity building in home-based care, curriculum integration and support for student groups.

#### *Research*

The Medical College (MUCHS) is a major research and research capacity building centre in the health sciences with a long-standing national and international reputation. It has a wide range of international partners and its research clusters are active in the basic sciences, virology, pathogenesis, pathology and social sciences. The university's involvement in HIV and AIDS research dates from mid 1980s, far earlier than the national response which only came into effect in 1999. The university's scientific and research community played a key leadership role in getting HIV and AIDS onto the national health agenda and has subsequently played a key role in the planning of a multi-sectoral response.

<sup>23</sup> Mbilima, M, *HIV and AIDS Status at the University of Dar es Salaam (UDSM)*, paper presented at the 13<sup>th</sup> Annual Consultative Meeting, 17-18<sup>th</sup> August 2006, Dar es Salaam.

In terms of capacity building, nine of its PhD students in 2006 were working on HIV and AIDS related topics through its partnership with SIDA/SAREC. Though historically predominated by males, the trend towards gender equity has improved with 50% of post-graduates being female.

All health sciences courses have included HIV related content and skills since 2002 and there is a commitment to constant updating in order to keep abreast of new developments in clinical care and treatment particularly the latter.

Most users of its training offerings are public and private health care professionals. Its newest innovation is in the area of professional development where a new directorate is being established. It is a new area of work with considerable promise and MUCHS wants to establish itself as the lead provider in the national market. A high proportion of research is typically externally initiated and funded.

The research community is increasingly concerned about the absence of a strategy to monitor seroprevalence levels in the UDSM community despite the availability of the expertise. It recognizes that its external focus is only partially useful in terms of an institutional response.

#### *Treatment access*

By late 2006, 54 patients at the Health Centre were enrolled in the ARV programme (50% students/ 50% staff). A further four patients (staff) were in HIV care. A small number of those on the ARV programme are co-infected with TB. Patients in care are checked every three months and complete a CD4 count test.

Stigma is a major obstacle to those in the HIV care programme. Though adherence is good amongst ARV patients it remains difficult to get patients to bring in their partners for counselling and support. Treatment supporters, often recognized as a key to successful adherence, are not a strong feature of the programme. They are typically present for the first few months, and then disappear. The profile of patients seeking access to ARVs shows they are already seriously ill (CD counts <200) a sign that few are accessing the care programme early enough to delay the use of ARVs.

UDSM is able to provide high quality ARV services because of a dedicated and trained pharmacist and counsellors. The PMTCT programme remains underutilized with most patients referred to the national hospital.

## *People Living with HIV and AIDS*



Sister Mary Lilungulu, a grandmother of five children, has worked at the UDSM Health Centre as a nurse since 1988. She has been an ART patient since March 2005, starting first at a district level hospital and then moving to the Health Centre to avoid the long queues and delays in dispensing at the hospitals. She remains concerned about friends and colleagues who need both testing and ARV treatment. Instead, the power of stigma keeps them from seeking access to care.

Working in collaboration with an NGO (Pathfinder) over five years, the office of the Dean of Students was instrumental in training nearly 300 peer educators in a programme that completed in 2004. Some of the peer educators remain actively involved in on-going work at the university though many have left in the course of completing their studies. The programme did nevertheless create the basis for other interventions such as gender focused programmes which followed on.

Changes in the profile of students coming to UDSM and finding ways to support them are ongoing concerns for management. Students are younger than in previous years and often unable to handle decision making. In-house capacity to provide to a population of 17,000 students is also severely limited.

### *Student involvement*

Early student activism on HIV and AIDS at UDSM was pioneered by students in the Department of Performing Arts. Using the principles of 'theatre for development' they engaged students and staff in discussions about risk and sexuality. At around the same time as the university's response began to take shape, female student groups were especially concerned about sexual exploitation and harassment. This engagement was against a backdrop of a very conservative social climate at the university in which even the discussion of condoms was difficult. Many faculty members were of the opinion that HIV and AIDS was an external problem rather than an issue that needed attention within the university community.

The activism coalesced around an Anti AIDS Club which started in 2002 and continues functioning today. Its current focus is on VCT and helping students manage the transition from high school to university life. Student leaders are keenly aware of the challenges students face both because of their newfound freedom but also their increased vulnerability. The latest evidence of these trends is the phenomenon of the 'Serengeti Boys' named after Tanzania's junior football team, young men who are considered the most attractive to older sexual partners.

After a number of incidents came to light which involved sexual harassment of female students and female employees by faculty members, the university took the decision to develop a Sexual Harassment Policy in 2006. For activists this represents an important step though one which took considerable time and effort to achieve. In the context of HIV and AIDS, they see it as one other instrument to further strengthen the response. The gay and lesbian community at the university is small and heavily constrained by repressive legislation and strongly homophobic public opinion. The university has not taken a position as yet on the rights of sexual minorities and gender activists opted instead to concentrate on issues such as sexual harassment as their primary human rights concern.

Student life on campus is also heavily constrained by inadequate accommodation. Fifty percent of the student population lives on campus in residences designed for half the number of the current occupants. Risk continues to be a part of life in response to harsh economic realities. Women with multiple partners often for economic reasons are unwilling to engage in education and programmes that expose their vulnerability. Here too, abstinence is most strongly promoted by faith based student groups but is widely acknowledged as a stance in response to social pressure rather than choice.

Student leaders at the university's Medical College (MUCHS) have focused their response to HIV and AIDS within a student club 'Save Life'. As a health sciences school, the college operates in a much smaller and specialized context. Professional competence in HIV and AIDS is well established as part of their curriculum though, at social and personal level, student leadership is still concerned about stigma, gender equality and disclosure.

### *Best Practice*

The strength of the HIV and AIDS Programme at UDSM rests in two areas: capacity building and the standard of clinical care available.

Tanzania's universities mirrored some of the parallel developments in Kenya. Starting from a base mostly in biomedical research, in 2000 the institutions responded quickly to government's call for public universities to put in place an institutional and programmatic response to HIV and AIDS. As the country's premier institution, the University of Dar es Salaam was expected to take the lead and to provide capacity for other institutions in the country. The University's Health Service



is a large, well staffed facility funded in part by a dedicated budget of \$10,000 a year of internal funds that now offers high quality prevention, testing and treatment services to students and staff. Since 2005, approximately 50 ARV users have registered at the Centre. As the focal point of the university's response, the Health Centre is constantly engaged in training staff and students, mobilizing new resources and interacting with the university's partners, especially government.

The HIV and AIDS Programme acts as the focal point for capacity building. In terms of the workplace response, its first priority was sensitisation of the management echelon in 2002 and then expanded to faculty level. Some small successes have been registered on this front. The manager of human resources is a trained counsellor and every new employee is briefed on HIV. Overall, one person per faculty was chosen for training in counselling. This totalled 28 people across the institution excluding health care personnel who received clinical training. At the Health Centre itself, 70 people were trained in-house, starting in 2004. A clinical meeting every Thursday deals with all aspects of the centre's work, including HIV and AIDS. The VCT counsellors at the centre benefit from supervision and support through the Ministry of Health and the National AIDS Control Programme.

### *Analysis*

UDSM's response demonstrates the strengths which large, comprehensive teaching and research universities can mobilise in a response to HIV and AIDS particularly those with well established health science faculties. Its Health Centre provides high levels of care by qualified and adequate staff who have been instrumental in developing the skills needed to manage HIV and AIDS in an institutional context. Despite these advantages, UDSM also demonstrates the challenges and constraints to scaling-up services. Good quality services (*effectiveness*) do not automatically generate higher levels of utilisation (*efficiency*). The Health Centre is fortunate in having a financial commitment from the University which ensures its *sustainability*, but in the long run that will depend on having to justify the need for expensive, labour intensive services such as VCT and clinical care for AIDS. Lastly, it is telling that the value of the clinical services available is undermined in this case (as in many others) by the power of stigma.

Contact: For more information on the HIV and AIDS Programme at the University of Dar es Salaam contact Dr Musiba Mbilima, [musiba@udsm.ac.tz](mailto:musiba@udsm.ac.tz)

### 3.7 Université de Cocody, Côte d'Ivoire



**The student-led NGO MESSI Le Mouvement Estudiantin Pour la Sensibilisation Sur le SIDA**

#### *Management of the response*

l'Université de Cocody is located in Abidjan and is the country's largest higher education institution. No management and co-ordination structure is in place as yet, but a key advocate Dr Assane Thiam in the Faculty of Dentistry leads the institutional response. The education sector in Côte d'Ivoire is governed by an overarching policy on HIV and AIDS and institutions are expected to follow up in developing their own. In the West African context, the response to the epidemic is important because of its status as a relatively high prevalence country.

The university operates under severe constraints at a number of levels. Firstly, its facilities were built for a population of 7,000 and now accommodates 55,000, a situation which has created enormous pressure on the existing infrastructure. Secondly, a situation of on-going conflict and a fragile security in large parts of the country has resulted in major population movements. Thirdly, student fees are negligible and are therefore a powerful constraint on service provision and infrastructure investment. Despite these limitations, there is a high level of interest and commitment at senior management level in developing a more comprehensive response to the epidemic.

### *Prevention services*

Testing for HIV is widely available across the country but a major preoccupation for health professionals is the follow up to testing and the acceptance of treatment. HIV testing is free as is treatment access for children. There are 85 VCT centres across the country as well as 103 PMTCT centres and 93 ARV sites.

Testing is still a cause for anxiety amongst students so it is still difficult to track the numbers who have tested. HIV is still a taboo subject and students prefer to be anonymous though generally cultural attitudes to sex and sexuality are more liberal in Côte d'Ivoire than other West African countries.

Women are often more interested in knowing their health status. The churches also strongly encourage young couples to test before marriage. Health professionals agree that although awareness and knowledge levels may be high, behaviour change is not likely or sustainable without testing. Government has committed to increasing the uptake of testing.

Testing is readily available at the main university campus and the Institute Pasteur which is a high level clinical research centre with 10 medical officers and a social worker available. Current capacity for VCT is limited to 12 clients per day at the Institute but there are plans for expansion.

The medical service is essentially a primary health facility and is in operation every weekday morning and, if needed, additional doctor consultations are paid for by institution.

Typically students think they are safe to stop using condoms within a few months which student leaders describe as a '*dieu est ma capote*' ('God is my condom/prevention') mentality. Student leaders themselves acknowledge failures in their awareness campaigns. Despite high levels of HIV and AIDS education across the country, knowledge and skills among new entering students is weak. Student leaders agree that more recently abstinence programming receives more attention than before, largely as a result of PEPFAR support, but there is still ambivalence about the extent to which it is succeeding with sexually active youth.

### *Access to treatment*

Treatment access within the city of Abidjan is good and costs have dropped significantly. However, public sector health authorities remain concerned about why the uptake of treatment has been low.

### *Curriculum integration*

Most research is in the health sciences and there are strong linkages, mostly with other French universities, with a limited amount in the social sciences. Curriculum

integration is in the pipeline but will initially be concerned only with the health sciences. This is in line with an initiative started in Dakar in 2006 towards harmonization of medical education. Senior management is committed to faster progress in this area but no broader strategy has yet been considered with respect to curriculum integration in other disciplines.

### *Best Practice*

Student involvement at the Université de Cocody sets an important example to institutions in other Francophone countries where the response to HIV and AIDS is still in its earliest stages. MESSI, the student-led HIV and AIDS NGO illustrates both the strengths and the constraints of interventions that need high levels of student input.



The student led NGO - "MESSI"

MESSI was established at the Université de Cocody in 2002. It was founded as a result of concerns about STIs and the levels of HIV prevalence. Its initial impetus was to start with prevention activities using sensitisation, messaging, targeted interventions through sports events, person to person outreach, mass mobilisation, media, condom distribution etc.

Targeted activities have focused on new students arriving during the orientation period, particularly women. There is concern amongst students about the vulnerability of women because of overcrowding, the cost of housing and the likelihood of being drawn into transactional sex or sex work to fund their education.

The organization acknowledges that its leadership is disproportionately male but at the same time, their level of commitment is what counts. All members of the leadership have taken an HIV test. MESSI's strategy is strongly focused on condom use, partner reduction and the use of VCT. Its priorities over the next three years include VCT, establishing a student-led centre medical, student centres on all campuses and using their offices as referral points.

Stigma, discrimination and disclosure are still a serious concern at the university and to date, only one person living with HIV has been involved in the efforts of the student organization.

MESSI places a high emphasis on outreach to youth and is committed to youth empowerment. UNFPA supported an initial peer education training programme in 2004 in which 13 peer educators were trained but no subsequent follow up has taken place.



### *Analysis*

The level of development in the response to HIV and AIDS at Université de Cocody is not unlike the overall trend amongst Francophone institutions. Pockets of high level clinical research and care such as the Institute Pasteur still lead the way, in a response which is still uneven and relatively low level. In such a context, student involvement of the kind led by MESSI provides a powerful alternative locus through which to mobilise students, develop new skills and leadership. What student led initiatives bring to an institutional response - above all - is *relevance*. MESSI was able to articulate a well considered position on most issues that are central to successful education, social mobilisation and prevention campaigns. As both the initiators and the target audience they are immediately aware of the *effectiveness* and weaknesses of the response to the epidemic. Despite the challenges facing the institution and the country more generally, MESSI has sustained its commitment, energy and focus on the epidemic in a way that deserves recognition.

Contact: For more information on the HIV and AIDS Programme at the Université de Cocody contact Prof Assane Thiam, [ascothiam@yahoo.fr](mailto:ascothiam@yahoo.fr)

### **3.8 Copperbelt University, Zambia**

#### *Management of the response to HIV and AIDS*

The Copperbelt University (CBU), based in Kitwe, Zambia, is a technical university developed around four faculties: natural resources, built environment, technology and business sciences. It accommodates approximately 3,300 full time students (recruited from across Zambia) and about 700 staff, a few of whom live on the university campus. Kitwe is an important city in the Zambian context because of its copper mining industry, transport links and migration patterns focused on the city. As a health district, it has a catchment area of around 450,000 people and has an estimated 21% prevalence rate. The misfortunes of the mining industry since the 1970s has created high unemployment levels, increased casual and transactional sex and a social culture built around the behaviour of migrant men.

The university's response to HIV and AIDS developed rapidly after its work was showcased at a meeting of Commonwealth universities in Zambia in 2002/3. In the interim the following developments have taken place:

- An institutional policy on HIV and AIDS was developed and approved.
- An HIV and AIDS co-ordinator is in place.
- The university has allocated a budget for HIV and AIDS activities.
- An HIV and AIDS Management Committee was established.
- A strategic plan on HIV and AIDS, up to 2008, was developed and an implementation committee has been formed.

The University Health Centre is a major locus of HIV and AIDS related activity on the campus but the university's management is keen to move its programme activities beyond a medical basis. The development of an institutional policy has been particularly influential and has helped to mobilize university management and create an enabling environment for various other changes. Departmental focal-point officers have also been designated and they are encouraged to bid for whatever funding is available.

Overall, most stakeholders have reported significant improvements in the co-ordination of the response to HIV and AIDS and express greater confidence in the likelihood that CBU graduates are AIDS competent.

## *Prevention Services*



**Nursing staff at Copperbelt University Health Centre**

The bulk of prevention services are handled by the Health Centre, a facility staffed by two clinical officers and 10 nurses all of whom have been trained in counselling and testing. The centre is open to employees, dependants and students. Funding for its operations comes through a contributory scheme paid by annual subscriptions from students (Zambian Kwacha 30,000).

On a normal day the facility handles between 40-50 patients, many of whom are likely to present with malaria or more general medical problems. Malaria is the cause for seeking medical assistance for an estimated 200 patients a month.

The range of services on offer at the centre includes:

- VCT
- ART
- PMTCT
- TB treatment
- STI treatment and management
- Condom distribution
- Contraception/family planning services

The centre has a strong public health focus through the clinics which it operates. These include an under five clinic for children, a TB programme, an ARV programme and the malaria programme. Though not formally linked to the public health system, it has a strong working relationship with the District Health authorities.

A VCT service has been in operation since 2000/2001. Though well established, it has been a challenge to sustain the utilization of the service. Stigma has been a persistent concern in the university community. One student leader described typical attitudes to VCT as 'it's like a crime, do it where nobody sees you'. To counter this resistance, marketing of VCT is being promoted by the Students Anti Aids Society and at the Health Centre as part of STI management.

Response to VCT marketing drives has been positive so far, mostly by men wanting to know their status before graduating. Using an external provider for VCT services proved even more effective. New Start Centre, a local NGO was able to increase uptake significantly. In the June 2006 campaign, 292 people tested within a month of whom eight were positive (3% infection rate). More campaigns of the same kind are planned to sustain the momentum for testing.

#### *Treatment access*

Despite starting from a low base in 2001, Kitwe now has VCT available in almost all its clinics. ART provision started in May 2005 with two sites based at clinics, aside from three large hospitals which were already established providers. Initially the university paid for its own ARV supply. However, since becoming an accredited site, it is able to offer free access to ART.

Approximately 20 people were using the ARV service at the university by the end of 2006, of which 12 are employees. Roughly the same number of people is at the pre-ART stage.

In the public sector, the limitations on treatment are much the same as elsewhere. Although clinical officers are trained to prescribe, the need for doctor supervision and equipment for base-line investigations limits more rapid roll out at this point. By late 2006, the public sector had approximately 750 patients on ART. The efforts of the public sector have also been hampered by stigma, which, encouragingly, is on the decrease as ART becomes more widespread and better understood.

#### *Student Services*

Student involvement in the response to HIV and AIDS at the university has an interesting slant since 80% of the student population is male whilst 20% are female. Most degree programmes run over four to five years.



The Copperbelt University Anti AIDS Society (formed in 1989 by a student leader) runs a drop-in centre on campus for information and condom distribution and as a contact point for students seeking support. Despite the imbalance between men and women on campus, women are well represented in the organization. The society organizes its activities around the academic calendar starting with a programme for 'freshers' around March of each year and including the training of peer educators. A small peer education group has already been active on the campus for a few years and is run by a local NGO.

Religion plays a big part of student life and there is some debate about the distribution of condoms on campus. Religious affiliation does have a bearing on attitudes towards discussions on sex, sexuality and risk. Premarital sex is generally frowned upon by most religious groups who prefer abstinence as an alternative. To avoid exclusion and social pressure, students are likely to adhere to the formal requirements of religious affiliation (abstinence) but differ significantly in their personal behaviour. As a minority on campus, women are especially concerned about 'reputational risk' if they are sexually active. Student leaders concede that this type of behaviour is counter-productive in that it can encourage a climate of denial and concealment.



**Student members of the Anti AIDS Society, Copperbelt University**

Residential mayors, usually older students, elected at halls of residence and who have been given some peer education training have been brought into the response to HIV and AIDS. A peer education focused NGO does monthly follow-up meetings to provide support.

Overall, student responses to most of the social mobilization activities have been good. The Anti AIDS Society regularly targets secondary schools in the province for its outreach activities to promote the idea of school-based Anti AIDS clubs.

### *HIV and AIDS in the Workplace*

The Copperbelt University Medical Trust represents the interests of university employees and their dependants. Formed in 1993 on a voluntary basis, the Trust acts as an in-house medical insurance scheme which does not discriminate according to the type of illnesses it covers.

The Trust became increasingly aware of the pressures which AIDS-related illnesses have placed on the scheme. Its success in providing assistance to chronically ill members, particularly those needing home-based care has to lead to co-operation with the University of Zambia which is considering replicating the model.

The Trust is, to some extent, linked to another autonomous employee support group at the university in the form of the Health Support Group. The CBUHSG as it is known also involves members of the Trust and was first established in 1995 and functioned as a welfare and support to employees and their families ('Ndosha'). The need for the group arose from the loss of employees and has spurred an interest in peer education as well as HIV-related education and advocacy. By 1997, the HSG formalized itself and refocused on a strategy to reduce the levels of illness and mortality at the university. Between 1992-1996, the institution has lost 50 employees<sup>24</sup>. Over the next six years (1998-2003) the institution lost an additional 81 employees.

In its early stages the HSG faced significant levels of denial, unwillingness to openly discuss HIV and AIDS, fear of disclosure and stigmatisation of the group itself as people with HIV.

It has since grown to 92 members all of whom are trained as peer educators and also includes 30 trained psycho-social counsellors. The university has a complement of 600 employees in total and the HSG draws its members from all levels. A grant from the institution supports its work and management sanctions the use of time off from their work schedules to run the HSG activities like the nutrition clinic. This level of support is indicative of generally strong support from management and the university's governing council.

The HSG does not limit itself to HIV and AIDS related work and is active on the community outreach front as well. Its nutrition clinic targets 'under fives' who attend the Health Centre. After a decade of activity, the HSG is more confident about having

<sup>24</sup> Report on the activities of the Copperbelt University Health Support Group to the Association of African Universities, 15<sup>th</sup> November 2006.

reduced stigma but, at the same time, there is still anxiety among employees about using campus-based testing and counselling services. Its strategy for overcoming the resistance is to move towards an 'employee wellness programme' of some sort.

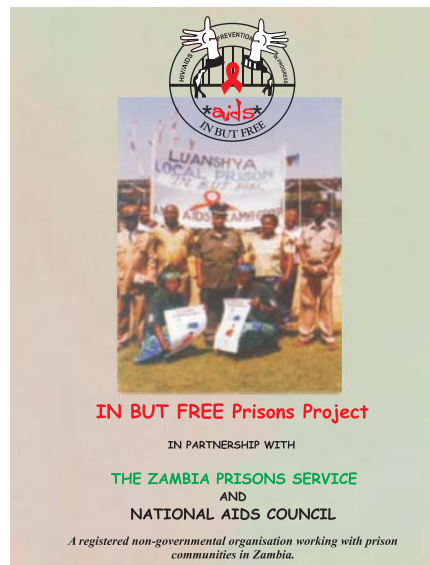
Its range of services now includes VCT, peer education, condom distribution, awareness and sensitisation workshops, home-based care and support, the nutrition clinic, PMTCT and psycho-social counselling. It also networks widely with other local and national organizations in related fields.

### *Curriculum integration*

The major development in curriculum integration at CBU has been in the form of an outline of a core course for all students that was still subject to finalisation in late 2006. It will comprise the following content and skills: nature, origin and extent of HIV and AIDS; transmission and prevention; factors contributing to the spread of STIs and HIV and AIDS, abuse, human sexuality and gender, social, economic and psychological effects of STIs and HIV and AIDS; management and care; counselling; access to treatment; HIV and AIDS in the workplace and recent trends in research<sup>25</sup>.

In terms of instructional time, a weekly allocation of two hours is planned for. Over 1,000 students will be targeted in each year with the course planned for implementation in 2007.

The university's HIV and AIDS co-ordinator is concerned that more needs to be done at the level of curriculum integration and research. One limitation is the mix of faculties at the institution which does not lend itself easily to research in the health sciences or the social sciences.



<sup>25</sup> Draft Health Education Syllabus for Copperbelt University Students, 2006.

### *Best Practice*

'*In But Free*' is an exemplary case of community outreach by a university which has led to widespread innovation and benefit to a largely ignored but vulnerable group in society – prison inmates. Beginning in 1995, the project was initially located at Kamfisa Prison in Kitwe, one of the largest such institutions with a current population of just over 1,000 inmates of whom only 60 were female.

Sexual and social practices amongst inmates, particularly unprotected sex between men, scarification/tattooing and intravenous drug use created an environment of high risk when combined with low knowledge levels about HIV transmission.

The core of the intervention was focused on making inmates responsible for their health through the peer education of prisoners and prison managers. By late 2006, 40 prison inmates were trained and active peer educators in addition to 22 prison warders at the Kamfisa prison. The routine of prison life now involves an HIV and AIDS education session at 7 p.m. every day. Prison authorities have noted a reduction in the practice of tattooing, a decline in sex between prisoners, a reduction in levels of TB and STIs and general improvements in hygiene. Behaviour change is being promoted through counselling. For example, previous practice involved punishing prisoners involved in sex with other men, now the peer educators rely on counselling.

Testing is available to prisoners and, to date, only one prisoner has been enrolled on ART in a treatment access programme which was initiated in 2006. A number of other prisoners living with HIV are still asymptomatic. Data on HIV prevalence levels in the prison are hard to track because of constant changes in the population.

The project facilitated the development of a policy on HIV and AIDS for the Prisons Service and has trained approximately 1,000 peer educators in the prison population over its life span. At the same time, 200 prison officers have been trained as peer educators, 27 were trained as psycho-social counsellors and a further 31 were trained as home-based care givers.

Over a decade, '*In But Free*' has partnered with the Zambia National AIDS Council and expanded to cover almost all prisons in Zambia and is the lead NGO partner of the Prisons Service which is responsible for 14,000 prison inmates and comprises 1,800 prison officers. Employees of the Zambia Prison's Service have their own internal HIV and AIDS Programme.

### *Analysis*

As an initiative more than a decade old, based at a small institution without major resources, this model of *community engagement* illustrates best practice criteria powerfully and convincingly. Prison inmates are an atypical target group in comparison to other high risk groups which have received high profile and sustained

attention in the recent past (e.g. sex workers, transport workers, injecting drug users). Prison environments were not typically designed to be places which foster a culture of 'self care'. Too often they are wracked by violence, drug use and other risky behaviours. This model has tested that assumption and proved otherwise. In another way, this model has tested the ethical dimensions of university based responses to the epidemic by focusing on a group whose rights are severely curtailed. As the partner of choice for both the prisons service and the AIDS Council this initiative has clearly influenced public policy and practice in the best possible ways.

Contact: For more information on the HIV and AIDS Programme at the Copperbelt University contact Dr Oscar Simooya, [cbumed@zamnet.zm](mailto:cbumed@zamnet.zm)

### 3.9 National University of Rwanda, Rwanda



#### *Management of the response*

The National University of Rwanda is a national resource and the country's oldest and best known trainer of high skill professionals. Most of the student population of 8,000 students arrive at university at the age of 21, after completing a year of solidarity camps and a year-long language course. Just under half of the population lives in university accommodation. The university comprises roughly 9,000 people including staff.

The focal point of the response at NUR is the *Ligue Universitaire Contre le Sida* (LUCS). Created in 1999, after an intensive consultation process called by the Rector, the LUCS provides a base for the institutional HIV and AIDS programme and

is staffed by a full time co-ordinator and the two other officers. Capacity building is a priority in the remit of the unit.

Creating the LUCS signalled the *institutionalisation* of a response to HIV and AIDS in a context where there was no previous history of organized institution-wide activity except for the Programme National de la Lutte Contre le SIDA (PNLS). It was also a high level commitment by the university to a national problem, a role which NUR felt compelled to take as the country's leading higher education institution.

Since 1999, the university has committed a dedicated budget to the LUCS which has been supplemented by income from donor partners as the LUCS has developed and elaborated its activities. Beginning with base funding of \$10,000 a year from internal resources starting in 2000 (mostly in the form of staff salaries), LUCS had an operating budget in 2006 of \$113,000. Its current activities form part of a well developed Strategic Plan for the period 2005-2009.

#### *Institutional policy*

By late 2006, the institutional policy on HIV and AIDS was in its final stages of development and was scheduled for implementation in 2007.

#### *Prevention services*

About 45 people per day use the Health Centre. Operating twenty four hours a day, the centre provides a range of primary health care services with referrals to the university hospital. Malaria is predictably the major cause for seeking medical assistance. The, approximately, 1,000 staff at NUR are expected to make use of the teaching hospital which, though relatively well resourced, has capacity constraints.

The VCT service managed by the LUCS started in 2001, and initially showed slow uptake, followed by major increases due to the impact of campaigns. By September 2006, an estimated 433 clients had used the testing service. Early estimations of

Seroprevalence in the university community (of people who chose to test on campus) were between 2.2-2.8% positive.

Condom distribution features prominently in the prevention strategy with a target of just under 80,000 planned for each trimester.

The baseline research for these estimates was conducted in 2001 and a follow up was planned for later in 2006 to assess changes and trends. As is the case with other campus based facilities, student feedback suggests anxiety about stigma and disclosure -- which necessarily limits uptake of the service. The LUCS is committed to a feedback process aimed at evaluating the quality of its services and ways in which to target service delivery more effectively.

### *People Living with HIV*

The 'Arc en Ciel' (Rainbow) organization is a group of staff members living with HIV. Established around 2003, the organization has about 25 members. Importantly, both the LUCS and the leaders of 'Arc en Ciel' have noted the levels of stigma that surround the organization are a major constraint.

#### *Curriculum integration*

Early attempts at integrating HIV and AIDS into the curriculum were non-formal and took place in the orientation programme for students starting in 2000. In terms of formal curriculum integration initiatives, the National University of Rwanda was one of the early participants in the UNDP supported programme of HIV and AIDS curriculum mainstreaming. Subsequent to the training, four of the trainees, based in public health, social sciences, education, economics and media studies, developed a core curriculum for all incoming students to the university.

Entitled '*HIV and AIDS and Society*', and initiated in 2004, the course carries four credits and entails a total of 60 hours of theory and practical work which is assessed by examination. In terms of content, it covers the historical, epidemiological and biological aspects of the epidemic, impacts on children, youth and gender, HIV and AIDS and development, human rights issues and lastly, behaviour change and community mobilization. In 2006, all entering 2,000 students completed the course.

The responses from students are worth noting. Feedback indicates an increased interest in knowing their health status, that students are encountering a range of HIV related issues and the wider implications for first time, and that the course succeeds in 'de-medicalising' the epidemic. For the moment, the course content is focussed more heavily on content knowledge than skills. The course managers acknowledge the need to supplement this intervention with other co-curricula activities that are skills based.

The only other initiatives in the pipeline include plans to introduce HIV-related issues into the Law Clinic in the faculty of law though no formal integration into the Curriculum has yet been planned. The faculty of health sciences is also aiming towards harmonization of its HIV-related skills and content requirements by 2007.

Whilst the lead producers of HIV and AIDS-related research at NUR remain the health sciences, management is concerned about the ongoing need to improve the quantity of research output. Though clinical research is a priority, it remains a challenge because of the costs involved and related capacity requirements. At national level, a research body attached to the Ministry of Health (TRAC) monitors and facilitates research initiatives. At institutional level SIDA/SAREC is a major partner among others.

The overall picture therefore shows a need for the university to consider seriously the curriculum integration of HIV and AIDS *at a professional level* as a priority for the future.

### *Student involvement*

Student life and culture in Rwanda could best be described as socially conservative backed by strong beliefs in reputation and anxiety about shame. Multiple sexual partners are frowned upon in a social code where 'confirmed partners' are the rule. To evade this taboo, men are likely to continue being involved with a number of partners out of public view. In contrast, there is much stronger pressure on women not to disclose that they are sexually active.

The LUCS works closely with a number of student organizations on campus as part of its outreach strategy, including the Medical Students Association, Campus Initiative Promotion, Arc en Ciel, Club Stop SIDA, University Womens' Association, and the Forum for Religious Associations.

Programming on sexual and reproductive health is also another major platform for LUCS. Other avenues include a journal published very three months on HIV and Reproductive Health. The Medical Students' Association has taken its activities beyond the university into local schools.

Because of the strong religious affiliations of most students, faith-based organizations are a powerful lobby. An estimated 90% of students belong to an FBO on campus.

Management has recognized the importance of mitigating the risk factors in student life and one of its interventions is to ensure that all women students get preferential access to university accommodation.





### *Best practice*

The ARV treatment access programme at the National University of Rwanda highlights the role of universities with a national role and the competence to deliver specialized health and other services.

Butare, the home of the university is the capital of a province with a population of 800,000 people and an HIV prevalence level of 6,7%. Notwithstanding the disease burden, poverty and nutrition are major factors influencing the epidemic in a context where 60% of the population live below the poverty line<sup>26</sup>.

Demand for ARVs is estimated at around 8,000 patients. Of these an estimated 2,000 are now within the public health sector's treatment programme. When the treatment programme was initiated in 1999, ART treatment cost \$1,400. There were other constraints in scaling up a treatment programme, primarily the challenge of capacity building for personnel, increased workloads, management of side effects, identifying treatment naive patients and those who were resistant.

The scenario facing the university's teaching hospital underlines the massive task facing the public health system and the need for action by the university in a national context:

- 30% of hospitalised patients in internal medicine were HIV+ (2002 data).
- 60% of deaths in internal medicine at the hospital were HIV+ (2002 data).
- 52% of TB patients are HIV+ at the hospital.
- 15% of women using the ante natal clinic are HIV+ (2000 data).

Since December 2003, ARV treatment access has been free of charge through a newly initiated programme. Scaling up the programme has involved training of health professionals, identification of infrastructure to host the programme, identification of support services, particularly laboratory services and pharmacy. Selection committees play an important part in determining treatment readiness with most patients recruited through Internal Medicine, Paediatrics and Obstetrics.

By April 2006, 762 patients were enrolled in the treatment programme with a further 550 in pre ART (on prophylaxis). Sixty five percent of patients are female. Seventy one percent of patients use the 1<sup>st</sup> line regimen (Triomune). Despite the successes in scaling up access to treatment, the programme managers acknowledge the huge unmet need for home-based care.

The Commission Nationale de Lutte Contre le SIDA (CNLS) is a key partner in the work of the university and attests to the national significance attached to their work.

<sup>26</sup> This section relies on data and analysis provided by Prof André Musemakweri, Chairman of the LUCS and Mrs Kayitesi Rusanganwa, Coordinator of LUCS.

## *Analysis*

This model of best practice puts the university centre stage as a national resource and as a lead agent in the development and delivery of new programmes with the highest priority. The institution has the responsibility for training the bulk of high skill professionals in the health sector and ensuring that programmes such as ART can be rolled out safely and sustainably. There can be question about the relevance of its contribution to the national response and its importance in the national response to the epidemic. This leadership role, accorded to the University, is echoed in the development of a range of other services and programmes which the institution is expected to model as a benefit to other institutions in the education sector.

Contact: For more information on the HIV and AIDS Programme at the National University of Rwanda, contact Ms Kayitesi Rusanganwa, [rusanganwak@yahoo.fr](mailto:rusanganwak@yahoo.fr)

### **3.10 University of the Western Cape, South Africa**

#### *Management of the response*

The University of the Western Cape in South Africa is one of five higher education institutions in the greater City of Cape Town area. It enrolls approximately 15,000 (2006 data) students annually and is home to a well established HIV and AIDS Programme with a permanent management and co-ordination unit. The university's rector is a member of the South African National AIDS Council (SANAC) on behalf of the higher education sub-sector. SANAC is the country's highest level stakeholder body and is convened by government and sector representatives.

Six years after formalizing the establishment of an HIV and AIDS Programme, the institution boasts a wide range of innovative and challenging initiatives including educational theatre, digital story telling on HIV and AIDS, health promoters, peer education and curriculum integration.

#### *Prevention services*

The focal point of prevention services is a privately run medical practice contracted by the university to perform a range of service, an arrangement that has been in operation since 2003. A team of eight staff includes two dedicated VCT counsellors and, apart for chronic patients, provides a fully fledged HIV service. The health centre handles 14,500 consultations over the space of a nine and a half month long academic year.

VCT is the biggest component of the service and is both a government accredited testing site as well as being the busiest test site in its catchment area. In 2006, an estimated 1,650 clients used the service, averaging 183 tests per month. In one campaign alone, 718 people volunteered to take an HIV test. Like other government

accredited sites, the health service gets access to some resources (test kits and drugs for the treatment of STIs) as well as access to networks and support from within the public sector. The programme managers are confident about increased uptake of VCT based on their investment in education, decreasing levels of stigma, high service levels and accessibility.

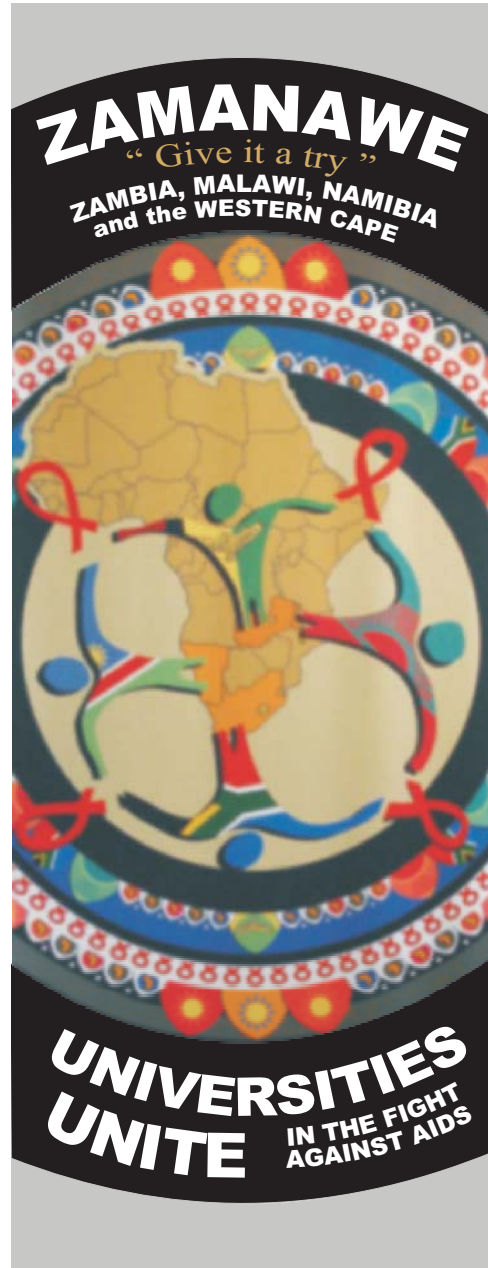
TB is a major cause for concern given that many students come from poor rural and urban communities where TB is a major health problem and access to care is equally unreliable. This flow of students between the city and their rural homes illustrates another important aspect of how university-based interventions impact on the epidemic. From a public health perspective, risks on university campuses have, to a large extent, been mitigated by the availability of good services. However, when these students return home, they are subject to the pressures of life and community in a very different way. For example, they are free to disclose their HIV status within the university community and be assured that their rights to dignity are respected. That may not be so easy in the countryside where stigma and traditional beliefs portray AIDS as a 'city disease'. A programme manager at the university who tested HIV+ was first asked to see a healer rather than a doctor to treat his opportunistic infections a normal practice in rural communities in Southern Africa. In this way, campus life has become a 'safe space' where students and staff are increasingly better prepared to handle HIV and AIDS and are supported at a personal and professional level by a community that is rights based and focused on access to essential services.

### *Peer education*

ZAMANAWE ('Give it a Try') is a flagship institutional co-operation and HIV and AIDS Peer Education project linking the University of the Western Cape (South Africa), University of Zambia, University of Malawi and the University of Namibia. Developed initially as 'ZAWECA' in late 2003, this was a two year long collaborative project between the University of the Western Cape and the University of Zambia supported by the South Africa Norway Tertiary Education Development (SANTED) Programme. Each of the partners trained 30 peer educators a year.

By 2006 it had expanded to include two other institutions in the SADC region as a direct response to the SADC Education Protocol and a strong institutional drive at the University of Western Cape towards inter-African partnerships.

The primary goal of ZAMANAWE is to promote institutional co-operation amongst higher education institutions through a regional response to the HIV and AIDS epidemic. Through intensive research, capacity building and student leadership development, it will test, promote and elaborate a peer education and behaviour change model aimed specifically at youth in higher education. At least 30 peer educators will be trained at the institution each year (a total of 120 among the four partners) in a rigorously monitored, evaluated and documented model. The model draws heavily on both psychology and counselling experience generated at the University of the Western Cape over a number of years.





**Bonile Peter (Health Promoter) and Tim Vergnani (Director of the HIV and AIDS Programme), University of the Western Cape**

Collaboration takes the form of regular exchange of staff between the institutions, regular exchange of students (annual) and electronic fora linking all the participants. Currently closed online discussions are hosted through [www.aidsportal.org](http://www.aidsportal.org) Using this portal allows all the participants to overcome the constraints of being spread across the SADC region.

The model implemented by the four partners is instructive both because of its strengths and limitations. Discussing sexuality and being sexually active amongst youth in South Africa is normative, whereas the strong religious affiliations of university students in countries like Zambia means having to adapt the model significantly. The concept of secondary abstinence is also increasingly popular in strong faith-based youth cultures.

Likewise, condom usage cannot be openly promoted in cultural and social contexts where pre-marital sex amongst youth is frowned upon. South African society and culture is also more supportive of gay and lesbian sexual orientations, another issue which is less easily accepted elsewhere in the Southern African context. The real value of collaboration is in the *quality of engagement* between young people in terms of values.

Using different modalities (in this case electronic chat rooms) to deliver peer education also creates space in a virtual community which allows for youth to engage with issues which may be 'off limits' in their everyday lives. What this means

in practice is that you can explore, discuss and learn about issues which you may not be able broach in your peer group, without some discomfort; take, for example, learning how to negotiate safe sex.

### *Curriculum integration*

In a partnership with INWENT Capacity Building International Germany -- the University of the Western Cape is also home to the Southern African region's first internet based teacher development programme on HIV and AIDS focused on teacher trainers; another regional initiative linking teacher training institutions in South Africa, Tanzania, Malawi and Namibia. As of 2006, 26 teacher trainers were trained in the pilot phase and were accredited by the University of the Western Cape. The project highlights new modalities of sharing expertise, developing student-led linkages, a commitment to regional co-operation and the potential value of a regional response led by universities.

On another level with an internal focus the university's Digital Academic Literacy course pioneered the teaching of HIV and AIDS in 2004 as a core competence for all incoming students. The course uses content developed for 'Your Moves' which is an interactive scenario-based game on risk and sexuality education especially developed for university level students. Each student uses a personalized user code and must complete pre-test and post-test surveys for assessment. In 2006, an estimated 2,400 incoming students completed the course. Here again, using a digital platform allows for a host of interactions on issues where youth are free to engage with no fear of public sanction. Using a digital platform also allows the course managers to deliver an otherwise difficult technical course with personal and behavioural content that is appealing to young students.

Feedback from the course is vital and has proved invaluable in the management of the university's HIV and AIDS programme. Three observations are worth noting in this respect: a) living with HIV as a student is now a reality, b) abstinence needs to be better understood, c) students show a clearer understanding of personal risk and self care, expressed in the notion '*to love me = to protect me*'. The reality of the loss of family and friends in their communities has driven home a powerful message about short term risk taking and taking personal responsibility for their life choices.

### *Best Practice*

Bonile Peter has been a Health Promoter at the University of the Western Cape since 2002. He was one of 25 young people living with HIV and who were initially recruited as Health Promoters by a group of South African universities working in partnership with Dramaide, a local NGO supported by the John Hopkins University in the United States. After testing positive for HIV in 2001, Bonile was a clinic volunteer for the Treatment Action Campaign (a South African NGO) at a new treatment site close to his home in Cape Town. Bonile was subsequently employed by the HIV and AIDS Programme in support of its peer education and outreach

strategy. Based initially in the student residences, his task was to interact informally with students, providing them with advice, education and support. His work makes living with HIV a reality and challenges his peers to discover their own health status.

In his work at the university, reaching young men remains a particular challenge but over the space of four years there is greater willingness among students to take a test and to disclose among those living with HIV. His recent experiences, supporting the ZAMANAWA peer education programme in other Southern African countries, brought to light the need for GIPA (Greater Involvement of People living with HIV and AIDS) initiatives in education. Students at one partner institution (with a well established HIV and AIDS programme) conceded to persistent problems with stigma, discrimination and anxieties about managing one's sexuality if you are HIV+. At another campus, students went so far as to question his right to freely engage in sexual relationships with HIV- people. Both of these incidents illustrate the extent to which living with HIV a reality for vast numbers of people in Southern Africa remains an abstraction for young people who need to be better informed and prepared in an AIDS-affected society. Programming based on the principles of GIPA is one way of overcoming this critical weakness.

### *Analysis*

Despite years of advocacy, the availability of resources and policy level commitment, too few institutions in African higher education can claim to have adhered to GIPA principles in their response to the epidemic. As this report attests, the reasons for this failure are complex and many. In this context, the example set by the University of the Western Cape is a hugely important as both a best practice model and an imperative for the future. It illustrates that GIPA principles are more than a human rights and ethical issue and they give the epidemic and the idea of Living Positively a visible, strong, positive image in a context where youth, vitality and success are key drivers of aspiration. Achieving this level of integration into the life of the institution was not easy even in a high prevalence country but that difficulty can no longer be a reason for tacitly accepting stigma and silence.

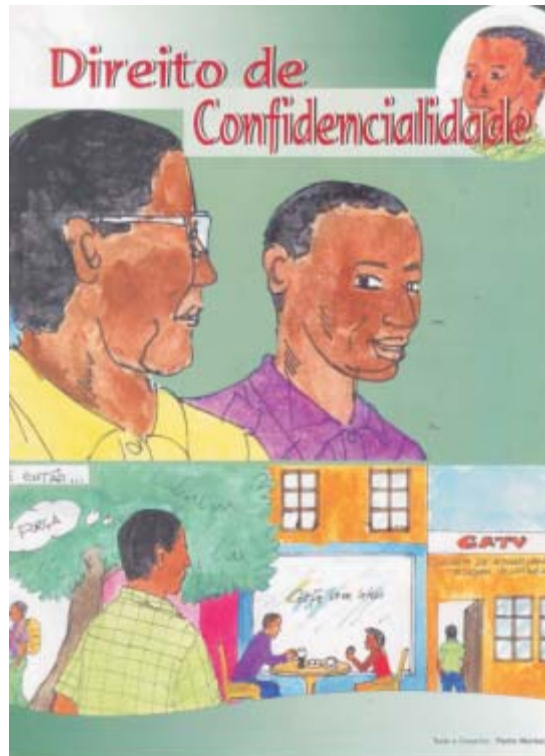
Contact: For more information on the HIV and AIDS Programme at the University of the Western Cape contact Dr Tania Vergnani, [tvergnani@uwc.ac.za](mailto:tvergnani@uwc.ac.za)

### **3.11 Universidade Eduardo Mondlane, Mozambique**

#### *Management of the response*

Jorge Nichols has been responsible for the management of the Universidade Eduardo Mondlane's (UEM) response to HIV and AIDS for the past seven years. However, the office through which the response is managed is now in its 14<sup>th</sup> year of operations. The office is better known as GASD Grupo des Activistas Anti SIDA/DTS. Founded fourteen years ago (by a former student of UEM in 1992) the

organisation has students and employees as its core focus and is based in offices within one of the university's student residences. The impetus for its establishment came from the university leadership who had recently participated in an AAU workshop during which the issue of HIV and AIDS was tabled.



**Advocacy materials on the right to confidentiality used at the Universidade Eduardo Mondlane**

The core of GASD comprises of its 26 peer educators (2007 data) and a handful of full time employees. Its financial base is secured by an internal budget of approximately US\$15000 which is supplemented by donor funding. UEM currently provides for approximately 12000 full time students and employs 2000 people at its campuses in Maputo. It is one of five public universities in the country.

With a history spanning fourteen years, GASD has succeeded in establishing itself as a part of the institutional architecture within the university and it enjoys both national and international recognition.



### *Partnerships*

In 1998, UEM joined a new initiative entitled 'Iniciativo Conjunto de Prevencao e Reducao do Impacto do HIV no Ensino Superior', which was geared to bringing together both the public and private higher education institutions. The impetus for this initiative came from a realisation that there was insufficient movement elsewhere in the higher education community on HIV and AIDS. The Catholic University of Beira was one of the first projects under this initiative and UEM took on the responsibility from 2001 of assisting the Catholic University to establish its own HIV and AIDS programme. Work continued for three years subsequently until a programme was in existence. This mechanism of capacity building which has led to the development of HIV and AIDS programmes at most of the eight higher education institutions in the country has generated a higher level of acceptance, ownership and commitment amongst university leaders.

GASD also works in partnership with the 'Conselho Nacional de Combato SIDA' (CNCS) the locus of the national HIV and AIDS programme in Mozambique. CNCS provides GASD with support for its work in research, mitigation and prevention. GASD's linkages with government (particularly the Ministry of Higher Education) have enabled it to be a recognised component of their strategic plans for the sector.

### *Prevention and Care Services*

Maputo is a high prevalence area with estimates of 21%, though this is lower than the central areas of the country around the port city of Beira, which has a history of conflict and instability. In southern Mozambique, transport routes are the major vectors of transmission.

The student population at UEM is notable for its disproportionate number of male students. An estimated 32% of students are female, a reflection of the dynamics in the broader education system in which few girls successfully complete secondary education. Though the indicators from the most recent KAP survey (2005) are very encouraging, there are some gaps in the knowledge base upon which to develop programming and services. Whilst a high proportion of students demonstrate adequate knowledge about HIV and AIDS, there is no data at the university on the numbers using condoms.

GASD provides a range of services and resources including:

- Awareness and sensitisation programmes
- IEC materials
- Peer education
- Condom distribution
- A news bulletin
- Counselling
- Video information sessions

Strictly speaking, prevention services are handled by the Posto Medico, an adjacent office of the health service which is intended to function as a primary health care centre. In practice, very few people use it for services and it basically functions as a referral point to the university's teaching hospital, Maputo Central Hospital. There is no felt need for an integrated relationship between university services and the hospital at present. Once students are referred to the hospital, they are absorbed into the public health system.

The primary delivery points for prevention services are through the public health system, which university managers expect students to use. Since students are treated as part of the general population, it is not easy to profile students specifically as a demographic group with respect to uptake of VCT or the potential demand for VCT. VCT centres, which are widespread in Maputo, only refer patients to the Central Hospital if they test positive and require further investigations. A counselling service which opened two years ago has a throughput of only six clients a month, a level which indicates the need for a review in strategy. No specific marketing has been targeted at students to increase the uptake of VCT. Opinions vary as to the acceptability of demand for VCT amongst the general population, with the dominant opinion being that it is still low but improving.

Efforts to increase service uptake and involvement in HIV and AIDS programming amongst employees are also relatively limited. Though most employees pay a contribution for medical insurance, it is not a benefit which many rely on. University managers recognise these limitations in access to prevention services and are expecting the situation to change once GASD itself moves onto the main university campus.

#### *People Living with HIV and AIDS*

Despite the existence of a programme at UEM for fourteen years, stigma is acknowledged as a persistent problem. To date, only one student – a peer educator has disclosed his status on campus. No support groups for positive or negative students are yet in existence either. It's a reasonable assessment to say that UEM, despite its advances on a few fronts, cannot yet be considered a 'safe space' for people living with or affected by AIDS.

#### *Institutional policy*

GASD took the lead in the development of institutional policy in 2005. In the context where a number of other universities in the region have already developed policy, the organisation felt the university needed guidance on a number of issues. Following a process based heavily on stakeholder inputs, a draft policy was developed but has yet to be approved.

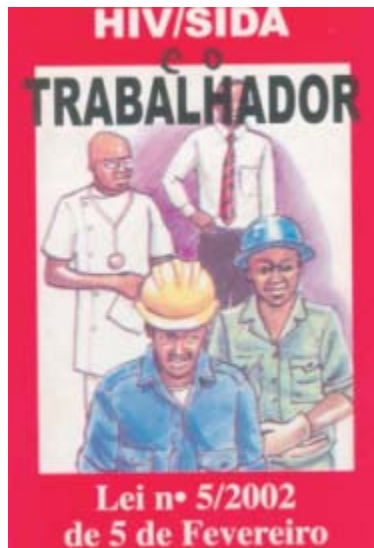
### *Peer education*

Peer educators have been active at UEM since 1992. Typically recruited in their 2<sup>nd</sup> year of study from all the faculties, they receive a short period of training and are then kept on for 3-4 years. The majority (22) of the current cohort are students, along with four employees. Their activities are planned on a monthly basis with debriefing meetings at the end of every week. Like many southern African universities, programme managers and peer educators themselves acknowledge that whilst abstinence is included in the content of the training, it has little relevance to their prevention strategy.

A focus group with peer educators yielded a strong personal commitment to behaviour change. All except one of the peer educators (including 4 employees) had tested for HIV at least once. They too agreed that stigma and discrimination remain a problem at the institution, despite the widespread availability of information. In comparison to peer educators in any other higher education setting, they are motivated, well informed and confident about the role in student life.

### *Curriculum integration*

Teaching and research on HIV and AIDS are well developed at UEM (particularly in the health sciences) but also in specialised institutes such as the Institute of African Studies and in the social sciences more generally. At the time of this review, no data was available on the range of course offerings or research programmes across the institution. At present, GASD lacks any connections to mainstream teaching and learning, an area which is likely to see new developments in the near future.



**A pamphlet on the law against discrimination in the workplace, Law No 5 of 2002**

### *Best practice*

In 1999 GASD started work on a project which is titled 'Law No 5 of 2002'. The project was focused on the development and implementation of new national legislation on HIV and AIDS in the workplace. In essence, the law was designed to protect the rights of employees and prospective employees and also to articulate the obligations on employers.

Following a SADC commitment which compelled member states to protect employees against discrimination in the workplace, GASD joined together with four other partners on a policy development process. They included:

- Organisaçao Trabalhadores Mozambique Central Syndical (OTM) - the country's largest public sector trade union
- RENSIDA a national network of people living with HIV and AIDS
- MONASO Mozambique's AIDS Service Organisation
- AMOPROC - an NGO with a long experience in issues concerning human rights and citizenship

The policy development process took the form of a campaign and consultations lasting two years. Though the policy itself was promulgated as law in 2002, the process of dissemination will continue till July 2007. Dissemination involved translating the law into six national languages, popularisation in materials which were widely distributed across the country and to all major enterprises. Though some employers were reluctant partners at first, they have come to see the legislation as useful. Enforcement of the law has resulted in some employers which tested employees without consent being penalised by the courts.

In this partnership GASD brought to the table its expertise in HIV and AIDS and advocacy, whilst gaining from being allied to large and powerful organisations in civil society. GASD subsequently embarked on developing new anti-discrimination policy which will have application to all Mozambicans. The first draft was presented to the National Assembly on 1 December 2006 and the process of legislating it is underway.

### *Analysis*

With clarity and simplicity, this example illustrates the value which higher education based activist groups and NGOs can bring to a standard setting process which significantly impacts on human rights culture, the law, the economy and society. It underlines the relevance, effectiveness and ethical value which universities lend to policy and standard setting processes. Furthermore, it re-enforces the core of higher education's mission as a leading social institution in a world affected by HIV and AIDS.

Contact: For more information on UEM's HIV and AIDS Programme, contact Mr Jorge Nicols: [nicolsjorge@yahoo.com.br](mailto:nicolsjorge@yahoo.com.br)

### **3.12 University of Namibia, Namibia (UNAM)**

#### *Management of the response*

The University of Namibia's HIV and AIDS programmes is amongst the most developed in Southern Africa. The core of the UNAM programme is sustained by an internally generated budget of US\$10000 per year. Having embarked on the development of institutional policy early on (2001), the challenge for programme managers at UNAM is now to implement the policy fully. Specifically, their concern is to make care and support for infected and affected students and employees visible and effective.

#### *Prevention services*

The health clinic is the focal point for prevention services delivery on the main campus and offers the following:

- Referrals to the public hospitals for treatment access
- Condom distribution
- Daily screening
- Contraception
- STI treatment and management
- TB treatment and management
- Counselling (all nurses are trained counsellors)

Importantly, no VCT service has yet been established at the clinic but UNAM management is likely to engage an NGO to provide the service. As yet demand for VCT looks very positive with significant numbers of students requesting the service. Like a number of other campus based services, programme managers at UNAM are working towards a wellness service which will move away from a limited disease management approach to HIV and AIDS.

#### *Care and support programmes*

UNAM is a key partner in the implementation of ZAMANAWAWE, the second phase of the four-country peer education programme based at the University of the Western Cape in South Africa. (*Details of the programme are described in Section 3.10 of this report*). Forty-nine UNAM students have already been trained and thirty will continue as implementers of the programme working on a new theme very month. Establishing support groups on campus is a priority to counter the persistent anxiety about stigma and disclosure. Thus far, only students testing negative have been willing to make their status known.

### *HIV and AIDS in the Workplace*

Though workplace responses are still developing, the university is considering important changes. To ensure compliance with the institutional policy, UNAM's human resources managers are also trying to make all existing contracts HIV and AIDS compliant and medical insurers are being urged to extend their coverage. For its part, management is exploring ways to expand treatment literacy and access. Currently the health clinic on the main campus caters only for the needs of students and is a site through which treatment can be accessed. Attempts are now underway to expand access to accommodate staff on a cost recovery basis in which the medical insurers will be charged for services provided to employees. University management are pursuing these options given the reality of real constraints in the public health system. A broader Employee Assistance Programme (EAP) is desirable but still only in its conceptual stages.

### *Partnerships*

UNAM has sustained partnerships on HIV and AIDS with African universities and elsewhere. It has collaborated often with Kenyatta University, most recently in the area of curriculum development and with the University of Toronto, Canada, through student exchange programmes. This latter partnership is long standing since 1999 and has involved an annual exchange of between 10-15 Canadian students studying at UNAM every year.

### *Best practice*

Since 2003 UNAM has been implementing a core course on HIV and AIDS comprising 3 modules on 'Social Contemporary Issues'. These include: gender, HIV and AIDS and ethics. Housed in the Faculty of Health Sciences, it has its own coordinator. Whilst this course continues, it is being reviewed and updated to address issues such as treatment literacy and access which have come to fore since 2003.

At the same time, the university has taken major steps towards greater *curriculum mainstreaming of HIV and AIDS*. In 2006, UNAM and its partner University of Toronto initiated a major consultation on HIV and AIDS in the curriculum involving the University of Dar es Salaam, Kenyatta University, University of Toronto and University of Zambia<sup>27</sup>. Under the title 'Capacity Building and HIV and AIDS Mainstreaming for the Development of a Health Promoting University', the

Consultation's most valuable outcome was five new course outlines (subsequently implemented) at certificate and degree level in the following areas:

- Cultural Aspects of HIV and AIDS
- Counselling and Psychosocial Care in HIV and AIDS

<sup>27</sup> Report on Workshop on Capacity Building and HIV and AIDS Mainstreaming for the Development of a Health Promoting University, 29 May-9 June, Windhoek, Namibia. (Unpublished)

- Introduction to Management and Care of HIV and AIDS
- Gender and HIV and AIDS
- Biological Aspects of HIV and AIDS
- Research Methods

Included in these new course outlines are: a schema of content, readings and assessment criteria. Five more courses were identified for development in the near future. These include:

- Human Rights, Law and HIV and AIDS
- Communication Strategies in the control of HIV and AIDS
- Mobilizing Communities and Health Promotion
- Food Security and HIV and AIDS
- Workplace Policy and HIV and AIDS

Alongside, this process, the consultation also developed the university's first draft Research Ethics Guidelines, as well as plans for student led research and research collaborations in the immediate future.

### *Analysis*

This model of curriculum integration is unique for its deliberate and systematic attention to HIV and AIDS. The consultation set a precedent in that it was organised around course development, a process which is more often left to individual academics or their departments. In doing so, this initiative prioritised four important benchmarks in approaches to curriculum development on HIV and AIDS: (1) it brought together research and teaching expertise across a wide spectrum from both Africa and North America; (2) it elevated course development to an institutional level, and, (3) it underlined the need for curriculum mainstreaming as an issue that cuts across all areas of teaching and learning in higher education, and lastly (4) teaching has to be backed by investment in research and attention to ethics.

Contact: For more information on UNAM's HIV and AIDS Programme, contact Dr Scholastika lipinge, [siipinge@unam.na](mailto:siipinge@unam.na)

### **3.13 Analysing Best Practice**

Based on the short profiles in this section, how do we make sense of them analytically? The obvious questions are: to what extent are they effective, sustainable, efficient, ethically sound and relevant. One route could be to measure each of these examples against the criteria for best practice which were outlined earlier on in the report. To do justice to such an exercise would require far more information on each of the case studies.

It is nevertheless useful to try and extrapolate some key elements from these examples that speak to the criteria.

*Ethics:* The pursuit of new knowledge, an area in which higher education institutions have a fundamental interest, must be governed by ethical principles. In the current context this is of paramount importance where lives are at stake, as well as the right to dignity and care. In research and teaching have in most cases been above reproach in their concern with ethics. Some are realising that they need to reconsider the conventions of ethical guidelines when confronting the realities of HIV and AIDS as the epidemic evolves and as they respond. The University of Namibia is one such example.

*Relevance:* Until recently, it has been a struggle to convince university managers to spend even small amounts of funding on the threat of HIV and AIDS which they imagined in societal or abstract terms not an immediate reality in the lecture theatre, residence hall or the workplace. That mentality has changed and it is most readily shifted when decision-makers see evidence of the university's role in personal, professional and societal terms. When universities take the lead in making governments, civil society, employers and workers themselves understand why it is necessary to protect the rights of workers who are infected or affected, they fulfil their mission of being relevant to the needs of their stakeholders and the people who need their intellectual and social support. The example of Universidade Eduardo Mondlane's involvement in Law No 5 of 2002 is a compelling example of this principle in action.

*Sustainability:* The pressures of scaling up and remaining sustainable are intricately connected. One lesson that is common to a few of the examples in this report is that linkages to the public sector (Ministries of Health, National AIDS Control Programme, etc) are potentially very powerful and a way of growing what would otherwise remain small, isolated and marginal interventions. VCT services, like that operated by Maseno University in Kenya, have shown that sustainability, relevance and efficiency are best achieved through integration and leveraging support through the public sector. One area remains a critical weakness in terms of sustainability – research on HIV and AIDS. Despite the proliferation of new programmes and increases in output, too few African institutions are yet in a position to build and maintain research capacity without major external interventions.

*Effectiveness and efficiency:* After more than six years of sustained advocacy, modest but significant investment and considerable human effort, there is good reason to be asking: how many infections have we prevented; how much behaviour change is being achieved; why is it that stigma remains so powerful in institutions of learning? These questions call for careful consideration of the effectiveness and the efficiency of the first generation on responses. Some are evidently not working optimally. Whilst support groups for people living with HIV and AIDS are common place at community level, they are rarely found at universities. Is it efficient to retain user fees for a service which is the key entry point to prevention and care? Workplace responses (or the lack thereof) remain a problematic area across the spectrum of higher education institutions on the continent. This report has sought to highlight examples like Copperbelt University's Health Support Group and its



internally sustained welfare trust which are pointers to what is possible even with limited resources but matched with creativity and commitment.



**Condoms on sale at a kiosk, University of Ghana**

## Part IV Gaps, weaknesses and trends

### 4.1 Risk assessments

Since the earliest attempts at assessing the actual and potential impacts of HIV and AIDS on higher education, there has been an ongoing concern with the lack of research and understanding of the cost implications for institutions. The impacts on higher education, like those on the education sector as a whole, are expressed in *direct, indirect and systemic costs*<sup>28</sup>. HIV and AIDS related impacts also have the potential to divert limited resources and to threaten key sources of income<sup>29</sup>. These include:

- Management resources
- Loan repayments (students)
- Loss of fee income (students)
- Declining numbers of students

This report highlights examples drawn below from a single South African cost risk study commissioned by the Higher Education HIV and AIDS Programme (HEAIDS) in South Africa. It is one of the first such exercises to be conducted rigorously and offers some important insights beyond the piece-meal evidence which has been generated by institutional case studies thus far.

The risk assessments have attempted to model the cost implications of the impacts on 11 higher education institutions in human resource terms. The names of the institutions were kept confidential<sup>30</sup>. It is important to bear in mind that this sample was 'self-selected' and illustrates trends which are more *typical of a high prevalence country* with a specific institutional landscape. There are also significant variations in prevalence levels within South Africa across regions and within population groups. South Africa's higher education system comprises 23 public institutions in total.

The estimated cost of HIV and AIDS on staff at the 11 institutions was analysed from the available data by projecting current estimated costs for the years 2005, 2008 and 2011 on the basis of current and higher ART levels.

<sup>28</sup> Whiteside and Sunter quoted in 'Expanding the Field of Inquiry: A Cross Country Study of Higher Education Responses to HIV and AIDS', UNESCO, 2006, p12

<sup>29</sup> UNESCO report, p 12

<sup>30</sup> A Cost-Risk Analysis of the impact of HIV AND AIDS at 11 South African Higher Education Institutions, Draft Synthesis Report, HEAIDS, May 2006.

Total Costs at Current ART Level (ZA Rands<sup>31</sup>)

	2005	2006	2007
Institution A	736 495	1 077 159	1 331 864
Institution B	1 689 920	2 727 578	3 625 962
Institution C	358 061	465 596	539 953
Institution D	1 960 809	2 487 352	2 795 017
Institution E	8 361 684	9 849 478	10 812 840
Institution G	1 441 770	1 689 233	1 758 096
Institution H	1 876 758	2 105 510	2 136 780
Institution I	1 533 128	1 961 762	2 364 034
Institution J	222 253	344 205	438 163
Institution K	2 017 976	2 985 614	3 855 952
TOTAL	20 198 854	25 694 487	29 658 661

The report argues that 'the available data suggests that substantial costs of HIV and AIDS are being incurred at all institutions. It can be seen that in 2005 the cost estimate was approximately ZAR20 million for the 11 participating institutions. At current ARV levels, the estimate is that this will rise to over ZAR25 million by 2008 and to just under ZAR30 million by 2011. When added up across the sector or over the years, the cost is clearly very high and justifies serious responses to the problem by [human resources] and other managers'.

Furthermore, in five of the sampled institutions, HIV and AIDS related costs added an additional 2% to the salary bill. These costs are noted as significant but can be managed with adequate planning. One of the institutions showed a possible 4.4% projected additional cost to its salary bill. The biggest savings can be made through increased access, enrolment and adherence to ART. These costs are best looked at over time and will be made up mostly of death benefits and health care, followed by indirect costs arising from lower productivity and absenteeism.

Total Savings for Higher ART Levels (ZA Rands)

	2005	2008	2011
Total	426 423	6 372 695	5 440 667

<sup>31</sup> Average exchange rate in 2007 estimated at US\$1 = ZAR 7.00

### Estimated HIV prevalence in participating institutions with full ARV usage after 2008

	2001	2005	2008	2011	2015
Institution A	9,3%	14,3%	16,3%	17,2%	18,1%
Institution B	11,2%	20,4%	25,4%	28,0%	30,6%
Institution C	3,1%	4,2%	4,7%	5,0%	5,3%
Institution D	4,2%	5,2%	5,6%	5,8%	6,0%
Institution E	3,5%	4,7%	5,5%	5,9%	6,7%
Institution F	1,1%	1,5%	1,8%	2,0%	2,2%
Institution G	16,4%	19,2%	20,1%	20,2%	20,9%
Institution H	15,2%	18,4%	19,9%	20,1%	20,5%
Institution I	1,9%	3,4%	4,1%	4,6%	5,1%
Institution J	1,2%	2,2%	2,7%	3,0%	3,2%
Institution K	4,0%	6,9%	8,4%	9,2%	10,1%

The report concludes that from these estimates, the demographic impact of HIV and AIDS on staff is slow but ongoing, with increased impact evident in some cases. It is clear that the increased implementation of ART will not avoid death and illness. HIV and AIDS-related deaths are likely to constitute the largest and most challenging public health problem.

Losing a high/scarce skill professional to chronic illness or premature death is both a personal, institutional and economic loss of huge proportions in a context where such scarce skills are in huge demand. It takes a generation to replace that level of experience and skills and there is no way of recuperating the value of intangible assets like institutional memory. The social and developmental role which universities play in mobilising, developing and sustaining these high level skills makes them unique among social institutions and is intrinsic to their value.

More universities are taking the threat to their employees (in general) more seriously. This is evinced by the proliferation of workplace prevention, care and support programmes. In effect, the response tends to remain a human resource management function. However, the management response needs to be reinforced by *human resource planning and development* in response to HIV and AIDS.

What does this mean in practice? Internal strategies aimed at growing the pool of skills ('growing one's own timber') have long been in existence, though not necessarily in response to the threat of HIV and AIDS. At a sector level, most

countries are committed to growing the numbers of high skill people in the economy and specifically in higher education. Large private sector enterprises have typically been more proactive about planning for their critical skill needs in the long term and putting in place the development mechanisms to ensure sustainability. Universities by comparison, are yet to treat the issue with the same sense of urgency.

## 4.2 Funding trends

On a positive note, this report documents several examples of institutions where a dedicated budget (albeit supplemented by external resources) is now available to HIV and AIDS programmes. Institutions which have invested their own resources (mostly in the form of skills, personnel and infrastructure) are reaping the rewards of recognition and new sources of funding.

Over the past five years, the range of funding sources in HIV and AIDS has changed significantly with resultant impacts on higher education. The large foundations, bilateral and multilateral partnerships continue but these are now overshadowed by the scale of the Global Fund to Fight AIDS, TB and Malaria (GFATM) and PEPFAR two of the new funding mechanisms. In 2001, at the time of the United Nations General Assembly Special Session on AIDS (UNGASS), US\$1.6 billion was available. By 2007, this total was expected to reach US\$10 billion. Alongside these changes, institutional arrangements for the mobilisation and management of funds have improved by adherence to the 'Three Ones'. A few examples are highlighted below of traditional and new sources of funding for HIV and AIDS in higher education.

Three foundations which are part of the Partnership for Higher Education in Africa<sup>32</sup> are expected to spend a significant part of their \$200 million fund on HIV and AIDS in the years ahead.

The Ford Foundation's All-Africa HIV and AIDS initiative is the broad framework through which the bulk of Ford's support for HIV and AIDS is channelled. Most of the funding has been used for improving CBO/NGO capacity, knowledge-building and behaviour-change communication, policy advocacy around access to treatment/stigma issues and increasing attention to gender and youth issues in relation to the epidemic.

The MacArthur Foundation has focused on higher education in Nigeria. Within the framework of 'Strengthening Nigeria's Universities', at least three institutions have received major grants (Bayero University, University of Ibadan and Port Harcourt University). Two of these institutional grants (Ibadan and Port Harcourt) involve HIV and AIDS-related outcomes. On an Africa-wide basis, the Rockefeller Foundation has made grants to a number of universities for work on HIV and AIDS, usually in biomedical research or clinical applications.

<sup>32</sup> <http://www.foundation-partnership.org/SummaryBookletofBestPractices,Issue1,p5,June1999>

Again in Nigeria, the PEPFAR programme has funded both small grants to a number of universities mostly for prevention and advocacy projects, while far larger resources have been channelled into programmes like APIN which are multi-year biomedical research and innovation initiatives involving the leading federal universities (among them, Kano and Ibadan) in collaboration with the Harvard University School of Public Health.

With respect to internally generated resources, the Commission for Higher Education in Kenya provides funding for AIDS Control Units (ACUs). In 1999 the Ministry of Education Science and Technology directed all public higher education institutions to establish and maintain these units. In most cases, funding from the Commission is used to support projects or the recurrent cost of services on campuses based on the submission of proposals.

In terms of bilateral agreements, the most significant programme targeting HIV and AIDS in higher education is in South Africa. Following on start up funding by DfID (UK) of £1 million, the HEAIDS programme started a second phase in 2005 based on a €20 million commitment from the European Union<sup>33</sup>. The second phase covering all 23 universities in the system will involve a major new audit of current activities and capacity, research and capacity building in teacher education on HIV and AIDS.

#### **4.3 Trend analysis**

As the section on best practice illustrates there is no shortage of innovation in the range of programmes being run by higher education institutions. What these examples show is that a number of institutions have invested in 1<sup>st</sup> generation responses especially in high prevalence countries. The results are impressive but they continue to mask key weaknesses. Too few of these institutions are asking: *where do we go next in our response to the epidemic?* The response to that question must address the following weaknesses and gaps in the higher education response to the epidemic.

*Firstly*, there is a growing consensus that HIV and AIDS interventions have to be integrated as part of Sexual and Reproductive Health Services or a Wellness Service in order to be more effective and to survive. The 'disease management' approach used thus far does little to reduce stigma on campuses (which is still a reality) and does not lend itself to mainstreaming.

*Secondly*, with a few exceptions, the involvement of People Living with HIV (PLHIV) in programming is low. In a similar vein, the level of disclosure on most campuses is equally low.

*Thirdly*, the uptake of VCT is proving to be a challenge for many programme managers. Why is that? VCT uptake is variable, often heavily dependent on campaigns and active recruitment rather than the everyday availability of the

<sup>33</sup> <http://www.hesa.org.za/hesa/content.asp?id=416>

service. In other words, the mere availability of the service does not induce most students or employees to test or seek counselling in consistently large numbers. VCT services are labour intensive and also require a fair amount of management time. In the future, they will need to be far better utilized to justify continued investment.

*Fourthly*, there is a view that universities could be making much better use of their resources and expertise by opening up their services to surrounding communities in some cases. If the services remain limited to students and employees (which is still a valid option) they need to demonstrate a far more proactive approach to the delivery of VCT and the follow up to testing.

*Fifthly*, peer education programmes are proliferating, which is a good sign, but they don't necessarily provide linkages or a route to actual behaviour change. It is increasing evident that the best way in which to initiate and promote behaviour change is by convincing people to take a test for HIV. That test and its outcomes whatever they are are a definitive moment. The test is a threshold to change and should be exploited as such. The argument being developed here is that all peer education must lead to recruiting larger numbers of candidates for testing and counselling - if they are to be of lasting value.

*Sixth*, since 2003, ARV treatment access has revolutionized the debate in HIV and AIDS between governments, development agencies, NGOs and civil society. What is role of universities in this context? Despite the massive changes in the price and availability of drugs, there are large swathes of the continent especially in high prevalence countries -- where access to treatment is severely limited. University based health and wellness programmes have a direct responsibility to be linked wherever possible to national public sector ARV treatment roll-out programmes. In doing so universities can both lead and help expand the national response. They stand to gain from the expertise in the public sector, from being part of the national effort and from oversight which the public sector provides. Their contribution is to make treatment access a reality, to make their expertise available to those most in need in their communities and to re-affirm their commitment to internal stakeholders that institutions can deliver on their commitments to provide care and support.

*Seventh*, integration of HIV and AIDS in the curriculum is the major pre-occupation of a number of multilateral initiatives. An analysis of the activities being delivered shows some degree of overlap/duplication and slow progress in relation to the level of effort and resources involved. Part of the problem may lie in the parallel programmes targeting many of the same countries and institutions with competing programmes. The programmes often reach different audiences at institutional level and therefore do not add up to a systematic and co-ordinated response. Furthermore, there is a lack of clarity about the extent which new courses should focus on knowledge or skills. The dominant trend is to favour content and knowledge instead of skills development when skills development is the most urgent need in the response.

#### 4.4 Way forward

1. The *1<sup>st</sup> generation of responses* to HIV and AIDS by higher education institutions was led by key actors in government, the development agencies and an influential group of institutional leaders starting in the late 1990s. Many of these responses have now matured or reached a stage of development which requires careful review involving the same actors, but also practitioners and stakeholders.
2. Despite some weaknesses in the work which continues, this report details increasing evidence of change, examples of best practice and a *growing community of practice on HIV and AIDS* in African higher education. This community of practice represents a critical mass of experience and expertise in the sector which needs to be recognised for its commitment and innovation. The vibrancy of this community is evident from the strength and proliferation of networks across the continent and internationally which are focused on higher education responses to the epidemic.
3. At this juncture the AAU, other international agencies and institutions themselves have the opportunity to define a new agenda in the response to HIV and AIDS by asking the *2<sup>nd</sup> generation questions*. The response to those questions must directly address the gaps and weaknesses which have been identified.
4. In programmatic terms, the new agenda should build on the foundations laid over the recent past and signal *a renewal of the response to HIV and AIDS*. This renewal must address the following:
  - a. Repositioning HIV and AIDS in terms of integrated Sexual and Reproductive Health Services.
  - b. Urgent attention to improve adherence to GIPA principles.
  - c. Uptake and utilization of existing services.
  - d. Closer collaboration with the public health sector and greater support to communities.
  - e. Improved peer education, linked to the promotion and uptake of VCT.
  - f. Expansion of treatment literacy and access.
  - g. Stronger focus on skills development in formal courses on HIV and AIDS.
5. It needs to be acknowledged that the HIV and AIDS response in higher education must take more account of malaria and tuberculosis (TB) as equally important health risks for most students and communities in the African context. Multi Drug Resistant (MDR) TB and Extreme Drug Resistant (XDR) TB have recently emerged as major threats in Southern Africa. As this report makes clear, co-infection with malaria and HIV is an area that needs



more clinical attention, especially given that most patients using university health centres are concerned about malaria.

6. Despite the greater focus on abstinence in peer education and other programmes, students are often unclear as to the real alternatives to being sexually active. Abstinence has been generally equated with a religious affiliation within a campus context. However, it should be possible to articulate an abstinence strategy without being tied to a faith based approach. There are significant tensions at some campuses about the extent to which faith based groupings limit opportunities for more open discussion of sexuality and may even be encouraging covert risk-taking behaviour.
7. Part of the renewal strategy must be about *re-inventing* or perhaps *re-conceptualizing* existing practices and programmes. For example, just as health care practitioners are constantly looking for new and more effective models of delivering HIV and AIDS services, universities need to rethink their role and the models on which their responses are based. Good examples of this are evident in programmes such as '*I Choose Life*' in Kenya which has mobilised students around behaviour change using widely different leisure and social activities including dance classes and other groups.
8. In terms of *curriculum reform*, some of the best higher education responses are still restricted by uncertainty among managers and academics about their role in the epidemic. This is often evident in their inability and unwillingness to take on the role of providing students with both the *professional and personal skills* to cope with an AIDS affected world. Too often it's a 'convert' who is willing to contemplate HIV and AIDS in the economics or law curriculum not the Dean or Head of the Department who should be instrumental in the decision. The picture is much the same, if not worse, in the natural sciences and engineering. This picture has to change fundamentally if a renewal is to occur at the level of curriculum integration.
9. *Anti-retroviral (ARV) treatment access* has fundamentally shifted the dynamics of the epidemic and has had implications in higher education. Two issues are worth noting. Firstly, despite the availability of ARV treatment, uptake at higher education based treatment centres is still low. The reasons for this trend are complex and need further attention. Secondly, there is a view that every university HIV and AIDS programme should be expected to act as a testing and treatment site. Despite major increases in the numbers of people accessing treatment in the developing world, access remains limited and universities can make an impact on that front with their resources and expertise. To start with, they can play a greater role in servicing the communities in which they are based.

10. Over the past five years or so, the 1<sup>st</sup> generation of responses has made universities a *safer space for affected and infected people* in many respects. Universities provide better access to education, services, care and support programmes and an environment which protects human rights particularly of people living with HIV. Despite the truth in this assertion, universities remain places where students and employees are also still extremely reluctant to disclose their HIV status. Why? Stigma is alive and well on our campuses. The persistence of this problem, as in so many others, must compel universities to critically revisit their role in defining *citizenship in an AIDS affected world*.
11. The challenge of expanding the *output and quality of research* in African higher education is far broader than simply putting HIV and AIDS on the research agenda. Despite some institutions being repositories of very high calibre skills and capacity on HIV and AIDS, the skill of high level researchers is often more likely to find its way into private consulting assignments for development agencies rather than publishing in academic journals. This is not a problem peculiar to research on HIV and AIDS and is more reflective of a broader problem in African higher education. In this view, universities run the risk of being seen as little better than co-opted NGOs who have no accountability to their constituency. A renewal strategy needs to shift that balance of power by re-valuing the task of research, its rewards and its applications.
12. Higher education's *intellectual capital* is its most powerful asset. In the response to HIV and AIDS this asset has immediate applications and is far more valuable when it is deployed as research in support of policy, programme development or capacity building. Professional development programmes for health professionals or managers in the public and private sectors is a huge and growing market, especially given the pace at which the epidemic changes and the need for new skills. Despite the potential of this opportunity, too few attempts have yet been made to capitalise on, or to use, higher education's expertise as an asset for the good of the institution and for the public good. Training programmes and contract research can generate income, create new linkages, build new expertise and leverage change within the public and private sectors.
13. Some of the institutions profiled in this report have traditionally operated in a service culture in which '*user fees*' are the norm. In other words, at the health centre everything *except the consultation* has a private cost. There is enough evidence to support the view that however small, user fees pose a barrier to access and uptake of key services. In the case of HIV and AIDS, higher education institutions should always be working towards reducing barriers to access and increasing the uptake of prevention, care and support services. The case is even stronger at university health centres and hospitals where the cost of a CD4 test is prohibitively high for most ordinary

people in the surrounding community. Clinical care is expensive but there are ways of reducing these barriers and institutions should be encouraged to find ways of garnering support through both the public and private sectors.

14. With the exception of the South African example, programmes at higher education institutions are either silent or avoid the issue of prevention, care and support for *sexual minorities* men who have sex with men (MSM), gay men and lesbians. Gay and lesbian communities now exist in many African cities, in some cases organized and visible, in others less so. The situation is not made easier by the existence of repressive legislation and state supported homophobia in many countries with respect to MSM and same sex relationships. Higher education has a responsibility to improve the popular understanding of this issue as both a human rights concern and public health challenge. That challenge is to find ways of ensuring that sexual minorities are more encouraged to make use of services, rather than driving risk-taking behaviour underground. If higher education takes sexual and reproductive health rights seriously in the years to come, these communities must be recognised and supported.
15. It is very encouraging to note that more institutions are using their own modest financial resources in support of their HIV and AIDS programmes to leverage additional support from external sources. Country level public sector and NGO programmes have experienced exponential growth since the advent of the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR) and the expansion of the World Bank's MAP. More institutions should be encouraged to pursue these opportunities by linking with national programmes, international research collaborations and areas in which they can add value.
16. As the international response to the epidemic has matured institutionally, there is increasing consensus around the *Three One's*:
  - One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners.
  - One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate.
  - One agreed country-level Monitoring and Evaluation System.

The Three One's were designed to increase accountability, improve coordination and strengthen the response to the epidemic. However, the importance of this shift does not appear to have made enough of an impact on the practice of planning and service delivery in higher education responses to the epidemic. The discourse of programme management at institutional level is often disconnected from any sense of a broader national framework this has to change. There are exceptions in higher education the

institutions which are accredited testing and treatment centres and those which have strong linkages with National AIDS Control Programmes. If education sector institutions simply pay lip service to the 'Three Ones' they will always remain junior partners in the national response. Higher education institutions which reach large numbers of people in terms of testing and clinical care can lead the way towards being more engaged in the national multi-sectoral response and national programmes.

17. Those universities which have responded to HIV and AIDS as more than a 'social obligation' or a way of mitigating a risk, have seized on a very different strategy *one that sees HIV and AIDS as an opportunity to reinvigorate the life of the university*. It is an opportunity to rethink the kind of graduates we aim to produce in a world which requires cognitive, creative and vocational skills that are able to respond with equal strength to globalisation, climate change, new technologies or HIV and AIDS.



African Universities House  
11, Aviation Road Extension  
P.O. Box AN 5744  
Accra, GHANA

Website: <http://www.aau.org>

