

**HIV/AIDS and Institutions of  
Higher Learning in SADC  
Countries**

**Theological, Ethical, Indigenous  
and Socio-Economic Perspectives**

Keynote Address to

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## The Scale and Scope of the HIV/AIDS Pandemic

Globally, the HIV/AIDS situation is considerably worse than the world's worst expectations. Ten or twelve years ago it was projected that the year 2000 might see 15 to 20 million persons living with the disease. Today we know that there are more than 40 million, in addition to upwards of 20 million who have died over the years from AIDS-related causes. Although there is more hope now than there was even five years ago, UNAIDS, the Joint United Nations Programme on HIV/AIDS, has warned that barring a miracle most of those who are currently infected will die over the next decade or so. UNAIDS has also advised that “unless action against the epidemic is scaled up drastically, the damage already done will seem minor compared with what lies ahead” (UNAIDS, 2000, p. 8). Things are going to get worse before they get better.

Currently, the epicentre of the disease is in Sub-Saharan Africa, and even more specifically in the SADC countries. At the end of 1999, the global infection rate for adults in their productive years, those aged between 15 and 49, was 1.1 percent, whereas it was 8.6 percent for Sub-Saharan Africa as a whole and 12.8 percent for the countries of the SADC region (Table 1). The data in the Table show that HIV infections in SADC countries accounted at the end of 1999 for more than one-third of the worldwide total of adult infections and close to half of the total in Sub-Saharan Africa. They also show that in the SADC countries one in every eight persons between the ages of 15 and 49 may well be HIV-infected. Put in human terms this means that, in the absence of other measures, a school in the SADC region with 16 teachers may lose two of them to AIDS in the coming few years, an enterprise with 240 employees may lose 30, an army of 40,000 may lose 5,000, there may be 20 infected individuals in a government ministry with 160 on its establishment.

	Adults (15-49) Living with HIV/AIDS	Adult Population (thousands)	Adult Infection Rate (percent)
Global	33,000,000	3,083,265	1.1
Sub-Saharan Africa	23,400,000	273,488	8.6
SADC Countries	11,430,500	89,589	12.8

**Source:** taken or derived from UNAIDS, 2000, p. 124

We should not, however, make the mistake of thinking that HIV/AIDS is an African disease. Very categorically, it is not. Neither is it a disease of poor countries. It is true that currently the disease is heavily concentrated in Africa, above all in the SADC countries, but ominous signs of rapid growth in other parts of the world may result in the situation becoming more calamitous there than in Africa. In Eastern Europe, and especially in the Russian Federation, HIV incidence is rising faster than anywhere else in the world (UNAIDS, 2001). The most populous country in the world, China,

has made a startling U-turn by acknowledging that it is facing a potential AIDS epidemic. In November 2001, it opened its first national HIV/AIDS conference against the sombre UNAIDS estimate that the current figure of HIV incidence in the country stands at more than one million infected and that if it did not move quickly to acknowledge and address its AIDS epidemic China would have twenty million cases by 2010 (*CDC Prevention News Update*, 12<sup>th</sup> November 2001). Further, although India is officially ranked as coming second to South Africa in terms of the number of infected persons, local experts believe that the real extent of the epidemic in India has been downplayed and that there could be as many as ten million HIV infected persons in the sub-continent (Gilada, 2002).

As for being a disease of poor countries, let us not forget that the United States has some 900,000 infected persons. This is more than there are in Zambia, or in Botswana, Lesotho, Namibia and Swaziland combined. Moreover, within the SADC region, apart from the island states, HIV prevalence tends to be highest in countries with the highest per capita income.

It is somewhat similar at the level of the individual. HIV/AIDS is not a disease of the poor. It occurred first among the wealthy and better off, and we continue to be aware of the way it occurs without regard for social or economic status. However, this is not to deny that the poor—poor countries and poor individuals—may be at greater risk of HIV infection, that they are more vulnerable to the disease, and that HIV/AIDS makes the poor poorer, at the levels of both individuals and countries.

There is now substantial evidence that factors that characterize poor societies and poor individuals contribute to higher rates of morbidity and mortality from infectious as well as non-infectious diseases, with HIV being included among the infectious diseases (Stillwaggon, 2000). These factors include protein-energy malnutrition, micronutrient deficiency, a heavy burden of parasites (malaria, bilharzia, nematodes), lack of hygiene, and lack of health care and medicines. This two-way interaction between HIV/AIDS and the conditions that bespeak poverty means that “HIV is inextricably linked to poverty and economic growth. While AIDS deepens the poverty of households and nations, poverty also favors the spread of HIV, forcing the least developed countries to face the dual challenge of fighting poverty and HIV” (Piot, 2001). No strategy against HIV/AIDS will ever be successful if it is not at the same time a strategy against poverty. And conversely, no strategy against poverty in a severely infected country will ever be successful unless at the same time it is a strategy against HIV/AIDS.

A further aspect of the global and regional AIDS situation, which is of crucial importance when considering implications for higher education, is the impact of the disease on the young. Indeed, one might almost refer to the predilection of the epidemic for devastating the prospects of the young. This shows itself in the massive problem of orphans and the special vulnerability of young people to HIV infection.

By the end of 2000, 12.1 million African children, almost five million of them in SADC countries, had lost their mother or both parents to AIDS (UNAIDS, 2001). But worse, it seems, is to come, with forecasts predicting that the total number of orphans from all causes in the region could exceed 15 million by the year 2010 (Hunter & Williamson, 2000). Responding to the needs of these children-without-parents is

taxing the resources and ingenuity of communities, civil society, governments and international aid agencies. All are in agreement that something drastic and creative must be done but nobody is quite sure what.

Compounding this problem is the fact that almost one-third of those currently living with HIV/AIDS are aged 15–24 (UNAIDS, 2001). Some 12 million young people are infected with the disease. These young people should be the mainstay of ongoing national and regional development. Instead, they are the AIDS generation (Kiragu, 2001). They have never known a world without AIDS. In the SADC countries, the majority of new infections occur in young adults, with young women being two to seven times more likely than young men to be infected (Table 2). In many respects, responding to the crisis of HIV/AIDS in SADC countries reduces very largely to preventing further infection among young people, mostly those who are at the very heart of education and training programmes in our third level institutions.

	Estimated HIV Prevalence Range (%)	
	Young Females	Young Males
Angola	2.6—2.9	1.1—1.4
Botswana	32.6—36.1	4.1—7.5
Dem. Republic of Congo	4.3—5.8	1.7—3.3
Lesotho	23.9—28.9	8.0—16.1
Malawi	14.5—16.0	6.1—8.0
Mauritius	0.04—0.05	0.02—0.06
Mozambique	13.4—16.1	4.5—9.0
Namibia	18.8—20.8	7.9—10.4
South Africa	22.5—27.1	7.6—15.1
Swaziland	25.9—31.2	8.7—17.4
Tanzania	6.9—9.3	2.6—5.3
Zambia	16.9—18.7	7.1—9.3
Zimbabwe	23.3—25.8	9.8—12.9

**Source:** derived from Annex 2, UNAIDS, 2000,  
No information available for Seychelles

## The Mandate of a University

Turning now to institutions of higher learning, let us remind ourselves that the core business of a university is knowledge. The university's teaching and research functions are both essentially concerned with knowledge. Its ability to serve society is based ultimately on its knowledge. Society invests heavily in its universities so that they may accumulate knowledge, transmit it through teaching and training, develop, elaborate and evaluate it through study, expand and generate it through research, disseminate and spread it through publications and conferences, promote its utilization through engagement with institutions and individuals within and outside the university world. Although the emphasis may vary from one university to another,

each of these knowledge-oriented endeavours is found in every university worthy of the name.

The presence of HIV/AIDS in a society does not change this mandate. However, the imperious demands of such a devastating disease necessitate that a university in a society affected by AIDS recognize that HIV/AIDS adds specific qualifications to its mandate. It is frequently stated that in a world with AIDS it can no longer be business as usual. Likewise, in a university that serves a society with AIDS it can no longer be university business as usual. The HIV/AIDS dimension must enter into every facet of the university's business, especially its core business of knowledge transmission (teaching), knowledge generation (research), and knowledge sharing (engagement with society).

**Box 1: The Mandate of a University in an AIDS-affected Society**

1. Respond to the needs of an AIDS-affected society
2. Do so through HIV/AIDS-informed knowledge and training
3. Protect, transmit and expand the storehouse of wisdom and knowledge
4. Adapt what is best from outside
5. Generate further knowledge, understanding, wisdom and practice
6. Engage with society by applying old and new knowledge to the identification and solution of problems occasioned by HIV/AIDS

In view of this, universities, such as those in southern and eastern Africa, that serve societies where HIV/AIDS is so pronounced, must interpret their basic mandate in terms of HIV/AIDS and its many implications. What we noted at the outset shows us the magnitude of the problem, with SADC countries accounting for more than one-third of the global total of those with HIV/AIDS. Universities that work in such circumstances could express the key task that has been entrusted to them by society as being to respond to the needs of an AIDS-affected society through HIV/AIDS-informed knowledge, training, research and engagement with external agencies and individuals (Box 1).

## **How a University Should Respond to HIV/AIDS**

An all too frequent response to HIV/AIDS is denial, at national, institutional, community and individual levels. To some extent silence and denial are a primordial and protective human response to situations that are excessively stressful. In the words of the poet, T. S. Elliott, "humankind cannot bear too much reality". But trying to cover up the existence of AIDS, as still commonly occurs even in the most severely affected countries, will never lead to mastery over the disease or its impacts. There

may be notional assent to all that is said about the epidemic, but this is accompanied by a practical denial that the disease is a matter for major personal or institutional concern, denial that the situation is as bad as is made out, denial that there is urgent need to take steps aimed at prevention, care, impact management and mitigation.

Denial can be found in a university as much as elsewhere, even in a university in a SADC country where more than one in every eight adults may be HIV infected. Therefore one of the first elements of a university response to HIV/AIDS is the honest recognition that it confronts a major problem and challenge—a problem that could jeopardize its own ability to survive as a functioning institution, a challenge to what it perceives as its core business in the AIDS-affected circumstances of society. No university is an AIDS-free enclave in a society where HIV is on the rampage. Quite the contrary, the university may well be more severely affected than the surrounding society. This is because the great majority of those who form the university community are young, in their late teens or early twenties, ages when the prevalence of HIV infection is particularly high. The risks for a university are also heightened by the liberal atmosphere that tends to characterize a university and by campus cultures that may be open to activities and life-styles that facilitate HIV transmission.

In crafting its response to the AIDS epidemic it is necessary, therefore, for a university to recognize that HIV/AIDS is a matter of vital concern that demands a coordinated university response (Box 2). This response must comprise two dimensions. One dimension looks inward and relates to the concern that the university should have to maintain itself as a functioning institution when it is already experiencing HIV/AIDS within itself. HIV/AIDS does to institutions what it does to the human body: it undermines the intrinsic capacity for self-defence against what would otherwise be relatively tractable problems. Ultimately it destroys the potential to function and deliver mandated services. The university needs to take full cognizance of this and hence to take whatever steps are necessary to ensure that, notwithstanding HIV/AIDS, it keeps itself in good working order.

The second dimension of the university response is outward looking and relates more strongly to the university's core functions of teaching, training, research, engagement with society, and service to the community. As indicated in Box 1 above, in a society which is affected by HIV/AIDS, the operations of a university in each of these areas must take full account of the disease.

### **Box 2: HIV/AIDS Issues for a University**

1. Recognize that HIV/AIDS is a vital university matter that demands a coordinated university response
2. Ensure that the university response has inward and outward-looking dimensions:
  - Inward-looking—protect its own functioning as an AIDS-affected institution
  - Outward-looking—serve the needs of an AIDS-affected society

## The Response of Universities in Africa to HIV/AIDS<sup>1</sup>

Given that the epicentre of the AIDS epidemic currently lies in Africa, and more particularly in SADC countries, it is instructive to know how universities in the region have tended to respond.

Reports coming from a number of institutions speak of the absence of good information on the extent and impacts of the disease on campus. In practical terms, there is much denial and secrecy, but this cannot mask the increase in the number of deaths, more extensive sickness, and some faltering in teaching and research functions (with older members of staff having to fill in for the absence through sickness or death of their younger colleagues).

While there is some evidence of increasing student sickness on campus, there has been no significant increase in student deaths, principally because in the majority of cases student HIV does not have time to progress to AIDS<sup>2</sup>. But this is offset by considerable evidence of high death rates among recent graduates from the universities. Thus, more than 30 percent of nurses graduating from the University of Natal in Durban are dying within three years of completing their study programme. This tremendous loss corroborates the estimates for South Africa, that by 2005 more than 30 percent of undergraduate students in the country's 25 public universities and more than 35 percent of those in its polytechnics or technikons will be infected with HIV. Evidence on death rates among academic and support staff is patchy, but seems to suggest that approximately two percent of academic staff and three percent of non-academic staff may be dying each year.

Notwithstanding staff losses, universities have tended to regard the disease as being principally a student problem that should be dealt with through campus student support and health services. There is extensive student awareness of the problem, even to the extent of AIDS fatigue, with students not welcoming any initiatives that have the manifest objective of encouraging them to develop a personal lifestyle in which they will not put themselves or others at risk of HIV infection. In addition to this, student attitudes are frequently characterized by denial, fatalism, inevitability, and invulnerability.

Given the climate of death within or very proximate to university years, it is astonishing that up to very recently there was so much silence at institutional, academic and personal levels. This was partly due to the colossal overwhelming nature of the problem and the difficulty of coming forward with any coherent solution. It was also partly due to the fear of openness, anxiety about stigmatization, and some tendency to petty but hurtful discrimination.

The result was that responses tended to be very piecemeal and uncoordinated. It is only since the commencement of the 21<sup>st</sup> century that universities have begun to

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<sup>1</sup> This section draws much of its data and observations from material presented in Kelly, 2001.

<sup>2</sup> Speaking at the launch of a student HIV project at the University of Nairobi in May 2002, the Kenyan Minister of Public Health decried the high number of AIDS-related deaths among university students and said that the prevalence rates at the universities, 20 percent among males and 30 percent among females, were double the national average (*East African Standard*, May 4, 2002).

develop worthwhile institutional responses, and even today many are taking little formal action. However, the absence of strong institutional response is compensated for by many generous individual initiatives, with academic members of staff valiantly striving to incorporate HIV/AIDS issues in their courses, a reasonably healthy corpus of research undertakings, several student-initiated anti-AIDS programmes (unfortunately, often short-lived), and considerable involvement of knowledgeable academics with agencies dealing with the disease in the non-university sector.

It is within this context that the Association of Commonwealth Universities (ACU) has been seeking, since 1999, to ensure that higher education institutions across the Commonwealth make a meaningful contribution to the fight against HIV/AIDS. In 2001, ACU undertook a brief mapping survey of the current perceived impact of HIV/AIDS on Commonwealth universities and of the current level of policy development in this area. Thirteen of the ninety-seven responding institutions were from five countries in the SADC region. The survey has been followed by workshops for Vice-Chancellors from a small number of African and Asian universities (in Lusaka, Zambia, in November 2001, and in Goa, India, in May 2002). Inputs from these workshops are currently being incorporated in a manual that the ACU is producing, *Commonwealth Universities in the Age of HIV/AIDS. Guidelines Towards a Strategic Response and Good Practice* (cf. ACU, April 2002). The workshops and the guidelines that are in process of being developed deal with the four principal areas of university response to the epidemic: management, teaching, research and community engagement.

In addition to this development, recent initiatives from South Africa and Namibia are worthy of note. One is the *Sex and Risk Programme* at the University of Durban-Westville. This is a compulsory credit-bearing course that seeks to introduce all three thousand incoming students to practical strategies and skills that will assist them in achieving the self-efficacy required to engage in responsible sexual behaviour and minimize risk of HIV infection (Bhagwanjee, 2002). The University of Pretoria approach is different in that it “places the onus on every faculty to ensure that students and teachers are AIDS literate and that HIV/AIDS is integrated into their degree structures” (ACU, 2002). The basic philosophy is that HIV/AIDS is relevant to every university discipline, and hence every university educator must ensure that it is integrated into the professional aspects of their programmes so that students achieve HIV/AIDS competence in relation to their professional areas.

Addressing the problem more from the perspective of engagement with society, the University of Natal established an HIV/AIDS Network, HIVAN, in August 2001. HIVAN seeks to provide the locus and impetus for multi-sectoral interaction around HIV/AIDS between tertiary institutions, CBOs and NGOs, local communities, the public and private sectors, and the international community. Its fundamental purpose is to facilitate networking between these agencies so as to enable Kwa-Zulu Natal become a leader in the fight against HIV/AIDS (Jones, 2001).



In a development along yet another dimension, the University of Namibia has developed a comprehensive HIV/AIDS policy<sup>3</sup> for the institution (UNAM, 2001). This policy has four principal components:

1. Rights and responsibilities of staff and students affected and infected by HIV/AIDS
2. Integration of HIV/AIDS into teaching, research and service activities of all university faculties, centres and units
3. Provision of preventive, care and support services on campus
4. Implementation of policy: structures, procedures, monitoring and review.

## **The Challenges of HIV/AIDS to Our Ways of Thinking**

It is very clear that HIV/AIDS presents us with numerous challenges: how to prevent the transmission of HIV, how to offer care and support for those who have become infected, how to achieve the correct balance between energies and resources devoted to prevention and those devoted to treatment of persons living with HIV/AIDS, how to mitigate the multifaceted impacts of the disease on individuals, families, communities and society, how to keep institutions in good working order when they are under unremitting attack from the pandemic, how to move from a world with AIDS to a world without AIDS.

### **The Basic Challenge to Theology**

Essentially these are challenges to our ways of acting. They require decisions about how we do things. But underlying these decisions, and at a much deeper level, HIV/AIDS challenges the way we think about things. The disease is so all-encompassing in our countries that it obliges us to re-arrange our understanding of what makes sense in our world. We see all round us the magnitude and extent of the suffering that it brings to individual human beings, the way this suffering extends to untold numbers of others, especially infants and children, the way it threatens the most hallowed structure in our society, the family, leading in some instances to its demise. No matter where we look, we see the disease snatching from us the securities that supported us in life and terrifying us with the prospect of annihilation. Our framework of understanding is no longer adequate for this situation of HIV/AIDS. We look for meaning and we find none.

For many who are infected, affected or genuinely concerned, the whole HIV/AIDS situation raises the agonizing question: "Where now is God?" In one way or another the majority of people, especially those in our SADC countries, believe in a personal and benevolent God, a supreme being who is all-powerful, all-caring, and all-loving. But how does one reconcile this belief with HIV/AIDS? How does one harmonize the goodness of God with the evil that AIDS is in itself? How does God relate to so much innocent suffering? Does God want it? Does God cause it? Why doesn't God stop it?

Seeing a fellow human being lingering in the pain and torment of AIDS, we cannot avoid asking, "Where is God now?" But perhaps our very asking the question helps us

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<sup>3</sup> The policy responses of various Commonwealth Universities to HIV/AIDS can be accessed on-line by going to "Policy" at [www.acu.ac.uk](http://www.acu.ac.uk).

also to hear the quiet murmur of the reply: “God is here, God is present in this person who suffers, God is present in a unique and intimate way in every person who suffers.”

This does not answer our questions or set our doubts to rest, but it may give us insights and direction for coming to grips with them. The AIDS pandemic defies every philosophical or theological theory constructed to explain it. But at the same time it forces us to look ever deeper for more explanations. Faced with the epidemic and with its manifestations in persons we know and love, traditional explanations are hollow, familiar advice is flat, customary religious expressions are inadequate. We want something more. Leading us forward to see and understand something more is surely one of the responsibilities that HIV/AIDS places on thinkers and practitioners in philosophical, religious studies and theological departments of universities.

### **Box 3: HIV/AIDS Challenges for Theology**

1. Reconciling the evil of AIDS with the goodness of God
2. Promoting community acceptance and the absence of stigma and discrimination
3. Developing a positive sexual ethics
4. Taking full account of the full and equal dignity of women as human persons

One move in the direction of a more comprehensive and human understanding of the meaning of HIV/AIDS was made about two years ago in a remarkable statement originating from South Africa and circulated by e-mail through AF-AIDS. Called “The Gifts AIDS Brings”, it highlights intimacy, presence, wisdom, love, meaning, service, community, surrender, gratitude and God as special gifts coming from the AIDS experience to both carers and those being cared for (Patient & Orr, 2001). Relevant university departments would do well to explore the depths of such statements, incorporating their basic insights into their teaching, research and publications programmes.

#### **Stigma and Discrimination**

Areas where theology and philosophy must be very resolute are those of stigma, discrimination and blameworthiness. Because HIV is transmitted sexually in the majority of cases, a strong tendency has developed that associates infection with sexual immorality. “On an individual level it is considered to be a punishment for personal sin, on a social level it is seen as an affliction that our society deserves because it has turned away from God, tradition, and customs” (Kachere, 2000, p. 4). This moralistic approach may blame commercial sex workers for the spread of HIV infection (but without asking how these sex workers became infected in the first instance). It may lead to hysterical condemnation of those who are gay and the denial of their fundamental human rights. It certainly leads to reluctance to acknowledge even the possibility of personal infection and makes it very difficult for those living with HIV/AIDS to come out publicly about their status.

Theology must be loud and clear in its message that HIV/AIDS is not a punishment from God, that it has no necessary link with immorality or promiscuity, that it does not always bespeak sinful behaviour. Likewise it must be fearless in rejecting the view that people with AIDS have only themselves to blame, when in fact the blame rests largely with poverty, oppression, and the unjust structures and organization of society. In practical terms, theology must also speak strongly against every form of condemnation, advocate fearlessly for the full acceptance of those with HIV or AIDS in every religious organisation or community, and press persistently for recognition in practice that AIDS is a disease, not a sin.

Fourteen years ago, Jonathan Mann, the esteemed director of what was then called the Global Programme on AIDS, said that we were dealing with three epidemics:

1. The silent epidemic of HIV that, for the greater part, is spread by that most basic of human activities, sex.
2. The second epidemic of the illness of AIDS, which is still devastatingly incurable.
3. The third epidemic of the adverse social reaction to persons infected with or affected by the disease (Walrond, 2000, p.59).

While there has been some improvement over the years, the social reaction to HIV/AIDS still tends to be very adverse. In addition to the denial which they themselves express, persons with AIDS and those in their immediate families frequently experience an intolerable violation of their basic human rights in the form of stigmatization and discrimination. They experience loss of reputation, defamation, false accusations, slander. They may be ostracised. They may lose their job. They may be denied accommodation or have to move out of their homes. They may meet obstacles in getting insurance or medical cover. Some have been abandoned by their families. Others have even faced physical violence which, in the notorious South African case of Gugu Dlamini, eventuated in murder.

Theology must throw its weight behind every move to put an end to such stigma and discrimination. It must arm its pastors and congregations to accept in practical terms that “my friend with AIDS is still my friend.” It must also recognize that its work to overcome stigma and discrimination can be as significant in the struggle against HIV/AIDS as the work of prevention or of care for those infected with the disease.

### **Sexual Ethics**

Issues of sexuality have bedevilled many of the attempts to deal with the crisis of HIV transmission. Many programmes, some of them with considerable international support, are based on the premiss that the answer to HIV transmission is change of behaviour, by which they mean change in sexual practices. Programmes tend to move rapidly from this premiss to focus on the knowledge, attitudes and skills involved in immediate sexual practice. They deal very quickly with prevention messages relating to abstinence, condom use, delaying sexual debut, reducing the number of sexual partners, remaining faithful to one partner in marriage. In doing so, they frequently encounter opposition—from some churches and traditionalists if they promote condom use, from the advocates of condoms if they emphasize abstinence and fidelity in marriage as the only routes to preventing transmission of the virus. In the final analysis, both approaches may find that the desired practices may be maintained as long as the programmes last, but do not persist when the programmes end.

What seems to be happening is that the programmes do not always begin at the proper beginning, that is, in an understanding of sexuality and relationships. It is this understanding that theology should help to develop, bringing it out strongly that sexuality is a beautiful, good, extremely powerful energy, experienced in every cell of our being as a mighty urge to overcome our incompleteness and to find fulfilment in a strong and abiding relationship with another. Having sex, or genitality, is a very important aspect of this larger reality of sexuality, but it is no more than an aspect. It does not exhaust the full notion of sexuality which can work powerfully and constructively even in the absence of the particularised, physical, short-lived bodily encounter with another that constitutes 'having sex'.

But theology has been slow about affirming the goodness of the human body and sexuality (Kelly, 1998, pp. 158 ff.). It has tended to look upon them with suspicion and to give only grudging approval to deriving immense pleasure and gratification from the act of sexual intercourse. It has rarely said unequivocally that sex is enjoyable and good—so good that like everything else that is precious it needs protection and safeguards, in this case the protection of an affirmative, supportive, abiding, respectful relationship of equality between the sexual partners, and the appropriate sexual safeguards, whether these be of no sex, deferred sex, or protected sex.

HIV/AIDS is challenging theology to reflect more on these matters and to share its reflections with people. Does the teaching that comes from our churches, our theological institutions, our universities, nourish them in this area so that they are simultaneously empowered to enjoy sex, abide by all that is best in the traditions, and at the same time stem the transmission of HIV? Or are they left to grope around without the supportive and understanding guidance that they need? The poet John Milton wrote, "The hungry sheep look up and are not fed." In today's HIV/AIDS circumstances, does theology feed the sheep or leave them to starve?

### **The Dignity of Women**

If every organ of society upheld in practical ways the full and equal dignity of women, many of the problems associated with HIV transmission would fade away. The sexual exploitation of women in their own marriage relationships would disappear. The exploitation of young unmarried women through the sugar daddy and similar phenomena would vanish. Casting the blame on sex workers for the spread of HIV would be a thing of the past. Girls would be safe on their way to school and would not be abused by their male colleagues or teachers. Married women would no longer be at such very high risk of HIV infection from husbands to whom they have remained loyal and faithful.

We have made progress along the road towards greater equality between the sexes, but we have not gone far enough and we have not gone quickly enough. The rapid heterosexual spread of HIV is proof of this. In many respects, HIV is a man's disease. It originated with men. It is spread by men. But it is women who must bear the burden. In our SADC countries, unlike in other parts of the world, it is women who carry most of the infections—55.1 percent at the beginning of this century (UNAIDS, 2000). It is young women who are two to seven times more likely to be HIV infected than young men of the same age.

Changing this situation needs the combined effort of all sectors of society. It also requires the underpinning of rigorous analysis coming from university departments, departments of philosophy and theology among them. Two areas in particular that such analysis must address are the patriarchal nature of our society which largely subordinates women to men, and the meaning of masculinity and femininity. It has not changed things that some women are in occupations previously held by men. Let us be frank and ask whether this has come about from recognition of the full and complete equality between women and men or from a yielding to the practical politics of the gender movement, but without any interior conversion of heart. Gender and religious studies departments need to work hand in hand together to bring about this new attitude. Without it, the situation of women will change only on the surface, and as a result control of HIV transmission will remain problematic and elusive.

Efforts must also be devoted to arriving at a better understanding of the true meaning of masculinity and femininity. Currently, being male is associated rather strongly with being aggressive, dominant, and 'macho', while being female is associated with being submissive, compliant, and yielding. Arising from these perceptions, double standards for sexual and other behaviour frequently prevail for men and women, for old and young. Lenient social, cultural and economic arrangements in society allow men a great deal of sexual licence, and many cultures encourage or even demand high-risk sexual behaviour from boys and young men. Society expects males to be knowledgeable about sexual matters, whereas it condemns females who show knowledge or interest in sexual issues as being immoral or promiscuous. Communication on sexual matters for boys and men may consist in little more than boastful accounts of 'conquests', whereas women and girls discuss issues more sensitively and intimately between themselves and within their families. For the greater part, virginity is highly prized in a girl, whereas in some cultures it is viewed with suspicion and concern in a boy.

The appropriate university departments need to place every one of these perceptions under the microscope of rigorous analysis and research, with a view to fostering a more comprehensive, personalist understanding of what it means to be male or female. The prevailing understanding gives rise to norms and expectations that place both men and women at high risk of HIV infection. There is need to replace the false sexually-macho image of masculinity with one that can find its expression and fulfilment in a more respecting and caring attitude for young women and girls. There is equal need to replace the timid, compliant image of femininity with one that provides space for independence, initiative, questioning, negotiation, and control. Nothing less will give adequate expression to the full and equal dignity of men and women.

## **Legal, Medical and Ethical Implications of HIV/AIDS**

### **Ethical Questions**

HIV/AIDS gives rise to a number of difficult ethical questions. As is so often the case with problems in ethics, most of these arise from the possibility of conflict between the rights of different parties. One of the most difficult AIDS-related questions faced

by lay-people and professionals alike relates to confidentiality. There are many dimensions to this:

- Do those who are about to marry have a right to know the HIV status of their prospective spouse?
- If one of couple engaged to be married has HIV, does a doctor, pastor or other third party who knows this have a right to inform the other party?
- Is it ever permissible for a doctor to reveal the HIV status of a patient to the patient's spouse?
- If in the course of a medical investigation, a doctor finds that a patient is HIV positive, is there an obligation to inform the patient about this or may the doctor remain silent?
- Is it ever legitimate to breach confidentiality about the HIV status of one individual in order to protect another individual from likely infection (cf. Gleeson and Leary, 2000)?
- Are there any circumstances when the wider public interest supersedes the individual right to privacy and confidentiality?

**Box 4: Legal, Ethical and Medical Challenges Arising from HIV/AIDS**

1. Balancing competing claims to rights and duties
2. Ensuring ethical probity in all vaccine trials
3. Attending simultaneously to the demands of prevention and treatment
4. Giving preferential access to ARV treatment

Other questions also arise:

- How should one advise a woman who has HIV but wants to have a child (cf. Faggioni, 2000)?
- What advice should be given when it is the husband who is HIV positive, while the wife is not?
- May a restaurant-owner move an HIV infected employee from work in the kitchen, say, to sweeping and cleaning?
- Should a nurse with HIV be transferred to non-nursing duties?
- In the interests of his own self-protection, may a doctor test a patient for HIV without first obtaining the patient's consent (which the patient may refuse)?
- Should there be a mandatory HIV test before marriage—as there was in the state of Illinois in the US in 1989 (Bacchus, 2000, p. 164)?
- More generally, is it lawful to make an HIV test a prerequisite for appointment to a certain post, admission to a certain career or training programme, or advancement within a certain career or profession? This question is as relevant for admission to the priestly life as for recruitment to the army.
- Can the law require that certain groups, such as commercial sex workers, prisoners, intravenous drug users, or men who are known to have sex with men be tested for HIV?

- Does (or should) the law offer any redress to one who has been infected with HIV by an identifiable other?

All of these are very difficult questions, certainly much too difficult and complex to be answered in the space of a conference presentation. Responding to them requires a host of qualifications, distinctions and nuances. Responding to them also requires a great sensitivity to how one understands the democratic process as it exists within a given country and as it is given expression within the constitutional and legal framework of that country. Many of them have not yet come before the courts and hence in the common-law jurisdictions that obtain in most SADC countries there is no tradition of usage or legal decision to give guidance.

With such a vacuum, what is needed is a careful application of human rights principles, guided wherever possible by decisions reached by the courts across the SADC countries. This surely places a considerable onus on university law, medical and humanities faculties to combine their best wisdom to understand the issues and to seek to arrive at answers that succeed in “walking the tightrope of competing claims to legal rights and duties” (Bacchus, 2000, p. 151).

But it is possible that traditional approaches may also contribute to resolving questions about confidentiality. A presentation to the 12<sup>th</sup> ICASA held in Ougadougou in December 2001 noted that traditional healers consider that the spirits may have caused a patient’s sickness, even the sickness of AIDS, and that this may be as a result of a bad spirit in a member of the family. Hence, the “family itself has to be part of the healing process and this means, of course, that they have to know the diagnosis” (Rogers, 2001, p. 1). A mini-survey, included as part of the presentation, showed that the families of those with AIDS believe that they have a right to know the HIV status of a family member so that they can help that person, and the majority believe that both the nuclear and extended family have this right.

### **Vaccine Trials**

Major ethical dilemmas also arise in relation to drug treatment for AIDS and vaccine trials. A recent message from the International AIDS Vaccine Initiative (IAVI) is that we should no longer think of an AIDS vaccine just as possible but confidently say that it is probable (Berkley, 2002). We have also learned that the first trials for HIV subtype C—the variant prevalent in southern Africa—could start as soon as regulatory approval is granted.<sup>4</sup> These are heartening developments, though it may still be several years before they eventuate in an affordable and universally applicable vaccine. Moreover, unless action is taken in the very near future to provide the human resources and physical infrastructure that will be needed for the production and administration of a vaccine to hundreds of millions of individuals, it will be several years after that again before an affordable vaccine becomes universally available.

Clinical evaluation of vaccines is a long process consisting in three main trial phases. The first two phases are conducted with volunteers at low risk of HIV infection in order to obtain information about safety, suitable doses, tolerance by different population sub-groups, etc. These are then followed by large-scale field trials to

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<sup>4</sup> Professor M. Makgoba, Chair, Medical Research Council, South Africa, quoted by Associated Press, 3<sup>rd</sup> June, 2002, in *CDC Prevention News Update*, 4<sup>th</sup> June 2002

assess the efficacy of the candidate vaccine for preventing infection or disease. Ethical dimensions relate to the information given to volunteers about the purpose of the trials, the treatment and the risks, the availability of medical and social follow-up throughout the period of treatment and subsequently, the extent of the information provided to those participating in the field trials, the untrammelled freedom of potential candidates to accept or decline participation in the field trials, the risks candidate vaccines might pose in the event of a pregnancy, and the need for complete certainty that at no stage will the candidate vaccine bring harm to the participant (and with provision for financial and medical cover should it happen that events prove otherwise). Notwithstanding the urgency of developing a vaccine for the virulent strain of HIV that is prevalent in SADC countries, the ethical standards governing trialling should never be compromised.

### **Ethical Questions Relating to Drug Therapy**

As to treatment of AIDS with antiretroviral drugs, we are already faced with major moral and ethical choices. A short time ago, an article in *The Lancet* suggesting that investment in prevention took preference over treatment sparked an international row. Yet the article did little more than reflect what the United Nations had agreed upon in June 2001, “prevention must be the mainstay of our response.” (UNGASS, 2001). As the AF-AIDS discussions have brought out, the mistake may be in polarizing prevention and treatment instead of seeing them as forming part of the same continuum, integrally related to one another.

Nevertheless, hard decisions have to be made when resources are scarce and money, infrastructure, testing facilities, other drugs, and medical backup are all insufficient to meet the needs. In such circumstances, should one choose to make drug treatment available to only certain members of the population? If so, to which ones? The ethical questions are first, how one justifies making any choice, and second, how one justifies a particular choice. When choices of this nature have to be made, we can drift perilously close to a form of social eugenics that would put a higher value on some human lives than on others. We are also close to a situation where power and wealth can determine whether one has access to the drugs and hence has the right to stay alive.

But there is one ethical choice here that seems relatively straightforward. It has to do with the fast-growing number of orphans. These are presenting humanity with a challenge of an intensity and on a scale never previously experienced. Thanks mostly to the dedicated, inspiring work of extended families and communities—personified above all in the matter-of-fact care and efforts of grandmothers, aunts, sisters, and other women members of communities—SADC countries have so far managed to cope with the magnitude of this problem. But it is not clear that they will be able to continue to do so as the problem grows in magnitude. The present prediction is that the number of children, aged 15 or below in SADC countries, who will be maternal or double orphans in the year 2010 will reach an estimated 8.6 million; that is, approximately ten percent of the children under the age of 15 will have lost both parents or their mother, mostly because of HIV/AIDS (Hunter and Williamson, 2000, Appendix 1).

It is humanly and morally intolerable that this should happen. We are watching the development of a situation which, like HIV/AIDS itself, is growing beyond our



control. Apart from the human suffering, trauma and grief that accompany this development, we are also seeing the emergence of a society where we will be overwhelmed by unanticipated educational, social, economic and security problems. But we still have it in our power to stem this tide, and we can do so by a resolute will on the part of society to keep mothers alive by ensuring access to antiretroviral treatment for all HIV positive mothers with young children who still stand in need of their care. Providing them with the appropriate treatment will allow them to live healthy lives so that they can raise their children in the nurturing environment of a mother's care. Thailand has already embarked on such a programme (Vannakit, 2002). The SADC countries should follow suit.

## **Taking Account of Culture**

It should cause us concern that the response to AIDS in the SADC countries tends to discount local cultures. Instead it is heavily embedded in the perspectives of western medicine and behavioural sciences. Two issues merit consideration, treatment through traditional healing approaches and prevention through approaches that embody cultural beliefs. The appropriate university departments should foster both.

### **Traditional Healing**

The pattern followed by many who are beginning to experience AIDS-related illnesses is to turn first to what western medicine can offer, and for many opportunistic infections and for tuberculosis it can offer much. But with the weakness and the illness persisting and often becoming worse, the individual or family may turn back to their roots and look to traditional healers for relief and a cure. Despite claims to the contrary, there is no evidence yet that traditional remedies can rid the body completely of HIV, thereby curing the condition. But there is considerable evidence that they can alleviate the symptoms and bring solace to an individual. This fund of knowledge has not been adequately capitalised on. It is not properly documented. Its applications are seldom monitored. Its effects have not been sufficiently evaluated. There is little effort at quality control and the setting of standards. There is insufficient attention to separating the genuine from the fake.

Bringing traditional healing approaches into the fold of accepted medical practice goes beyond the responsibility of medical schools. This is not just a matter of deciding whether or not the African Potato is effective against HIV/AIDS. Biochemistry and similar departments are challenged to analyse the treatments employed, so that their beneficial components may be accentuated even more and their toxic elements eliminated. Psychology, sociology, human behaviour and religious studies departments are challenged to understand the complex human interactions, motivations and psychological releases that are integral to the traditional healing process. Performing arts and education departments are challenged to incorporate elements of these processes into their programmes so that understanding of the potential of traditional healing approaches may be more widely disseminated.

The traditional healing approach also underlines that any sickness, including those related to AIDS, is not just a matter of a virus or microbe that affects a body system or even the entire body. In the traditional view, it is the person who is sick. The whole person is affected—and by extension, the person's family and community. The

approach is not so narrowly clinical as that of western medicine. The treatment is more holistic, extending beyond the physical condition to relationships. In a different context, Anne Bayley, one of the first doctors to become aware of HIV/AIDS in Zambia, has written that “AIDS is helping to restore a human face to Western medical care” (Bayley, 1996, p. 71). Traditional healing approaches also serve to stress the human dimension of treatment and thereby can be effective in a way that surpasses the bio-medical composition of the actual medications they employ.

### **Traditional Beliefs and What Causes AIDS**

Secondly, although there has been a great investment of resources in developing the HIV/AIDS and sexuality curriculum in schools, there has been less concern about incorporating approaches that take account of traditional and cultural beliefs. The result is that students hear messages at two levels. First there is the level of the educational programme itself, with its scientific messages about the physiological cause of HIV/AIDS and how it is transmitted. Much deeper and more influential is what is heard at the traditional level, where the disease and its causes are seen in terms of the cultural world of taboos, obligations, and sorcery. Sickness and disease are almost invariably considered to have external causes other than the viruses, germs and microbes identified by medical science. Very often, the external cause is thought to be an ill-willed, malevolent human agent who uses the powers and forces that are at the disposal of a sorcerer. The external cause can also lie with ancestral spirits who are offended by the violation of certain taboos or failure to observe certain rituals.

This deep-rooted view that sorcery and witchcraft are the root causes of HIV/AIDS manifests itself not just in rural people, but also in those from urban and well-to-do settings. The educated are no strangers to it. Neither are those who adhere to the major world religious traditions. Individuals from all classes and categories seek to discover the source of the ill-will that brought them their sickness, in the belief that once this cause has been identified appropriate remedial action can be taken.

No educational programme is known in SADC countries that takes sorcery/witchcraft seriously and uses this world-view in strengthening its participants to protect themselves against HIV infection. No attempt appears to have been made to incorporate this world-view and then move forward from it towards developing an understanding that HIV/AIDS is due not so much to the ill will of an external witch but rather to the witchcraft that is within each one:

For in African belief, all persons, inasmuch as they have propensity to wrongdoing are potentially witches. The human task, which is unending, is for every person to control this propensity or inclination to fundamental waywardness as much as possible so that no harm is done to oneself or to other persons (Magesa, 2000, p. 82).

With its concentration of knowledge, understanding and insights, a university should be able to change this situation. The struggle to prevent HIV transmission may never be won through the cold logical causal explanations of modern science alone. The assumption that the social world can be altered by seemingly logical argument—the belief that change can be achieved by what George Bernard Shaw calls ‘brute sanity’—needs to be questioned (Fullan, 1991, p. 96). What is necessary is to harmonize the factual analytic explanations of science with the vital holistic perspectives of cultural interpretations. Instead of being presented with competing and contradictory forms of discourse on how to avoid HIV infection (Yamba, 1997),

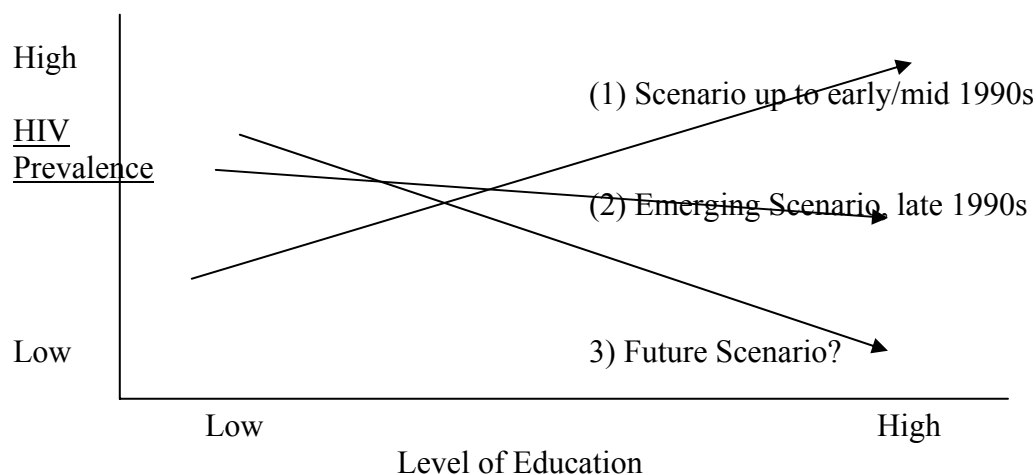
people need to encounter a balanced set of compatible messages that compel action because rooted in both the scientific and cultural traditions. This is one of the most monumental tasks that HIV/AIDS poses for universities in Africa, especially those here in the SADC region.

## The Changing Socio-Economic Profile of HIV/AIDS

At the beginning of this paper we noted that AIDS is not a disease of poor countries or of poor people. It affects rich and poor alike. In the first ten to fifteen years of the epidemic, when there was limited understanding about the dynamics of transmission, HIV/AIDS first affected those with more education, more wealth and greater mobility. Because of the long latency period between initial HIV infection and progression to clinical AIDS, numerous cases of sickness and death still occur among those who are better educated and better off. But evidence is emerging that the social profile of the pandemic is changing and that increasingly HIV infection is becoming more concentrated among those with less education (Vandemoortele and Delamonica, 2000).

Thus, studies in Zambia have found a substantial decline in prevalence rates among 15–19 year-old girls with higher levels of education, but signs of continued increase in prevalence among the least educated—an out-of-school girl was three times more likely to be HIV infected than an age-mate who was still attending school (Fylkesnes *et al.*, 2001). Something similar was found in Zimbabwe where a large population survey showed that those attending school had much lower prevalence rates than those who were not in school (Gregson, Waddell & Chandiwana, 2001<sup>5</sup>).

**Figure 1: The Changing Relationship between HIV Prevalence and Level of Education<sup>6</sup>**



<sup>5</sup> Referred to in Bennell, Hyde & Swainson, 2002, p. 21.

<sup>6</sup> Figure 1 originates from a presentation made by Professor K. Fylkesnes, University of Bergen, to the XIIIth International AIDS Conference, Durban, July 2000.

The change that we are beginning to perceive in the relationship between level of education and HIV prevalence is reflected schematically in the three scenarios presented in Figure 1. The first represents the positive association between level of education and HIV prevalence that was observed up to the early 1990s. The second shows how this trend has changed in recent years. The third suggests what the relationship might be like in the future, if change continues along its present course.

For university educators, this situation, which is still developing, has two implications. The first is that a university must throw its full weight and expertise behind efforts to ensure that every child can have access to education. Given that there is no cure for HIV infection, that it will be another decade before a vaccine becomes universally available, and that large-scale treatment with antiretroviral drugs is beset with a wide range of serious difficulties, education is the only mechanism available to society for combating HIV/AIDS on a large scale. Our responsibility is to ensure that every child can access education, that the education provided is of good quality, and that children can remain in school for as many years as possible (cf. World Bank, 2002). A university can support this drive by being a strong advocate for more and better education for children, especially girls. But it must also take the practical steps of helping to make this a reality, through its support for teacher education and curriculum development programmes.

The second implication of the changing socio-economic profile of HIV/AIDS is that AIDS will increasingly become a disease of the poor. Already marginalized by their poverty, the poor seem destined to become even more marginalized through HIV/AIDS. A university must do what it can to prevent this. The Association of Commonwealth Universities has reminded us that “In a world that depends increasingly on universities for its knowledge, health and prosperity, (universities are) required to become engines of development for people, institutions (including government) and for democracy in general” (ACU, 2001, p. 1). Being an engine of development in a society severely affected by HIV/AIDS compels a university to re-evaluate its role so that it becomes a leader in the three-pronged struggle against HIV/AIDS, poverty and female disempowerment.

In each of these areas a university can

- Engage with communities in a common identification of problems and a common search for a solution to those problems
- Share facilities, energies, expertise with the wider community of which it is part
- Make itself available as a reservoir of resources for participation in local and community initiatives
- Re-design degree and diploma programmes to incorporate real life community-based projects as an integral, credit-bearing component
- Provide the incentives of space, time, recognition, and advancement to staff who add community and civic action against HIV/AIDS, poverty and female disempowerment to their teaching and research responsibilities
- Be an unfailing advocate for sustained and concerted action along all three fronts
- Show that it cares about HIV/AIDS in society and in its own ranks and that it will never rest until it has succeeded in defeating the epidemic—out there in society, in here in the university.

## Leading a Comprehensive University Response

The investigations conducted in Africa are unanimous in reporting that committed leadership at a sufficiently high level is the most critical factor for driving a strong university response to HIV/AIDS. Given the right leadership it is possible to inspire key stakeholders, mobilize resources, establish policies, establish management structures. Above all, active and dynamic leadership can bring it about that until the disease has been overcome, responding creatively and proactively to HIV/AIDS will stand at the heart of a university's business.

In turning their universities round to become leading institutions in the combat with HIV/AIDS, university executives and senior managers will have to be courageous: even at university level, HIV/AIDS continues to thrive in an atmosphere of secrecy, denial, stigma and discrimination, all of which will contribute to resistance and misunderstanding. Given that the impacts of HIV/AIDS frequently tend to be complex and surprising, the senior management will have to be innovative and resourceful. In addition, their leadership and commitment will have to be sustained, since the impacts of the disease are likely to be long-term.

If this leadership is present, the university can hope to accomplish much. It will indeed become an engine of development for people and institutions. Even more, it will become a beacon of light in an AIDS-affected society, and a focus of hope that society will emerge victorious in the struggle with HIV/AIDS.

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