

**Directory of African
Higher Education Institutions
Responding to the Threat of HIV/AIDS**

Working Group on Higher Education (WHGE)

Accra, Ghana

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Preface

The HIV/AIDS pandemic has hit Africa particularly hard. During 2000, about 80 percent of the global total of AIDS deaths and almost 72 percent of the new HIV infections occurred in Africa. The effects of HIV/AIDS on social and economic development and welfare are considerable. These include, among others, reduction in household productivity and income, increase in health costs, increase in AIDS-related mortality, decline in life expectancy and a decrease in rate of population growth, increase in the number of orphans and dependents, a deepening of poverty, and a reduction in the number of persons to be educated.

The HIV/AIDS pandemic is also compounding the challenges facing African higher education institutions (HEIs), which have been struggling hard to emerge from the debilitating impact of massification and scarcity of resources to cope with the challenges. The close interaction among the campus community, as well as the norms and practices pertaining to social and sexual life on the campuses make these institutions particularly vulnerable to HIV/AIDS. Its devastating effects on HEIs include the death of teachers, students and administrators; an increase on the workload of replacements; frequent teacher absenteeism and intermittent student attendance due to illness or for caring for affected family members; low teacher and student morale; a rise in institutional expenditure (due to missed classes, lost investment in staff and students, high health service costs); a decline in quality of education; and a fall in the number of graduating students.

In view of adverse impact, ADEA's Working Group on Higher Education (WGHE) has taken up HIV/AIDS as one of its major intervention areas. As part of its capacity building programme, the WGHE has provided support to higher education institutions to develop AIDS-related institutional policies, organised training programs to enhance HIV/AIDS awareness, and facilitated experience and information-sharing among the higher education community. In collaboration with its partners in 2003, it also commissioned studies on the responses of African universities, teacher training colleges and polytechnics to the threat of HIV/AIDS in Africa. These parallel surveys covered a total of 338 African tertiary institutions, both public and private.

The reports synthesising the findings and recommendations of the surveys are published in a separate volume under the title, "***African Tertiary Education Institutions Responding to the Threat of HIV/AIDS***". This *Directory* presents profiles of the institutions surveyed and details of their individual responses. The WGHE hopes that these two companion volumes will serve to enhance experience-sharing among the institutions, and provide pertinent information to partners interested in building the capacity of the HEIs.

Acknowledgements

The Working Group on Higher Education (WGHE) of the Association for the Development of Education in Africa (ADEA) gratefully acknowledges the continues financial from its member agencies, which enabled the Group, as part of its Work Program Activities, to conduct the survey of the Response of Higher Education Institutions in Africa to HIV/AIDS and the resultant Directory.

The WGHE is extremely grateful to the institutional leaders: Vice chancellors, Rectors, Principals and institutional HIV/AIDS Coordinators and Focal persons for their cooperation with the Consultants.

WGHE would like, in particular, to thanks Dr Taye Assefa for editing the reports for publication.

PREFACE

The HIV/AIDS pandemic has hit Africa particularly hard. During 2000, about 80 percent of the global total of AIDS deaths and almost 72 percent of the new HIV infections occurred in Africa. The effects of HIV/AIDS on social and economic development and welfare are considerable. These include, among others, reduction in household productivity and income, increase in health costs, increase in AIDS-related mortality, decline in life expectancy and a decrease in rate of population growth, increase in the number of orphans and dependents, a deepening of poverty, and a reduction in the number of persons to be educated.

The HIV / AIDS pandemic is also compounding the challenges facing African higher education institutions (HEIs), which have been struggling hard to emerge from the debilitating impact of massification and scarcity of resources to cope with the challenges. The close interaction among the campus community, as well as the norms and practices pertaining to social and sexual life on the campuses make these institutions particularly vulnerable to HIV/AIDS. Its devastating effects on HEIs include the death of teachers, students and administrators; an increase on the workload of replacements; frequent teacher absenteeism and intermittent student attendance due to illness or for caring for affected family members; low teacher and student morale; a rise in institutional expenditure (due to missed classes, lost investment in staff and students, high health service costs); a decline in quality of education; and a fall in the number of graduating students..

Considering the gravity of the HIV / AIDS situation on the continent and the implications for tertiary education systems, the ADEA-WGHE, in its 2003-5 Strategic Plan made a conscious decision to maintain priority focus on HIV / AIDS. In doing so, to build on past and existing strategies of analysis, research, advocacy and capacity-building through small-scale pilot initiatives. WGHE has provided support to higher education institutions (Universities, Polytechnics and Colleges of Education) to develop institutional HIV / AIDS policies, organise training programs to enhance HIV / AIDS awareness, and facilitated experience and information-sharing.

During the period 2003-5, WGHE collaborated with partners to commission the Survey of the Responses of Higher Education Institutions in Africa to HIV/AIDS, covering a total of 338 public and private institutions. The report, which synthesises the findings and recommendations of the surveys is published in a separate volume under the title, "*Higher Education Institutions in Africa Responding to HIV/AIDS*".

This *Directory* presents the profiles of the institutions surveyed, with details of their individual institutional responses. The WGHE hopes that the two companion volumes will serve to enhance experience-sharing among the institutions, and provide pertinent information to partners interested in building the capacity of HEIs in Africa to address the challenges posed by the HIV / AIDS pandemic.

ACKNOWLEDGMENTS

The Working Group on Higher Education (WGHE) of the Association for the Development of Education in Africa (ADEA) gratefully acknowledges the continued financial support from its member agencies, which enabled the Group, as part of its Work Program Activities, to conduct the survey of the *Response of Higher Education Institutions in Africa to HIV/AIDS* and the resultant Directory

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Response of Universities and Colleges to HIV/AIDS

Barnabas Otaala, Emmanuel Lutaaya, and Maurice Ocquaye

1. BACKGROUND AND INTRODUCTION

1.1 *The HIV/AIDS Situation Globally and in Sub-Saharan Africa*

The first news of a sudden rise of infections among young gay men appeared in 1981, stemmed from the reports of the US Centre for Disease Control. Out of this grew the awareness of a new syndrome and the beginning of the history of a disease that has taken hold of the public imagination like no other disease. Two years after the “gay plague”, as it was then known, it was becoming clear that this disease was not limited to gay men, and was spreading fast. By 1986 it was apparent that the infection spread mainly through sex and could target anyone. Today, the epidemic is affecting heterosexual men, women and children alike who are dying in their thousands around the world.

Box 1. Global HIV/AIDS situation

- Since its first documented appearance 20 years ago, HIV has infected over 60 million people worldwide;
- An estimated 42 million people are currently living with HIV
- About one-third of those currently living with HIV are aged 15 – 24
- Diverse epidemics in terms of scale and maturity
- General trend is still one of rising epidemics instead of stabilizing ones within the countries of the region

(Source: AIDS Epidemic Update: UNAIDS/WHO, December 2001)

Clearly, HIV/AIDS is one of the biggest threats to the achievement of the Millennium Development Goals agreed by all UN member states in September 2000. See for Millennium Development Goals (2001); EFA Goals (2000); and UGASS Declaration of Commitment on HIV/AIDS (2001).

Sub-Saharan Africa remains the region most severely affected by HIV/AIDS. For a continent representing one tenth of the world's population, nine out of ten HIV positive cases originate from Africa (FAO Focus 2000). More than 13 million children under the age of 15 have been orphaned by HIV/AIDS, and this number is projected to double by 2010.

Box 2. HIV/AIDS situation in Sub-Saharan Africa

- 3.5 million new infections in 2002
- 29.4 million people living with HIV/AIDS in the region
- 2.4 million Africans died of AIDS in 2002
- Southern Africa has prevalence rates exceeding 30% among pregnant women
- At least 10% of those aged 15-49 infected with HIV live in 16 African countries
- At least 20% of those aged 15-49 infected with HIV live in 7 southern African countries
- Sub-Saharan Africa has 70% (28.5 million) of the world's population with HIV and AIDS

(Sources: *AIDS Epidemic Update: UNAIDS/WHO, December 2002*; *Report on the global HIV/AIDS epidemic: UNAIDS, July 2002*)

Africa has 21 countries with the highest prevalence of HIV in the world, while in at least 10 countries, prevalence rates among adults exceed 10 percent. At the individual level, 44 percent of pregnant urban women in Botswana were HIV+ in 2001; 1 in 4 adults in Zimbabwe and Botswana carries the virus, and of the 13 million AIDS orphans worldwide, 10 million of them are in Sub-Saharan Africa (*Africa Today*, Vol. 9, No. 5, May 2003, p. 19).

Box 3. Estimated number of people living with HIV/AIDS, end of 2001

• Angola	350,000
• Lesotho	360,000
• Namibia	230,000
• Swaziland	170,000
• South Africa	5,000,000

Box 4. Countries with highest prevalence rates among adult population (15-49 years)

• Botswana	33.8%
• Lesotho	31.0%
• Namibia	22.0%
• South Africa	20.1%
• Swaziland	33.4%
• Zambia	21.5%
• Zimbabwe	21.5%

Box 5. Estimated AIDS-related deaths in 2001

• Angola	24,000
• Lesotho	25,000
• Namibia	13,000
• Swaziland	12,000
• South Africa	36,000

Madavo emphasizes this tragic situation differently. He states: "Let us not get caught up only in numbers – HIV infection rates, HIV prevalence rates, and mortality rates. Behind these numbers there is flesh and blood. Behind these numbers there are husbands, wives, parents, children, farmers, teachers, doctors. It's the wellspring of African knowledge and wisdom being drained before our eyes." (2001, 1) According to a West African proverb, "Every time an elder dies, it's as if a library has burned down...." As President Mwai Kibaki of Kenya put it very poignantly at the recent 13th International Conference on AIDS and Sexually-transmitted Infections in Africa (ICASA) held in Nairobi (2002): "As we continue to talk about the HIV/AIDS pandemic, the disease strikes our people every minute. It takes away our children -- our future. It leaves beds cold, as loved ones depart by day and night. It leaves villages in wailing, as another breadwinner is plucked from society, increasing the numbers of orphaned children".

It is thus clear that HIV/AIDS is one of the major challenges our world has faced. Indeed, two decades after AIDS has become globally recognized, its consequences are only beginning to be felt, while its precise nature and its impact on the fabric of our societies is yet to be fully determined.

1.2 Impact of HIV/AIDS on Development

The disease is causing economic crises, and continues to wreck havoc and undermine development in the region. The scope of its impact is wide, and includes the following:

Destruction of social capital

- Undermines knowledge base of society
- Weakens production sectors: agriculture, industry

Weakening of institutions and services

- Governance, civil service, judiciary, armed forces, education, health
- Inhibition of private sector growth

Wider, deeper poverty

- Reduced savings, profit, production, food security
- In 1998, UNDP estimated that the Human Development Index (HDI) of South Africa would be 15% lower due to AIDS in 2010 and in the hardest hit countries, per capita GDP may drop by 8% by 2010
- Leads to urban migration
- Stigma and discrimination cause lack of access to accurate information
- Lack of sexual and reproductive health services
- Gender inequality
- Overwhelms social support systems
- Orphans
 - risk of a lost generation
 - little or no education
 - poor socialization
 - social upheaval of economic underclass
 - Rising HIV infection rates trigger more adult AIDS deaths and a rapidly growing orphan population.
 - In the most affected countries, families and communities are not coping – desperation, vulnerability and disparity are increasing.
- The disease strikes hardest not only at the young, the weak, or the eldest, but devastates the ranks of the most productive members of society.

- The disease has a long incubation period of 5-8 years, which makes it to easy spread by those infected before they are suspected to have contracted it.
- The spread of the disease through sexual intercourse embeds it on the most endeared human activity. In some places where HIV/AIDS campaign has been waged, societies have used the phrase “umbuntu”, which is sometimes interpreted as: “we will just die together since it is difficult to change our sexual patterns.” Indeed, some psychologists maintain that sexual drive is the most dominant human instinct. This makes it difficult to reduce the infection rate.
- The burden of HIV/AIDS is not shared equally among the countries of the world, as its prevalence is highest in the poorest countries which lack the means to control the disease and the research capacity to find solutions.

Box 6. Magnitude of orphans

1. 13.4 million children under the age of 15 years lost a mother or father or both to AIDS, mostly in Sub-Saharan Africa (UNAIDS, UNICEF, USAID 2002). By 2010, an estimated 106 million children in 88 countries (Sub-Saharan Africa, Asia, Latin America and the Caribbean) are projected to lose one or both parents with 25 million of this group orphaned due to HIV/AIDS (UNAIDS, UNICEF, USAID 2002).
2. With few exceptions, the number of children being orphaned in the countries currently hardest hit by AIDS will accelerate through at least 2010 (USAID 2000).
3. United Nations' statistics show that 35 countries have experienced a doubling, tripling, or quadrupling (as in Botswana) of the number of orphans between 1994 and 1997 (UNAIDS 2000).
4. In 2000, 3.8 million people in Africa contracted the virus (World Bank 2001). The U.S. Census Bureau projects a total population loss of 118.9 million people in 24 heavily infected Sub-Saharan African countries by 2015. In at least 7 Sub-Saharan nations, infection levels in the general population are 20% or higher: 1 in 3 adults in Botswana; 1 in 4 adults in Zimbabwe and Swaziland; 1 in 5 adults in South Africa, Lesotho, Namibia, and Zambia. Most of those infected are of reproductive age, likely to live on average 10 years; all their children will become orphans. In Africa, only Uganda and Senegal seem to have curbed their growing epidemics (USAID 2000).
5. In at least 8 countries of Sub-Saharan Africa, between 1 in 5 and 1 in 3 children under 15 have lost one or more parents. In Brazil, 10,400 children have already been orphaned as of 1998, and during that year about 137,000 more children had mothers living with HIV.
6. 34 million African children are orphans (12% of all African children), of which 11 million are due to AIDS. By 2010 this population will be over 42 million, half of which will have been orphaned by AIDS.
7. 70% of Africa's orphans are living in 12 countries most severely affected by HIV/AIDS. By 2010 orphans will account for 15-25% of all children in 12 African countries.
8. Orphaned children are more likely to die or be malnourished, to suffer psycho-social problems, to drop out of school, to be abused and exploited, and are more vulnerable to HIV infection than other children.

Research has shown that young girls in Sub-Saharan Africa have up to six times HIV infection rate than boys of their age because of cross-generation sexual relations between girls and older male partners. In response to this tragic situation a number of governments around the world have adopted strategies to mitigate the impact of the disease.

In Uganda for instance, in 1987, a multi-sectoral, multi-disciplinary approach was initiated to address the socio-cultural and economic impacts of the epidemic. Uganda's HIV/AIDS Control Program integrates all sectors of society and has emphasized the involvement of people living with AIDS. Within Sub-Saharan Africa, Uganda is a model for the successful reduction of rates of HIV prevalence and President Museveni had demonstrated, by example, the importance of strong, consistent, high-level leadership in the fight against HIV/AIDS.

In Cambodia, strong leadership at all levels and effective community-based prevention programs have been key to controlling the epidemic. Thailand, where condom use has increased significantly, and Senegal have also been models of good practice in HIV/AIDS prevention for some time. Progress can be made, but there is an urgent need for other countries to learn from these successes. Despite these encouraging pockets of success it is clear that the global response to the epidemic has so far been inadequate. There is need for a much more intensive effort which goes beyond the health sector. Countries across the region are expanding and upgrading their responses. These responses entail: political commitment, a multi-sectoral approach, and institutional arrangements.

High prevalence rates mean that even exceptional success on the prevention front will only gradually reduce the human toll. Nevertheless, in some of the most heavily affected countries there is growing evidence that prevention efforts are bearing fruit. Progress has also been made on the treatment and care front. For instance, as a result of public-private partnership between five research and pharmaceutical companies and five United Nations agencies, there is now increasing access to antiretroviral therapy in Africa. Accordingly, as of the end of 2001, more than 10 African countries were able to provide antiretroviral therapy to people living with HIV/AIDS.

There is compelling evidence that if all sectors of society and individuals join forces to form a unified and effective response to the HIV/AIDS epidemic, success can indeed be achieved. However,

massive efforts from the world at large are needed to bring treatment and care to the millions of Africans in need, and to cushion the epidemic's impact

1.3 Review of Higher Education Responses to HIV/AIDS

1.3.1 AAI/AAU Sponsored Online Discussions

In March 2003, the Africa-America Institute (AAI), in partnership with the Association of African Universities (AAU), conducted an online discussion as part of the AAU's Conference of Rectors, Vice-Chancellors and Presidents (COREVIP) to elicit ideas on the role and response of African universities to HIV/AIDS. The participants numbering 54 included AAI alumni and persons who have lived or worked in Africa. Among the key questions discussed were:

- a) How do universities perceive their role and contribution to the fight against HIV/AIDS?
- b) What are the institutions currently doing in order to contribute to the fight against HIV/AIDS?
- c) How are they addressing the gender dimension of the epidemic as they formulate institutional strategies?
- d) What measures are the institutions taking to replenish or replace professionals who are succumbing to the disease? How are they coping?
- e) What are the constraints institutions face in mounting programs to combat the impact of HIV/AIDS?
- f) How can they be assisted to do more and by whom?

From the discussion it was apparent that a number of universities, mostly in Namibia, Nigeria, South Africa, Tanzania and Uganda, have institutional HIV/AIDS policies in place. A number of other institutions have initiated peer education, awareness campaigns, and condom distribution. While these are aimed at prevention of further infection, sadly, most interventions do not seem to be achieving the desired impact of behaviour change. Participants suggested that institutions could do more by providing treatment for staff and students; creating support groups; and enforcing policy. It was generally agreed that despite these efforts, a lot more was needed from the universities to address HIV/AIDS not only within their institutions, but also in their

countries. Several of the participants also expressed concern that many more institutions of higher learning were yet to begin making serious efforts to address the challenges posed by HIV/AIDS. Some of these are still in denial, others are lukewarm and do not consider HIV/AIDS a workplace issue.

The participants identified the following as constraints facing their institutions in efforts to respond to the threat of HIV/AIDS:

- lack of funding support;
- lack of skilled human resources;
- resistance among academics to accept the pervasiveness of the epidemic;
- stigma and discrimination;
- lack of leadership and commitment from senior university staff.

Participants put forward a number of suggestions on how tertiary institutions should address HIV/AIDS. These include:

- a) In view of limited resources, tertiary institutions should embark on fewer but more tightly focused programs to educate staff and students as well as provide support to those affected by HIV/AIDS.
- b) Mainstream HIV/AIDS into the curriculum and institutional activities.
- c) Determine the prevalence and incidence rates among staff and students as a basis for mounting an effective response.
- d) Senior staff should provide leadership in the fight against HIV/AIDS.
- e) Network with other institutions so as to share experiences on best practices. Multi-discipline and multi-sectoral approaches involving government, NGOs and donors should be encouraged.

1.3.2 Issues Raised on HIV/AIDS in Tertiary Institutions at COREVIP

At the 2003 COREVIP, although several heads of institutions acknowledged that HIV/AIDS was a major threat facing the education sector in Africa, prevalence among staff and students is not well documented. At the same time there are increasing reports of systems

whose operations are affected by absenteeism and deaths. Staff absenteeism occurs with increasing frequency because of periodic bouts of illness during the HIV stage of the disease; these absences become more prolonged and eventually permanent when the disease has progressed to full-blown AIDS. There is also absenteeism among students, but this may be less marked. Staff and student absenteeism also arises from attending the funerals of fellow staff members, students, members of one's family, and members of one's community.

The extensive absenteeism and loss of human resources which results from HIV/AIDS is hampering higher education institutions in achieving their educational, research and social goals. The institutions are finding it difficult to respond to society's needs for highly skilled and qualified personnel.

The following highlights from earlier studies demonstrate the scale of the challenge from HIV/AIDS:

- The University of Nairobi believes that an average of two members of the university community die from AIDS each week (Kelly 2001);
- The AIDS death rate for staff at the University of Zambia is higher than the national rate, and more than half of those who have died at this university in the past decade have been in the age-range 20-34, the age-range in which AIDS deaths occur very frequently (Kelly 2001);
- In the period 1994-2000, 18 academic and 72 non-academic staff died at the relatively small Copperbelt University in Zambia (Lungu, Beele & Mulenga 2001);
- One in every six students drops out of the University of Western Cape each year for financial or personal reasons which are very likely HIV-related (Kelly 2001);
- 30 percent of the nurses graduating from the University of Natal are dying within three years of completing their study program (Jones 2001);
- Estimates for South Africa are that by 2005 more than 30 percent of undergraduate students in the 25 public universities and more than 35 percent of those in the technikons or polytechnics will be infected with HIV (Kingham 2000).

Against this background of actual and potential loss, and in the light of other considerations that have been extensively surveyed elsewhere (Chetty 2000; Kelly 2001), higher education institutions have two major responsibilities in relation to HIV/AIDS. On the one hand, they must protect themselves so that they can operate efficiently and effectively in an environment where unchecked HIV/AIDS threatens to disrupt the human capital formation process, and on the other hand they must gear themselves to respond more dynamically to the needs of an HIV/AIDS-infected society. The first, self-protection, is crucial, because unless they protect themselves the institutions will never be able to serve the training, research and knowledge needs of society. When traveling by air, we are accustomed to hearing the message that in the event of a loss of air pressure we should put on our own oxygen masks before attending to the needs of others. In the context of rampant HIV/AIDS, every institution must affix its own oxygen mask first before trying to save others.

Concerned with the gravity of the HIV/AIDS situation in Africa and its implications for tertiary education, the Working Group on Higher Education (WGHE) of the Association for the Development of Education in Africa (ADEA) commissioned a survey of HIV/AIDS activities and contributions by African tertiary institutions in the second quarter of 2003. (See Annex 1 for the list of institutions surveyed.)

2. METHODOLOGY

2.1 Aims and Objective of the Study

The study aimed to gather and share information on on-going higher education initiatives and contributions to the fight against HIV/AIDS. It also assessed the challenges faced by higher education institutions in maximizing their role and contributions. The survey results are meant to raise awareness about the challenges of tertiary institutions in responding to HIV/AIDS, to facilitate experience sharing and enhance institutional cooperation, to mobilise support for tertiary education institutions in their efforts to address the challenges and threats posed by HIV/AIDS to the individuals, the institutions and the systems.

2.2 Study Instruments

A questionnaire in English was designed, translated into French and Portuguese to ensure regional and linguistic coverage and distributed to the tertiary institutions. The questionnaire focused on:

- Basic facts about the institution;
- Existence of HIV/AIDS Policy and/or guidelines;
- Implementation, monitoring and evaluation of HIV/AIDS Policy;
- Personal assessment of strengths and weaknesses of institutional responses to HIV/AIDS;

The first batch of the questionnaires was distributed in July 2003. The consultant also took advantage of two conferences (in Accra, September 2003 and Cape Town, October 2003) to distribute a second batch of the questionnaires and hold individual interviews with heads of institutions present at these meetings. A total of 128 tertiary institutions responded to the survey among the institutions that received the questionnaire (See Annex 1).

2.3 Profile of the institutions surveyed

Most of the institutions that responded were those that are public institutions and universities. The responses were predominantly from the English speaking countries.

Table 1. Profile of institutions

Category	Total	Percentage
<u>Ownership</u>		
• Public	91	81.3
• Private	21	18.7
<u>Type</u>		
• University	83	72.2
• Other*	32	27.8
<u>Language</u>		
• English	114	89.1
• French	11	8.6
• Portuguese	3	2.3

*Other includes other institutions of higher learning (polytechnics, colleges of education, institutes, etc.)

3. RESULTS OF THE SURVEY

3.1 Impact of HIV/AIDS

As Table 2 shows, a significant number of institutions admitted having been affected by HIV/AIDS. The most obvious way in which institutions have been affected by HIV/AIDS is through increased deaths (80.6%, n = 36). Other ways in which institutions have been affected include absenteeism, intermittent attendance of affected students, high turnover rates, loss of skilled personnel, increased expenditure (health care, funerals, recruitment of part-time lecturers), over-stretching of medical services, reduced productivity, stigmatization of the infected, lowered morale, inability of students to pay tuition and other fees, poor student performance and uncertainties in human resource planning and development.

HIV and AIDS affect both teachers and learners equally. Staff members may be sick or have to attend to a sick family member. Irregular attendance of students has led to reduction in academic performance. Apart from physical pain, there is a psychological dimension of HIV/AIDS: the depression, stress and anxiety. Not only do depression, stress and chronic anxiety among affected staff and students impact on their performance, but on their social interaction as well.

Some patterns are emerging especially in countries with advanced epidemics. Universities are seeing increasing number of student orphans; an increasing number of HIV positive patients are presenting themselves in teaching hospitals; an increase in uptake at institutional clinics for treatment of opportunistic infections; an increase in counseling workload; and there is a noticeable increase in student drop-out rates. This has serious implications for university planning with regard to student needs, capacity, facilities and operation of bursary schemes.

Although most of the impacts are negative, a few respondents stated some positive developments. For instance, a respondent from Muhimbili University College of Health Sciences in Dar Es Salaam, Tanzania, stated that there has been an increase in research activities.

3.2 HIV/AIDS Policy

Table 2 presents the results on issues pertaining to policy on HIV/AIDS in the institutions of higher learning in Sub-Saharan Africa. Of the institutions surveyed, 38.8% reported having been significantly affected by HIV/AIDS. Surprisingly, only 36.1% of the institutions have a written HIV/AIDS policy; what's encouraging, however, is that of those with no written policy, 60% (n = 70) are developing a draft HIV/AIDS policy. For those institutions where there is no written HIV/AIDS policy, 55.9% (n = 59) have guidelines or code of conduct or ethics that guide them on HIV/AIDS activities.

Table 2. Institutional HIV/AIDS policy

<i>Attribute</i>	<i>Yes</i>	<i>No</i>	<i>Total</i>	<i>Yes (%)</i>
HIV/AIDS has had a significant impact	40	63	103	38.8
Written HIV/AIDS policy exists	39	69	108	36.1
Draft HIV/AIDS policy is being developed	42	28	70	60
Guidelines or code of conduct/ethics exist	33	26	59	55.9

Public institutions were 2.6 times more likely to have written policies than private ones. On the other hand, the odds of private institutions having guidelines on HIV/AIDS were 3.3 times higher than those for public ones.

The procedures followed in developing policy on HIV/AIDS by those institutions that have their own policies, were varied and largely involved participation of many stakeholders. Among the stakeholders were staff and students, senate and executive management, local community members and government. A few institutions sought the services of consultants to strengthen the draft policy before it was discussed and adopted. In some institutions, the HIV/AIDS policy was adopted from that of national governments. The sources of funding for developing HIV/AIDS policy (n = 37) were varied: 51.4% of the institutions used their own funds; government financed 10.8% of the policies; and the rest of the institutions with policies obtained funding from other sources (donors, SAUVCA, UN organizations, ADEA/WGHE

and World Bank). Some institutions obtained partial funding for development of their HIV/AIDS policy with the rest of the resources mobilized internally.

Although details of policy may differ from one institution to another, the main components are similar. As an example, the principal components outlined below are those for the University of Namibia (Andre du Pisani and Otaala 2001):

- a) rights and responsibilities of staff and students affected by HIV/AIDS;
- b) integration of HIV/AIDS into teaching, research and service activities of all University faculties, centers and units;
- c) provision of preventive, care and support services on campus;
- d) implementation of policy: structures, procedures, monitoring and review.

Other institutions have policies that also include: Voluntary Counseling and Testing (VCT); extending services to the local community; advocacy, networking and collaboration with other organizations and the community; behavioral change surveillance; rape and sexual abuse; gender and AIDS; and institutional capacity building.

3.2.1 HIV/AIDS policy implementation, monitoring and evaluation

The key person or unit or department for implementation of HIV/AIDS policy varies among institutions. At one extreme are institutions that have no policy and hence the responsible person/unit/department has not been appointed or created. For other institutions with an HIV/AIDS policy, the responsibility may fall on specially appointed officers (e.g., Institutional Officer for HIV/AIDS, HIV/AIDS Action Committee Chairperson), HIV/AIDS Unit, Health Services Center, and Personnel Division.

Table 3 gives information regarding HIV/AIDS policy implementation. A substantial proportion of institutions (46.3%) have a specialized unit (e.g., center, HIV/AIDS Unit) that coordinates HIV/AIDS activities. However, only 34.6% of the institutions have budgetary allocation for HIV/AIDS. The structures established for dealing with HIV/AIDS vary across institutions. On the one hand are institutions where specific

structures do not exist. In these, interested units or groups undertake HIV/AIDS activities on an ad hoc basis; there is no central co-ordinating unit. In many institutions, however, task forces (19.7%), committees (38.2%) and others (health units, HIV/AIDS control units, clubs, university leagues, forums, groups, specialized departments e.g. Department of Haematology, Department of Dermatology and Venereology) are charged with implementing HIV/AIDS activities, or for some, on a voluntary basis. A few institutions notably in South Africa, have established AIDS Research Institutes or departments specializing on HIV/AIDS, with some of International reputation.

Table 3. HIV/AIDS policy implementation

<i>Item</i>	<i>Yes</i>	<i>No</i>	<i>Total</i>	<i>Yes (%)</i>
Specialized unit for coordinating HIV/AIDS activities exists	50	58	108	46.3
Budgetary allocation specific for HIV/AIDS exists	38	72	110	34.6
HIV/AIDS awareness programs for staff exist	65	43	108	60.2
HIV/AIDS data exist	30	80	110	27.3
HIV/AIDS integrated into curriculum	43	56	99	43.4
Efforts underway to mainstream HIV/AIDS course into curriculum	38	17	55	69.1

Table 4 presents the activities undertaken by the institutions to address HIV/AIDS. It should be noted that most institutions undertook a range of activities, with the most predominant being education and awareness, community outreach programs, research and integration of HIV/AIDS into curriculum. Education and awareness takes the form of distribution of IEC materials, peer education training on sexuality and risk, publication of newsletters and journals. A very small number of institutions also carry out home-based care, peer counseling, training of trainers, networking with other organizations and provision of ARVs. One institution reported having participated in lobbying for legislation against cultural practices that fuel the spread of HIV/AIDS.

Table 4. Activities undertaken to address HIV/AIDS*

<i>Activity</i>	<i>Frequency</i>	<i>Percent</i>
VCT	45	12.8
HIV/AIDS Education and awareness	94	26.8
Integration of HIV/AIDS in curriculum	49	14
Workplace programs	43	12.3
Research	54	15.4
Community outreach programs	57	16.2
Others**	9	2.6

* Frequencies were derived from respondents who indicated they undertook an activity; many respondents undertook a combination of activities.

** Includes home-based care, networking, provision of ARVs, etc.

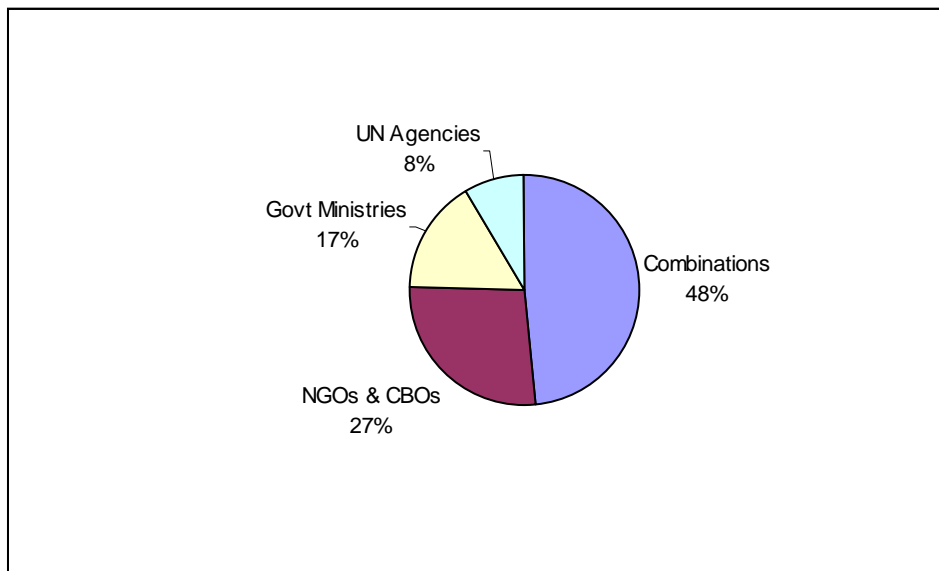
A significant proportion (43.4%) of institutions has integrated HIV/AIDS into the curriculum. Moreover, 69.1% of those institutions without HIV/AIDS in the curriculum are planning to mainstream it as a course. Some respondents indicated that HIV/AIDS has been integrated in courses in just some Departments. On the other hand other institutions, although not having HIV/AIDS formally integrated into the curriculum, already include this component in their training. Although most institutions do not have a policy on HIV/AIDS, these findings provide evidence that HIV/AIDS is being taken seriously. No distinct pattern emerges, however, in how institutions have integrated the course in the curriculum. Rather, there are all sorts of variations and combinations that include integration as: core course for all first year students, foundation course, stand-alone course, elective module, projects and workshops, and short course for health care professionals. A number of institutions have HIV/AIDS included as a topic in a more general course. For example the University of Namibia has a course – “Contemporary Social Issues” – that covers three topics of equal length: “Orientation in Ethics”, “Introduction to Gender Issues” and “HIV/AIDS”.

Only 27.3% of the institutions have HIV/AIDS data (for example, on prevalence) available. This information is collected through: surveys among students; KAPB studies; sero-prevalence surveys; voluntary disclosure of students about their HIV status; hospital/health centre records (e.g., on STDs and TB, unwanted pregnancies, demand for the

“morning after pill”); questionnaires administered at VCT sites; suggestions box; and records on condom distribution. Most of the data (68.6%) is obtained through surveys.

In addressing HIV/AIDS, institutions have a range of collaborating partners (Figure 1). Institutions predominantly collaborate with (Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs), with less but still a significant participation of government ministries (16.5%), UN agencies (8.3%). Other collaborating partners include national commissions on HIV/AIDS, SAUVCA, development partners and other institutions. In the pie chart, combinations refer to collaboration between institution and several other partners including all those mentioned above.

Figure 1. Partners in addressing HIV/AIDS



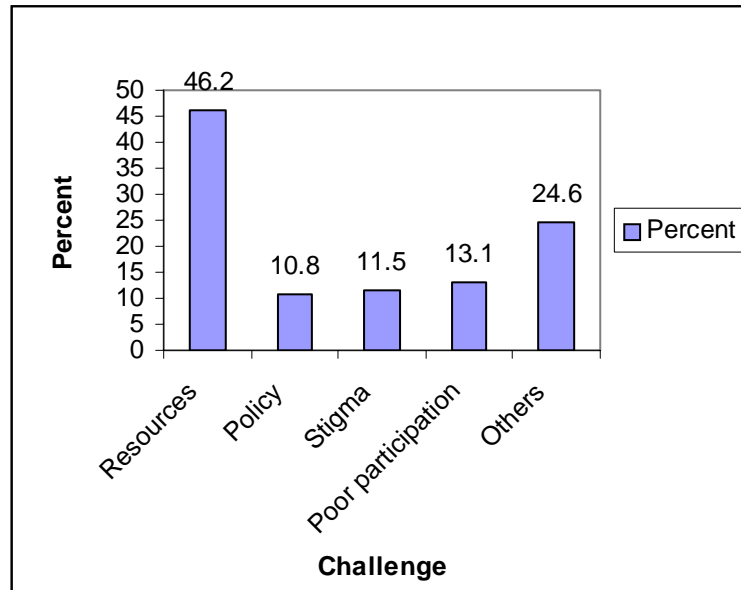
3.2.2 Main challenges faced in addressing HIV/AIDS

Institutions are faced with a number of challenges in addressing HIV/AIDS. The main challenge being lack of resources (human, material and financial) (46.2%). Figure 2 presents a breakdown of the responses according to how frequently a constraint was mentioned by respondents. Other constraints identified were:

- addressing stigma and discrimination;

- integrating HIV/AIDS into the curriculum;
- developing and sustaining HIV/AIDS programs in all aspects of institutional work;
- lack of institutional commitment;
- poor participation of staff and students in HIV/AIDS campaigns (perhaps due to apathy);

Figure 2. Challenges in addressing HIV/AIDS



- complacency by some students and staff;
- collecting information on the HIV/AIDS situation, for example, on prevalence;
- developing and maintaining fresh, innovative, humanistic and effective awareness programs that would lead to behavioral change;
- inadequate trained personnel, counselors and peer educators;
- lack of a policy on HIV/AIDS;
- lack of time to participate in activities;
- tackling issues like poverty that increase vulnerability to HIV/AIDS, especially among students;

- boosting health unit capacity to respond to HIV/AIDS related illnesses and ability to offer VCT;
- handling issues of support and care for the infected and affected;
- providing ARVs to staff and students who are HIV positive poses tremendous strain on the financial resources of institutions;
- overwhelming amount of work involved in HIV/AIDS initiatives;
- HIV/AIDS awareness fatigue;
- difficulty on the part of counselors in balancing between respect of privacy and openly seeking information, for example, on privacy;
- coordination of HIV/AIDS research;
- socio-cultural barriers, stereotyping, secrecy and denial.

3.3 Assessment of institutional responses to HIV/AIDS: Strengths and Weaknesses

a) Strengths

In responding to the HIV/AIDS epidemic each institution has its own strong points. The main areas of strength identified by respondents were:

- HIV/AIDS integration into curriculum (e.g., as a core course);
- setting up of an HIV/AIDS unit;
- existence of a policy, including structures, for addressing HIV/AIDS;
- ongoing activities such as peer counseling, sensitization, training (e.g., of peer educators, religious leaders) and community outreach programs;
- establishment and maintenance of VCT program;
- specific budgets for HIV/AIDS activities;
- distribution of condoms on campus;
- dedicated personnel in an HIV/AIDS center;

- good campus health services and an increase in the number of students going for VCT;
- establishment of a comprehensive program for the care and support of HIV positive patients;
- support from senior management;
- collaborative support and networking with government ministries, donors and NGOs;
- engagement of some departments in research (clinical, basic, behavioral) not only for drug and vaccine development, but also to assess effectiveness of awareness campaigns and inform policy.

b) Weaknesses

Although institutions are striving to address the HIV/AIDS epidemic, they have a number of weaknesses that hamper such efforts. Almost fifty percent (n = 61) of the respondents identified lack of funds as the main weakness. Other shortcomings identified were:

- lack of a policy on HIV/AIDS and the difficulty in implementing the HIV/AIDS policy for those with one;
- lack of a coordinated structure for implementation of HIV/AIDS activities;
- lack of committed leadership (sometimes because of lack of exposure) in supporting HIV/AIDS programs;
- lack of integration of HIV/AIDS into curriculum;
- lack of qualified personnel to address issues at institutional level and develop policy and programs on HIV/AIDS;
- inadequate permanent staff dedicated to HIV/AIDS activities;
- lack of commitment from some players, including departments, academic staff;
- poor response to VCT;
- lack of expertise in behavioral change and how to monitor success of programs;
- paucity of data on the HIV/AIDS situation in institutions;

- poor response to awareness campaigns;
- absence of outreach programs;
- denial and lack of openness in some institutions;
- programs focused on students and none organized specifically for employees;
- some institutions report a lot of research done but findings have never been published;
- lack of infrastructure, for example, buildings for VCT, meeting rooms;
- challenge in implementing new programs in an institution.

c) Suggestions for improvement

There were a number of suggestions made on how institutions can improve their responses to HIV/AIDS. These included the following:

- formulation of an HIV/AIDS policy;
- establishing HIV/AIDS centers;
- integration of HIV/AIDS into curriculum and set standards for minimum acceptable content;
- capacity building in counseling, behavior change, research;
- budgetary allocation specifically for HIV/AIDS and increase it where possible;
- mobilize additional funds from private sector and donors to support implementation of HIV/AIDS activities;
- increased awareness on HIV/AIDS;
- increased collaboration and networking among tertiary institutions and also with government agencies and NGOs;
- establish prevalence rates as to enable institutions mount informed responses;
- conduct research on impact of HIV/AIDS programs;
- review policies on medical aid, student bursaries, hostel security;
- need to consider HIV/AIDS as a core issue.

d) Additional comments on institutional response to HIV/AIDS

A few respondents provided additional comments regarding the HIV/AIDS situation and what ought to be done. These were:

- traditional beliefs may stand in the way of HIV/AIDS campaigns;
- institutions should realize that HIV/AIDS can negate the development gains of several decades and hence should be a driving force in national response;
- more information is needed on how to combat the HIV/AIDS epidemic;
- need to network with other tertiary institutions that are implementing their policies, for instance, with regard to integration of HIV/AIDS into the curriculum;
- a call for local studies on the economic, social and anthropological aspects of HIV/AIDS;
- tertiary institutions should form a forum to address HIV/AIDS.

3.3.1 Discussion of Key Issues

a) Rate of Infection and Policy Issues

The institutions covered in this survey were predominantly public, although there is an increasing number of private ones, whose main motive might be profit. Devastating effects of national epidemics are to some extent mirrored by what's happening in institutions of higher learning. Only 38.8% of the institutions reported having been significantly affected by the epidemic. It is plausible that, because the epidemic is still in early stages in many countries, the impacts have not yet been felt. Most of the institutions do not have an HIV/AIDS policy, yet this is one of the foundations for guiding them in tackling the epidemic. Notwithstanding this shortcoming, many of the institutions do have guidelines or codes of conduct or ethics in place. Moreover, most of those without a policy on HIV/AIDS are drafting one. Such efforts need to be supported materially and financially, as these appear to be the main constraints. The number of private tertiary institutions has proliferated in the past 10 years and because of pressure for finances, these are more likely to place issues of HIV/AIDS on the

periphery and hence need special consideration in helping them as they grapple with the epidemic.

The capability of institutions to deliver on their mandate is being eroded and efforts to stem and mitigate the epidemic need to be increased. Institutions reported being affected by high death rates, increased costs, stigma, inability of students to pay fees, lowered performance of affected students, uncertainty in human resource planning and ultimately lowered productivity. The long-wave nature of the epidemic (Barnett and Whiteside 2002) implies that institutions need to change the way they operate. There is need to plan for mitigation of impact and as a first step this may require institutional audits and a review of existing policies, for instance, on manpower training, health care benefits, recruitment, and retirement. There is also need to plan for the increased costs, disruption and contingency for revenue shortfalls from student fees.

Institutions have embarked on a number of efforts to prevent the further spread of the epidemic. The structures for implementing HIV/AIDS programs vary across institutions from those with informal ones to those more elaborate with assigned duties and responsibilities to cadres. One clear sign of committed institutional leadership in the fight against HIV/AIDS is having specific budget allocations to the same (Kelly 2001); unfortunately, for the majority this is not so, implying a lukewarm response. An HIV/AIDS policy lays a framework that defines the roles and responsibilities of cadres in an institution in this ongoing battle against the scourge. This systematic approach is recommended as structures that are set up to ensure sustainability, as opposed to the piecemeal approach by volunteers or concerned individuals and groups.

b) Contributions of institutions

The contributions of institutions in the fight against HIV/AIDS are many and varied. They include awareness campaigns both within institutions and the local community, workplace programs, education through introducing new courses that incorporate HIV/AIDS, VCT, research, networking, and home-based care. Higher education institutions have large numbers of intellectuals that can engage in debate and research that will inform society in addressing issues such as HIV/AIDS and this potential must be put to its full use. These contributions can be increased by encouraging and facilitating academics' involvement and

nurturing aspects of critical thinking among students in their areas of specialization as well as in getting out the message that HIV/AIDS is not just a medical problem, but one with wider ramifications for society.

Some institutions reported having problems in coordinating research on HIV/AIDS especially because of its multidimensional facets. Many researchers work in small groups missing out on opportunities for developing synergies across disciplines. Some institutions like the University of Witwatersrand, South Africa have established an AIDS Research Institute that coordinates and integrates HIV/AIDS research in the university and is also tasked with raising funds.

c) Collecting and establishing data on HIV/AIDS

Programs need to be monitored and evaluated to make necessary adjustments, but this requires collecting data. The survey indicated that there was paucity of data on HIV/AIDS, for example on prevalence. Impact assessment and planning to mitigate impact require data, and although this may be difficult to get, the challenge is for institutions to find ways of doing so. Such data could be obtained through random samples using non-intrusive HIV/AIDS tests done routinely among employees and students. Other information that can be collected is on KAPB among students and staff, hospital records, student and staff mortality, lecture attendance, and leave requests. This information needs to be collected and used in ethically and legally acceptable ways that do not infringe on the rights of the individual.

d) Difficulty in assessing impact

HIV/AIDS is a long-wave event with impacts difficult to measure in the short-term. Although a number of institutions mentioned increasing negative impacts like deaths, absenteeism and reduced productivity, many do not have precise data on the magnitude of the impact. Besides, in a number of countries the epidemic is still in its early stage with its impact yet to be felt. As one respondent noted: "The gross effect on the institution is not yet overtly visible. However, with the trends in the country and the increasing national overall prevalence, the impact will be more visible in the next few years." This suggests a need to design systems of information capture that will enable institutions to assess the impact of the epidemic and to plan for mitigation.

e) Challenges to HIV/AIDS programs

Institutions face a number of challenges as they seek to contribute to the fight against HIV/AIDS. Many of those that are well established are facing dramatic cutbacks in funding due to structural adjustment policies in many countries' economies; the nascent ones are struggling to put up infrastructure and run programs. Yet in spite of these funding shortages, institutions cannot stand aloof: they have to be part and parcel of the players in addressing the HIV/AIDS epidemic.

Another disturbing fact is the apathy and poor participation of staff and students in HIV/AIDS campaigns. Additionally, stigma, absence of policy, lack of time to participate in activities, inadequate awareness among staff, cultural barriers and denial stand in the way in addressing the HIV/AIDS epidemic.

These issues need to be fully addressed, if institutions are to play an effective role in the fight against the scourge. Institutions must find innovative ways of raising funds for the added responsibilities of HIV/AIDS, for example through partnerships. They must also engage in more research to establish why stigma persists and why prevention campaigns have largely failed and look into cultural practices that hinder campaigns against the epidemic; that is the economic and socio-cultural aspects that increase susceptibility and vulnerability and are at the roots of the epidemic (Barnett and Whiteside 2002) must be carefully considered.

f) Integrating HIV/AIDS into the curriculum

The survey also gathered information on the overall impression of each institution's response to HIV/AIDS; more specifically, the strengths, weaknesses and suggestions for improvement were sought. A substantial proportion of institutions have integrated HIV/AIDS in the curriculum and there are many other activities taking place, for instance, VCT, peer counseling, condom distribution. Although HIV/AIDS has been integrated into the curricula of many institutions, there may be differences in content. Guidelines need to be developed on the aspects that warrant inclusion in the courses and these can then be adapted to suit specific institutions. The content should, among other things, include aspects of disease epidemiology, the long wave nature of the epidemic and the socio-economic implications on society.

g) Constraints in implementing HIV/AIDS programs

Among the weaknesses identified were shortage of funds, lack of policy, difficulty in implementing policies and new programs, and lack of expertise in behavioral change. Policies are not a panacea for solving problems, but provide a working platform and hence should be developed where they do not exist yet. A policy on HIV/AIDS needs to be followed by requisite commitment to execute it, for example, by budgetary allocation and other facilitation. Institutions can benefit if forums were established to share experiences on policy implementation and best practices. Institutions could also send staff for training in areas they have deficiencies in, for example, behavioral change and counseling.

3.3.2 Tertiary institutions must be involved

President J.F. Kennedy stated in his message to Congress on 20th February 1961, "our progress as a nation can be no swifter than our progress in education... The human mind is our fundamental resource". This statement is universally true, and in the case of Africa is doubly so, particularly in relation to tertiary education and economic and national development.

African tertiary institutions face a number of challenges including those that relate to globalization and the challenges of ICT development. More recently the challenge posed by HIV/AIDS has taken a paramount place in our thinking, actions, strategies, and programming.

Underlying all these challenges is the traditional role of a tertiary institution or university embedded in:

- Transmitting the accumulated body of global knowledge relevant to the development of society through *teaching*;
- Creating new knowledge and extending boundaries of knowledge through *research*;
- Preserving knowledge on national and international values of culture, history, art and science, through *technology, publication and library acquisitions*; and
- Providing *advisory, extension and consultancy services* on issues which are relevant to the socio-economic advancement of society at large.

Tertiary institutions are well placed to respond to these varied and daunting challenges for a variety of reasons, including the following:

- a) To paraphrase the words of Boyer, the University Campus (tertiary institution) can be considered as a purposeful, open, just, disciplined, caring and celebrative community.

It is an educationally *purposeful* community, a place where staff and students share academic goals and work together to strengthen teaching and learning on campus. It is an *open* community, a place where freedom of expression is uncompromisingly protected and where civility is powerfully affirmed. It is a *just* community, a place where the sacredness of the person is honored. It is a *disciplined* community, a place where individuals accept their obligations to the group and where well-defined governance procedures guide behavior for the common good. It is a *caring* community, a place where the well-being of each member is sensitively supported and where service to others is encouraged. And it is a *celebrative* community, one in which the heritage of the institution is remembered and where rituals affirming both tradition and change are widely shared. Given such a community, one would expect it to rise to the occasion, by "challenging the challenger" HIV/AIDS.

- b) HIV/AIDS has clearly affected the core business of tertiary institutions: teaching and learning; research; management and community engagement. HIV/AIDS is no respecter of race, ethnicity, gender, age, or economic status; it is also no respecter of institutions. In fact, tertiary institutions which have large numbers of young people in the age bracket 19 - 25 years who have been found to engage in risky sexual behavior are particularly vulnerable.
- c) Given the magnitude of the crisis that HIV/AIDS has brought into the lives of individuals and of the countries, the education system, including tertiary institutions, has a serious obligation to cooperate with all other bodies in stemming the spread of this infection. As one of the major socializing forces in society, it has a grave obligation to educate the young on this matter, providing knowledge, fostering awareness, promoting life-asserting attitudes. It also has an obligation to those who work in the

system, heightening their awareness and strengthening their determination and efforts to remain uninfected. The system has a further responsibility towards those who are already infected, helping them in a compassionate and unpatronizing manner, to live positively. The latter responsibility is all the more grave and delicate in relation to school-going children who are HIV/AIDS infected.

4. RECOMMENDATIONS AND CONCLUSION

4.1 Recommendations

- a) Recommendations are likely to differ based on each university's peculiar needs, experience, prevalence rate and where they are on the gamut of HIV/AIDS response. However, there are some general steps which, when taken and implemented, will strengthen the response in all institutions of higher learning in addressing the challenges posed by HIV/AIDS. The following are some general recommendations.
- b) **HIV/AIDS policy development:** The survey revealed that many institutions do not have an HIV/AIDS policy, although some are in the process of preparing one. As policy forms a framework for sustainable efforts in addressing the myriad issues posed by HIV and AIDS, there is need for support for the development of a policy in all institutions of higher learning. This support could be in the form of technical expertise or financial assistance to enable the development, production and dissemination of the policy to all actors to create a sense of shared vision and mission.
- c) **The need for active engagement of all players in institutions of higher learning.** This can be achieved through the development of a comprehensive HIV/AIDS response initiative that will address all areas of HIV/AIDS prevention, treatment and management, including stigma and discrimination and the intensification of advocacy and sensitization activities at all levels of the tertiary institutions.
- d) **Specific budgetary allocation:** A significant challenge was the lack of resources (financial, material and human). This can be addressed partly through the provision of specific budget allocations

for HIV and AIDS response in all institutions of higher learning. Tertiary Institutions should also devise innovative ways of mobilizing additional resources through fees structure, collaboration and soliciting donor and development partners' support.

- e) **Mitigation of impact of HIV/AIDS:** As the epidemic continues to ravage society, its negative impact on the various tertiary institutions can not be overlooked. It is therefore imperative to plan for increased human resources training, increased costs due to benefits (healthcare, funerals) for those affected, and revenue shortfalls because students are unable to pay fees. Institutions of higher learning should also consider avenues for prolonging the life of those employees that are HIV positive through providing ARVs as the costs become more affordable. Where necessary, policies must be reviewed with regard to retirement, health insurance, recruitment and staff training.
- f) **Institutional audits:** Institutions need to periodically examine their vulnerabilities with regard to HIV/AIDS in areas such as critical personnel and financial obligations, to ensure they continue delivering on their mandate. Institutions should put in place relevant structures, with due accountability framework to coordinate, monitor and manage resources effectively and efficiently.
- g) **Integration of HIV/AIDS into the curriculum:** As a matter of priority, conscious efforts must be made to integrate HIV/AIDS into the curriculum of all institutions of higher learning. Guidelines should be developed on some of the critical components that should be included in the curriculum.
- h) **Data collection:** For effective planning and also to monitor and evaluate program, data is required. Institutions should develop systems for collection of vital information pertaining to HIV/AIDS and analyze this data to allow necessary adjustments in programs and plan for mitigation of impacts. Researchers should also be supported to publish their work and have it easily accessible to others outside the university community.
- i) **Recruitment of permanent staff:** Many institutions assign HIV and AIDS responsibilities to staff as an add-on and this is unlikely to result in effective response because of time constraints. Adequate numbers of qualified permanent staff should be recruited to oversee

implementation of the HIV and AIDS programs in the respective institutions.

- j) **Capacity building:** Many institutions lack or have shortage of expertise in areas of behavior change, counseling and research among others. There is need for technical support in strengthening such areas which form a critical link in program delivery. Training and retraining workshops should be organized in spheres including research methodology, program management and Proposals writing.
- k) **Tackling stigma and discrimination:** Stereotyping, stigma and discrimination regarding HIV and AIDS still abound in many institutions. There is need for effective stigma reduction programs on the various campuses for actors at all levels. Greater involvement of PLWHAs in programs will greatly enhance understanding and reduce fear and prejudices associated with AIDS.
- l) **Inclusive program for all:** Most institutions' HIV/AIDS campaigns are focused on students, with minimal attention paid to academic and non-academic staff. Similarly, some students and staff have shown denial, apathy, complacency; hence, ways must be found to overcome these attitudes. To address these, innovative and creative programs using all available media and fora within the university structure such as classroom teaching, the use of inter-educative activities, health centers, peer education, university intranet, production and distribution of newsletters, development of effective BCC programs and action research activities must be undertaken for all players in institutions of higher learning. This way everyone will be captured and interest sustained.
- m) **Networking:** Many institutions are on the learning curve in implementing HIV/AIDS programs. Networking and increased collaboration with other partners will help institutions learn from others and share best practices, particularly on innovative ways of working. Periodic meetings, seminars and conferences among stakeholders should be encouraged for sharing of information on HIV/AIDS and experiences in working with PLWHAs. For instance, institutional heads and/or HIV/AIDS Coordinators could convene to update each other and to make collaborative plans and strategize for future programs. To engage everyone in the campaign, there

should be periodic updating of the present list of contacts. This should be done annually to ensure that new ones are not left out.

- n) **Leadership commitment:** Strong and active leadership and commitment at all levels has proven to be the key behind many successful programs as demonstrated in Uganda and elsewhere. Institutional leaders need to emulate this and some of the ways in which they can do so is by ensuring that there are specific budget allocations to HIV and AIDS activities and a policy in place.

What Vice Chancellors and Rectors could do:

- Survey their staff to determine the level of expertise regarding bioethics issues generally and specifically as regards HIV in their nations;
- Encourage staff to attend bioethics seminars or courses;
- Encourage development of curricula, especially for students in the sciences and social sciences, in bioethics. Suggested bedrock documents include the *Nuremberg Code* (1949), the Belmont Report (formally known as the *Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, 1978), and the *Ethical Principles for Medical Research Involving Human Subjects*, known as the Declaration of Helsinki, with its amendments;
- Contact funders such as the Wellcome Trust, based in London, which has expressed an interest in funding bioethics explorations for developing countries. (The UNAM experience with a Wellcome Trust application is that the funder requires a certain level of bioethics expertise at an institution before it will provide funding there.) A SADC proposal for a regional bioethics consultation may be fundable provided there is a continuing dialogue with the funder during the application preparation process.

Societal Standards:

- **Research on susceptibility and vulnerability factors:** Researchers in institutions of higher learning should critically examine why prevention messages have largely failed, the poor response to VCT and why there is low staff and student participation in HIV/AIDS programs. The underlying root causes of the epidemic such as poverty, inequality, gender bias, stigma

and discrimination and cultural beliefs must be rigorously examined. Also, the tools for impact assessment of long-wave events such as HIV/AIDS are not well developed and researchers should strive to improve on them.

- ***Follow-up of institutions that did not respond to the questionnaire:*** Many tertiary institutions, particularly in North and Western Africa (especially in Francophone and Lusophone countries) did not respond to the questionnaire, for a variety of reasons. Since AAU is targeting assistance and support to all tertiary institutions in Africa, it would be advisable to make a follow-up contact with those institutions that did not respond with a view to getting them to complete the questionnaire and to offer technical assistance.
- ***Collaboration with UNESCO:*** UNESCO's strategy in HIV and AIDS prevention is to assist Member States, in particular Ministries of Education, Teacher Training Institutions, NGOs, civil society and faith-based organizations, in advocacy, capacity building, promoting research and information sharing and facilitating networking (UNESCO/BREDA 2002).

UNESCO in Africa is divided into Cluster Offices. For instance the Windhoek Cluster Office covers Angola, Lesotho, Namibia, South Africa, and Swaziland. The Nairobi Cluster office covers, Burundi, Kenya, Rwanda, and Uganda. It is **recommended** that tertiary institutions falling within designated clusters liaise and collaborate with those respective clusters, in developing their own programs and seeking support.

- ***Links with Ministries of Education to access support from the Mobile Task Team (MTT):*** At the 15th Commonwealth Conference of Education Ministers (15CCEM) held in October 2003, Ministers endorsed the Youth Summit recommendation that there was need to act urgently to improve education on HIV and AIDS and committed themselves to take urgent action to mitigate the impact of AIDS on education (ACU Bulletin, No. 158, March 2004, 9). In some of the countries surveyed (e.g., Namibia), Ministries of Education have developed policies on HIV/AIDS and in the process of so doing, have increasingly utilized the services of the Mobile Task Team (MTT) to assist them.

Co-developed by USAID/AFR-SD and the Health Economics and HIV/AIDS Research Division (HEARD) of the University of Natal, South Africa, MTT assists Ministries of Education in Sub-Saharan Africa to understand, manage and mitigate the impact of HIV and AIDS on their sectors and systems (MTT 2003, 2).

MTT activity in each country requesting assistance constitutes a partnership with the Ministry or Department of Education concerned. It is recommended that tertiary institutions that do not yet have access to MTT services and need them apply to access their facilities through their Ministries or Departments of Education.

- **Role of the WGHE/AAU:** COREVIP (2003) recommended that the role of AAU in the fight against HIV and AIDS should be to:
 - Be more facilitative and encourage regional exchange;
 - Conduct an audit on various institutional policies formulated by universities to determine core requirements;
 - Identify strategies that have worked for other institutions and form a directory of various studies and disseminate that information;
 - Act as a bridge between academia and government policies.

This study endorses these recommendations and suggests additional ones, including that the WGHE continue to:

- Play a catalytic role in enabling tertiary institutions to develop and implement workplace HIV/AIDS policies;
- Help establish and facilitate centers of excellence in AIDS management and research into inventing a drug from the wealth of African medicinal plants; creation of chairs to assist in this regard would be germane;
- Work with mobile teams on HIV/AIDS (such as the Mobile Task Team referred to earlier) to create useful resources;
- Support purposeful researches going on in its member institutions, such as the development of the vaccine in the University of Nairobi;

- Identify strategies that have worked for other institutions, form a directory of various studies and disseminate that information;
- Establish a directory of institutions engaged in HIV and AIDS activities for purposes of contacts and mutual sharing.

In addition, AAU should continue to cooperate with various regional and sub-regional bodies in Sub-Saharan Africa that have already taken initiatives in the area of HIV/AIDS and education. These include:

- The United Nations Economic Commission for Africa (ECA)
- The Southern African Development Community (SADC)
- The Economic Community of West African States (ECOWAS)
- The Forum for African Women Educators (FAWE)
- The South African Vice-Chancellors' Association (SAUVCA)
- The soon to be formed association of SADC Vice Chancellors
- The Inter-University Council for East Africa
- The Zimbabwe Universities Vice Chancellors' Association
- Association of Universities in the Indian Ocean
- Association of Nigerian Universities.

4.2 Conclusion

Tertiary institutions are directly responsible for the physical welfare and education of a large number of young people many of whom will be leaders of social, economic and political development. Typically, university students engage in high-risk sexual practices such as unprotected sex, frequent change and exchange of partners, sex for financial gains and prostitution. Alcohol consumption is also common among students and this often leads to irresponsible behavior. The high incidence of pregnancy and STIs are also an indication that students engage in unprotected sex. Sexual harassment, un-negotiated sexual intercourse between female and male partners, rape and violence against women are also common on university campuses (Kelly 2000)

The HIV/AIDS pandemic has had a marked impact on tertiary institutions and will continue to do so. Tertiary institutions have a responsibility in developing effective strategies to deal with HIV both within the institutions themselves and the wider community. Given the seriousness of the threat posed by HIV/AIDS to the core business of tertiary education institutions, a clear vision is critical about what needs to be done to minimize the impact of the epidemic on students and staff. Such institutions must develop effective policies and practices to deal with the need to integrate HIV/AIDS into teaching, research and community service activities. There must be provision for education and prevention of HIV, with care and support services to students and staff living with HIV/AIDS. Appropriate management structures are needed to ensure that HIV/AIDS policies and strategies are implemented.

It has been demonstrated that HIV prevention works. In the USA, prevention has helped to slow down the rate of new infections from over 150,000 in the mid-1980s to around 40,000 per year in 2002. Prevention programs have been effective with a variety of populations: clinic visitors, heterosexual men and women, youth at high risk, prisoners, injection drug users, and men having sex with men (MSM). Intervention programs have been extended to individuals, groups and communities in settings ranging from storefront to gay bars, from health centers to public housing, and from schools to universities.

These prevention successes were accomplished through collaboration among the infected and affected communities, national agencies, local organizations, the private sector, and community-based groups. They demonstrate the power of collective effort to fight HIV/AIDS (CDC 2002).

Managing the response to HIV/AIDS requires informed and committed leadership that knows what needs to be done, why it needs to be done and how it needs to be done.

It is also pointed out that to succeed, HIV prevention efforts must be comprehensive and science-based. The following conditions must be fulfilled in order for HIV prevention to work:

- An effective community planning process;

- Epidemiological and behavioral surveillance; compilation of the health and demographic data relevant to HIV risks, incidence or prevalence;
- HIV counseling, testing, partner counseling and referral, with strong linkages to medical care, treatment and needed prevention services;
- Health education and risk reduction activities, including individual, group and community level interventions;
- Accessible diagnosis and treatment of other STDs;
- Public information and education programs;
- Comprehensive school health programs;
- Training and quality assurance;
- HIV prevention and capacity-building activities;
- An HIV prevention technical assistance assessment and plan;
- Monitoring and evaluation of major program activities, interventions and services.

The magnitude of the fight against HIV/AIDS is enormous. Consequently, the responsibility taken by the community of tertiary institutions through present and future activities designed to arrest the spread of HIV/AIDS must be equally enormous. Many of the institutions surveyed have certainly begun to do some commendable work, but much remains to be done to respond comprehensively to the threat posed by HIV/AIDS. Many others are only beginning to realize this threat and need all the support and help to respond comprehensively. We believe that the message is not at all bleak, for the future does not have to be like the past. We know how to prevent the spread of HIV. We can deal with the consequences of AIDS. We believe that with strong and visible leadership from the Administration of tertiary institutions there will be resonance from below.

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Annex 1

List of Universities and Colleges Surveyed

1. Catholic University of Angola
2. University of Botswana
3. University Polytechnique (Burkina Faso)
4. School of Computer Sciences (Burkina Faso)
5. Eier (Burkina Faso)
6. Institute of Rural Development (Burkina Faso)
7. University of Burundi
8. University of Buea (Cameroon)
9. University of Yaoundé (Cameroon)
10. The Jean Piaget University of Cape Verde
11. University of Kisangani, Goma Campus (DR Congo)
12. Zagazig Faculty of Medicine (Egypt)
13. Debub Univeristy (Ethiopia)
14. Jimma University (Ethiopia)
15. Microlinc Information Technology College (Ethiopia)
16. University of the Gambia
17. ISC (Gambia)
18. University of Cape Coast (Ghana)
19. University for Development Studies (Ghana)
20. University of Ghana
21. Ho Polytechnic (Ghana)
22. Institute of Adult Education (Ghana)
23. Institute of Professional Studies (Ghana)
24. Kwame Nkrumah University of Science and Technology (Ghana)
25. University of Abobo-Adjame/Abidjan (Ivory Coast)
26. University of Cocody (Ivory Coast)
27. Kenyatta University
28. Egerton University (Kenya)
29. Maseno University (Kenya)
30. Moi University (Kenya)
31. Jomo Kenyatta University of Agriculture and Technology (Kenya)
32. University of Nairobi (Kenya)

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33. Western University College of Science and Technology (Kenya)
 34. Catholic University of Eastern Africa (Kenya)
 35. Highridge Teachers College (Kenya)
 36. Africa Nazarene University (Kenya)
 37. University of Eastern Africa, Baraton (Kenya)
 38. United States International University (Kenya)
 39. National University of Lesotho
 40. Lesotho College of Education
 41. University of Technology (Mauritius)
 42. Eduardo Mondlane University (Mozambique)
 43. The Cotton Institute of Mozambique
 44. Rundu College of Education (Namibia)
 45. Windhoek TRC (Namibia)
 46. Zambezi Vocational Training Centre (Namibia)
 47. University Abdou Moumouni (Niger)
 48. University of Agriculture (Nigeria)
 49. Federal Polytechnic – Oko – Anambra State (Nigeria)
 50. Federal College of Education (Nigeria)
 51. Federal University of Technology (Nigeria)
 52. Obafemi Awolowo University, Ile-Ife (Nigeria)
 53. University of Jos (Nigeria)
 54. University of Nigeria, Nsukka
 55. University of Calabar (Nigeria)
 56. Hassan Usman Katsina Polytechnic (Nigeria)
 57. University of Lagos (Nigeria)
 58. Lagos State University (Nigeria)
 59. Olabisi Onabanjo University (Nigeria)
 60. Federal University of Technology, Yola (Nigeria)
 61. Institute of Management and Technology (Nigeria)
 62. Usmanu Danfodiyo University, Sokoto (Nigeria)
 63. Kigali Institute of Science, Technology and Management (Rwanda)
 64. National University of Rwanda
 65. University of Sierra Leone
 66. Border Technikon (South Africa)
 67. Cape Technikon (South Africa)

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68. Durban Institute of Technology (South Africa)
 69. Eastern Cape Technikon (South Africa)
 70. Technikon Free State (South Africa)
 71. Mangosuthu Technikon (South Africa)
 72. Tshwane University of Technology (Formerly Technikon North West) (South Africa)
 73. Peninsula Technikon (South Africa)
 74. Port Elizabeth Technikon (South Africa)
 75. Tshwane University of Technology (Formerly Technikon Pretoria) (South Africa)
 76. University of South Africa (UNISA - formerly Technikon South Africa)
 77. Technikon Witwatersrand (South Africa)
 78. Vaal University of Technology (Formerly Vaal Triangle Technikon) (South Africa)
 79. University of Cape Town (South Africa)
 80. University of Kwazulu Natal (Formerly University of Durban-Westville) (South Africa)
 81. University of Kwa Zulu Natal (Formerly University of Natal) (South Africa)
 82. University of Fort Hare (South Africa)
 83. University of the Free State (South Africa)
 84. Medical University of South Africa (South Africa)
 85. University of the North (South Africa)
 86. North-West University (Formally University of North-West) (South Africa)
 87. University of Port Elizabeth (South Africa)
 88. North-West University (Formerly Potchefstroom University for Christian Higher Education) (South Africa)
 89. University of Pretoria (South Africa)
 90. Vista University (South Africa)
 91. University of Venda (South Africa)
 92. University of Durban-Westville (South Africa)
 93. Rand Afrikaans University (South Africa)
 94. Rhodes University (South Africa)
 95. University of Stellenbosch (South Africa)
 96. University of Transkei (South Africa)
 97. University of Venda for Science and Technology (South Africa)
 98. University of Western Cape (South Africa)
 99. University of the Witwatersrand (South Africa)

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100. University of Zululand (South Africa)
 101. Durban Institute of Technology (South Africa)
 102. Ahfad University for Women (Sudan)
 103. Omdurman Ahlia Unviersity (Sudan)
 104. Upper Nile University (Sudan)
 105. University of Swaziland (Swaziland)
 106. University of Dar es Salaam (Tanzania)
 107. University College of Lands and Architectural Studies (Tanzania)
 108. Dar es Salaam Institute of Technology (Tanzania)
 109. Muhimbili University College of Health Sciences (Tanzania)
 110. Mzumbe University (Tanzania)
 111. The Open University of Tanzania
 112. Tumaimi University (Tanzania)
 113. Zanzibar University (Tanzania)
 114. Busoga University (Uganda)
 115. Makerere University Business School (Uganda)
 116. Ndejje University (Uganda)
 117. Mbarara University of Science and Technology (Uganda)
 118. Nkumba University (Uganda)
 119. Uganda Martyrs University (Uganda)
 120. Uganda Christian University
 121. The University of Zambia
 122. Great Zimbabwe University (Zimbabwe)
 123. Zimbabwe Open University
 124. Midlands State University (Zimbabwe)
 125. Bindura University of Science Education (Zimbabwe)
 126. Masvingo State University (Zimbabwe)
 127. Solusi University (Zimbabwe)
 128. Women's University in Africa (Zimbabw)

CHAPTER TWO

Response of Teacher Training Colleges in Africa to HIV/AIDS

Pan African Teachers' Centre (Lomé, Togo)

1. INTRODUCTION

1.1 Overview of the Scale of the HIV/AIDS Epidemic in Africa

The latest updates on HIV/AIDS regional data indicate that Africa is the worst affected region, with 70 percent of the world's 42 million infected people. The pandemic has killed 25 million Africans so far and orphaned more than 12 million. Each year, 3.2 million Africans (i.e., 8,700 Africans every minute) are infected with the HIV virus. Approximately 2.3 million Africans, largely in the prime of their lives as parents and workers, are killed by HIV/AIDS each year.

In just over a decade, the HIV/AIDS pandemic has reversed many of Africa's development achievements of previous decades. It has reduced life expectancy in some countries by nearly 40 years and is the leading cause of death on the continent. The pandemic has emerged clearly as the paramount threat to development in the region (World Bank 2004).

Seven countries, all in southern Africa, now have prevalence rates higher than 20%: Botswana (38.8%), Lesotho (31%), Namibia (22.5%), South Africa (20.1%), Swaziland (33.4%), Zambia (21.5%) and Zimbabwe (33.7%). Uganda remains the only country to have subdued a major HIV/AIDS epidemic, with the adult HIV prevalence rate continuing to drop from 8.3% at the end of 1999 to 5% at the end of 2001.

HIV/AIDS remains extremely dynamic, growing and changing character as it exploits new opportunities for transmission. Girls and young women are at greatest risk, with women accounting for nearly 50% of all people living with HIV worldwide and 57% in Sub-Saharan Africa in 2003.

Young people (15–24 years old) account for half of all new HIV infections worldwide; more than 6000 contract the virus each day. (For country specific prevalence estimates, see Annex 2).

The 2001 UN Declaration of Commitment on HIV/AIDS envisions major progress in delivering comprehensive care services by 2005. However, only minimal coverage has been achieved for care and treatment of HIV-related disease. Current prevention efforts in most low- and middle-income countries come nowhere near the scale of the epidemic thus making HIV/AIDS a paramount threat to development in Africa.

1.2 Implications of HIV/AIDS in Africa

The human toll and suffering due to HIV/AIDS in Africa have been well documented (UNAIDS 2002 and 2004). AIDS is now by far the leading cause of death in Sub-Saharan Africa, having so far taken away the lives of over 15 million Africans since the first reported cases in 1981. An estimated 2.3 million adults and children died as a result of AIDS in Sub-Saharan Africa during 2004 alone.

Many countries in Sub-Saharan Africa have failed to bring the epidemic under control. Nearly two-thirds of the world's HIV-positive people live in Sub-Saharan Africa, although this region contains little more than 10% of the world's population. In many countries of Sub-Saharan Africa, AIDS is erasing decades of progress in extending life expectancy. Average life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. In less than ten years' time, many countries in Southern Africa will see life expectancies fall to near 30 years, levels not seen since the end of the 19th Century (Stanecki 2002).

There is a significant risk that for some countries, if nothing drastic is done about the AIDS epidemic in Africa, the implications could be catastrophic for demographic, household, health educational, workplace and economic sectors.

In all affected countries the HIV/AIDS epidemic is reported to be bringing additional pressure to bear on the health sector as the epidemic matures, with increasing number of people living with HIV/AIDS demanding for health care services. In Sub-Saharan Africa, the annual direct medical costs of AIDS (excluding antiretroviral therapy) have been estimated at about US\$30 per

capita, three times the overall public health spending for most African countries.

Generally, as HIV infection progresses to AIDS, hospitalization increases. The World Bank estimates that the number of hospital beds needed for AIDS patients could exceed the total number available in Swaziland by 2004 and in Namibia by 2005 (Haacker 2001). Shortage of hospital beds is likely to result in long waiting in the cue thus worsening the chances of recovering on admission.

While the demand for health services is expanding, more-health care professionals are also reported to be affected by HIV/AIDS. This, coupled with the high brain drain of health workers to Europe and North America in search of greener pastures, makes the situation more serious. For example, Malawi and Zambia are experiencing a 5-6 fold increase in health worker HIV/AIDS related-illness and death rates.

The effect of HIV/AIDS on households in Africa is also very damaging as parents die and children are sent to relatives for care and upbringing, thus eventually dissolving the family unit, which serves as the focal point around which society evolves. A study in Zambia revealed that 65% of households in which the mother had died had dissolved. Not only does the HIV/AIDS epidemic dissolve the family but it also strips the family of its income-earners and in some cases, its assets (Bechu 1998). The loss of access to basic necessities of life (Kaiser 2002), and reduced agricultural productivity (FAO 2001) that the disease induces further worsens the poverty situation in Africa.

Another important effect of HIV/AIDS is on labour. The vast majority of people living with HIV/AIDS in Africa are between the ages of 15 and 49 – people in the prime of their working lives. AIDS is said to weaken economic activity by squeezing productivity, adding costs, diverting productive resources, depleting skills and ultimately reducing market demand for products (goods) and services. The epidemic affects productivity adversely through increased absenteeism and loss of skilled personnel. Comparative studies of East and Southern African businesses have shown that absenteeism can account for as much as 25-54% of company costs (Haacker 2002).

The impact of HIV/AIDS on the economies of African countries is difficult to measure but through its impact on the labour force, households and enterprises, HIV/AIDS can act as a significant brake on economic growth and development. Besides the human cost, HIV/AIDS affects Africa's ability to cope with the epidemic. The economies of many of the worst affected countries were already struggling with development challenges, debt and declining trade before HIV/AIDS started to affect Africa. Together with these factors, HIV/AIDS has had a devastating effect on the economies of many countries.

Indeed, HIV/AIDS has increased labour mortality and morbidity in Africa with the attendant consequences of loss of skills in key sectors of the labour market, thus retarding economic growth. The economic developmental goals of many African countries depend on among other things, their abilities to expand exports and attract foreign investment. The scarcity of skilled labour which increases cost of production and reduces profits, tend to limit the ability of African countries to attract the much needed foreign investment which constitute the very foundation for economic development (Rosen *et al.* 2004).

Of particular importance to this study is the likely impact of HIV/AIDS on the education sector of Africa. This is because, the extent to which schools and other education institutions are able to continue functioning will influence how well societies eventually recover from the epidemic. Good basic education ranks among the most cost-effective means of preventing HIV (World Bank 2002).

One of the visible effects of the epidemic in the education sector is decline in school enrolment, with its attendant consequences of fewer children receiving basic education, thus rendering bleak the prospects of achieving Education for All targets set by the Dakar 2000 Forum (EFA Global Monitoring Report, 2004). It has been projected by the World Bank (2000) that the population of children of primary school age in 2010 for four African countries will be as follows without and with AIDS (see table 1):

Table 1. Impact of AIDS on the size of school-aged population in selected African countries

Country	Projected population of children of Primary School Age in 2010		
	Without AIDS scenario	With AIDS scenario	Expected percentage decrease due to AIDS
Kenya	8,200,000	7,100,000.	13.4
Uganda	6,800,000	6,000,00	11.8
Zambia	2,700,000	2.200,000	18.5
Zimbabwe	3,000,000	2,300,000	23.3

Source: World Bank 2000.

According to Peter Piot, Director of UNAIDS, (see World Bank, UNESCO and UNAIDS Joint Press Release 2002), "Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach". The low enrolment is attributed to:

- Removal of children from school to care for infected parents and family members;
- Inability to afford school fees and other expenses;
- AIDS-related infertility and a decline in birth rate, leading to fewer children; and
- More children themselves infected and either do not live long enough to start school or do not survive the years of schooling.

Another visible effect of the HIV/AIDS is reduced number of qualified teachers in schools due to increased infection among teachers. A study in Zimbabwe found that 19% of male teachers and almost 29% of female teachers were infected with HIV. In 2004, it is estimated that 17% of Mozambique's teachers were HIV-positive and skilled teachers are not easily replaced. Swaziland has estimated that it will have to train 13,000 teachers over the next 17 years, just to keep services at their 1997 levels - 7000 more than it would have trained if there were no AIDS deaths. The consequences of this include increased teacher absenteeism (World Bank 2002), possible combining of two or more classes for

one teacher, poor teaching and learning, and most invariably, a decline in the overall quality of education.

It has also been established that gender and HIV/AIDS are inextricably linked. Women are the worst hit by the disease and remain among the most vulnerable. Twice as many women are infected as men by the HIV. Several factors, including cultural and traditional practices revolving around masculinity and femininity among the youth, poverty and the absence of sexual harassment policies and programmes to curb rape and other forms of violence, have been documented as contributing to increased vulnerability of women to HIV in Africa. It has been noted in particular that transactional sex and sex work are increasingly gaining grounds among young female students in tertiary institutions as coping strategies to mitigate the effects of poverty.

It is against the background of the devastating impact of HIV/AIDS on the education sector in Africa that the Teacher Education Department (TED) of the United Nations Scientific and Cultural Organization (UNESCO TED) in collaboration with the Working Group of Higher Education of the Association for the Development of Higher Education in Africa commissioned this study.

The study focuses on the responses of teacher training colleges to the HIV/AIDS pandemic in Africa. Teacher training colleges are part of the premier institutions of human resource development and as such have a critical role in training professionals to fight against and mitigate the effects of HIV/AIDS in Africa. Teachers can exert a lot of influence on the behaviour, attitudes and skills of the young as well as the community at large through their academic and social roles. If the fight against the HIV/AIDS pandemic is to be achieved, then teacher trainees should be adequately equipped with the requisite knowledge and skills to assist the pupils in the classrooms to prevent as well as effectively deal with emotional and psychological problems associated with HIV/AIDS. The extent to which teacher training colleges have responded effectively to the training needs of trainees to be able to deal with the challenges posed by HIV/AIDS to the education sector in Africa is not very clear.

1.3 Objectives of the Study

The specific objectives of this study were:

- Conduct a continent-wide survey of teacher training institutions in Africa to assess what these institutions are doing to develop and implement a comprehensive approach to HIV/AIDS prevention and education;
- Conduct three in-depth case studies on policies and programmes (on-going or being developed) along with needs in the area of HIV/AIDS prevention and education in teacher training institutions in Africa;
- Develop a set of guidelines, using the results of the survey and case studies, to assist teacher training colleges in implementing comprehensive HIV/AIDS policies and programmes, usable by UNESCO, African governments/policy and decision makers and other development agencies that support education in Africa; and
- Publish a directory of the profiles of Teacher Training Institutions addressing the HIV/AIDS pandemic.

1.4 Methodology

1.4.1 *Sample*

The survey covered 178 teacher training colleges (see Annex 3) drawn from twenty (20) African countries (see table 2). Ninety-eight percent (98%) of these colleges are public while 2% are private. Thirty-one (31) countries, spread across the three major linguistic zones (anglophone, francophone and lusophone) were originally targeted through consultations with National Teachers' Organizations (Member Organizations of the Pan African Teachers' Centre). Although the unit of analysis of the study is training colleges, country participation was equally important as far as the objectives of the study were concerned. Against this background, it is worth noting that in terms of country participation, the response rate is 65%, which can be considered as quite reasonable in view of the general poor response rate associated with self-administered and mailed questionnaires.

Table 2. Number of colleges by country

No.	Country	Colleges	
		Frequency	Percentage
1.	Benin	5	2.8
2.	Burkina Faso	5	2.8
3.	Burundi	9	5.1
4.	Cameroon	7	3.9
5.	Congo Brazzaville	3	1.7
6.	Cote D'Ivoire	5	2.8
7.	Gambia	7	3.9
8.	Ghana	35	19.9
9.	Guinea Bissau	3	1.7
10.	Kenya	10	5.6
11.	Mozambique	5	2.8
12.	Niger	4	2.2
13.	Nigeria	18	10.1
14.	Senegal	6	3.4
15.	Sierra Leone	6	3.4
16.	Tanzania	4	2.2
17.	Togo	3	1.7
18.	Uganda	31	17.4
19.	Zambia	9	5.1
20.	Zimbabwe	3	1.7
Total		178	100

With the exception of Northern Africa, there is representation from the major sub-regions of Africa. Unfortunately, the Coordinators of the survey in South Africa, one of the most hard hit HIV countries in Africa, could not administer the questionnaires in time due to reasons beyond her control.

The three case study colleges targeted for in-depth study were purposefully selected from Zambia (National In-Service Training College, Chalimbana); Mozambique (Instituto do Majestério Primário, Matola) and Togo (Ecole Normale Supérieure d'Atakpamé). The choice of the colleges was based on consultations with the National Teachers' Organizations in the respective countries. They are believed to have played a pioneering role in the training of teachers in these countries. A cross-section of tutors (40), non-teaching staff (22) and students (48) were sampled from the three colleges for completion of the questionnaires. Sixty-four percent (64%) were males and 36% females.

1.4.2 Survey Instruments

Two kinds of questionnaires were employed for the survey. The first was the individual college questionnaire administered to the heads or their representatives and the second was administered to a cross-section of people (lecturers/tutors, students and non-teaching staff) from the three lead colleges.

In addition, select group interviews of tutors/lecturers, students and non-teaching staff were conducted in the three lead training colleges to cross-validate the responses obtained from the heads of the colleges.

Relevant documents on the situation of the disease in Africa and annual reports of the three lead colleges were also reviewed.

Essentially, the focus of the questionnaires and interviews was on the following areas:

- Background information on the colleges;
- HIV/AIDS-related programmes, activities and facilities available;
- College community awareness and perception of the disease;
- Extent of college collaboration with other key stakeholders in HIV/AIDS prevention and education; and
- Capacity building needs for improved HIV/AIDS prevention and education.

The profile of the colleges surveyed has been presented in a separate volume as a directory of African tertiary institutions responding to HIV/AIDS.

1.5 Limitations of the Study

The study faced a number of problems which tended to limit its scope and depth of analysis. The first major problem was lack of uniform school calendar year for the sample teacher training colleges. Some of the colleges had vacated for holidays when the survey commenced. This resulted in the delay of the administration of the questionnaires in such countries. A second problem was poor telephone and internet services for the colleges. Most of them did not have functional telephones thus resulting in delays in providing feedback to the country Coordinators on the status of questionnaire completion. In some

cases, the Coordinators had to make several trips to the colleges before they finally got the questionnaires completed. This most invariably increased the cost of administration of the questionnaires.

Also, the time period set for the completion of the study was too short, given the large area to be covered without good communication networks. Last but not least, the funding provided for the study was generally inadequate, thus limiting the ability to conduct in-depth field analysis as well as make the needed follow-ups to achieve a higher response rate. Personal observations of the training colleges' environments would have afforded the researcher the opportunity to gain better insights into, and appreciations of, the situations on the ground.

2. FINDINGS

2.1 Composition of Respondents

The respondents consisted of various members of the college staff, including principals, vice principals, HIV/AIDS focal persons, heads of departments/units and lecturers/tutors (see Table 3).

Table 3. Composition of respondents

Category of respondents	Frequency	Percentage
Principals	68	39.8
Vice Principals	20	11.7
HIV/AIDS Coordinator/ Focal Person	15	8.8
Heads of Departments/Units	5	2.9
Principal lecturer	2	1.1
Senior lecturer	1	0.6
Tutor/lecturer	51	29.8
Deputy Registrar	5	2.9
Senior Housemaster	1	0.6
Academic Secretary	2	1.1
Senior Curriculum Officer	1	0.6
Missing values	7	3.9
Total	178	100

The majority of the respondents were principals, followed by vice-principals and tutors/lecturers, thus suggesting that most teacher training colleges vest decision making with regard to HIV/AIDS in the top-most officials. This may constitute a good sign since

evidence available indicates that leadership involvement and commitment are critical for effective HIV/AIDS programming in institutions.

Only about nine percent (8.8%) of the colleges had HIV/AIDS coordinators or focal persons. Notwithstanding the need for the involvement of top leadership of the training colleges in dealing with HIV/AIDS, the apparent lack of dedicated Coordinators to provide the necessary guidance and support at the action level, could undermine institutional prevention, care, and counseling efforts. The establishment of HIV/AIDS Coordinators' positions in training colleges is absolutely necessary in order to provide the attention needed for effective coordination of the development, implementation, monitoring and evaluation of comprehensive HIV/AIDS prevention programmes.

2.2 Acceptance of HIV/AIDS on College Campuses

A fairly significant percentage of the respondents (largely college management staff) acknowledged that they had observed the incidence of HIV/AIDS and deaths related to HIV/AIDS among lecturers/tutors, students and non-teaching staff of the colleges involved in the survey (see Table 4).

Table 4. Observed incidence of HIV/AIDS and its related deaths among college community

Category of college community	Incidence (%)			Deaths (%)		
	Yes	No	Total	Yes	No	Total
Tutors/Lecturers	37.7	63.7	100	35.8	64.2	100
Non-teaching staff	27.5	72.5	100	24.4	75.6	100
Students	29.2	78.8	100	25.7	74.3	100

As can be seen from the Table, both the incidence and deaths observed seem to be more conspicuous among tutors/lecturers (37.7% and 35.8%) than among the students (29.2% and 25.7%) and non-teaching staff (27.5% and 24.4%), respectively. This difference may be due to the fact that infected lecturers/tutors who are comparatively older would be at the latter stages of the

gestation period of the disease when its symptoms begin to appear and result in deaths.

Nearly forty-two percent (41.9%), out of the sixty respondents who answered the question, were of the opinion that the prevalence and incidence rates of the disease were the same, while 37.1% and 17.7% considered them to be decreasing and increasing, respectively, over the past few years. The reality is that most (69%) of the colleges do not keep data/ information on HIV/AIDS, thus, making it difficult for them to provide a reliable description of the trends of the disease in the colleges. Trends of the disease can only be accurately assessed using longitudinal data collected by the colleges from various sources and HIV/AIDS related activities, including the clinics and counseling centres where college communities go for services.

2.3 Impact of HIV/AIDS on Colleges

The respondents could not provide hard data for the impact of HIV/AIDS on the colleges beyond perceptions. They had varying perceptions of the impact of HIV/AIDS on the college communities (see Table 5).

Table 5: Perceptions of the impact of HIV/AIDS on college

Impact of HIV/AIDS	Responses	
	Frequency	Percentage
Awareness created	39	33.0
Minimal	28	24.9
Bad and serious	17	14.5
Under control	11	9.0
High	9	7.6
Difficult to tell	6	5.0
Increased use of condoms	3	2.6
Shortage of personnel	2	1.7
Formation of HIV/AIDS clubs	1	0.85
Apprehensiveness	1	0.85
Total	117	100

The majority (33%) of the respondents were of the opinion that the impact of HIV/AIDS was the creation of awareness of the disease among the college communities. A fairly large percentage (24%) of the respondents felt the impact was minimal while others considered the impact as bad and serious (14.5%) or high (9%).

Also significant to note is that a reported increased use of condoms was considered as an impact while some found it difficult to tell the impact of HIV/AIDS on the college communities.

The apparent lack of in-depth and critical analysis of the impact of the disease provided by the respondents raises serious doubts as to whether they have adequate knowledge and full appreciation of the real impact of HIV/AIDS. One would have expected the respondents to provide information on the lecture hours lost due to the inability of infected tutors to attend classes, the increasing financial burden on the colleges resulting from increasing demand for health care of infected staff and students and the shortage of lecturers through the contract of the disease. The collection and maintenance of reliable data/ information by colleges is critical for effective initiation, monitoring and evaluation of any form of HIV/AIDS intervention. Unfortunately, 69% of the colleges involved in the study did not collect data / information on HIV/AIDS-related incidence and activities. The need for the establishment of HIV/AIDS database system by training colleges is highly recommended if the impact of the disease is to be assessed accurately for appropriate institutional responses to be initiated to reduce the incidence of new cases and mitigate the effects on those people with HIV.

2.4 Response of Training Colleges to HIV/AIDS Pandemic

Training colleges' response to HIV/AIDS can take several forms, including the initiation of prevention, education and treatment programmes, the development of policies and institutional arrangements for effective coordination, etc. Against this background, respondents were asked to indicate whether or not their institutions had any of these in place (see Table 6).

Table 6. Any HIV/AIDS policy and other related items in place

Items	Items in place	
	Yes (%)	No (%)
Education programme	80	20
Institutional arrangements	69	30

Prevention programme	65	33
Integration into curriculum	62	37
Training manuals	58	40
Teaching and learning materials	56	42
Code of conduct for dealing with AIDS	36	61
Voluntary counseling programme	35	63
Work-place programme	35	61
Specialized units	35	64
Community outreach programme	34	65
Written policy	29	65
Annual financial provision in the budget for HIV	8	90
Voluntary Testing programme	7	90
Treatment facilities	6	91

Note: Based on 178 respondents and % rounded off to the nearest whole number. (Percentages do not add up to 100% due to exclusion of missing cases.)

HIV/AIDS education programmes are the most common among colleges (79%), followed by the establishment of institutional arrangements (69%) for addressing HIV/AIDS issues. Many of the colleges also reported having prevention programmes (65%), integration of HIV/AIDS into their curricula (62%), having developed training manuals for HIV/AIDS (58%) as well as teaching and learning resource materials (56%). While these figures suggest significant responses being made by the colleges, what the study has not been able to establish for one to pass a vote of confidence to them, is the physical existence and qualities of these facilities/ tools as well as the level of stakeholder involvement in their design and development. If the colleges' responses to the HIV/AIDS disease are to produce the desired results, then the approach to developing the tools and institutional arrangements must be participatory and cross-cutting.

A large number of the colleges did not have treatment facilities (91%) or voluntary testing facilities (90%). They lacked written HIV/AIDS policy (65%) as well as community outreach programmes (65%). They also had no specialized Units (65%) or voluntary counseling (63%). While treatment is very important, it

may not be strategically feasible for colleges to establish treatment centres within campus as people with HIV may feel uncomfortable to make their cases openly known. An alternative could be to link up college communities with treatment and counseling centres in nearby hospitals.

Generally, the training colleges involved in the study appear to be more interested in programmes than in institutional facilities and written policies for addressing HIV/AIDS. What is not clear is the extent to which these programmes are comprehensive enough to effectively address HIV/AIDS prevention and education.

The more pertinent issue is the very low percentage (8%) of the respondents reporting of having made financial provisions annually in their budgets for HIV/AIDS activities. Comprehensive HIV/AIDS prevention and education programmes require adequate resources for effective implementation. Training colleges need to consider the issue of resource mobilization for HIV/AIDS prevention very important. College internal sources as well as in-country sources (NGOs, bilateral and multi-lateral donors) have to be explored vigorously to ensure provision of adequate and sustainable funding for a comprehensive response to the HIV/AIDS disease.

Another important area of concern is the lack of written HIV/AIDS policies to guide management of training colleges to develop systematic prevention and education programmes as well as curriculum. As many as 36% and 40% of the colleges involved in the study do not integrate HIV/AIDS into their curricula nor have any HIV/AIDS related teaching and learning materials and training manuals, respectively. Without clear policies, the inclusion of HIV/AIDS in the teaching programmes is left to the discretion of individual tutors/ lecturers and departments with the attendant consequences of variations in terms of focus, depth and scope across academic departments. Written HIV/AIDS policies set the appropriate framework for the training colleges to situate comprehensive HIV/AIDS programmes and must therefore be given the needed attention.

When further asked what the colleges' responses to the HIV/AIDS had been, the majority (48%) indicated that they had conducted sensitization while 40% simply said it was positive (See Table 7). Efforts have also been made at integrating HIV/AIDS into the curriculum by a few colleges (15%) and reported formation of

HIV/AIDS Prevention Clubs (12%). A few felt the response has been poor and weak due to inadequate finances.

Table 7. What has been the college's response to the HIV/AIDS pandemic?

Colleges' Response to HIV/AIDS	Response	
	Yes (%)	No (%)
Positive response	40.4	59.6
Sensitization	47.8	52.2
Integration into curriculum	15.2	84.8
Creation of HIV/AIDS clubs	12.4	87.6
Embarking on workshops	9.0	91.0
Poor	4.5	95.5
Lack of finance	1.7	98.3

2.5 Training of Tutors/ Lecturers in HIV/AIDS and Family Life Education

When asked if the teachers had been trained in HIV/AIDS and Family Life Education, 74% responded in the affirmative. A majority (33.7%) of the colleges had the training from the Ministry of Education and NGOs, followed by National AIDS Commission (nearly 15%). A few benefited from joint training programmes from NGOs and the Ministry of Education (nearly 4%), Ministry of Health and Council of Churches (2.8%). What is quite clear from the data is that a large number of the tutors in the training colleges has not been trained in HIV/AIDS and Family Life Education. A summary of the training providers is given in Table 8.

Table 8. Providers of HIV/AIDS and Family Life Education Training for colleges

Training providers	Response	
	Yes (%)	No (%)
Ministry of Education	33.7 (60)	65.7 (117)
NGO's	33.7 (60)	66.3 (118)
National AIDS programme	14.6 (26)	85.4 (152)
NGOs and Ministry of Education	3.9 (7)	96.1 (171)
Ministry of Health	2.8 (5)	97.2 (173)
Council of Churches	2.8 (5)	97.2 (173)

World Bank	2.2 (4)	97.8 (174)
Consultants	1.1 (2)	98.9 (176)
Department for Gender Issues	0.6 (1)	99.4 (177)

2.6 Content of the HIV/AIDS Training Programmes Attended by Teachers

The quality of a training programme is partly determined by its content. Table 9 presents the content of the HIV/AIDS and Family Life Education training offered to their tutors.

Table 9. Content of the training programme

Content of training programme	Percentage attended	
	Yes (%)	No (%)
Sensitization	46.1	53.9
Prevention strategies	34.8	65.2
Integration into curriculum	8.4	91.6
Guidance and counselling	5.6	94.4
Interactive methodology	3.9	96.1
Training of trainees	3.9	96.1
Population and Family Life Education	3.9	96.1
Reproductive Health	3.4	96.6
Gender program	1.7	98.3
Formation of HIV/AIDS clubs	1.1	98.9
Establishment of HIV/AIDS unit	0.6	99.4

It can be seen from table 9 that most (46%) of the tutors received sensitization training programmes followed by prevention strategies (35%). Very few of them had training in such core areas as integrating HIV/AIDS into the curriculum, guidance and counseling, population life education and gender mainstreaming. College tutors need to be equipped with adequate skills and knowledge in these areas to be able to work through the often difficult situations associated with people living with HIV. The survey was not able to ascertain the quality and duration of the training content, and the number of tutors who benefited. An effective HIV/AIDS prevention training programme must be based on well developed training plans derived from systematic training needs assessments.

2.7 Collaboration with Other Key Stakeholders

It has become clear over the years that the fight against HIV/AIDS cannot be won by a single individual organization. It requires multi-sectoral and institutional collaboration in efforts aimed at HIV/AIDS prevention, education and treatment to yield effective results. When asked if there was any on-going collaboration between the college and other key stakeholders, the respondents provided the following responses (see Table 10)

Table 10. On-going collaboration with other key stakeholders

Organizations	Areas of collaboration							
	HIV prevention		HIV education		HIV treatment		Community outreach	
	Yes	No	Yes	No	Yes	No	Yes	No
NGOs	43.8	35.4	49.4	29.2	6.2	60	18.0	52.2
Donors	16.3	51.1	18.0	45.5	2.2	57.3	11.2	50.6
Private Sector	10.1	51.1	10.7	47.8	1.1	55.6	5.6	52.8
Government Sector	48.3	31.5	56.7	29.8	10.1	57.3	21.9	47.2

Although not as high as expected, the results in the table suggest that training colleges have more collaboration in HIV/AIDS prevention, education and treatment activities with NGOs and Government Agencies than with donors and the private sector. College community outreach collaboration is also generally low.

Regarding the specific organizations that Colleges collaborate with, the most widely mentioned were:

- Ministry of Education;
- Ministry of Health;
- National AIDS Program; and
- World Bank.

Some respondents, however, could not recollect the names of the specific NGOs that had collaborated with them, thus raising doubts as to how serious or significant those collaborations indicated in table 10 had been.

2.8 Main Sources of HIV/AIDS Information for Colleges

In terms of access to information about HIV/AIDS, the mass media is the major source for most colleges (nearly 33%), followed by written materials (nearly 26%), training manuals (nearly 22%), Ministry of Education (about 16%) and workshops/seminars, NGOs and Ministry of Health in that descending order (see Table 11).

Table 11. Main sources of information about HIV/AIDS for training colleges

Source	Response	
	Yes (%)	No (%)
Mass Media	32.6	67.4
Written Material on AIDS	25.8	74.2
Training Manual	21.9	78.1
Ministry of Education	16.3	83.7
Through Workshops and Seminars	14.0	86.0
NGOs	10.1	89.9
Ministry of Health	9.0	91.0
National AIDS Secretariat	5.6	94.4
Anti-AIDS Club	4.5	95.5
Training of Trainees	2.2	97.8
Interactive Methodology	1.1	98.3

The comparatively lower percentages of respondents not getting HIV/AIDS information from the above traditional sources suggest limited access to HIV/AIDS information in general among the training colleges. This hampers the attainment of one of the major targets set by the United Nations General Assembly Special Session held in 1999, which states among other things that:

Governments with the assistance from UNAIDS and donors should, by 2005, ensure that 90% and by 2010 at least 95% of young people aged 15-24 have access to the information, education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as male and female condoms, voluntary testing, and counseling and follow up.

2.9 Respondents' Perceptions of the Way Forward

Integration of HIV/AIDS into the curriculum was considered by most respondents as a measure to be taken to enhance the capacities of the training colleges to promote effective HIV/AIDS prevention, education, care and community outreach. This was

followed by the development of sustained sensitization and education programmes, training of tutors/ lecturers in HIV/AIDS and provision of adequate resources in that descending order (see Table 12).

Table 12. Perceptions of the way forward

Capacity building needs	Responses	
	Yes (%)	No (%)
Integration of HIV/AIDS into curriculum	32.0	68.0
Initiation of college community sensitization of programme	28.1	71.9
Intensification of HIV/AIDS education programmes	27.5	72.5
Training of teachers in HIV/AIDS	24.7	75.3
Provision of adequate resources	21.9	78.1
Establishment of counseling centre	7.3	92.7
Establishment of units for coordination of HIV/AIDS programmes	2.8	97.2

Essentially, it can be inferred from the data in Table 12 that three areas, namely, integration of HIV/AIDS into the curriculum, strengthening of prevention and education programmes, and provision of adequate resources, are required to promote any effective response of training colleges to the HIV/AIDS pandemic.

It is surprising to note that no mention is made of the need for colleges to develop written HIV/AIDS work-place policies to guide them even though many of them reported of not having any written policies in place.

3. CASE STUDIES

3.1 Togo

3.1.1 *Socio-Economic Background*

Population

According to the Population Reference Bureau (2004), Togo has a population of 5,600,000 million people, with a natural increase rate of 2.7% and a total fertility rate of 5.5. The number of births and

deaths per 1000 people are 38 and 11, respectively. The infant mortality rate is 72. The projected population by 2025 is 7.600,000. The life expectancy at birth is 54, with females living longer than males on the average.

Economy

The economic performance is said to have improved over the past three years, with GDP real growth rate estimated at 2.7 percent in 2003, after a record 4.2 percent in 2002. The GDP per capita is 310 USD. The improved economic performance is attributed largely to increased productivity in the agricultural sector as a result of favorable climatic conditions experienced over the period.

The overall budget (on commitment basis and excluding grants) recorded a surplus estimated at 0.8 percent of GDP in 2003, compared with a deficit of the same magnitude in 2002. However, because of the continued suspension of external budgetary aid, this was accompanied by further accumulation of external payment arrears.

Educational Attainment

The total adult literacy rate is estimated at 57.1 % in 2000, with greater percent for males than females (UNAIDS/WHO Epidemiological Fact Sheet 2004 Update). Gross primary school enrolment ratio for males is 138 in 2000/2001 and 110 for females in 1996 (UNAIDS/WHO Epidemiological Fact Sheet 2004 Update). The secondary school gross enrolment ratios in 1996 for males and females were 54 and 24, respectively (UNAIDS/WHO Epidemiological Fact Sheet 2004 Update).

3.1.2 HIV/AIDS Situation

The HIV/AIDS situation in Togo is presented in Table 13. The prevalence rate among adults aged (15-49) is estimated at 4.1% at the end of 2003. The number of people living with HIV/AIDS for the same age group for the same period is 96,000 with females accounting for 56%. Reported AIDS related deaths for both children and adults are estimated to be 10,000 in 2003.

Table 13. HIV and AIDS estimates, ending 2003

Adult (15-49) HIV prevalence rate	4.1% (Range: 2.7%-6.4%)
Adults (15-49) Living with HIV	96 000 (range: 61 000-150 000)
Adults and children (0-49) Living with HIV	110 000 (range: 67 000-170 000)
Women (15-49) Living with HIV	54 000 (range: 35 000-84 000)
AIDS deaths (adults and children) in 2003	10 000 (range: 6400-16 000)

Source: [2004 Report on the global AIDS Epidemic](#)

3.1.2.1 Consequences of HIV/AIDS

There is hardly any systematic empirical analysis of the economic impact of HIV/AIDS on Togo. What is found in the literature are international studies conducted using models to explore the potential effect of AIDS on the education and health systems. Based on such studies and specific empirical country studies in many sub-Saharan African countries, there is consensus that the impact of HIV/AIDS is likely to be similar in Togo. Some of the identified impacts include reduction in incomes of households, agricultural productivity, increased illness and death leading to increased expenditure, increased pressure on the health system, reduced savings and shifts in productivity patterns, shortage in skilled labour, reduced school enrolment, loss of experienced teachers, and decline in overall quality of education among others.

3.1.2.2 National Response to HIV/AIDS

Togo has no written national HIV/AIDS policy (UNAIDS 2000). However, a National Anti-HIV/AIDS Committee has been formed. Also, a national strategic plan (2001–2005) has been developed with the full commitment and involvement of all key partners from the public sector, civil society, development partners and the private sector. Sectoral operational plans were drawn up and budgeted in 2002. This served as a basis for drafting the Global Fund proposal, which was approved on its second application (UNAIDS 2004).

The five-year plan aims at curbing the expansion of the HIV/AIDS epidemic and reducing its impact on the population. The plan has widened the partnership in the setting up of interventions to ensure coordinated participation of the government, private sector and NGOs. It reinforces the response to the fight against HIV/AIDS by focusing on improving the provision of ARV treatment to PLWHAs who meet the eligibility criteria as well as medical and social care to them and extend the vertical prevention programme to reach HIV mother-child groups. Safety of blood transfusion is to be reinforced throughout the country and young people from age 10 to 25, sex workers and their partners have also been targeted.

The main strengths of the plan include:

- Its comprehensiveness in terms of scope (including ARV and pertinent medical and psycho-social care, intervention on vertical transmission, safety of blood transfusion and populations at risk);
- Services to be provided to pregnant women including VCT;
- Widened partnership to include coordinated participation of the Government, NGOs and private sector;
- Detailed education plans at schools; and
- Detailed participatory monitoring and evaluation programme (involving people living with HIV/AIDS and the community).

3.1.3 HIV/AIDS Situation in Ecole Normale Supérieure (ENS) d'Atakpamé, Togo

3.1.3.1 Awareness and Acceptance of HIV/AIDS

Very few of the three categories of the college community were aware of the incidence of, and, HIV/AIDS-related deaths among their members (see Tables 14 and 15). The incidence is more likely to be observed among students (12.1%) than any other category of the college. This difference may not be surprising in view of the fact that research evidence shows that young people (of student age) are more vulnerable to HIV/AIDS infection since they are sexually very active and engage in risk-seeking behaviour.

The low awareness of HIV/AIDS incidence and deaths may be due to the fact that national prevalence is quite low. However, it would be useful for the college to document HIV/AIDS incidence and deaths among its community.

Table 14. Awareness of the incidence of HIV/AIDS among community

Category of community	Response		
	Yes (%)	No (%)	Total (%)
Students	12.1	87.9	100
Teachers/tutors	6.1	93.9	100
Non-teaching staff	3.0	97.0	100

Note: NS = 33

Table 15. Awareness of HIV/AIDS related deaths

Category of community	Response		
	Yes (%)	No (%)	Total (%)
Students	1.0	93.9	94.9
Teachers/tutors	0.0	97.0	97.0
Non-teaching staff	0.0	97.0	97.0

Note: NS = 33; Missing: 3 & 5, respectively.

3.1.3.2 Consequences of HIV/AIDS on the Ecole Normale Supérieure d'Atakpamé

The interview with the principal of the college revealed that the College had no records on HIV/AIDS-related activities, incidence and deaths. This was attributed to lack of human and material resources. The result is that the college could not provide empirical evidence on the socio-economic impact of the disease on the college communities. The lack of impact assessment of HIV/AIDS on the college community mirrors the national situation in Togo. Empirical socio-economic impact assessments of the disease at the national level are yet to be done.

3.1.3.3 Ecole Normale Supérieure d'Atakpamé's Response to the HIV/AIDS Situation

Sensitization is the only HIV/AIDS-related activity that the community of ENS d'Atakpamé was aware had taken place. Even with this one activity (sensitization program), only 52 % of the respondents participated in it.

The sensitization programmes were organized mainly by Non-Governmental Organizations (NGOs) and the National HIV/AIDS Program (Table 16). It is surprising to note that there is no involvement of the critical Ministries such as Education and Health in the HIV/AIDS sensitization programme in ENS d'Atakpamé. Teacher training colleges in the country in general operate under the Ministry of Education and would therefore require its support for the design and implementation of HIV/AIDS programmes.

Table 16. Providers of HIV/AIDS training and life skills education

Providers	Response	
	Yes	No
NGOs	9.1	90.9
National HIV/AIDS program	12.1	87.9

Note: NS = 33

3.1.3.4 Main Sources of Information about HIV/AIDS for Ecole Normale Supérieure d'Atakpamé

The most popular source of HIV/AIDS information for this college is the mass media, followed by literature, National HIV/AIDS programmes and Internet in that descending order (see Table 17). It is not clear what the respondent meant by "literature" on HIV/AIDS. It could be printed information.

It is worth noting that the mass media has not always provided very reliable and valid information on sensitive social issues such as HIV/AIDS and hence the need for the college to provide other alternative sources from which its community members can obtain information to cross-validate or complement what is obtained from the mass media to enhance their knowledge and understanding of HIV/AIDS.

Table 17. Main sources of information about HIV/AIDS

Source	Response		
	Yes (%)	No (%)	Total (%)
Mass media	90.9	9.1	100

NGOs	33.3	66.7	100
Literature on HIV/AIDS	27.3	72.7	100
Internet	27.3	72.7	100
National HIV/AIDS programme	21.2	78.8	100

Note: NS = 33

3.1.3.5 Proposals to Strengthen HIV/AIDS Unit in Ecole Normale Supérieure d'Atakpamé

ENS d'Atakpamé has no HIV/AIDS Unit. Issues related to HIV/AIDS emanate from the Principal's office. There is no designated Coordinator for HIV/AIDS activities. Without strong leadership and institutional arrangements, colleges cannot develop comprehensive HIV/AIDS programmes for prevention, education, treatment and care.

3.1.3.6 Proposals to Improve Teaching and Learning about HIV/AIDS in Ecole Normale Supérieure d'Atakpamé

Integrating HIV/AIDS into the curriculum of the academic programmes is considered by the majority (66%) of the college community as a strategy to improve teaching and learning about HIV/AIDS in the college (See Table 18).

Table 18. Proposals to improve teaching and learning about HIV/AIDS in the college

Proposed measure to be undertaken	Percentage	
	Yes	No
Integrate HIV/AIDS education into the school curriculum	66.7	33.3
Organize more sensitization programmes	3.0	97.0

Note: NS=33

3.1.3.7 Proposals to Promote HIV/AIDS Prevention, Education, Care and Outreach Activities in Ecole Normale Supérieure d'Atakpamé

The majority of the respondents (nearly 91%) proposed giving regular sex-education as a strategy for promoting HIV/AIDS prevention, education and care as well as outreach activities in ENS d'Atakpamé (Table 19). Continued sensitization and college

and community interactions were also proposed as measures for promoting HIV/AIDS prevention, education, and care and outreach activities.

Table 19. Proposals for promoting HIV/AIDS prevention, education, care and community outreach

Measures to be taken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programme	15.2	84.8	100
Give regular sex education	90.9	9.1	100
College and community interactions	3.0	97.0	100

Note: NS = 33

3.1.3.8 Proposals to Promote Active Academic Staff Involvement in HIV/AIDS Activities

With regard to promoting the involvement of academic staff in HIV/AIDS related activities, a fairly large number of respondents (36%) suggested the organization of HIV/AIDS sensitization programmes, followed by provision of teaching and learning aids (see Table 20). It is surprising that only 6% and 3% suggested the provision of training for academic staff in HIV/AIDS and integration of HIV/AIDS into the College teaching curriculum, respectively as strategies for promoting academic staff involvement. College teachers/tutors must be well trained to be able to handle the complex and often hard situations associated with people with HIV/AIDS. Deepening the knowledge and understanding of teachers/tutors and college students in HIV/AIDS can only be achieved through integration or mainstreaming of HIV/AIDS into the college academic curriculum.

Table 20. Proposals for promoting active involvement of academic staff in HIV/AIDS activities

Measures to be undertaken	Response		
	Yes (%)	NO (%)	Total (%)
Organize sensitization programmes for staff	36.4	63.6	100
Provide teaching and learning aids	18.2	81.8	100
Train academic staff on HIV/AIDS	6.1	93.9	100
Integrate HIV/AIDS education into the school curriculum	3.0	97.0	100

Note: NS = 33

3.1.3.9 Proposals for promoting of active involvement of students in HIV/AIDS activities

In terms of promoting active involvement of students in HIV/AIDS, a fairly significant percentage (24%) of the respondents suggested the organization of sensitization programmes for students. About nine (9.1%) percent of the respondents suggested integration of HIV/AIDS into the teaching curriculum, and the formation of HIV/AIDS clubs (Table 21).

Table 21. Proposals for promoting active involvement of students in HIV/AIDS activities

Proposed action to be undertaken	Response		
	Yes (%)	No (%)	Total
Organize sensitization programmes for students	24.2	75.8	100
Integrate HIV/AIDS education into the school curriculum	9.1	90.9	100
Form anti-HIV/AIDS clubs	9.1	90.9	100
Involve students in HIV/AIDS activities	6.1	93.9	100

Note: NS=33

3.1.3.10 Proposals to Promote Active Involvement of Non-teaching staff in HIV/AIDS Activities

Similarly, for the promotion of active involvement of non-teaching staff in HIV/AIDS activities, a significant percentage (30%) of the respondents suggested the organization of sensitization programmes and involving non-teaching staff in college HIV/AIDS activities (see Table 22). Interactions with members of the non-teaching staff suggest that they have not been involved in HIV/AIDS activities in the college. Tackling the HIV/AIDS situation in the college community requires the involvement of the entire community, including the non-teaching and academic staff and students.

Table 22. Proposals to promote active Involvement of non-teaching staff in HIV/AIDS activities

Proposed action to be undertaken	Response
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	Yes (%)	No (%)	Total (%)
Organize sensitization programmes	30.3	69.7	100
Involving Non-teaching staff in HIV/AIDS activities	30.3	69.7	100

Note: NS= 33

3.2 MOZAMBIQUE

3.2.1 *Socio-Economic Background*

3.2.1.1 *Population*

Mozambique is said to have an estimated population of about 18.8 million (CIA World Fact Book, 2004) with an annual growth rate of 1.22% resulting from a total fertility rate of 4.78 children per woman. The birth rate is about 36.6/ 1000 (CIA World Fact Book, 2004) and the death rate, 23.86/1000 (CIA World Fact Book, 2004). Infant mortality stands at 137.08/1000 births and average life expectancy is 37.1 years at birth.

3.2.1.2 *Economy*

The country has just about recovered from being one of the poorest in the world at the time of attaining independence in 1975, a situation later exacerbated by a fourteen-year long civil war. This is as a result of a series of macroeconomic reforms embarked upon by the government and donor assistance. In addition, the country has been quite stable politically since its multi-party elections in 1994. Inflation has been drastically reduced, but the country still depends on foreign assistance for much of its annual budget. Subsistence agriculture continues to employ the vast majority of the country's workforce. A substantial trade imbalance persists although the opening of the MOZAL aluminium smelter, the country's largest foreign investment project to date, has increased export earnings. The country also has investment projects in titanium extraction and processing and garment manufacturing. Mozambique's once substantial foreign debt has been reduced through debt cancellation and rescheduling under the IMF's Heavily Indebted Poor Countries (HIPC) and Enhanced HIPC initiatives.

The GDP purchasing power parity is \$21.23 billion (CIA World Fact Book 2003) and the growth is 7 % (2003). Though the investment

gross fixed rate stands at 47.8%, a 70% majority of the population live below the poverty line (CIA World Fact Book 2001). Also, in spite of a 9.2 million labour force made up of 81% agriculture, 6% in industry and 13% in services, there is still an unemployment rate of 21% (CIA World Fact Book 1997).

3.2.1.3 Educational Attainment

Mozambique, as a signatory to the World Declaration on Education For All, has had as her aim the achievement of a gross enrolment of 86% by the year 2000 (UNESO). Also, it has been implementing an Education Sector Strategic Plan since 1999. However, only about 47.8% (CIA World Fact Book 2003) of the population of the country is literate with a definition age of 15 years and above. Also, very few people completed primary school, as many adolescents, especially girls, dropped out of school due to early marriages or pregnancies (UN Office for the Coordination of Humanitarian Affairs, 2004).

3.2.2 HIV/AIDS Situation

A report on the global HIV/AIDS epidemic indicates that the country has the World's tenth highest HIV infection rate (UNAIDS 2004). The national prevalence rate is given as 12.2%, with an estimated 1.2 million people living with HIV/AIDS. The rate, however, goes as high as 20.7% in the four Central provinces of Manica, Tete, Sofala and Zambezia. This is because this is the area that bears the brunt of the huge human traffic of transiting men and women who seek access through what is usually known as the Beira corridor to the coast for trading, business and other purposes with the attendant possibility of sexual activity between people who are not in any way committed to each other. Also, it should be noted that in a country where 70% of the population is purported to be living below the poverty line (CIA World Fact Book 2004), the easy access to money that the sex trade offers is a real lure. Incidentally, many of these transiting persons come from such countries as Swaziland with rather high national rates of infection themselves (38.8%) and Zimbabwe (24.6%) (UNAIDS 'Report on the Global AIDS Epidemic' (2004). Indeed, though figures given during interviews consistently described the current national infection rate as having gone down to 13%, with 13.5% in Maputo the capital, these provinces continue to record very high rates of infection with Sofala, whose capital is Beira, leading the pack with a rate of 26%.

3.2.2.1 Consequences of HIV/AIDS

The disease is essentially 100% fatal (Bollinger & Stover 1999) and as it has a high infection rate among people in the most productive stage of their lives where they could contribute to national building and development, it tends to have, by consequence, a crippling effect on the national economy. The impact is felt first of all by the family for whom the infected may be the breadwinner or on whose resources the illness may cause a drain. There can also be emotional and psychological impact on the children and other dependants of the infected if the illness results in death leaving them with no emotional care. In Mozambique there was an estimated 146,000 orphans from AIDS in 1996, a figure projected to rise to 400,000 by year 2000. (Bollinger and Stover, 1999). And indeed, the UNAIDS report of 2004 states that out of a total of 12 million children orphaned by AIDS by the end of 2003, 470,000 were Mozambicans. As a country highly dependent on subsistence farming, HIV/AIDS infection touches directly on the economy when farmers are infected and are unable to plant or harvest neither cash nor food crops. As explained by the leader of a development project, HIV/AIDS could disable the increase or stabilization of agricultural yields especially with mechanized agriculture and thereby necessitate the education and training of additional personnel.

The disease has similar crippling effects on all sectors of the national economy. When trained personnel such as teachers, engineers and other service providers are infected or die from the disease, development efforts are stalled. According to Bollinger and Stover (1999) the disease for instance, affects the health sector of the country seriously as health personnel get infected and as the number of infected people needing health care increases. This is because the country already has one of the lowest numbers of doctors per capita on the continent. Also, the transport sector of the country faces a great challenge from the disease because data on workers in that sector collected in the central Beira corridor presented a high rate of 30.3% and yet most transport managers are highly trained and therefore, difficult to replace.

The impact on the Education sector is also great. The number of experienced teachers is reduced as they are lost to the disease. Again, children are kept out of school to look after the infected or

because they are sick themselves or have no means of paying for their education. In effect, the country's literacy drive efforts are being eroded by the disease.

The negative socio-economic impact of the disease on Mozambique is indeed great considering the submission of the UNAIDS (2004) that life expectancy of the Mozambican, which is 42.5 years, will drop to 27.1 by the year 2010 as a result of HIV/AIDS. It will be next to impossible to replace the huge numbers of skilled humanpower lost to the disease. Also, the provision of triple combination of antiretroviral therapy to HIV-positive adults in the country would erode 67% of the GDP (Bollinger and Stover 1999), which is a great drain considering the fact that over 75% of the government's budget is sourced from donors who do not have HIV/AIDS prevention programmes on their priority list (Bollinger and Stover 1999).

3.2.2.2 National Response to HIV/AIDS

The country has a Conselho Nacional de Combate ao HIV/AIDS, a National Anti-HIV/AIDS Council. There is also the Gabinete de Combat HIV/SIDA, a national office for HIV/AIDS education, which has branches in all the provinces. The Ministry of Education also has a Technical Group on HIV/AIDS with representatives from each directorate of the Ministry, including Teacher Education. Though the Ministry is yet to incorporate the policy on HIV/AIDS drafted by the Group into its general policy, it has constituted a committee that executes the decisions and recommendations of the Technical Group. Consequently, HIV/AIDS education has been integrated into Basic- level education. The Ministry is also working with UNESCO on extending the integration to Teacher Training Colleges. The Committee has, however, been providing education on sexual and reproductive health as well as HIV/AIDS to teachers already in the field through in-service training programmes while the preparations towards full integration into Teacher Training Programmes of instruction continue. The Ministry also has magazines and other educational journals such as 'Contacto' through which HIV/AIDS information and education are given, and copies of these are supplied to Teacher Training Colleges.

There have also been reforms in Mozambique to protect the rights of people living with HIV/AIDS. Laws protecting the labour rights

of civil servants have been introduced and there are efforts to ensure private firms apply the same policies.

Again, there are a number of non-governmental organizations in the country trying to educate the people on the disease. The Mozambican Association for the Development of the Family (AMODEFA) has been organizing workshops in schools, work places and neighbourhoods to increase awareness of the disease in order to prevent new infections. There are others like the Biz-Generation, Save the Children (Norway), as well as 'My Future is my Choice' supported by UNICEF with the view to creating a 'window of hope' by influencing children with safer sex and abstinence messages using trained peer educators.

3.2.3 *HIV/AIDS Situation in Instituto do Majestério Primário, (IMAP) Matola*

3.2.3.1 *Awareness and Acceptance of HIV/AIDS*

The results indicate that the IMAP community was more aware of the incidence of HIV/AIDS among the students than the tutors and non-teaching staff (Table 23). None of the respondents was aware of any incidence of HIV/AIDS-related death among the community.

Table 23. Awareness of the incidence of HIV/AIDS among community

Category of college community	Response		
	Yes (%)	No (%)	Total (%)
Students	23.3	73.3	96.6
Teachers/tutors	6.9	90.0	96.9
Non-teaching staff	0.0	96.7	96.6

Note: NS = 30: Missing: 3

It is surprising that there is a low level of acceptance of the prevalence of HIV/AIDS by the IMAP community in spite of the fairly high national HIV/AIDS prevalence. There appears to still be a high level of denial of the existence of the disease among the college community.

3.2.3.2 *Consequences of HIV/AIDS on Instituto do Majestério Primário*

The college had no records on HIV/AIDS related activities and its incidence/ prevalence and could not therefore provide any

empirical evidence on the socio-economic impact of the disease on the college community. Lack of record keeping was partly attributed to inadequate human and material resources by the college.

3.2.3.3 *Response of Instituto do Majestério Primário to the HIV/AIDS Situation*

The IMAP response to the HIV/AIDS pandemic took several forms, including training, drama, discussions, lectures, sensitization and guidance and counseling (see Table 24). However it must be noted that even though many of the respondents were aware of these HIV/AIDS-related activities in the college, very few (see Table 25) participated in them.

Table 24. HIV/AIDS related activity organized during academic year

Activity undertaken	Response		
	Yes (%)	No (%)	Total
Training	76.7	23.3	100
HIV/AIDS drama	53.3	46.7	100
Discussions	40.0	60.0	100
Lectures	30.0	70.0	100
Sensitization programmes	26.7	73.3	100
Guidance and Counseling	3.3	96.7	100

Note: NS = 30

Training was the activity that attracted most participation, followed by Drama and discussions (see Table 25). It appears the Ministry of Education is playing a leading role in the provision of HIV/AIDS-related training for the college, followed by NGOs (See Table 26). It is commendable that there is collaboration between the college and the Ministry of Education in HIV/AIDS-related activities. Other key Ministries, like Health, need to be involved.

Table 25. Participation in HIV/AIDS-related activity in the college

Activity	Response		
	Yes (%)	No (%)	Total (%)
Training	36.7	63.3	100
HIV/AIDS drama	16.7	83.3	100
Discussions	16.7	83.3	100
Sensitization programmes	13.3	86.7	100

Lectures	3.3	96.7	100
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Note: NS = 30

Table 26. Providers of HIV/AIDS Training and Life Skills Education

Provider	Response		
	Yes (%)	No (%)	Total (%)
Ministry of Education	50.0	50.0	100
NGOs	20.0	80.0	100

Note: NS = 30

3.2.3.4 Main Sources of Information about HIV/AIDS for Instituto do Majestério Primário

The most popular source of HIV/AIDS information for the college community is the mass media, followed by the Ministry of Education and the National AIDS Programme in that descending order (see Table 27). In terms of accuracy of information, the mass media has generally not been the best, thus raising concern about the findings below.

Table 27. Main sources of information about HIV/AIDS

Source	Response		
	Yes (%)	No (%)	Total (%)
Mass media	86.7	13.3	100
Ministry of Education	16.7	83.3	100
National HIV/AIDS programme	10.0	90.0	100
NGOs	3.3	96.7	100
Literature on HIV/AIDS	3.3	96.7	100

Note: NS = 30

3.2.3.5 Proposals to Strengthen AIDS Unit in Instituto do Majestério Primário

Generally, it can be summed up (from Table 28) that provision of adequate teaching and learning materials was considered by the college community as the best course of action to strengthen the college HIV/AIDS Unit for effective performance. Much as teaching and learning resource materials are essential for deepening the

understanding of HIV/AIDS issues, the right leadership to manage the Unit is equally critical and should be seriously considered.

Table 28. Proposals to strengthen HIV/AIDS unit

Proposed action to be undertaken	Responses		
	Yes (%)	No (%)	Total (%)
Equip the unit with audio-visual devices	43.3	56.7	100
Provide the unit with adequate teaching and learning resource materials	26.7	73.3	100
Provide the unit with adequate funds	13.3	86.7	100
Organize more sensitization programmes	6.7	73.3	100

Note: NS = 30

3.2.3.6 Proposals to Improve Teaching and Learning about HIV/AIDS in Instituto do Majestério Primário

Slightly over a quarter (26.7%) of the respondents suggested integrating HIV/AIDS into the curriculum of the academic programmes for improvement in teaching and learning about HIV/AIDS (see Table 29). A curriculum can only be effectively utilized if there are teaching and learning resource materials (TLRMs) to accompany it. It is therefore not surprising that mention was also made of the provision of TLRMs as a measure to improve teaching and learning about HIV/AIDS in the college.

Table 29. Proposals to improve teaching and learning about HIV/AIDS in the college

Proposed action to be undertaken	Response		
	Yes (%)	No (%)	Total
Integrate HIV/AIDS education into the school curriculum	26.7	73.3	100
Provide adequate teaching and learning materials	13.3	86.7	100

Note: NS = 30

3.2.3.7 Proposals to Promote HIV/AIDS Prevention, Education, Care and Outreach Activities in Instituto do Majestério Primário

For the promotion of HIV/AIDS prevention, education and care in the college, a significant percentage of the respondents proposed

among other things, the organization of inter-college discussions, creation of an equipped guidance and counseling unit as well as the organization of sensitization and training programmes (see Table 30).

Table 30. Proposals to promote HIV/AIDS prevention, education, care and community outreach.

Measures to be undertaken	Responses		
	Yes (%)	No (%)	Total (%)
Organize inter-college discussions	30.0	70.0	100
Create and equip guidance and counseling unit	20.0	80.0	100
Organize sensitization programme	16.7	83.3	100
Organize regular training programmes	16.7	83.3	100
Give regular sex education	16.7	83.3	100
College and community interactions	16.7	83.3	100
Exposure to HIV/AIDS victims	13.3	86.7	100
Integrate HIV/AIDS education into curriculum	6.7	93.3	100
Provide funding for HIV/AIDS activities	3.3	96.7	100

Note: NS = 30

3.2.3.8 Proposals to Promote Active Involvement of Academic Staff in HIV/AIDS Activities

With regard to promoting the involvement of academic staff in HIV/AIDS-related activities, a fairly large percentage of the respondents (43%) and (38%) suggested the integration of HIV/AIDS into the College training curriculum and training of academic staff on HIV/AIDS, respectively (see Table 32).

Table 31. Proposals to promote active academic staff involvement in HIV/AIDS activities

Measures to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Integrate HIV/AIDS education into the school curriculum	43.3	56.7	100
Train academic staff on HIV/AIDS	36.7	63.3	100
Provide teaching and learning aids	6.7	93.3	100

Note: NS = 30

3.2.3.9 Proposals to Promote Active Involvement of Students in HIV/AIDS Activities

In the case of promoting active involvement of students in HIV/AIDS-related activities, only about seventeen percent (16.7%) suggested the integration of HIV/AIDS into the teaching curriculum (see Table 32).

Table 32. Proposals to promote active involvement of students in HIV/AIDS activities

Measures to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Integrate HIV/AIDS education into the school curriculum	16.7	83.3	100
Give students assignments on HIV/AIDS	13.3	86.7	100
Train students on dangers of HIV/AIDS	6.7	93.3	100
Expose students to HIV/AIDS victims	3.3	96.7	100

Note: NS = 30

3.2.3.10 Proposals to Promote Active Involvement of Non-teaching staff in HIV/AIDS Activities

Concerning the promotion of active involvement of non-teaching staff in HIV/AIDS activities, only 13% of the respondents suggested the organization of training sessions.

3.3 ZAMBIA

3.3.1 Socio-Economic Background

Population

Zambia has a population of 10.9 million people, with a natural increase rate of 1.8 (Population Reference Bureau 2004). The births and deaths per 1000 population are 42 and 24, respectively. The projected population for 2025 is 18.5 million. The country has infant mortality and fertility rates of 95 per 1000 births and 5.6 per woman, respectively. Zambia has a very youthful population with 46% less than 15 years old and only 3% above 65. The life expectancy rate at birth is 35 years, which is quite low compared to many Sub-Saharan African countries. Thirty-five percent of the population lives in urban areas while 65% live in the rural areas.

Economy

Since the late 1980s, the economy of Zambia has been experiencing a decline, with an average annual growth rate of 2.4% in the 1970s to 0.7% in 2004. The GNP per capita income is US\$800.

Educational Attainment

The adult literacy rate for both males and females of Zambia is 82% (UNAIDS-UNECA 2000). However, with the high prevalence of HIV/AIDS, this is expected to decline in the long run as increasing the number of children of school-going age dropout due to their inability to sponsor their education as a result of the loss of their parents through the deadly disease.

HIV/AIDS Situation

Zambia has an adult infection rate of 16.5% (Population Reference Bureau 2004) with 650,000 orphans in 2003. Only 34% of married women aged 15-49 use some contraceptive methods with only 23% using modern methods, thus suggesting the need for more education to increase use, especially of condoms which could help to minimize the risk of contracting HIV/AIDS.

Consequences of HIV/AIDS

Bollinger and Stover (1999) provide a summary of the economic impact of HIV/AIDS in Zambia. Several households have lost incomes due to HIV-related illness. The sick breadwinners are unable to work and yet incur huge medical expenses. Baggaley and Needham (1999) found that the illness of parents forces

children to be the care-givers, thereby sacrificing their education through poor attendance or simply dropping out of school. They also indicated that, since the disease affects the productivity of the patient, it affects the household income adversely. One of the major consequences of this is malnourishment in the children of that household, a condition often worsened when the child is orphaned and sent to a guardian's house.

Kassawa (1993) reported that the people of the Mansa District of Luapula Province perceived that AIDS had many economic repercussions on the families of AIDS patients, including malnutrition and a crippling effect on their ability to meet the cost of their children's educational requirements or provide them with adequate shelter. This is because it causes a reduced income flow in the family. Haworth (1991), in a tracer study of 116 families throughout Zambia, found that 54 fathers and 20 mothers had died; only 13 of the parents who were still alive did not show any symptoms of AIDS. In this sample, 42 percent of the children stopped attending school, 102 families suffered economic problems and 59.8 percent of the households had food shortages.

In general, research has found that approximately 37 percent of all households in Zambia are caring for one or more orphans, while about 25 percent of the households were headed by widows. By the year 2000, as one study projected, there would be over 1,000,000 or 18% of children orphaned due to AIDS. Over half of the households in each study caring for orphans cited financial pressures associated with their care. Non-orphans are 1.3 times more likely to attend school than orphans (Mulenga, Kamwanga, *et al.* 1993).

In a study of two areas in Zambia, Kafue, Mutangadura and Webb (1998/99) found that care-givers in the less affluent community reported lost earnings of 10,000 kwachas (K) per month, where half of the sample earned less than K100,000 annually. Those in the more affluent area had lost earnings of K24,583 per month, where more than 85% of the sample had an annual income of over K1,000,000. The average funeral cost was between K112,000 and K240,700. The average cost for a visit to a clinic ranged from K8,542 to K16,500 for the two areas. Households that were affected by AIDS reported annual income levels of 30-35% less than unaffected households. The affected households also reported selling off assets such as bicycles and radios in order to pay health and funeral costs.

In terms of agriculture in Zambia, Ching'ambo, Mwanza *et al.* (1995), in a study of 29 agricultural organizations, found significant effects of HIV/AIDS, including increased absenteeism; an increase in the number of deaths, especially in the management categories; and increased expenditures for both medical costs and terminal benefits.

AIDS has had a significant impact on some firms. For example, ILOEAMAT (1995) found that the petroleum refining company INDENI Petroleum paid out K22.6 million (US\$33,781) in medical costs for AIDS patients and funeral expenses, which was greater than their profits of K16.4 million (US\$24,514). In a study that was conducted in Lusaka, four organizations out of ten surveyed reported that AIDS was a problem in their companies, causing high death rates, reducing productivity, while others reported increasing sick leave, absenteeism and increased funeral cost. It is important to note that, for some smaller firms the loss of one or more key employees could be catastrophic and could even lead to the collapse of the firm.

Other effects of HIV/AIDS in Zambia are felt in the health, transport, mining, water and education sectors. Foster and Buve (1995) found in Monze Hospital in Zambia that the costs of treatment of HIV disease in the in-patient wards and the out-patient department to the health services in the 2 years before death was US\$110.60 per person. The daily cost on the other hand, ranged from US\$1.70 to US\$7.20 for in-patient care depending on the location of the hospital (Loewensen and Whiteside 1997).

The mining industry in Zambia faces huge economic costs as a result of the high prevalence of this disease. Early estimates in the late 1980s indicate that 68% of the men who tested positive for HIV in the Copperbelt area were professionals in the mining industry (Green 1988).

The education system also faces the additional challenge of educating students about AIDS and equipping them to protect themselves. In a study centered in two provinces of Lusaka and Northern Zambia, the impact of AIDS was examined using a survey conducted on 346 students and 74 teachers drawn from 20 rural and urban primary and secondary schools. Respondents mentioned AIDS as the major cause of death. Effects for the

students included increased absenteeism and increased dropout rates, especially in the urban areas. Enrollment was not affected, since there was a shortage of places in schools. Teachers reported that they had experienced increased absenteeism due to illness and funeral attendance, and found it more difficult to teach due to worries and depression. It is anticipated that teacher training and recruitment costs will increase by 25% to replace teachers who die, since in 1998 alone, 1,500 teachers died from AIDS (Mukuka and Kalikiti 1995)

It is difficult to assess the macro-economic impacts of HIV/AIDS. However, there are several mechanisms by which AIDS affects macroeconomic performance. For example, AIDS deaths lead directly to a reduction in the number of workers available, leading to shortage of workers, higher wages, higher production costs, loss of international competitiveness which can cause foreign exchange shortages and most invariably lower government revenues and reduce private savings and capital accumulation, among others. According to UN sources, the infant mortality rate in Zambia will be 60% higher by 2010 due to the impact of AIDS, the child mortality rate will double, the crude death rate will triple, life expectancy will decrease from 60.1 to 30.3 years and the overall population growth will be reduced from 3.1% to 2.1%, all as a result of the effect of AIDS (Cohen 1997).

National Response to HIV/AIDS

The national response began with the establishment of the National AIDS Surveillance Committee in 1998. This was replaced by the National HIV/AIDS/STD/TB Council established in 2003 to provide the requisite technical leadership in the fight against the HIV/AIDS. In order to have political clout and show the commitment of the Government, a Committee of Cabinet Ministers was appointed to give guidance to the Council.

A Strategic Framework for HIV/AIDS/STD/TB has been developed, with short-term plans developed in 1987 to protect the blood supply and medium term plan for 1988-1992 focusing on eight priority areas (leprosy, Information, Education and Communication, laboratory support, epidemiology and research, STDS, and clinical care, programme management, and home-based care). The second medium term plan (1994-1998) integrated AIDS, TB and STDS with greater emphasis on sectoral approaches, behavioral change, access to STD care, condom use,

de-stigmatization of the disease, increased voluntary counseling and testing (VCT), and mother to child transmission (MTCT). A programme management information system is being developed to facilitate collection and analysis to guide management decision-making.

An organization for the care of orphans aged 20 or younger, CINDI (Children in Distress) with funding largely from the Zambian Government has also been formed. It provides children funds to attend school and buy clothing and assistance to families to buy food. It must be noted, however, that even combined with other projects, only a small percentage of those who have been orphaned by AIDS have benefited. A strong political commitment to the fight against AIDS as demonstrated by Uganda, Senegal and Thailand, is setting the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts; facilitating a multi-sectoral approach by making it clear that the fight against AIDS is a national priority and signaling individuals and community-based organizations involved in the AIDS programmes that their efforts are appreciated and valued.

3.3.2 HIV/AIDS Situation in National In-Service Training College, Zambia

3.3.2.1 Awareness and Acceptance of HIV/AIDS

The results indicate that the college community was aware of the incidence of HIV/AIDS among them and more so among the students, followed by the teachers/tutors (see Table 33). However, the awareness of the incidence of HIV/AIDS-related deaths was more among teachers/tutors and non-teaching staff than the students (See Table 34). This observation may not be surprising since students are generally younger and would have been at an earlier stage of the HIV/AIDS infection and less likely to die compared to the tutors and non-teaching staff.

Table 33. Awareness of the incidence of HIV/AIDS among college community

Category of college community	Response		
	Yes (%)	No (%)	Total
Students	53.2	31.9	85.1
Teachers/Tutors	44.7	38.3	83.0

Non-teaching staff	38.3	44.7	83.0
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Note: NS = 47; Missing: 3

Table 34. Awareness of HIV/AIDS-related deaths among college community

Category of college community	Response		
	Yes (%)	No (%)	Total (%)
Students	25.5	57.4	82.9
Teachers/tutors	31.9	51.1	83.0
Non-teaching staff	27.7	55.3	83.0

Note: NS = 47; Missing: 3

3.3.2.2 Consequences of HIV/AIDS on National In-Service Training College, Zambia

The college could not provide any empirical evidence of the socio-economic impact of HIV/AIDS on its community due to lack of record keeping. Record keeping requires availability of both adequate human and material resources which the college lacks. However, several national and individual studies indicate significant socio-economic consequences in Zambia. Colleges in the country should network with other key stakeholders to gain knowledge and skills on how to collect, analyze and utilize information for various purposes.

3.3.2.3 National In-Service Training College's Response to HIV/AIDS

It can be seen from Table 35 that the most widely known HIV/AIDS-related activity among the college community is quiz, followed by sensitization programmes. Other responses included organization of inter-college meetings, drama and debate.

However, very few of the respondents participate in the activities (see Table 36) usually provided by various organizations, including NGOs, Ministries of Education and Health, and the National AIDS Programme (see Table 37).

Table 35. HIV/AIDS related activity organized during academic year

Activity organized	Responses
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	Yes (%)	No (%)	Total (%)
Quiz	57.4	42.6	100
Sensitization program	21.3	78.7	100
Inter-college meetings	8.5	91.5	100
HIV/AIDS drama	6.4	93.6	100
Workshop	6.4	93.6	100
Debate	4.3	95.7	100
Wearing HIV/AIDS T-Shirts every Friday	2.1	97.9	100
Lectures	2.1	97.9	100

Note: NS = 47

Table 36. Participation in HIV/AIDS-related activity in the college

Activity participated in	Response		
	Yes (%)	No (%)	Total (%)
Quiz	8.5	91.5	100
Sensitization programmes	8.5	91.5	100
Workshop	6.4	93.6	100
Guidance and Counseling	4.3	95.7	100
Discussions	4.3	95.7	100
Inter-college meeting	2.1	97.9	100
Anti-HIV/AIDS club meeting	2.1	97.9	100

Note: NS = 47

Table 37. Providers of HIV/AIDS training and Life Skills Education

Provider	Response		
	Yes (%)	No (%)	Total (%)
NGOs	8.5	91.5	100
Ministry of Education	6.4	93.6	100
National HIV/AIDS program	4.3	95.7	100
Ministry of Health	2.1	97.9	100
TEVETA	2.1	97.9	100

Note: N = 47

3.3.2.4 *Main Sources of Information about HIV/AIDS for National In-Service Training College*

The most popular source of HIV/AIDS information for the college is the mass media, followed by literature, and drama, in that descending order (see Table 38). It is not clear what the respondent meant by “literature” on HIV/AIDS. It could be printed information. Mention is also made of the Internet as a source of information on HIV/AIDS.

Table 38. Main sources of information about HIV/AIDS

Source	Response		
	Yes (%)	No (%)	Total (%)
Mass media	76.6	23.4	100
Literature on HIV/AIDS	40.4	59.6	100
Drama	8.5	91.5	100
Ministry of Education	6.4	93.6	100
Peer educators	6.4	93.6	100
Community	4.3	95.7	100
Internet	4.3	95.7	100
Workshop	4.3	95.7	100
Discussions	2.1	97.9	100
National HIV/AIDS programme	2.1	97.9	100
NGOs	2.1	97.9	100

Note: NS = 47

3.3.2.5 Proposals to Strengthen AIDS Unit in National In-Service Training College

When asked about what needed to be done to strengthen the AIDS Unit for effective performance, the college community suggested the following (see Table 39).

Table 39. Proposal to strengthen HIV/AIDS unit

Proposed action	Response		
	Yes (%)	No (%)	Total (%)
Provide the unit with adequate funds	21.3	78.7	100
Provide unit with adequate teaching and learning resource materials	8.5	91.5	100
Organize more sensitization programmes	8.5	91.5	100
Organize regular workshops	6.4	93.6	100
Train more coordinators	6.4	93.6	100
Integrate HIV/AIDS education into the school curriculum	4.3	95.7	100

Note: NS = 47

As can be seen from Table 39, very few responded to the question. The only areas worth noting is the provision of adequate funding.

3.3.2.6 *Proposals to Improve Teaching and Learning about HIV/AIDS in National In-Service Training College*

Integrating HIV/AIDS into the curriculum of the academic programmes and provision of teaching and learning materials were proposed by a significant percentage of the respondents as the means to improve effective teaching and learning about HIV/AIDS (see Table 40).

Table 40. Proposals to improve teaching and learning about HIV/AIDS in the college

Proposed action	Response		
	Yes (%)	No (%)	Total (%)
Integrate HIV/AIDS education into the school curriculum	36.2	63.8	100
Provide adequate teaching and learning materials	23.4	76.6	100
Organize more sensitization programmes	19.1	80.9	100
Provide enough funds for HIV/AIDS activities	8.5	91.5	100
Organize more seminars/workshops	6.4	93.6	100
Organize regular training sessions	4.3	95.7	100

Note: NS = 47

3.3.2.7 *Proposals to Promote HIV/AIDS Prevention, Education, Care and Outreach Activities in National In-Service Training College*

A significant percentage of the respondents considered the provision of sensitization and adequate funding as important inputs towards improving HIV/AIDS prevention, education and care (see Table 41).

Table 41. Proposals to promote HIV/AIDS prevention, education, care and community outreach

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programme	46.8	53.2	100
Provide funding for HIV/AIDS activities	17.0	83.0	100
Integrate HIV/AIDS education into	10.6	89.4	100

curriculum			
Conduct workshops regularly	10.6	89.4	100
Organize anti-HIV/AIDS clubs	10.6	89.4	100
Organize drama shows on HIV/AIDS	10.6	89.4	100
Encourage voluntary counseling and testing	8.5	91.5	100
Give regular sex education	6.4	93.6	100
Promote abstinence	6.4	93.6	100
Organize regular training programmes	4.3	95.7	100
Exposure to HIV/AIDS victims	4.3	95.7	100
Provide teaching and learning materials on HIV/AIDS	4.3	95.7	100
College and community interactions	4.3	95.7	100
Create and equip guidance and counseling unit	2.1	97.9	100
Organize inter-college discussions	2.1	97.9	100
Teach good morals	2.1	97.9	100
Organize quiz competitions	2.1	97.9	100
Faithful to one partner	2.1	97.9	100

Note: NS = 47

3.3.2.8 *Proposals to Promote Active Academic Staff Involvement in HIV/AIDS Activities*

Very few of the respondents provided suggestions as to how to promote the involvement of academic staff in HIV/AIDS-related activities (see Table 43). Organization of sensitization programmes, regular workshops and integration of HIV/AIDS into the education training curriculum were among suggestions made by some key stakeholders for the promotion of active involvement of the academic staff.

Table 42. Proposals to promote active academic staff involvement in HIV/AIDS activities

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programmes for staff	14.9	85.1	100
Organize regular workshops	12.8	87.2	100
Integrate HIV/AIDS education into the school curriculum	10.6	89.4	100
Train academic staff on HIV/AIDS	6.4	93.6	100
Form anti-HIV/AIDS clubs	4.3	95.7	100
Involve in HIV/AIDS activities	4.3	95.7	100
Encourage voluntary counseling and testing	2.1	97.9	100
Maintain a counseling unit for staff	2.1	97.9	100
Provide teaching and learning aids	2.1	97.9	100

Organize outreach programmes	2.1	97.9	100
Drama shows on HIV/AIDS	2.1	97.9	100

Note; NS = 47

3.3.2.9 *Proposals to Promote Active Involvement of Students in HIV/AIDS Activities*

In the case of promoting active involvement of students in HIV/AIDS-related activities, a fairly significant percent of the respondents suggested the organization of sensitization programmes for students and the integration of HIV/AIDS in the teaching curriculum, respectively (see Table 43).

Table 43. Important measures to promote active involvement of students in HIV/AIDS activities

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programmes for students	38.3	61.7	100
Integrate HIV/AIDS education into the school curriculum	19.1	80.9	100
Form anti-HIV/AIDS clubs	10.6	89.4	100
Organize regular seminars on HIV/AIDS for students	10.6	89.4	100
Organize quiz programmes for students	4.3	95.7	100
Organize drama shows for students	4.3	95.7	100
Motivate students	4.3	95.7	100
Train more peer educators	2.1	97.9	100
Involve students in HIV/AIDS activities	2.1	97.9	100
Provide funds for HIV/AIDS activities	2.1	97.9	100

Note: NS = 47

3.3.2.10 *Proposals to Promote Active Involvement of Non-teaching staff in HIV/AIDS Activities*

Regarding the promotion of active involvement of non-teaching staff in HIV/AIDS activities, a significant percentage of the respondents suggested the organization of sensitization programmes, formation of anti HIV/AIDS clubs and regular workshops (see Table 44). Mention was also made of inclusion of non-teaching staff in HIV/AIDS-related activities. Interviews with

selected non-teaching staff members revealed that the college did not include them in most HIV/AIDS activities.

Table 44. Proposals to promote active involvement of non-teaching staff in HIV/AIDS activities

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programmes	10.6	89.4	100
Form anti-HIV/AIDS clubs	10.6	89.4	100
Organize regular workshops	8.5	91.5	100
Involve non-teaching staff in HIV/AIDS activities	6.4	93.6	100
Organize drama shows	4.3	95.7	100
Promote faithfulness to one partner	4.3	95.7	100
Encourage voluntary counseling and testing	2.1	97.9	100
Train more peer educators	2.1	97.9	100
Organize quiz programmes	2.1	97.9	100

Note: NS = 47

4. SUMMARY AND DISCUSSION OF KEY FINDINGS

4.1 Continent-Wide Sample of Colleges

4.1.1 *Acceptance of HIV/AIDS on College Campuses*

Awareness and acceptance of the HIV/AIDS, its incidence and cause of death among the college communities (tutors, students and non-teaching staff) was quite high. However, there is no consistency in the perceptions about the trends as to whether the prevalence of the disease has been increasing, remaining the same or decreasing over the past few years. This may be partly due to the fact that the colleges have no data on HIV/AIDS activities and incidence.

The variations in terms of level of awareness and acceptance of HIV/AIDS among the three case study colleges may suggest the need for circumspection in over-generalizing the findings obtained from the continent-wide aerial sample. It is difficult to explain why, in spite of the very high prevalence of HIV/AIDS in Mozambique, there was a low percentage of the community of Instituto do Majestério Primário accepting the prevalence of the

disease. Against this background, it may be appropriate to conduct in-depth analysis of all colleges in each country to provide a clearer picture of the situation of the level of response so far made. Denial of the disease appears to still be lingering in some colleges and must be addressed with more aggressive and systematic education programmes.

4.1.2 Impact of HIV/AIDS on Colleges

The colleges have no empirical data on the impact of the disease on their operations and therefore could not provide concrete information on how the disease affects productivity and operations of the colleges. The findings of the case study colleges confirm the same situation. Their main measure of the impact of the disease is the creation of awareness of the disease among the college communities. The fact that as large as 24% of the respondents were of the opinion that the impact of the disease was minimal, gives cause for much concern, particularly in countries such as Zambia and Mozambique, where the national prevalence rates are quite high.

The failure on the part of the college authorities to examine the impact of the HIV/AIDS may be considered as a more convenient way of postponing the problems until they reach insurmountable heights. HIV/AIDS impact data/information is invaluable in view of the difference it could make in mitigating the effects of the disease when used appropriately to better manage HIV/AIDS prevention programmes. Appropriate policies and systems should be put in place by colleges to enable them periodically assess the effects of the disease on their operations.

4.1.3 Collection of Data on HIV/AIDS

The culture of collecting data/information by colleges on HIV/AIDS activities as well as monitoring and evaluating HIV/AIDS interventions is very poor. The collection of data provides management with decision support information and an “Early Warning” system. It also provides the basis for evaluation of the impact of HIV/AIDS.

While lack of adequate resources may be a factor (as was reported by the case study colleges) to the poor documentation of HIV/AIDS activities, there, however, seems to be a general lack of interest on the part of management of training colleges.

Considerable progress has been made by the World Bank and UNESCO in developing guidelines to assist organizations in the education sector to develop process, output, outcome and impact indicators for HIV/AIDS. The Colleges need to take the initiative to obtain the guidelines and to begin to determine their HIV/AIDS information needs, the methods to use to collect the data, and the hard and software as well as human resource requirements to manage the monitoring and evaluation system.

4.1.4 Response of Training Colleges to the HIV/AIDS Pandemic

The responses of colleges to the HIV/AIDS, though ad hoc in nature, took several forms, including initiating HIV/AIDS prevention and education programmes and establishing institutional arrangements. They also include to a very limited extent the integration of HIV/AIDS into the curricula and the development of training manuals and teaching and learning resource materials for HIV/AIDS. What are conspicuously absent in their efforts are the creation of treatment facilities, voluntary testing and counseling facilities, development of written HIV/AIDS policies and the initiation of community outreach programmes. Strong leadership is also lacking.

The results of the case study colleges showed that some colleges had only one HIV/AIDS-related activity in a year with very limited involvement and participation of the staff and students. For example, sensitization was the only activity carried out by the Ecole Normale Supérieure d'Atakpamé in Togo in the past year.

The results of the case study on colleges indicate variations in the response to HIV/AIDS from college to college. This suggests the need to assess the relative effectiveness of the various responses so as to share lessons learnt for improved programming. It also requires that initiation of future programmes should take into consideration the type and quality of HIV/AIDS programme activities being carried out in each teacher training college, the key stakeholders involved, and the gaps to be bridged.

The results of the case study colleges also indicate a low participation of college community members in HIV/AIDS-related activities. Whether this is due to sheer apathy or some other latent factors needs further investigation.

The level of involvement and participation of the Ministry of Education (MOE) in HIV/AIDS activities carried out by the three case study colleges varied. The Ministries of Education oversee the management and administration of teacher training colleges in most African countries. Their involvement and participation in HIV/AIDS activities in the colleges would serve as approval and strengthen the leadership of the colleges to command the requisite support from the entire college community.

One particular important area that requires the involvement of the Ministries of Education is the review of the curriculum to incorporate and infuse life skills education on attitudes, values and behaviour, population, sexuality and reproductive health as well as include extra curricular activities such as club activities, school debates and peer education to help establish the necessary character formation and behavioral change. As underscored by Carol Bellamy, the Executive Director of UNICEF (February 2004), knowledge is critical in the fight against the HIV/AIDS pandemic and therefore the development and implementation of a skills-based HIV/AIDS curriculum in teacher training colleges will no doubt minimize the impact of the operations of the colleges and ultimately the education sectors at large.

4.1.5 Training of Tutors/Lecturers in HIV/AIDS and Family Life Education

Many of the colleges have provided some form of training in HIV/AIDS and Family Life Education for the tutors/lecturers in collaboration mainly with the Ministry of Education, NGOs and the National AIDS Commission. However, the training essentially was more of sensitization than on substantive core areas such as integrating HIV/AIDS into the curriculum, guidance and counseling, population life education and gender mainstreaming. There was no information available with the case study colleges regarding the types of training conducted, the content, the number of beneficiaries and the training facilitators or providers.

It is also not clear if the training or activities were based on any comprehensive needs assessments. The knowledge and skills of tutors/ teachers of training colleges need to be built to enable them deal effectively with the often difficult socio-psychological and emotional situations associated with HIV/AIDS cases. This can only be accomplished by systematic inventory taking of the

capacity building needs of each teacher training college, identification and adoption of the best practices in place and use of lessons learnt to guide the design of more comprehensive HIV/AIDS prevention, education, treatment, support and care programmes. To facilitate improved teaching and learning of HIV/AIDS in teacher training colleges and also to improve sex and sexuality self-awareness/ change, evidence based HIV and AIDS activities targeting the students, teachers and non-teaching staff must be implemented.

In the mean time, it is worth noting that the Association of African Universities (AAU) has developed a Toolkit with ten training modules for Institutions of Higher Learning in Africa, which is available in print and will soon be available on its Website. The Toolkit is quite flexible and can be adopted or be adapted by management of teacher training colleges to develop, plan and manage the responses to HIV/AIDS across the entire core functional areas of the college.

Other important sources of materials that management of African teacher training colleges can use in developing programmes in response to HIV/AIDS include the UNESCO Harare Cluster Office and the virtual Institute for Higher Education in Africa.

4.1.6 Collaboration and Development of Partnerships

Although not as high as expected, there is evidence of collaboration in HIV/AIDS prevention, education and treatment activities among the training colleges, NGOs, and Government Agencies (Ministries of Education and Health and AIDS Commissions).

The collaboration between the colleges, the donors and the communities, however, leaves much to be desired. Developing collaboration and partnerships with other key stakeholders broadens and extends the college's HIV/AIDS responses from an internally focused one to an external one which affords it to take advantage of opportunities in its external environment. It can serve as a vehicle for referrals and skills exchanges and thus contribute to the enhancement of the fight against HIV/AIDS. The battle against HIV/AIDS can neither be fought and won by only one individual, group or organization nor with only one strategy. Teacher Training colleges need to expand their networks and

partnerships in order to effectively achieve the objectives of their HIV/AIDS responses.

4.1.7 Main Sources of HIV/AIDS Information for Colleges

There are very limited sources of HIV/AIDS information available to the college communities. The mass media and written materials are the main sources of HIV/AIDS information to the teacher training college community.

The results of the case study colleges indicate other additional sources as the Internet, materials from NGOs and National HIV/AIDS Programme (in the case of Ecole Normale Supérieure d'Atakpamé in Togo). Research evidence indicates that the mass media has not been the best source of HIV/AIDS information in terms of accuracy and targeting of specific group needs of the community. The limited sources of information to the college communities have serious adverse implications, including the denial of access to preventive methods such as male and female condoms, voluntary testing, counseling and follow-up. This consequently, actually increases their vulnerability to HIV infection.

The colleges should provide more reliable alternative sources of information to the students and teaching staff. More systematic integration of HIV/AIDS into the academic programmes of the colleges needs to be done to provide both accurate and standardized information to all members of the college community, particularly to the students. There are other well developed HIV/AIDS information sources (for example, <http://www.unesco.org/iiep>; www.edna.sn/africaso.org) the communities of training colleges can access.

4.1.8 Perceptions of the Way Forward

The general perception of the way forward for improved college HIV/AIDS programmes are integration of HIV/AIDS into the curriculum, development of sustained sensitization and education programmes, training of tutors/ lecturers in HIV/AIDS and provision of adequate resources.

However, what is equally important but excluded by the respondents, is the need for the development of written HIV/AIDS

institutional policies that are consistent with national policies to provide the frame within which all HIV/AIDS responses can be situated.

An equally critical requisite is the development of strong committed leadership to ensure that the colleges' HIV/AIDS response is developed, implemented and monitored in a consistent manner.

4.2 Conclusions

Based on the above findings, the following conclusions have been drawn.

- a) Teacher training colleges in Africa, to some extent, have been aware of and accepted the incidence and prevalence of HIV/AIDS within their communities even though there still exist some traces of denial among some college communities.**
- b) The responses of the colleges to the HIV/AIDS pandemic have neither been systematic nor comprehensive to achieve significant positive results.**
- c) The colleges lack systematic data on HIV/AIDS-related activities and impact and are therefore unable to assess the socio-economic effect of the disease on their operations.**
- d) The tutors/teachers lack both the requisite knowledge to impart to the students and the skills to be able to effectively handle the complex and value-laden issues related to HIV/AIDS.**
- e) The college communities have limited and unreliable sources for HIV/AIDS information.**
- f) Most colleges lack the requisite leadership and commitment to galvanize the college communities to respond effectively to the HIV/AIDS problem.**
- g) There is little partnership building among training colleges, NGOs, Government Agencies and the wider community to take advantage of opportunities for effective HIV/AIDS response.**

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- h) Few colleges have HIV/AIDS policies to provide the needed framework for integration of HIV/AIDS into the academic curriculum.**
 - i) Very few colleges have financial provisions for HIV/AIDS in their annual budgets.**
 - j) Colleges have no monitoring and evaluation systems to enable them assess the extent to which the HIV/AIDS programmes being implemented are achieving the stated outcomes and impact.**

4.3 Recommendations

Against the above conclusions, it is recommended that:

- a) An in-depth analysis of all colleges should be done to determine the level of denial or acceptance that exists for the design and implementation of sustained HIV/AIDS education programmes.**
- b) Colleges be supported to develop comprehensive programmes that meet the needs of their communities.**
- c) The capacities of colleges be built to collect, analyze and store data on HIV/AIDS in order to promote evidence-based response to the pandemic.**
- d) Teachers' knowledge and skills on HIV/AIDS be built in order for them to be able to effectively impart same to students and also be able to handle the often delicate and difficult situations associated with people with HIV.**
- e) College Management/leadership should accord HIV/AIDS the required attention and commitment, using the HIV/AIDS Task Team Approach, in order to ensure active and collaborative involvement of all stakeholders.**
- f) Colleges should endeavour to develop and partnership with NGOs, Government Agencies (particularly Ministries of Education and Health) and the wider community in order to share cost in programme activities as well as take advantage**

of the services of experts and social capital within their external environment.

- g) Colleges be encouraged to develop HIV/AIDS policies to provide the needed framework for institutionalization and integration of HIV/AIDS into the academic curriculum.**
- h) Colleges should develop reliable alternative sources for HIV/AIDS information for its community members in order to enable them have full access to prevention services, including voluntary testing and counseling, contraceptive services, referrals, care and support.**
- i) Management of colleges should develop more aggressive and innovative resource mobilization strategies beyond their internal budgetary provisions to include local and international NGOs and development partners in order to ensure adequate and sustained funding for HIV/AIDS programmes.**
- j) Colleges should be assisted to develop systematic monitoring and evaluation systems with well defined and comprehensive HIV/AIDS programme performance indicators that facilitate the assessment of the achievement of the objectives of college HIV/AIDS programmes.**

5. DEVELOPING GUIDELINES FOR A COMPREHENSIVE RESPONSE OF TEACHER TRAINING COLLEGES TO HIV/AIDS

It has become evident from the results of the study that there is a general acceptance among teacher training colleges that HIV/AIDS is real and prevalent among their communities. This is proven with observed incidences and deaths among members although the concrete figures on the magnitude of the disease have not been documented to facilitate assessment of its consequences on the operations of the colleges.

The findings have also indicated that there have been sporadic, ad hoc and un-coordinated initiatives made by the colleges to address the HIV/AIDS situation. The scope of the activities has not only been limited but they have also not been participatory enough in approach, thus excluding some sections of the college communities. What is evidently lacking is a clear institutional

HIV/AIDS policy consistent with the respective national policies to set the framework within which all College responses to HIV/AIDS could be situated.

The results further suggest that the colleges have not provided the leadership needed for ensuring the design and implementation of comprehensive HIV/AIDS programmes. Many of the colleges lacked established Units and positions dedicated to HIV/AIDS programmes. The design and implementation of the HIV/AIDS programmes are left to the discretion of individuals. The consequence of this situation has been the unfortunate failure of many colleges to integrate HIV/AIDS into the curriculum of the teaching programmes.

It has become evident that the tutors/lecturers who are supposed to be championing the HIV/AIDS activities through teaching, are themselves not adequately equipped with the requisite knowledge and skills to effectively play their leading roles. Most of them have attended only sensitization workshops not covering substantive core areas to enable them in turn impart to teacher trainees. Effective college response to HIV/AIDS will depend partly on the existence of adequate numbers of well-trained and committed tutors.

The findings further indicate the general lack of annual budgetary provisions for HIV/AIDS in the colleges. There cannot be any hope of success in any battle, including the war against the spread of HIV/AIDS, without the commitment to allocate adequate resources.

The good news from the study is that the teacher training colleges have realized the need to improve upon what they have variously started. Essentially, what is needed is the requisite assistance to enable them review and strengthen their efforts for a take-off. The right starting point is for them to acquaint themselves with the essential guidelines and tools for developing comprehensive HIV/AIDS prevention and education programmes. An attempt has been made to outline the requisite guidelines which can be adopted with modifications to suit individual college situation.

The cardinal objectives of these guidelines are to contextualize the HIV/AIDS disease within the college environment and identify key challenges in the context. The guidelines will then set the framework to assist management of Teacher Training Colleges to

plan, implement and monitor appropriate and effective responses to HIV/AIDS within their environment. It is important to note that the HIV/AIDS response of a college is an integral part of the broader national response to the HIV/AIDS epidemic and should stem from that.

According to Kelly (2001), the first requirement for developing a comprehensive HIV/AIDS Prevention Programme is a total management commitment. He outlined the following as essential elements to consider in developing a comprehensive HIV/AIDS prevention programme:

- HIV/AIDS policy and Strategy
- Developing culturally appropriate prevention messages
- Tackling socio-economic factors
- Establishing partnerships
- Sustaining awareness and education
- Challenging denial and stigma
- Situating prevention in community context; linking care to prevention
- Rigorous scientific reflection.

There has been international consensus on core principles that should underline institutional response to HIV/AIDS and this should be taken into consideration in developing guidelines for teacher training colleges' response to the disease. The essence of the principles is that they provide guidance on responses to new and changing situations which might not have been covered by existing policies/laws.

The core principles to provide guidance for the development of guidelines for a comprehensive response of teacher training colleges to HIV/AIDS prevention and education should therefore include but not be limited to the following:

- Non-discrimination on the basis of HIV/AIDS
- Safety in the workplace
- Prohibition on forced HIV testing
- Encouragement of voluntary counseling and testing
- Confidentiality; and
- Openness, acceptance, care and support for college community members living with HIV/AIDS.

Against this background and within the context of the key findings of the study, the following guidelines, in a chronological

order, have been recommended for adoption by teacher training colleges in Africa to provide the framework for the development of a comprehensive response to HIV/AIDS. It is important to note that there are several detailed processes and analyses involved in each of the stages to ensure adequacy, efficacy as well as minimum standards with regard to the outputs that are not presented here.

a) Development of Committed and Competent Leadership

Training Colleges should demonstrate leadership commitment by way of creating a high level position to be filled by an experienced and skilled senior member of staff to be responsible for ensuring that the colleges' HIV/AIDS response is developed, implemented and monitored in a consistent manner. To provide the needed support for the leadership, an HIV/AIDS Committee with adequate representation and support from all relevant stakeholders of the college (tutors, non-teaching staff, teacher trainees, Ministries of Education and Health, etc.) should be established.

Leadership Commitment to HIV/AIDS must be demonstrated within and outside the college. This can be done through visible participation in HIV/AIDS events and the promotion of cross-sector HIV/AIDS partnership. It can also be done through the prioritization of resources for the delivery of HIV/AIDS programmes to facilitate the transfer of innovative solutions on HIV/AIDS problems to all departments and stakeholders of the college. Also, expressing principled stances on human rights, gender issues, particularly as they relate to infected or affected college community members and their families will be helpful. Indeed, leadership should be a role model in showing commitment to HIV/AIDS needs, not discriminating against people living with HIV/AIDS (PLWHAs), for instance.

b) Development of Institutional HIV/AIDS Policy

Training colleges should develop well defined institutional HIV/AIDS policies that set the framework within which all responses can be situated. The policy should contain principles on management responsibilities, establishment of multi-level structures and partnerships responsible for all aspects of HIV/AIDS responses in the college as well as the integration of HIV/AIDS into existing human resource management policies.

The Association of African Universities (AAU) Tool Kit provides details on why the need for an HIV/AIDS policy, the pros and cons for it, the procedures for developing one and the scope of coverage. It also provides examples of HIV/AIDS which can be adapted to suit the peculiarities of teacher training colleges in Africa.

c) Development of Partnership

Strong partnerships and networks should be developed between the colleges and other identified key stakeholders, including Ministries, NGOs, and CBOs for effective coordination and sharing of experiences and best practices. Collaborative responses are more effective than individual responses. It enables the college to take advantage of opportunities in its environment to enhance its HIV/AIDS programme activities.

d) Development of HIV/AIDS Medium Term Strategic Plans

The college needs to know where it is now with regard to HIV/AIDS and determine where it wants to be in the next 3-5 years. This involves the development of a medium term strategic plan that identifies key issues including, community members at high risk of contracting HIV/AIDS, curriculum development, teacher education and development, human resource management challenges, voluntary testing, guidance and counseling, capacity building needs, care and support. It also involves setting objectives, formulating strategies and preparing action plans for implementation to achieve the objectives. The college's HIV/AIDS response may stand alone or be integrated into the broader institutional strategic plan as well as into each year's operational plan.

The development of an HIV/AIDS medium term strategic plan should involve a cross-section of the academic staff, non-academic staff and the students in order to create a sense of ownership for it.

Adequate allocation of human resources and funding to the HIV/AIDS programmes should be made to ensure effective implementation.

e) *Development and Implementation of Capacity Building Plan*

Teachers are critical in HIV/AIDS intervention and health promotion. Provision of a good curriculum with adequate teaching materials is necessary but teachers need the requisite knowledge and skills to be able to deal with the complex and value-laden issues of HIV/AIDS effectively. There is therefore the need for the teachers' capacities to be built to enable them not only impart the knowledge and skills acquired to the students but deal effectively with the socio-psychological and emotional situations associated with people with HIV. This will also enable them confront their own values, beliefs, and fears.

Teacher training must emphasize the role of teachers in attitude and behaviour formation and change for learners.

The Association of African Universities' (AAU) Toolkit provides excellent training modules on integration of HIV/AIDS in curriculum, HIV/AIDS policy development, student services, community engagement, and monitoring and evaluation which could be adapted by teacher training colleges to suit their training needs.

f) *Development of Support Services for Students*

Students form the majority of the communities of teacher training colleges. They also constitute the most sexually active sector of the community. By virtue of being out of home where parental control is absent, they are pre-disposed to engaging in adventurous undesirable social activities, including drinking and smoking which are favourable recipe for unprotected sex. HIV/AIDS is likely to thrive among the student populations in college environments under the given circumstance and this calls for the need to develop comprehensive services to address their needs.

There must be an institutional policy which ensures that students have access to the following (AAU Toolkit 2004):

- Health services, instruction, work opportunities, training, financial support;
- Information on prevention, treatment , care
- Academic and psycho-social; and

-
- **Protection (Confidentiality, non-discrimination, equity and gender sensitivity).**

There should be staff and student involvement in the development of programmes to provide the needed services to students. Some of the common programme options outlined in the AAU Toolkit include:

- **Voluntary Counselling and Testing**
- **Guidance and Counseling**
- **Referral services**
- **AIDS clubs**
- **Peer Educators**
- **Contraceptive services.**

g) Resource Mobilization for HIV/AIDS Programmes

The successful implementation and achievement of the objectives of a comprehensive HIV/AIDS prevention, education, treatment, support and care plan depends on the availability of resources and commitment. Teacher training colleges need to be innovative and aggressive in their resource mobilization strategies. They should look beyond their internal budgetary provisions to their external environments (local and international), for example CBOs, NGOs, bilateral and multilateral donors, development partners, etc.

Prioritization of needs and activities is crucial in the bid to use resources judiciously, efficiently and effectively. Prioritization brings into greater focus the fact that HIV/AIDS is a crosscutting issue that requires simultaneous action on several fronts. The use of local materials and human resources at the level of the college and immediate community as well as existing social capital could be some of the innovative ways of promoting participatory community-based initiatives and at the same time complementing the resources provided by external donors and the government.

h) Development of Monitoring and Reporting System for HIV/AIDS Programmes

It is imperative for the teacher training college to demonstrate whether or not its HIV/AIDS programmes are yielding the desired outcomes and impacts. The complexity of HIV/AIDS interventions requires detailed and refined monitoring and evaluation at inter- and intra college levels, particularly for crosscutting issues such

as policy, resource mobilization and utilization, programme design and implementation. Against this background, the colleges need to develop a system that will enable them document HIV/AIDS activities, collect and analyze data to determine the extent to which they are achieving their stated HIV/AIDS objectives.

The key factors to consider in the development of a monitoring and evaluation system should include, but not limited to, the development of performance indicators that are:

- Useable;
- Realistic; and
- Dependant on the type of change expected to be achieved.

The indicators should include both quantitative or process target/measures and indicators (that measure numbers) and qualitative targets and indicators (that measure quality of output or impact). The framework for developing indicators and on-going monitoring should be developed in collaboration with key stakeholders/partners. Most national HIV/AIDS strategic frameworks provide guidelines for the development of indicators of performance in relation to the overall national target of reducing HIV/AIDS among the ages of 15-49 years under the following areas and these could serve as a guide to training colleges:

- Culture and HIV/AIDS
- Prevention of HIV transmission
- Youth, social change and HIV/AIDS
- Socio-economic status and HIV/AIDS
- Despair and hopelessness and HIV/AIDS
- HIV/AIDS management
- HIV/AIDS and orphans, widows and widowers
- HIV/AIDS information, education, and communication; and
- Voluntary counseling and testing.

It is important to take into consideration the human resource as well as hard and soft ware requirement for effective and efficient management. The human resource training needs should be analyzed to develop the appropriate training programmes to bridge skill and knowledge gaps for effective and efficient performance.

The types of reports/ information to be generated periodically should be determined. Also, efforts should be made at ensuring

that the information is reliable, timely, user-friendly and secured in terms of integrity.

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Annex 2

Country-specific Estimates of HIV/AIDS in Sub-Saharan Africa as at End of 2003

Country	Estimated number of people living with HIV					
	Adults and children, end 2003		Adults and children, end 2001		Adults (15–49), end 2003	
	Estimate	[Low estimate - high estimate]	Estimate	[Low estimate - high estimate]	Estimate	[Low estimate - high estimate]
Global Total	37,800,000	[34,600,000 - 42,300,000]	34,900,000	[32,000,000 - 39,000,000]	35,700,000	[32,700,000 - 39,800,000]
Sub-Saharan Africa	25,000,000	[23,100,000 - 27,900,000]	23,800,000	[22,000,000 - 26,600,000]	23,100,000	[21,400,000 - 25,700,000]
Angola	240,000	[97,000 - 600,000]	220,000	[86,000 - 550,000]	220,000	[88,000 - 540,000]
Benin	68,000	[38,000 - 120,000]	65,000	[36,000 - 110,000]	62,000	[35,000 - 110,000]
Botswana *	350,000	[330,000 - 380,000]	350,000	[330,000 - 380,000]	330,000	[310,000 - 340,000]
Burkina Faso *	300,000	[190,000 - 470,000]	280,000	[180,000 - 440,000]	270,000	[170,000 - 420,000]
Burundi	250,000	[170,000 - 370,000]	240,000	[160,000 - 360,000]	220,000	[150,000 - 320,000]
Cameroon *	560,000	[390,000 - 810,000]	530,000	[370,000 - 770,000]	520,000	[360,000 - 740,000]
Central African Republic	260,000	[160,000 - 410,000]	250,000	[150,000 - 400,000]	240,000	[150,000 - 380,000]
Chad	200,000	[130,000 - 300,000]	190,000	[120,000 - 290,000]	180,000	[120,000 - 270,000]
Comoros	...	...	...	...	...	...
Congo	90,000	[39,000 - 200,000]	90,000	[39,000 - 200,000]	80,000	[34,000 - 180,000]
Côte d'Ivoire	570,000	[390,000 - 820,000]	510,000	[350,000 - 740,000]	530,000	[370,000 - 750,000]
Dem. Republic of Congo **	1,100,000	[450,000 - 2,600,000]	1,100,000	[430,000 - 2,500,000]	1,000,000	[410,000 - 2,400,000]
Djibouti	9,100	[2,300 - 24,000]	8,100	[2,400 - 23,000]	8,400	[2,100 - 21,000]
Equatorial	...	...	...	...	...	...

Guinea						
Eritrea	60,000	[21,000 - 170,000]	61,000	[22,000 - 160,000]	55,000	[19,000 - 150,000]
Ethiopia	1,500,000	[950,000 - 2,300,000]	1,300,000	[820,000 - 2,000,000]	1,400,000	[890,000 - 2,100,000]
Gabon	48,000	[24,000 - 91,000]	39,000	[19,000 - 78,000]	45,000	[23,000 - 86,000]
Gambia	6,800	[1,800 - 24,000]	6,700	[1,800 - 24,000]	6,300	[1,700 - 23,000]
Ghana *	350,000	[210,000 - 560,000]	330,000	[200,000 - 540,000]	320,000	[200,000 - 520,000]
Guinea *	140,000	[51,000 - 360,000]	110,000	[40,000 - 310,000]	130,000	[48,000 - 330,000]
Guinea-Bissau	...	...	...	...	...	...
Kenya	1,200,000	[820,000 - 1,700,000]	1,300,000	[890,000 - 1,800,000]	1,100,000	[760,000 - 1,600,000]
Lesotho *	320,000	[290,000 - 360,000]	320,000	[290,000 - 360,000]	300,000	[270,000 - 330,000]
Liberia	100,000	[47,000 - 220,000]	86,000	[37,000 - 190,000]	96,000	[44,000 - 200,000]
Madagascar	140,000	[68,000 - 250,000]	100,000	[50,000 - 180,000]	130,000	[66,000 - 220,000]
Malawi *	900,000	[700,000 - 1,100,000]	850,000	[660,000 - 1,100,000]	810,000	[650,000 - 1,000,000]
Mali	140,000	[44,000 - 420,000]	130,000	[40,000 - 390,000]	120,000	[40,000 - 380,000]
Mauritania	9,500	[4,500 - 17,000]	6,300	[3,000 - 11,000]	8,900	[4,400 - 15,000]
Mauritius	...	...	...	...	...	...
Mozambique	1,300,000	[980,000 - 1,700,000]	1,200,000	[930,000 - 1,600,000]	1,200,000	[910,000 - 1,500,000]
Namibia	210,000	[180,000 - 250,000]	200,000	[170,000 - 230,000]	200,000	[170,000 - 230,000]
Niger	70,000	[36,000 - 130,000]	56,000	[28,000 - 110,000]	64,000	[34,000 - 120,000]
Nigeria	3,600,000	[2,400,000 - 5,400,000]	3,400,000	[2,200,000 - 5,000,000]	3,300,000	[2,200,000 - 4,900,000]
Rwanda *	250,000	[170,000 - 380,000]	240,000	[160,000 - 360,000]	230,000	[150,000 - 350,000]
Senegal *	44,000	[22,000 - 89,000]	40,000	[20,000 - 81,000]	41,000	[21,000 - 83,000]
Sierra Leone	...	...	...	...	...	...
Somalia	...	...	...	...	...	...
S/Africa *	5,300,000	[4,500,000 - 6,200,000]	5,000,000	[4,200,000 - 5,900,000]	5,100,000	[4,300,000 - 5,900,000]
Swaziland **	220,000	[210,000 - ...]	210,000	[190,000 - ...]	200,000	[190,000 - ...]

		230,000]		220,000]		210,000]
Togo	110,000	[67,000 - 170,000]	100,000	[65,000 - 160,000]	96,000	[61,000 - 150,000]
Uganda *	530,000	[350,000 - 880,000]	620,000	[420,000 - 980,000]	450,000	[300,000 - 730,000]
U/td Rep. of Tanzania *	1,600,000	[1,200,000 - 2,300,000]	1,600,000	[1,100,000 - 2,200,000]	1,500,000	[1,100,000 - 2,000,000]
Zambia	920,000	[730,000 - 1,100,000]	890,000	[710,000 - 1,100,000]	830,000	[680,000 - 1,000,000]
Zimbabwe	1,800,000	[1,500,000 - 2,000,000]	1,700,000	[1,500,000 - 2,000,000]	1,600,000	[1,400,000 - 1,900,000]

Source: 2004 Report on the Global AIDS Epidemic

Annex 3

Teacher Training Institutions Involved in the Survey

BENIN

1. Ecole Normale des Instituteurs (ENI) de Natitingon
2. Ecole Normale Supérieure (ENS) de Porto Novo
3. Institut National de la Jeunesse, de l'Éducation Physique et des Sports (INJEPS)

BURKINA FASO

4. Ecole Nationale des Enseignants du Primaire (ENEP) - Bobo Dioulasso
5. Ecole Nationale des Enseignants du Primaire (ENEP) - Fada Ngourma
6. Ecole Nationale des Enseignants du Primaire (ENEP) - Gaoua
7. Ecole Nationale des Enseignants du Primaire (ENEP) - Loubila
8. Ecole Nationale des Enseignants du Primaire (ENEP) - Ouahigouya

BURUNDI

9. Lycée Don Bosco College
10. Lycée de Kirembe- Sud
11. Lycée Monseigneur Joachim Ruhuna de Muyaga
12. Lycée Notre Dame de la Sagesse
13. Lycée Pédagogique de Ngagara
14. Lycée Sainte Marie Immaculée de Buhonga
15. Lycée Sainte Thérèse
16. Lycée Scheppers de Nyakabiga

CAMEROON

17. ENIEG Batouri
18. ENIEG d'Abong-Mbang
19. ENIEG de Bamemba
20. ENIEG de Bertona
21. ENIEG de Deido
22. ENIEG de Dschang
23. ENSET Douala

CONGO

24. Ecole Normale des Instituteurs (ENI)
25. Ecole Normale Supérieure (ENS)
26. ISEPS – Brazzaville-
27. COTE D'IVOIRE
28. CAFOP Abengourou
29. CAFOP -Abidjan

30. CAFOP -Aboisso
31. CAFOP –Dabou
32. CAFOP – Grand Bassam
33. CAFOP -Supérieur de Yamoussokro
34. CFPEN

GAMBIA

35. Gambia College
36. Gambia College – Brikama Campus

GHANA

37. Abetifi Presby Training College
38. Ada Training College
39. Agogo Presbyterian Training College
40. Akatsi Training College
41. Akrokerri Training College
42. Atebubu Training College
43. Bagabaga Training College
44. Berekum Training College
45. Dambai Training College
46. Enchi Training College
47. E.P Training College, Bimbilla
48. E.P Training College-Amedzofe
49. Fosu Training College
50. Gbewaa Training College
51. Jasikan Teachers' Training College
52. Kibi Presby Training College
53. Komenda College
54. Mampong Technical Training College
55. N.J Ahmadiyya Muslim Teachers' Training College
56. OLA Training College
57. Peki Government Training College
58. Presbyterian Training College
59. Presbyterian Women's Training College
60. St Francis Training College
61. St. John Bosco Training College
62. St. Joseph's Training College
63. St Monica's Training College
64. St Teresa's Training College
65. Tamale Training College
66. Tumu Training College
67. Wesley College
68. Wiawso Training College

GUINEA BISSAU

69. ENAL - Bolama
70. Ecole Normale Supérieure (ENS) de Tchico Te

71.17 Fevereiro

KENYA

- 72. Egoji Teachers' Training College
- 73. Kericho Teachers' College
- 74. Machakos Teachers' Training College
- 75. Moi Teachers' Training College
- 76. Mombasa Polytechnic
- 77. Narok Teachers' Training College
- 78. Shanzu Teachers' Training College
- 79. St. Marks Teachers' Training College (Kigali)
- 80. Tambach Teachers' Training College
- 81. Thogoto Teachers' Training College

MALI

- 82. Institut de Formation des Maîtres (IFM) – Bakary Thiero de Niono- Public
- 83. Institut de Formation des Maîtres (IFM) – Djimé Diallo de Kangaba- Public
- 84. Institut de Formation des Maîtres (IFM) – Ousmane Balomo Maiga de Bougouni- Public.

85. MOZAMBIQUE

- 86. Centro de Formação de Professores Primários - Namaacha
- 87. Escola de Professores do Futuro– Nhamatanda
- 88. Instituto do Majestério Primário, Chibututuine (IMAP) - Manhiça
- 89. Instituto do Majestério Primário, Matola (IMAP)
- 90. Instituto do Majestério Primário, Inhamízia (IMAPI) - Beira
- 91. Instituto Nacional de Educação de Adultos– (INEA)

NIGER

- 92. Ecole Normale Bawa Jangorzo
- 93. Ecole Normale Kaocen
- 94. Ecole Normale Mali Bero/Dosso
- 95. Ecole Normale – Tanimoune

NIGERIA

- 96. College of Education (COE) – Ekiadolor
- 97. College of Education – Gindiri
- 98. College of Education – Minna
- 99. Federal College of Education – Akoka
- 100. Federal College of Education – Albor
- 101. Federal College of Education – Asaba, Delta State
- 102. Federal College of Education (Tech) – Gombe
- 103. Federal College of Education – Kano
- 104. Federal College of Education – Okene –
- 105. Federal College of Education – Pankshin
- 106. Federal College of Education – Umunze
- 107. Federal College of Education – Yola
- 108. Federal College of Education – Zaria
- 109. E.C.O.E. – Enugu

110. Kaduna State College of Education – Ankda
111. Kaduna State College of Education – Gidan Waya
112. Nasarawa State College of Education – Akwanga
113. Nwafor Orizu College of Education – Nsugbe
114. SENEGAL
115. CEF – Thiaroye Sur Mer
116. Ecole Normale Supérieure (ENS) – Dakar
117. EFI Diouna Alboury Ndiaye Low
118. EFI of Ziguinchor
119. ENFEFS – Dakar
120. NSEPS – Dakar

SIERRA LEONE

121. Bo Teachers' College
122. Eastern Polytechnic
123. Freetown Teachers' College
124. Makeni Teachers' College
125. Milton Margai College of Education & Technology
126. Port Loko Teachers' College

TANZANIA

127. Klerruu Teachers' College
128. Marangu Teachers' College
129. Monduli Teachers' College
130. Tukuyu

TOGO

131. Ecole Normale des Instituteurs (ENI) de Kara
132. Ecole Normale des Instituteurs (ENI) de Notsè
133. Ecole Normale Supérieure (ENS) d'Atakpamé

UGANDA

134. Arua Primary Teachers' College
135. Bishop Willis Core Primary Teachers' College
136. Bulera Core - Primary Teachers' College
137. Busuubizi Core Primary Teachers' College
138. Canon Apolo Primary Teachers College F/Portal
139. Canon Lawrence Primary Teachers' Training College
140. Gaba Primary Teachers' College
141. Gulu Core Primary Teachers' College
142. Jinga Primary Teachers' College
143. Kabwangazi Primary Teachers' College
144. Kaliro
145. Kamurasi Primary Teachers' College
146. Kapchorwa Primary Teachers' College

147. Kibuli Core Primary Teachers' College
148. National Training College – Kabale
149. National Training College – Kakoba
150. National Teachers' College – Mubende
151. Ndegeya Core - Primary Teachers' College
152. Ndegeya Primary Teachers' College
153. Nyondo Teachers' College
154. Shimoni Primary Teachers' College
155. Soroti Teachers' Training College
156. St Aloysius Primary Teachers' College – Ngora
157. St John Bosco Primary Teachers' College - Lodonga
158. St John Bosco Primary Teachers' College - Nyondo
159. National Training College – Nkozi-

ZAMBIA

- 160. Charles Lwanga College of Education
- 161. Copper Belt Teachers' Training College
- 162. David Livingstone College of Education
- 163. Kitwe College of Education
- 164. Malcolm Moffat College
- 165. Mufulira College of Education
- 166. National In-Service Training College
- 167. Nkrumah College of Education
- 168. Solwezi Teachers' Training College-

ZIMBABWE

- 169. Belvedere Technical Teachers' College
- 170. Hillside Teachers' College
- 171. Morgan Zintec

CHAPTER THREE

Response of Polytechnics in Africa to HIV/AIDS

*Cecilia N. Ogulla, Wilfred N. Gichuki, Pascal Chewe,
George Afeti, and William Rwambulla*

1. Introduction

At the United Nations General Assembly Special Session (UNGASS, 2001), the Heads of State and Governments expressed deep concern on the global HIV/AIDS epidemic: its scale and impact on the youth and the communities in general. They also noted with profound concern that Africa, in particular Sub-Saharan Africa, is currently the worst affected region, with HIV/AIDS considered as an epidemic which threatens development, social cohesion, political stability, food security and life expectancy.

The Working Group on Higher Education (WGHE) of the Association for Development of Education in Africa (ADEA) too has had a lot of concern about the youth in the Polytechnics and Universities in Africa due to their vulnerability and risk to HIV/AIDS. As a result, several studies have been commissioned to survey the response of African Universities and Teacher Training Colleges to the threat of HIV/AIDS epidemic.

One such study undertaken by Kelly (2001) titled "Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV/AIDS", (March 2001) sought information from universities on their response to HIV/AIDS. One main observation made by Kelly was that there is a deafening silence surrounding the HIV/AIDS in the universities. In his other study, "The Response of Information Technology to the Challenge of HIV/AIDS in Higher Education Institutions in Africa" (November 2001), Kelly observed that African universities need to exchange research results on HIV/AIDS using the information technology highway.

The WGHE and ADEA also provided funds to several institutions, including Mombasa Polytechnic (2003) and Highridge Teachers College (2003), to develop institutional policies on HIV/AIDS. The policies which were developed show the activities the colleges will undertake and the action plans envisaged for the prevention, control, care and treatment of HIV/AIDS in the respective colleges.

Out of similar concern, WGHE of ADEA has commissioned this survey on the "Response of Polytechnics in Africa to the threat of HIV/AIDS pandemic".

1.1 Objectives of the Study

The main objective of the survey was to assess the level of response by the polytechnics in Africa to the threat of HIV/AIDS. The specific objectives included:

- To ascertain whether the polytechnics have developed HIV/AIDS policy or guidelines and whether they have translated the policy into actions and programmes to address the pandemic;
- Establish the extent to which the policy implementation integrates and mainstreams HIV/AIDS programmes into polytechnic curricula;
- Assess the level of monitoring and evaluation of HIV/AIDS programme and the extent to which polytechnics share information in partnership with other HIV/AIDS education providers;
- Assess the degree of commitment by the polytechnic leadership to the reduction of HIV/AIDS prevalence and identify the challenges faced.

1.2 Justification for the Study

The available statistics show that there is still an upward progression in the prevalence of HIV infection in many African countries and yet there is a tremendous world-wide campaign to contain the pandemic. The upward trend in the prevalence rate in itself is a clear indication that a lot more has to be done, and that on the whole, many people are either still ignorant about HIV/AIDS or are just adamant and not yet prepared for behavioral change.

The grip of the epidemic on Africa and in particular, Sub-Sahara African countries (SSA) raises concern in everybody. Studies indicate that even if the situation improves, the effects of the epidemic will remain for a long time especially in the education sector.

It is also believed that the situation is likely to grow even worse before some improvements can be registered. And yet in Sub-Saharan Africa, the prevalence rate is still on the increase. Already the disease has claimed 25 million people and 40 million others are currently infected. At the end of 2001, the infection rate for adults in their productive years, those aged between 15 and 49, was 8.9 per cent for Sub-Saharan Africa and only 0.4% for the rest of the world. Still, in terms of

the world population, Sub-Saharan Africa accounts for 10.4%. By the end of 2003, UNAIDS estimates put the figure of people living with HIV/AIDS at 26.6 million (UNAIDS 2004).

In Sub-Saharan Africa, the epidemic has reduced the average life expectancy from an estimated 62 years to a mere 45 years, and in some countries like Botswana, Malawi, Mozambique and Swaziland, the average life expectancy has been reduced to 40 years (UNAIDS 2004). The disease continues to expand relentlessly, destroying people's lives and damaging the fabric of society despite the many efforts being put in place to control the spread. In addition, HIV/AIDS has increased poverty levels and undermined the very foundations of progress, by reversing the developmental gains registered over decades. This has impacted heavily on the ranks of professionals and skilled labour force, with some countries losing as much as 25% of their personnel (ICAD 2002)

The polytechnics in Africa have not been spared by the pandemic. It is against this background that staff and students in the polytechnics understand and are informed about HIV infection, prevention strategies, voluntary counseling and testing, care and treatment. In order to realize these objectives, the polytechnics have to create and promote an enabling environment that is conducive to all, including those living with HIV/AIDS, and to advocate for their rights.

There may be limited information, but there is enough evidence to show that teachers are falling ill and others are dying because of the epidemic. The discovery of anti-retroviral therapy has given hope to many people living with HIV/AIDS by prolonging life. However, in Africa, access to HIV/AIDS treatment is on one hand a costly service and on the other, still hampered by the stigma and discrimination that surround people living with HIV/AIDS. The challenge is to address stigmatization and discrimination within the institutions and to ensure that preventive methods against the pandemic take the center stage within the institutional programmes.

With the needed political will and support by African governments, polytechnics in Africa can put in place strategies and programmes initiated to combat the pandemic. These structures, programmes and strategies can form the basis for an institutional policy framework on HIV/AIDS.

1.3 Conceptual Framework

By putting into place institutional policies, integrating HIV/AIDS into curricula, developing and implementing awareness programmes for their constituents and communities, conducting research, forming partnerships and funding HIV/AIDS initiatives in their respective institutions, the polytechnics in Africa can not only sustain quality

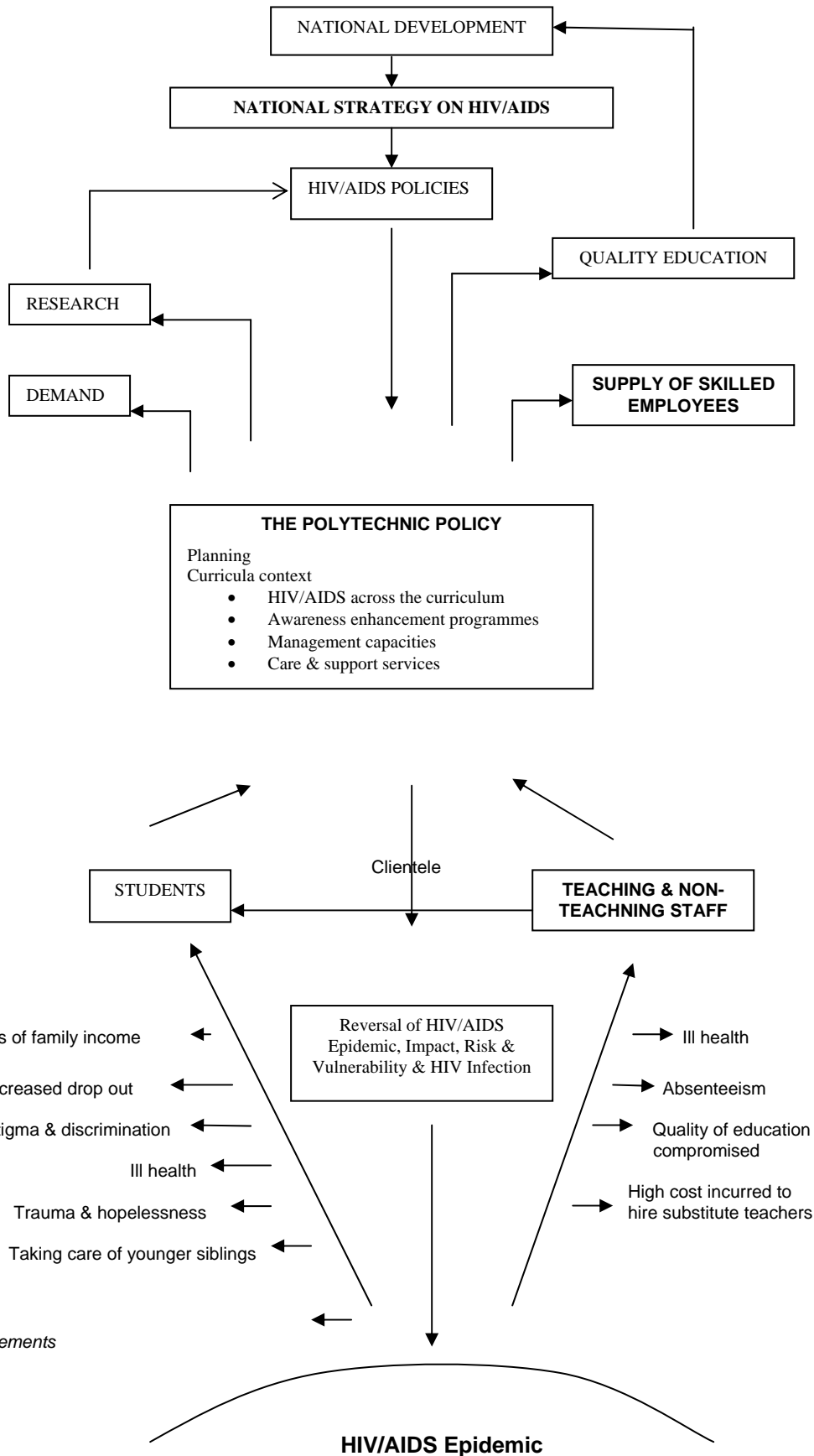
education, supply and demand of education but can also reverse the impact of HIV/AIDS and revive national development (See Fig. 1).

If the world's response to AIDS continues in its well intended but in a haphazard and ineffectual fashion then AIDS will continue to outrun efforts to stop it. In the past, responses to the HIV/AIDS epidemic have too often been piece-meal and small scale, health-oriented and weakly integrated into related efforts (World Bank 2002; UNAIDS 2004).

1.4 Africa's Response to HIV/AIDS

Faced with eminent devastation, many African countries have made AIDS a priority. National strategic plans against AIDS are in place. Despite their effort to have met the UN Declaration goals by 2005, they have not achieved their targets on protection of vulnerable groups and the provision of care to those infected (UNAIDS 20

Figure 1. Conceptual framework for polytechnics' response to threat of HIV/AIDS



Speaking about the crisis posed by HIV/AIDS in Africa, former President Nelson Mandela stressed that HIV/AIDS is preventable despite its devastating nature. He said: "I am shocked to learn that one in two, that is half of our young people will die of AIDS. The most frightening thing is that all these infections which statistics tell us about *were preventable*" (School Health Situational Analysis, July 2000).

According to statistics, young people aged 15 – 24 account for half of all new HIV infections and are getting infected at the rate of 6000 – 7000 everyday. The future trajectory of the epidemic, therefore, will mainly depend on how well we empower young people to protect themselves against HIV infections (UNESCO 2004).

At the XIII International AIDS Conference in Durban, July 2000, the delegates saw that there was every reason for governments to invest in HIV prevention. As a follow up, African leaders at the Abuja Declaration re-affirmed their fight against the epidemic through personal commitment and through investing more resources, including a commitment to allocate 15% of the government budget to the health sector.

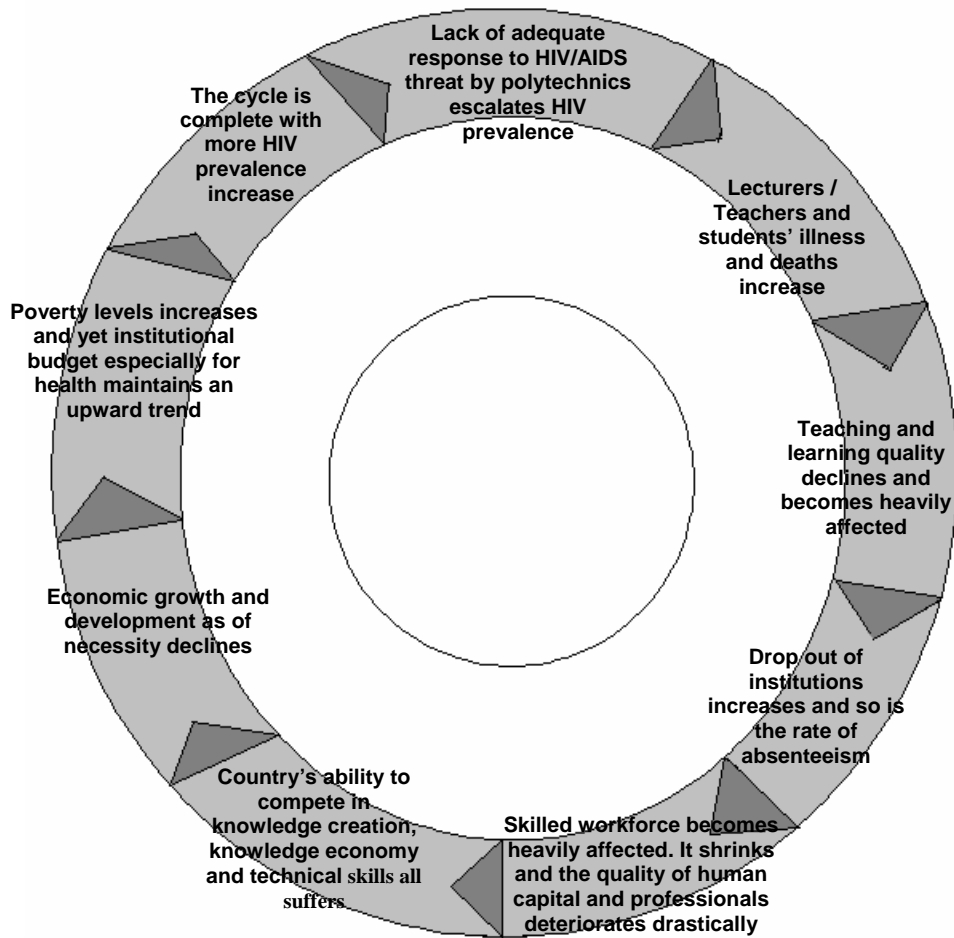
1.5 Polytechnics' Response to HIV/AIDS

The polytechnics have a major share in the development of human capital. They train millions of people to become highly skilled employees and successful entrepreneurs to meet the needs of an ever changing world. It is the work of these important institutions that future economic progress will depend on.

It is evident that the polytechnic sector is important in driving countries towards achieving the Millennium Development Goals of eradicating extreme poverty and hunger by 2015. To achieve this goal, countries will be required to reduce by half the proportion of people living on less than a dollar a day and those who suffer from hunger.

These goals are unlikely to be met due to HIV/AIDS. "Not only does it mean that development goals will be unattainable, but in fact there may be a reversal in the development of many nations and development cannot be business as usual. Nowhere is this more the case than in the education sector," say Badcock-Walters and Whiteside (1999). If there is no immediate response by the polytechnics to the pandemic, then there will be a vicious cycle of HIV/AIDS and education, as shown in Fig. 2.

Figure 2. HIV/AIDS and technical education in a vicious cycle



Source: "A window of hope" (World Bank 2002) (improved version)

Polytechnic institutions in Africa therefore have a critical role in training professionals to fight against and mitigate the effects of HIV / AIDS within the institution and surrounding communities.

1.6 HIV/AIDS' Impact on Teaching Staff and Students

A report by the World Bank entitled "Education and HIV/AIDS: A Window of Hope" says that the disease is killing teachers faster than they can be trained and is rapidly orphaning a large number of

students, a phenomenon that threatens to derail the very foundation of the education system, including the millennium development goals, to achieve universal primary education by 2015.

According to the report, nearly a third of all teachers in parts of Uganda and Malawi carry the HIV virus. In Zambia, teacher deaths rose from 680 in 1996 to 1,300 in the first 10 months of 1998. In Central African Republic, 85% of 340 teachers who died between 1996 and 1998 had HIV. In Southern Africa, it is believed that teachers have a higher rate of HIV infection than the general population.

In Kenya, an average of 18 teachers die from AIDS-related diseases every month (*Daily Nation*, October 29, 2001). At this rate, it means that 6,570 teachers die annually. From a training perspective, teacher training colleges and universities cannot cope with that kind of attrition rate over the long term, the effect on the economy notwithstanding.

The World Bank Report further says that the disease is also emptying classrooms of students as young people are infected or orphaned by the disease and are forced to leave school to care for their younger siblings.

Young people, especially young women, are particularly at risk from HIV/AIDS. Statistics from all over the world corroborate young people's vulnerability to HIV infections. In Eastern and Southern Africa sub-region, about half of those who become infected with HIV are between the ages of 15 and 24 (ICAD 2002), when they should be in secondary schools or in tertiary colleges. At secondary or tertiary levels of education, students' attendance and enrolment is bound to be adversely affected by HIV/AIDS as a result of:

- Loss of family income from AIDS-related illness and death, as well as costs of care and funerals;
- Increased drop-out rates as young people are required to care for sick family members and generate income;
- Damage to extended family and community structures and consequent loss of the traditional "safety net";
- Trauma arising from illness and death;
- Stigma and discrimination suffered by students as a result of their HIV status or HIV/AIDS in the family;
- The perception that investment in education is not worthwhile given the growing prospect of premature mortality.

1.7 HIV/AIDS and Quality Education

The education sector is by far the largest employer of public service staff engaged in the delivery of quality education. Other than the teaching staff, there are teacher trainers, college and university lecturers, education officers, inspectors, planners and managers. All these key players in the supply of education are equally impacted on by HIV/AIDS just as the teachers are.

When HIV/AIDS takes its toll, the productivity of the education is severely compromised. According to the World Bank (2002) and UNAIDS Report (2004) HIV/AIDS leads to high rate of teacher absenteeism, and these teachers are often not replaced. In some cases, much of the time is spent on attending funerals of their departed colleagues or friends.

It is against this background that the education sectors need to re-evaluate their roles in bringing the epidemic down. The World Bank is urging countries to curb HIV/AIDS through the classroom. It suggests that education ministries design a broad strategy response rooted in education and set within a national and multi-sectoral context.

The educational approach to curb HIV/AIDS is hinged on three areas: policy, supply and quality, and demand and access, where national governments and their education ministries can make a decisive impact in using education to prevent the further spread of HIV/AIDS. This in turn could protect children and teachers from infection. According to UNESCO (2004), when students are involved in designing HIV/AIDS education programme, they are likely to stick to their own rules for prevention of HIV infections. Similarly when teachers are involved in disseminating HIV information on prevention they are likely to practice what they teach.

UNESCO (2004) suggests five core tasks necessary for comprehensive prevention. These are:

- a) Advocacy
- b) Customizing the message
- c) Changing risk behaviour
- d) Caring for the infected
- e) Coping with the institutional impact of HIV/AIDS.

The polytechnics in Africa can adequately respond to all these challenges. Owing to large numbers of people who are either working or studying at these institutions, the polytechnics can disseminate HIV/AIDS information to very many people. Through individual staff and students, their families, communities, regions and nations, polytechnics can thus reach many people in ways that no other organizations can do.

1.8 MAINSTREAMING HIV/AIDS INTO THE CURRICULUM

The polytechnics have the capacity to customize the message or mainstream HIV/AIDS into the curriculum. They have access to a rich reservoir of information drawn from various disciplines. They have extra advantage of their experience in curriculum development, capacity building, planning and monitoring of educational output. They are, therefore, better placed to customize HIV/AIDS messages to their students for better understanding and future implementation of HIV/AIDS programmes at workplaces.

The other tasks which involve, changing risk behaviour, caring for the infected and coping with institutional impact on HIV/AIDS, are so interrelated that reducing vulnerability to HIV infection is fundamental to reversing the spread of the virus. Decreasing the risk of infection slows down the epidemic. Decreasing vulnerability, decreases the risk of infection and the impact of the epidemic. Decreasing the impact of the epidemic, decreases vulnerability to HIV/AIDS. This positive cycle of simultaneously reducing risk, vulnerability and impact can well be handled by educational institutions such as the polytechnics, which largely handle the young, the category at greatest risk of becoming infected with HIV (UNAIDS 2003 and 2004).

2. METHODOLOGY

2.1 Study Instrument

The study aimed to collect data from a cross-section of polytechnics in Africa. The study intended to cover polytechnics in the Anglophone, Francophone and Lusophone countries in the Sub-Saharan Africa.

A questionnaire was developed to measure levels of participation, practices, attitudes and commitment by the polytechnics towards the response to the threat of HIV/AIDS. The designed questionnaire was structured to cover the following four broad areas:

- a) information on institutional data such as institution's staff and student population and their gender distribution;
- b) information on institutional policy on HIV/AIDS;
- c) issues related to HIV/AIDS policy implementation;
- d) issues of monitoring and evaluation.

The survey sought to bring out the following issues:

- a) Whether the institutions collect and keep records of data on HIV/AIDS;

- b) Who is responsible for data collection and record keeping and for what purpose;
- c) What strengths, weaknesses, opportunities and threats the institutions have identified in their response to HIV/AIDS;
- d) What challenges the institutions face in their effort to respond to HIV/AIDS.

2.2 DATA COLLECTION

The study sought data from one hundred polytechnics in the Anglophone and Francophone countries of Africa. The Lusophone countries in Africa could not be reached due to translation problems.

Every effort was made to have responses from the Francophone polytechnic institutions, but no single questionnaire was returned. Similar efforts were made to reach the South Africa Technikons without success either. The reason given was that the Technikons were in the process of becoming Universities of Technology through mergers and as such, nobody took the responsibility to respond to the questionnaire. There were also similar cases in other countries where institutions failed to respond to the questionnaire despite constant reminders by e-mails and through telephone calls.

The responses received were from Anglophone countries of Sierra Leone, Ghana and Nigeria in the Western sub-region; Kenya, Uganda and Tanzania in the Eastern sub-region; and Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe in the Southern sub-region. In all forty institutions (see Annex 4 for institutions covered) responded fully to the questionnaire.

The distribution of institutions that covered the Western, Eastern and Southern sub-regions of African countries, gave a wide coverage, a good comparative perspective and a better understanding of how polytechnics in each sub-region respond to HIV/AIDS epidemic.

A few institutions were selected (not randomly though) for an in-depth study through structured direct interviews and with the help of survey assistants. Those reached through direct interviews were Ho Polytechnic – Ghana, Federal Polytechnic Bida – Nigeria, Kenya Polytechnic – Kenya, Uganda Polytechnic Kyambogo – Uganda and Technical and Vocational Teachers College – Luanshya – Zambia. The rest of the polytechnics were reached by post and e-mail.

3. THE FINDINGS

The findings were based on responses received from forty institutions drawn from Western, Eastern and Southern Africa sub-regions. The responses received were encouraging as they came from senior members of staff at the levels of Directors of institutional medical services units, Registrars, Deputy Principals and from Institutional Heads themselves. The information given, is therefore, assumed to be reliable and credible.

The institutional data showed that polytechnics in Africa handle large populations of staff and students but with an imbalanced gender distribution, as shown in table 1. For example, Kaduna Polytechnic in Nigeria has a population of 32,000 students while Federal Polytechnic Offa has a student population of 25,368 and a staff of 1,356, males and females. Other institutions also have populations ranging from hundreds to tens of thousands of staff and students.

The women in polytechnics account for 40% of the population while students alone account for 91% of the institutional population.

Table 1. Staff and students population distribution (000)

Region	Total number of staff				Total no. of students	
	TEACHING		Non-teaching		M	F
	M	F	M	F		
Southern region (Institutions: 9)	415	183	706	370	6,712	4,657
Eastern region (Institutions: 10)	799	426	911	561	18,459	9,881
Western region (Institutions: 21)	4,146	1,944	7,528	3,985	110,301	76,971
TOTAL	5,360	2,553	9,145	4,916	135,472	91,509

Every year, each polytechnic enrolls a new cohort of young men and women who are in the most vulnerable group. Polytechnic institutions should be the ideal place to respond to HIV/AIDS pandemic, so that those who enter the institutions and those who graduate to the world of work receive the vital information especially on HIV/AIDS prevention and on health care services. This would help the polytechnic community to live responsibly.

3.1 INSTITUTIONAL POLICY/GUIDELINES ON HIV/AIDS

One of the objectives of the survey was to establish whether the institutions have policies or guidelines on HIV/AIDS in place, whether these policies/guidelines are being fully implemented and the likely challenges being faced in this process.

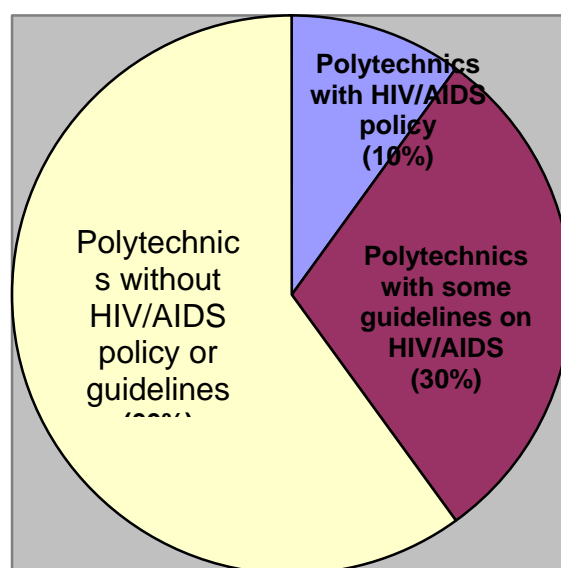
It is quite clear from the findings that most polytechnics in Africa do not have a policy or any guideline on HIV/AIDS. In all the institutions surveyed, only 10% were found to have a policy. Those that have policies in the Southern Africa sub-region include, Zambia Telecommunications College [ZAMTEL], Technical and Vocational Teachers College, Zambia and Kitwe Vocational Training Centre, Zambia.

In Eastern Africa sub-region, it is only Mombasa Polytechnic, Kenya, which has a policy, developed with the financial assistance from the Working Group on Higher Education [WGHE].

In Western Africa sub-region, Milton Margai College of Education and Technology, Sierra Leone and Yaba College of Technology, Lagos - Nigeria, are the only ones with a policy on HIV/AIDS. In the case of Milton Margai College, the policy was developed by a Cabinet sub-committee on HIV/AIDS, together with partners involved in HIV/AIDS within Sierra Leone. The funding for the policy came from the World Bank through UNAIDS.

The institutions that have some guidelines make up to 30%, while 60% stated that they do not have any policy or guidelines on HIV/AIDS (Fig. 3)

Fig. 2: Polytechnics with or without HIV / AIDS policy / guidelines.



Source: Compiled from analyzed data.

What is striking from the study is that some institutions have left the challenges of HIV/AIDS to volunteer individuals, or to some clubs run by students, like the anti-AIDS clubs or Rotaract clubs, but without financial or even moral support from the institutions.

The end result is uncoordinated HIV/AIDS activities and with no clear guidance. The funding of HIV/AIDS policy development or guidelines within polytechnics seems to be an uphill task and varies from institution to institution. Generally, they all reported lack of funds or at least lack of adequate funds for the exercise. Those that get funding identified the source as government through National AIDS Councils or Commissions, Non-governmental Organizations (NGOs) interested in HIV/AIDS, or from donor agencies. The government funding was reported to be inadequate.

It was found that the institutions which have developed policies or guidelines have well laid out preventive strategies. Some of the goals and objectives reported include:

- Control the spread of HIV/AIDS among staff and students including the surrounding communities;
- Educate staff and students on the dangers of HIV/AIDS;
- Mitigate the impact of HIV/AIDS in education and try to eliminate stigmatization;
- Create awareness and reduce risks and factors that promote HIV/AIDS spread and prevalence;
- Influence behaviour change and reduce stigma and discrimination;

- Help communities to know how to avoid the infection and stop further transmission;
- Help communities with information on health care services including the use of ARVs therapy;
- Reduce HIV/AIDS prevalence through the promotion of safer sexual behaviour and safer non-sexual behaviour.

The majority of the institutions, however, indicated that the pandemic is handled through the office of the Dean of students, who organizes seminars and workshops and invites knowledgeable speakers on the topic. Some of the speakers are drawn from hospitals, voluntary counseling and testing [VCT] centers. A few pointed out that students and staff get the necessary information on HIV/AIDS through public media, posters, drama, puppetry and public lectures organized by the National AIDS Commissions or NGOs.

A challenge was posed to those institutions without a policy, on what plans they had to develop one. Various responses were received, some of which conveyed interesting messages such as “*we have not witnessed any epidemic*”, implying that there is no immediate need for a plan to have a policy on the epidemic. Some stated that they were in the process of developing one, while others revealed that they were waiting for the governments to provide the necessary guidelines and funding.

All this shows that the institutional leadership has not taken HIV/AIDS epidemic seriously and lacks initiative to put such plans and policies in place.

The development of HIV/AIDS policy to some institutions, is seen as a hard task to the institutional leadership. There are those that lack the know-how and there are others that are waiting to develop a policy once the funds for this purpose are available. They expect to solicit such funds from collaborators and International Donor Agencies like the World Bank, UNAids and HOPE - Worldwide (HIV/AIDS Prevention Care and Support), which has been very supportive to many polytechnics in Nigeria including Yaba College of Technology. There was no mention of getting such funds from institutions or government budgetary allocation.

This means that most institutions do not consider HIV/AIDS as a problem that requires immediate attention.

3.2 Research as a Tool in the Fight against HIV/AIDS

One of the most effective means of addressing and preventing the spread of HIV/AIDS is through research. Research generates new information and recommends best practices to reduce the pandemic.

Surprisingly, only one institution in Western Africa sub-region – Federation Polytechnic Bida, Nigeria, responded as having conducted research on HIV/AIDS by the medical centre of the polytechnic. Apparently, the research did not reveal the number of HIV/AIDS-related deaths in the institution in the past years. It did not also indicate how helpful the research findings were.

In Eastern Africa sub-region, it is only Mzumbe University which has conducted a research on HIV/AIDS and has shown that there have been some HIV/AIDS-related deaths among teaching staff (2), non-teaching staff (6) and students (3).

In Southern Africa sub-region, only the Polytechnic of Namibia has conducted research on HIV/AIDS through the office of the Dean of Students. Interestingly, no HIV/AIDS-related deaths have been recorded from the research findings.

Though other institutions were unable to conduct research on HIV/AIDS, they indicated their institutions' loss of some members of their staff and students through HIV/AIDS-related deaths.

Research in HIV/AIDS need to be encouraged within polytechnics and the resulting information shared widely as a means of combating the spread of the pandemic.

Table 2. HIV/AIDS-related deaths in the past 5 years within polytechnic institutions

Region	Staff		Students	Total
	Teaching	Non-teaching		
Western (21 Institutions)	4	13	9	26
Eastern (10 Institutions)	15	28	18	61
Southern (9 Institutions)	24	21	33	78
Total	43	62	60	165

Most of the polytechnics concede that they were unable to give figures for HIV/AIDS-related deaths because they have not carried out any research and have not been keeping records on the epidemic. Some respondents gave the impression that they are not aware of any related deaths due to HIV/AIDS.

Quite a number of staff and students die due to HIV/AIDS. However, in the absence of record keeping, the figures indicated in table 3 are likely to be mere estimates and by far on the lower side.

The table, however, supports the claim that there is a tendency of more non-teaching staff dying of HIV/AIDS than the academic staff because of their (non-teaching staff) social status. This claim has to be supported by further research.

3.3 INSTITUTIONAL HIV/AIDS RESPONSE STRATEGY

According to the survey, different polytechnics are using different strategies in the fight against the pandemic.

Twenty-three institutions out of forty or 57.5% have an officer specifically responsible for the implementation of HIV/AIDS within the institution. The remaining 42.5% do not have any officer or unit responsible for HIV/AIDS programmes.

If the implementation has to take place as required and for the benefit of students and staff, it is necessary for each institution to identify an officer responsible for the co-ordination and implementation of the policy.

The implementing officers are reported to be stationed in different units or sections of the institutions as follows:

- The medical services department of students affairs;
- School of general studies;
- Guidance and counseling unit of the polytechnic;
- Liberal studies/general studies department;
- Human Resources Department.

Others stated that there is no specific unit. They had embarked on the process of establishing committees with the mandate to co-ordinate HIV/AIDS activities and be headed by the office of the Dean of Students.

Five modes of implementation had been proposed for the polytechnics to indicate which ones they use and if none of those, to indicate which other option they use. Some institutions indicated that they were using more than one proposed implementation strategy and others had no programme to implement.

a) Infused or Integrated Program

Three institutions in Western Africa sub-region, namely, Federal Polytechnic Oko, Plateau State Polytechnic Burkin and Milton Margai College of Education and Technology indicated that they were implementing the “*infused*” method. Four other institutions in West Africa were using seminars and workshops as the mode of implementation.

In the Southern Africa sub-region, three out of nine institutions have infused or integrated HIV/AIDS courses within the curriculum.

b) Core Course Programme

Only one institution in Zambia teaches HIV/AIDS as a core course. A few others teach it to first year students only.

c) Other Programmes

Other institutions reported that they were using Peer Education method, sensitization through students’ resource centers, seminars and talks to first year students during the orientation week.

d) HIV/AIDS Awareness Strategy among Polytechnic Students

Another strategy used is the briefing to all new students during the orientation week. The orientation week awareness approach to HIV/AIDS seems to be the most favoured method according to the results of the study. The majority of institutions use the orientation week to sensitize students and to some extent staff as well, about HIV/AIDS epidemic.

The orientation week awareness approach can only have an impact if there is a well-organized and articulated orientation programme that is mandatory for all, especially the new students. Such an orientation programme should focus on getting students familiar with HIV-prevention methods and by emphasizing the mode of transmission, care, treatment and where to find health clinics and voluntary counseling and testing centers [VCTs].

A majority of the students, these days, join polytechnics when they have a fair knowledge and good idea about the disease, either from secondary schools, national campaigns, or through the media. Others see sick relatives and believe that AIDS is real. However, according to Kelly (2001), some students do not take such talks about HIV/AIDS during orientation week seriously. “*They take them to be the usual talk*”, says Kelly (2001). Even those who listen attentively to the talks about the dangers of HIV/AIDS, and learn where to go in case of need for HIV/AIDS services, such as medical centers where voluntary

counseling and testing can be done, or where they can obtain free information on condom use and other provisions, end up not putting into practice what they hear and learn.

At the polytechnic level, there is also the problem of pressure from peer groups which forces the meek students, into HIV/AIDS high risk activities such as alcohol consumption, drug abuse, casual sex, pornography venturing and interacting with prostitutes, thus forgetting all about the talk.

Educational talks on HIV/AIDS should not be limited to orientation weeks. Polytechnic institutions have to use a multi-dimensional approach. One other way the institutions could use is to occasionally invite people who have trained in HIV/AIDS and/or have openly declared to be HIV-positive, to give talks about the epidemic. Real testimonies have a great impact on the youth.

The more information about HIV/AIDS the students get, the more they are likely to have behavioural change and be in a position to change others.

e) Foundation or Stand-alone Course

None of the institutions is implementing HIV/AIDS as a foundation course, stand-alone or even as elective modules. May be these are not popular programmes with polytechnics. However, whatever mode an institution chooses to use, it must be effective and address every aspect of HIV/AIDS pandemic.

3.4 HIV/AIDS Budgetary Allocation

The funding of HIV/AIDS in all polytechnic institutions was reported to be generally poor.

In Southern Africa sub-region, two out of nine polytechnics have budgetary allocation, which accounts for less than 20%.

In Western Africa sub-region, the situation is similar to other regions in that only two institutions out of 21 or less than 10% have a budgetary allocation for HIV/AIDS.

In Eastern Africa sub-region, out of 10 institutions, only Mzumbe University has a budgetary allocation for HIV/AIDS activities.

3.5 Plans to Create Funds

Many proposals on how to create funds towards the fight against HIV/AIDS were suggested. Thirteen polytechnics out of forty came up with the following proposals on how to solicit funds:

- Through the institution with the support of NGO's;

- From institutional budget and donors;
- To incorporate institutional budget with governments grants;
- Hope to create funds when the budget of the institution improves;
- To solicit funds from National AIDS Commissions and Ministry of Education and Health;
- From institutional production units;
- Requesting funding from government and other sources when the project starts.

4. INSTITUTIONAL MONITORING AND EVALUATION

Monitoring and evaluation of HIV/AIDS is an important undertaking which every institution should endeavour to conduct on a regular basis. It requires the institution to collect data (information) from both staff and students on a regular basis for comparison purposes. That is, to compare the present results with the past so as to gauge the need for improvement or change of strategy.

The survey reveals that in the Western Africa sub-region, two institutions collect HIV/AIDS data on staff and students, while two more collect data only on students.

In Eastern Africa sub-region only Mombasa Polytechnic, Kenya, and Mzumbe University, Tanzania, collect data on HIV/AIDS data from staff and students. In Southern Africa Namibia polytechnic collects data on staff and two other institutions collect data only on students.

The polytechnics need to be encouraged to collect data on HIV/AIDS so as to monitor and establish the prevalence rate and to use such data to advocate for behaviour change. Collected data also provide basic facts for future planning and decision making.

5. INSTITUTIONAL CHALLENGES

The institutions were asked to specify the main challenges in the fight against HIV/AIDS pandemic and they listed some of the following as the main challenges:

- Fear of stigmatization and discrimination;
- Difficulty in change of attitudes due to cultural values and beliefs;
- Lack of funds for the development of an HIV/AIDS Institutional Policy and sustainability of HIV/AIDS programmes;
- Lack of political commitment, skilled and trained personnel to handle HIV/AIDS programmes, and materials for teaching and reading;

- Students' unwillingness to change their sexual behaviour.

Others indicated that there is no challenge yet.

6. RECOMMENDATIONS

Although all polytechnics are concerned about the needs of individuals, staff and students, they still lack institutional response to HIV/AIDS. No evidence from the survey was found to show that the institutions are taking concrete strategies to reduce the risks of infection among students and staff, with the exception of very few. The institutions have been very slow in translating their concern into meaningful action plan, but some have made suggestions for improving their response to HIV/AIDS.

6.1 Institutions' Suggestions for Improvement of Response to HIV/AIDS

The institutions were asked to come up with suggestions for improvement and to give comments on the fight against the pandemic. They suggested that there should be more voluntary counseling and testing centers where staff and students can easily get services including affordable ARVs.

They also emphasized that funds be made available for HIV/AIDS programmes including research and that there is need to train and motivate those professionals involved in HIV/AIDS programmes.

There is also need for capacity building within the polytechnics in HIV/AIDS.

Based on the analysis of the data collected from the polytechnics, the following recommendations are put forward.

6.2 Institutional HIV/AIDS Policy

The main strategic intervention in the fight against the HIV/AIDS epidemic demands that every polytechnic in Africa should have a well developed policy, with well funded programmes for prevention, care for the infected, treatment for the sick and support for the vulnerable.

This arrangement should ensure that staff and students are free from the threat of infection and that those who get infected are properly

counselled, supported and treated to ensure they remain active members of the institution's community.

The polytechnic staff and students are at high risk and mechanisms to prevent further spread of HIV need not wait any longer. Those institutions that do not have a policy framework should wake up and take the necessary action.

While developing such a framework, consideration should be given to the following factors:

- Define the goals and main objectives that are measurable and achievable.
- Define institution's position and how it relates to staff and students concerning HIV/AIDS.
- Set standards of behaviour and attitude expected of staff and students towards HIV/AIDS.
- Establish compliance with the National Policy on HIV/AIDS so that students and staff know where to go for services that cannot be provided by the institution.
- Provide information and activities that guide the institution's response to HIV/AIDS.
- Target staff and students in general as the main players in forming opinions, and influencing the behaviour and that of surrounding communities.
- Help to develop information and education programmes that foster greater awareness and understanding of HIV/AIDS related issues.
- Help to provide informed direction for development and implementation strategies that can enhance behaviour change, care and support to those infected and affected by HIV/AIDS.

The policy must also have components to cover:

- Institutional Vision and Mission;
- Institutional principles and values;
- Rights and responsibilities of the infected and affected;
- Provisions for the integration of HIV/AIDS programmes into main activities and curriculum;
- Provisions for implementation of HIV/AIDS programme;
- A system for monitoring and evaluation.

It is only when an institution has a well-planned policy framework that it can effectively respond to the issues pertaining to HIV/AIDS epidemic.

A good policy framework among other things, helps the institution to create an environment that is conducive, supportive and responsive to staff and students and free from stigma and discrimination.

All polytechnic institutions in Africa are, therefore, strongly encouraged to have a policy and exert every effort to fight the epidemic.

6.3 Mainstreaming HIV/AIDS into the Curriculum

Polytechnics need to solicit and provide adequate funding for HIV/AIDS policy development and implementation. The institutions should endeavour to interest the governments, partners and willing donors for policy development and programmes sustainability.

There is a need to mainstream the professional aspects of HIV/AIDS into all the polytechnic programmes.

Even in those few polytechnics where there is a comprehensive policy framework in place, there is no recognition that HIV/AIDS should be integrated into all main activities, so as to reach each and every individual within the institution and the neighbouring communities.

There is no deliberate attempt towards the mainstreaming HIV/AIDS into the institutional curricula, reasons advanced being that they lack resources.

6.4 The Role of Institutional Leadership and HIV/AIDS

Attention by institutional leadership is usually directed towards academics, to ensure that students pass the exams and graduate. The leadership does not realise that HIV/AIDS can have a big negative impact on the quality of education within the institution.

The prime responsibility for mainstreaming HIV/AIDS into all the polytechnic's activities and operations rests entirely with the institutional leadership.

The leadership has the capacity to initiate any policy that can bring about development within the institution, including the capacity to influence governments' support for such policies.

Lack of a policy on HIV/AIDS in an institution is tantamount to lack of commitment by the institutional leadership.

Responding to HIV/AIDS should be everybody's concern but in this case, polytechnics require leadership that is committed to spearhead, manage, control and reduce the spread of the pandemic.

The polytechnic leaders must be at the forefront in the fight against the disease, for without their commitment the battle will be only half won.

6.5 HIV/AIDS Awareness among Students and Staff

The leadership of the polytechnics should ensure that at every opportunity given, students and staff get constant reminders about the threat posed by the epidemic through awareness campaigns.

Polytechnic students and staff seem to be generally aware of the repercussions associated with HIV/AIDS and its mode of transmission, if not from institutions' programmes, then at least from the public mass media.

Almost all students know the problem of HIV/AIDS and can even narrate cases of relatives who have died as a result. According to Kelly (2001), despite this knowledge, the majority of students behave as if the epidemic does not exist and they do not consider themselves as being at high risk of HIV infection.

The awareness campaign may not deter submissive students from yielding to the peer pressure that entices each member to engage in risky activities like alcohol consumption, drug abuse, casual sex and prostitution, all of which can lead to HIV infection. However, the effectiveness of the awareness campaigns lies squarely on repetitive talks by the administration, staff and students and from the public, especially the affected and infected people. The emphasis should be directed towards attitude and behaviour change.

The only way to succeed in the fight against the epidemic is "*Never to give up*", but use a holistic approach.

6.6 STUDENTS' ANTI-AIDS CLUBS

The polytechnic institutions that have students' Anti-AIDS Clubs, as in Hassan Usman Katsina Polytechnic, are commended and encouraged to continually support and facilitate these clubs. Other activities such as puppetry, drama, and use of posters should also be encouraged. The students' anti-AIDS clubs can do a good job, if properly motivated, to prevent the spread of HIV, especially among fellow students. They can also be effective in community outreach programmes.

Students normally feel at ease when sharing information among the peer group and can form an opportunity for behaviour change.

According to Kelly (2001), no evaluation of the impact of these non-formal associations has yet been undertaken. However, the evidence from secondary schools reveals that they can be powerful channels for HIV/AIDS education.

The fact that young people themselves voluntarily get involved in such programme design and delivery and also speak the kind of language that young people like to hear and understand, is in itself good enough to be encouraged.

These clubs can also be instrumental in the promotion, procurement and distribution of condoms and literature among students as a measure to prevent spread of HIV.

6.7 YOUNG PEOPLE AT HIGH RISK

Polytechnic institutions handle a large population of staff and students. Over 90% of the population are young people who are at high risk of HIV infection.

Polytechnics have a lesson to learn in light of the large number of young people they handle and are at the centre of the risk.

The survey revealed that no one at the polytechnic knows the magnitude of HIV/AIDS infection and prevalence. The only way out is to ensure that proper knowledge and accurate information, which are considered to be the baseline to the defense against the pandemic, are received continuously by every polytechnic student.

Access to AIDS information by itself may not be enough unless accompanied by behaviour change. All the same, HIV/AIDS education is still the most powerful weapon against the epidemic.

When polytechnic youth are given the appropriate tools on HIV/AIDS and the necessary support, they are capable of changing their behaviour and can be powerful behaviour change agents. So let the polytechnics ensure the availability of such tools to every member.

6.8 Breaking the Silence

The fear by the polytechnic institutions to get the root problem of HIV/AIDS out into the open and promote its tackling is no longer acceptable, as it contributes greatly to the suffering of those who experience the disease. Such circumstances make the situation difficult even for those who may be willing to come out publicly about their HIV status.

Failure by the polytechnic institutions to create an enabling environment, inhibits the acceptance and openness about one's HIV-

status and instead contributes to the spread of the virus. It limits the opportunity for more information and awareness of the disease both within the institution and the community at large.

Inhibiting information about HIV/AIDS has adverse consequences as people occasionally decide to get alternative information from any other available sources especially those who are infected and affected.

Out of desperation and helplessness, AIDS patients can go anywhere they feel they can get some assistance.

6.9 Myths and Misconceptions about HIV/AIDS

In African societies, the general practice has been that matters to do with health, if the right institutions cannot handle the problem, the patients resort to quack doctors or traditional healers. In case of HIV/AIDS, the quack doctors have gained popularity because of there being no scientific cure for HIV/AIDS at the moment.

Those quacks who claim to have mythical powers or a cure for HIV/AIDS are actually destroyers of the very people they are supposed to heal. They are the agents for the spread of HIV in the name of *“AIDS cleansing rituals”*, as one of the prescriptions they recommend to their clients, is *“Rape a virgin and your health status will immediately transform from HIV-positive to HIV-negative”*.

Such a deceptive method of healing has sent the infected men on sex rampage – raping children and young girls that come their way. Subsequently, cases of rape are on the increase everywhere in Africa.

Ignorance about HIV/AIDS has created a lot of damage to society as none of such infected men can claim to have been healed through such crude acts; instead, young girls have become victims, infected and traumatized for life.

Tertiary institutions, in particular polytechnics, working together with medical institutions and other collaborators are the best placed to give accurate information and fight the HIV/AIDS through proper HIV/AIDS education. Education and proper counseling about HIV/AIDS has helped even those already infected to live a happy and positive life.

6.10 Strategy for Prevention and Treatment of Opportunistic Infections

While advocating for behaviour change, polytechnic institutions should make it clear to staff and students that there is no known drug yet for curing AIDS. Most of the drug regimes presently being used help to delay the progression of the disease to full blown AIDS and to prevent and treat opportunistic infections.

However, the combination of therapies such as the new anti-retroviral therapy has shown to improve the quality of life and extend the survival of people with AIDS, but they are far from being a completely cured and still out of reach for the majority of HIV/AIDS patients due to the cost.

Polytechnic institutions should help the infected members of their community to access treatment when infected.

6.11 Abstinence or Condom Use

People who are HIV-positive are advised to abstain from sex or use a condom each time they have sex. Studies indicate that there are various strains or types of HIV and different people carry various types. Hence abstaining or use of a condom can protect one from contracting another strain from someone else.

Sad enough, a lot of people infected with HIV, with or without proper understanding of the dynamics of HIV infection, go about having unprotected sex. Besides infecting others, their life spans are drastically shortened.

In their situation of helplessness, some unscrupulous people would also want to spread the disease to healthy people in what would be called revenge. A case in point was reported in the *Daily Nation* of 14th April 2005, where a university student from Moi University (Eldoret, Kenya), infected 118 people with HIV. The girl who identified herself only as a fourth year Law student, claimed that she had sex with 124 people and that only 6 used condoms, the rest had unprotected encounter with the girl. She also claimed that some of the people she had sex with included lecturers. She said that she had decided to take revenge on her male colleagues after one of them ruined her life by infecting her with the virus.

There are many people in society who are not ashamed of spreading the virus, let alone ruining the life of their colleagues.

Infected people should learn just how to fight the pandemic and desist from spreading it.

Existing evidence shows that many people living with AIDS who brave their HIV status, abstain from unprotected sex, have balanced diet and treatment for opportunistic infections live much longer. Many of them are out advocating for sexual behaviour change and exposing the AIDS challenges.

At the institutional level, policy makers are challenged to develop an appropriate curriculum, based on acceptable religious, moral and social values for all people who are sexually active. This might reduce anger and revenge from the infected.

6.12 Voluntary Counseling and Testing Centers [VCT]

To be able to help the infected and affected to come to terms with HIV/AIDS, there must be a well-equipped voluntary counseling and testing [VCT] centre, where polytechnic staff and students can get such AIDS counseling services. Voluntary counseling and testing is another HIV prevention intervention which polytechnics should undertake in that it gives clients an opportunity to explore their HIV status and learn their HIV test results in complete confidence.

Through VCT, individuals learn their HIV status. Most people who take advantage of the VCT service, find that they are not infected with HIV, and this helps them to reduce their risk of getting infected and encourage colleagues to use VCT services as well.

The VCT intervention is client centered in that it focuses on each client's unique issues and circumstances related to HIV risk and risk reduction.

Usually, people *misunderstand* the role of VCT centers. They think that the centers are for clinical diagnosis, to find out who is HIV negative or positive within the institution or community. The centers are not even supposed to compile data on HIV infection in the institution and they are not for mandatory testing for enrolment or employment.

It is important that VCT counselors should be people who are well-trained, motivated, enthusiastic, sensitive and with genuine desire to help others. The VCT counselors are agents of change in relation to HIV/AIDS and are responsible for influencing and sustaining behaviour change among individuals and communities.

The VCT Counselors are supposed to prepare clients with pre-test counseling, carry out the test where acceptable and give post-test and risk reduction counseling.

It is essential, therefore, that in the whole process, confidentiality is maintained. Confidentiality can be achieved through the use of anonymous procedures where only codes can be used, but also where the management of the waiting rooms, client flow to the clinic are kept confidential so that they are not readily identified by the public or other patients using the same health facility.

Voluntary Counselling and Testing Centres give professional services which every polytechnic and community should benefit from. All institutions that have the plight of their staff and students at heart should invest in VCTs services.

6.13 Living Positively with HIV/AIDS

Living with HIV/AIDS can be very distressing, but those infected [PLWA] should be comforted and properly counseled never to despair or lose hope.

Eradicating the stigma among HIV-positive people has been a major challenge even to polytechnics in their anti-AIDS war. This is one of the reasons why people fear to go for VCTs and declare their status. They fear being ostracized or discriminated against.

Polytechnics are encouraged to break the silence and remove the stigma associated with HIV/AIDS.

This is one of the strategic interventions polytechnics can affect, by informing the infected and affected to realise that there are many people living with HIV/AIDS, who brave their HIV status, abstain from unprotected sex, have good diet and seek treatment for opportunistic infections and end living a positive life.

It is because HIV/AIDS has been treated with a lot of suspicion and misunderstanding that the disease is associated with desperation, hopelessness and eminent death. Because of this, many have lost their hope and the will to live. However, those infected need Ambassadors of hope to tell them that being positive towards life together with healthy eating and proper use of ARVs can prolong and ease life. Though the infection may ultimately lead to death, this does not mean one has to be condemned to a life full of misery and never ending damnation.

Many people are ignorant about HIV/AIDS and it should be the responsibility of education institutions to ensure that such education and health services are available to those who are in need.

6.14 Research as a Strategic Intervention

Polytechnics must encourage research into HIV/AIDS so as to acquire new knowledge that can enable the institutions to manage and control the spread. Information generated from research can be useful for future use and therefore, should be widely shared. To achieve this noble goal, polytechnics need to institute a mechanism for data collection on HIV/AIDS. Good record keeping on HIV/AIDS also helps to monitor the level of HIV-prevalence and behaviour change.

Governments should also encourage research on HIV/AIDS especially at micro-level, to cover communities, which are expected to be badly hit by the pandemic.

Financial support and all other logistics should be availed to those interested in HIV/AIDS research.

Institutional leadership, well wishers and governments should bear the responsibility of soliciting such funds. Research funding has never

been a priority to the African governments but time has come to give HIV/AIDS the priority it deserves and polytechnics are encouraged to be at the forefront.

7. CONCLUSION

The scale of HIV/AIDS impact is still on the increase and being felt in every homestead and by every nation. The fight against the pandemic as of necessity should be everybody's concern. Polytechnics in Africa should rise up to the challenge and squarely respond to the pandemic. Those polytechnics without HIV/AIDS policy or guidelines and proper funding for HIV/AIDS programmes, show lack of seriousness and commitment on their part.

The necessary resources should be mobilized from donor agencies and governments for the purpose of effective response to the pandemic.

There is hope though because, at individual level, many people are beginning to change their sexual behaviour, habits, and practices. Some families have started discussing sexuality and AIDS. Institutions and communities are beginning to wake up to the realities of HIV/AIDS and silence on the pandemic is being broken, but there is still need for strong prevention programmes, committed political will and leadership at all levels. Polytechnics in Africa should not rest until the spread of HIV has been brought firmly under control.

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Annex 4

The Institutions Covered in the Survey

WESTERN REGION

1. Hassan Usman Katsina Polytechnic
2. Federal Polytechnic – Idah
3. Abubakar Tatali Ali Polytechnic, Bauchi
4. National Board for Technical Education [NBTE]
5. Kogi State Polytechnic, Lokaja
6. Federal Polytechnic, Oko
7. Federal Polytechnic, Offa
8. Plateau State Polytechnic, Barkin-Ladi
9. Federal Polytechnic, Bida
10. Milton Margai College of Technology
11. Federal College of Education & Technology, Yaba-Lagos
12. Yaba College of Technology, Lagos
13. Federal Polytechnic, Bauchi
14. Adamawa State Polytechnic, Yola
15. Ho Polytechnic
16. Rivers State Polytechnic, Bori
17. Rufus Giwa Polytechnic, Owo
18. Institute of Management & Technology, Enugu
19. Takoradi Polytechnic
20. Kuduna Polytechnic
21. Sunyani Polytechnic

EASTERN REGION

22. Kenya Polytechnic
23. Mombasa Polytechnic
24. Eldoret Polytechnic
25. Kenya Technical Teachers College
26. Uganda Polytechnic – Kyambogo (Kyambogo University)
27. Uganda College of Commerce – Tororo
28. Technical College Arusha
29. Tanzania Institute of Accountancy, Dar-es-Salaam
30. Mzumbe University
31. Mbeya Technical College

OUTHERN REGION

32. Technical And Vocational Teachers College [TVTC]
33. Kasiya Secretarial College
34. Kitwe Vocational Training College
35. Zambia Telecommunication Training College [ZAMTEL]
36. Lerotholi Polytechnic
37. Gweru Polytechnic
38. Swaziland College Of Technology
39. Polytechnic Of Namibia
40. The Malawi Polytechnic

Annex 5

Factoring HIV/AIDS Education in Institutional Curriculum (Source: World Bank: 2002)

Policy	<ul style="list-style-type: none"> • Policies include formal directives such as constitutional provisions laws or regulations, as well as standards of practice and formal guidelines. The purpose of policies is to authorize actions for needed service. The institutional policy would, therefore, formalize the rights and responsibilities of every person involved, directly or indirectly, in the polytechnic sector with regard to HIV/AIDS: the learners, their parents or caregivers, staff and the community in which the institution is located. • Argue the case for the polytechnic activities: With a policy, polytechnics can argue the case for an urgent national priority and undertaking its crucial role in HIV/AIDS prevention and the grave dangers of inaction including set-backs of educational for all (EFA). • Ensures close collaboration with other sectors: The polytechnics can forge strong links with ministries dealing with health, communication and youth affairs recognizing that the fight against HIV/AIDS can only be won with multisectoral efforts. • Engage in systematic planning: Developing the needed skills and methods and identifying key constraints to realizing objectives as well as cost effective way to overcome them. • Ensure adequate arrangements for monitoring and evaluation: To measure not only progress in education outcomes but also the impact and spread of HIV/AIDS as well as the impact of preventive measures calls for a policy in the first place.
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HIV/AIDS Education	<ul style="list-style-type: none"> • Reduce impact, vulnerability and risks to HIV Infection: Reducing vulnerability to HIV infection is fundamental to reversing the spread of the virus. Decreasing the risk of infection slows the epidemic. Decreasing vulnerability decreases the risk of infection and the impact of the epidemic. Decreasing the impact of the epidemic decreases vulnerability to HIV/AIDS.
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Demand & Access	<ul style="list-style-type: none"> • Redouble efforts to ensure access to and completion of girls schooling. For demographic purposes, when girls are educated, they ensure high survival of their children. They also tend to protect themselves from getting infected with HIV/AIDS. • Expand reliance on innovative approaches to reach out-of-school young people: Young people have tremendous influence on other youth. Exploring distance deduction and other non-formal alternatives to provide education to rural youth.
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Supply & Quantity	<ul style="list-style-type: none"> • Ensure adequate supply of skilled employees including teachers. This will ensure comparison for higher mortality and absenteeism by increasing employees training rates through revision of academic curricula to include adoption of distance learning and information technology (IT). • Strengthening delivery of prevention education by expanding in-service training in this area, emphasizing participatory and other innovative teaching methods that promote teaching of life skills aimed at behavioural change, training youth to be peer educators and counselors, linking programmes with health services and encouraging young people to create youth culture for behaviour change. • Adapt curriculum and learning materials by introducing HIV/AIDS education into existing curriculum that HIV/AIDS is taught within the context and principles of every discipline. This will help every teacher and every student to get involved and to give HIV/AIDS a multidisciplinary approach.
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CHAPTER TWO

Response of Teacher Training Colleges in Africa to HIV/AIDS

Pan African Teachers' Centre (Lomé, Togo)

1. INTRODUCTION

1.1 Overview of the Scale of the HIV/AIDS Epidemic in Africa

The latest updates on HIV/AIDS regional data indicate that Africa is the worst affected region, with 70 percent of the world's 42 million infected people. The pandemic has killed 25 million Africans so far and orphaned more than 12 million. Each year, 3.2 million Africans (i.e., 8,700 Africans every minute) are infected with the HIV virus. Approximately 2.3 million Africans, largely in the prime of their lives as parents and workers, are killed by HIV/AIDS each year.

In just over a decade, the HIV/AIDS pandemic has reversed many of Africa's development achievements of previous decades. It has reduced life expectancy in some countries by nearly 40 years and is the leading cause of death on the continent. The pandemic has emerged clearly as the paramount threat to development in the region (World Bank 2004).

Seven countries, all in southern Africa, now have prevalence rates higher than 20%: Botswana (38.8%), Lesotho (31%), Namibia (22.5%), South Africa (20.1%), Swaziland (33.4%), Zambia (21.5%) and Zimbabwe (33.7%). Uganda remains the only country to have subdued a major HIV/AIDS epidemic, with the adult HIV prevalence rate continuing to drop from 8.3% at the end of 1999 to 5% at the end of 2001.

HIV/AIDS remains extremely dynamic, growing and changing character as it exploits new opportunities for transmission. Girls and young women are at greatest risk, with women accounting for nearly 50% of all people living with HIV worldwide and 57% in Sub-Saharan Africa in 2003.

Young people (15–24 years old) account for half of all new HIV infections worldwide; more than 6000 contract the virus each day. (For country specific prevalence estimates, see Annex 2).

The 2001 UN Declaration of Commitment on HIV/AIDS envisions major progress in delivering comprehensive care services by 2005. However, only minimal coverage has been achieved for care and treatment of HIV-related disease. Current prevention efforts in most low- and middle-income countries come nowhere near the scale of the epidemic thus making HIV/AIDS a paramount threat to development in Africa.

1.2 Implications of HIV/AIDS in Africa

The human toll and suffering due to HIV/AIDS in Africa have been well documented (UNAIDS 2002 and 2004). AIDS is now by far the leading cause of death in Sub-Saharan Africa, having so far taken away the lives of over 15 million Africans since the first reported cases in 1981. An estimated 2.3 million adults and children died as a result of AIDS in Sub-Saharan Africa during 2004 alone.

Many countries in Sub-Saharan Africa have failed to bring the epidemic under control. Nearly two-thirds of the world's HIV-positive people live in Sub-Saharan Africa, although this region contains little more than 10% of the world's population. In many countries of Sub-Saharan Africa, AIDS is erasing decades of progress in extending life expectancy. Average life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. In less than ten years' time, many countries in Southern Africa will see life expectancies fall to near 30 years, levels not seen since the end of the 19th Century (Stanecki 2002).

There is a significant risk that for some countries, if nothing drastic is done about the AIDS epidemic in Africa, the implications could be catastrophic for demographic, household, health educational, workplace and economic sectors.

In all affected countries the HIV/AIDS epidemic is reported to be bringing additional pressure to bear on the health sector as the epidemic matures, with increasing number of people living with HIV/AIDS demanding for health care services. In Sub-Saharan Africa, the annual direct medical costs of AIDS (excluding antiretroviral

therapy) have been estimated at about US\$30 per capita, three times the overall public health spending for most African countries.

Generally, as HIV infection progresses to AIDS, hospitalization increases. The World Bank estimates that the number of hospital beds needed for AIDS patients could exceed the total number available in Swaziland by 2004 and in Namibia by 2005 (Haacker 2001). Shortage of hospital beds is likely to result in long waiting in the cue thus worsening the chances of recovering on admission.

While the demand for health services is expanding, more-health care professionals are also reported to be affected by HIV/AIDS. This, coupled with the high brain drain of health workers to Europe and North America in search of greener pastures, makes the situation more serious. For example, Malawi and Zambia are experiencing a 5-6 fold increase in health worker HIV/AIDS related-illness and death rates.

The effect of HIV/AIDS on households in Africa is also very damaging as parents die and children are sent to relatives for care and upbringing, thus eventually dissolving the family unit, which serves as the focal point around which society evolves. A study in Zambia revealed that 65% of households in which the mother had died had dissolved. Not only does the HIV/AIDS epidemic dissolve the family but it also strips the family of its income-earners and in some cases, its assets (Bechu 1998). The loss of access to basic necessities of life (Kaiser 2002), and reduced agricultural productivity (FAO 2001) that the disease induces further worsens the poverty situation in Africa.

Another important effect of HIV/AIDS is on labour. The vast majority of people living with HIV/AIDS in Africa are between the ages of 15 and 49 – people in the prime of their working lives. AIDS is said to weaken economic activity by squeezing productivity, adding costs, diverting productive resources, depleting skills and ultimately reducing market demand for products (goods) and services. The epidemic affects productivity adversely through increased absenteeism and loss of skilled personnel. Comparative studies of East and Southern African businesses have shown that absenteeism can account for as much as 25-54% of company costs (Haacker 2002).

The impact of HIV/AIDS on the economies of African countries is difficult to measure but through its impact on the labour force, households and enterprises, HIV/AIDS can act as a significant brake

on economic growth and development. Besides the human cost, HIV/AIDS affects Africa's ability to cope with the epidemic. The economies of many of the worst affected countries were already struggling with development challenges, debt and declining trade before HIV/AIDS started to affect Africa. Together with these factors, HIV/AIDS has had a devastating effect on the economies of many countries.

Indeed, HIV/AIDS has increased labour mortality and morbidity in Africa with the attendant consequences of loss of skills in key sectors of the labour market, thus retarding economic growth. The economic developmental goals of many African countries depend on among other things, their abilities to expand exports and attract foreign investment. The scarcity of skilled labour which increases cost of production and reduces profits, tend to limit the ability of African countries to attract the much needed foreign investment which constitute the very foundation for economic development (Rosen *et al.* 2004).

Of particular importance to this study is the likely impact of HIV/AIDS on the education sector of Africa. This is because, the extent to which schools and other education institutions are able to continue functioning will influence how well societies eventually recover from the epidemic. Good basic education ranks among the most cost-effective means of preventing HIV (World Bank 2002).

One of the visible effects of the epidemic in the education sector is decline in school enrolment, with its attendant consequences of fewer children receiving basic education, thus rendering bleak the prospects of achieving Education for All targets set by the Dakar 2000 Forum (EFA Global Monitoring Report, 2004). It has been projected by the World Bank (2000) that the population of children of primary school age in 2010 for four African countries will be as follows without and with AIDS (see table 1):

Table 1. Impact of AIDS on the size of school-aged population in selected African countries

Country	Projected population of children of Primary School Age in 2010		
	Without AIDS scenario	With AIDS scenario	Expected percentage decrease due to AIDS
Kenya	8,200,000	7,100,000.	13.4
Uganda	6,800,000	6,000,00	11.8
Zambia	2,700,000	2.200,000	18.5
Zimbabwe	3,000,000	2,300,000	23.3

Source: World Bank 2000.

According to Peter Piot, Director of UNAIDS, (see World Bank, UNESCO and UNAIDS Joint Press Release 2002), "Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach". The low enrolment is attributed to:

- Removal of children from school to care for infected parents and family members;
- Inability to afford school fees and other expenses;
- AIDS-related infertility and a decline in birth rate, leading to fewer children; and
- More children themselves infected and either do not live long enough to start school or do not survive the years of schooling.

Another visible effect of the HIV/AIDS is reduced number of qualified teachers in schools due to increased infection among teachers. A study in Zimbabwe found that 19% of male teachers and almost 29% of female teachers were infected with HIV. In 2004, it is estimated that 17% of Mozambique's teachers were HIV-positive and skilled teachers are not easily replaced. Swaziland has estimated that it will have to train 13,000 teachers over the next 17 years, just to keep services at their 1997 levels - 7000 more than it would have trained if there were no AIDS deaths. The consequences of this include increased teacher absenteeism (World Bank 2002), possible combining of two or more

classes for one teacher, poor teaching and learning, and most invariably, a decline in the overall quality of education.

It has also been established that gender and HIV/AIDS are inextricably linked. Women are the worst hit by the disease and remain among the most vulnerable. Twice as many women are infected as men by the HIV. Several factors, including cultural and traditional practices revolving around masculinity and femininity among the youth, poverty and the absence of sexual harassment policies and programmes to curb rape and other forms of violence, have been documented as contributing to increased vulnerability of women to HIV in Africa. It has been noted in particular that transactional sex and sex work are increasingly gaining grounds among young female students in tertiary institutions as coping strategies to mitigate the effects of poverty.

It is against the background of the devastating impact of HIV/AIDS on the education sector in Africa that the Teacher Education Department (TED) of the United Nations Scientific and Cultural Organization (UNESCO TED) in collaboration with the Working Group of Higher Education of the Association for the Development of Higher Education in Africa commissioned this study.

The study focuses on the responses of teacher training colleges to the HIV/AIDS pandemic in Africa. Teacher training colleges are part of the premier institutions of human resource development and as such have a critical role in training professionals to fight against and mitigate the effects of HIV/AIDS in Africa. Teachers can exert a lot of influence on the behaviour, attitudes and skills of the young as well as the community at large through their academic and social roles. If the fight against the HIV/AIDS pandemic is to be achieved, then teacher trainees should be adequately equipped with the requisite knowledge and skills to assist the pupils in the classrooms to prevent as well as effectively deal with emotional and psychological problems associated with HIV/AIDS. The extent to which teacher training colleges have responded effectively to the training needs of trainees to be able to deal with the challenges posed by HIV/AIDS to the education sector in Africa is not very clear.

1.3 Objectives of the Study

The specific objectives of this study were:

- Conduct a continent-wide survey of teacher training institutions in Africa to assess what these institutions are doing to develop and implement a comprehensive approach to HIV/AIDS prevention and education;
- Conduct three in-depth case studies on policies and programmes (on-going or being developed) along with needs in the area of HIV/AIDS prevention and education in teacher training institutions in Africa;
- Develop a set of guidelines, using the results of the survey and case studies, to assist teacher training colleges in implementing comprehensive HIV/AIDS policies and programmes, usable by UNESCO, African governments/ policy and decision makers and other development agencies that support education in Africa; and
- Publish a directory of the profiles of Teacher Training Institutions addressing the HIV/AIDS pandemic.

1.4 Methodology

1.4.1 Sample

The survey covered 178 teacher training colleges (see Annex 3) drawn from twenty (20) African countries (see table 2). Ninety-eight percent (98%) of these colleges are public while 2% are private. Thirty-one (31) countries, spread across the three major linguistic zones (anglophone, francophone and lusophone) were originally targeted through consultations with National Teachers' Organizations (Member Organizations of the Pan African Teachers' Centre). Although the unit of analysis of the study is training colleges, country participation was equally important as far as the objectives of the study were concerned. Against this background, it is worth noting that in terms of country participation, the response rate is 65%, which can be considered as quite reasonable in view of the general poor response rate associated with self-administered and mailed questionnaires.

Table 2. Number of colleges by country

No.	Country	Colleges	
		Frequency	Percentage
1.	Benin	5	2.8
2.	Burkina Faso	5	2.8
3.	Burundi	9	5.1
4.	Cameroon	7	3.9
5.	Congo Brazzaville	3	1.7
6.	Cote D'Ivoire	5	2.8
7.	Gambia	7	3.9
8.	Ghana	35	19.9
9.	Guinea Bissau	3	1.7
10.	Kenya	10	5.6
11.	Mozambique	5	2.8
12.	Niger	4	2.2
13.	Nigeria	18	10.1
14.	Senegal	6	3.4
15.	Sierra Leone	6	3.4
16.	Tanzania	4	2.2
17.	Togo	3	1.7
18.	Uganda	31	17.4
19.	Zambia	9	5.1
20.	Zimbabwe	3	1.7
Total		178	100

With the exception of Northern Africa, there is representation from the major sub-regions of Africa. Unfortunately, the Coordinators of the survey in South Africa, one of the most hard hit HIV countries in Africa, could not administer the questionnaires in time due to reasons beyond her control.

The three case study colleges targeted for in-depth study were purposefully selected from Zambia (National In-Service Training College, Chalimbana); Mozambique (Instituto do Majestério Primário, Matola) and Togo (Ecole Normale Supérieure d'Atakpamé). The choice of the colleges was based on consultations with the National Teachers' Organizations in the respective countries. They are believed to have played a pioneering role in the training of teachers in these countries. A cross-section of tutors (40), non-teaching staff (22) and students (48) were sampled from the three colleges for completion of the questionnaires. Sixty-four percent (64%) were males and 36% females.

1.4.2 Survey Instruments

Two kinds of questionnaires were employed for the survey. The first was the individual college questionnaire administered to the heads or their representatives and the second was administered to a cross-section of people (lecturers/tutors, students and non-teaching staff) from the three lead colleges.

In addition, select group interviews of tutors/lecturers, students and non-teaching staff were conducted in the three lead training colleges to cross-validate the responses obtained from the heads of the colleges.

Relevant documents on the situation of the disease in Africa and annual reports of the three lead colleges were also reviewed.

Essentially, the focus of the questionnaires and interviews was on the following areas:

- Background information on the colleges;
- HIV/AIDS-related programmes, activities and facilities available;
- College community awareness and perception of the disease;
- Extent of college collaboration with other key stakeholders in HIV/AIDS prevention and education; and
- Capacity building needs for improved HIV/AIDS prevention and education.

The profile of the colleges surveyed has been presented in a separate volume as a directory of African tertiary institutions responding to HIV/AIDS.

1.5 Limitations of the Study

The study faced a number of problems which tended to limit its scope and depth of analysis. The first major problem was lack of uniform school calendar year for the sample teacher training colleges. Some of the colleges had vacated for holidays when the survey commenced. This resulted in the delay of the administration of the questionnaires in such countries. A second problem was poor telephone and internet services for the colleges. Most of them did not have functional telephones thus resulting in delays in providing feedback to the country Coordinators on the status of questionnaire completion. In some cases,

the Coordinators had to make several trips to the colleges before they finally got the questionnaires completed. This most invariably increased the cost of administration of the questionnaires.

Also, the time period set for the completion of the study was too short, given the large area to be covered without good communication networks. Last but not least, the funding provided for the study was generally inadequate, thus limiting the ability to conduct in-depth field analysis as well as make the needed follow-ups to achieve a higher response rate. Personal observations of the training colleges' environments would have afforded the researcher the opportunity to gain better insights into, and appreciations of, the situations on the ground.

2. FINDINGS

2.1 Composition of Respondents

The respondents consisted of various members of the college staff, including principals, vice principals, HIV/AIDS focal persons, heads of departments/units and lecturers/tutors (see Table 3).

Table 3. Composition of respondents

Category of respondents	Frequency	Percentage
Principals	68	39.8
Vice Principals	20	11.7
HIV/AIDS Coordinator/ Focal Person	15	8.8
Heads of Departments/Units	5	2.9
Principal lecturer	2	1.1
Senior lecturer	1	0.6
Tutor/lecturer	51	29.8
Deputy Registrar	5	2.9
Senior Housemaster	1	0.6
Academic Secretary	2	1.1
Senior Curriculum Officer	1	0.6
Missing values	7	3.9
Total	178	100

The majority of the respondents were principals, followed by vice-principals and tutors/lecturers, thus suggesting that most teacher

training colleges vest decision making with regard to HIV/AIDS in the top-most officials. This may constitute a good sign since evidence available indicates that leadership involvement and commitment are critical for effective HIV/AIDS programming in institutions.

Only about nine percent (8.8%) of the colleges had HIV/AIDS coordinators or focal persons. Notwithstanding the need for the involvement of top leadership of the training colleges in dealing with HIV/AIDS, the apparent lack of dedicated Coordinators to provide the necessary guidance and support at the action level, could undermine institutional prevention, care, and counseling efforts. The establishment of HIV/AIDS Coordinators' positions in training colleges is absolutely necessary in order to provide the attention needed for effective coordination of the development, implementation, monitoring and evaluation of comprehensive HIV/AIDS prevention programmes.

2.2 Acceptance of HIV/AIDS on College Campuses

A fairly significant percentage of the respondents (largely college management staff) acknowledged that they had observed the incidence of HIV/AIDS and deaths related to HIV/AIDS among lecturers/tutors, students and non-teaching staff of the colleges involved in the survey (see Table 4).

Table 4. Observed incidence of HIV/AIDS and its related deaths among college community

Category of college community	Incidence (%)			Deaths (%)		
	Yes	No	Total	Yes	No	Total
Tutors/Lecturers	37.7	63.7	100	35.8	64.2	100
Non-teaching staff	27.5	72.5	100	24.4	75.6	100
Students	29.2	78.8	100	25.7	74.3	100

As can be seen from the Table, both the incidence and deaths observed seem to be more conspicuous among tutors/lecturers (37.7% and 35.8%) than among the students (29.2% and 25.7%) and non-

teaching staff (27.5% and 24.4%), respectively. This difference may be due to the fact that infected lecturers/tutors who are comparatively older would be at the latter stages of the gestation period of the disease when its symptoms begin to appear and result in deaths.

Nearly forty-two percent (41.9%), out of the sixty respondents who answered the question, were of the opinion that the prevalence and incidence rates of the disease were the same, while 37.1% and 17.7% considered them to be decreasing and increasing, respectively, over the past few years. The reality is that most (69%) of the colleges do not keep data/ information on HIV/AIDS, thus, making it difficult for them to provide a reliable description of the trends of the disease in the colleges. Trends of the disease can only be accurately assessed using longitudinal data collected by the colleges from various sources and HIV/AIDS related activities, including the clinics and counseling centres where college communities go for services.

2.3 Impact of HIV/AIDS on Colleges

The respondents could not provide hard data for the impact of HIV/AIDS on the colleges beyond perceptions. They had varying perceptions of the impact of HIV/AIDS on the college communities (see Table 5).

Table 5: Perceptions of the impact of HIV/AIDS on college

Impact of HIV/AIDS	Responses	
	Frequency	Percentage
Awareness created	39	33.0
Minimal	28	24.9
Bad and serious	17	14.5
Under control	11	9.0
High	9	7.6
Difficult to tell	6	5.0
Increased use of condoms	3	2.6
Shortage of personnel	2	1.7
Formation of HIV/AIDS clubs	1	0.85
Apprehensiveness	1	0.85
Total	117	100

The majority (33%) of the respondents were of the opinion that the impact of HIV/AIDS was the creation of awareness of the disease among the college communities. A fairly large percentage (24%) of the respondents felt the impact was minimal while others considered the impact as bad and serious (14.5%) or high (9%). Also significant to note is that a reported increased use of condoms was considered as an impact while some found it difficult to tell the impact of HIV/AIDS on the college communities.

The apparent lack of in-depth and critical analysis of the impact of the disease provided by the respondents raises serious doubts as to whether they have adequate knowledge and full appreciation of the real impact of HIV/AIDS. One would have expected the respondents to provide information on the lecture hours lost due to the inability of infected tutors to attend classes, the increasing financial burden on the colleges resulting from increasing demand for health care of infected staff and students and the shortage of lecturers through the contract of the disease. The collection and maintenance of reliable data/information by colleges is critical for effective initiation, monitoring and evaluation of any form of HIV/AIDS intervention. Unfortunately, 69% of the colleges involved in the study did not collect data / information on HIV/AIDS-related incidence and activities. The need for the establishment of HIV/AIDS database system by training colleges is highly recommended if the impact of the disease is to be assessed accurately for appropriate institutional responses to be initiated to reduce the incidence of new cases and mitigate the effects on those people with HIV.

2.4 Response of Training Colleges to HIV/AIDS Pandemic

Training colleges' response to HIV/AIDS can take several forms, including the initiation of prevention, education and treatment programmes, the development of policies and institutional arrangements for effective coordination, etc. Against this background, respondents were asked to indicate whether or not their institutions had any of these in place (see Table 6).

Table 6. Any HIV/AIDS policy and other related items in place

Items	Items in place	
	Yes (%)	No (%)
Education programme	80	20
Institutional arrangements	69	30
Prevention programme	65	33
Integration into curriculum	62	37
Training manuals	58	40
Teaching and learning materials	56	42
Code of conduct for dealing with AIDS	36	61
Voluntary counseling programme	35	63
Work-place programme	35	61
Specialized units	35	64
Community outreach programme	34	65
Written policy	29	65
Annual financial provision in the budget for HIV	8	90
Voluntary Testing programme	7	90
Treatment facilities	6	91

Note: Based on 178 respondents and % rounded off to the nearest whole number. (Percentages do not add up to 100% due to exclusion of missing cases.)

HIV/AIDS education programmes are the most common among colleges (79%), followed by the establishment of institutional arrangements (69%) for addressing HIV/AIDS issues. Many of the colleges also reported having prevention programmes (65%), integration of HIV/AIDS into their curricula (62%), having developed training manuals for HIV/AIDS (58%) as well as teaching and learning resource materials (56%). While these figures suggest significant responses being made by the colleges, what the study has not been able to establish for one to pass a vote of confidence to them, is the physical existence and qualities of these facilities/ tools as well as the level of stakeholder involvement in their design and development. If the colleges' responses to the HIV/AIDS disease are to produce the

desired results, then the approach to developing the tools and institutional arrangements must be participatory and cross-cutting.

A large number of the colleges did not have treatment facilities (91%) or voluntary testing facilities (90%). They lacked written HIV/AIDS policy (65%) as well as community outreach programmes (65%). They also had no specialized Units (65%) or voluntary counseling (63%). While treatment is very important, it may not be strategically feasible for colleges to establish treatment centres within campus as people with HIV may feel uncomfortable to make their cases openly known. An alternative could be to link up college communities with treatment and counseling centres in nearby hospitals.

Generally, the training colleges involved in the study appear to be more interested in programmes than in institutional facilities and written policies for addressing HIV/AIDS. What is not clear is the extent to which these programmes are comprehensive enough to effectively address HIV/AIDS prevention and education.

The more pertinent issue is the very low percentage (8%) of the respondents reporting of having made financial provisions annually in their budgets for HIV/AIDS activities. Comprehensive HIV/AIDS prevention and education programmes require adequate resources for effective implementation. Training colleges need to consider the issue of resource mobilization for HIV/AIDS prevention very important. College internal sources as well as in-country sources (NGOs, bilateral and multi-lateral donors) have to be explored vigorously to ensure provision of adequate and sustainable funding for a comprehensive response to the HIV/AIDS disease.

Another important area of concern is the lack of written HIV/AIDS policies to guide management of training colleges to develop systematic prevention and education programmes as well as curriculum. As many as 36% and 40% of the colleges involved in the study do not integrate HIV/AIDS into their curricula nor have any HIV/AIDS related teaching and learning materials and training manuals, respectively. Without clear policies, the inclusion of HIV/AIDS in the teaching programmes is left to the discretion of individual tutors/lecturers and departments with the attendant consequences of variations in terms of focus, depth and scope across academic departments. Written HIV/AIDS policies set the appropriate framework

for the training colleges to situate comprehensive HIV/AIDS programmes and must therefore be given the needed attention.

When further asked what the colleges' responses to the HIV/AIDS had been, the majority (48%) indicated that they had conducted sensitization while 40% simply said it was positive (See Table 7). Efforts have also been made at integrating HIV/AIDS into the curriculum by a few colleges (15%) and reported formation of HIV/AIDS Prevention Clubs (12%). A few felt the response has been poor and weak due to inadequate finances.

Table 7. What has been the college's response to the HIV/AIDS pandemic?

Colleges' Response to HIV/AIDS	Response	
	Yes (%)	No (%)
Positive response	40.4	59.6
Sensitization	47.8	52.2
Integration into curriculum	15.2	84.8
Creation of HIV/AIDS clubs	12.4	87.6
Embarking on workshops	9.0	91.0
Poor	4.5	95.5
Lack of finance	1.7	98.3

2.5 Training of Tutors/ Lecturers in HIV/AIDS and Family Life Education

When asked if the teachers had been trained in HIV/AIDS and Family Life Education, 74% responded in the affirmative. A majority (33.7%) of the colleges had the training from the Ministry of Education and NGOs, followed by National AIDS Commission (nearly 15%). A few benefited from joint training programmes from NGOs and the Ministry of Education (nearly 4%), Ministry of Health and Council of Churches (2.8%). What is quite clear from the data is that a large number of the tutors in the training colleges has not been trained in HIV/AIDS and Family Life Education. A summary of the training providers is given in Table 8.

Table 8. Providers of HIV/AIDS and Family Life Education Training for colleges

Training providers	Response	
	Yes (%)	No (%)
Ministry of Education	33.7 (60)	65.7 (117)
NGO's	33.7 (60)	66.3 (118)
National AIDS programme	14.6 (26)	85.4 (152)
NGOs and Ministry of Education	3.9 (7)	96.1 (171)
Ministry of Health	2.8 (5)	97.2 (173)
Council of Churches	2.8 (5)	97.2 (173)
World Bank	2.2 (4)	97.8 (174)
Consultants	1.1 (2)	98.9 (176)
Department for Gender Issues	0.6 (1)	99.4 (177)

2.6 Content of the HIV/AIDS Training Programmes Attended by Teachers

The quality of a training programme is partly determined by its content. Table 9 presents the content of the HIV/AIDS and Family Life Education training offered to their tutors.

Table 9. Content of the training programme

Content of training programme	Percentage attended	
	Yes (%)	No (%)
Sensitization	46.1	53.9
Prevention strategies	34.8	65.2
Integration into curriculum	8.4	91.6
Guidance and counselling	5.6	94.4
Interactive methodology	3.9	96.1
Training of trainees	3.9	96.1
Population and Family Life Education	3.9	96.1
Reproductive Health	3.4	96.6
Gender program	1.7	98.3
Formation of HIV/AIDS clubs	1.1	98.9
Establishment of HIV/AIDS unit	0.6	99.4

It can be seen from table 9 that most (46%) of the tutors received sensitization training programmes followed by prevention strategies (35%). Very few of them had training in such core areas as integrating HIV/AIDS into the curriculum, guidance and counseling, population life education and gender mainstreaming. College tutors need to be equipped with adequate skills and knowledge in these areas to be able to work through the often difficult situations associated with people living with HIV. The survey was not able to ascertain the quality and duration of the training content, and the number of tutors who benefited. An effective HIV/AIDS prevention training programme must be based on well developed training plans derived from systematic training needs assessments.

2.7 Collaboration with Other Key Stakeholders

It has become clear over the years that the fight against HIV/AIDS cannot be won by a single individual organization. It requires multi-sectoral and institutional collaboration in efforts aimed at HIV/AIDS prevention, education and treatment to yield effective results. When asked if there was any on-going collaboration between the college and other key stakeholders, the respondents provided the following responses (see Table 10)

Table 10. On-going collaboration with other key stakeholders

Organizations	Areas of collaboration							
	HIV prevention		HIV education		HIV treatment		Community outreach	
	Yes	No	Yes	No	Yes	No	Yes	No
NGOs	43.8	35.4	49.4	29.2	6.2	60	18.0	52.2
Donors	16.3	51.1	18.0	45.5	2.2	57.3	11.2	50.6
Private Sector	10.1	51.1	10.7	47.8	1.1	55.6	5.6	52.8
Government Sector	48.3	31.5	56.7	29.8	10.1	57.3	21.9	47.2

Although not as high as expected, the results in the table suggest that training colleges have more collaboration in HIV/AIDS prevention,

education and treatment activities with NGOs and Government Agencies than with donors and the private sector. College community outreach collaboration is also generally low.

Regarding the specific organizations that Colleges collaborate with, the most widely mentioned were:

- Ministry of Education;
- Ministry of Health;
- National AIDS Program; and
- World Bank.

Some respondents, however, could not recollect the names of the specific NGOs that had collaborated with them, thus raising doubts as to how serious or significant those collaborations indicated in table 10 had been.

2.8 Main Sources of HIV/AIDS Information for Colleges

In terms of access to information about HIV/AIDS, the mass media is the major source for most colleges (nearly 33%), followed by written materials (nearly 26%), training manuals (nearly 22%), Ministry of Education (about 16%) and workshops/seminars, NGOs and Ministry of Health in that descending order (see Table 11).

Table 11. Main sources of information about HIV/AIDS for training colleges

Source	Response	
	Yes (%)	No (%)
Mass Media	32.6	67.4
Written Material on AIDS	25.8	74.2
Training Manual	21.9	78.1
Ministry of Education	16.3	83.7
Through Workshops and Seminars	14.0	86.0
NGOs	10.1	89.9
Ministry of Health	9.0	91.0
National AIDS Secretariat	5.6	94.4
Anti-AIDS Club	4.5	95.5
Training of Trainees	2.2	97.8
Interactive Methodology	1.1	98.3

The comparatively lower percentages of respondents not getting HIV/AIDS information from the above traditional sources suggest limited access to HIV/AIDS information in general among the training colleges. This hampers the attainment of one of the major targets set by the United Nations General Assembly Special Session held in 1999, which states among other things that:

Governments with the assistance from UNAIDS and donors should, by 2005, ensure that 90% and by 2010 at least 95% of young people aged 15-24 have access to the information, education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as male and female condoms, voluntary testing, and counseling and follow up.

2.9 Respondents' Perceptions of the Way Forward

Integration of HIV/AIDS into the curriculum was considered by most respondents as a measure to be taken to enhance the capacities of the training colleges to promote effective HIV/AIDS prevention, education, care and community outreach. This was followed by the development of sustained sensitization and education programmes, training of tutors/ lecturers in HIV/AIDS and provision of adequate resources in that descending order (see Table 12).

Table 12. Perceptions of the way forward

Capacity building needs	Responses	
	Yes (%)	No (%)
Integration of HIV/AIDS into curriculum	32.0	68.0
Initiation of college community sensitization of programme	28.1	71.9
Intensification of HIV/AIDS education programmes	27.5	72.5
Training of teachers in HIV/AIDS	24.7	75.3
Provision of adequate resources	21.9	78.1
Establishment of counseling centre	7.3	92.7
Establishment of units for coordination of HIV/AIDS programmes	2.8	97.2

Essentially, it can be inferred from the data in Table 12 that three areas, namely, integration of HIV/AIDS into the curriculum,

strengthening of prevention and education programmes, and provision of adequate resources, are required to promote any effective response of training colleges to the HIV/AIDS pandemic.

It is surprising to note that no mention is made of the need for colleges to develop written HIV/AIDS work-place policies to guide them even though many of them reported of not having any written policies in place.

3. CASE STUDIES

3.1 Togo

3.1.1 *Socio-Economic Background*

Population

According to the Population Reference Bureau (2004), Togo has a population of 5,600,000 million people, with a natural increase rate of 2.7% and a total fertility rate of 5.5. The number of births and deaths per 1000 people are 38 and 11, respectively. The infant mortality rate is 72. The projected population by 2025 is 7.600,000. The life expectancy at birth is 54, with females living longer than males on the average.

Economy

The economic performance is said to have improved over the past three years, with GDP real growth rate estimated at 2.7 percent in 2003, after a record 4.2 percent in 2002. The GDP per capita is 310 USD. The improved economic performance is attributed largely to increased productivity in the agricultural sector as a result of favorable climatic conditions experienced over the period.

The overall budget (on commitment basis and excluding grants) recorded a surplus estimated at 0.8 percent of GDP in 2003, compared with a deficit of the same magnitude in 2002. However, because of the continued suspension of external budgetary aid, this was accompanied by further accumulation of external payment arrears.

Educational Attainment

The total adult literacy rate is estimated at 57.1 % in 2000, with greater percent for males than females (UNAIDS/WHO Epidemiological Fact Sheet 2004 Update). Gross primary school enrolment ratio for males is 138 in 2000/2001 and 110 for females in 1996 (UNAIDS/WHO Epidemiological Fact Sheet 2004 Update). The secondary school gross enrolment ratios in 1996 for males and females were 54 and 24, respectively (UNAIDS/WHO Epidemiological Fact Sheet 2004 Update).

3.1.2 HIV/AIDS Situation

The HIV/AIDS situation in Togo is presented in Table 13. The prevalence rate among adults aged (15-49) is estimated at 4.1% at the end of 2003. The number of people living with HIV/AIDS for the same age group for the same period is 96,000 with females accounting for 56%. Reported AIDS related deaths for both children and adults are estimated to be 10,000 in 2003.

Table 13. HIV and AIDS estimates, ending 2003

Adult (15-49) HIV prevalence rate	4.1% (Range: 2.7%-6.4%)
Adults (15-49) Living with HIV	96 000 (range: 61 000-150 000)
Adults and children (0-49) Living with HIV	110 000 (range: 67 000-170 000)
Women (15-49) Living with HIV	54 000 (range: 35 000-84 000)
AIDS deaths (adults and children) in 2003	10 000 (range: 6400-16 000)

Source: 2004 Report on the global AIDS Epidemic

3.1.2.1 Consequences of HIV/AIDS

There is hardly any systematic empirical analysis of the economic impact of HIV/AIDS on Togo. What is found in the literature are international studies conducted using models to explore the potential

effect of AIDS on the education and health systems. Based on such studies and specific empirical country studies in many sub-Saharan African countries, there is consensus that the impact of HIV/AIDS is likely to be similar in Togo. Some of the identified impacts include reduction in incomes of households, agricultural productivity, increased illness and death leading to increased expenditure, increased pressure on the health system, reduced savings and shifts in productivity patterns, shortage in skilled labour, reduced school enrolment, loss of experienced teachers, and decline in overall quality of education among others.

3.1.2.2 National Response to HIV/AIDS

Togo has no written national HIV/AIDS policy (UNAIDS 2000). However, a National Anti-HIV/AIDS Committee has been formed. Also, a national strategic plan (2001–2005) has been developed with the full commitment and involvement of all key partners from the public sector, civil society, development partners and the private sector. Sectoral operational plans were drawn up and budgeted in 2002. This served as a basis for drafting the Global Fund proposal, which was approved on its second application (UNAIDS 2004).

The five-year plan aims at curbing the expansion of the HIV/AIDS epidemic and reducing its impact on the population. The plan has widened the partnership in the setting up of interventions to ensure coordinated participation of the government, private sector and NGOs. It reinforces the response to the fight against HIV/AIDS by focusing on improving the provision of ARV treatment to PLWHAs who meet the eligibility criteria as well as medical and social care to them and extend the vertical prevention programme to reach HIV mother-child groups. Safety of blood transfusion is to be reinforced throughout the country and young people from age 10 to 25, sex workers and their partners have also been targeted.

The main strengths of the plan include:

- Its comprehensiveness in terms of scope (including ARV and pertinent medical and psycho-social care, intervention on vertical transmission, safety of blood transfusion and populations at risk);
- Services to be provided to pregnant women including VCT;

- Widened partnership to include coordinated participation of the Government, NGOs and private sector;
- Detailed education plans at schools; and
- Detailed participatory monitoring and evaluation programme (involving people living with HIV/AIDS and the community).

3.1.3 HIV/AIDS Situation in Ecole Normale Supérieure (ENS) d'Atakpamé, Togo

3.1.3.1 Awareness and Acceptance of HIV/AIDS

Very few of the three categories of the college community were aware of the incidence of, and, HIV/AIDS-related deaths among their members (see Tables 14 and 15). The incidence is more likely to be observed among students (12.1%) than any other category of the college. This difference may not be surprising in view of the fact that research evidence shows that young people (of student age) are more vulnerable to HIV/AIDS infection since they are sexually very active and engage in risk-seeking behaviour.

The low awareness of HIV/AIDS incidence and deaths may be due to the fact that national prevalence is quite low. However, it would be useful for the college to document HIV/AIDS incidence and deaths among its community.

Table 14. Awareness of the incidence of HIV/AIDS among community

Category of community	Response		
	Yes (%)	No (%)	Total (%)
Students	12.1	87.9	100
Teachers/tutors	6.1	93.9	100
Non-teaching staff	3.0	97.0	100

Note: NS = 33

Table 15. Awareness of HIV/AIDS related deaths

Category of community	Response		
	Yes (%)	No (%)	Total (%)
Students	1.0	93.9	94.9
Teachers/tutors	0.0	97.0	97.0
Non-teaching staff	0.0	97.0	97.0

Note: NS = 33; Missing: 3 & 5, respectively.

3.1.3.2 Consequences of HIV/AIDS on the Ecole Normale Supérieure d'Atakpamé

The interview with the principal of the college revealed that the College had no records on HIV/AIDS-related activities, incidence and deaths. This was attributed to lack of human and material resources. The result is that the college could not provide empirical evidence on the socio-economic impact of the disease on the college communities. The lack of impact assessment of HIV/AIDS on the college community mirrors the national situation in Togo. Empirical socio-economic impact assessments of the disease at the national level are yet to be done.

3.1.3.3 Ecole Normale Supérieure d'Atakpamé's Response to the HIV/AIDS Situation

Sensitization is the only HIV/AIDS-related activity that the community of ENS d'Atakpamé was aware had taken place. Even with this one activity (sensitization program), only 52 % of the respondents participated in it.

The sensitization programmes were organized mainly by Non-Governmental Organizations (NGOs) and the National HIV/AIDS Program (Table 16). It is surprising to note that there is no involvement of the critical Ministries such as Education and Health in the HIV/AIDS sensitization programme in ENS d'Atakpamé. Teacher training colleges in the country in general operate under the Ministry of Education and would therefore require its support for the design and implementation of HIV/AIDS programmes.

Table 16. Providers of HIV/AIDS training and life skills education

Providers	Response	
	Yes	No
NGOs	9.1	90.9
National HIV/AIDS program	12.1	87.9

Note: NS = 33

3.1.3.4 *Main Sources of Information about HIV/AIDS for Ecole Normale Supérieure d'Atakpamé*

The most popular source of HIV/AIDS information for this college is the mass media, followed by literature, National HIV/AIDS programmes and Internet in that descending order (see Table 17). It is not clear what the respondent meant by "literature" on HIV/AIDS. It could be printed information.

It is worth noting that the mass media has not always provided very reliable and valid information on sensitive social issues such as HIV/AIDS and hence the need for the college to provide other alternative sources from which its community members can obtain information to cross-validate or complement what is obtained from the mass media to enhance their knowledge and understanding of HIV/AIDS.

Table 17. Main sources of information about HIV/AIDS

Source	Response		
	Yes (%)	No (%)	Total (%)
Mass media	90.9	9.1	100
NGOs	33.3	66.7	100
Literature on HIV/AIDS	27.3	72.7	100
Internet	27.3	72.7	100
National HIV/AIDS programme	21.2	78.8	100

Note: NS = 33

3.1.3.5 *Proposals to Strengthen HIV/AIDS Unit in Ecole Normale Supérieure d'Atakpamé*

ENS d'Atakpamé has no HIV/AIDS Unit. Issues related to HIV/AIDS emanate from the Principal's office. There is no designated Coordinator for HIV/AIDS activities. Without strong leadership and institutional arrangements, colleges cannot develop comprehensive HIV/AIDS programmes for prevention, education, treatment and care.

3.1.3.6 *Proposals to Improve Teaching and Learning about HIV/AIDS in Ecole Normale Supérieure d'Atakpamé*

Integrating HIV/AIDS into the curriculum of the academic programmes is considered by the majority (66%) of the college community as a strategy to improve teaching and learning about HIV/AIDS in the college (See Table 18).

Table 18. Proposals to improve teaching and learning about HIV/AIDS in the college

Proposed measure to be undertaken	Percentage	
	Yes	No
Integrate HIV/AIDS education into the school curriculum	66.7	33.3
Organize more sensitization programmes	3.0	97.0

Note: NS=33

3.1.3.7 *Proposals to Promote HIV/AIDS Prevention, Education, Care and Outreach Activities in Ecole Normale Supérieure d'Atakpamé*

The majority of the respondents (nearly 91%) proposed giving regular sex-education as a strategy for promoting HIV/AIDS prevention, education and care as well as outreach activities in ENS d'Atakpamé (Table 19). Continued sensitization and college and community interactions were also proposed as measures for promoting HIV/AIDS prevention, education, and care and outreach activities.

Table 19. Proposals for promoting HIV/AIDS prevention, education, care and community outreach

Measures to be taken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programme	15.2	84.8	100
Give regular sex education	90.9	9.1	100
College and community interactions	3.0	97.0	100

Note: NS = 33

3.1.3.8 Proposals to Promote Active Academic Staff Involvement in HIV/AIDS Activities

With regard to promoting the involvement of academic staff in HIV/AIDS related activities, a fairly large number of respondents (36%) suggested the organization of HIV/AIDS sensitization programmes, followed by provision of teaching and learning aids (see Table 20). It is surprising that only 6% and 3% suggested the provision of training for academic staff in HIV/AIDS and integration of HIV/AIDS into the College teaching curriculum, respectively as strategies for promoting academic staff involvement. College teachers/tutors must be well trained to be able to handle the complex and often hard situations associated with people with HIV/AIDS. Deepening the knowledge and understanding of teachers/tutors and college students in HIV/AIDS can only be achieved through integration or mainstreaming of HIV/AIDS into the college academic curriculum.

Table 20. Proposals for promoting active involvement of academic staff in HIV/AIDS activities

Measures to be undertaken	Response		
	Yes (%)	NO (%)	Total (%)
Organize sensitization programmes for staff	36.4	63.6	100
Provide teaching and learning aids	18.2	81.8	100
Train academic staff on HIV/AIDS	6.1	93.9	100
Integrate HIV/AIDS education into the school curriculum	3.0	97.0	100

Note: NS = 33

3.1.3.9 Proposals for promoting of active involvement of students in HIV/AIDS activities

In terms of promoting active involvement of students in HIV/AIDS, a fairly significant percentage (24%) of the respondents suggested the organization of sensitization programmes for students. About nine (9.1%) percent of the respondents suggested integration of HIV/AIDS into the teaching curriculum, and the formation of HIV/AIDS clubs (Table 21).

Table 21. Proposals for promoting active involvement of students in HIV/AIDS activities

Proposed action to be undertaken	Response		
	Yes (%)	No (%)	Total
Organize sensitization programmes for students	24.2	75.8	100
Integrate HIV/AIDS education into the school curriculum	9.1	90.9	100
Form anti-HIV/AIDS clubs	9.1	90.9	100
Involve students in HIV/AIDS activities	6.1	93.9	100

Note: NS=33

3.1.3.10 Proposals to Promote Active Involvement of Non-teaching staff in HIV/AIDS Activities

Similarly, for the promotion of active involvement of non-teaching staff in HIV/AIDS activities, a significant percentage (30%) of the respondents suggested the organization of sensitization programmes and involving non-teaching staff in college HIV/AIDS activities (see Table 22). Interactions with members of the non-teaching staff suggest that they have not been involved in HIV/AIDS activities in the college. Tackling the HIV/AIDS situation in the college community requires the involvement of the entire community, including the non-teaching and academic staff and students.

Table 22. Proposals to promote active Involvement of non-teaching staff in HIV/AIDS activities

Proposed action to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programmes	30.3	69.7	100
Involving Non-teaching staff in HIV/AIDS activities	30.3	69.7	100

Note: NS= 33

3.2 MOZAMBIQUE

3.2.1 *Socio-Economic Background*

3.2.1.1 *Population*

Mozambique is said to have an estimated population of about 18.8 million (CIA World Fact Book, 2004) with an annual growth rate of 1.22% resulting from a total fertility rate of 4.78 children per woman. The birth rate is about 36.6/ 1000 (CIA World Fact Book, 2004) and the death rate, 23.86/1000 (CIA World Fact Book, 2004). Infant mortality stands at 137.08/1000 births and average life expectancy is 37.1 years at birth.

3.2.1.2 *Economy*

The country has just about recovered from being one of the poorest in the world at the time of attaining independence in 1975, a situation later exacerbated by a fourteen-year long civil war. This is as a result of a series of macroeconomic reforms embarked upon by the government and donor assistance. In addition, the country has been quite stable politically since its multi-party elections in 1994. Inflation has been drastically reduced, but the country still depends on foreign assistance for much of its annual budget. Subsistence agriculture continues to employ the vast majority of the country's workforce. A substantial trade imbalance persists although the opening of the MOZAL aluminium smelter, the country's largest foreign investment project to date, has increased export earnings. The country also has investment projects in titanium extraction and processing and garment manufacturing.

Mozambique's once substantial foreign debt has been reduced through debt cancellation and rescheduling under the IMF's Heavily Indebted Poor Countries (HIPC) and Enhanced HIPC initiatives.

The GDP purchasing power parity is \$21.23 billion (CIA World Fact Book 2003) and the growth is 7 % (2003). Though the investment gross fixed rate stands at 47.8%, a 70% majority of the population live below the poverty line (CIA World Fact Book 2001). Also, in spite of a 9.2 million labour force made up of 81% agriculture, 6% in industry and 13% in services, there is still an unemployment rate of 21% (CIA World Fact Book 1997).

3.2.1.3 Educational Attainment

Mozambique, as a signatory to the World Declaration on Education For All, has had as her aim the achievement of a gross enrolment of 86% by the year 2000 (UNESCO). Also, it has been implementing an Education Sector Strategic Plan since 1999. However, only about 47.8% (CIA World Fact Book 2003) of the population of the country is literate with a definition age of 15 years and above. Also, very few people completed primary school, as many adolescents, especially girls, dropped out of school due to early marriages or pregnancies (UN Office for the Coordination of Humanitarian Affairs, 2004).

3.2.2 HIV/AIDS Situation

A report on the global HIV/AIDS epidemic indicates that the country has the World's tenth highest HIV infection rate (UNAIDS 2004). The national prevalence rate is given as 12.2%, with an estimated 1.2 million people living with HIV/AIDS. The rate, however, goes as high as 20.7% in the four Central provinces of Manica, Tete, Sofala and Zambezia. This is because this is the area that bears the brunt of the huge human traffic of transiting men and women who seek access through what is usually known as the Beira corridor to the coast for trading, business and other purposes with the attendant possibility of sexual activity between people who are not in any way committed to each other. Also, it should be noted that in a country where 70% of the population is purported to be living below the poverty line (CIA World Fact Book 2004), the easy access to money that the sex trade offers is a real lure. Incidentally, many of these transiting persons come from such countries as Swaziland with rather high national rates of infection themselves (38.8%) and Zimbabwe (24.6%) (UNAIDS 'Report on the

Global AIDS Epidemic' (2004). Indeed, though figures given during interviews consistently described the current national infection rate as having gone down to 13%, with 13.5% in Maputo the capital, these provinces continue to record very high rates of infection with Sofala, whose capital is Beira, leading the pack with a rate of 26%.

3.2.2.1 Consequences of HIV/AIDS

The disease is essentially 100% fatal (Bollinger & Stover 1999) and as it has a high infection rate among people in the most productive stage of their lives where they could contribute to national building and development, it tends to have, by consequence, a crippling effect on the national economy. The impact is felt first of all by the family for whom the infected may be the breadwinner or on whose resources the illness may cause a drain. There can also be emotional and psychological impact on the children and other dependants of the infected if the illness results in death leaving them with no emotional care. In Mozambique there was an estimated 146,000 orphans from AIDS in 1996, a figure projected to rise to 400,000 by year 2000. (Bollinger and Stover, 1999). And indeed, the UNAIDS report of 2004 states that out of a total of 12 million children orphaned by AIDS by the end of 2003, 470,000 were Mozambicans. As a country highly dependent on subsistence farming, HIV/AIDS infection touches directly on the economy when farmers are infected and are unable to plant or harvest neither cash nor food crops. As explained by the leader of a development project, HIV/AIDS could disable the increase or stabilization of agricultural yields especially with mechanized agriculture and thereby necessitate the education and training of additional personnel.

The disease has similar crippling effects on all sectors of the national economy. When trained personnel such as teachers, engineers and other service providers are infected or die from the disease, development efforts are stalled. According to Bollinger and Stover (1999) the disease for instance, affects the health sector of the country seriously as health personnel get infected and as the number of infected people needing health care increases. This is because the country already has one of the lowest numbers of doctors per capita on the continent. Also, the transport sector of the country faces a great challenge from the disease because data on workers in that sector collected in the central Beira corridor presented a high rate of 30.3%

and yet most transport managers are highly trained and therefore, difficult to replace.

The impact on the Education sector is also great. The number of experienced teachers is reduced as they are lost to the disease. Again, children are kept out of school to look after the infected or because they are sick themselves or have no means of paying for their education. In effect, the country's literacy drive efforts are being eroded by the disease.

The negative socio-economic impact of the disease on Mozambique is indeed great considering the submission of the UNAIDS (2004) that life expectancy of the Mozambican, which is 42.5 years, will drop to 27.1 by the year 2010 as a result of HIV/AIDS. It will be next to impossible to replace the huge numbers of skilled humanpower lost to the disease. Also, the provision of triple combination of antiretroviral therapy to HIV-positive adults in the country would erode 67% of the GDP (Bollinger and Stover 1999), which is a great drain considering the fact that over 75% of the government's budget is sourced from donors who do not have HIV/AIDS prevention programmes on their priority list (Bollinger and Stover 1999).

3.2.2.2 National Response to HIV/AIDS

The country has a Conselho Nacional de Combate ao HIV/AIDS, a National Anti-HIV/AIDS Council. There is also the Gabinete de Combat HIV/SIDA, a national office for HIV/AIDS education, which has branches in all the provinces. The Ministry of Education also has a Technical Group on HIV/AIDS with representatives from each directorate of the Ministry, including Teacher Education. Though the Ministry is yet to incorporate the policy on HIV/AIDS drafted by the Group into its general policy, it has constituted a committee that executes the decisions and recommendations of the Technical Group. Consequently, HIV/AIDS education has been integrated into Basic-level education. The Ministry is also working with UNESCO on extending the integration to Teacher Training Colleges. The Committee has, however, been providing education on sexual and reproductive health as well as HIV/AIDS to teachers already in the field through in-service training programmes while the preparations towards full integration into Teacher Training Programmes of instruction continue. The Ministry also has magazines and other educational journals such

as 'Contacto' through which HIV/AIDS information and education are given, and copies of these are supplied to Teacher Training Colleges.

There have also been reforms in Mozambique to protect the rights of people living with HIV/AIDS. Laws protecting the labour rights of civil servants have been introduced and there are efforts to ensure private firms apply the same policies.

Again, there are a number of non-governmental organizations in the country trying to educate the people on the disease. The Mozambican Association for the Development of the Family (AMODEFA) has been organizing workshops in schools, work places and neighbourhoods to increase awareness of the disease in order to prevent new infections. There are others like the Biz-Generation, Save the Children (Norway), as well as 'My Future is my Choice' supported by UNICEF with the view to creating a 'window of hope' by influencing children with safer sex and abstinence messages using trained peer educators.

3.2.3 HIV/AIDS Situation in Instituto do Majestério Primário, (IMAP) Matola

3.2.3.1 Awareness and Acceptance of HIV/AIDS

The results indicate that the IMAP community was more aware of the incidence of HIV/AIDS among the students than the tutors and non-teaching staff (Table 23). None of the respondents was aware of any incidence of HIV/AIDS-related death among the community.

Table 23. Awareness of the incidence of HIV/AIDS among community

Category of college community	Response		
	Yes (%)	No (%)	Total (%)
Students	23.3	73.3	96.6
Teachers/tutors	6.9	90.0	96.9
Non-teaching staff	0.0	96.7	96.6

Note: NS = 30; Missing: 3

It is surprising that there is a low level of acceptance of the prevalence of HIV/AIDS by the IMAP community in spite of the fairly high national HIV/AIDS prevalence. There appears to still be a high level of denial of the existence of the disease among the college community.

3.2.3.2 Consequences of HIV/AIDS on Instituto do Majestério Primário

The college had no records on HIV/AIDS related activities and its incidence/ prevalence and could not therefore provide any empirical evidence on the socio-economic impact of the disease on the college community. Lack of record keeping was partly attributed to inadequate human and material resources by the college.

3.2.3.3 Response of Instituto do Majestério Primário to the HIV/AIDS Situation

The IMAP response to the HIV/AIDS pandemic took several forms, including training, drama, discussions, lectures, sensitization and guidance and counseling (see Table 24). However it must be noted that even though many of the respondents were aware of these HIV/AIDS-related activities in the college, very few (see Table 25) participated in them.

Table 24. HIV/AIDS related activity organized during academic year

Activity undertaken	Response		
	Yes (%)	No (%)	Total
Training	76.7	23.3	100
HIV/AIDS drama	53.3	46.7	100
Discussions	40.0	60.0	100
Lectures	30.0	70.0	100
Sensitization programmes	26.7	73.3	100
Guidance and Counseling	3.3	96.7	100

Note: NS = 30

Training was the activity that attracted most participation, followed by Drama and discussions (see Table 25). It appears the Ministry of Education is playing a leading role in the provision of HIV/AIDS-related training for the college, followed by NGOs (See Table 26). It is commendable that there is collaboration between the college and the Ministry of Education in HIV/AIDS-related activities. Other key Ministries, like Health, need to be involved.

Table 25. Participation in HIV/AIDS-related activity in the college

Activity	Response		
	Yes (%)	No (%)	Total (%)
Training	36.7	63.3	100
HIV/AIDS drama	16.7	83.3	100
Discussions	16.7	83.3	100
Sensitization programmes	13.3	86.7	100
Lectures	3.3	96.7	100

Note: NS = 30

Table 26. Providers of HIV/AIDS Training and Life Skills Education

Provider	Response		
	Yes (%)	No (%)	Total (%)
Ministry of Education	50.0	50.0	100
NGOs	20.0	80.0	100

Note: NS = 30

3.2.3.4 *Main Sources of Information about HIV/AIDS for Instituto do Majestério Primário*

The most popular source of HIV/AIDS information for the college community is the mass media, followed by the Ministry of Education and the National AIDS Programme in that descending order (see Table

27). In terms of accuracy of information, the mass media has generally not been the best, thus raising concern about the findings below.

Table 27. Main sources of information about HIV/AIDS

Source	Response		
	Yes (%)	No (%)	Total (%)
Mass media	86.7	13.3	100
Ministry of Education	16.7	83.3	100
National HIV/AIDS programme	10.0	90.0	100
NGOs	3.3	96.7	100
Literature on HIV/AIDS	3.3	96.7	100

Note: NS = 30

3.2.3.5 *Proposals to Strengthen AIDS Unit in Instituto do Majestério Primário*

Generally, it can be summed up (from Table 28) that provision of adequate teaching and learning materials was considered by the college community as the best course of action to strengthen the college HIV/AIDS Unit for effective performance. Much as teaching and learning resource materials are essential for deepening the understanding of HIV/AIDS issues, the right leadership to manage the Unit is equally critical and should be seriously considered.

Table 28. Proposals to strengthen HIV/AIDS unit

Proposed action to be undertaken	Responses		
	Yes (%)	No (%)	Total (%)
Equip the unit with audio-visual devices	43.3	56.7	100
Provide the unit with adequate teaching and learning resource materials	26.7	73.3	100
Provide the unit with adequate funds	13.3	86.7	100
Organize more sensitization programmes	6.7	73.3	100

Note: NS = 30

3.2.3.6 Proposals to Improve Teaching and Learning about HIV/AIDS in Instituto do Majestério Primário

Slightly over a quarter (26.7%) of the respondents suggested integrating HIV/AIDS into the curriculum of the academic programmes for improvement in teaching and learning about HIV/AIDS (see Table 29). A curriculum can only be effectively utilized if there are teaching and learning resource materials (TLRMs) to accompany it. It is therefore not surprising that mention was also made of the provision of TLRMs as a measure to improve teaching and learning about HIV/AIDS in the college.

Table 29. Proposals to improve teaching and learning about HIV/AIDS in the college

Proposed action to be undertaken	Response		
	Yes (%)	No (%)	Total
Integrate HIV/AIDS education into the school curriculum	26.7	73.3	100
Provide adequate teaching and learning materials	13.3	86.7	100

Note: NS = 30

3.2.3.7 Proposals to Promote HIV/AIDS Prevention, Education, Care and Outreach Activities in Instituto do Majestério Primário

For the promotion of HIV/AIDS prevention, education and care in the college, a significant percentage of the respondents proposed among other things, the organization of inter-college discussions, creation of an equipped guidance and counseling unit as well as the organization of sensitization and training programmes (see Table 30).

Table 30. Proposals to promote HIV/AIDS prevention, education, care and community outreach.

Measures to be undertaken	Responses		
	Yes (%)	No (%)	Total (%)
Organize inter-college discussions	30.0	70.0	100
Create and equip guidance and counseling unit	20.0	80.0	100
Organize sensitization programme	16.7	83.3	100
Organize regular training programmes	16.7	83.3	100
Give regular sex education	16.7	83.3	100
College and community interactions	16.7	83.3	100
Exposure to HIV/AIDS victims	13.3	86.7	100
Integrate HIV/AIDS education into curriculum	6.7	93.3	100
Provide funding for HIV/AIDS activities	3.3	96.7	100

Note: NS = 30

3.2.3.8 Proposals to Promote Active Involvement of Academic Staff in HIV/AIDS Activities

With regard to promoting the involvement of academic staff in HIV/AIDS-related activities, a fairly large percentage of the respondents (43%) and (38%) suggested the integration of HIV/AIDS into the College training curriculum and training of academic staff on HIV/AIDS, respectively (see Table 32).

Table 31. Proposals to promote active academic staff involvement in HIV/AIDS activities

Measures to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Integrate HIV/AIDS education into the school curriculum	43.3	56.7	100
Train academic staff on HIV/AIDS	36.7	63.3	100
Provide teaching and learning aids	6.7	93.3	100

Note: NS = 30

3.2.3.9 Proposals to Promote Active Involvement of Students in HIV/AIDS Activities

In the case of promoting active involvement of students in HIV/AIDS-related activities, only about seventeen percent (16.7%) suggested the integration of HIV/AIDS into the teaching curriculum (see Table 32).

Table 32. Proposals to promote active involvement of students in HIV/AIDS activities

Measures to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Integrate HIV/AIDS education into the school curriculum	16.7	83.3	100
Give students assignments on HIV/AIDS	13.3	86.7	100
Train students on dangers of HIV/AIDS	6.7	93.3	100
Expose students to HIV/AIDS victims	3.3	96.7	100

Note: NS = 30

3.2.3.10 Proposals to Promote Active Involvement of Non-teaching staff in HIV/AIDS Activities

Concerning the promotion of active involvement of non-teaching staff in HIV/AIDS activities, only 13% of the respondents suggested the organization of training sessions.

3.3 ZAMBIA

3.3.1 Socio-Economic Background

Population

Zambia has a population of 10.9 million people, with a natural increase rate of 1.8 (Population Reference Bureau 2004). The births and deaths per 1000 population are 42 and 24, respectively. The projected population for 2025 is 18.5 million. The country has infant mortality and fertility rates of 95 per 1000 births and 5.6 per woman, respectively. Zambia has a very youthful population with 46% less than 15 years old

and only 3% above 65. The life expectancy rate at birth is 35 years, which is quite low compared to many Sub-Saharan African countries. Thirty-five percent of the population lives in urban areas while 65% live in the rural areas.

Economy

Since the late 1980s, the economy of Zambia has been experiencing a decline, with an average annual growth rate of 2.4% in the 1970s to 0.7% in 2004. The GNP per capita income is US\$800.

Educational Attainment

The adult literacy rate for both males and females of Zambia is 82% (UNAIDS-UNECA 2000). However, with the high prevalence of HIV/AIDS, this is expected to decline in the long run as increasing the number of children of school-going age dropout due to their inability to sponsor their education as a result of the loss of their parents through the deadly disease.

HIV/AIDS Situation

Zambia has an adult infection rate of 16.5% (Population Reference Bureau 2004) with 650,000 orphans in 2003. Only 34% of married women aged 15-49 use some contraceptive methods with only 23% using modern methods, thus suggesting the need for more education to increase use, especially of condoms which could help to minimize the risk of contracting HIV/AIDS.

Consequences of HIV/AIDS

Bollinger and Stover (1999) provide a summary of the economic impact of HIV/AIDS in Zambia. Several households have lost incomes due to HIV-related illness. The sick breadwinners are unable to work and yet incur huge medical expenses. Baggaley and Needham (1999) found that the illness of parents forces children to be the care-givers, thereby sacrificing their education through poor attendance or simply dropping out of school. They also indicated that, since the disease affects the productivity of the patient, it affects the household income adversely. One of the major consequences of this is malnourishment in the

children of that household, a condition often worsened when the child is orphaned and sent to a guardian's house.

Kassawa (1993) reported that the people of the Mansa District of Luapula Province perceived that AIDS had many economic repercussions on the families of AIDS patients, including malnutrition and a crippling effect on their ability to meet the cost of their children's educational requirements or provide them with adequate shelter. This is because it causes a reduced income flow in the family. Haworth (1991), in a tracer study of 116 families throughout Zambia, found that 54 fathers and 20 mothers had died; only 13 of the parents who were still alive did not show any symptoms of AIDS. In this sample, 42 percent of the children stopped attending school, 102 families suffered economic problems and 59.8 percent of the households had food shortages.

In general, research has found that approximately 37 percent of all households in Zambia are caring for one or more orphans, while about 25 percent of the households were headed by widows. By the year 2000, as one study projected, there would be over 1,000,000 or 18% of children orphaned due to AIDS. Over half of the households in each study caring for orphans cited financial pressures associated with their care. Non-orphans are 1.3 times more likely to attend school than orphans (Mulenga, Kamwanga, *et al.* 1993).

In a study of two areas in Zambia, Kafue, Mutangadura and Webb (1998/99) found that care-givers in the less affluent community reported lost earnings of 10,000 kwachas (K) per month, where half of the sample earned less than K100,000 annually. Those in the more affluent area had lost earnings of K24,583 per month, where more than 85% of the sample had an annual income of over K1,000,000. The average funeral cost was between K112,000 and K240,700. The average cost for a visit to a clinic ranged from K8,542 to K16,500 for the two areas. Households that were affected by AIDS reported annual income levels of 30-35% less than unaffected households. The affected households also reported selling off assets such as bicycles and radios in order to pay health and funeral costs.

In terms of agriculture in Zambia, Ching'ambo, Mwanza *et al.* (1995), in a study of 29 agricultural organizations, found significant effects of HIV/AIDS, including increased absenteeism; an increase in the number

of deaths, especially in the management categories; and increased expenditures for both medical costs and terminal benefits.

AIDS has had a significant impact on some firms. For example, ILOEAMAT (1995) found that the petroleum refining company INDENI Petroleum paid out K22.6 million (US\$33,781) in medical costs for AIDS patients and funeral expenses, which was greater than their profits of K16.4 million (US\$24,514). In a study that was conducted in Lusaka, four organizations out of ten surveyed reported that AIDS was a problem in their companies, causing high death rates, reducing productivity, while others reported increasing sick leave, absenteeism and increased funeral cost. It is important to note that, for some smaller firms the loss of one or more key employees could be catastrophic and could even lead to the collapse of the firm.

Other effects of HIV/AIDS in Zambia are felt in the health, transport, mining, water and education sectors. Foster and Buve (1995) found in Monze Hospital in Zambia that the costs of treatment of HIV disease in the in-patient wards and the out-patient department to the health services in the 2 years before death was US\$110.60 per person. The daily cost on the other hand, ranged from US\$1.70 to US\$7.20 for in-patient care depending on the location of the hospital (Loewensen and Whiteside 1997).

The mining industry in Zambia faces huge economic costs as a result of the high prevalence of this disease. Early estimates in the late 1980s indicate that 68% of the men who tested positive for HIV in the Copperbelt area were professionals in the mining industry (Green 1988).

The education system also faces the additional challenge of educating students about AIDS and equipping them to protect themselves. In a study centered in two provinces of Lusaka and Northern Zambia, the impact of AIDS was examined using a survey conducted on 346 students and 74 teachers drawn from 20 rural and urban primary and secondary schools. Respondents mentioned AIDS as the major cause of death. Effects for the students included increased absenteeism and increased dropout rates, especially in the urban areas. Enrollment was not affected, since there was a shortage of places in schools. Teachers reported that they had experienced increased absenteeism due to illness and funeral attendance, and found it more difficult to teach due to worries and depression. It is anticipated that teacher training and

recruitment costs will increase by 25% to replace teachers who die, since in 1998 alone, 1,500 teachers died from AIDS (Mukuka and Kalikiti 1995)

It is difficult to assess the macro-economic impacts of HIV/AIDS. However, there are several mechanisms by which AIDS affects macroeconomic performance. For example, AIDS deaths lead directly to a reduction in the number of workers available, leading to shortage of workers, higher wages, higher production costs, loss of international competitiveness which can cause foreign exchange shortages and most invariably lower government revenues and reduce private savings and capital accumulation, among others. According to UN sources, the infant mortality rate in Zambia will be 60% higher by 2010 due to the impact of AIDS, the child mortality rate will double, the crude death rate will triple, life expectancy will decrease from 60.1 to 30.3 years and the overall population growth will be reduced from 3.1% to 2.1%, all as a result of the effect of AIDS (Cohen 1997).

National Response to HIV/AIDS

The national response began with the establishment of the National AIDS Surveillance Committee in 1998. This was replaced by the National HIV/AIDS/STD/TB Council established in 2003 to provide the requisite technical leadership in the fight against the HIV/AIDS. In order to have political clout and show the commitment of the Government, a Committee of Cabinet Ministers was appointed to give guidance to the Council.

A Strategic Framework for HIV/AIDS/STD/TB has been developed, with short-term plans developed in 1987 to protect the blood supply and medium term plan for 1988-1992 focusing on eight priority areas (leprosy, Information, Education and Communication, laboratory support, epidemiology and research, STDS, and clinical care, programme management, and home-based care). The second medium term plan (1994-1998) integrated AIDS, TB and STDS with greater emphasis on sectoral approaches, behavioral change, access to STD care, condom use, de-stigmatization of the disease, increased voluntary counseling and testing (VCT), and mother to child transmission (MTCT). A programme management information system is being developed to facilitate collection and analysis to guide management decision-making.

An organization for the care of orphans aged 20 or younger, CINDI (Children in Distress) with funding largely from the Zambian Government has also been formed. It provides children funds to attend school and buy clothing and assistance to families to buy food. It must be noted, however, that even combined with other projects, only a small percentage of those who have been orphaned by AIDS have benefited. A strong political commitment to the fight against AIDS as demonstrated by Uganda, Senegal and Thailand, is setting the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts; facilitating a multi-sectoral approach by making it clear that the fight against AIDS is a national priority and signaling individuals and community-based organizations involved in the AIDS programmes that their efforts are appreciated and valued.

3.3.2 HIV/AIDS Situation in National In-Service Training College, Zambia

3.3.2.1 Awareness and Acceptance of HIV/AIDS

The results indicate that the college community was aware of the incidence of HIV/AIDS among them and more so among the students, followed by the teachers/tutors (see Table 33). However, the awareness of the incidence of HIV/AIDS-related deaths was more among teachers/tutors and non-teaching staff than the students (See Table 34). This observation may not be surprising since students are generally younger and would have been at an earlier stage of the HIV/AIDS infection and less likely to die compared to the tutors and non-teaching staff.

Table 33. Awareness of the incidence of HIV/AIDS among college community

Category of college community	Response		
	Yes (%)	No (%)	Total
Students	53.2	31.9	85.1
Teachers/Tutors	44.7	38.3	83.0
Non-teaching staff	38.3	44.7	83.0

Note: NS = 47; Missing: 3

Table 34. Awareness of HIV/AIDS-related deaths among college community

Category of college community	Response		
	Yes (%)	No (%)	Total (%)
Students	25.5	57.4	82.9
Teachers/tutors	31.9	51.1	83.0
Non-teaching staff	27.7	55.3	83.0

Note: NS = 47; Missing: 3

3.3.2.2 Consequences of HIV/AIDS on National In-Service Training College, Zambia

The college could not provide any empirical evidence of the socio-economic impact of HIV/AIDS on its community due to lack of record keeping. Record keeping requires availability of both adequate human and material resources which the college lacks. However, several national and individual studies indicate significant socio-economic consequences in Zambia. Colleges in the country should network with other key stakeholders to gain knowledge and skills on how to collect, analyze and utilize information for various purposes.

3.3.2.3 National In-Service Training College's Response to HIV/AIDS

It can be seen from Table 35 that the most widely known HIV/AIDS-related activity among the college community is quiz, followed by sensitization programmes. Other responses included organization of inter-college meetings, drama and debate.

However, very few of the respondents participate in the activities (see Table 36) usually provided by various organizations, including NGOs, Ministries of Education and Health, and the National AIDS Programme (see Table 37).

Table 35. HIV/AIDS related activity organized during academic year

Activity organized	Responses		
	Yes (%)	No (%)	Total (%)
Quiz	57.4	42.6	100
Sensitization program	21.3	78.7	100
Inter-college meetings	8.5	91.5	100
HIV/AIDS drama	6.4	93.6	100
Workshop	6.4	93.6	100
Debate	4.3	95.7	100
Wearing HIV/AIDS T-Shirts every Friday	2.1	97.9	100
Lectures	2.1	97.9	100

Note: NS = 47

Table 36. Participation in HIV/AIDS-related activity in the college

Activity participated in	Response		
	Yes (%)	No (%)	Total (%)
Quiz	8.5	91.5	100
Sensitization programmes	8.5	91.5	100
Workshop	6.4	93.6	100
Guidance and Counseling	4.3	95.7	100
Discussions	4.3	95.7	100
Inter-college meeting	2.1	97.9	100
Anti-HIV/AIDS club meeting	2.1	97.9	100

Note: NS = 47

Table 37. Providers of HIV/AIDS training and Life Skills Education

Provider	Response		
	Yes (%)	No (%)	Total (%)
NGOs	8.5	91.5	100
Ministry of Education	6.4	93.6	100
National HIV/AIDS program	4.3	95.7	100
Ministry of Health	2.1	97.9	100
TEVETA	2.1	97.9	100

Note: N = 47

3.3.2.4 *Main Sources of Information about HIV/AIDS for National In-Service Training College*

The most popular source of HIV/AIDS information for the college is the mass media, followed by literature, and drama, in that descending order (see Table 38). It is not clear what the respondent meant by "literature" on HIV/AIDS. It could be printed information. Mention is also made of the Internet as a source of information on HIV/AIDS.

Table 38. Main sources of information about HIV/AIDS

Source	Response		
	Yes (%)	No (%)	Total (%)
Mass media	76.6	23.4	100
Literature on HIV/AIDS	40.4	59.6	100
Drama	8.5	91.5	100
Ministry of Education	6.4	93.6	100
Peer educators	6.4	93.6	100
Community	4.3	95.7	100
Internet	4.3	95.7	100
Workshop	4.3	95.7	100
Discussions	2.1	97.9	100
National HIV/AIDS programme	2.1	97.9	100
NGOs	2.1	97.9	100

Note: NS = 47

3.3.2.5 *Proposals to Strengthen AIDS Unit in National In-Service Training College*

When asked about what needed to be done to strengthen the AIDS Unit for effective performance, the college community suggested the following (see Table 39).

Table 39. Proposal to strengthen HIV/AIDS unit

Proposed action	Response		
	Yes (%)	No (%)	Total (%)
Provide the unit with adequate funds	21.3	78.7	100
Provide unit with adequate teaching and learning resource materials	8.5	91.5	100
Organize more sensitization programmes	8.5	91.5	100
Organize regular workshops	6.4	93.6	100
Train more coordinators	6.4	93.6	100
Integrate HIV/AIDS education into the school curriculum	4.3	95.7	100

Note: NS = 47

As can be seen from Table 39, very few responded to the question. The only areas worth noting is the provision of adequate funding.

3.3..2.6 Proposals to Improve Teaching and Learning about HIV/AIDS in National In-Service Training College

Integrating HIV/AIDS into the curriculum of the academic programmes and provision of teaching and learning materials were proposed by a significant percentage of the respondents as the means to improve effective teaching and learning about HIV/AIDS (see Table 40).

Table 40. Proposals to improve teaching and learning about HIV/AIDS in the college

Proposed action	Response		
	Yes (%)	No (%)	Total (%)
Integrate HIV/AIDS education into the school curriculum	36.2	63.8	100
Provide adequate teaching and learning materials	23.4	76.6	100
Organize more sensitization programmes	19.1	80.9	100
Provide enough funds for HIV/AIDS activities	8.5	91.5	100
Organize more seminars/workshops	6.4	93.6	100
Organize regular training sessions	4.3	95.7	100

Note: NS = 47

3.3.2.7 *Proposals to Promote HIV/AIDS Prevention, Education, Care and Outreach Activities in National In-Service Training College*

A significant percentage of the respondents considered the provision of sensitization and adequate funding as important in-puts towards improving HIV/AIDS prevention, education and care (see Table 41).

Table 41. Proposals to promote HIV/AIDS prevention, education, care and community outreach

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programme	46.8	53.2	100
Provide funding for HIV/AIDS activities	17.0	83.0	100
Integrate HIV/AIDS education into curriculum	10.6	89.4	100
Conduct workshops regularly	10.6	89.4	100
Organize anti-HIV/AIDS clubs	10.6	89.4	100
Organize drama shows on HIV/AIDS	10.6	89.4	100
Encourage voluntary counseling and testing	8.5	91.5	100
Give regular sex education	6.4	93.6	100
Promote abstinence	6.4	93.6	100
Organize regular training programmes	4.3	95.7	100
Exposure to HIV/AIDS victims	4.3	95.7	100
Provide teaching and learning materials on HIV/AIDS	4.3	95.7	100
College and community interactions	4.3	95.7	100
Create and equip guidance and counseling unit	2.1	97.9	100
Organize inter-college discussions	2.1	97.9	100
Teach good morals	2.1	97.9	100
Organize quiz competitions	2.1	97.9	100
Faithful to one partner	2.1	97.9	100

Note: NS = 47

3.3.2.8 *Proposals to Promote Active Academic Staff Involvement in HIV/AIDS Activities*

Very few of the respondents provided suggestions as to how to promote the involvement of academic staff in HIV/AIDS-related activities (see Table 43). Organization of sensitization programmes, regular workshops and integration of HIV/AIDS into the education training curriculum were among suggestions made by some key stakeholders for the promotion of active involvement of the academic staff.

Table 42. Proposals to promote active academic staff involvement in HIV/AIDS activities

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programmes for staff	14.9	85.1	100
Organize regular workshops	12.8	87.2	100
Integrate HIV/AIDS education into the school curriculum	10.6	89.4	100
Train academic staff on HIV/AIDS	6.4	93.6	100
Form anti-HIV/AIDS clubs	4.3	95.7	100
Involve in HIV/AIDS activities	4.3	95.7	100
Encourage voluntary counseling and testing	2.1	97.9	100
Maintain a counseling unit for staff	2.1	97.9	100
Provide teaching and learning aids	2.1	97.9	100
Organize outreach programmes	2.1	97.9	100
Drama shows on HIV/AIDS	2.1	97.9	100

Note; NS = 47

3.3.2.9 *Proposals to Promote Active Involvement of Students in HIV/AIDS Activities*

In the case of promoting active involvement of students in HIV/AIDS-related activities, a fairly significant percent of the respondents suggested the organization of sensitization programmes for students

and the integration of HIV/AIDS in the teaching curriculum, respectively (see Table 43).

Table 43. Important measures to promote active involvement of students in HIV/AIDS activities

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programmes for students	38.3	61.7	100
Integrate HIV/AIDS education into the school curriculum	19.1	80.9	100
Form anti-HIV/AIDS clubs	10.6	89.4	100
Organize regular seminars on HIV/AIDS for students	10.6	89.4	100
Organize quiz programmes for students	4.3	95.7	100
Organize drama shows for students	4.3	95.7	100
Motivate students	4.3	95.7	100
Train more peer educators	2.1	97.9	100
Involve students in HIV/AIDS activities	2.1	97.9	100
Provide funds for HIV/AIDS activities	2.1	97.9	100

Note: NS = 47

3.3.2.10 Proposals to Promote Active Involvement of Non-teaching staff in HIV/AIDS Activities

Regarding the promotion of active involvement of non-teaching staff in HIV/AIDS activities, a significant percentage of the respondents suggested the organization of sensitization programmes, formation of anti HIV/AIDS clubs and regular workshops (see Table 44). Mention was also made of inclusion of non-teaching staff in HIV/AIDS-related activities. Interviews with selected non-teaching staff members revealed that the college did not include them in most HIV/AIDS activities.

Table 44. Proposals to promote active involvement of non-teaching staff in HIV/AIDS activities

Proposed measure to be undertaken	Response		
	Yes (%)	No (%)	Total (%)
Organize sensitization programmes	10.6	89.4	100
Form anti-HIV/AIDS clubs	10.6	89.4	100
Organize regular workshops	8.5	91.5	100
Involve non-teaching staff in HIV/AIDS activities	6.4	93.6	100
Organize drama shows	4.3	95.7	100
Promote faithfulness to one partner	4.3	95.7	100
Encourage voluntary counseling and testing	2.1	97.9	100
Train more peer educators	2.1	97.9	100
Organize quiz programmes	2.1	97.9	100

Note: NS = 47

4. SUMMARY AND DISCUSSION OF KEY FINDINGS

4.1 Continent-Wide Sample of Colleges

4.1.1 Acceptance of HIV/AIDS on College Campuses

Awareness and acceptance of the HIV/AIDS, its incidence and cause of death among the college communities (tutors, students and non-teaching staff) was quite high. However, there is no consistency in the perceptions about the trends as to whether the prevalence of the disease has been increasing, remaining the same or decreasing over the past few years. This may be partly due to the fact that the colleges have no data on HIV/AIDS activities and incidence.

The variations in terms of level of awareness and acceptance of HIV/AIDS among the three case study colleges may suggest the need for circumspection in over-generalizing the findings obtained from the continent-wide aerial sample. It is difficult to explain why, in spite of the very high prevalence of HIV/AIDS in Mozambique, there was a low

percentage of the community of Instituto do Majestério Primário accepting the prevalence of the disease. Against this background, it may be appropriate to conduct in-depth analysis of all colleges in each country to provide a clearer picture of the situation of the level of response so far made. Denial of the disease appears to still be lingering in some colleges and must be addressed with more aggressive and systematic education programmes.

4.1.2 Impact of HIV/AIDS on Colleges

The colleges have no empirical data on the impact of the disease on their operations and therefore could not provide concrete information on how the disease affects productivity and operations of the colleges. The findings of the case study colleges confirm the same situation. Their main measure of the impact of the disease is the creation of awareness of the disease among the college communities. The fact that as large as 24% of the respondents were of the opinion that the impact of the disease was minimal, gives cause for much concern, particularly in countries such as Zambia and Mozambique, where the national prevalence rates are quite high.

The failure on the part of the college authorities to examine the impact of the HIV/AIDS may be considered as a more convenient way of postponing the problems until they reach insurmountable heights. HIV/AIDS impact data/information is invaluable in view of the difference it could make in mitigating the effects of the disease when used appropriately to better manage HIV/AIDS prevention programmes. Appropriate policies and systems should be put in place by colleges to enable them periodically assess the effects of the disease on their operations.

4.1.3 Collection of Data on HIV/AIDS

The culture of collecting data/information by colleges on HIV/AIDS activities as well as monitoring and evaluating HIV/AIDS interventions is very poor. The collection of data provides management with decision support information and an "Early Warning" system. It also provides the basis for evaluation of the impact of HIV/AIDS.

While lack of adequate resources may be a factor (as was reported by the case study colleges) to the poor documentation of HIV/AIDS

activities, there, however, seems to be a general lack of interest on the part of management of training colleges.

Considerable progress has been made by the World Bank and UNESCO in developing guidelines to assist organizations in the education sector to develop process, output, outcome and impact indicators for HIV/AIDS. The Colleges need to take the initiative to obtain the guidelines and to begin to determine their HIV/AIDS information needs, the methods to use to collect the data, and the hard and software as well as human resource requirements to manage the monitoring and evaluation system.

4.1.4 Response of Training Colleges to the HIV/AIDS Pandemic

The responses of colleges to the HIV/AIDS, though ad hoc in nature, took several forms, including initiating HIV/AIDS prevention and education programmes and establishing institutional arrangements. They also include to a very limited extent the integration of HIV/AIDS into the curricula and the development of training manuals and teaching and learning resource materials for HIV/AIDS. What are conspicuously absent in their efforts are the creation of treatment facilities, voluntary testing and counseling facilities, development of written HIV/AIDS policies and the initiation of community outreach programmes. Strong leadership is also lacking.

The results of the case study colleges showed that some colleges had only one HIV/AIDS-related activity in a year with very limited involvement and participation of the staff and students. For example, sensitization was the only activity carried out by the Ecole Normale Supérieure d'Atakpamé in Togo in the past year.

The results of the case study on colleges indicate variations in the response to HIV/AIDS from college to college. This suggests the need to assess the relative effectiveness of the various responses so as to share lessons learnt for improved programming. It also requires that initiation of future programmes should take into consideration the type and quality of HIV/AIDS programme activities being carried out in each teacher training college, the key stakeholders involved, and the gaps to be bridged.

The results of the case study colleges also indicate a low participation of college community members in HIV/AIDS-related activities. Whether

this is due to sheer apathy or some other latent factors needs further investigation.

The level of involvement and participation of the Ministry of Education (MOE) in HIV/AIDS activities carried out by the three case study colleges varied. The Ministries of Education oversee the management and administration of teacher training colleges in most African countries. Their involvement and participation in HIV/AIDS activities in the colleges would serve as approval and strengthen the leadership of the colleges to command the requisite support from the entire college community.

One particular important area that requires the involvement of the Ministries of Education is the review of the curriculum to incorporate and infuse life skills education on attitudes, values and behaviour, population, sexuality and reproductive health as well as include extra curricular activities such as club activities, school debates and peer education to help establish the necessary character formation and behavioral change. As underscored by Carol Bellamy, the Executive Director of UNICEF (February 2004), knowledge is critical in the fight against the HIV/AIDS pandemic and therefore the development and implementation of a skills-based HIV/AIDS curriculum in teacher training colleges will no doubt minimize the impact of the operations of the colleges and ultimately the education sectors at large.

4.1.5 Training of Tutors/Lecturers in HIV/AIDS and Family Life Education

Many of the colleges have provided some form of training in HIV/AIDS and Family Life Education for the tutors/lecturers in collaboration mainly with the Ministry of Education, NGOs and the National AIDS Commission. However, the training essentially was more of sensitization than on substantive core areas such as integrating HIV/AIDS into the curriculum, guidance and counseling, population life education and gender mainstreaming. There was no information available with the case study colleges regarding the types of training conducted, the content, the number of beneficiaries and the training facilitators or providers.

It is also not clear if the training or activities were based on any comprehensive needs assessments. The knowledge and skills of tutors/ teachers of training colleges need to be built to enable them

deal effectively with the often difficult socio-psychological and emotional situations associated with HIV/AIDS cases. This can only be accomplished by systematic inventory taking of the capacity building needs of each teacher training college, identification and adoption of the best practices in place and use of lessons learnt to guide the design of more comprehensive HIV/AIDS prevention, education, treatment, support and care programmes. To facilitate improved teaching and learning of HIV/AIDS in teacher training colleges and also to improve sex and sexuality self-awareness/ change, evidence based HIV and AIDS activities targeting the students, teachers and non-teaching staff must be implemented.

In the mean time, it is worth noting that the Association of African Universities (AAU) has developed a Toolkit with ten training modules for Institutions of Higher Learning in Africa, which is available in print and will soon be available on its Website. The Toolkit is quite flexible and can be adopted or be adapted by management of teacher training colleges to develop, plan and manage the responses to HIV/AIDS across the entire core functional areas of the college.

Other important sources of materials that management of African teacher training colleges can use in developing programmes in response to HIV/AIDS include the UNESCO Harare Cluster Office and the virtual Institute for Higher Education in Africa.

4.1.6 Collaboration and Development of Partnerships

Although not as high as expected, there is evidence of collaboration in HIV/AIDS prevention, education and treatment activities among the training colleges, NGOs, and Government Agencies (Ministries of Education and Health and AIDS Commissions).

The collaboration between the colleges, the donors and the communities, however, leaves much to be desired. Developing collaboration and partnerships with other key stakeholders broadens and extends the college's HIV/AIDS responses from an internally focused one to an external one which affords it to take advantage of opportunities in its external environment. It can serve as a vehicle for referrals and skills exchanges and thus contribute to the enhancement of the fight against HIV/AIDS. The battle against HIV/AIDS can neither be fought and won by only one individual, group or organization nor with only one strategy. Teacher Training colleges need to expand their

networks and partnerships in order to effectively achieve the objectives of their HIV/AIDS responses.

4.1.7 Main Sources of HIV/AIDS Information for Colleges

There are very limited sources of HIV/AIDS information available to the college communities. The mass media and written materials are the main sources of HIV/AIDS information to the teacher training college community.

The results of the case study colleges indicate other additional sources as the Internet, materials from NGOs and National HIV/AIDS Programme (in the case of Ecole Normale Supérieure d'Atakpamé in Togo). Research evidence indicates that the mass media has not been the best source of HIV/AIDS information in terms of accuracy and targeting of specific group needs of the community. The limited sources of information to the college communities have serious adverse implications, including the denial of access to preventive methods such as male and female condoms, voluntary testing, counseling and follow-up. This consequently, actually increases their vulnerability to HIV infection.

The colleges should provide more reliable alternative sources of information to the students and teaching staff. More systematic integration of HIV/AIDS into the academic programmes of the colleges needs to be done to provide both accurate and standardized information to all members of the college community, particularly to the students. There are other well developed HIV/AIDS information sources (for example, <http://www.unesco.org/iiep>; www.edna.sn/africaso.org) the communities of training colleges can access.

4.1.8 Perceptions of the Way Forward

The general perception of the way forward for improved college HIV/AIDS programmes are integration of HIV/AIDS into the curriculum, development of sustained sensitization and education programmes, training of tutors/ lecturers in HIV/AIDS and provision of adequate resources.

However, what is equally important but excluded by the respondents, is the need for the development of written HIV/AIDS institutional policies

that are consistent with national policies to provide the frame within which all HIV/AIDS responses can be situated.

An equally critical requisite is the development of strong committed leadership to ensure that the colleges' HIV/AIDS response is developed, implemented and monitored in a consistent manner.

4.2 Conclusions

Based on the above findings, the following conclusions have been drawn.

- a) Teacher training colleges in Africa, to some extent, have been aware of and accepted the incidence and prevalence of HIV/AIDS within their communities even though there still exist some traces of denial among some college communities.
- b) The responses of the colleges to the HIV/AIDS pandemic have neither been systematic nor comprehensive to achieve significant positive results.
- c) The colleges lack systematic data on HIV/AIDS-related activities and impact and are therefore unable to assess the socio-economic effect of the disease on their operations.
- d) The tutors/teachers lack both the requisite knowledge to impart to the students and the skills to be able to effectively handle the complex and value-laden issues related to HIV/AIDS.
- e) The college communities have limited and unreliable sources for HIV/AIDS information.
- f) Most colleges lack the requisite leadership and commitment to galvanize the college communities to respond effectively to the HIV/AIDS problem.
- g) There is little partnership building among training colleges, NGOs, Government Agencies and the wider community to take advantage of opportunities for effective HIV/AIDS response.

- h) Few colleges have HIV/AIDS policies to provide the needed framework for integration of HIV/AIDS into the academic curriculum.
- i) Very few colleges have financial provisions for HIV/AIDS in their annual budgets.
- j) Colleges have no monitoring and evaluation systems to enable them assess the extent to which the HIV/AIDS programmes being implemented are achieving the stated outcomes and impact.

4.3 Recommendations

Against the above conclusions, it is recommended that:

- a) An in-depth analysis of all colleges should be done to determine the level of denial or acceptance that exists for the design and implementation of sustained HIV/AIDS education programmes.
- b) Colleges be supported to develop comprehensive programmes that meet the needs of their communities.
- c) The capacities of colleges be built to collect, analyze and store data on HIV/AIDS in order to promote evidence-based response to the pandemic.
- d) Teachers' knowledge and skills on HIV/AIDS be built in order for them to be able to effectively impart same to students and also be able to handle the often delicate and difficult situations associated with people with HIV.
- e) College Management/leadership should accord HIV/AIDS the required attention and commitment, using the HIV/AIDS Task Team Approach, in order to ensure active and collaborative involvement of all stakeholders.
- f) Colleges should endeavour to develop and partnership with NGOs, Government Agencies (particularly Ministries of Education and Health) and the wider community in order to share cost in programme activities as well as take advantage of the services of experts and social capital within their external environment.

- g) Colleges be encouraged to develop HIV/AIDS policies to provide the needed framework for institutionalization and integration of HIV/AIDS into the academic curriculum.
- h) Colleges should develop reliable alternative sources for HIV/AIDS information for its community members in order to enable them have full access to prevention services, including voluntary testing and counseling, contraceptive services, referrals, care and support.
- i) Management of colleges should develop more aggressive and innovative resource mobilization strategies beyond their internal budgetary provisions to include local and international NGOs and development partners in order to ensure adequate and sustained funding for HIV/AIDS programmes.
- j) Colleges should be assisted to develop systematic monitoring and evaluation systems with well defined and comprehensive HIV/AIDS programme performance indicators that facilitate the assessment of the achievement of the objectives of college HIV/AIDS programmes.

5. DEVELOPING GUIDELINES FOR A COMPREHENSIVE RESPONSE OF TEACHER TRAINING COLLEGES TO HIV/AIDS

It has become evident from the results of the study that there is a general acceptance among teacher training colleges that HIV/AIDS is real and prevalent among their communities. This is proven with observed incidences and deaths among members although the concrete figures on the magnitude of the disease have not been documented to facilitate assessment of its consequences on the operations of the colleges.

The findings have also indicated that there have been sporadic, ad hoc and un-coordinated initiatives made by the colleges to address the HIV/AIDS situation. The scope of the activities has not only been limited but they have also not been participatory enough in approach, thus excluding some sections of the college communities. What is evidently lacking is a clear institutional HIV/AIDS policy consistent with the respective national policies to set the framework within which all College responses to HIV/AIDS could be situated.

The results further suggest that the colleges have not provided the leadership needed for ensuring the design and implementation of comprehensive HIV/AIDS programmes. Many of the colleges lacked established Units and positions dedicated to HIV/AIDS programmes. The design and implementation of the HIV/AIDS programmes are left to the discretion of individuals. The consequence of this situation has been the unfortunate failure of many colleges to integrate HIV/AIDS into the curriculum of the teaching programmes.

It has become evident that the tutors/lecturers who are supposed to be championing the HIV/AIDS activities through teaching, are themselves not adequately equipped with the requisite knowledge and skills to effectively play their leading roles. Most of them have attended only sensitization workshops not covering substantive core areas to enable them in turn impart to teacher trainees. Effective college response to HIV/AIDS will depend partly on the existence of adequate numbers of well-trained and committed tutors.

The findings further indicate the general lack of annual budgetary provisions for HIV/AIDS in the colleges. There cannot be any hope of success in any battle, including the war against the spread of HIV/AIDS, without the commitment to allocate adequate resources.

The good news from the study is that the teacher training colleges have realized the need to improve upon what they have variously started. Essentially, what is needed is the requisite assistance to enable them review and strengthen their efforts for a take-off. The right starting point is for them to acquaint themselves with the essential guidelines and tools for developing comprehensive HIV/AIDS prevention and education programmes. An attempt has been made to outline the requisite guidelines which can be adopted with modifications to suit individual college situation.

The cardinal objectives of these guidelines are to contextualize the HIV/AIDS disease within the college environment and identify key challenges in the context. The guidelines will then set the framework to assist management of Teacher Training Colleges to plan, implement and monitor appropriate and effective responses to HIV/AIDS within their environment. It is important to note that the HIV/AIDS response of a college is an integral part of the broader national response to the HIV/AIDS epidemic and should stem from that.

According to Kelly (2001), the first requirement for developing a comprehensive HIV/AIDS Prevention Programme is a total management commitment. He outlined the following as essential elements to consider in developing a comprehensive HIV/AIDS prevention programme:

- HIV/AIDS policy and Strategy
- Developing culturally appropriate prevention messages
- Tackling socio-economic factors
- Establishing partnerships
- Sustaining awareness and education
- Challenging denial and stigma
- Situating prevention in community context; linking care to prevention
- Rigorous scientific reflection.

There has been international consensus on core principles that should underline institutional response to HIV/AIDS and this should be taken into consideration in developing guidelines for teacher training colleges' response to the disease. The essence of the principles is that they provide guidance on responses to new and changing situations which might not have been covered by existing policies/laws.

The core principles to provide guidance for the development of guidelines for a comprehensive response of teacher training colleges to HIV/AIDS prevention and education should therefore include but not be limited to the following:

- Non-discrimination on the basis of HIV/AIDS
- Safety in the workplace
- Prohibition on forced HIV testing
- Encouragement of voluntary counseling and testing
- Confidentiality; and
- Openness, acceptance, care and support for college community members living with HIV/AIDS.

Against this background and within the context of the key findings of the study, the following guidelines, in a chronological order, have been recommended for adoption by teacher training colleges in Africa to provide the framework for the development of a comprehensive response to HIV/AIDS. It is important to note that there are several detailed processes and analyses involved in each of the stages to

ensure adequacy, efficacy as well as minimum standards with regard to the outputs that are not presented here.

a) *Development of Committed and Competent Leadership*

Training Colleges should demonstrate leadership commitment by way of creating a high level position to be filled by an experienced and skilled senior member of staff to be responsible for ensuring that the colleges' HIV/AIDS response is developed, implemented and monitored in a consistent manner. To provide the needed support for the leadership, an HIV/AIDS Committee with adequate representation and support from all relevant stakeholders of the college (tutors, non-teaching staff, teacher trainees, Ministries of Education and Health, etc.) should be established.

Leadership Commitment to HIV/AIDS must be demonstrated within and outside the college. This can be done through visible participation in HIV/AIDS events and the promotion of cross-sector HIV/AIDS partnership. It can also be done through the prioritization of resources for the delivery of HIV/AIDS programmes to facilitate the transfer of innovative solutions on HIV/AIDS problems to all departments and stakeholders of the college. Also, expressing principled stances on human rights, gender issues, particularly as they relate to infected or affected college community members and their families will be helpful. Indeed, leadership should be a role model in showing commitment to HIV/AIDS needs, not discriminating against people living with HIV/AIDS (PLWHAs), for instance.

b) *Development of Institutional HIV/AIDS Policy*

Training colleges should develop well defined institutional HIV/AIDS policies that set the framework within which all responses can be situated. The policy should contain principles on management responsibilities, establishment of multi-level structures and partnerships responsible for all aspects of HIV/AIDS responses in the college as well as the integration of HIV/AIDS into existing human resource management policies.

The Association of African Universities (AAU) Tool Kit provides details on why the need for an HIV/AIDS policy, the pros and cons for it, the procedures for developing one and the scope of coverage. It also

provides examples of HIV/AIDS which can be adapted to suit the peculiarities of teacher training colleges in Africa.

c) *Development of Partnership*

Strong partnerships and networks should be developed between the colleges and other identified key stakeholders, including Ministries, NGOs, and CBOs for effective coordination and sharing of experiences and best practices. Collaborative responses are more effective than individual responses. It enables the college to take advantage of opportunities in its environment to enhance its HIV/AIDS programme activities.

d) *Development of HIV/AIDS Medium Term Strategic Plans*

The college needs to know where it is now with regard to HIV/AIDS and determine where it wants to be in the next 3-5 years. This involves the development of a medium term strategic plan that identifies key issues including, community members at high risk of contracting HIV/AIDS, curriculum development, teacher education and development, human resource management challenges, voluntary testing, guidance and counseling, capacity building needs, care and support. It also involves setting objectives, formulating strategies and preparing action plans for implementation to achieve the objectives. The college's HIV/AIDS response may stand alone or be integrated into the broader institutional strategic plan as well as into each year's operational plan.

The development of an HIV/AIDS medium term strategic plan should involve a cross-section of the academic staff, non-academic staff and the students in order to create a sense of ownership for it.

Adequate allocation of human resources and funding to the HIV/AIDS programmes should be made to ensure effective implementation.

e) *Development and Implementation of Capacity Building Plan*

Teachers are critical in HIV/AIDS intervention and health promotion. Provision of a good curriculum with adequate teaching materials is necessary but teachers need the requisite knowledge and skills to be able to deal with the complex and value-laden issues of HIV/AIDS

effectively. There is therefore the need for the teachers' capacities to be built to enable them not only impart the knowledge and skills acquired to the students but deal effectively with the socio-psychological and emotional situations associated with people with HIV. This will also enable them confront their own values, beliefs, and fears.

Teacher training must emphasize the role of teachers in attitude and behaviour formation and change for learners.

The Association of African Universities' (AAU) Toolkit provides excellent training modules on integration of HIV/AIDS in curriculum, HIV/AIDS policy development, student services, community engagement, and monitoring and evaluation which could be adapted by teacher training colleges to suit their training needs.

f) Development of Support Services for Students

Students form the majority of the communities of teacher training colleges. They also constitute the most sexually active sector of the community. By virtue of being out of home where parental control is absent, they are pre-disposed to engaging in adventurous undesirable social activities, including drinking and smoking which are favourable recipe for unprotected sex. HIV/AIDS is likely to thrive among the student populations in college environments under the given circumstance and this calls for the need to develop comprehensive services to address their needs.

There must be an institutional policy which ensures that students have access to the following (AAU Toolkit 2004):

- Health services, instruction, work opportunities, training, financial support;
- Information on prevention, treatment , care
- Academic and psycho-social; and
- Protection (Confidentiality, non-discrimination, equity and gender sensitivity).

There should be staff and student involvement in the development of programmes to provide the needed services to students. Some of the common programme options outlined in the AAU Toolkit include:

- Voluntary Counselling and Testing
- Guidance and Counseling
- Referral services
- AIDS clubs
- Peer Educators
- Contraceptive services.

g) Resource Mobilization for HIV/AIDS Programmes

The successful implementation and achievement of the objectives of a comprehensive HIV/AIDS prevention, education, treatment, support and care plan depends on the availability of resources and commitment. Teacher training colleges need to be innovative and aggressive in their resource mobilization strategies. They should look beyond their internal budgetary provisions to their external environments (local and international), for example CBOs, NGOS, bilateral and multilateral donors, development partners, etc.

Prioritization of needs and activities is crucial in the bid to use resources judiciously, efficiently and effectively. Prioritization brings into greater focus the fact that HIV/AIDS is a crosscutting issue that requires simultaneous action on several fronts. The use of local materials and human resources at the level of the college and immediate community as well as existing social capital could be some of the innovative ways of promoting participatory community-based initiatives and at the same time complementing the resources provided by external donors and the government.

h) Development of Monitoring and Reporting System for HIV/AIDS Programmes

It is imperative for the teacher training college to demonstrate whether or not its HIV/AIDS programmes are yielding the desired outcomes and impacts. The complexity of HIV/AIDS interventions requires detailed and refined monitoring and evaluation at inter- and intra college levels, particularly for crosscutting issues such as policy, resource mobilization and utilization, programme design and implementation. Against this background, the colleges need to develop a system that will enable them document HIV/AIDS activities, collect and analyze data to determine the extent to which they are achieving their stated HIV/AIDS objectives.

The key factors to consider in the development of a monitoring and evaluation system should include, but not limited to, the development of performance indicators that are:

- Useable;
- Realistic; and
- Dependant on the type of change expected to be achieved.

The indicators should include both quantitative or process target/measures and indicators (that measure numbers) and qualitative targets and indicators (that measure quality of output or impact). The framework for developing indicators and on-going monitoring should be developed in collaboration with key stakeholders/partners. Most national HIV/AIDS strategic frameworks provide guidelines for the development of indicators of performance in relation to the overall national target of reducing HIV/AIDS among the ages of 15-49 years under the following areas and these could serve as a guide to training colleges:

- Culture and HIV/AIDS
- Prevention of HIV transmission
- Youth, social change and HIV/AIDS
- Socio-economic status and HIV/AIDS
- Despair and hopelessness and HIV/AIDS
- HIV/AIDS management
- HIV/AIDS and orphans, widows and widowers
- HIV/AIDS information, education, and communication; and
- Voluntary counseling and testing.

It is important to take into consideration the human resource as well as hard and soft ware requirement for effective and efficient management. The human resource training needs should be analyzed to develop the appropriate training programmes to bridge skill and knowledge gaps for effective and efficient performance.

The types of reports/ information to be generated periodically should be determined. Also, efforts should be made at ensuring that the information is reliable, timely, user-friendly and secured in terms of integrity.

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Annex 2

Country-specific Estimates of HIV/AIDS in Sub-Saharan Africa as at End of 2003

Country	Estimated number of people living with HIV					
	Adults and children, end 2003		Adults and children, end 2001		Adults (15–49), end 2003	
	Estimate	[Low estimate - high estimate]	Estimate	[Low estimate - high estimate]	Estimate	[Low estimate - high estimate]
Global Total	37,800,000	[34,600,000 - 42,300,000]	34,900,000	[32,000,000 - 39,000,000]	35,700,000	[32,700,000 - 39,800,000]
Sub-Saharan Africa	25,000,000	[23,100,000 - 27,900,000]	23,800,000	[22,000,000 - 26,600,000]	23,100,000	[21,400,000 - 25,700,000]
Angola	240,000	[97,000 - 600,000]	220,000	[86,000 - 550,000]	220,000	[88,000 - 540,000]
Benin	68,000	[38,000 - 120,000]	65,000	[36,000 - 110,000]	62,000	[35,000 - 110,000]
Botswana *	350,000	[330,000 - 380,000]	350,000	[330,000 - 380,000]	330,000	[310,000 - 340,000]
Burkina Faso *	300,000	[190,000 - 470,000]	280,000	[180,000 - 440,000]	270,000	[170,000 - 420,000]
Burundi	250,000	[170,000 - 370,000]	240,000	[160,000 - 360,000]	220,000	[150,000 - 320,000]
Cameroon *	560,000	[390,000 - 810,000]	530,000	[370,000 - 770,000]	520,000	[360,000 - 740,000]
Central African Republic	260,000	[160,000 - 410,000]	250,000	[150,000 - 400,000]	240,000	[150,000 - 380,000]
Chad	200,000	[130,000 - 300,000]	190,000	[120,000 - 290,000]	180,000	[120,000 - 270,000]
Comoros	...	...	...	...	...	...
Congo	90,000	[39,000 - 200,000]	90,000	[39,000 - 200,000]	80,000	[34,000 - 180,000]

Côte d'Ivoire	570,000	[390,000 - 820,000]	510,000	[350,000 - 740,000]	530,000	[370,000 - 750,000]
Dem. Republic of Congo **	1,100,000	[450,000 - 2,600,000]	1,100,000	[430,000 - 2,500,000]	1,000,000	[410,000 - 2,400,000]
Djibouti	9,100	[2,300 - 24,000]	8,100	[2,400 - 23,000]	8,400	[2,100 - 21,000]
Equatorial Guinea	...	...	...	...	...	...
Eritrea	60,000	[21,000 - 170,000]	61,000	[22,000 - 160,000]	55,000	[19,000 - 150,000]
Ethiopia	1,500,000	[950,000 - 2,300,000]	1,300,000	[820,000 - 2,000,000]	1,400,000	[890,000 - 2,100,000]
Gabon	48,000	[24,000 - 91,000]	39,000	[19,000 - 78,000]	45,000	[23,000 - 86,000]
Gambia	6,800	[1,800 - 24,000]	6,700	[1,800 - 24,000]	6,300	[1,700 - 23,000]
Ghana *	350,000	[210,000 - 560,000]	330,000	[200,000 - 540,000]	320,000	[200,000 - 520,000]
Guinea *	140,000	[51,000 - 360,000]	110,000	[40,000 - 310,000]	130,000	[48,000 - 330,000]
Guinea-Bissau	...	...	...	...	...	...
Kenya	1,200,000	[820,000 - 1,700,000]	1,300,000	[890,000 - 1,800,000]	1,100,000	[760,000 - 1,600,000]
Lesotho *	320,000	[290,000 - 360,000]	320,000	[290,000 - 360,000]	300,000	[270,000 - 330,000]
Liberia	100,000	[47,000 - 220,000]	86,000	[37,000 - 190,000]	96,000	[44,000 - 200,000]
Madagascar	140,000	[68,000 - 250,000]	100,000	[50,000 - 180,000]	130,000	[66,000 - 220,000]
Malawi *	900,000	[700,000 - 1,100,000]	850,000	[660,000 - 1,100,000]	810,000	[650,000 - 1,000,000]
Mali	140,000	[44,000 - 420,000]	130,000	[40,000 - 390,000]	120,000	[40,000 - 380,000]
Mauritania	9,500	[4,500 - 17,000]	6,300	[3,000 - 11,000]	8,900	[4,400 - 15,000]
Mauritius	...	...	...	...	...	...

Mozambique	1,300,000	[980,000 - 1,700,000]	1,200,000	[930,000 - 1,600,000]	1,200,000	[910,000 - 1,500,000]
Namibia	210,000	[180,000 - 250,000]	200,000	[170,000 - 230,000]	200,000	[170,000 - 230,000]
Niger	70,000	[36,000 - 130,000]	56,000	[28,000 - 110,000]	64,000	[34,000 - 120,000]
Nigeria	3,600,000	[2,400,000 - 5,400,000]	3,400,000	[2,200,000 - 5,000,000]	3,300,000	[2,200,000 - 4,900,000]
Rwanda *	250,000	[170,000 - 380,000]	240,000	[160,000 - 360,000]	230,000	[150,000 - 350,000]
Senegal *	44,000	[22,000 - 89,000]	40,000	[20,000 - 81,000]	41,000	[21,000 - 83,000]
Sierra Leone	...	...	...	...	...	...
Somalia	...	...	...	...	...	...
S/Africa *	5,300,000	[4,500,000 - 6,200,000]	5,000,000	[4,200,000 - 5,900,000]	5,100,000	[4,300,000 - 5,900,000]
Swaziland **	220,000	[210,000 - 230,000]	210,000	[190,000 - 220,000]	200,000	[190,000 - 210,000]
Togo	110,000	[67,000 - 170,000]	100,000	[65,000 - 160,000]	96,000	[61,000 - 150,000]
Uganda *	530,000	[350,000 - 880,000]	620,000	[420,000 - 980,000]	450,000	[300,000 - 730,000]
U/td Rep. of Tanzania *	1,600,000	[1,200,000 - 2,300,000]	1,600,000	[1,100,000 - 2,200,000]	1,500,000	[1,100,000 - 2,000,000]
Zambia	920,000	[730,000 - 1,100,000]	890,000	[710,000 - 1,100,000]	830,000	[680,000 - 1,000,000]
Zimbabwe	1,800,000	[1,500,000 - 2,000,000]	1,700,000	[1,500,000 - 2,000,000]	1,600,000	[1,400,000 - 1,900,000]

Source: 2004 Report on the Global AIDS Epidemic

Annex 3

Teacher Training Institutions Involved in the Survey

BENIN

1. Ecole Normale des Instituteurs (ENI) de Natitingon
2. Ecole Normale Supérieure (ENS) de Porto Novo
3. Institut National de la Jeunesse, de l'Éducation Physique et des Sports (INJEPS)

BURKINA FASO

4. Ecole Nationale des Enseignants du Primaire (ENEP) - Bobo Dioulasso
5. Ecole Nationale des Enseignants du Primaire (ENEP) - Fada Ngourma
6. Ecole Nationale des Enseignants du Primaire (ENEP) - Gaoua
7. Ecole Nationale des Enseignants du Primaire (ENEP) - Loubila
8. Ecole Nationale des Enseignants du Primaire (ENEP) - Ouahigouya

BURUNDI

9. Lycée Don Bosco College
10. Lycée de Kirembe- Sud
11. Lycée Monseigneur Joachim Ruhuna de Muyaga
12. Lycée Notre Dame de la Sagesse
13. Lycée Pédagogique de Ngagara
14. Lycée Sainte Marie Immaculée de Buhonga
15. Lycée Sainte Thérèse
16. Lycée Scheppers de Nyakabiga

CAMEROON

17. ENIEG Batouri
18. ENIEG d'Abong-Mbang
19. ENIEG de Bamemba
20. ENIEG de Bertona
21. ENIEG de Deido
22. ENIEG de Dschang
23. ENSET Douala

CONGO

24. Ecole Normale des Instituteurs (ENI)
25. Ecole Normale Supérieure (ENS)
26. ISEPS – Brazzaville-
27. COTE D'IVOIRE
28. CAFOP Abengourou
29. CAFOP -Abidjan
30. CAFOP -Aboisso
31. CAFOP –Dabou
32. CAFOP – Grand Bassam
33. CAFOP -Supérieur de Yamoussokro
34. CFPEN

GAMBIA

35. Gambia College
36. Gambia College – Brikama Campus

GHANA

37. Abetifi Presby Training College
38. Ada Training College
39. Agogo Presbyterian Training College
40. Akatsi Training College
41. Akrokerri Training College
42. Atebubu Training College
43. Bagabaga Training College
44. Berekum Training College
45. Dambai Training College
46. Enchi Training College
47. E.P Training College, Bimbilla
48. E.P Training College-Amedzofe
49. Fosu Training College
50. Gbewaa Training College
51. Jasikan Teachers' Training College
52. Kibi Presby Training College
53. Komenda College
54. Mampong Technical Training College
55. N.J Ahmadiyya Muslim Teachers' Training College
56. OLA Training College
57. Peki Government Training College
58. Presbyterian Training College
59. Presbyterian Women's Training College

60. St Francis Training College
61. St. John Bosco Training College
62. St. Joseph's Training College
63. St Monica's Training College
64. St Teresa's Training College
65. Tamale Training College
66. Tumu Training College
67. Wesley College
68. Wiawso Training College

GUINEA BISSAU

69. ENAL - Bolama
70. Ecole Normale Supérieure (ENS) de Tchico Te
71. 17 Fevereiro

KENYA

72. Egoji Teachers' Training College
73. Kericho Teachers' College
74. Machakos Teachers' Training College
75. Moi Teachers' Training College
76. Mombasa Polytechnic
77. Narok Teachers' Training College
78. Shanzu Teachers' Training College
79. St. Marks Teachers' Training College (Kigali)
80. Tambach Teachers' Training College
81. Thogoto Teachers' Training College

MALI

82. Institut de Formation des Maîtres (IFM) – Bakary Thiero de Niono- Public
83. Institut de Formation des Maîtres (IFM) – Djimé Diallo de Kangaba- Public
84. Institut de Formation des Maîtres (IFM) – Ousmane Balomo Maiga de Bougouni- Public.
85. MOZAMBIQUE
86. Centro de Formação de Professores Primários - Namaacha
87. Escola de Professores do Futuro– Nhamatanda
88. Instituto do Majestério Primário, Chibututuine (IMAP) - Manhiça
89. Instituto do Majestério Primário, Matola (IMAP)
90. Instituto do Majestério Primário, Inhamítua (IMAPI) - Beira
91. Instituto Nacional de Educação de Adultos– (INEA)

NIGER

- 92. Ecole Normale Bawa Jangorzo
- 93. Ecole Normale Kaocen
- 94. Ecole Normale Mali Bero/Dosso
- 95. Ecole Normale – Tanimoune

NIGERIA

- 96. College of Education (COE) – Ekiadolor
- 97. College of Education – Gindiri
- 98. College of Education – Minna
- 99. Federal College of Education – Akoka
- 100. Federal College of Education – Albor
- 101. Federal College of Education – Asaba, Delta State
- 102. Federal College of Education (Tech) – Gombe
- 103. Federal College of Education – Kano
- 104. Federal College of Education – Okene –
- 105. Federal College of Education – Pankshin
- 106. Federal College of Education – Umunze
- 107. Federal College of Education – Yola
- 108. Federal College of Education – Zaria
- 109. E.C.O.E. – Enugu
- 110. Kaduna State College of Education – Ankda
- 111. Kaduna State College of Education – Gidan Waya
- 112. Nasarawa State College of Education – Akwanga
- 113. Nwafor Orizu College of Education – Nsugbe
- 114. SENEGAL
- 115. CEF – Thiaroye Sur Mer
- 116. Ecole Normale Supérieure (ENS) – Dakar
- 117. EFI Diouna Alboury Ndiaye Low
- 118. EFI of Ziguinchor
- 119. ENFEFS – Dakar
- 120. NSEPS – Dakar

SIERRA LEONE

- 121. Bo Teachers' College
- 122. Eastern Polytechnic
- 123. Freetown Teachers' College
- 124. Makeni Teachers' College
- 125. Milton Margai College of Education & Technology
- 126. Port Loko Teachers' College

TANZANIA

127. Klerruu Teachers' College
128. Marangu Teachers' College
129. Monduli Teachers' College
130. Tukuyu

TOGO

131. Ecole Normale des Instituteurs (ENI) de Kara
132. Ecole Normale des Instituteurs (ENI) de Notsè
133. Ecole Normale Supérieure (ENS) d'Atakpamé

UGANDA

134. Arua Primary Teachers' College
135. Bishop Willis Core Primary Teachers' College
136. Bulera Core - Primary Teachers' College
137. Busuubizi Core Primary Teachers' College
138. Canon Apolo Primary Teachers College F/Portal
139. Canon Lawrence Primary Teachers' Training College
140. Gaba Primary Teachers' College
141. Gulu Core Primary Teachers' College
142. Jinga Primary Teachers' College
143. Kabwangazi Primary Teachers' College
144. Kaliro
145. Kamurasi Primary Teachers' College
146. Kapchorwa Primary Teachers' College
147. Kibuli Core Primary Teachers' College
148. National Training College – Kabale
149. National Training College – Kakoba
150. National Teachers' College – Mubende
151. Ndegeya Core - Primary Teachers' College
152. Ndegeya Primary Teachers' College
153. Nyondo Teachers' College
154. Shimoni Primary Teachers' College
155. Soroti Teachers' Training College
156. St Aloysius Primary Teachers' College – Ngora
157. St John Bosco Primary Teachers' College - Lodonga
158. St John Bosco Primary Teachers' College - Nyondo
159. National Training College – Nkozi-

ZAMBIA

- 160. Charles Lwanga College of Education
- 161. Copper Belt Teachers' Training College
- 162. David Livingstone College of Education
- 163. Kitwe College of Education
- 164. Malcolm Moffat College
- 165. Mufulira College of Education
- 166. National In-Service Training College
- 167. Nkrumah College of Education
- 168. Solwezi Teachers' Training College-

ZIMBABWE

- 169. Belvedere Technical Teachers' College
- 170. Hillside Teachers' College
- 171. Morgan Zintec

CHAPTER THREE

Response of Polytechnics in Africa to HIV/AIDS

*Cecilia N. Ogulla, Wilfred N. Gichuki, Pascal Chewe,
George Afeti, and William Rwambulla*

1. Introduction

At the United Nations General Assembly Special Session (UNGASS, 2001), the Heads of State and Governments expressed deep concern on the global HIV/AIDS epidemic: its scale and impact on the youth and the communities in general. They also noted with profound concern that Africa, in particular Sub-Saharan Africa, is currently the worst affected region, with HIV/AIDS considered as an epidemic which threatens development, social cohesion, political stability, food security and life expectancy.

The Working Group on Higher Education (WGHE) of the Association for Development of Education in Africa (ADEA) too has had a lot of concern about the youth in the Polytechnics and Universities in Africa due to their vulnerability and risk to HIV/AIDS. As a result, several studies have been commissioned to survey the response of African Universities and Teacher Training Colleges to the threat of HIV/AIDS epidemic.

One such study undertaken by Kelly (2001) titled “Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV/AIDS”, (March 2001) sought information from universities on their response to HIV/AIDS. One main observation made by Kelly was that there is a deafening silence surrounding the HIV/AIDS in the universities. In his other study, “The Response of Information Technology to the Challenge of HIV/AIDS in Higher Education Institutions in Africa” (November 2001), Kelly observed that African universities need to exchange research results on HIV/AIDS using the information technology highway.

The WGHE and ADEA also provided funds to several institutions, including Mombasa Polytechnic (2003) and Highridge Teachers College (2003), to develop institutional policies on HIV/AIDS. The policies which were developed show the activities the colleges will

undertake and the action plans envisaged for the prevention, control, care and treatment of HIV/AIDS in the respective colleges.

Out of similar concern, WGHE of ADEA has commissioned this survey on the "Response of Polytechnics in Africa to the threat of HIV/AIDS pandemic".

1.1 Objectives of the Study

The main objective of the survey was to assess the level of response by the polytechnics in Africa to the threat of HIV/AIDS. The specific objectives included:

- To ascertain whether the polytechnics have developed HIV/AIDS policy or guidelines and whether they have translated the policy into actions and programmes to address the pandemic;
- Establish the extent to which the policy implementation integrates and mainstreams HIV/AIDS programmes into polytechnic curricula;
- Assess the level of monitoring and evaluation of HIV/AIDS programme and the extent to which polytechnics share information in partnership with other HIV/AIDS education providers;
- Assess the degree of commitment by the polytechnic leadership to the reduction of HIV/AIDS prevalence and identify the challenges faced.

1.2 Justification for the Study

The available statistics show that there is still an upward progression in the prevalence of HIV infection in many African countries and yet there is a tremendous world-wide campaign to contain the pandemic. The upward trend in the prevalence rate in itself is a clear indication that a lot more has to be done, and that on the whole, many people are either still ignorant about HIV/AIDS or are just adamant and not yet prepared for behavioral change.

The grip of the epidemic on Africa and in particular, Sub-Sahara African countries (SSA) raises concern in everybody. Studies indicate that even if the situation improves, the effects of the epidemic will remain for a long time especially in the education sector.

It is also believed that the situation is likely to grow even worse before some improvements can be registered. And yet in Sub-Saharan Africa, the prevalence rate is still on the increase. Already the disease has claimed 25 million people and 40 million others are currently infected. At the end of 2001, the infection rate for adults in their productive years, those aged between 15 and 49, was 8.9 per cent for Sub-Saharan Africa and only 0.4% for the rest of the world. Still, in terms of the world population, Sub-Saharan Africa accounts for 10.4%. By the end of 2003, UNAIDS estimates put the figure of people living with HIV/AIDS at 26.6 million (UNAIDS 2004).

In Sub-Saharan Africa, the epidemic has reduced the average life expectancy from an estimated 62 years to a mere 45 years, and in some countries like Botswana, Malawi, Mozambique and Swaziland, the average life expectancy has been reduced to 40 years (UNAIDS 2004). The disease continues to expand relentlessly, destroying people's lives and damaging the fabric of society despite the many efforts being put in place to control the spread. In addition, HIV/AIDS has increased poverty levels and undermined the very foundations of progress, by reversing the developmental gains registered over decades. This has impacted heavily on the ranks of professionals and skilled labour force, with some countries losing as much as 25% of their personnel (ICAD 2002)

The polytechnics in Africa have not been spared by the pandemic. It is against this background that staff and students in the polytechnics understand and are informed about HIV infection, prevention strategies, voluntary counseling and testing, care and treatment. In order to realize these objectives, the polytechnics have to create and promote an enabling environment that is conducive to all, including those living with HIV/AIDS, and to advocate for their rights.

There may be limited information, but there is enough evidence to show that teachers are falling ill and others are dying because of the epidemic. The discovery of anti-retroviral therapy has given hope to many people living with HIV/AIDS by prolonging life. However, in Africa, access to HIV/AIDS treatment is on one hand a costly service

and on the other, still hampered by the stigma and discrimination that surround people living with HIV/AIDS. The challenge is to address stigmatization and discrimination within the institutions and to ensure that preventive methods against the pandemic take the center stage within the institutional programmes.

With the needed political will and support by African governments, polytechnics in Africa can put in place strategies and programmes initiated to combat the pandemic. These structures, programmes and strategies can form the basis for an institutional policy framework on HIV/AIDS.

1.3 Conceptual Framework

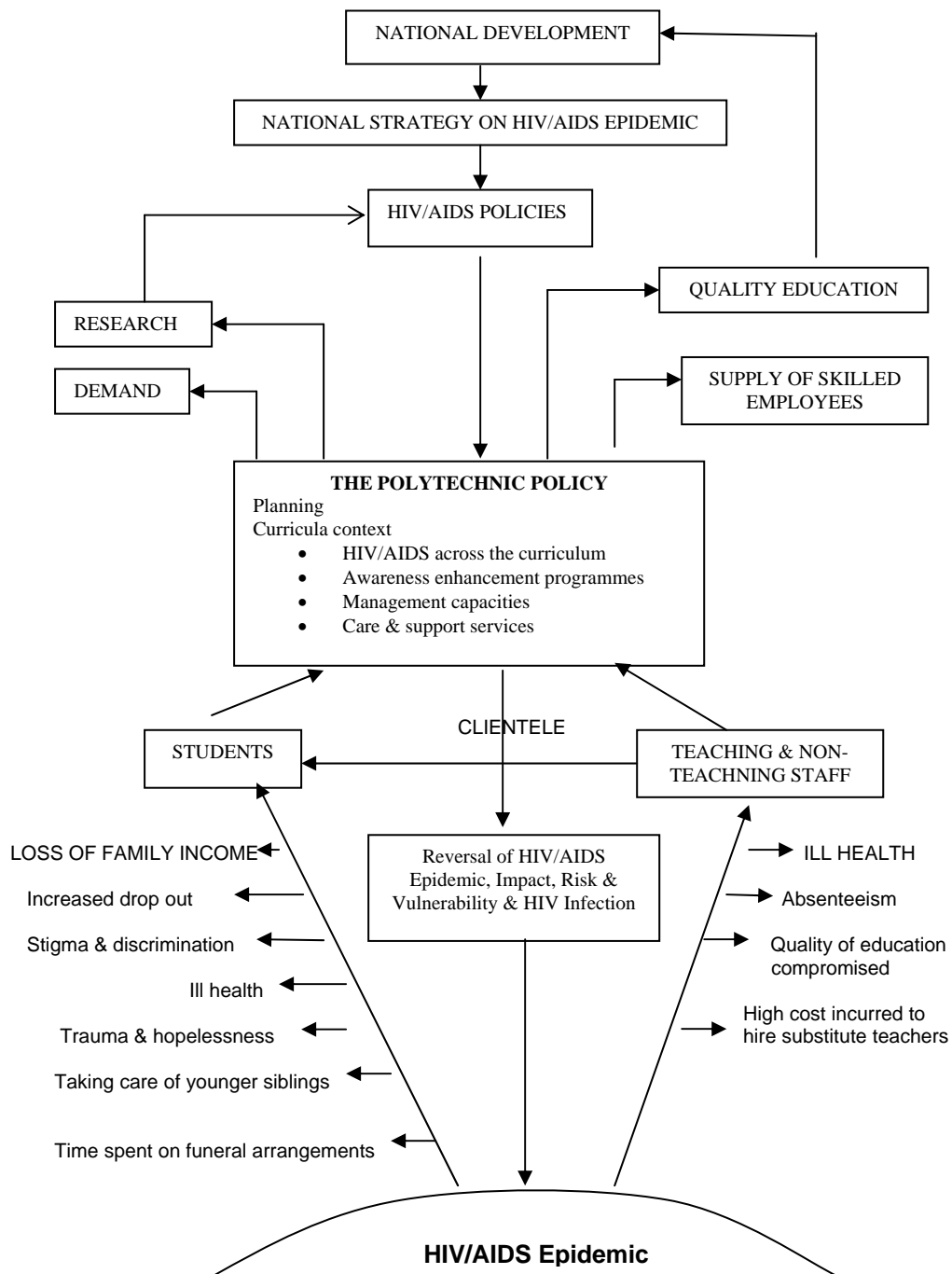
By putting into place institutional policies, integrating HIV/AIDS into curricula, developing and implementing awareness programmes for their constituents and communities, conducting research, forming partnerships and funding HIV/AIDS initiatives in their respective institutions, the polytechnics in Africa can not only sustain quality education, supply and demand of education but can also reverse the impact of HIV/AIDS and revive national development (See Fig. 1).

If the world's response to AIDS continues in its well intended but in a haphazard and ineffectual fashion then AIDS will continue to outrun efforts to stop it. In the past, responses to the HIV/AIDS epidemic have too often been piece-meal and small scale, health-oriented and weakly integrated into related efforts (World Bank 2002; UNAIDS 2004).

1.4 Africa's Response to HIV/AIDS

Faced with eminent devastation, many African countries have made AIDS a priority. National strategic plans against AIDS are in place. Despite their effort to have met the UN Declaration goals by 2005, they have not achieved their targets on protection of vulnerable groups and the provision of care to those infected (UNAIDS 2003).

Figure 1. Conceptual framework for polytechnics' response to threat of HIV/AIDS



Speaking about the crisis posed by HIV/AIDS in Africa, former President Nelson Mandela stressed that HIV/AIDS is preventable despite its devastating nature. He said: "I am shocked to learn that one in two, that is half of our young people will die of AIDS. The most frightening thing is that all these infections which statistics tell us about *were preventable*" (School Health Situational Analysis, July 2000).

According to statistics, young people aged 15 – 24 account for half of all new HIV infections and are getting infected at the rate of 6000 – 7000 everyday. The future trajectory of the epidemic, therefore, will mainly depend on how well we empower young people to protect themselves against HIV infections (UNESCO 2004).

At the XIII International AIDS Conference in Durban, July 2000, the delegates saw that there was every reason for governments to invest in HIV prevention. As a follow up, African leaders at the Abuja Declaration re-affirmed their fight against the epidemic through personal commitment and through investing more resources, including a commitment to allocate 15% of the government budget to the health sector.

1.5 Polytechnics' Response to HIV/AIDS

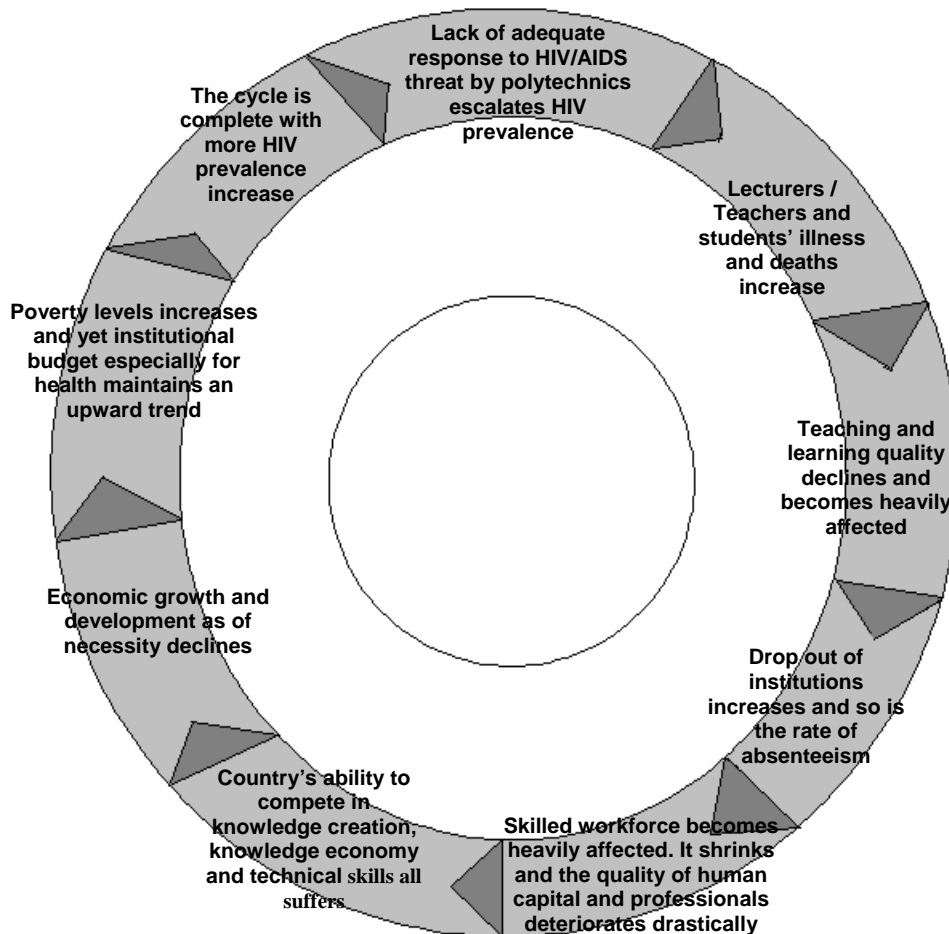
The polytechnics have a major share in the development of human capital. They train millions of people to become highly skilled employees and successful entrepreneurs to meet the needs of an ever changing world. It is the work of these important institutions that future economic progress will depend on.

It is evident that the polytechnic sector is important in driving countries towards achieving the Millennium Development Goals of eradicating extreme poverty and hunger by 2015. To achieve this goal, countries will be required to reduce by half the proportion of people living on less than a dollar a day and those who suffer from hunger.

These goals are unlikely to be met due to HIV/AIDS. "Not only does it mean that development goals will be unattainable, but in fact there may be a reversal in the development of many nations and development cannot be business as usual. Nowhere is this more the case than in the education sector," say Badcock-Walters and Whiteside (1999). If there is no immediate response by the polytechnics to the pandemic,

then there will be a vicious cycle of HIV/AIDS and education, as shown in Fig. 2.

Figure 2. HIV/AIDS and technical education in a vicious cycle



Source: "A window of hope" (World Bank 2002) (improved version)

Polytechnic institutions in Africa therefore have a critical role in training professionals to fight against and mitigate the effects of HIV / AIDS within the institution and surrounding communities.

1.6 HIV/AIDS' Impact on Teaching Staff and Students

A report by the World Bank entitled "Education and HIV/AIDS: A Window of Hope" says that the disease is killing teachers faster than they can be trained and is rapidly orphaning a large number of students, a phenomenon that threatens to derail the very foundation of the education system, including the millennium development goals, to achieve universal primary education by 2015.

According to the report, nearly a third of all teachers in parts of Uganda and Malawi carry the HIV virus. In Zambia, teacher deaths rose from 680 in 1996 to 1,300 in the first 10 months of 1998. In Central African Republic, 85% of 340 teachers who died between 1996 and 1998 had HIV. In Southern Africa, it is believed that teachers have a higher rate of HIV infection than the general population.

In Kenya, an average of 18 teachers die from AIDS-related diseases every month (*Daily Nation*, October 29, 2001). At this rate, it means that 6,570 teachers die annually. From a training perspective, teacher training colleges and universities cannot cope with that kind of attrition rate over the long term, the effect on the economy notwithstanding.

The World Bank Report further says that the disease is also emptying classrooms of students as young people are infected or orphaned by the disease and are forced to leave school to care for their younger siblings.

Young people, especially young women, are particularly at risk from HIV/AIDS. Statistics from all over the world corroborate young people's vulnerability to HIV infections. In Eastern and Southern Africa sub-region, about half of those who become infected with HIV are between the ages of 15 and 24 (ICAD 2002), when they should be in secondary schools or in tertiary colleges. At secondary or tertiary levels of education, students' attendance and enrolment is bound to be adversely affected by HIV/AIDS as a result of:

- Loss of family income from AIDS-related illness and death, as well as costs of care and funerals;

- Increased drop-out rates as young people are required to care for sick family members and generate income;
- Damage to extended family and community structures and consequent loss of the traditional “safety net”;
- Trauma arising from illness and death;
- Stigma and discrimination suffered by students as a result of their HIV status or HIV/AIDS in the family;
- The perception that investment in education is not worthwhile given the growing prospect of premature mortality.

1.7 HIV/AIDS and Quality Education

The education sector is by far the largest employer of public service staff engaged in the delivery of quality education. Other than the teaching staff, there are teacher trainers, college and university lecturers, education officers, inspectors, planners and managers. All these key players in the supply of education are equally impacted on by HIV/AIDS just as the teachers are.

When HIV/AIDS takes its toll, the productivity of the education is severely compromised. According to the World Bank (2002) and UNAIDS Report (2004) HIV/AIDS leads to high rate of teacher absenteeism, and these teachers are often not replaced. In some cases, much of the time is spent on attending funerals of their departed colleagues or friends.

It is against this background that the education sectors need to re-evaluate their roles in bringing the epidemic down. The World Bank is urging countries to curb HIV/AIDS through the classroom. It suggests that education ministries design a broad strategy response rooted in education and set within a national and multi-sectoral context.

The educational approach to curb HIV/AIDS is hinged on three areas: policy, supply and quality, and demand and access, where national governments and their education ministries can make a decisive impact in using education to prevent the further spread of HIV/AIDS.

This in turn could protect children and teachers from infection. According to UNESCO (2004), when students are involved in designing HIV/AIDS education programme, they are likely to stick to their own rules for prevention of HIV infections. Similarly when teachers are involved in disseminating HIV information on prevention they are likely to practice what they teach.

UNESCO (2004) suggests five core tasks necessary for comprehensive prevention. These are:

- a) Advocacy
- b) Customizing the message
- c) Changing risk behaviour
- d) Caring for the infected
- e) Coping with the institutional impact of HIV/AIDS.

The polytechnics in Africa can adequately respond to all these challenges. Owing to large numbers of people who are either working or studying at these institutions, the polytechnics can disseminate HIV/AIDS information to very many people. Through individual staff and students, their families, communities, regions and nations, polytechnics can thus reach many people in ways that no other organizations can do.

1.8 Mainstreaming HIV/AIDS into the Curriculum

The polytechnics have the capacity to customize the message or mainstream HIV/AIDS into the curriculum. They have access to a rich reservoir of information drawn from various disciplines. They have extra advantage of their experience in curriculum development, capacity building, planning and monitoring of educational output. They are, therefore, better placed to customize HIV/AIDS messages to their students for better understanding and future implementation of HIV/AIDS programmes at workplaces.

The other tasks which involve, changing risk behaviour, caring for the infected and coping with institutional impact on HIV/AIDS, are so interrelated that reducing vulnerability to HIV infection is fundamental to reversing the spread of the virus. Decreasing the risk of infection slows down the epidemic. Decreasing vulnerability, decreases the risk of infection and the impact of the epidemic. Decreasing the impact of the epidemic, decreases vulnerability to HIV/AIDS. This positive cycle of

simultaneously reducing risk, vulnerability and impact can well be handled by educational institutions such as the polytechnics, which largely handle the young, the category at greatest risk of becoming infected with HIV (UNAIDS 2003 and 2004).

2. METHODOLOGY

2.1 Study Instrument

The study aimed to collect data from a cross-section of polytechnics in Africa. The study intended to cover polytechnics in the Anglophone, Francophone and Lusophone countries in the Sub-Saharan Africa.

A questionnaire was developed to measure levels of participation, practices, attitudes and commitment by the polytechnics towards the response to the threat of HIV/AIDS. The designed questionnaire was structured to cover the following four broad areas:

- a) information on institutional data such as institution's staff and student population and their gender distribution;
- b) information on institutional policy on HIV/AIDS;
- c) issues related to HIV/AIDS policy implementation;
- d) issues of monitoring and evaluation.

The survey sought to bring out the following issues:

- a) Whether the institutions collect and keep records of data on HIV/AIDS;
- b) Who is responsible for data collection and record keeping and for what purpose;
- c) What strengths, weaknesses, opportunities and threats the institutions have identified in their response to HIV/AIDS;
- d) What challenges the institutions face in their effort to respond to HIV/AIDS.

2.2 Data Collection

The study sought data from one hundred polytechnics in the Anglophone and Francophone countries of Africa. The Lusophone countries in Africa could not be reached due to translation problems.

Every effort was made to have responses from the Francophone polytechnic institutions, but no single questionnaire was returned. Similar efforts were made to reach the South Africa Technikons without success either. The reason given was that the Technikons were in the process of becoming Universities of Technology through mergers and as such, nobody took the responsibility to respond to the questionnaire. There were also similar cases in other countries where institutions failed to respond to the questionnaire despite constant reminders by e-mails and through telephone calls.

The responses received were from Anglophone countries of Sierra Leone, Ghana and Nigeria in the Western sub-region; Kenya, Uganda and Tanzania in the Eastern sub-region; and Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe in the Southern sub-region. In all forty institutions (see Annex 4 for institutions covered) responded fully to the questionnaire.

The distribution of institutions that covered the Western, Eastern and Southern sub-regions of African countries, gave a wide coverage, a good comparative perspective and a better understanding of how polytechnics in each sub-region respond to HIV/AIDS epidemic.

A few institutions were selected (not randomly though) for an in-depth study through structured direct interviews and with the help of survey assistants. Those reached through direct interviews were Ho Polytechnic – Ghana, Federal Polytechnic Bida – Nigeria, Kenya Polytechnic – Kenya, Uganda Polytechnic Kyambogo – Uganda and Technical and Vocational Teachers College – Luanshya – Zambia. The rest of the polytechnics were reached by post and e-mail.

3. THE FINDINGS

The findings were based on responses received from forty institutions drawn from Western, Eastern and Southern Africa sub-regions. The responses received were encouraging as they came from senior members of staff at the levels of Directors of institutional medical

services units, Registrars, Deputy Principals and from Institutional Heads themselves. The information given, is therefore, assumed to be reliable and credible.

The institutional data showed that polytechnics in Africa handle large populations of staff and students but with an imbalanced gender distribution, as shown in table 1. For example, Kaduna Polytechnic in Nigeria has a population of 32,000 students while Federal Polytechnic Offa has a student population of 25,368 and a staff of 1,356, males and females. Other institutions also have populations ranging from hundreds to tens of thousands of staff and students.

The women in polytechnics account for 40% of the population while students alone account for 91% of the institutional population.

Table 1. Staff and students population distribution (000)

Region	Total number of staff				Total no. of students	
	Teaching		Non-teaching		M	F
	M	F	M	F		
Southern region (Institutions: 9)	415	183	706	370	6,712	4,657
Eastern region (Institutions: 10)	799	426	911	561	18,459	9,881
Western region (Institutions: 21)	4,146	1,944	7,528	3,985	110,301	76,971
<i>TOTAL</i>	5,360	2,553	9,145	4,916	135,472	91,509

Every year, each polytechnic enrolls a new cohort of young men and women who are in the most vulnerable group. Polytechnic institutions should be the ideal place to respond to HIV/AIDS pandemic, so that those who enter the institutions and those who graduate to the world of work receive the vital information especially on HIV/AIDS prevention and on health care services. This would help the polytechnic community to live responsibly.

3.1 Institutional Policy/Guidelines on HIV/AIDS

One of the objectives of the survey was to establish whether the institutions have policies or guidelines on HIV/AIDS in place, whether these policies/guidelines are being fully implemented and the likely challenges being faced in this process.

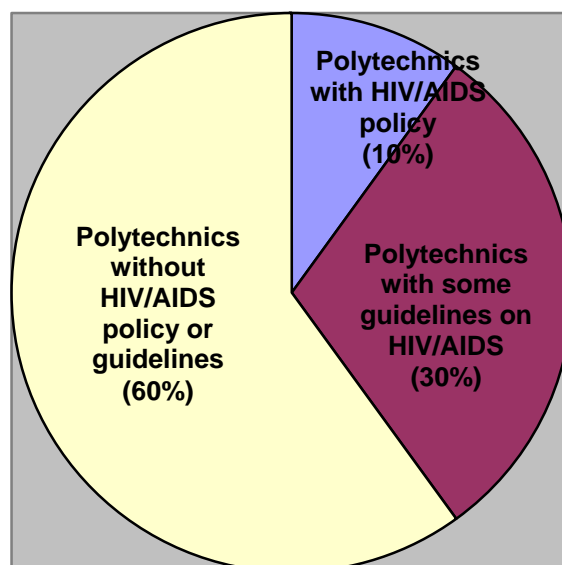
It is quite clear from the findings that most polytechnics in Africa do not have a policy or any guideline on HIV/AIDS. In all the institutions surveyed, only 10% were found to have a policy. Those that have policies in the Southern Africa sub-region include, Zambia Telecommunications College [ZAMTEL], Technical and Vocational Teachers College, Zambia and Kitwe Vocational Training Centre, Zambia.

In Eastern Africa sub-region, it is only Mombasa Polytechnic, Kenya, which has a policy, developed with the financial assistance from the Working Group on Higher Education [WGHE].

In Western Africa sub-region, Milton Margai College of Education and Technology, Sierra Leone and Yaba College of Technology, Lagos - Nigeria, are the only ones with a policy on HIV/AIDS. In the case of Milton Margai College, the policy was developed by a Cabinet sub-committee on HIV/AIDS, together with partners involved in HIV/AIDS within Sierra Leone. The funding for the policy came from the World Bank through UNAIDS.

The institutions that have some guidelines make up to 30%, while 60% stated that they do not have any policy or guidelines on HIV/AIDS (Fig. 3)

Fig. 2: Polytechnics with or without HIV / AIDS policy / guidelines.



Source: Compiled from analyzed data.

What is striking from the study is that some institutions have left the challenges of HIV/AIDS to volunteer individuals, or to some clubs run by students, like the anti-AIDS clubs or Rotaract clubs, but without financial or even moral support from the institutions.

The end result is uncoordinated HIV/AIDS activities and with no clear guidance. The funding of HIV/AIDS policy development or guidelines within polytechnics seems to be an uphill task and varies from institution to institution. Generally, they all reported lack of funds or at least lack of adequate funds for the exercise. Those that get funding identified the source as government through National AIDS Councils or Commissions, Non-governmental Organizations (NGOs) interested in HIV/AIDS, or from donor agencies. The government funding was reported to be inadequate.

It was found that the institutions which have developed policies or guidelines have well laid out preventive strategies. Some of the goals and objectives reported include:

- Control the spread of HIV/AIDS among staff and students including the surrounding communities;
- Educate staff and students on the dangers of HIV/AIDS;
- Mitigate the impact of HIV/AIDS in education and try to eliminate stigmatization;
- Create awareness and reduce risks and factors that promote HIV/AIDS spread and prevalence;
- Influence behaviour change and reduce stigma and discrimination;
- Help communities to know how to avoid the infection and stop further transmission;
- Help communities with information on health care services including the use of ARVs therapy;
- Reduce HIV/AIDS prevalence through the promotion of safer sexual behaviour and safer non-sexual behaviour.

The majority of the institutions, however, indicated that the pandemic is handled through the office of the Dean of students, who organizes seminars and workshops and invites knowledgeable speakers on the topic. Some of the speakers are drawn from hospitals, voluntary counseling and testing [VCT] centers. A few pointed out that students and staff get the necessary information on HIV/AIDS through public media, posters, drama, puppetry and public lectures organized by the National AIDS Commissions or NGOs.

A challenge was posed to those institutions without a policy, on what plans they had to develop one. Various responses were received, some of which conveyed interesting messages such as “*we have not witnessed any epidemic*”, implying that there is no immediate need for a plan to have a policy on the epidemic. Some stated that they were in the process of developing one, while others revealed that they were waiting for the governments to provide the necessary guidelines and funding.

All this shows that the institutional leadership has not taken HIV/AIDS epidemic seriously and lacks initiative to put such plans and policies in place.

The development of HIV/AIDS policy to some institutions, is seen as a hard task to the institutional leadership. There are those that lack the know-how and there are others that are waiting to develop a policy once the funds for this purpose are available. They expect to solicit such funds from collaborators and International Donor Agencies like the World Bank, UNAids and HOPE - Worldwide (HIV/AIDS Prevention Care and Support), which has been very supportive to many polytechnics in Nigeria including Yaba College of Technology. There was no mention of getting such funds from institutions or government budgetary allocation.

This means that most institutions do not consider HIV/AIDS as a problem that requires immediate attention.

3.2 Research as a Tool in the Fight against HIV/AIDS

One of the most effective means of addressing and preventing the spread of HIV/AIDS is through research. Research generates new information and recommends best practices to reduce the pandemic.

Surprisingly, only one institution in Western Africa sub-region – Federation Polytechnic Bida, Nigeria, responded as having conducted research on HIV/AIDS by the medical centre of the polytechnic. Apparently, the research did not reveal the number of HIV/AIDS-related deaths in the institution in the past years. It did not also indicate how helpful the research findings were.

In Eastern Africa sub-region, it is only Mzumbe University which has conducted a research on HIV/AIDS and has shown that there have been some HIV/AIDS-related deaths among teaching staff (2), non-teaching staff (6) and students (3).

In Southern Africa sub-region, only the Polytechnic of Namibia has conducted research on HIV/AIDS through the office of the Dean of Students. Interestingly, no HIV/AIDS-related deaths have been recorded from the research findings.

Though other institutions were unable to conduct research on HIV/AIDS, they indicated their institutions' loss of some members of their staff and students through HIV/AIDS-related deaths.

Research in HIV/AIDS need to be encouraged within polytechnics and the resulting information shared widely as a means of combating the spread of the pandemic.

Table 2. HIV/AIDS-related deaths in the past 5 years within polytechnic institutions

Region	Staff		Students	Total
	Teaching	Non-teaching		
Western (21 Institutions)	4	13	9	26
Eastern (10 Institutions)	15	28	18	61
Southern (9 Institutions)	24	21	33	78
Total	43	62	60	165

Most of the polytechnics concede that they were unable to give figures for HIV/AIDS-related deaths because they have not carried out any research and have not been keeping records on the epidemic. Some respondents gave the impression that they are not aware of any related deaths due to HIV/AIDS.

Quite a number of staff and students die due to HIV/AIDS. However, in the absence of record keeping, the figures indicated in table 3 are likely to be mere estimates and by far on the lower side.

The table, however, supports the claim that there is a tendency of more non-teaching staff dying of HIV/AIDS than the academic staff because of their (non-teaching staff) social status. This claim has to be supported by further research.

3.3 Institutional HIV/AIDS Response Strategy

According to the survey, different polytechnics are using different strategies in the fight against the pandemic.

Twenty-three institutions out of forty or 57.5% have an officer specifically responsible for the implementation of HIV/AIDS within the

institution. The remaining 42.5% do not have any officer or unit responsible for HIV/AIDS programmes.

If the implementation has to take place as required and for the benefit of students and staff, it is necessary for each institution to identify an officer responsible for the co-ordination and implementation of the policy.

The implementing officers are reported to be stationed in different units or sections of the institutions as follows:

- The medical services department of students affairs;
- School of general studies;
- Guidance and counseling unit of the polytechnic;
- Liberal studies/general studies department;
- Human Resources Department.

Others stated that there is no specific unit. They had embarked on the process of establishing committees with the mandate to co-ordinate HIV/AIDS activities and be headed by the office of the Dean of Students.

Five modes of implementation had been proposed for the polytechnics to indicate which ones they use and if none of those, to indicate which other option they use. Some institutions indicated that they were using more than one proposed implementation strategy and others had no programme to implement.

a) Infused or Integrated Program

Three institutions in Western Africa sub-region, namely, Federal Polytechnic Oko, Plateau State Polytechnic Burkin and Milton Margai College of Education and Technology indicated that they were implementing the “*infused*” method. Four other institutions in West Africa were using seminars and workshops as the mode of implementation.

In the Southern Africa sub-region, three out of nine institutions have infused or integrated HIV/AIDS courses within the curriculum.

b) Core Course Programme

Only one institution in Zambia teaches HIV/AIDS as a core course. A few others teach it to first year students only.

c) Other Programmes

Other institutions reported that they were using Peer Education method, sensitization through students' resource centers, seminars and talks to first year students during the orientation week.

d) HIV/AIDS Awareness Strategy among Polytechnic Students

Another strategy used is the briefing to all new students during the orientation week. The orientation week awareness approach to HIV/AIDS seems to be the most favoured method according to the results of the study. The majority of institutions use the orientation week to sensitize students and to some extent staff as well, about HIV/AIDS epidemic.

The orientation week awareness approach can only have an impact if there is a well-organized and articulated orientation programme that is mandatory for all, especially the new students. Such an orientation programme should focus on getting students familiar with HIV-prevention methods and by emphasizing the mode of transmission, care, treatment and where to find health clinics and voluntary counseling and testing centers [VCTs].

A majority of the students, these days, join polytechnics when they have a fair knowledge and good idea about the disease, either from secondary schools, national campaigns, or through the media. Others see sick relatives and believe that AIDS is real. However, according to Kelly (2001), some students do not take such talks about HIV/AIDS during orientation week seriously. "*They take them to be the usual talk*", says Kelly (2001). Even those who listen attentively to the talks about the dangers of HIV/AIDS, and learn where to go in case of need for HIV/AIDS services, such as medical centers where voluntary counseling and testing can be done, or where they can obtain

free information on condom use and other provisions, end up not putting into practice what they hear and learn.

At the polytechnic level, there is also the problem of pressure from peer groups which forces the meek students, into HIV/AIDS high risk activities such as alcohol consumption, drug abuse, casual sex, pornography venturing and interacting with prostitutes, thus forgetting all about the talk.

Educational talks on HIV/AIDS should not be limited to orientation weeks. Polytechnic institutions have to use a multi-dimensional approach. One other way the institutions could use is to occasionally invite people who have trained in HIV/AIDS and/or have openly declared to be HIV-positive, to give talks about the epidemic. Real testimonies have a great impact on the youth.

The more information about HIV/AIDS the students get, the more they are likely to have behavioural change and be in a position to change others.

e) Foundation or Stand-alone Course

None of the institutions is implementing HIV/AIDS as a foundation course, stand-alone or even as elective modules. May be these are not popular programmes with polytechnics. However, whatever mode an institution chooses to use, it must be effective and address every aspect of HIV/AIDS pandemic.

3.4 HIV/AIDS Budgetary Allocation

The funding of HIV/AIDS in all polytechnic institutions was reported to be generally poor.

In Southern Africa sub-region, two out of nine polytechnics have budgetary allocation, which accounts for less than 20%.

In Western Africa sub-region, the situation is similar to other regions in that only two institutions out of 21 or less than 10% have a budgetary allocation for HIV/AIDS.

In Eastern Africa sub-region, out of 10 institutions, only Mzumbe University has a budgetary allocation for HIV/AIDS activities.

3.5 Plans to Create Funds

Many proposals on how to create funds towards the fight against HIV/AIDS were suggested. Thirteen polytechnics out of forty came up with the following proposals on how to solicit funds:

- Through the institution with the support of NGO's;
- From institutional budget and donors;
- To incorporate institutional budget with governments grants;
- Hope to create funds when the budget of the institution improves;
- To solicit funds from National AIDS Commissions and Ministry of Education and Health;
- From institutional production units;
- Requesting funding from government and other sources when the project starts.

4. INSTITUTIONAL MONITORING AND EVALUATION

Monitoring and evaluation of HIV/AIDS is an important undertaking which every institution should endeavour to conduct on a regular basis. It requires the institution to collect data (information) from both staff and students on a regular basis for comparison purposes. That is, to compare the present results with the past so as to gauge the need for improvement or change of strategy.

The survey reveals that in the Western Africa sub-region, two institutions collect HIV/AIDS data on staff and students, while two more collect data only on students.

In Eastern Africa sub-region only Mombasa Polytechnic, Kenya, and Mzumbe University, Tanzania, collect data on HIV/AIDS data from staff and students. In Southern Africa Namibia polytechnic collects data on staff and two other institutions collect data only on students.

The polytechnics need to be encouraged to collect data on HIV/AIDS so as to monitor and establish the prevalence rate and to use such data to advocate for behaviour change. Collected data also provide basic facts for future planning and decision making.

5. INSTITUTIONAL CHALLENGES

The institutions were asked to specify the main challenges in the fight against HIV/AIDS pandemic and they listed some of the following as the main challenges:

- Fear of stigmatization and discrimination;
- Difficulty in change of attitudes due to cultural values and beliefs;
- Lack of funds for the development of an HIV/AIDS Institutional Policy and sustainability of HIV/AIDS programmes;
- Lack of political commitment, skilled and trained personnel to handle HIV/AIDS programmes, and materials for teaching and reading;
- Students' unwillingness to change their sexual behaviour.

Others indicated that there is no challenge yet.

6. RECOMMENDATIONS

Although all polytechnics are concerned about the needs of individuals, staff and students, they still lack institutional response to HIV/AIDS. No evidence from the survey was found to show that the institutions are taking concrete strategies to reduce the risks of infection among students and staff, with the exception of very few. The institutions have been very slow in translating their concern into meaningful action plan, but some have made suggestions for improving their response to HIV/AIDS.

6.1 Institutions' Suggestions for Improvement of Response to HIV/AIDS

The institutions were asked to come up with suggestions for improvement and to give comments on the fight against the pandemic. They suggested that there should be more voluntary counseling and testing centers where staff and students can easily get services including affordable ARVs.

They also emphasized that funds be made available for HIV/AIDS programmes including research and that there is need to train and motivate those professionals involved in HIV/AIDS programmes.

There is also need for capacity building within the polytechnics in HIV/AIDS.

Based on the analysis of the data collected from the polytechnics, the following recommendations are put forward.

6.2 Institutional HIV/AIDS Policy

The main strategic intervention in the fight against the HIV/AIDS epidemic demands that every polytechnic in Africa should have a well developed policy, with well funded programmes for prevention, care for the infected, treatment for the sick and support for the vulnerable.

This arrangement should ensure that staff and students are free from the threat of infection and that those who get infected are properly counselled, supported and treated to ensure they remain active members of the institution's community.

The polytechnic staff and students are at high risk and mechanisms to prevent further spread of HIV need not wait any longer. Those institutions that do not have a policy framework should wake up and take the necessary action.

While developing such a framework, consideration should be given to the following factors:

- Define the goals and main objectives that are measurable and achievable.

- Define institution's position and how it relates to staff and students concerning HIV/AIDS.
- Set standards of behaviour and attitude expected of staff and students towards HIV/AIDS.
- Establish compliance with the National Policy on HIV/AIDS so that students and staff know where to go for services that cannot be provided by the institution.
- Provide information and activities that guide the institution's response to HIV/AIDS.
- Target staff and students in general as the main players in forming opinions, and influencing the behaviour and that of surrounding communities.
- Help to develop information and education programmes that foster greater awareness and understanding of HIV/AIDS related issues.
- Help to provide informed direction for development and implementation strategies that can enhance behaviour change, care and support to those infected and affected by HIV/AIDS.

The policy must also have components to cover:

- Institutional Vision and Mission;
- Institutional principles and values;
- Rights and responsibilities of the infected and affected;
- Provisions for the integration of HIV/AIDS programmes into main activities and curriculum;
- Provisions for implementation of HIV/AIDS programme;
- A system for monitoring and evaluation.

It is only when an institution has a well-planned policy framework that it can effectively respond to the issues pertaining to HIV/AIDS epidemic.

A good policy framework among other things, helps the institution to create an environment that is conducive, supportive and responsive to staff and students and free from stigma and discrimination.

All polytechnic institutions in Africa are, therefore, strongly encouraged to have a policy and exert every effort to fight the epidemic.

6.3 Mainstreaming HIV/AIDS into the Curriculum

Polytechnics need to solicit and provide adequate funding for HIV/AIDS policy development and implementation. The institutions should endeavour to interest the governments, partners and willing donors for policy development and programmes sustainability.

There is a need to mainstream the professional aspects of HIV/AIDS into all the polytechnic programmes.

Even in those few polytechnics where there is a comprehensive policy framework in place, there is no recognition that HIV/AIDS should be integrated into all main activities, so as to reach each and every individual within the institution and the neighbouring communities.

There is no deliberate attempt towards the mainstreaming HIV/AIDS into the institutional curricula, reasons advanced being that they lack resources.

6.4 The Role of Institutional Leadership and HIV/AIDS

Attention by institutional leadership is usually directed towards academics, to ensure that students pass the exams and graduate. The leadership does not realise that HIV/AIDS can have a big negative impact on the quality of education within the institution.

The prime responsibility for mainstreaming HIV/AIDS into all the polytechnic's activities and operations rests entirely with the institutional leadership.

The leadership has the capacity to initiate any policy that can bring about development within the institution, including the capacity to influence governments' support for such policies.

Lack of a policy on HIV/AIDS in an institution is tantamount to lack of commitment by the institutional leadership.

Responding to HIV/AIDS should be everybody's concern but in this case, polytechnics require leadership that is committed to spearhead, manage, control and reduce the spread of the pandemic.

The polytechnic leaders must be at the forefront in the fight against the disease, for without their commitment the battle will be only half won.

6.5 HIV/AIDS Awareness among Students and Staff

The leadership of the polytechnics should ensure that at every opportunity given, students and staff get constant reminders about the threat posed by the epidemic through awareness campaigns.

Polytechnic students and staff seem to be generally aware of the repercussions associated with HIV/AIDS and its mode of transmission, if not from institutions' programmes, then at least from the public mass media.

Almost all students know the problem of HIV/AIDS and can even narrate cases of relatives who have died as a result. According to Kelly (2001), despite this knowledge, the majority of students behave as if the epidemic does not exist and they do not consider themselves as being at high risk of HIV infection.

The awareness campaign may not deter submissive students from yielding to the peer pressure that entices each member to engage in risky activities like alcohol consumption, drug abuse, casual sex and prostitution, all of which can lead to HIV infection. However, the effectiveness of the awareness campaigns lies squarely on repetitive talks by the administration, staff and students and from the public, especially the affected and infected people. The emphasis should be directed towards attitude and behaviour change.

The only way to succeed in the fight against the epidemic is "*Never to give up*", but use a holistic approach.

6.6 Students' Anti-AIDS Clubs

The polytechnic institutions that have students' Anti-AIDS Clubs, as in Hassan Usman Katsina Polytechnic, are commended and encouraged to continually support and facilitate these clubs. Other activities such

as puppetry, drama, and use of posters should also be encouraged. The students' anti-AIDS clubs can do a good job, if properly motivated, to prevent the spread of HIV, especially among fellow students. They can also be effective in community outreach programmes.

Students normally feel at ease when sharing information among the peer group and can form an opportunity for behaviour change.

According to Kelly (2001), no evaluation of the impact of these non-formal associations has yet been undertaken. However, the evidence from secondary schools reveals that they can be powerful channels for HIV/AIDS education.

The fact that young people themselves voluntarily get involved in such programme design and delivery and also speak the kind of language that young people like to hear and understand, is in itself good enough to be encouraged.

These clubs can also be instrumental in the promotion, procurement and distribution of condoms and literature among students as a measure to prevent spread of HIV.

6.7 Young People at High Risk

Polytechnic institutions handle a large population of staff and students. Over 90% of the population are young people who are at high risk of HIV infection.

Polytechnics have a lesson to learn in light of the large number of young people they handle and are at the centre of the risk.

The survey revealed that no one at the polytechnic knows the magnitude of HIV/AIDS infection and prevalence. The only way out is to ensure that proper knowledge and accurate information, which are considered to be the baseline to the defense against the pandemic, are received continuously by every polytechnic student.

Access to AIDS information by itself may not be enough unless accompanied by behaviour change. All the same, HIV/AIDS education is still the most powerful weapon against the epidemic.

When polytechnic youth are given the appropriate tools on HIV/AIDS and the necessary support, they are capable of changing their behaviour and can be powerful behaviour change agents. So let the polytechnics ensure the availability of such tools to every member.

6.8 Breaking the Silence

The fear by the polytechnic institutions to get the root problem of HIV/AIDS out into the open and promote its tackling is no longer acceptable, as it contributes greatly to the suffering of those who experience the disease. Such circumstances make the situation difficult even for those who may be willing to come out publicly about their HIV status.

Failure by the polytechnic institutions to create an enabling environment, inhibits the acceptance and openness about one's HIV-status and instead contributes to the spread of the virus. It limits the opportunity for more information and awareness of the disease both within the institution and the community at large.

Inhibiting information about HIV/AIDS has adverse consequences as people occasionally decide to get alternative information from any other available sources especially those who are infected and affected.

Out of desperation and helplessness, AIDS patients can go anywhere they feel they can get some assistance.

6.9 Myths and Misconceptions about HIV/AIDS

In African societies, the general practice has been that matters to do with health, if the right institutions cannot handle the problem, the patients resort to quack doctors or traditional healers. In case of HIV/AIDS, the quack doctors have gained popularity because of there being no scientific cure for HIV/AIDS at the moment.

Those quacks who claim to have mythical powers or a cure for HIV/AIDS are actually destroyers of the very people they are supposed to heal. They are the agents for the spread of HIV in the name of "*AIDS cleansing rituals*", as one of the prescriptions they recommend to

their clients, is *“Rape a virgin and your health status will immediately transform from HIV-positive to HIV-negative”*.

Such a deceptive method of healing has sent the infected men on sex rampage – raping children and young girls that come their way. Subsequently, cases of rape are on the increase everywhere in Africa.

Ignorance about HIV/AIDS has created a lot of damage to society as none of such infected men can claim to have been healed through such crude acts; instead, young girls have become victims, infected and traumatized for life.

Tertiary institutions, in particular polytechnics, working together with medical institutions and other collaborators are the best placed to give accurate information and fight the HIV/AIDS through proper HIV/AIDS education. Education and proper counseling about HIV/AIDS has helped even those already infected to live a happy and positive life.

6.10 Strategy for Prevention and Treatment of Opportunistic Infections

While advocating for behaviour change, polytechnic institutions should make it clear to staff and students that there is no known drug yet for curing AIDS. Most of the drug regimes presently being used help to delay the progression of the disease to full blown AIDS and to prevent and treat opportunistic infections.

However, the combination of therapies such as the new anti-retroviral therapy has shown to improve the quality of life and extend the survival of people with AIDS, but they are far from being a completely cured and still out of reach for the majority of HIV/AIDS patients due to the cost.

Polytechnic institutions should help the infected members of their community to access treatment when infected.

6.11 Abstinence or Condom Use

People who are HIV-positive are advised to abstain from sex or use a condom each time they have sex. Studies indicate that there are various strains or types of HIV and different people carry various types.

Hence abstaining or use of a condom can protect one from contracting another strain from someone else.

Sad enough, a lot of people infected with HIV, with or without proper understanding of the dynamics of HIV infection, go about having unprotected sex. Besides infecting others, their life spans are drastically shortened.

In their situation of helplessness, some unscrupulous people would also want to spread the disease to healthy people in what would be called revenge. A case in point was reported in the *Daily Nation* of 14th April 2005, where a university student from Moi University (Eldoret, Kenya), infected 118 people with HIV. The girl who identified herself only as a fourth year Law student, claimed that she had sex with 124 people and that only 6 used condoms, the rest had unprotected encounter with the girl. She also claimed that some of the people she had sex with included lecturers. She said that she had decided to take revenge on her male colleagues after one of them ruined her life by infecting her with the virus.

There are many people in society who are not ashamed of spreading the virus, let alone ruining the life of their colleagues.

Infected people should learn just how to fight the pandemic and desist from spreading it.

Existing evidence shows that many people living with AIDS who brave their HIV status, abstain from unprotected sex, have balanced diet and treatment for opportunistic infections live much longer. Many of them are out advocating for sexual behaviour change and exposing the AIDS challenges.

At the institutional level, policy makers are challenged to develop an appropriate curriculum, based on acceptable religious, moral and social values for all people who are sexually active. This might reduce anger and revenge from the infected.

6.12 Voluntary Counseling and Testing Centers [VCT]

To be able to help the infected and affected to come to terms with HIV/AIDS, there must be a well-equipped voluntary counseling and testing [VCT] centre, where polytechnic staff and students can get such

AIDS counseling services. Voluntary counseling and testing is another HIV prevention intervention which polytechnics should undertake in that it gives clients an opportunity to explore their HIV status and learn their HIV test results in complete confidence.

Through VCT, individuals learn their HIV status. Most people who take advantage of the VCT service, find that they are not infected with HIV, and this helps them to reduce their risk of getting infected and encourage colleagues to use VCT services as well.

The VCT intervention is client centered in that it focuses on each client's unique issues and circumstances related to HIV risk and risk reduction.

Usually, people *misunderstand* the role of VCT centers. They think that the centers are for clinical diagnosis, to find out who is HIV negative or positive within the institution or community. The centers are not even supposed to compile data on HIV infection in the institution and they are not for mandatory testing for enrolment or employment.

It is important that VCT counselors should be people who are well-trained, motivated, enthusiastic, sensitive and with genuine desire to help others. The VCT counselors are agents of change in relation to HIV/AIDS and are responsible for influencing and sustaining behaviour change among individuals and communities.

The VCT Counselors are supposed to prepare clients with pre-test counseling, carry out the test where acceptable and give post-test and risk reduction counseling.

It is essential, therefore, that in the whole process, confidentiality is maintained. Confidentiality can be achieved through the use of anonymous procedures where only codes can be used, but also where the management of the waiting rooms, client flow to the clinic are kept confidential so that they are not readily identified by the public or other patients using the same health facility.

Voluntary Counselling and Testing Centres give professional services which every polytechnic and community should benefit from. All institutions that have the plight of their staff and students at heart should invest in VCTs services.

6.13 Living Positively with HIV/AIDS

Living with HIV/AIDS can be very distressing, but those infected [PLWA] should be comforted and properly counseled never to despair or lose hope.

Eradicating the stigma among HIV-positive people has been a major challenge even to polytechnics in their anti-AIDS war. This is one of the reasons why people fear to go for VCTs and declare their status. They fear being ostracized or discriminated against.

Polytechnics are encouraged to break the silence and remove the stigma associated with HIV/AIDS.

This is one of the strategic interventions polytechnics can affect, by informing the infected and affected to realise that there are many people living with HIV/AIDS, who brave their HIV status, abstain from unprotected sex, have good diet and seek treatment for opportunistic infections and end living a positive life.

It is because HIV/AIDS has been treated with a lot of suspicion and misunderstanding that the disease is associated with desperation, hopelessness and eminent death. Because of this, many have lost their hope and the will to live. However, those infected need Ambassadors of hope to tell them that being positive towards life together with healthy eating and proper use of ARVs can prolong and ease life. Though the infection may ultimately lead to death, this does not mean one has to be condemned to a life full of misery and never ending damnation.

Many people are ignorant about HIV/AIDS and it should be the responsibility of education institutions to ensure that such education and health services are available to those who are in need.

6.14 Research as a Strategic Intervention

Polytechnics must encourage research into HIV/AIDS so as to acquire new knowledge that can enable the institutions to manage and control the spread. Information generated from research can be useful for future use and therefore, should be widely shared. To achieve this noble goal, polytechnics need to institute a mechanism for data

collection on HIV/AIDS. Good record keeping on HIV/AIDS also helps to monitor the level of HIV-prevalence and behaviour change.

Governments should also encourage research on HIV/AIDS especially at micro-level, to cover communities, which are expected to be badly hit by the pandemic.

Financial support and all other logistics should be availed to those interested in HIV/AIDS research.

Institutional leadership, well wishers and governments should bear the responsibility of soliciting such funds. Research funding has never been a priority to the African governments but time has come to give HIV/AIDS the priority it deserves and polytechnics are encouraged to be at the forefront.

7. CONCLUSION

The scale of HIV/AIDS impact is still on the increase and being felt in every homestead and by every nation. The fight against the pandemic as of necessity should be everybody's concern. Polytechnics in Africa should rise up to the challenge and squarely respond to the pandemic. Those polytechnics without HIV/AIDS policy or guidelines and proper funding for HIV/AIDS programmes, show lack of seriousness and commitment on their part.

The necessary resources should be mobilized from donor agencies and governments for the purpose of effective response to the pandemic.

There is hope though because, at individual level, many people are beginning to change their sexual behaviour, habits, and practices. Some families have started discussing sexuality and AIDS. Institutions and communities are beginning to wake up to the realities of HIV/AIDS and silence on the pandemic is being broken, but there is still need for strong prevention programmes, committed political will and leadership at all levels. Polytechnics in Africa should not rest until the spread of HIV has been brought firmly under control.

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Annex 4

The Institutions Covered in the Survey

Western Region

1. Hassan Usman Katsina Polytechnic
2. Federal Polytechnic – Idah
3. Abubakar Tatali Ali Polytechnic, Bauchi
4. National Board for Technical Education [NBTE]
5. Kogi State Polytechnic, Lokaja
6. Federal Polytechnic, Oko
7. Federal Polytechnic, Offa
8. Plateau State Polytechnic, Barkin-Ladi
9. Federal Polytechnic, Bida
10. Milton Margai College of Technology
11. Federal College of Education & Technology, Yaba-Lagos
12. Yaba College of Technology, Lagos
13. Federal Polytechnic, Bauchi
14. Adamawa State Polytechnic, Yola
15. Ho Polytechnic
16. Rivers State Polytechnic, Bori
17. Rufus Giwa Polytechnic, Owo
18. Institute of Management & Technology, Enugu
19. Takoradi Polytechnic
20. Kuduna Polytechnic
21. Sunyani Polytechnic

Eastern Region

22. Kenya Polytechnic
23. Mombasa Polytechnic
24. Eldoret Polytechnic
25. Kenya Technical Teachers College
26. Uganda Polytechnic – Kyambogo (Kyambogo University)
27. Uganda College of Commerce – Tororo
28. Technical College Arusha
29. Tanzania Institute of Accountancy, Dar-es-Salaam
30. Mzumbe University
31. Mbeya Technical College

Southern Region

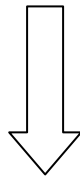
32. Technical And Vocational Teachers College [TVTC]
33. Kasiya Secretarial College
34. Kitwe Vocational Training College
35. Zambia Telecommunication Training College [ZAMTEL]
36. Lerotholi Polytechnic
37. Gweru Polytechnic
38. Swaziland College Of Technology
39. Polytechnic Of Namibia
40. The Malawi Polytechnic

Annex 5

Factoring HIV/AIDS Education in Institutional Curriculum

(Source: World Bank: 2002)

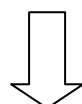
Policy	<ul style="list-style-type: none">• Policies include formal directives such as constitutional provisions laws or regulations, as well as standards of practice and formal guidelines. The purpose of policies is to authorize actions for needed service. The institutional policy would, therefore, formalize the rights and responsibilities of every person involved, directly or indirectly, in the polytechnic sector with regard to HIV/AIDS: the learners, their parents or caregivers, staff and the community in which the institution is located.• Argue the case for the polytechnic activities: With a policy, polytechnics can argue the case for an urgent national priority and undertaking its crucial role in HIV/AIDS prevention and the grave dangers of inaction including set-backs of educational for all (EFA).• Ensures close collaboration with other sectors: The polytechnics can forge strong links with ministries dealing with health, communication and youth affairs recognizing that the fight against HIV/AIDS can only be won with multisectoral efforts.• Engage in systematic planning: Developing the needed skills and methods and identifying key constraints to realizing objectives as well as cost effective way to overcome them.• Ensure adequate arrangements for monitoring and evaluation: To measure not only progress in education outcomes but also the impact and spread of HIV/AIDS as well as the impact of preventive measures calls for a policy in the first place.
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HIV/AIDS Education	<ul style="list-style-type: none"> • Reduce impact, vulnerability and risks to HIV Infection: Reducing vulnerability to HIV infection is fundamental to reversing the spread of the virus. Decreasing the risk of infection slows the epidemic. Decreasing vulnerability decreases the risk of infection and the impact of the epidemic. Decreasing the impact of the epidemic decreases vulnerability to HIV/AIDS.
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Demand & Access	<ul style="list-style-type: none"> • Redouble efforts to ensure access to and completion of girls schooling. For demographic purposes, when girls are educated, they ensure high survival of their children. They also tend to protect themselves from getting infected with HIV/AIDS. • Expand reliance on innovative approaches to reach out-of-school young people: Young people have tremendous influence on other youth. Exploring distance deduction and other non-formal alternatives to provide education to rural youth.
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Supply & Quantity	<ul style="list-style-type: none"> • Ensure adequate supply of skilled employees including teachers. This will ensure comparison for higher mortality and absenteeism by increasing employees training rates through revision of academic curricula to include adoption of distance learning and information technology (IT). • Strengthening delivery of prevention education by expanding in-service training in this area, emphasizing participatory and other innovative teaching methods that promote teaching of life skills aimed at behavioural change, training youth to be peer educators and counselors, linking programmes with health services and encouraging young people to create youth culture for behaviour change. • Adapt curriculum and learning materials by introducing HIV/AIDS education into existing curriculum that HIV/AIDS is taught within the context and principles of every discipline. This will help every teacher and every student to get involved and to give HIV/AIDS a multidisciplinary approach.
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