# THE IMPACT OF HIV/AIDS ON THE UNIVERSITY OF BOTSWANA:

# DEVELOPING A COMPREHENSIVE STRATEGIC RESPONSE

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# EXECUTIVE SUMMARY

This report presents the findings of an impact assessment of HIV/AIDS on the University of Botswana and outlines a comprehensive prevention and support strategy. The report is structured around the following set of questions:

- What measures have been taken to date to prevent the spread of HIV/AIDS among both staff and students?
- What has been the impact on student and staff to date?
- What has been done to maintain staff productivity (in particular as a result of increased absenteeism and staff turnover)?
- What should be done to minimise the impact of the epidemic during the next 10-15 years?

A mixed method design using quantitative and qualitative approaches and multiple techniques of gathering data that included focus group interviews, key informants' interviews, and document analysis was utilised in the study. Quantitative data was mainly obtained from the University data base sources.

**THE UNIVERSITY RESPONSE TO DATE**

The university response to date has focused mainly on interventions to prevent the spread of HIV among staff and students. The university clinic, counselling centre and the recently established Wellness Centre provide education, treatment and supportive care mainly for students. There is also an STI/HIV/AIDS Committee responsible for mainstreaming HIV/AIDS throughout the university. However, the heavy workloads of committee members result in poor meeting attendance. Support staff complain that the committee is not 'visible' and that they are not properly represented.

The Committee has developed an HIV/AIDS Strategic Plan 2000-2005 and is also formulating an HIV/AIDS policy. The main weakness of the strategic plan is that it does not deal adequately with staff and student support.

The group, Student Against HIV/AIDS, is active in disseminating education, communication and information to students and communities outside the University, especially to primary and secondary school students. Its membership is, however, very small (only 0.5% of total student enrolment). The University clinic provides medical support to students and is involved in a number of HIV/AIDS prevention activities, including condom distribution. The Counselling Centre provides counselling for students and staff, but it is under-utilised because of lack of confidentiality, perceived inappropriate counselling by students, stigmatisation associated with seeking counselling and poor overall awareness of the services provided. There are also efforts by some lecturers to educate students about HIV/AIDS through the curriculum and research. However, these efforts are limited and depend largely on the interest of the individual lecturer.

Despite the prevention campaigns by the university, student sexual behaviour has not changed. The numbers of student pregnancies and students with STDs are increasing. Students attribute the lack of change of behaviour to:

- Unplanned sexual encounters under the influence of liquor
- Un-negotiated sexual intercourse between female and male partners

- Societal pressure on both male and female students to have a first child
- Sexual violence on campus
- Societal pressure on females to look for a husband
- A culture of promiscuity for university student age group
- Social life that include partying an moonlight activities
- Sex exchange for money, grades and other favours

**IMPACT ON STUDENTS**

The main impact indicators HIV prevalence and mortality rates, psychological trauma, and absenteeism from classes and attrition. However, there is no comprehensive and accurate information on HIV prevalence among students mainly because voluntary testing is not common. The majority of the students is not covered by medical insurance so most feel that knowing their HIV status would not help them because they cannot access good quality medical support, including anti-retroviral drugs. Out of a total of 179 students attending the clinic with STD and HIV-related symptoms between 1997 and 2000, 53 (30%) tested HIV positive. The illness-related mortality rate was 0.13% in 1999/2000, which is 10 times less than the projected AIDS-related mortality rate for the 20-24 age group for the population as a whole.

AIDS-related mortality is projected to increase from 206 students in 2000 to 546 in 2010.

The greatest impact experienced to date is that of emotional stress, psychological trauma, demoralisation, de-motivation, pain and agony, and fear and anxiety either because of sickness, nursing or the loss of a parent, spouse, sibling, child, relative or friend. These conditions contribute to student absenteeism from classes and withdrawal from the university. Student withdrawal rates due to medical, personal or other reasons increased from 0.75% in 1995/96 to 1.2% in 1999/2000. In addition, another 20 students died and 132 were excluded or asked to discontinue because of poor performance. Thus, the total attrition rate was 2.52%. The repetition rate was 2%.

These trends have implications for the care and support of students, strategies for the prevention of HIV/AIDS and the university's mission to supply skilled labour in a timely manner. The report presents the following recommendations:

**Care and support:** The University should develop clear policy guidelines for students living with HIV/AIDS. There should be medical insurance cover for all students, which inclides entitlements for anit-retroviral drugs. A support system should also be established which can identify, monitor and care for the sick, especially those that are resident in hostels. Caregivers should receive counselling and basic training on how to care for the sick.

**Student enrolment:** Given projected AIDS-related attrition rates, student intakes should be increased by at least 4-5% above planned levels. Detailed national human resource planning with the Ministry of Finance and Development Planning working closely with the university is required to identify critical shortages of skilled human resources.

**Counselling:** Decisive action is required in order to de-stigmatise counselling at UB and encourage students to visit the Counselling Centre. A client tracking system should be worked out to ensure that clients consistently get the support they need.

**Education, information and communication:** More imaginative ways of delivering information on HIV/AIDS and sexual reproductive health to students should be introduced. A full-time IEC co-ordinator should be appointed with a proven track record in running effective IEC programmes for young people.

**Sexual harassment:** Students should be aware of the university policy on sexual harassment. Strong action should be taken against students found guilty of sexual harassment and all students who are raped should be prescribed AZT as this has been shown to prevent HIV infection.

**Personal tutors:** The new personal tutor system is a major step in the right direction. However, it will not be effective unless all tutors receive intensive, on-going training so that they have the commitment and skills to be able to respond to the diverse needs of the students that they will have to assist.

**Curriculum infusion**: HIV/AIDS issues should be infused in the course offerings of every department at the university. The university-wide course to be offered by the Department of Nursing is an important development. There is thus an obvious need for UB to offer HIV/AIDS courses either at faculty and/or departmental level.

## IMPACT ON ACADEMIC AND SUPPORT STAFF

HIV prevalence rates among staff are not known because voluntary testing is not common. BOMAID records however show that 17 (2%) of the 846 members at UB are HIV positive and enrolled on their anti-retroviral drug scheme. However, the total number of infected staff is likely to be much higher because most junior and industrail support staff do not belong to BOMAID. Illness-related mortality rates are 4-5 times higher among these support staff than among academics. Mortality rates among expatriate academic staff are three times higher among national academics.

Absenteeism among academic staff is not, as yet, a serious problem. However, rates of absenteeism are much higher among junior staff and industrial support staff. In some cases, staff continue to show up for work even when they are too weak. This happens when doctors have not recommended sick leave or when the leave days have elapsed before the person is well or the person has exhausted all their sick leave days and can only be granted leave without pay. Sick staff sometimes experience unnecessary deployment, transfer and at times termination of service. They also experience isolation, stigmatisation and subtle forms of discrimination.

Trends in staff absenteeism show a rise in the number of people taking sick leave from 77 in 1995 to 146 in 1997. However, starting in 1998, there has been a noticeable decline in the number of staff taking sick leave. This is probably due to the increased availability of anti-retroviral drugs.

## STAFF PREVENTION AND SUPPORT

The projected number of staff deaths is projected to increase from 68 in 200 to 189 in 2010. However, as is the case than students, the actual number of deaths among staff is much less than projected. A total of 20 staff died in 2000. Whatever the future level of AIDS-related

staff mortality is likely to be, it is imperative that the University develops a comprehensive AIDS in the Workplace programme with the following key components:

**Human resource planning:** The current and likely impacts of the AIDS epidemic is must be fully incorporated into the planning process at the university. HIV prevalence rates for each major staff category must be ascertained (on the basis of anonymous voluntary testing), and consultants should then be contracted to develop detailed projections of staff mortality and, in conjunction with the university's overall strategic plan, establish annual recruitment targets
.

**Education, communication and information**: High mortality rates, especially among industrial class, point to the need for the University to intensify education campaigns on HIV/AIDS. The highest risk groups (for example, female students and female industrial staff) should be targeted. Educational programmes should as far as possible be context and situation dependent. The HIV/AIDS Committee and the Wellness Centre Co-ordinator should draw up annual work plans with all relevant staff (training directors, deans and heads of department, other managers) as a matter of urgency.

**University-based health services:** Currently, the health services offered by the university clinic are not available to staff. It is recommended that the new Faculty of Health should accommodate staff members who wish to utilise such services. The university should also make arrangements with private clinics to allow its staff to receive immediate attention to cut down on the work time that is otherwise spent queuing for medical attention.

**Creating an AIDS-friendly work environment:** Staff support groups should be formed to provide care, spiritual and psychological counselling, and nutritional advice to those affected (both those who are infected and those who are not) by HIV/AIDS.

**Testing expatriate staff**: All expatriates working for government ministries are tested for HIV on appointment and again if their contracts are renewed. The government states that this is necessary because of high repatriation costs. Given UB's continued heavy reliance on foreigners, it seems sensible to test expatriate staff.

**Medical aid:** Industrial class workers, the majority of whom are women, are unable to benefit from the medical aid scheme, mainly because of low wages. The university should do all it can to ensure that every staff member is a member of BOMAID or another medical aid scheme.

**Teaching cover:** Core teaching and team teaching should be encouraged so those colleagues can easily cover for those who are sick. Modules should be developed so that those students who can not attend classes can benefit from the course modules.

## ORGANISATION, PLANNING AND MANAGEMENT ISSUES

The University should establish an HIV/AIDS management programme headed by a Director working with the following full-time staff:

- A co-ordinator responsible for HIV/AIDS prevention and support among students.
- A co-ordinator responsible for HIV/AIDS prevention and support among staff.
- A management information officer to develop and maintain a comprehensive HIV/AIDS information system.

- A curriculum specialist to assist departments to infuse HIV/AIDS issues in the curriculum.

The information system should include data on staff and students, mortality, morbidity and absenteeism, students and staff attrition, students' performance and AIDS education. Key information sources (most notably the Public Relations Office, individual faculties, the Clinic, Counselling Centre, Human Resource Unit and Information Technology Services (ITS) should review and computerise their data records in order to ensure that all relevant HIV/AIDS-related information is captured and is easily retrievable.

# CHAPTER 1

# INTRODUCTION

HIV/AIDS threatens to reduce the effectiveness and efficiency of educational systems in high prevalence countries in Sub-Saharan Africa. It is estimated that 7 out of 10 new HIV/AIDS cases and 83% of AIDS deaths are in Africa. Southern Africa alone accounts for 69% of the total AIDS deaths in the region (IIEP, 2000). The pandemic will affect both the demand and supply of education. Attrition rates due to deaths, illness, financial constraints, demand for home care of the sick and other family and social circumstances will reduce enrolment rates. The costs of training academic and support staff due to premature deaths, and costs incurred in the form of employee benefits during illness or after death will divert funds from projects focused on educational improvement and growth. This will result in the reduced capacity of the educational system to provide education and training services. The pandemic also impacts on the quality of education and could further widen the gender gap in educational access because female students are more adversely affected than males. Learning may be viewed as a consequence of interaction between individual characteristics and the learning environment. In the context of the pandemic, teaching students who are sick, depressed, demotivated or demoralised will impact on instructional outcomes. Taking time off to nurse the sick, seek medical care and attend funerals will also adversely affect learning outcomes.

## 1.1 HIV/AIDS IN BOTSWANA

Botswana is reported to have the highest national HIV prevalence rate in the world with 17% of the total population infected in 1999. It is projected that about 22% of the population will be infected by 2010. The prevalence rate among adults aged 15-59 was estimated to be 29% in 1999 and, without any change in sexual behaviour, it is expected to rise to 38% by 2010. The prevalence rate is currently highest among the 25-29 year age group (see Table 1).

Table 1: Age-specific prevalence rates among pregnant women (percentages)

| Year | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 |
|---|---|---|---|---|---|---|
| 1992 | 16.4 | 20.5 | 19.4 | 16.5 | 13.5 | 9.3 |
| 1993 | 21.8 | 27.1 | 24.2 | 16.8 | 13.3 | 9.4 |
| 1994 | 20.7 | 31.5 | 30.2 | 18 | 11.8 | 8 |
| 1995 | 32.4 | 34.8 | 32.6 | 33.5 | 11.1 | 15 |
| 1996 | 27.2 | 40.9 | 34 | 32 | 25 | 20 |
| 1997 | 28 | 41.4 | 41 | 33.3 | 39 | 23.1 |
| 1998 | 28.6 | 42.8 | 45.2 | 38.2 | 33.3 | 23.9 |
| 1999 | 21.5 | 38.7 | 43.3 | 42 | 33.3 | 25.5 |
| 2000 | 25.3 | 41.0 | 52.6 | 49.6 | 41.9 | 34.9 |

*Source: STD/AIDS Unit, Ministry of Health, HIV/AIDS Sentinel Surveillance Surveys, 1992-1999*

A recent report on the demographic impacts of the AIDS epidemic in Botswana estimates AIDS-related death among adults aged 15-59 to be have been around 2% in 1999, which is projected to increase to nearly 5% in 2010 (see AbT, 2000). The highest rates of AIDS-

related deaths are in the 30-34 age cohort (3.72% in 2000, increasing to 9.21 % in 2010)[1] (see Table 2).

Table 2: Projected AIDS-related mortality rates by age cohort, 2000-2009 (percentages)

| Year | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 |
|---|---|---|---|---|---|---|---|---|---|
| 2000 | 0.24 | 1.47 | 3.26 | 3.72 | 2.61 | 1.44 | 0.67 | 0.28 | 0.09 |
| 2001 | 0.24 | 1.56 | 3.71 | 4.51 | 3.25 | 1.78 | 0.83 | 0.35 | 0.11 |
| 2002 | 0.24 | 1.64 | 4.12 | 5.35 | 3.97 | 2.16 | 0.99 | 0.42 | 0.14 |
| 2003 | 0.24 | 1.68 | 4.46 | 6.22 | 4.79 | 2.60 | 1.1 | 0.49 | 0.17 |
| 2004 | 0.24 | 1.71 | 4.72 | 7.05 | 5.70 | 3.08 | 1.3 | 0.57. | 0.20 |
| 2005 | 0.24 | 1.71 | 4.91 | 7.81 | 6.69 | 3.61 | 1.55 | 0.64 | 0.22 |
| 2006 | 0.23 | 1.71 | 5.03 | 8.42 | 7.74 | 4.20 | 1.75 | 0.71 | 0.25 |
| 2007 | 0.23 | 1.69 | 5.08 | 8.87 | 8.83 | 4.84 | 1.96 | 0.78 | 0.27 |
| 2008 | 0.24 | 1.68 | 5.08 | 9.13 | 9.91 | 5.54 | 2.18 | 0.83 | 0.29 |
| 2009 | 0.24 | 1.66 | 5.05 | 9.24 | 10.8 | 6.31 | 2.41 | 0.89 | 0.31 |
| 2010 | 0.24 | 1.65 | 4.99 | 9.21 | 11.6 | 7.15 | 2.66 | 0.94 | 0.32 |

There is a growing body of research and other information on HIV/AIDS in Botswana. This includes impact assessments on the health sector (AbT Associates, 2000a), and the economy (BIDPA, 2000) as well as the above mentioned population projections (AbT Associates, 2000b). The UNDP has also commissioned HIV/AIDS situational analyses in eight districts. However, no comprehensive impact assessment of the epidemic on the education sector has been undertaken. It is widely anticipated that the epidemic will have a devastating impact on education provision in the high prevalence countries in East and Southern Africa. For example, Coombe predicts that in South Africa, unless preventive measures are taken, school effectiveness will decline to a point where 30% to 40% of teachers, officials and children are ill, lacking morale and unable to concentrate on teaching and learning (see Coombe, 2000). However, most predictions of this kind are not supported by detailed research.

## 1.2 STUDY OBJECTIVES

This study assesses the impact of HIV/AIDS on the University of Botswana. The discussion is structured around the following set of questions:

- What has been the impact to date?
- What measures have been taken to date to prevent the spread of HIV/AIDS among both staff and students?
- What has been done to support staff and students who have been directly affected by the epidemic?
- What has been done to maintain staff productivity (in particular as a result of increased absenteeism and staff turnover)?
- How effective have these interventions been?
- What will be the likely impact of HIV/AIDS on staff and students and, more generally, the overall capacity of the university to deliver high quality teaching and learning?
- What should be done to minimise the impact of the epidemic during the next 10-15 years?

[1] * I am grateful to Anthony Kinghorn of AbT Associates for providing these projections by age cohort

This study forms part of a multi-country research project on the impact of the AIDS epidemic on the education sector in Botswana, Malawi and Uganda. A separate impact assessment has already been undertaken for primary and secondary education in Botswana (see Bennell et al, 2001).

## 1.3 THE UNIVERSITY OF BOTSWANA

The university community consists of students, and academic and support staff. A total of 3,085 people were employed at UB in late 2000, 60% of whom are aged 30 to 44. There are six faculties (Business, Education. Engineering and Technology, Humanities, Science and Social Sciences). A new Faculty of Health is also being established. The student population has grown very rapidly during the last decade - from just 2,554 in 1992 to 11, 000 in 2000.

## 1.4 METHODOLOGY

Carrying out an assessment of the impact of HIV/AIDS on an organisation such as UB is a complex exercise that requires a variety of data to estimate both the overall magnitude and nature of the impacts. Essential 'hard', quantitative data will only be available where an institution has a well-established management information system. Although the University has several databases, there is no organisational framework that links them together. There are, therefore, major information gaps. In addition, the stigma, secrecy and denial surrounding HIV/AIDS precludes any comprehensive documentation of HIV/AIDS. Although many people in Botswana have died from HIV/AIDS, very few are willing to admit that they or a close relative is sick or has died from AIDS-related disease.

In studying HIV/AIDS, it is also very important to obtain the perceptions of individuals as well as making use of the limited hard data that is usually available. Perceptions are particularly important because they provide key insights into how individuals have responded to the AIDS crisis and how this affects the translation of strategies and other interventions to tackle the crisis into practice. It also very important to establish any trends in key performance indicators and to assess the extent to which these trends can be attributed to the consequences of the epidemic.

Estimations and future projection of an HIV/AIDS impact study are also based on assumptions about behaviour change and the culture and values of an institutional community. On values and behaviour, this study builds on the study of knowledge, attitudes and behavioural aspects if HIV/AIDS among students at UB which was published in late 1999 (see Jack et al, 1999). However, our knowledge and understanding about how the epidemic is affecting students remains very imperfect.

A mixed method design using quantitative and qualitative approaches and multiple techniques of gathering data was utilised. This entailed collecting data from a variety of primary and secondary sources, in particular interviews and semi-structured focus group discussions, and all relevant university records. A literature review was also undertaken. One of the main benefits of this approach is that it facilitates triangulation' and complementarity[2].

[2] Triangulation is concerned with the use of multiple methods to address a single question, where the methods do not share the same kind of bias (Shortland & Mark 1987). It seeks convergence, corroboration, and correspondence of results from different methods to increase the validity of constructs and inquiry results (Caracelli & Graham, 1989).

In this study, perceptions and other views from focus group discussions and interviews have, wherever possible, been corroborated with quantitative impact indicators. Complementary purposes in a mixed method design seek elaboration, enhancement, illustration, and clarification of the results from one method with the results from another in order to increase the interpretability, meaningfulness and validity of constructs and inquiry results. Again, interview and focus group data complemented statistical data on morbidity and mortality trends and other impact indicators.

The main research questions and the sources of data are presented in Table 3.

Table 3: Main research questions and sources of data

| Questions | Sources and Methods |
|---|---|
| What has been done to date to prevent the spread of HIV/AIDS at UB, to provide medical and psychological support and care for those infected and affected by HIV/AIDS? | Review of current prevention programs and structures:<br>• The STD/HIV/AIDS committee<br>• Five year strategic plan<br>• The HIV/AIDS policy<br>• The Clinic<br>• Counselling Centre<br>• Students Against HIV/AIDS<br>• Condom distribution and use |
| What is the HIV/AIDS situation at the University i.e. HIV prevalence rates, AIDS cases, and overall mortality and morbidity rates? | • University Clinic Counselling Centre data on HIV/AIDS<br>• BOMAID data on morbidity<br>• Public Relations Office data on mortality<br>• Interviewees impressions on HIV/AIDS |
| What is the likely impact of HIV/AIDS on<br>• Quality of teaching and learning<br>• Student enrolment<br>• Job performance<br>• Quality of life of students and staff | • Students and key informants interviewees<br>• Request for absence from classes forms<br>• Annual examination results books<br>• Database on staff absenteeism |
| What strategies has the University adopted to address possible low productivity, and higher absenteeism and attrition?. | • Interviews with key informants<br>• Review of terms and conditions of service. |

### 1.4.1 HIV prevalence and mortality

Inferences about prevalence rates have been made using data from the university clinic on voluntary testing by students and mortality rates among staff and students. Data on the mortality of students, academic and support staff for the years 1992-2000 was obtained from the Public Relations Office, which sends out death notices for every member of the university community who dies. These give information on the sex of the deceased, cause of death, and the date of death. Cause of death is identified as illness, accident or suicide.

Trends in student attrition, repetition and expulsion for the years 1994-2000 have been ascertained using information from Senate results books, memos on withdrawals from the Admissions Office, and University of Botswana Annual Reports.

### 1.4.2 Absenteeism

The Human Resource Unit supplied data on morbidity for academic and support staff. Student absenteeism was determined by analysing student absenteeism forms from a sample of faculties. The form shows program of study, number of lessons to be missed, and the number of days the student will be absent and the reasons for absence. Some forms, in addition, request the student to indicate tests to be missed and the student's relationship to the person to be buried if the request is to attend a funeral. Medical certificates are required to support absence due to illness. However, trends were not possible to establish because of poor record keeping.

### 1.4.3 Student and staff perceptions

Qualitative approaches using interviews and focus group interviews were used to gather data on the university community's views on the impact of HIV/AIDS on staff and students. Key informants were selected for interviews. Among the key informants selected were Deputy Vice Chancellors, Directors, Deans, Heads of Departments and Units, nurses, librarians, lecturers, counsellors, wardens, members of the HIV/AIDS committee and academic staff doing research on HIV/AIDS. A total of about sixty people were interviewed.

Semi-structured focus group discussions using participatory research techniques were also held with students and support staff. Each group was given 23 prepared statements to discuss and then asked to indicate whether they 'agree', 'disagree' or are 'not sure' about each statement. The groups were also asked to substantiate their choice and to suggest ways to address the issues. 22 group sessions were held (20 with students, one with postal service workers and one with secretaries). Each group consisted of six people. The researcher was also a participant observer at two workshops on HIV/AIDS run by the Faculty of Education.

University annual reports, development plans, strategic planning documents and minutes from committees dealing with HIV/AIDS were reviewed to find out how the university is coping with the HIV/AIDS pandemic.

### 1.4.4 Data quality

The task of assessing and measuring teaching and learning quality and job performance indicators was difficult because the university does not have an adequate information system for monitoring the impact of HIV/AIDS on the institution. There is an abundant amount of paper work (forms, memos, reports etc) that is submitted by students and staff on a daily basis. There are, for example, student absenteeism forms, death notices, compiled annual reports on student pass rates, repetition and withdrawal rates. The problem is that most of this information is not computerised and there is no uniform framework for data collection and retrieval.

Computerised data does exist for staff leave of absence and other biographical data. The ITS system also provides data on the 'academic standing' of each student (although this does not include data on socio-economic status). It was not possible, therefore, to build up a comprehensive profile of the student population. The only personal characteristics that can be retrieved are gender, marital status, and age.

# CHAPTER 2

# RESPONDING TO THE AIDS CRISIS: UNIVERSITY INTERVENTIONS TO DATE

Efforts to prevent HIV infection at UB have been heavily influenced by national policies and strategies that have been adopted to combat the disease. Two years after the first case of AIDS was diagnosed in 1985, a National Aids Control Programme was established and an emergency plan (known as Medium Term Plan I) was subsequently developed for the period 1989-1995. MTP II, which covers the period 1997-2002, has two main goals namely, to reduce HIV infection and transmission and to minimise the impact of epidemic at the macro-economic, social, household, community and personnel levels. The first goal emphasises prevention, treatment and supportive strategies to deal with the pandemic. The second goal focuses on efforts to mitigate higher morbidity and mortality at the workplace. These goals are supported by a national policy on HIV/AIDS that was adopted in 1998 and are also incorporated into the National Vision 2016.

In parallel with this national policy framework, UB has developed its own policies and practices with respect to HIV/AIDS prevention and mitigation. The University Clinic, Counselling and Wellness Centres provide education, treatment and supportive care. Education campaigns have also been mounted and a Strategic Plan has been recently formulated.

## 2.1 HIV/AIDS ORGANISATION, POLICY AND PLANNING

### 2.1.1 The STI/HIV/AIDS Committee

This committee seeks to mainstream the fight against HIV/AIDS at the university. It has 29 members - two from each faculty as well as representatives from administration and finance, the Student Council, counselling centre, and the library. Its terms of reference are as follows: [when established?]

- To assist and encourage students and staff to form and utilise self-support groups to promote positive living with STI/HIV/AIDS as a coping strategy within and outside campus.
- To establish and encourage peer education on STD/STI/HIV/AIDS on campus and to combat the transmission and spread among students and staff.
- To provide pre- and post-test counselling for individuals needing such services within the university community.
- To provide supportive therapy for members of the university community with STI/HIV/AIDS or whose family members are HIV positive or living with AIDS.
- To foster positive attitudes among members of the University community towards people with STI/HIV/AIDS.
- To embark more on behaviour modification and behavioural change strategies in addressing the transmission and spread of STI/ HIV/AIDS.
- To offer guidance and moral support to those providing care to people living with STI/HIV/AIDS

**Main activities:** Over the last two years, the Committee has sponsored several activities geared towards improving student knowledge and awareness of STI/HIV/AIDS. These include AIDS awareness games, Youth Against STI/HIV/AIDS Month, panel discussions, drama presentations, cultural nights, and a study of the knowledge, attitudes and behaviour of UB students (see Jack et al, 1999). The committee has also assisted in drawing up the five-year strategic plan 2000-2005 and is currently in the process of formulating an STI/HIV/AIDS policy for the university.

**Overall effectiveness**: The Committee meets regularly, but poor attendance has meant that relatively little has been achieved. Most interview respondents stated that the committee did not have a high profile and that they were not, therefore, aware of its activities. Support staff complained that that they were not represented on the committee and their particular needs were not adequately addressed.

The Committee's chairperson clearly recognises that there is a limit to what a committee operating on a voluntary basis can achieve. Individual workloads are a hindrance to active involvement in the activities of the committee. The power hierarchy within UB also disempowers committee members in situations where they have to depend on the support of their senior supervisors.

### 2.1.2 The HIV/AIDS Strategic Plan 2000-2005

The main objectives of this plan are to:

- Increase knowledge and awareness
- Promote and provide voluntary testing and counselling
- Prevent and treat conventional STIs
- Promote safe sexual practises
- Increase access to condoms
- Reduce other high risk behaviour
- Promote UB as a supportive environment for staff and students living with AIDS

A multi-sectoral approach has been adopted whereby actors at various levels choose a strategic entry point to prevent and mitigate the impact of HIV/AIDS on the institution. However, the plan does not adequately address the following key areas:

**Research monitoring and evaluation**: Close surveillance of the STI/HIV/AIDS situation at the university is crucial for any effective AIDS management programme. One would thus expect the plan to discuss strategies that the University should adopt to document and monitor HIV/AIDS not only to monitor behavioural change but to inform institutional planning, for instance, factoring HIV/AIDS in enrolment of students, training and recruitment of staff and budgeting.

**Human and legal rights**: Although the plan seeks to create a supportive social environment for students and staff, it is silent on strategies to ensure an appropriate HIV/AIDS legal and policy environment.

**AIDS in the Workplace**: The plan also fails to discuss strategies to deal with possible low productivity, high absenteeism, high morbidity, high employment benefits, high labour

replacement and training costs, shortage of skills and opportunistic infection epidemics, that may exacerbate student and staff morbidity leading to high attrition rates. This is despite the fact that MTP II addresses these issues and has suggested various interventions that institutions should adopt.

### 2.1.3 The HIV/AIDS Policy

The university's HIV/AIDS policy document is still at a draft stage. The policy has adopted a multi-sectoral approach with every faculty and department assigned specific responsibilities. It also addresses issues concerning recruitment, discrimination, sick leave, termination of employment, HIV testing, confidentiality, employees benefits, affordibilility of medical treatment, accessibility of health services, injuries on duty and screening of staff going for further education. These are crucial issues that should guide the University in mainstreaming HIV/AIDS in the institution as a whole. However, the structures to implement, co-ordinate and monitor the HIV/AIDS activities are not clearly specified. In particular, the role of each implementation team needs to be better defined as well as the relationship between these teams.

## 2.2 SUPPORT INSTITUTIONS

### 2.2.1 The university clinic

The university clinic has nine staff (a director, two part-time doctors, two sister nurses, and four staff nurses) who are involved in a number of HIV/AIDS prevention activities, including condom distribution. The clinic receives some assistance from the Ministry of Health through its AIDS/STD Unit (mainly educational materials, videos, and condoms). In collaboration with the AIDS Awareness Committee, HIV/AIDS prevention workshops are organised for students. The workshops stress condom use and abstinence. The clinic also provides pre-testing and post-test counselling and is participating in the national Mother to Child Transmission prevention programme.

The clinic is not popular with the large majority of students. This is largely because most students feel that the nurses at the clinic associate attending the clinic with contracting STDs. As one student put it 'the first question every one is asked is 'when was the last time you had sex?'. Given the stigma that is attached to the clinic, most students use medical facilities off-campus. An analysis of medical absence forms shows that around 80 percent of these students attended either private or government clinics and hospitals. The 1999 KAP study of UB students also reported that only one in four of students who sought medical help visited the university clinic. Total visits to the clinic were 15005 in 1999 but only 10646 in 2000 (see Table 4). The highest daily attendance during this period was 101 students.

Table 4: Total student visits to the university clinic by reason , 1999 and 2000

| REASON | 1999 | 2000 |
|---|---|---|
| Pregnancy | 58 | 69 |
| Family planning | 55 | 47 |
| Tuberculosis | 26 | 34 |
| Psychiatric | 9 | 14 |
| STDs | 795 | 1264 |
| Total visits | 15005 | 10646 |
| Condoms distributed | 150,000 | 156,000 |

### 2.2.2 The Health and Wellness Centre

In view of the urgent need to further promote health and wellness among all members of the UB community, a Health and Wellness Centre has recently been established. The Centre's co-ordinator took office in August 2000. The main objectives of the Centre are as follows:

- Promotion, protection and improvement of health in UB through awareness and educational programs.
- Playing an important role through the implementation of awareness and educational programs in the fight against the spread of HIV/ AIDS.
- Collaboration with campus clinic, careers and counselling services and other departments in resolving health problems of the UB community.
- Organising and conducting sensitisation workshops and seminars for students and staff on different health matters.
- Providing support to staff and students of UB with health problems especially those related to HIV/AIDS.
- Co-ordinating activities of students of UB willing to promote awareness on health matters.
- Initiating and supporting peer counselling among students on HIV/AIDS issues.
- Liasing with other support services within and outside the University that are concerned with issues of HIV/AIDS.
- Promoting incorporation of national health prevention strategies into the UB system

### 2.2.3 The Counselling Centre

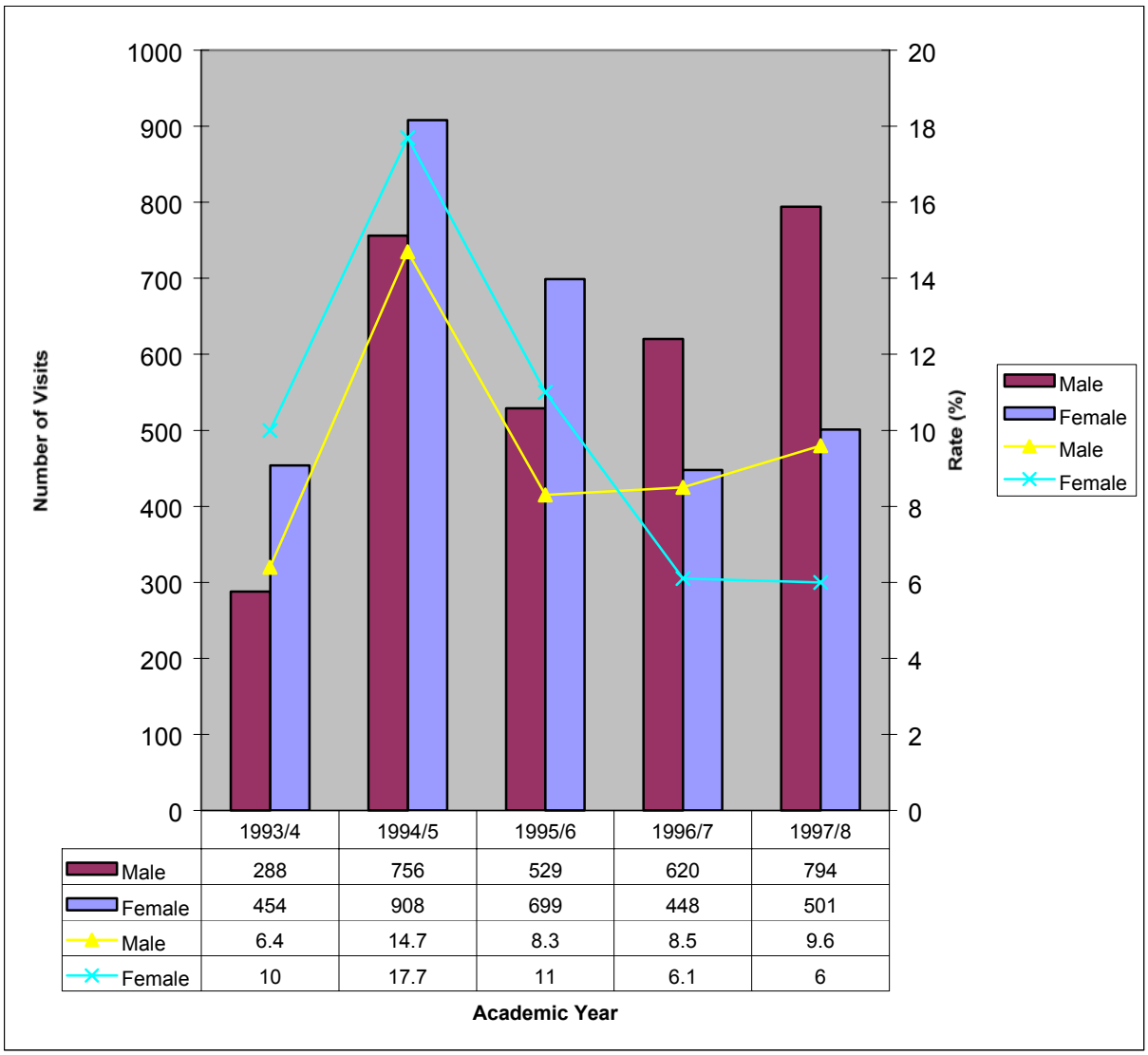
Support services are essential in order to counsel those who are terminally ill, infected or traumatised by the deaths of relatives and friends. The overall quality of these services is a key indicator of the University's commitment to the quality of life of the staff and students.

The Counselling Centre, which was established in 1993, has 10 staff: a director, two deputy directors, and eight counsellors who specialise in counselling, clinical psychology, psychiatric nursing, and social work. The role of the Centre is to provide academic support services, careers information and development services, testing services and counselling/clinical services to staff and students on an individual basis and in groups. Centre staff are also actively involved with HIV/AIDS issues and collaborate with other units and agencies to promote HIV/AIDS prevention (Alao, 1999).

**Student visits**: Counselling staff are concerned that the centre is under-utilised. Total visits by female students declined from over 900 in 1994 to 501 in 1997, but for male students there

was a slight increase - from 756 to 794 - during this period (see Figure 1). However, as a percentage of the total student population, male student visit rates declined from 28.8% in 1994/5 to 18.3% in 1998/99. The corresponding percentages among female students are 36.4% and 16.5% respectively.

Figure 1: Student visits to the Counselling Centre, 1993/94 to 1997/98




| | 1993/4 | 1994/5 | 1995/6 | 1996/7 | 1997/8 |
|---|---|---|---|---|---|
| Male | 288 | 756 | 529 | 620 | 794 |
| Female | 454 | 908 | 699 | 448 | 501 |
| Male | 6.4 | 14.7 | 8.3 | 8.5 | 9.6 |
| Female | 10 | 17.7 | 11 | 6.1 | 6 |

Students tend to visit the Centre in 'crisis situations' when there is absolutely nowhere else to turn. One of the deputy directors, for instance, has seen only one client who is living with AIDS. One counsellor who has been with centre for four years has counselled only four people who are HIV positive. This suggests that the large majority of students and staff who are HIV positive are not visiting the Centre.

**Reasons for students visits:** The Counselling Centre makes an annual analysis of the types of problems for which staff and students seek counselling. The problems are classified into eleven categories (see Table 5). An analysis of the types of problems for which students visit the centre reveals a change in the pattern of visits (see Table 6). Between 1993/94 and 1998/99, the most common reason was academic study. In 1997/98, career issues ranked first. Throughout the period, sexual relations featured among the first four areas of most concern. The majority of clients seeking counselling for sexual relations are women. Between 1996/97

to 1998/99, psychological problems started featuring as one of the four areas of most concern. This includes stress, depression, terminal illness, bereavement, suicide, substance abuse and phobia. The increasing number of students with these kinds of problems may well be due to the emotional trauma associated with HIV/AIDS.

Table 5: Definitions of problem areas and examples

| Problem area | Meaning | Example |
|---|---|---|
| Physical health | Issues that need medical attention prior to counselling and | Reaction to substance abuse, HIV/AIDS and other illnesses. Acute stress. |
| Financial | Needy clients from financially disadvantaged background, managing own finances | Financial needs to support self and others |
| Social relations | Lack of interpersonal skills for optimal performance | Generally poor relations with others, ineffective social skills. |
| Sexual relations | Intimate relations issues/problems | Fights/discord in intimate relations including marital issues |
| Social-psychology | Feelings of social rejection and inhibition (perceived or real) | Low self esteem, self doubt, lack of confidence, inhibitions |
| Personal-psychology | Issues that impact more on the inner person, affect normal functioning | Stress, depression, terminal illness, Bereavement, suicide, substance abuse, phobia etc. |
| Morals and religion | Beliefs and interpretation of moral and religious issues | Personal and family values, rules and regulations |
| Home and family | Family and extended family relations | Step families, parent-child relations |
| Future security and well-being | Issues around the world of work | Job search skills, getting a job and keeping it |
| Academic study | Study skills | Time management, tests and examinations, anxiety, procrastination etc. |
| University adjustment | Surveying at University | Transition from high school to university |
| Careers | Relating programme of study to career interest | Career exploration, career choice. |

**Staff visits:** Very few UB staff visit the Centre. The majority of staff in 1998/99 visited the Centre for psychological problems compared to visits for financial problems in 1994/95. In 1994/95, about 13 staff members visited the Centre for social psychological problems compared to 48 in 1998/99 (See Table 4). It would appear, therefore, that more staff are going through emotional stress and psychological trauma, which may be related to loss of relatives, spouses, friends, siblings, and nursing sick friends and relatives.

There are three main sets of reasons for the under-utilisation of the Centre: lack of confidentiality, inappropriate counselling, and poor overall awareness of the services provided.

Students are very concerned about the lack of confidentiality at the Centre. Counselling staff, on the other hand, complain that they are frequently pressurised by Heads of Departments and Deputy Deans to write extensive reports ‘to convince Department and Faculty Boards

Table 6: Student and staff visits to the Counselling Centre, 1994/95 and 1999/00

| REASON | STUDENTS | | STAFF | |
|---|---|---|---|---|
| | 1994/95 | 1998/99 | 1994/95 | 1998/99 |
| Health | 106 | 147 | 19 | 38 |
| Financial | 38 | 50 | 50 | 5 |
| Social relationships | 45 | 74 | 2 | 27 |
| Sexual relationships | 156 | 162 | 18 | 23 |
| Social psychological | 49 | 72 | 2 | 45 |
| Personal psychological | 89 | 196 | 13 | 47 |
| Moral and religious | 21 | 40 | 3 | 1 |
| Home and family | 40 | 62 | 39 | 29 |
| Future security | 301 | 44 | 7 | 4 |
| Academic | 607 | 99 | | |
| University adjustment | | | | |
| Careers | | | | |
| TOTAL | 1452 | 946 | 153 | 219 |

that a student has a problem'. It is not uncommon (especially when examination results are being discussed) for Boards to spend hours arguing about the reliability and validity of a report on a student from the Counselling Centre. In some cases reports have been returned to the Counselling Centre requiring staff to be more specific about the nature of a student's problem. Counselling staff are worried that this pressure sometimes forces them to violate basic counselling ethics.

Visiting the centre is also associated with being infected with HIV/AIDS and/or an inability to solve one's problems. The centre operates from portakabins isolated from the main university complex.

Finally, many students are poorly informed about the Counselling Centre and its role. Many of the students who have visited the Centre are critical of the type of counselling that is offered. Some students feel that the counselling is 'too academic and removed from the cultural context within which problems occur.' There were suggestions that the Centre should provide other types of counselling such as spiritual counselling. Peer counselling under the directorship of the counselling centre was recorded. There was concern that the Counselling did not utilise students currently taking counselling courses in the University. These students it was observed could diversify the type of counselling currently offered. Counselling services should also be extended to the hostels in order to assist hard-pressed wardens.

## 2.3 STUDENT ACTIVITIES

A handful of students started the Society against HIV/AIDS (SAHA) in 1998. Currently, the Society has a membership of around 50 students (less than 0.5% of total enrolment). Its aims and objectives are:

- To conscientise the entire university community on matters relating to HIV/AIDS
- To discuss health issues e.g. pregnancy
- To work with groups dealing with HIV/AIDS
- To promote research and documentation of HIV/AIDS issues
- To work with the public or communities outside the University on HIV/AIDS issues

SAHA is involved in national and international HIV/AIDS activities. It participates in the Month of Youth and HIV/AIDS, the Month of Prayer, and World AIDS Day. During the month of Youth and HIV/AIDS, it organises various activities (ball games, culture show/night and talkshow, national youth groups such as Ngwao Boswa). During these activities, young people are encouraged to share ideas concerning HIV/AIDS, especially through drama and poems. Sports are encouraged as a way of keeping healthy, fit and busy.

**Month of Prayer:** During the month of prayer (which is usually during September), SAHA selects a day and invites students, lecturers, performers and pastors from inside and outside to gather and share a word of hope. During this session, there is a moment of prayer to remember the affected and infected as well as a candle lighting ceremony to bring hope to students.

**World AIDS Day**: SAHA observes World AIDS Day each year. Activities on this day include drama, songs and lecturers on HIV/AIDS. Each year, the activity starts with a march by students and staff. There are also different stalls mounted at each faculty where students normally gather with booklets and videos on HIV/AIDS.

**Annual First Year Workshop**: The first year workshop is held every August when the first years register. The purpose of this workshop is to educate and keep the first year students informed on matters relating to HIV/AIDS.

**Out-Reach Activities:** Out-reach activities are aimed at disseminating HIV/AIDS information to the public. Activities include visiting schools to educate students on how to be responsible citizens, sharing information on HIV/AIDS, teaching more on behaviour change and abstinence and also teaching students on how they can reach out for other youths.

SAHA identified the following needs: Funds to buy materials and equipment. Human resources in the form of skilled and experienced people who can teach or advice SAHA on how to handle HIV/AIDS issues. Technical advice is also needed to help in planning, budgeting and proposal writing for funding purposes for AIDS activities and projects. SAHA also needs training on how to counsel people and advice on how to deal with home based patients (home based care) and an office to run HIV/AIDS activities.

SAHA membership is very small. Much more should be done, therefore, to encourage students to join SAHA.

## 2.4 THE FORMAL CURRICULUM

Some faculties at UB are trying to sensitise students about HIV/AIDS through the curriculum and research. However, relatively little has been done to infuse HIV/AIDS in teaching and research in a systematic and concerted manner. The University also seems to have missed the opportunity to address HIV/AIDS under the semesterisation process. Semesterisation documents only mention the general health course, which is to be offered. A lot more effort is needed therefore in order to sensitise students on all key HIV/AIDS issues through the curriculum.

### 2.4.1 Faculty of Social Sciences

Individual lecturers in the Departments of Sociology, Social Work, Statistics, Demography and Economics have infused HIV/AIDS in their teaching. Most of these are lecturers who have carried out consultancies on various aspects of HIV/AIDS for government ministries, the World Health Organisation, and the United Nations Development Programme. In the Department of Sociology and Social Work, students are encouraged to carry out projects on HIV/AIDS. The Department of Law has started a series of seminars on HIV/AIDS and the Law.

### 2.4.2 Faculty of Education

The Department of Nursing is about to introduce a three-credit course on HIV/AIDS. The department is also developing a model for home-based care. Most lecturers in this department are infusing HIV/AIDS in their courses. In the Department of Home Economics, final year students have conducted research on HIV/AIDS. The Departments of Adult Education and Educational Foundations have developed work plans to infuse HIV/AIDS in their courses, develop strategies to create supportive workplace environment for students and lecturers, design outreach programmes for at risk groups and to carryout research on HIV/AIDS. Appendix 1 presents the work-plan for the Department of Adult Education.

A number of lecturers in the Faculty of Education have carried out AIDS-related consultancies. One of the lecturers is carrying out a study on student's understanding of HIV/AIDS. Some lecturers offer informal counselling to students and staff affected by HIV/AIDS.

### 2.4.3 Faculty of Humanities

A lecturer in the Department of Theology is doing a consultancy on HIV/AIDS for the Norwegian Church Agency. She has also produced a video on orphans. Final year students in the department have written dissertations on HIV/AIDS and the department also runs a series of seminars on HIV/AIDS.

# CHAPTER 3

# PREVENTING HIV INFECTION AMONG STUDENTS

The key impact indicators of HIV prevention programmes are student knowledge about HIV/AIDS, willingness to dispel myths, cultural practices and societal pressures that fuel the spread of HIV/AIDS, change in sexual behaviour, and changes in HIV prevalence and mortality rates.

While a large majority of students (70% of the focus groups) perceive HIV/AIDS to be a serious problem at the university (see Table 7), many appear to engage in high-risk sexual behaviour. Students perceive that they are susceptible to HIV/AIDS for a variety of reasons including their age, dominant cultural practices, alcohol and drug abuse, and sexual violence.

Table 7: Student FGD responses to statements concerning the extent to which HIV/AIDS is a problem at the university

| | **AGREE** | | | **DISAGREE** | | | **NOT SURE** | | |
|---|---|---|---|---|---|---|---|---|---|
| Statements | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| HIV/AIDS is a big problem at this university | 6(30%) | 8(40%) | 14(70%) | 3(15%) | 2(10%) | 5(25%) | 1(5%) | | 1(5%) |
| HIV/AIDS affects teaching and learning | 6(30%) | 5(25%) | 11(55%) | 3(15%) | 2(10%) | 5(25%) | 1(5%) | 3(15%) | 4(20%) |
| HIV/AIDS affects student performance | 7(35%) | 9(45%) | 16(80%) | 1(5%) | | 1(5%) | 1(5%) | 2(10%) | 3(15%) |

## 3.1 STUDENT SEXUAL BEHAVIOUR

The knowledge, attitudes and behaviour study of UB students that was conducted in 1999 reveals the extent to which students engage in the following kinds of high-risk sexual behaviour: unprotected sex, frequent change and exchange of partners, sex for financial gain, prestige of multiple partners, sex and peer pressure, and sex to relieve stress as well as sex for good grades. It is important to note, however, that this kind of behaviour is not unique to university students in Botswana. Recent studies on the impact of HIV/AIDS at seven universities in sub-Saharan Africa (Benin, Ghana, Kenyatta University College, Namibia, Western Cape, and Zambia) report similar patterns of student sexual behaviour[3].

Only 20% of the student focus groups agreed with the statement that 'students have changed their behaviour as a result of HIV/AIDS'. 25% disagreed and 55% were unsure (see Table 8). The following reasons were given for limited behaviour change:

- High levels of alcohol consumption, which leads to irresponsible behaviour
- Students sometimes relieve 'academic stress' by engaging in irresponsible behaviour.
- There is a lot of prostitution and promiscuity around campus
- Students engage in moonlighting activities that entail high-risk, 'irresponsible' sex

[3] See

The following comment made by a male student is typical of student views on this issue

*Sexual attitudes have not changed. Girls have relationships with married men while boys have sexual relationship with secondary school girls. We are all going to die despite our knowledge.*

Lack of information about the causes and consequences of HIV/AIDS is an important factor; Only 60% of the student focus groups agreed that 'the students get all the information and advice they need about HIV/AIDS'. Students also argue that knowledge does not translate into behaviour change because too many messages are naïve/unrealistic, ambiguous, and offensive/insensitive. They are particularly critical of common messages such as 'abstain, be faithful, condomise' and 'don't be stupid, condomise'. As one group noted:

> *Information on HIV/AIDS is there, but it is not being utilised. Information like condoms are not 100% safe is confusing. You feel there is no need to use condoms because they are not safe.*

Another group observed*:*

> *No one can abstain, no one can live without sex, it is natural, it is a stress relief, we must be realistic, the message to abstain is not realistic, we should emphasise the message to be faithful and condomise, we should cancel abstain from AIDS campaigns.*

Table 8: Focus group responses to statements concerning student's sexual behaviour

| | **AGREE** | | | **DISAGREE** | | | **NOT SURE** | | |
|---|---|---|---|---|---|---|---|---|---|
| STATEMENT | M | F | TOTAL | M | F | TOTAL | M | F | TOTAL |
| Students have changed their behaviour as result of HIV/AIDS | 3(15%) | 1(5%) | 4(20%) | 2(10%) | 3(15%) | 5(25%) | 5(25%) | 6(30%) | 11(55%) |
| Sexual harassment among students is a problem | 4(20%) | 7(35%) | 11(55%) | 4(20%) | 3(15%) | 7(35%) | 1(1%) | 1(5%) | 2(10%) |
| Sexual harassment by lecturers is a problem | 2(10%) | 1(5%) | 3(15%) | 4(20%) | 7(35%) | 11(55%) | 3(15%) | 2(10%) | 5(25%) |
| Sexual harassment is getting worse | 1(5%) | 1(5%) | 2(10%) | 5(25%) | 9(45%) | 14(70%) | 4(20%) | 0 | 4(20%) |
| Fighting and bullying is a common problem | 1(5%) | 8(40%) | 9(45%) | 2(10%) | 3(15%) | 4(20%) | 5(25%) | 2(10%) | 6(30%) |
| Cultural beliefs increase the risk of contacting HIV/AIDS | 6(30%) | 7(35%) | 13(65%) | 1(5%) | 1(5%) | 2(10%) | 3(15%) | 2(10%) | 5(25%) |

The increasing incidence of pregnancy and sexually transmitted diseases (STDs) also indicates that many students continue to engage in unprotected safe. University clinic records show that the number of pregnancies increased from 58 in 1998/99 to 78 in 1999/2000, around 1.5% of total female enrolment in each of these years. However, it should be pointed out that the pregnancy rate for females aged 20-24 population was 16.2% in 1997. The number of STD cases treated at the university clinic increased from 795 (8.9% of total enrolments) in 1998/1999 to 1264 (11.5%) in 1999/2000. In the KAP study, about one-third of the 1327 questionnaire respondents indicated that they has experienced STD symptoms.

The following reasons were advanced for the increases in STDs and pregnancies:

- Improper use of condoms
- Unplanned sexual encounters under the influence of liquor
- Un-negotiated sexual intercourse between female and male partners
- Societal pressure on both male and female students to have a first child

Opportunistic AIDS-related infections (in particular TB) are also increasing. The university clinic recorded 34 TB patients in 1999/2000, up from 26 in 1998/1999 (See Table 6). On a more positive note, however, condom use appears to be increasing.

## 3.2 AGE, CULTURE AND INTER-GENERATIONAL SEX

The majority of the students are in the 20-24 and 25-29 age cohorts which, according to antenatal clinic sentinel surveys, have the highest HIV prevalence rates in the country. The majority of students are in their 20s and are not married. Societal expectations that a woman should have a child by a certain age exert powerful pressures on female students to practice unsafe sex with the intention to conceive. Moreover, most prospective husbands expect the woman to prove that they can conceive before they are prepared to marry. Some female students 'end up sleeping with 20 men a year, looking for the right man', while others 'must conceive to prove their womanhood'.

Unprotected sex practices are also exacerbated by 'the belief that sexual relations are not negotiable'. The perception of most men, which is supported by cultural beliefs, is that 'consent to a love relationship is consent to sex'. In other words, as soon as a woman is in a love relationship, sex is not negotiable. Culturally, men are also expected to marry women younger than themselves. A power hierarchy based on age thus becomes part of highly unequal relationships that are dominated by men. Older men also target younger women of the university age group in order 'to cleanse their blood'.

Male resistance to protected sex is further reinforced by the opposition of many church groups to the use of condoms. Young women are further exposed to the risk of HIV/AIDS because of cultural beliefs and practices that encourage men to have multiple partners. Two-third of the student focus groups agreed with the statement that 'cultural beliefs expose women to the risk of contacting HIV/AIDS' (See Table 5). Among the traditional sayings that continue to be passed from generation to generation are the following:

- Monna ke poo ga a agelelwe losaka (a man is a bull to be let loose)
- Monna ke tlhotse o a nama (a man is a seed to multiply)
- Monna ke selepe o a a dimangwa (a man is an axe to be exchanged)

Customary courts have invoked some of these sayings to chastise women who complain about promiscuity in a marriage thus reinforcing the subordinate role of women in any sexual relationship. In addition, wife inheritance (se ya ntlong) in the case of death of a male partner further exposes the 20-29 age group to the risk of HIV infection.

## 3.3 SEX AND VIOLENCE

Sexual harassment adds to the risk of contacting HIV/AIDS. The majority (55%) of the student focus groups agreed with the statement that 'sexual harassment between students is a

problem at this university'. Sexual harassment of female students by male students is reported to take place outside the dorms and in the dorms, especially in the toilets and showers. 'Male students who watch blue movies and those who are drunk invade the bathrooms while female students are bathing'. Peeping through the windows and using torches to see what is in the rooms also invades privacy. Roommates who have guests of the opposite sex over night also abuse other roommates. Sharing of rooms exposes students to possible rape in situations where one has to seek for accommodation.

Fourth year and graduate male students are also known to target first year female students. Girls walking around at night, especially near the bar, are at risk of being raped. There are cases where rape victims have contracted HIV. As one group narrated, 'men come into your room, refuse to leave, and rape you. One is afraid to report for fear that no one will believe you… Female students who drink are also sexually abused'. Rape also occurs after excessive consumption of beer. Other forms of sexual abuse are common, for example, 'whistling', 'unwarranted comments' and 'grabbing, touching, and physical advances' .

Sexual harassment of students by lecturers is not considered to be that common. Only 15% of the student focus groups agreed with the statement that 'sexual harassment by lecturers is a problem at this university', with 55% not sure (See Table 5). Some students stated that a small number of lecturers demand sex from students while other request 'hugs' from female students who visit their offices. Instances were also cited where female students seeking academic assistance are asked to see the lecturer at odd hours. There are also cases where lecturers have consensual love relations with students.

While sexual violence in Botswana is increasing, conviction rates remain low (Human Development Report, 2000). In the past, sexual harassment at UB was dealt with through standard disciplinary procedures. However, very few staff have ever been found guilty and effectively disciplined. A new sexual harassment policy came into effect in August, 2000.

# CHAPTER 4

# IMPACT ON STUDENTS

## 4.1 STUDENT ENROLMENTS

The student population at UB has grown very rapidly during the last decade- from 3664 in 1991/92 to 10,997 in 1999/2000. The gender ratio is exceptionally high: 47.7% of students are female (see Table 9). Only about 5% of the students are married. Nearly 84% of students are aged between 20-34, which are the highest HIV prevalence age cohorts (see Figure 4).

Table 9: Student enrolments, 1991 – 2000

| Year | Male | Female | Total |
|---|---|---|---|
| 1991/92 | 1929(53%) | 1735(47%) | 3664 |
| 1992/93 | 2049(51%) | 1968(49%) | 4017 |
| 1993/94 | 2090(48%) | 2228(52%) | 4318 |
| 1994/95 | 2624(51%) | 2508(49%) | 5132 |
| 1995/96 | 3338(52%) | 3022(48%) | 6360 |
| 1996/97 | 3843(52%) | 3493(48%) | 7336 |
| 1997/98 | 4332(52%) | 3970(48%) | 8302 |
| 1998/99 | | | 8,947 |
| 1999/2000 | 5757(52%) | 5240(48%) | 10,997 |

## 4.2 HIV INFECTION AMONG STUDENTS

There is no comprehensive and accurate information on HIV prevalence among students. National HIV sentinnel surveys of pregnant women attending antenatal clinics is the only reliable source of information. However, generalising the results of these surveys to the UB student population could be seriously problematic because the education level of university students is so different from the adult population as a whole.

HIV prevalence data in Botswana is also estimated from male patients with sexually transmitted diseases (STD). Results from this group give high HIV prevalence rates but, by their very nature, they are clearly not representative of the overall population. The university clinic conducts voluntary HIV testing among students who present with various STD and HIV-related symptoms (most notably herpes zoster, persistent cough, and weight loss, pneumonia, bells-palsy and karpoiss sarcoma/dermatitis). The results show that, out of a total of 179 students tested between 1997 and 2000, 30 percent of students tested positive, but there is no significant upward trend (see Table 10).

Figure 2: Age distribution of UB students, 1999/2000

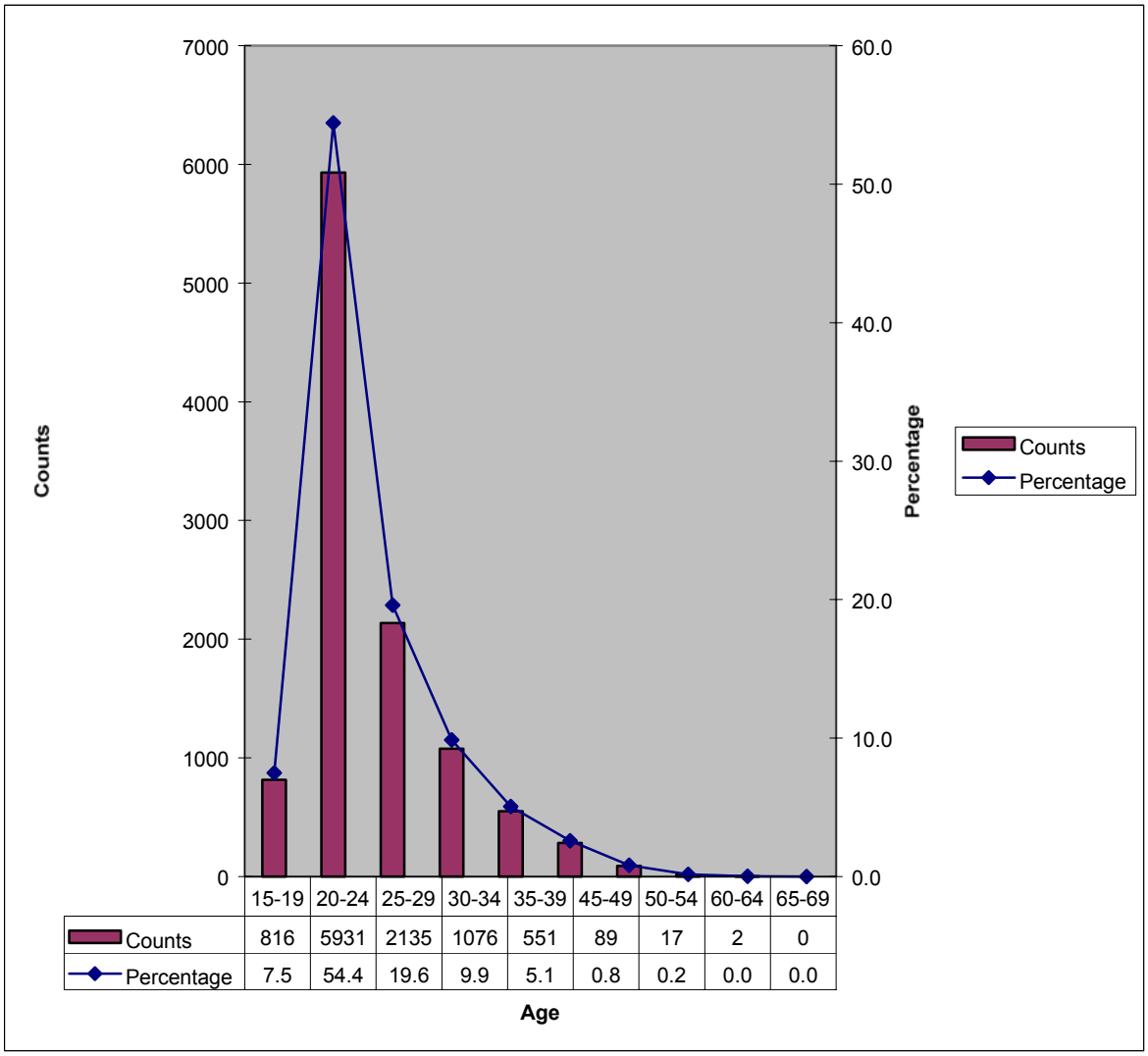



Table 10: HIV prevalence among UB students with STDs

| Year | Sample | HIV positive |
|---|---|---|
| 1997 | 37 | 19(51%) |
| 1998 | 46 | 12(26%) |
| 1999 | 47 | 9 (19%) |
| 2000 | 49 | 13(27%) |
| Total | 179 | 53 (30%) |

*Source: University clinic records*

In comparison with pregnant women and adults with STDs, HIV prevalence rates appear to have much lower among UB students since 1998 (see Table 11). The sample of UB students is, however, too small to make any meaningful conclusions.

Table 11: HIV prevalence rates among UB students and adult population living in Gaborone (percentages)

| Year | UB students with STDs | Pregnant women 20-24, Gaborone | Pregnant women 25-29, Gaborone | All males with STDs, Gaborone |
|---|---|---|---|---|
| 1997 | 51 | 41.4 | 41.0 | 38.8 |
| 1998 | 26 | 42.8 | 45.2 | 54.2 |
| 1999 | 19 | 38.7 | 43.3 | 50.7 |
| 2000 | 27 | na | na | Na |

## 4.3 STUDENT DEATHS

Data on deaths was compiled from the files of memos issued by the Public Relations Office to notify the university community of a death. Starting in 1991, cause of death was categorised as follows: road accident, fire, murder, found dead (a euphemism for suicide), short illness and long illness. However, in 1996, PRO memos stopped mentioning any cause of death related to illness because staff had complained that 'long illness' was too obvious an indicator of HIV/AIDS. Since then, most memos just announce that the death has occurred, unless it was an accident or sudden heart attack. However, the PRO confirmed that virtually all non-accidental deaths continue to be illness-related.

### 4.3.1 Trends in mortality and comparative mortality

A total of 85 students died between 1991/92 and 1999/2000 - 62 students (73%) from illness, 18 in road accidents, and 5 other accidents (see Table 12). Male students accounted for 56.3% of all deaths. More females than males died from illnesses. The annual number of deaths remained at 7-9 between 1991/92 and 1998/1999, but increased sharply in 1999/2000, which is cause for concern. Up until 1999, the annual mortality rate among students was falling. Even with the sharp increase in 1999/2000, the illness-related mortality rate was only 0.13%. This is not only very low in absolute terms, but is over 10 times less than the projected AIDS-related mortality rates for the adult population in the 20-29 age cohorts (see Table 13).

Table 12: Student deaths by gender and cause of death, 1991/92 - 1999/2000

| Year | Male | | Female | | Total | Total students enrolled | Mortality rate |
|---|---|---|---|---|---|---|---|
| | Illness | Other | Illness | Other | | | |
| 1991/92 | 1 | 3 | 1 | 2 | 7 | 3556 | 0.19 |
| 1992/93 | 2 | 1 | 2 | 2 | 7 | 4017 | 0.17 |
| 1993/94 | 0 | 2 | 4 | 1 | 7 | 4518 | 0.15 |
| 1994/95 | 3 | 1 | 4 | 1 | 9 | 5132 | 0.17 |
| 1995/96 | 4 | 2 | 3 | 0 | 9 | 6360 | 0.14 |
| 1996/97 | 2 | 3 | 4 | 0 | 9 | 7356 | 0.12 |
| 1997/98 | 3 | 0 | 4 | 1 | 8 | 8302 | 0.10 |
| 1998/99 | 6 | 0 | 3 | 0 | 9 | 8947 | 0.10 |
| 1999/2000 | 11 | 3 | 5 | 1 | 20 | 10997 | 0.18 |
| Total | 32 | 15 | 30 | 8 | 85 | | 0.14 |

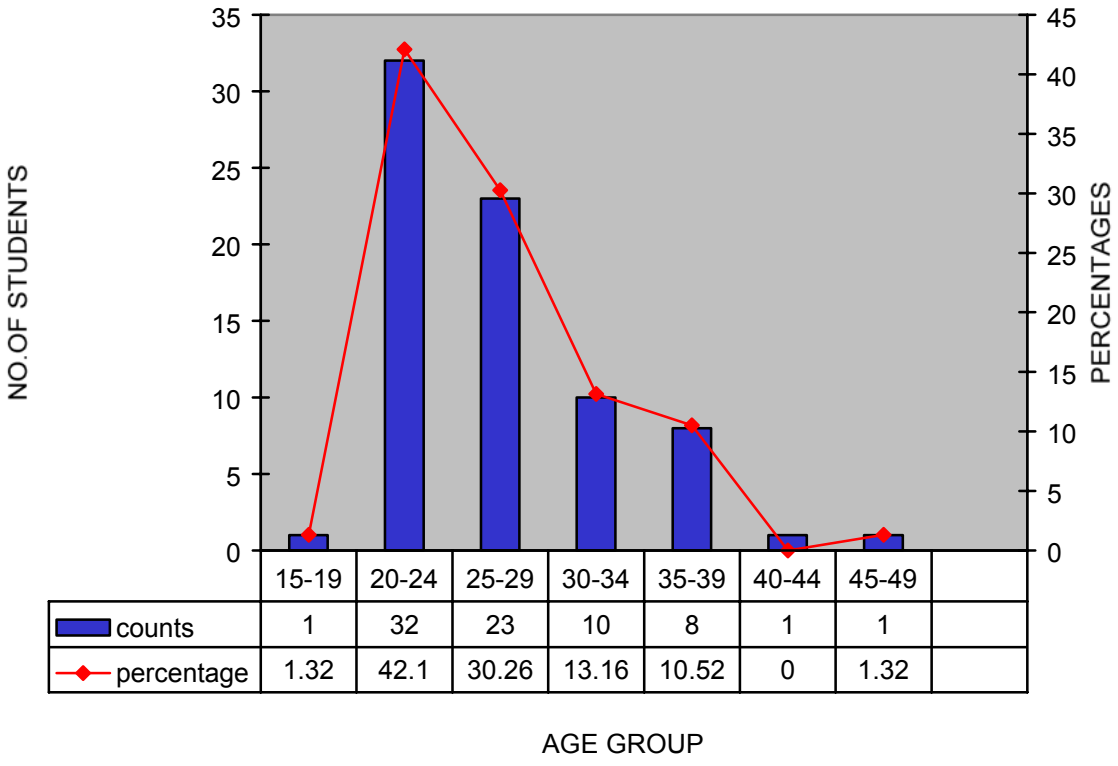
Table 13: Student and adult mortality rates, 1991-2000 (deaths/'000)

| Year | UB students (all causes) | Projected AIDS-related, all adults 20-24 | Projected AIDS-related,all adults 25-29 | University of Zambia |
|---|---|---|---|---|
| 1991 | 2.7 | 2.2 | 2.9 | 1.5 |
| 1992 | 1.7 | 3.1 | 4.3 | 1.2 |
| 1993 | 1.5 | 4.3 | 6.2 | 2.2 |
| 1994 | 1.7 | 5.6 | 8.5 | 2.3 |
| 1995 | 1.4 | 7.2 | 11.4 | 1.5 |
| 1996 | 1.2 | 8.8 | 14.9 | 4.3 |
| 1997 | 1.0 | 10.4 | 18.8 | |
| 1998 | 1.0 | 12.0 | 23.2 | 4.5 |
| 1999 | 1.8 | 13.4 | 27.9 | |

### 4.3.2 Age and Gender

42.1% of the student deaths occurred in the 20-24-age cohort and 30.3% in the 25-29 age cohort (see Figure 3). Male students accounted for 56.3% of all deaths, but more females have died from illness. Table 14 shows student deaths by faculty. The Faculty of Engineering was only established in 1995/96 with the incorporation of the polytechnic into the university. The Faculty of Business Studies first admitted students in 1997.

Figure 3: Age distribution of student deaths 1991/92-1999/00



Students who are dying of AIDS-related illnesses are almost certainly infected before they reach the university. Relatively large numbers of students are dying in the first and second years which indicates that they were infected in their mid-late teens (see Table 15). This highlights the importance of preventing infection while children are still at secondary school.

Table 14: Student deaths by faculty 1991-1999

| Faculty | Females | Males | Total |
|---|---|---|---|
| Education | 11 | 13 | 24 |
| Business | 2 | 4 | 6 |
| Humanities | 14 | 9 | 23 |
| Social science | 10 | 7 | 17 |
| Science | 2 | 8 | 10 |
| Engineering and technology | 1 | 4 | 5 |
| Total | 40 | 45 | 85 |

Table 15: Student deaths by year of study, 1991-2000

| Year of study | 1 | 2 | 3 | 4 | 5 | Total |
|---|---|---|---|---|---|---|
| No. deaths | 26 | 21 | 14 | 18 | 1 | 80 |

## 4.4 IMPACT ON TEACHING AND LEARNING

The impact of the AIDS epidemic on teaching and learning at UB was assessed by analysing focus group responses to statements concerning student performance as well as standard performance indicators (in particular student withdrawals, absenteeism, examinations). This was complemented by interview data from academic and support staff.

### 4.4.1 Overall impact

Roughly half (55%)of the student focus groups agreed that HIV/AIDS is affecting teaching and learning. The remaining groups disagreed or were not sure (see Table 16). Most agreed that that absenteeism from classes by students and lecturers who are sick, seeking medical care, hospitalised, bedridden, taking care of the sick or attending funerals disrupts classes, and thus lowers student performance. Some students who have clinical AIDS stay away from classes because of the stigma attached to HIV/AIDS and the discrimination that they experience from the university community. Students living with AIDS often give up on learning. There are also concerns that some suicides on campus could possibly be attributed to HIV/AIDS.

During the focus group discussions, students recounted that the presence of a person suspected of 'having AIDS' in a class created tension, resulting in lack of concentration during lessons and a poor learning environment. Students also expressed various concerns about congested classrooms and hostels, noting that this exposed them to infectious diseases such as TB. Support staff also worry about crowded working conditions. Some staff recommended TB tests especially for boarding students who share rooms.

Interviews with Heads of Departments revealed that the number of mentally disturbed students has increased in recent years. One department referred six students to the counselling centre in one academic year. A student threatened to throw himself from the top of a high

storey building if marks for his assignments were not raised. In another incident, a student who was certified unfit for classes for an indefinite period of time demanded to be registered in the middle of a semester. Records from the University clinic do show an increase in the number of mentally disturbed students.

### 4.4.2 Absenteeism

**Student FGD**: The quality of education is affected if students and lecturers spend less time on academic work. Only 40% of the student FGDs agreed with the statement that 'students affected by HIV/AIDS are often absent from classes (see Table 16). Similarly, only 15% of the groups agreed with the statement that 'students whose relatives and close friends are affected by HIV/AIDS are often absent from class'. Only 25% agreed that 'students affected by HIV/AIDS withdraw from the university' and not one group agreed with the statement that 'students who have to look after sick relatives withdraw from the university'.

Table 16: Student responses to statements concerning the impact of HIV/AIDS on students

| STATEMENT | M | F | TOTAL | M | F | TOTAL | M | F | TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| Cultural beliefs and practices expose those affected by HIV/AIDS to discrimination | 1(5%) | 2(10%) | 3(15%) | 4(20%) | 4(20%) | 8((40%) | 4(20%) | 5(25%) | 9(45%) |
| Students affected by HIV/AIDS are discriminated against by the University community | 0(0%) | 0(0%) | 0(0%) | 7(35%) | 9(45%5) | 16(80%) | 2(10%) | 2(10%) | 4(20%) |
| University management has taken firm action to counter any discrimination against any lecturer or student who has HIV/AIDS | 0(0%) | 0(0%) | 0(0%) | 7(35%) | 8(40%) | 15(75%) | 2(10%) | 2(10%) | 4(20%) |
| Orphans at this University should receive special help | 1(5%) | 2(10%) | 3(15%) | 7(35%) | 9(45%) | 16(80%) | 1(5%) | 0(0%) | 1(5%) |
| Students affected by HIV/AIDS are often absent from classes | 1(5%) | 7(35%) | 8(40%) | 8(40%) | 3(15%) | 11(55%) | 1(5%) | 0(0%) | 1(5%) |
| Students whose relatives and close friends are affected by HIV/AIDS are often absent from classes | 1(5%) | 2(10%) | 3(15%) | 7(35%) | 4(20%) | 11(55%) | 2(10%) | 2(10%) | 4(20%) |
| Students affected by HIV/AIDS withdraw form the University | 2(10%) | 3(15%) | 5(25%) | | 3(15%) | 3(15%) | 2(10%) | 4(20%) | 6(30%) |
| Students who have to look after relatives withdraw from the University | 0(0%) | 0(0%) | 0(0%) | 3(15%) | 5(25%) | 8(40%) | 8(40%) | 3(15%) | 11(55%) |

**Staff interviews**: In contrast to the views of students, faculty tutors, deans and heads of departments all reported that the number of students seeking permission to be absent from classes has increased noticeably during the last 2–3 years. One head of department estimated that up to 30% of the students miss classes due to illness, nursing the sick or attending funerals. Absenteeism forms underestimate the rates of student absenteeism mainly because students only ask for permission if they are likely to miss a test, submit an assignment late or be away for a noticeable period of time. It was also noted that truancy is a common problem across campus, especially for large classes.

Affected students also miss tests, examinations, and tutorials and are not able to submit assignments in time. For example, out of a sample of 106 students in the Faculty of Education who were asked to indicate classes, assignments and tests they would miss after being granted a leave of absence, 53 (50%) indicated they would miss lessons and tests. Eleven (10%) students indicated they would not be able to submit assignments on the due date. The general consensus among students is that academic staff should show sensitivity to students who are absent from classes for good reasons. Lecturers should also be more flexible and supportive of students who are living with AIDS. Lecturers, on the other hand, are concerned about the increase in their workload that results from having to redesign equivalent tests for students who miss tests and holding tutorials for those who miss lessons.

### 4.4.3 Faculty absenteeism records

A total of 609 student absenteeism records from the Faculty of Education (1998/99 and 1999/200) and the Faculty of Humanities (1999/2000) were analysed. Data was also obtained from examination results books between 1994/95 and 1999/00.

Of the 1,682 students enrolled in the Faculty of Education in 1998/99, 293 (17.4 %) were granted leave of absence from classes. In the Faculty of Humanities, out of a total of 1,513 students, 166 (11%) students requested leave of absence from classes in 1999/2000. In both faculties, a total of 45 students (7.4%) were granted leave of absence for an indefinite period. Most students, however, were absent for 1-5 days (see Table 17).

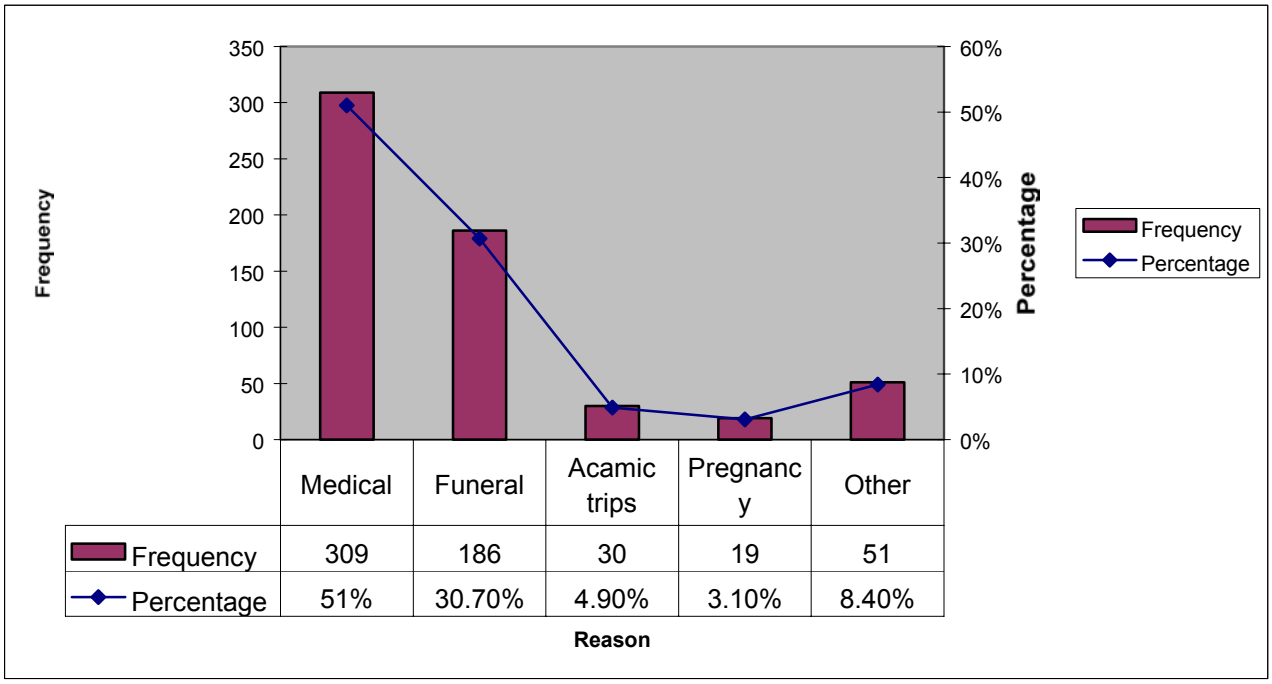
Table 17: Days absent by reason

| Days absent | Medical | Funerals | Academic trips | Pregnancy | Other | Total |
|---|---|---|---|---|---|---|
| 1-5 | 198 | 153 | 24 | 1 | 39 | 417 |
| 6-10 | 27 | 22 | 5 | 2 | 3 | 56 |
| 11-15 | 22 | 8 | 0 | 10 | 0 | 40 |
| 16+ | 21 | 0 | 0 | 3 | 2 | 26 |
| Indefinite | 31 | 0 | 0 | 0 | 0 | 31 |
| Total | 299 | 183 | 29 | 16 | 51 | 605 |

One-half of all student absences were due to illness. Funerals accounted for one-third of all absences (see Figure 4).

The number of days absent to attend a funeral ranged from 1 to 14 days. Days vary for the funeral attendee, depending on the relationship to the deceased and the social standing of the attendee in the family. Funerals in Botswana are held on weekends. Those married are expected to avail themselves immediately the death occurs and to go through a period of seclusion that lasts until the day of the burial if they are women. Those who lose parents, especially if they are in the age range of the majority of the university students, are expected to take part in the funeral arrangements of the deceased. As such, they are expected to avail themselves immediately that death is announced. Table 17 shows the frequency of days students were absent by reason.

Figure 4: Reasons for student absence




## 4.5 CARE AND SUPPORT

Care of sick students at the University is generally poor. A sick student who is bedridden has no one to care for him/her, bring food from the refectory, and generally offer help (with bathing, feeding, taking medication, and visits to the health clinic). Where the student has a rapport with the roommate, care giving becomes the burden of the roommate. In the majority of cases, however, because of the stigma attached to HIV/AIDS and the fear and anxiety of contracting infectious diseases like TB, the roommate vacates the room.

Students in the FGDs observed that watching sick friends suffer and die is emotionally stressful and engenders despair in the student community and also among lecturers. One student who had nursed a roommate commented that she was relieved when her friend finally passed away because she had watched her helplessly go through pain, agony, despair and finally death. Students, academic and support staff are concerned that there is no support on campus for caregivers (see Box 1) and that stress levels are highest amongst those who are in constant contact with the sick and as such needed support. Deans and heads of departments readily agree that they lack the skills to deal with students who are HIV patients. They urgently need training in this area.

The examples of the two sick students presented in Box 1 highlights the need for urgent action including:

- Daily visits to the rooms by wardens to identify bedridden students.
- Close monitoring of sick students by the university clinic.
- Setting up student support groups .
- Identifying personnel with the responsibilities to provide care for students in the hostels.

- Medical insurance for all students. The Ministry of Education is making arrangements for a medical scheme for all students.

**BOX 1: Case studies of student care and support**

**STUDENT, male, 23 years old.**

I am a third year humanities student. I have not been very well for a long time. My condition has continued to deteriorate since June 1997. At the beginning of September 1997, my condition became worse and I could not even attend classes properly. I finally stopped going to class altogether and just stayed in my room, sleeping most of the time.

On October 3rd 1997, a lady came into my room and introduced herself as coming from the Careers and Counselling Centre. We talked for a while before she asked me to accompany her to the Centre. I was more than willing to do that since it was very relaxing to talk with this lady. I had already missed a lot of classes and had not been able to really do any work towards my CA (continuous assessment). Among other things, we talked about proper care, recuperation, and temporary withdrawal. I also agreed to a referral to the Campus Clinic where this lady took me to see one of the campus doctors. We all agreed that given the situation, I would benefit from temporary withdrawal. Both the doctor and my counsellor helped me with the procedures for temporary withdrawal. Everything was done and completed by the 18th October and I was able to leave for home with my brother. I was to be away from the University (on sick leave) for the rest of the first semester.

**COUNSELLOR**

Our cleaning lady who has seen him "just lying there for some weeks" reported this client to us. I acted promptly to the report by visiting him in his room. What touched me the most was the fact that the room was dark (both the windows and the door were shut tight). When I knocked, I could not hear him inviting me in but a cleaning lady who was there told me to open because "the person inside was sick." Despite the October heat, he was well under covers. I introduced myself and requested that I sit for a while. He was looking frail, pale, and tired. Talking was obviously an effort for him but he was very welcoming and seemingly happy to talk to me.

After taking him to the Centre to continue our discussion, I finally took him to the clinic for further assessment. He had apparently been put on a TB treatment but the response was poor. His body was being ravaged by opportunistic infections. The doctor put him back on the TB treatment and also supported temporary withdrawal. I also got in touch with two close relatives in Gaborone (an aunt and a cousin). They visited him on the 4th October 1997. Like all of us, they were surprised that they had never really heard about his deteriorating condition till then. They were upset that he even had to be found by a cleaner. I got their telephone numbers for follow- up purposes even long after my client had left the University. I also reported to the warden but since we were already handling the case, we proceeded with it.

I made two follow- ups (December 1997/January 1998) that reported some kind of improvement on my client's health. He was living in Francistown with his brother since he had already lost both parents and a sister. Despite the positive report, my client was reported dead a few months after that. He never really got well enough to come back to the University. I advised them on reporting to the relevant offices at the University.

## 4.6 ORPHANS

The number of orphans in the country is increasing rapidly. By 2010 around one-third of all children under 15 will have lost both parents or their mother (See Table 18). Studies on orphans describe an orphan as suffering from serious emotional stress, stigmatisation, and

isolation and in need of basic survival need such as food and shelter (see Ministry of Health, 1998).

A growing proportion of students admitted to UB will, therefore, be orphans. The student FGDs had little to say about orphans and most groups did not think that orphans students should receive any special assistance from the university (see Table 16). However, during the next decade, it is clear that the university must liase closely with the appropriate government agencies and non-governmental agencies so as to ensure that disadvantaged orphans who manage to get to UB are properly supported.

Table 18: Projected number of orphans, 2000 to 2010

| | Maternal and double orphans from all causes | Maternal double orphans as % of children < 15 | % of maternal/ double orphans from AIDS | Paternal orphans as % of children <15 | Total orphans as % of children < age 15 |
|---|---|---|---|---|---|
| 2000 | 67,455 | 10.5% | 70.6% | 12.9% | 23.4% |
| 2005 | 97,056 | 15.2% | 83.0% | 15.2% | 30.4% |
| 2010 | 120,458 | 20.0% | 89.5% | 16.4% | 36.4% |

## 4.7 STUDENT DROPOUT AND REPETITION

### 4.7.1 Overview

Student attrition (as a result of voluntary withdrawal, poor academic performance and death) undermines the university's efforts to train high level personnel in a timely and efficient manner. In 1999/2000, a total of 282 students (2.6%) dropped out. Another 206 students (2.4%) had to repeat the year.

### 4.7.2 Voluntary withdrawals

The Department of Academic Services has compiled data on students' withdrawals since 1995/96. A list of withdrawn students is circulated to all faculties in order to inform academic staff about the status of their students. A trend analysis of withdrawn students from 1995/96 to 1999/200 shows a nearly threefold increase in the number of students who withdrew from the university for medical reasons. The withdrawal rates due to illness increased from 0.22% in 1995/96 to 0.43% in 1999/2000 (See Table 19).

Table 19: Non-academic withdrawals by reason, 1995/96 - 1999/2000

| Academic year | Medical | Personal | Transfer and other | Total | Total enrolment | Withdrawal rate |
|---|---|---|---|---|---|---|
| 1995/96 | 14 (0.22%) | 29 | 15 | 48 | 6360 | 0.75 |
| 1997/98 | 25 (0.30%) | 30 | 15 | 70 | 8302 | 0.84 |
| 1998/99 | | | | 75 | 8947 | 0.84 |
| 1999/00 | 48 (0.43%) | 80 | 2 | 130 | 10997 | 1.18 |

If it is assumed that all students who withdraw for medical reasons eventually die, then the overall mortality rate among students in 1999/2000 increases to 0.61%. It is also possible that some students who withdraw for 'personal' reasons are sick. The ratio of students withdrawal for medical reasons to illness-related deaths while still registered at UB was 3:1 in that year.

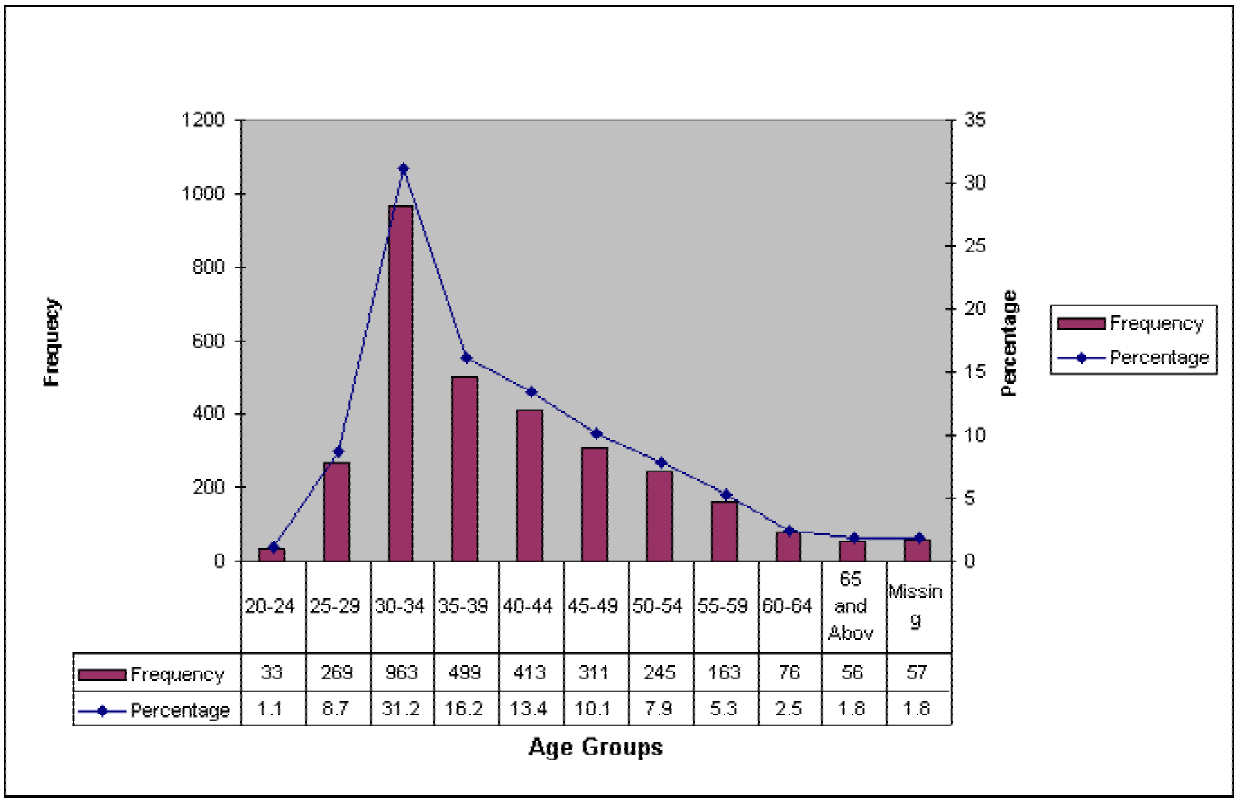
# CHAPTER 5

# ACADEMIC AND SUPPORT STAFF

## 5.1 STAFFING SITUATION

At the end of 2000, UB employed 3085 staff. 59% were male and 50% were married. It can be observed in Figure 5 that nearly 60% of staff is aged under-40 and are, therefore, in the high HIV prevalence age cohorts.

Figure 5: Age distribution of UB staff, late 2000




### 5.1.1 Academic staff

Academics account for slightly more than one-half of all employees (see Table 20). Less than one-quarter of academics at UB are nationals with permanent and pensionable status and employed on a full time basis. 28% are foreign nationals on short-term contracts and another 33.5% are nationals working on a part-time, temporary basis. Three out of ten academics at UB are women (but 36% of permanent and pensionable staff).

### 5.1.2 Support staff

Support staff are employed in three main categories: senior, junior and industrial workers (see Table 20). Junior support staff are the second largest group of staff at the university. Women comprise 50-60% of junior and industrial support staff..

Table 20: Academic and support staff, December 2000

| | Female | Male | Total |
|---|---|---|---|
| **ACADEMIC** | | | |
| Sabbatical | 3 | 15 | 18 |
| Full-time temporary | 39 | 45 | 84 |
| Local contract | 18 | 23 | 41 |
| Overseas contract | 54 | 391 | 445 |
| Part-time temporary | 162 | 364 | 526 |
| Permanent and pensionable | 132 | 237 | 369 |
| Staff development | 39 | 48 | 87 |
| **Sub-total** | **447** | **1124** | **1571** |
| **SENIOR SUPPORT** | | | |
| Overseas contract | 4 | 26 | 30 |
| Permanent and pensionable | 51 | 34 | 85 |
| Local contract | 6 | **61** | 25 |
| **Sub-total** | **61** | **79** | **140** |
| **JUNIOR SUPPORT** | | | |
| Permanent and pensionable | 384 | 315 | 699 |
| Overseas contract | 4 | 50 | 54 |
| Local contract | 6 | 19 | 29 |
| Temporary | 35 | 15 | 50 |
| Staff development | 1 | | 1 |
| Part-time | 1 | 3 | 4 |
| Sub-Total | 431 | 402 | 837 |
| **INDUSTRIAL SUPPORT** | | | |
| Permanent and pensionable | 325 | 205 | 530 |
| Temporary | 6 | 1 | 7 |
| **Sub Total** | **331** | **206** | **537** |

## 5.2 HIV PREVALENCE

Accurate and up to date information on HIV prevalence rates among academic and non-academic staff is essential in order to make a proper assessment of the AIDS epidemic on the university. Unfortunately, however, this data is not available, which makes it very difficult for the university to develop a coherent response to the crisis. It is necessary, therefore, to use other types of information in order to try to establish to what extent UB staff have been and are likely to be affected.

Most staff use outside medical facilities and the counselling centre does not record visits by staff member seeking counselling related to HIV/AIDS.

## 5.3 STAFF DEATHS

### 5.3.1 Academic staff

According to university records, a total of 18 full-time academic staff died in the ten year period from 1991 to 2000 – 1 senior academic, 14 lecturers (including 1 staff development fellow), and 3 tutors[4] (see Table 21). Most of these deaths were due to illness. Only four of the 14 lecturers were nationals. All three tutors were expatriates. The number of academic deaths at UB is much lower than at the University of Zambia where 43 academics died between 1990 and 1998[5] (see Table 22). Age at death is as follows: 25-29 – 4, 30-39 –2, 40-44 – 4, 45> 5.

Table 21: Academic staff mortality 1991/92-2000/01

| Year | Nationals | | | Expatriates | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| 1991/92 | | 0 | | | 0 | | | 0 | |
| 1992/93 | | 0 | | | 1 | | | 1 | |
| 1993/94 | | 0 | | | 1 | | | 1 | |
| 1994/95 | 212 | 0 | 0 | 246 | 3 | 1.22 | 458 | 3 | 0.66 |
| 1995/96 | 205 | 1 | 0.49 | 286 | 0 | 0 | 491 | 1 | 0.20 |
| 1996/97 | 282 | 1 | 0.35 | 272 | 0 | 0 | 554 | 1 | 0.18 |
| 1997/98 | 325 | 1 | 0.31 | 289 | 2 | 0.69 | 614 | 3 | 0.49 |
| 1998/99 | 357 | 0 | 0 | 312 | 3 | 0.96 | 669 | 3 | 0.45 |
| 1999/00 | 397 | 1 | 0.25 | 300 | 0 | 0 | 697 | 1 | 0.14 |
| Total | 1778 | 4 | | 1705 | 10 | | 3483 | 12 | |

Table 22: Academic deaths at UB and UNZA, 1990-2000

| **Year** | **Staff in-post** | **Deaths** | **Mortality rates** | **Deaths at UNZA** |
|---|---|---|---|---|
| 1990/91 | | | | 5 |
| 1991/92 | | | | 1 |
| 1992/93 | | 1 | | 2 |
| 1993/94 | | 1 | | 6 |
| 1994/95 | 459 | 3 | 0.65 | 5 |
| 1995/96 | 540 | 1 | 0.18 | 5 |
| 1996/97 | 554 | 1 | 0.18 | 3 |
| 1997/98 | 624 | 3 | 0.48 | 8 |
| 1998/99 | 643 | 3 | 0.47 | 6 |
| 1999/00 | | 1 | | |

It would appear, therefore, that the impact to date of the AIDS epidemic on academic staff at UB, and particularly nationals, has relatively very limited. Academic mortality rates are well under half the projected AIDS-related mortality rates for the adult population as a whole in 1998/99, which again suggests that the epidemic may have a much lower impact on the university than has been suggested in the media and elsewhere.

[4] Information on deaths among academic staff is available only for full time employees

[5] Mortality rates were not calculated in the UNZA study

### 5.3.2 Junior support staff

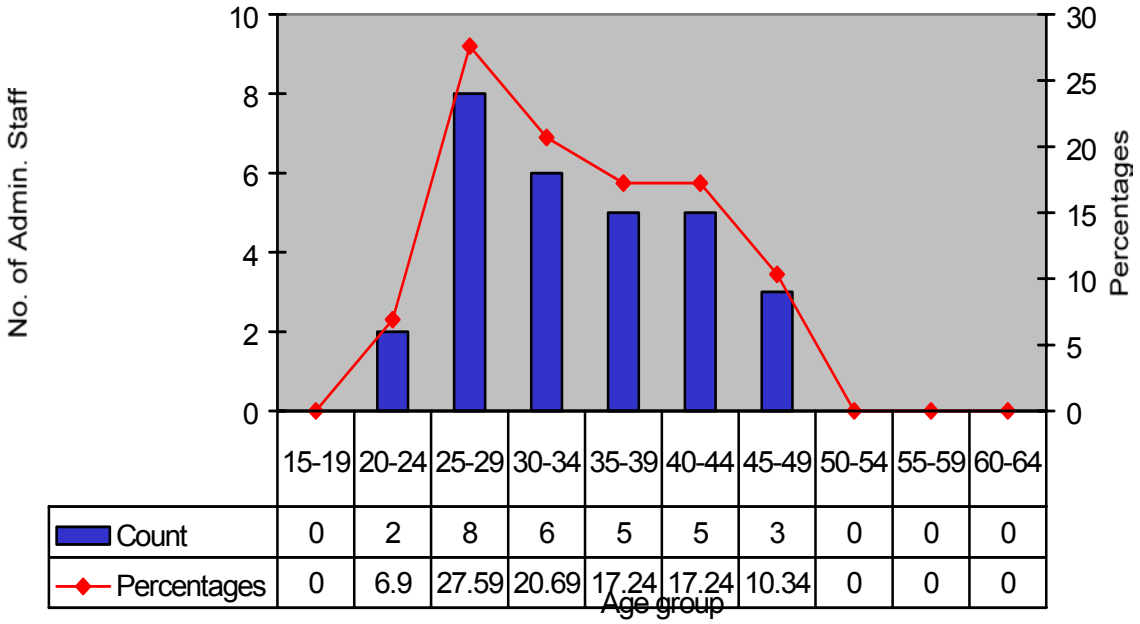
A total of 33 junior staff died employees died between 1991/92 and 1999/2000. Of these, 18 were women. The number of deaths increased from 1 in 1992/93 to 10 in 1999/2000 (see Table 23). The majority of deaths were due to illness.

Table 23: Full-time junior support staff deaths, 1991/92 – 1999/2000

| Year | Number deaths | | | Total staff | Mortality rate |
|---|---|---|---|---|---|
| | Male | Fem. | Total | | |
| 1991/92 | | | | | |
| 1992/93 | 1 | | 1 | | |
| 1993/94 | | 2 | 2 | | |
| 1994/95 | 2 | 1 | 3 | | |
| 1995/96 | 2 | 2 | 4 | | |
| 1996/97 | 2 | 1 | 3 | | |
| 1997/98 | 2 | 2 | 4 | 658 | 0.75 |
| 1998/99 | 1 | 3 | 4 | 602 | 0.66 |
| 1999/00 | 3 | 7 | 10 | 640 | 1.56 |
| Total | 13 | 18 | 31 | | |

Deaths by age cohort are presented in Figure 6. Unlike academic staff, mortality rates for junior staff have risen very rapidly in recent years and were nearly two percent in 1999/2000, which is very high.

Figure 6: Age distribution of deaths among junior support staff, 1991/92-1999/00



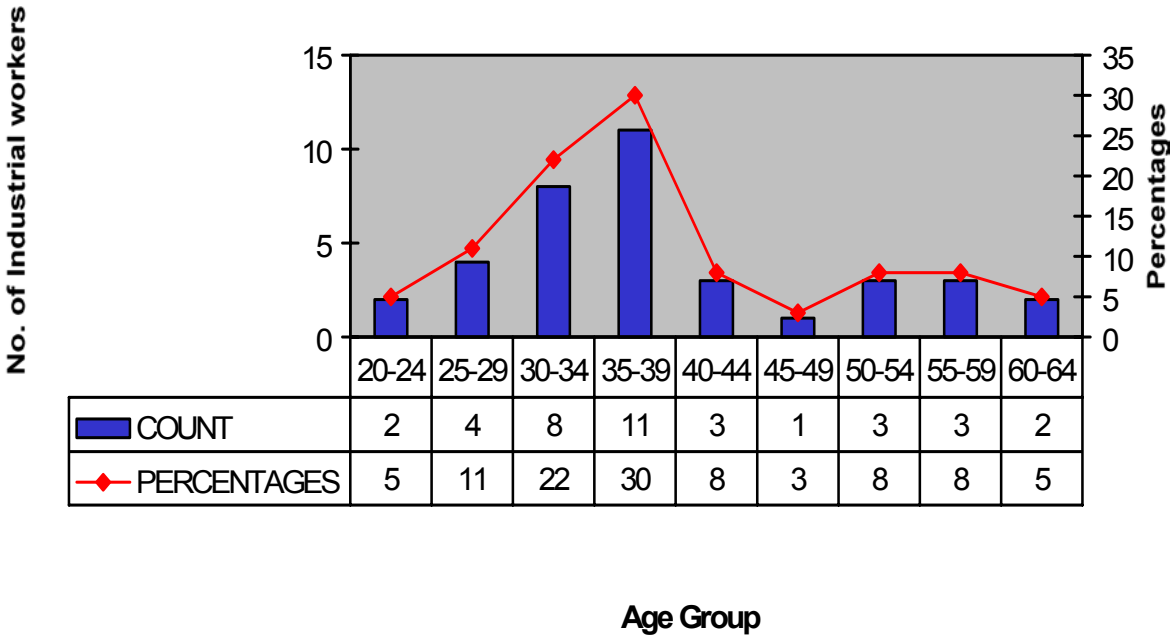
### 5.3.3 Industrial class

A total of 46 full-time industrial support staff died between 1991/92 and 1999/2000. Of these, 31 (72 %) were women. Again, the majority of deaths were due to illness (see Table 24). The overall mortality rate for these staff, most of whom are poorly educated, low paid, and not members of any medical aid scheme was 1.7 in 1999/200, nearly four times higher than for academic staff. Similar mortality rate differentials exist in the public service as a whole in Botswana (see Bennell et al, 2001).

Table 24: Full-time industrial class deaths, 1991/92 - 1999/2000

| Year | Number deaths | | | Total staff | Mortality rate |
|---|---|---|---|---|---|
| | Male | Fem. | Total | | |
| 1991/92 | | 1 | 1 | | |
| 1992/93 | | 1 | 1 | | |
| 1993/94 | 1 | 1 | 2 | | |
| 1994/95 | | 1 | 1 | | |
| 1995/96 | 3 | 4 | 7 | | |
| 1996/97 | 2 | 5 | 7 | | |
| 1997/98 | 3 | 3 | 6 | 507 | 1.3 |
| 1998/99 | 2 | 10 | 12 | 526 | 2.3 |
| 1999/00 | 4 | 5 | 9 | 483 | 1.8 |
| Total | 15 | 31 | 46 | | |

Figure 7: Industrial worker deaths by age cohort, 1991/92-1999/00



### 5.3.4 Comparative mortality

Table 25 compares mortality rates among staff and students at UB with those for teaching staff at primary and secondary schools as well as projected AIDS-related deaths for the adult 15-59 population in 2000.[6]

Table 25: Mortality rates among teaching staff at primary and secondary schools and UB staff and students, nationals only (deaths/000)

| | Female | Male | All |
|---|---|---|---|
| Primary teachers | 7.2 | 7.7 | 7.4 |
| Junior secondary teachers | 3.5 | 5.3 | 4.4 |
| Senior secondary teachers | 2.3 | 5.1 | 3.7 |
| University teachers | | | 2.0 |
| Support staff | | | 17.0 |
| Industrial class | | | 18.0 |
| Students | | | 1.8 |
| Adult population 15-59 | | | 20.0 |

The three groups with university training (senior secondary school teachers, university academics, and university students) all have similar mortality rates (of between 2-4 per thousand), which are five-ten times less than projected AIDS-related mortality for the adult population as a whole. More research needs to be urgently undertaken in order to identify the reasons for these very large differences in mortality rates.

## 5.4 MORBIDITY AND ABSENTEEISM

It is difficult to measure absenteeism among academic staff because absences from work are not always reported. The Human Resources Unit does, however, keep a record of academic and support staff leave of absence. Leave is taken for a variety of reasons including illness of self, funerals of relatives and friends and looking after sick family members and relatives.

The number of staff taking leave increased from 150 in 1995 to 450 in 1999. Total leave days taken increased from 1,200 in 1995 to about 5, 000 in 1999[7] (see Figure 8).

In general, absenteeism among academic staff is not seen as a serious problem. There is one faculty where the Dean reported that a few staff were experiencing health problems, which had caused some delays in setting, marking and submitting of examinations. Some students also complained that the examinations had topics, which had not been taught.

Absenteeism is, however, a major problem among junior support staff and industrial support staff.

[6] These mortality rates need to be adjusted for age, location and gender

[7] Thus the average number of days absent increased from 8 in 1995 to 11.1 in 1999

Figure 8: Total leave days taken by UB staff, 1994-2000

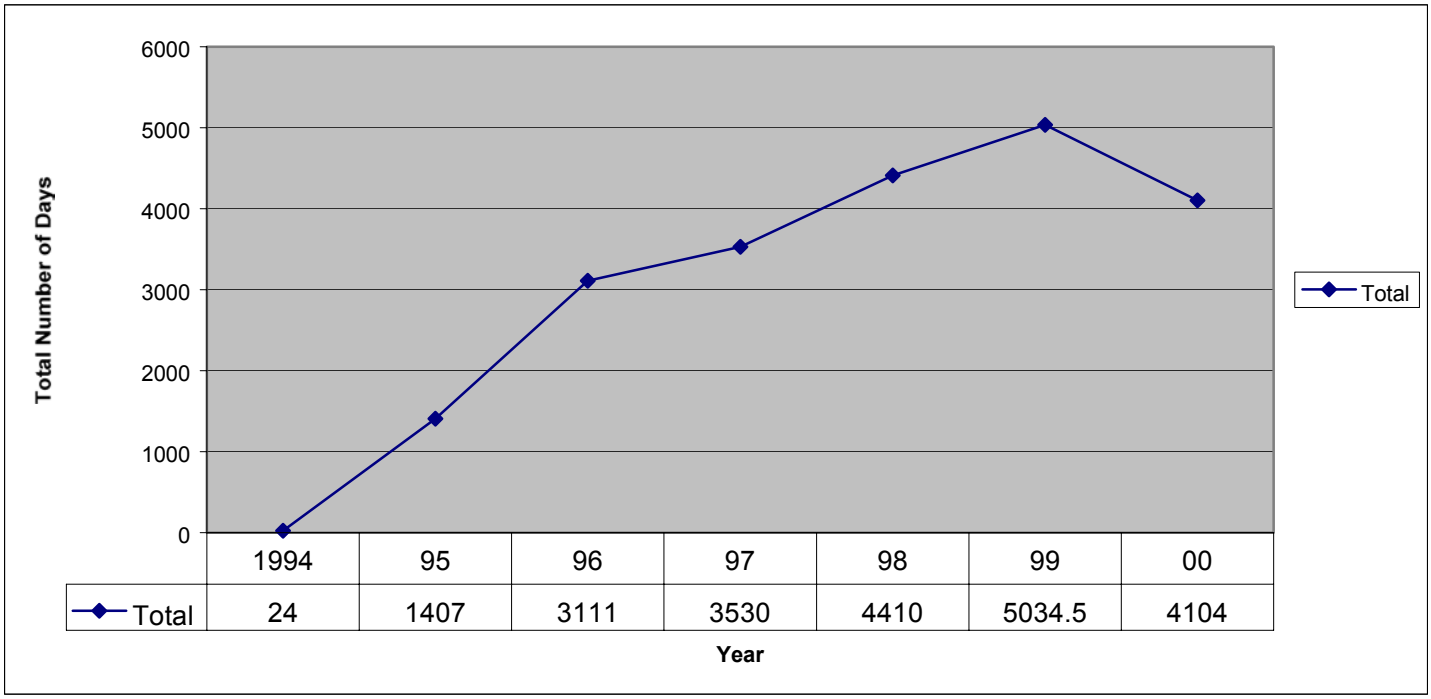
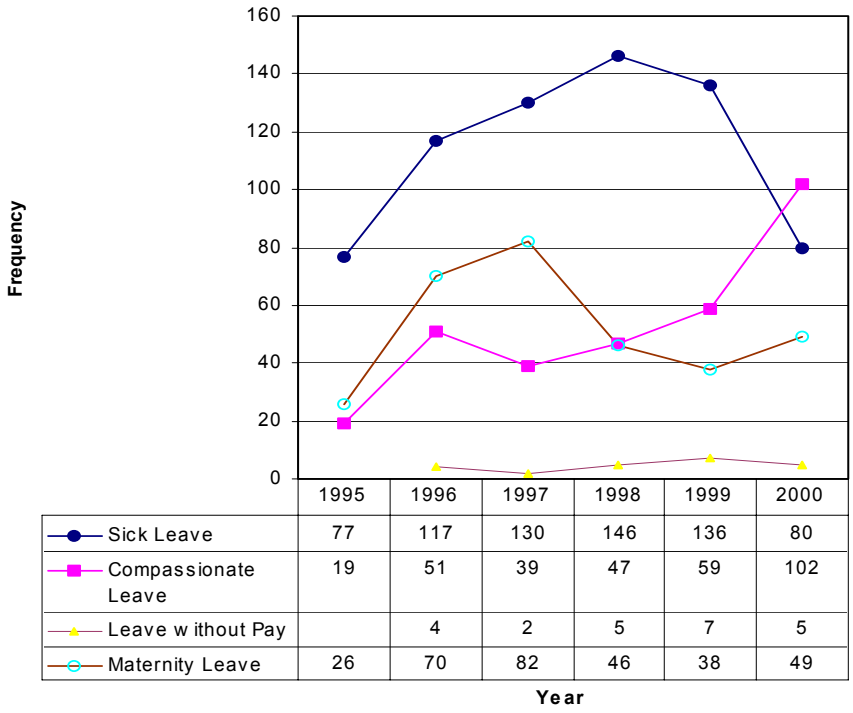



Figure 9: Staff leave of absence by reason, 1995-2000




### 5.4.1 Compassionate leave

Compassionate leave is granted for staff to make arrangements for funerals of relatives and friends, to nurse sick family members and friends. Out of 1348 staff who took leave between

1995-2000, 327 (24.3%) took compassionate leave (see Table 26). The number of staff taking compassionate leave increased from 19 in 1995 to 102 in 2000 (see Figure 9), which is almost certainly related to increasing levels of AIDS-related morbidity and mortality.

Table 26: Type of leave by duration, 1995-2000

| Leave Type | Days absent | | | | | |
|---|---|---|---|---|---|---|
| | 1-5 | 6-10 | 11-15 | 16-30 | +31 | Total |
| Compassionate | 221 | 78 | 18 | 0 | 0 | 327 |
| Without Pay | 3 | 6 | 4 | 7 | 4 | 18 |
| Maternity | 8 | 7 | 3 | 17 | 276 | 311 |
| Sick | 486 | 88 | 44 | 43 | 25 | 686 |
| Total | 718 | 179 | 69 | 67 | 309 | 1342 |

### 5.4.2 Sick leave

668 members of staff took sick leave between 1995 and 2000. The numbers of staff taking sick leave increased very rapidly up to 1999 but declined sharply in 2000 (see Figure 9). This may be because more staff now take anti-retroviral drugs (see below). These drugs prevent opportunistic infections and allow individuals living with AIDS to function normally.

Absenteeism records show that some staff who died after "short illnesses" were only absent for between 1-10 days. Only 25 sick staff were absent for more 30 days during this five-year period. The longest period for those who died from long illness was 156 days. Heads of department noted that, in some cases, sick staff showed up at work even when they were too weak to do so. This happens when doctors have either not recommended sick leave or when the sick leave days recommended elapse before the person has recovered from the illness. Staff also covered for sick colleagues who although came to work did not look fit to work.

### 5.4.3 Maternity leave

Pregnant women are entitled to six weeks leave before delivery and another six weeks leave after the birth. A total of 311 UB staff took maternity leave between 1995 and 2000. The number of women taking maternity leave declined starting from 1998 and has remained consistently low compared to 1997 and 1996. This could be because of greater contraceptive use and/or lower fertility (which is a well-known consequence of HIV infection).

### 5.4.4 Other attrition

No records are kept of staff who leave UB and the reasons for why they leave. However, four academic staff left for ‘greener pastures’ in 1998/99. This academic year (2000/2001), five academic and senior support staff members have already left the university and still others may be preparing to leave. Resignations are likely to increase as a result of the AIDS epidemic.

## 5.5 AIDS IN THE WORKPLACE

A range of ‘best practices’ has been developed in workplaces around the world to prevent HIV infection and to support staff directly affected by AIDS. Almost everyone interviewed for this study lamented the absence of well-conceived AIDS in the Workplace (AIW)

programme at the university. There is an urgent need to mainstream HIV/AIDS in the university's mission and values so that dealing effectively with the manifold consequences of the epidemic is central to the university thinking and operations. Currently, the dominant student perception (as revealed in FGDs) is that 'only the vice-chancellor is concerned about HIV/AIDS'. During interviews, many managers revealed that they still know very little about HIV/AIDS.

Progressive public and private sector employers in high HIV prevalence countries have adopted comprehensive prevention and care programmes for their staff. The key components of these programmes include:

- Risk assessment with voluntary, anonymous testing of samples of employees in order to establish precise levels of HIV infection, which provides the basis for well-conceived human resource development strategies that fully taken into the impacts of HIV/AIDS
- Enhanced medical support including the provision of anti-retroviral drugs
- Voluntary testing and counselling
- Professional counselling services
- Education campaigns on the use of contraceptives and behaviour change, education on HIV/AIDS and sexuality
- Re-deployment of affected staff
- Changes in conditions of service, adaptation of working conditions, and new working practices (including multi-skilling).

The following discussion briefly reviews what has been done at UB with respect to each of these areas.

### 5.5.1 Risk assessment and institutional planning

No systematic risk assessment has been undertaken, which means that the university, even at this late stage of the epidemic, still has no clear idea how the epidemic will affect both staff and students during the next 10-15 years. HIV/AIDS is hardly mentioned in key planning documents. HIV/AIDS has also not been incorporated into most departmental strategic plans. Deans and heads of department continue to plan for staff development without taking into consideration possible attrition rates of staff. There is a distinct possibility that, as more people die, university staff will be increasingly 'poached' by other employers, in both the private and public sectors.

### 5.5.2 AIDS and life skills education

There is no comprehensive HIV/AIDS education programme that covers both academic and support staff at university. and focuses on both information dissemination and behaviour change. Most staff correctly observe that only students have been targeted for HIV/AIDS education. Industrial class workers have, however, received a limited amount of training in HIV prevention from the clinic staff.

### 5.5.3 Voluntary testing

Although testing facilities for HIV are available at the university clinic, no concerted effort has been made to encourage staff to go for voluntary testing with professional pre- and post-testing counselling.

### 5.5.4 Transfers, deployment and termination

During interviews, it was revealed that there is a tendency for some managers to transfer around junior staff who are sick. It was also noted that some staff who had been absent for two semesters because of illness had their services terminated. There was a feeling among those interviewed that the terms and conditions of service (in particular, sick leave for industrial staff and retirement and terminal benefits) should be reviewed.

### 5.5.5 Staff replacement

Most faculties and departments reported that its takes far too long (often six months or more) to replace a member of staff who has died or left the university. In one department, staff complained about increased workloads due to the non-replacement of all staff who have been lost since 1998. Recruitment policies and practices need, therefore, to be urgently reviewed.

### 5.5.6 Anti-discrimination

The presence of person who is suspected of being HIV positive creates fear and anxiety among most staff. There is a tendency to isolate the person, which obviously increases the emotional strain felt by the affected staff member. This behaviour, as one interviewee noted, arises because of staff ignorance and the stigma attached to HIV/AIDS. Some staff genuinely think that they can catch opportunistic infections like tuberculosis and flu from HIV-infected colleagues. There is an urgent need therefore for comprehensive work place guidelines to counter all forms of discrimination and stigmatisation.

### 5.5.7 Employee benefits

The university has lost money due to costs incurred in the form of employee benefits during illness or after death. Among academic staff an employee is entitled to six months paid sick leave followed by vacation leave of six months. There are also significant costs in repatriation of the deceased to their homes. Permanent and pensionable are also entitled to a four years salary. The university has not worked out a framework to track, monitor and document costs according to the various areas of concern.

### 5.5.8 Medical support

All UB academic staff can voluntarily join the Botswana Medical Aid Society (BOMAID). 846 were member in February 2001. However, a handful of the industrial class support staff, which has the highest mortality rates belong to BOMAID and only around 45% of junior support staff belong to the scheme (see Tables 27 and 28).[8]

Table 27: BOMAID members at UB, late 2000

| | Members | % staff in-post |
|---|---|---|
| Academic | 618 | 67.2 |
| Senior support | 81 | 57.8 |
| Junior support | 370 | 55.2 |
| Industrial support | 5 | 0.9 |

Over 85% of BOMAID members at UB earn more than P3199 per month. Most staff in this income bracket are academics and senior support staff.

Table 28: BOMAID membership at UB by income category, early 2001

| Salary range (Pula) | Number members |
|---|---|
| 0-600 | 0 |
| 601-1500 | 6 |
| 1501-2299 | 49 |
| 2300-3199 | 57 |
| 3199> | 734 |
| Total | 846 |

### 5.5.9 Anti-retroviral drug therapies

BOMAID has a special scheme, which started in 1998, that enables its 50,000 members nation-wide to access anti-retroviral drugs (ARTs). Members who test HIV positive have a monthly entitlement of P1000 for ARTs. In early 2001, 17 UB staff (2.0% of members) were participating in this scheme (out of a total of 846 members nation-wide). Seven have clinical AIDS while 10 are HIV positive but asymptomatic (see Table 29). The availability of these life-prolonging drugs is a key reason why rates mortality among academic staff are so low at UB.

[8] The number of staff who are covered by other medical schemes (in particular BPOMAS) is not known.

Table 29: BOMAID members employed by UB who are taking anti-retroviral drugs, early 2001

| Marital status | Number |
|---|---|
| Single | 6 (35.3%) |
| Married | 7 (41.2%) |
| Divorced | 2 (11.8%) |
| Widow | 1 (5.9%) |
| Domestic partners | 1 (5.9%) |
| Total | 17 |

# CHAPTER 6

# DEVELOPING A COMPREHENSIVE STRATEGIC RESPONSE

The discussion so far has focused on the impact to date of HIV/AIDS on the university and what has been done so far to prevent further infection and mitigate the negative impacts of the epidemic on both students and staff. This final chapter presents a set of recommendations concerning what should be done in each of the key impact areas, namely student prevention, student support, and staff prevention and support.

Despite the various initiatives by UB management in this area, only 25% of the student focus groups agreed with the statement that 'the university has an effective policy to deal with HIV/AIDS'.

## 6.1 HIV/AIDS STRATEGIC PLAN 2000-2005

The development of this strategic plan represents a major step forward in the development of a comprehensive, co-ordinated response to the threat posed to UB by the AIDS epidemic in Botswana. The strategy has five main objectives.

1: Increasing knowledge and awareness of STI/HIV/AIDS among the university community.

- Establish an AIDS in the workplace programme
- Establish an STI/HIV/AIDS hotline.
- Include STI/HIV/AIDS in the curriculum.
- Encourage student organisations to include STI/HIV/AIDS in their annual program activities.

2: Establish a Voluntary Counselling and Testing (VCT) service at UB.

3: Prevent and treat conventional STIs.

4: Promote safer sexual practice

- Reduce risk behaviours.
- Promote the correct and consistent use of condoms.
- Increase availability and accessibility of condoms by 100% by October 2001.
- Promote safer sexual practice.

5: Create a supportive community for everyone directly affected by AIDS

- Encourage the development of post-test clubs and support groups.
- Advocate for reduced substance abuse.
- Support the early treatment of opportunistic infection related to STI/HIV/AIDS.
- Implementation of the Mother to Child Transmission (MTCT) programme.

6: Effective monitoring and evaluation

- Ensure the implementation of the five year plan
- Mobilise resources to support the activities of the University of Botswana STI/HIV/AIDS plan. Evaluate the impact of UB STI/HIV/AIDS program.

The following discussion expands on these interventions and other recommendations proposed in the strategic plan.

## 6.2 RISK AND BEHAVIOUR ASSESSMENT

The Strategic Pan must be based on a precise assessment of HIV prevalence rates among both staff and students. Everyone in the university community, managers, staff and students need to know exactly what the situation is at the university if this crisis is to be confronted openly and university management is to have the information to mount an effective response. This information will also enable the impact of the proposed AIDS education programme and other interventions that target behavioural change among staff and students to monitored and evaluated properly and will, with the appropriate provision of ARTs, provide the incentive for individuals to go for voluntary testing and counselling. The experience of countries such as Uganda highlights the key role of VTC in creating the necessary 'enabling environment' to tackle effectively the AIDS scourge. The analysis of mortality rates presented in this report also suggests that the impact of the AIDS epidemic on the university community may not be as serious as for the population as a whole. But, without appropriate testing, it will simply not be possible to confirm this.

It is recommended, therefore, that anonymous, voluntary testing (using simple but reliable saliva tests) be undertaken among stratified random samples of staff and students. Debswana (the national diamond company) has already successfully carried out testing of its staff as part of its HIV/AIDS audit. The HIV/AIDS Co-ordinator at Debswana emphasises that the success of anonymous voluntary testing depends on a rigorous education campaign to ensure that there is awareness, knowledge and understanding of the testing process. As she noted, some people may resist testing because they 'think you can identify them from the colour of their saliva'. However, over 75% of staff at Debswana agreed to be tested.

## 6.3 STUDENT PREVENTION

### 6.3.1 Voluntary testing and counselling

Most students do not know their HIV status. As one respondent noted:

> *I cannot go for testing because there is no incentive to test, there is no cure and I cannot afford the drugs. If I tested HIV positive, I will die from fear of the disease and stress. I will be lonely. I do not have a medical insurance to assist me to buy drugs.*

Students at UB, unlike students studying abroad, are not covered by medical insurance. The Ministry of Education has proposed that all students should have medical insurance cover, which is essential in the context of such a devastating epidemic.

The following steps need to be taken in order to encourage students to go for voluntary testing:

- Mount an intensive education campaign to encourage voluntary testing.
- Speed up the process to obtain a proper medical insurance cover for all UB students so that they can access good-quality medical support, including ARTs.

Pre- and post-test counselling should continue to be offered for those who volunteer to be tested.

### 6.3.2 Counselling

Decisive action is required to de-stigmatize counselling at UB and encourage students to visit the counselling centre. The declining number of students who visit the counselling centre is a clear indication that it is seriously under-utilised. Counselling should also be diversified to include peer, spiritual, and personal counselling. Counselling centre staff are concerned that many students who come to the Centre for help, stop attending before they should do. A client tracking system should be worked out to ensure that clients consistently get the support they need.

### 6.3.3 Education, information and communication

More imaginative ways of delivering information on HIV/AIDS and sexual reproductive health to students should be introduced as soon as possible. The current approach should be diversified to include: lecturers and talk shows, drama and plays, student radio and television talk shows, and age, culture and gender relevant and sensitive posters. Information on the bio-medical aspects of HIV/AIDS should be balanced with information on key social and emotional issues, for instance, how to live and care for friends and relatives affected by HIV/AIDS. There should be information on nutrition and support groups for people living with AIDS.

A full-time IEC co-ordinator should be appointed as a soon as possible with a proven track record in running effective IEC programmes for young people. It will clearly be necessary to contract outside individuals and organisations to assist in the design and delivery of this programme.

### 6.3.4 Sexual harassment

Students should be aware of the university policy on sexual harassment. They should be educated about their rights and encouraged to report cases of sexual harassment. Strong action should be taken against students found guilty of sexual harassment including rape, verbal abuse, grabbing and touching to mention a few. All students who are raped should be prescribed AZT as this has been shown to prevent HIV infection.

### 6.3.5 Personal tutors

There is an urgent need for a better system of pastoral care for students at UB. The number of students has grown extremely quickly. As a result, the university is no longer the friendly and supportive place that it was, even five years ago. As has been discussed in considerable detail in this report, the AIDS epidemic will compound the anxiety, trauma, stress, fear, loneliness

and demoralisation that many students experience as they try to cope with all the work and social pressures of university life on a large campus. The new personal tutor system is a major step in the right direction. However, it will not be effective unless all tutors receive intensive, on-going training so that they have the commitment and skills to be able to respond to the diverse needs of the students that they will have to assist.

### 6.3.6 Curriculum infusion

HIV/AIDS issues should be infused in the course offerings of every department at the university. The university-wide course to be offered by the Department of Nursing is an important development. HIV/AIDS interfaces with all social issues such as gender and sexuality, human rights, culture, the media, economy, morality, spirituality, protection and security and all aspects of an individual's life. There is thus an obvious need for UB to offer HIV/AIDS courses either at faculty and/or departmental level. As one lecturer observed:

> '*All efforts to engage students academically are dwarfed by the HIV/AIDS pandemic. You stand in front of a class to teach and suddenly you think what is more important to teach students on how to cope deal with the disease and prevent infection or to lecture them on material that some may not live to utilise.*

HIV/AIDS will also affect UB graduates in their future workplaces in a variety of ways. The Department of Law should run a course that deals with HIV/AIDS and the law and the Faculty of Engineering a course on HIV/AIDS and safety. Rutgers University in the USA, for example, offers the following courses: AIDS in the Criminal Justice System, Teaching AIDS, AIDS in Literature, Aids and the Media, Psychology of AIDS and AIDS in the workplace. At the University of Ghana, HIV/AIDS is taught as a course in the Department of Nursing, School of Public Health and the Medical school. In the Faculty of Law and the Department of Geography, HIV/AIDS is listed in course outlines (Anarfi, 2000). There is need for a policy directive with regard to mainstreaming of HIV/AIDS in the curriculum.

It is recommended that the university appoints an appropriately qualified and experienced curriculum development professional whose job it will be to ensure that all aspects of the AIDS epidemic are fully incorporated into the curriculum of every degree and other qualification offered by the university.

## 6.4 STUDENTS LIVING WITH AIDS

Students who are living with AIDS are clearly the key group who will need to supported by the university community. Unlike younger children in primary and secondary, it is less likely that students at UB who have been orphaned will have significantly higher dropout rates. This section first provides 'worst case' scenario estimates of the number of students who will be affected and the next section then discusses what should be done to support these students.

Without knowing what HIV prevalence rates are among students, it is very difficult to make robust projections of student morbidity and mortality over the next 10-15 years. Currently, student mortality appears to be much lower than projected AIDS-related mortality for the adult population as a whole. This is a hopeful sign. Certainly, if the current university

student-adult mortality differentials are accurate and persist into the future then, even at the height of the epidemic in ten years time, HIV/AIDS will have much less impact on the student population than is widely anticipated.

For the time being at least, let us assume that HIV prevalence is the same among students as it is for all young adults in Botswana and no significant behavioural change occurs (increased condom use, fewer sexual partners). Table 30 shows the projected number of students who are likely to die at UB assuming that total student enrolments increase to 13,000 by 2005 and 15,000 by 2010 and the age distribution of the student population remains unchanged.

Table 30: Projected number of student deaths at UB, 2000-2010.

| YEAR | Projected Enrolment | PROJECTED DEATHS | | | | | | Percent Enrolment |
|---|---|---|---|---|---|---|---|---|
| | | 15-19 | 20-24 | 25-29 | 30-34 | 35> | Total | |
| 2000 | 11000 | 2 | 88 | 70 | 41 | 5 | 206 | 1.87 |
| 2005 | 13000 | 2 | 121 | 125 | 101 | 58 | 407 | 3.13 |
| 2010 | 15000 | 3 | 135 | 147 | 137 | 124 | 546 | 3.64 |

Notes: Based on projections of AIDS-related deaths by age cohort made by AbT Associates.

According to these projections, the number of student deaths will increase from 206 in 2000 to over 400 by 2005 and nearly 550 by 2010. After 2004, between 3-4 percent of all students are projected to die each year. By 2010, nearly half of all deaths will be among students who are over 30 years old who account for less than 20% of total enrolment. Thus, the younger the age profile of students, the less will be the impact of the epidemic with respect to student deaths.[9] Obviously, the university does not want to discriminate against mature students, but every effort should be made to reduce the average age of the first year intake.

Adult AIDS cases are projected to between 45-50% higher than AIDS-related deaths during this period (see AbT, 2000). This will mean that, by 2005, around 4.7% of students at UB will have clinical AIDS rising to 5.5% in 2010.

Given these increases in student attrition, intakes to the university should, at the very least, be increased by 4-5% The AIDS epidemic will also exacerbate labour shortages for high level personnel in all sectors. Again, therefore, it is crucial that intakes to UB and other higher institutions are increased in order to ensure that replacement personnel are available. This will require detailed national human resource planning, with the Ministry of Finance and Economic Development working closely with UB planners.

## 6.5 SUPPORTING AFFECTED STUDENTS

The university needs to develop a clear policy concerning students living with AIDS. Everything should be done to support these students but, without ARTs, most of them will eventually become too ill to continue their studies and will have to withdraw. While the university has an important role to play in supporting sick students, it cannot be expected to take full responsibility for the medical and personal welfare of sick students.

[9] Under this scenario, 25% of deaths will occur among students who are under 25 who comprise 62% of total enrolments.

### 6.5.1 Mandatory testing for overseas bursary holders

The government has decided that, given the enormous costs of repatriation, all students who receive government bursaries to study overseas are to be tested. Since there is no question that students wishing to attend UB and other higher education institutions in Botswana should be tested, this decision will mean that more students living with AIDS will be admitted to the university than before.

### 6.5.2 Medical support and ARTs

With proper medical supervision and patient compliance, the provision of ARTs for both infected staff and students is the single most important way of reducing the impact of the AIDS epidemic on the university. Given the high toxicity of these drugs, the current medical evidence strongly indicates that they should, as a general rule, only be taken fairly late on in the course of the HIV infection when an individual's CD4 count drops below 200. This normally does not occur until at least 5-6 years after infection.

A key question is what should the university's role be in providing medical support to affected students? The university clinic does not have the capacity at present to administer ARTs to relatively large numbers of students and staff. However, the university should lobby hard for these drugs to be made available.

### 6.5.3 Support for the sick

There is an urgent need to set up a properly resourced and managed support system that can identify, monitor, and care for all sick students, especially those who are resident in the hostels. Policy guidelines are required on what care should be provided by the university and other agencies and when sick students should be sent home. All relevant support personnel (counsellors, clinic staff, wardens and personal tutors) must be work together in a co-ordinated manner, but with clearly demarcated areas of responsibility. Wardens should be sensitised and trained about how to deal with sick students.

### 6.5.4 Support for caregivers

The current situation in the hostels requires students to share rooms. When a student becomes ill, their roommates are usually expected the shoulder the burden of care but, as noted earlier, many students vacate their rooms. Those students who do take on this responsibility are subjected to considerable psychological trauma including fear, anxiety and stress. While students have a moral responsibility to assist their fellow students, there are clearly limits to the support they should be expected to give.

The university must do all it can to support student caregivers. Every student should receive basic training in caring for AIDS patients and how to avoid infection. Hostel wardens should be included in the list for caregivers to be counselled.

## 6.6 STAFF PREVENTION AND SUPPORT

Table 31 presents the projected number of AIDS-related deaths among UB staff on the assumption that AIDS-related mortality rates will be the same for all categories of staff at UB as is projected to be for the adult population as a whole. It is also assumed that the total

number of staff in post remains constant at its 2000 level of 3085 and that the age distribution of staff remains unchanged.

According to these projections, AIDS-related staff deaths will increase from 68 in 2000 to 189 in 2010. The corresponding AIDS-related mortality rates will be 2.2% and 6.1% respectively, which is very high and would have a major impact on the overall staffing situation at the university.

Table 31: Projected AIDS-related staff deaths at UB, 2000-2010

| YEAR | Projected Staff In-post | PROJECTED DEATHS | | | | | | | | Percent total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50> | Total | |
| 2000 | 3085 | 1 | 9 | 36 | 13 | 6 | 2 | 1 | 68 | 2.2 |
| 2005 | 3085 | 1 | 13 | 75 | 34 | 15 | 5 | 1 | 144 | 4.7 |
| 2010 | 3085 | 1 | 13 | 87 | 48 | 30 | 8 | 2 | 189 | 6.1 |

*Source: Calculated from projected AIDS-related mortality rates by age cohort supplied by AbT Associates*

However, actual staff deaths (from all causes) at UB in 1999/2000 totalled 20. If it is assumed that 75% if these deaths were AIDS-related, then the (AbT) projections for 2000 are 4-5 times higher than the probable number of AIDS-related deaths that actually occurred.

Whatever the future level of AID-related mortality among staff is likely to be, it is imperative that the university develops a comprehensive AIDS in the Workplace programme, which is based on the 'best practices' which have been successfully introduced by progressive employers throughout the region. The key components of such a programme are: medical support including the provision of anti-retroviral drugs, counselling with and without testing, education campaigns on the use of contraceptives and behaviour change, education on HIV/AIDS and sexuality, adaptation of working conditions, human resource planning and delivery of services.

### 6.6.1 Human resource planning

It is essential that the current and likely impacts of the AIDS epidemic is fully incorporated into the planning process at the university. In particular, all human resource planning must take into account higher attrition rates among each of the main categories of staff. To do this, major improvements are needed in the university's information system for human resource planning and management so that all key indicators (including absenteeism, mortality, productivity) can be properly monitored. Once HIV prevalence rates have been ascertained, the university should contract consultants to develop detailed mortality projections for each group of staff and, in conjunction with the university's overall strategic plan, establish annual recruitment targets.

### 6.6.2 Education, communication and information

The impact of the epidemic on staff differs depending on job category. Industrial staff, who are the least educated, lowest paid and without private medical support, currently have the highest mortality rates while mortality rates among academic staff are much lower. However, staff morbidity and mortality is on the increase. High mortality rates, especially among

industrial class, point to the need for the University to intensify education campaigns on HIV/AIDS. The main objectives of the campaign should be as follows:

- Confront the silence, denial, and secrecy about HIV/AIDS which pervades the UB community and create in its place a culture of openness and acceptance
- Ensure easy access to contraceptives, including female condom
- Highlight the benefits of testing and subscribing to a medical insurance scheme
- Counter discrimination
- Encourage supportive behaviour for colleagues who are sick

The HIV/AIDS Committee and the Wellness Centre Co-ordinator should draw up annual work plans with all relevant staff (training directors, deans and heads of department, other managers) as a matter of urgency. The highest risk groups (for example, female students and female industrial staff) should be targeted. Educational programmes should as far as possible be context and situation dependent. It should be recognised that the University has a diverse population and that every sub-group at the university (for instance, postal workers, secretaries, security guards and cleaners) have specific characteristic and needs.

### 6.6.3 University-based health services

Currently, the health services offered by the university clinic are not available to staff. The current staffing and facilities at the clinic are simply too small to service both staff and students. It is recommended that the new Faculty of Health should accommodate staff members who wish to utilise such services. The university should also make arrangements with private clinics to allow its staff to receive immediate attention. This will cut down on the work time that is otherwise spent queuing for medical attention.

### 6.6.4 Creating an AIDS-friendly work environment

Staff support groups should be formed to provide care, spiritual and psychological counselling, and nutritional advice to those affected (both those who are infected and those who are not) by HIV/AIDS. This includes staff living with AIDS, mothers with sick children, orphans, men and women with sick partners, and the bereaved. The university should cultivate a spirit of community service among staff and students and also create a structure to reward community service for students. The current lack of support for people living with AIDS (some students suggested that PLWA should have a separate university) is indicative of an unsupportive, uncaring environment. Everyone in the university community should be encouraged do something, however small, to help those who are affected by this scourge. The University should take a lead in producing caring and compassionate graduates.

### 6.6.5 Testing expatriate staff

All expatriates working for government ministries are tested for HIV on appointment and again if their contracts are renewed. The government states that this is necessary because of high repatriation costs. As noted earlier, most of the academic staff who have died since 1990 have been expatriates. Given UB's continued heavy reliance on foreigners, it seems sensible to test expatriate staff.

### 6.6.6 Membership of medical aid schemes

Industrial class workers, the majority of them women, are unable to benefit from the medical aid scheme mainly because of low wages. The university should do all it can to ensure that every staff member is a member of BOMAID or another medical aid scheme. The following actions are needed:

- Mounting an intensive information and education campaign to publicise the benefits of belonging to a medical aid scheme.
- Making membership to a medical aid scheme compulsory for all senior employees at the same time keeping individual contributions for the lower paid employees at an affordable rate.
- The University should increase its contribution to the medical aid scheme in order to encourage people to join. Debswana has a compulsory medical insurance scheme for its senior management. The University could seriously consider compulsory medical insurance for all staff.

### 6.6.7 Teaching cover

Core teaching and team teaching should be encouraged so those colleagues can easily cover for those who are sick. Modules should be developed so that those students who can not attend classes can benefit from the course modules.

# CHAPTER 7

# ORGANISATION, PLANNING AND MANAGEMENT ISSUES

Given the seriousness of the threat posed by the AIDS epidemic to the 'core business' of the University, it is essential that the university's response to this crisis be rapidly mainstreamed across all key activities. It is crucially important that the university has a clear idea about what needs to be done to minimise the impact of the epidemic on students and staff. However, it is essential that appropriate organisation and management structures are put in place that will ensure that the HIV/AIDS strategy is effectively and efficiently implemented. Again, the university is able to draw on well-established 'best practices' about how the AIDS crisis should be managed. Large and complex organisations, which are successfully tackling this crisis, have established separate AIDS Management Programmes (AMP). Each programme is staffed by a full-time team of managers who have both the power and authority, and the resources and expertise (knowledge and skills) to achieve all key objectives.

It is strongly recommended, therefore, that the same kind of management programme and team be established at UB. The AMP should have its own Director who reports directly to the Vice-Chancellor. This person should have a proven track record in managing a programme of this kind. Three AIDS Co-ordinators should also be appointed to manage on, a day to day basis, the university's response to the main impact areas, namely student prevention, student support, and staff prevention and support. Other key managers and professional staff at the university should also be fully incorporated into the AMP, although this will not be on a full-time basis.

The currently constituted HIV/AIDS Committee clearly has an important role to play. However, smaller, more activity-driven committees need to be established to oversee program design, implementation and evaluation in each of the three impact areas.

## 7.1 RESEARCH AND INFORMATION NEEDS

### 7.1.1 An HIV/AIDS information system

In order for the AMP to be effective, there must be a comprehensive, up-to-date information system as well as on-going action-oriented research on key issues. There needs to be a dramatic improvement in the level of understanding and knowledge about how the epidemic is currently affecting the University and what is likely to happen in the future. As noted earlier, most of the necessary information is currently being collected, but it is very fragmented and difficult, if not impossible, to access quickly.

The core components of an HIV/AIDS information system are as follows:

**Staff morbidity and absenteeism:** The Human Resource Department already captures data on sick leave. Monthly and yearly analysis could indicate levels of morbidity that can inform decision-making.

**Mortality**: The Public Relation Office keeps mortality data. This data should be computerised so those trends in mortality can be continuously monitored.

**Student dropout**: Information on students' withdrawals by reason is not sufficiently accessible. On has to rely on filed hard copies of the data. There is need to computerise data on student enrolment and attrition in such a way that trends can be established.

**Student morbidity and absenteeism**: Every Faculty keeps a file that shows students who request to be absent from classes either due to illness, attending funerals, academic reasons, or for sports purposes. The form is however not standardised across faculties. The data is not computerised and record keeping in some faculties is very poor. There is need to standardise the forms across faculties and to computerise the information. The data should be analysed on a semester basis in order to monitor morbidity levels.

**Student performance**: Summaries of student performance in each Faculty are published in examination result books. However, this is difficult to analyse because the reporting format differs from faculty to faculty and from year to year. Again, there is a need to standardise the format so that trends in student performance can be monitored.

**AIDS education**: The university has no real idea how effective HIV prevention programmes have been in reducing infection. Surveys on student knowledge and attitudes should be conducted regularly out to determine the success of the HIV/AIDS education strategies. These surveys should also be extended to include all staff, but especially junior support and industrial staff.

**The Clinic**: The Clinic is another important source of information but, at present, data is not systematically recorded and analysed. The key indicators of student behaviour are as follows: STDs, pregnancies, condoms distributed, TB and other AIDS-related opportunistic diseases, HIV tests. Data should be disaggregated by sex, year of study and should include age of client.

**The Counselling Centre**: The counselling centre is the only department that has an elaborate monitoring evaluation framework that is utilised for decision making purposes. The centre analyses the data and reports the findings in the University annual report. The reports provide valuable information on the activities of the centre. However, other departments which provide counselling services (mainly Social Work, Guidance and Counselling, and Nursing) Department should also keep records so that a comprehensive picture of counselling at the University can be established.

**Human Resource Unit:** There is a paucity of good quality data on staff attrition. In particular, it is important to monitor continuously the reasons for attrition (deceased, ill health, medical treatment, compulsory retirement, and voluntary retirement, deserted, dismissed, resigned or seconded)**.**

It is recommended that a full-time officer manages the information system for the AMP with professional expertise in this area

### 7.1.2 An HIV/AIDS research programme

Research on HIV/AIDS should be given a high priority. Every faculty should be expected to contribute fully to this programme. Funds should be made available for those wishing to carry out research on HIV/AIDS.

# CHAPTER 8

# CONCLUSION

A key conclusion of this study is that the impact to date of the AIDS epidemic on academic staff and students at the University Botswana has been relatively limited and, with respect to students, is certainly much less than the sensational claims that have appeared in the local media. If UB students have the risk profile as the wider adult population, then adjusting for age, a total of 208 (1.9% of total enrolments) should have died in 2000. However, the actual number of illness-related deaths could not have exceeded 66 and was probably considerably less than this. Similarly, only 18 academic staff (and just two nationals) died throughout the 1990s. While it is conceivable that something is seriously wrong with the AIDS-related mortality projections, it seems unlikely that this could account for such large differences in projected and actual outcomes. To reiterate, only systematic voluntary anonymous testing can provide the basis for a robust assessment of the future impact of the epidemic on the university community.

UB staff who have been seriously affected by HIV/AIDS are junior and industrial support staff. Both groups have high illness-related mortality rates, which are roughly the same as projected rates for the adult population as a whole. There appears, therefore, to be a strong negative correlation between AIDS-related mortality and occupational status. Better-educated occupations (such as university lecturers) may have changed their sexual behaviour and/or are living longer because they can access anti-retroviral drugs. These differentials in illness-related mortality point to the need for AIDS prevention programmes to target less privileged groups in urban and rural areas.

Finally, despite lower than expected student mortality, it also appears that there has been no major change in student sexual behaviour. With such high levels of high-risk behaviour, HIV prevalence rates should be as high, if not higher, than the population at large. What is clear though is that there is an urgent need to intensify, diversify and professionalise AIDS education and other prevention interventions at the university.

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## ANNEX

## DEPARTMENT OF ADULT EDUCATION WORKPLAN ON HIV/AIDS DECEMBER 2000

On 3/11/00 the Department of Adult Education (DAE) held a workshop to decide what it should do relation to HIV/AIDS in respect of: a) its curriculum and teaching programmes; b) its research programme; c) its services activities outside the University. The focus of the discussion was to identify a number of specific and achievable activities consistent with the Department's mission an area of expertise.

The outcomes of the meeting have not been fully reported. This is therefore an interim report to the Departmental Board to enable it to agree on key activities, the staff responsible and the time frame for action. An elaborated Departmental Work plan in Log frame format will be developed later.

| **GOAL: To mitigate the impact of HIV/AIDS through behavioural change, using strategies based on principles of adult learning** | | | |
|---|---|---|---|
| **Dimension** | **Activity** | **Staff Responsible** | **Time Frame** |
| Teaching Programmes | a. Ensure DAE students have access to courses, workshops or individual advice on HIV/AIDS as it affects them<br><br>b. Teach DAE students how to promote HIV/AIDS behavioural change strategies in their work as adult educators.<br>ISSUE: Develop a stand-alone course and/or infuse in different courses? | a. Programme Co-ordinators and Personal Tutors<br><br>b. All staff during the development of the semesterised curriculum | a. Commence January 2001<br><br>b. Commence December 2000 |
| RESEARCH | Undertake a research and development project to evaluate current HIV/AIDS information, Education and Communication strategies and materials, and to recommend alternative educational approaches, methods and materials for promoting behavioural change.<br>ISSUE: i. Should another department be invited to participate in the project?<br>ii. How can student research projects be linked to this theme | Ntseane and Preece | Commence in January 2001 and complete by July 2002 |
| PROFESSIONAL SERVICE | a. Include training in behavioural change strategies for HIV/AIDS in the in-service training of extension workers.<br>b. Develop a training manual for counsellors and others working with HIV/AIDS | a. Dipholo<br><br>b. Gaborone | Present a proposal to the Sub RECC on Training in February 2001.<br><br>b. Undertake during sabbatical leave i.e. August 2001 to July 2002 |

One implication of this workplan is that the staff of the Department of Adult education themselves will need further training related to HIV/AIDS