Higher Education Response to HIV/AIDS Pandemic in Ethiopia: Rhetoric, Reality, Challenges and the Way Forward*

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Abstract: Higher education response to HIV/AIDS has been found to be below expectations. Lack of policy and/or strategic plan of actions to combat the pandemic and absence of dedicated HIV/AIDS units to coordinate activities characterise the scene. Since planning for HIV/AIDS is the exception rather than the rule, there was no place for monitoring and evaluation. The magnitude of the problem and its impacts is unknown; hence little knowledge exists to guide informed actions. However, anecdotal evidence suggests that HIV/AIDS has been impacting in many ways. Workplace interventions as well as organised staff response are non-existent. Almost everywhere there are student-based efforts; however, in the absence of institutional support these efforts have largely been dependent on external resources that render the activities to be piecemeal. With the exception of health/medical faculties, there is no attempt to integrate HIV/AIDS issues into the curriculum. Similarly, efforts to train staff to appropriately handle HIV/AIDS related subjects are very rare. HIV/AIDS related research is isolated, accidental and externally induced; individual staff research and consultancy involvement dominate the scene rather than institutional, organized research undertaking. No other robust variable can better explain such inaction than inadequate or virtual absence of leadership, ownership, and commitment at all levels.

Introduction and Background

The role of higher education occupies a central and strategic position for a sustainable and effective response against the HIV/AIDS pandemic both in terms of work-place intervention as well as educational, research and outreach programs. Higher education is not just there to service the economy and society as it exists, but also to

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shape it into what it could and should be. Higher education response to HIV/AIDS needs to be seen in that light.

The purpose of this paper is to assess the ways in which higher education institutions have been responding to the challenges posed by the HIV/AIDS pandemic and the extent to which they have been contributing or aim to contribute to solutions through training, research, policy formulation and outreach programs. Both secondary and primary data were collected from the various units of public universities including senior officials, faculty deans, department heads, staff and students. Moreover, interviews were conducted with officials and heads of units within government ministries, relevant NGOs and donors that have an HIV/AIDS focus.

The paper is organised into four sections. The first section quickly presents an overview of the HIV/AIDS epidemic in the country as well as the national response. Section two expands the first section by contextualising it to reflect the education sector situation and responses. Section three addresses HIV/AIDS and higher education in Ethiopia, which is the main body of the paper. Finally Section 4 concludes the paper by outlining major gaps, challenges, opportunities and the way forward.

Overview of HIV/AIDS Epidemic in the Country

Ethiopia is currently experiencing a generalized HIV epidemic among the overall population[1]. It is one of the countries that are worst hit by HIV/AIDS[2]. Since the country has a relatively large population size, it

[1] A 'generalized' epidemic is defined as an HIV prevalence among sexually active adults in the general population in excess of 1 per cent. However, specific high-risk groups such as sex-workers, youth, and mobile populations demonstrate increased prevalence levels compared with the general population.

[2] Sentinel surveillance started in Addis Ababa in 1989 in three other urban centers in 1992-93. However, only in Addis Ababa was it possible to continue collecting samples yearly (except for 1998) from the first round in 1989 to 2001 (MoH, 2002).

is significant that sheer number matters in addition to the high prevalence rates. Though Ethiopia's population constitutes 1% of world population, it contributes about 9% of the world's HIV/AIDS cases (USAID-Ethiopia, 2002).

Available statistics would show that overall infection rate in the country was about 6.6%. The situation is worse in urban areas where the estimate on infection is about 13.7%, with the capital Addis Ababa taking the highest toll at 15.6% (MoH, 2002). The estimate for rural[3] prevalence was about 3.7%. This may seem lower compared with prevalence rate in some other African countries such as South Africa (24%), and Swaziland (35%). However, the figure in itself should be alarming especially when compared with results of earlier surveys where no infection was revealed in the urban population until 1984. The presence of HIV was first sensed in 1984, with the first two officially acknowledged cases reported in 1986 (MoH, 2002). The 1986 and 1987 sample surveys on army recruits produced respectively 0.08% and 0.90% rate of infection. Already by 1986, the rate of infection among multi-partner sex contact females and males attending STD clinics in Addis Ababa had reached 6.7% and 1.7%, respectively. A sero-epidemiological survey on female sex-workers conducted three years later in 1989 covering 23 towns excluding Addis Ababa revealed an average rate of HIV prevalence of 17%. The estimate for Addis Ababa, among pregnant women, in 1989 was 4.6%; the figure for 2001 was 15.6% (also ranging between 12.3% and 17.7% depending on sentinel surveillance sites). Highest prevalence rates are reported in larger towns situated along the roads connecting the capital with the seaports such as Dire Dawa (15.2%) and Nazareth (18.7%) as well as in other bigger towns such as Bahir Dar (23.4%), Gondar (15.1%), Jijiga (19%), and Mekele (17.2%).

Available estimates also suggest that there were, in 2001, about 2.2 million persons living with HIV/AIDS in Ethiopia, of which 2 million

[3] MoH cautions that the database for estimating rural prevalence rates was inadequate for estimation of a more realistic HIV prevalence rate.

were adults while the remaining 200,000 were children. Approximately 10% of these are estimated to be full blown AIDS cases. About 91% of infections occur among adults between 15 and 49 years of age. The highest concentration of infected persons is found between 20 and 29 years of age, while peak age groups for AIDS cases are between 25 and 29 for both sexes. Infection rates are higher among females than males between the ages of 15 and 19, which perhaps reflect an earlier sexual activity among young females with older male partners. However, infection rate differences between the two sexes were not found to be significant, perhaps reflecting, the fact that most infection has been acquired through heterosexual contact.

Cumulative number of deaths in Ethiopia since the beginning of the epidemic is estimated to be about 1.7 million. Forecasts have it that even if incidence is reduced to zero, the worst impacts are yet to come[4]. The proportion of young adult (15-49) deaths attributed to AIDS in Ethiopia has accounted for about 50% of all deaths (MoH, 2002). AIDS is now the cause of nearly 68% of deaths that occur annually between the ages of 20 and 54 (AIDS Journal 2003, 17:1209-1216, in Tekeste, 2003).

Apart from the spread of the pandemic like wild fire, what should be worrisome is the fact that most of those infected already are not aware of their status; hence representing a reservoir capable of transmitting the virus to uninfected individuals. Moreover, despite high level of knowledge and awareness of prevention methods among sexually active population[5], a significant proportion does not seem to

[4] UNAIDS ranks Ethiopia 3rd in terms of absolute number of people infected with HIV. However, Yigeremu Abebe, et al (2003) argue that this is an overestimation – their results suggest 7.2% (urban) and 3.8% (rural) HIV prevalence among young, presumably healthy, army recruits in Ethiopia. Risk factors for HIV infection for rural recruits in multivariate analysis include age, education, and urban-based professions.

[5] Target groups included in the BSS were school and out-of-school youth, female sex- workers, military personnel, farmers and pastoralists, long-distance drivers, and factory workers.

have brought about any significant desirable behavioural changes, and thus remain at high risk of HIV infection (FHI, 2002). If the present trend is allowed to continue, the country will have lost in the very near future in many more ways like it has never witnessed before. And this is not just in terms of sheer number of deaths, which should be frightening in its own right, and perhaps seems to be sufficient enough reason to declare a state of emergency. According to Ministry of Health estimates, a total of 5.25 million Ethiopians would die by 2014 if the present trend is to continue (MoH, 2000) – a figure that is more than the entire population of many countries.

The prevalence rate reported above is already high enough to cause an alarm and the likelihood of it spreading fast is quite high given the extent of poverty among the population. For example, a survey of 15 firms in Ethiopia has shown that, over a five-year period, 53% of all illnesses among staff were AIDS related. UNAIDS revealed that during the four years, between 1997-2000, of the financial expenditure of Akaki Fiber Products Factory attributable to HIV, 42.7% was accounted for by lost productivity, while 47.5% was expenditure on medical care and sick leave (UNAIDS, 2001). Such a situation, which probably holds true for all industrial enterprises, of increased absenteeism of workers from work place and increased expenditure associated with HIV/AIDS not only affects the effective performance of the existing industrial enterprises, but discourages further investment from going to this sector. This surely is going to be an obstacle to expansion of employment and poverty reduction.

The direct impact on provision of social services such as health is insurmountable. According to Ministry of Health (MoH, 2000), AIDS patients occupied as much as 42% of all hospital beds during the year 2000, and this figure was expected to grow to 54% by 2004. Such a crowding out effect will obviously raise the mortality rate caused by other curable diseases among HIV-negative patients as a result of

being unable to get medical care[6]. Spending on HIV/AIDS diverts limited resources from surmounting other major health problems and also erodes the skilled human resource base in the sector where skills are hard to replace. In the case of Ethiopia, life expectancy is expected to decline by 10 years in 2014.

In the context of this bleak scenario, education cannot escape the blow either. HIV/AIDS impacts enrolment, school attendance by teachers, educators and students, as well as provision of educational services. The direct impact on the educational sector would even be more serious since education is human-intensive in its very organization and activity. The pandemic also increases education sector costs. According to the World Bank's estimate (WB, 2000) the increase in cost due to HIV/AIDS of achieving EFA in the 33 African countries studied would amount to between US$450 million and US$550 million per year.

The National Response: Policies and Strategies for HIV/AIDS Prevention and Impact Mitigation

The Government of Ethiopia issued an HIV/AIDS policy in 1998 "... with the overall objectives of guiding the implementation of successful programs to prevent the spread of the disease, to decrease vulnerability of individuals and communities, care for those living with the disease and to reduce the adverse socio-economic consequences of the epidemic" (FDRE, 2002). The Government has also developed the Strategic Framework for the National Response to HIV/AIDS covering years 2000-2004 that outlines a number of intervention areas including:

(a) Intensifying efforts on risk reduction interventions such as IEC/BCC, condom promotion and distribution, STI control and

[6] MoH's estimates suggest that 'probably one-half of all adults in the country carry a latent TB infection that is suppressed by a healthy immune system. HIV seems to be driving the TB epidemic in Ethiopia (MoH, 2002).

management, and VCT. In the educational effort, behavioural change targeted interventions (BCC) will be the priorities than what is already and commonly practiced in the context of IEC. It is planned that BCC will be conducted based on findings from formative and other types of studies and surveys such as the Behavioural Sentinel Surveillance (BSS). The BSS, which is a second generation surveillance tool, was introduced in Ethiopia in 2001 to complement the extensive sero-prevalence and HIV surveillance systems instituted nationally.

(b) Intensifying care and support and other impact mitigation efforts for infected and/or affected individuals, families and communities. This will be focusing on the most vulnerable population such as commercial sex workers (CSWs), the youth, especially out of school youth, and the already affected families and communities.

(c) Designing interventions in such a way that they are gender-sensitive. Gender will have a special emphasis on interventions such as BCC, STI control, and VCT and care and support and impact mitigation.

(d) Enhancing the mainstreaming of HIV/AIDS response into all forms of interventions by government, non-government and private actors. A positive response for such emergency situation calls for an urgent need to coordinate the response through a multi-sectoral approach. All actors - government, non-government, community-based structures and the private sectors - need to give priority considerations to HIV prevention and incorporate it into their routine activity plans and budgeting systems.

(e) Establishment of functional institutional framework from the federal to the community level with National and Regional HIV/AIDS Councils and Secretariats having to coordinate, facilitate, monitor and evaluate national and regional efforts.

(f) Enhancing community level responses to risk and vulnerability reduction activities.

(g) Tracking ongoing activities, distribution of diseases, and trends of the epidemic over time, follow-up of contributions of all stakeholders and partners, and as a result having a functional information sharing and dissemination system as a crucial step towards success in the fight against the epidemic. This will require setting up of an HIV/AIDS monitoring and evaluation system including the strengthening of surveillance systems, and encourage the conduct of research and study (FDRE, 2002).

Some of the medium term goals include a target of reducing the level of HIV transmission by 25% within 5 years. The strategy envisages a multi-pronged approach of intervention including reaching out to all segments of communities using all available channels of communication and institutions. Where sectoral integration of HIV/AIDS issue is concerned, it refers to "…providing technical assistance to the different sectors to ensure that appropriate measures are taken for creating awareness of their workers and their families on the disease and for providing the necessary prevention and control services".

HIV/AIDS AND THE EDUCATION SECTOR

Prevalence of HIV/AIDS and its Impacts on the Education Sector

HIV/AIDS could have a devastating impact on education since the sector is human-intensive. It impacts on demand for education through reducing willingness and ability of affected and or infected students to attend and complete education. For example, a study (Gabre, 1999) conducted in a senior secondary school in Addis Ababa reports 53% and 24% of male and female students respectively as sexually active, most of whom having more than one sexual partner and without using condoms. The impact study commissioned by the Ministry of Education (MoE, 2003) reports that

of the 1,990 students covered by the study, those in grade 9 and above, 31.5% had boy/girl friends of whom about one-fifth reported to have had more than one. Of these, 17.3% are reportedly sexually active and 29.1% of them had multiple sexual contacts while 59% of them rarely or never used condoms. Clearly, this group of young people have a high risk of becoming infected with HIV.

Moreover, there were about 1.2 million orphans in Ethiopia in 2001 (MOH, 2002). Projections suggest that by 2010 there would be about 6,862,000 orphans in Ethiopia[7] who would have lost either one or both of their parents from all causes. This would constitute about 17.7% of children below the age of 15. Those who would have lost either their mothers or both parents are estimated to be 3,774,000 of whom 67.3% would be accountable to AIDS (Hunter and Williamson, 2000; cited in Kelly, 2000:58). The impact assessment study (MoE, 2003) reports that of the 4,418 students (above the age of 11 and reached grade 5 or above) in 37 primary schools covered by the study, 23.8% have lost one or both parents. In terms of gender perspectives, it is the traditionally disadvantaged social sectors on which the impact of HIV/AIDS is going take its toll most, since it is girls who will be retained in the household for all practical purposes. It could also be noted that prevalence rate among young girls is higher.

Evidences suggest that dropout rates among primary school students have been on the rise between years 1996/97 and 2000/01. Similarly, repeaters are increasing between 1998/99 and 2000/01. Compared with the target of 8.9% and 6.4% respectively of dropout and repeater rates to be reached by 2004/05, the actual figures in 2000/01 of 16.2% and 9.7% are significantly high and would require doubling of efforts. The impact assessment study report (MoE, 2003) indicates that of the 504 students who had dropped out of school at least once, one's own sickness (28.8% of cases), sickness of parents (9.3%), death of parents (12.3%), shouldering family responsibility (17.7%),

[7] In terms of number, this is only to be surpassed by Nigeria where the figure is 7,579,000 (see Kelly, 2000).

and inability to cover school costs (12.5%) have been the reasons for having to drop out of schools. Similarly, of the 1226 students who had repeated at least once, the corresponding figures for one's own sickness, sickness of parents, death of parents, shouldering family responsibility, and inability to cover school costs were found to be 25.7%, 7.9%, 5.4%, 8.9%, and 12.5%, respectively. Even though it is difficult to attribute all cases of illness and death to HIV/AIDS only, since little information could be available on sero-status of the concerned cases, the mere magnitude of the incidents in scales that are unprecedented before and the relatively young age at which parental deaths have occurred would suggest that HIV/AIDS might have well taken its toll. Obviously, as the impact assessment report confirms, high prevalence of orphanage and school dropout rates or repeating classes are positive correlates.

HIV/AIDS impacts on supply of education through directly withdrawing teachers and educational personnel who are infected and/or affected from the educational system either through death or inability to attend their regular activities due to illness. For example, there are some reports that about 51,000 primary school pupils out of 4.3 million have lost teachers due to AIDS in 1999 (Berhanu, 1999 quoted in MoE, 2003). According to the impact study (MoE, 2003), a total of at least 2,858 teachers and 640 support staff have reportedly died in the five years period between 1997/98 and 2001/02. This implies that on average more than 570 teachers died per year. In the 39 sample schools (17 primary, 20 secondary and 2 teacher training institutes) covered by the study, a total of 133 teachers died in the five year period alone, i.e., about 27 teacher deaths per year. More than 85% of those who died were less than 50 years of age, of which about 42% were within the ranges of 30-39 years of age. More than 60% of those who died had educational qualifications of at least a college diploma, whereas 87% of who died had more than 10 years of teaching experience. Teachers' absenteeism from classes has also been cited as frequent among schools, and of the different reasons mentioned 65.5% has been ascribed to sickness of either the concerned

teachers (34.8%) or that of their family (13.8%), and death of teacher's family (15.2%) or that of another staff member (1.7%).

HIV/AIDS also impacts on the process and quality of education through its effects on demand and supply by destabilising the smooth functioning of affected and/or infected learners, educators, families and the schooling system in general. At a macroeconomic level, expenditure on HIV/AIDS may crowd out investment in education; hence it will be difficult to enhance or maintain quality standards with fewer and dwindling resources. Moreover, it affects the role, responsibilities, and organisations of education providers to deal with the new challenge.

Education Sector Policy and Strategies on HIV/AIDS

The strategic framework and the Ethiopian Multi-sectoral HIV/AIDS Project (EMSAP) provide a basis for the education sector at federal and regional levels to prepare their own action plans that target the youth in schools as agents and beneficiaries of anti-HIV/AIDS activities. In the plan document (ESDP-II) of the Ministry of Education, there is a section on '*HIV/AIDS and Education*' in which the threat of HIV/AIDS on educational demand, supply and quality is acknowledged and the imperative for responding to this threat both to survive its impact as well as to counter its spread is underlined. A study to undertake the impact of HIV/AIDS on the education sector is envisaged[8]. Of particular concern that are highlighted in the study include the impact of HIV/AIDS on teacher supply and student demand. Possible responses are charted out in terms of:

(a) getting students and teachers informed about HIV/AIDS and providing them with learning opportunities to reduce their vulnerability and to enable them avoid risky behaviours,

[8] A study on the impact of HIV/AIDS on the education sector and the status and problems of HIV/AIDS education has been undertaken in 2003 (see, MoE, 2003).

(b) protect, care for and support children and others living with HIV/AIDS through the curricular approach (through integration of HIV/AIDS education in all subjects and for all grade levels), the various extra-curricular activities including the Anti-AIDS Clubs and radio and TV programs produced and broadcasted by the Education Media Agency,
(c) producing supplementary materials, source books, posters, leaflets, etc., in the different nationality languages and distributing them to schools,
(d) encouraging NGOs working on HIV/AIDS to use schools as centres of intervention and entry points to prevent HIV infection among young people, and
(e) establishing task forces at various levels within the sector (ministry, regional bureaus, district desks, etc) to follow up activities.

In addition, the plan gives due attention to preventive drug, population and family life education, programs and activities to discourage harmful traditional practices at all levels of education. It sets out to strengthen linkages between schools and health institutions. And, it aims to incorporate the cost required to undertake HIV/AIDS and other health related activities at the different sub-programs (MoE, 2002).

HIV/AIDS Programming in the Education Sector

Even though HIV/AIDS cases had been reported since the middle of the 1980s in Ethiopia, it was not until 1996/97 that some work was initiated through a pilot project called "*AIDS/STD Education*" focussing on secondary school clubs. Three years later in 1999/2000, there were some attempts to incorporate HIV/AIDS issues in the curriculum, setting up of anti-AIDS clubs, and use of educational media. This was facilitated by the opportune moment that the educational and training policy was in the revision process at the time. It was possible to include, at all levels of pre-university education (primary, secondary and TTC), aspects of HIV/AIDS in textbooks and teaching aid;

particularly, in environmental science, basic science, biology, language studies, physical education (in secondary); English and Amharic.

The Ethiopian Multi-Sectoral HIV/AIDS Project (EMSAP) under HIV/AIDS Prevention and Control Coordination Office (HAPCO) has implementation manual that outlines each sector ministry's activities. Accordingly, the ministry of education set-up a task force at the beginning of 2001. A technical team provides managerial and follow-up roles for the projects designed under the task force. Focus areas are: 'work-place intervention' at headquarters and its branches, and activities to be undertaken in educational institutions.

Consultative meetings with regional educational bureaus as well as several workshops took place to discuss activities that need to be undertaken jointly including support mechanisms, etc. Some of the activities and outcomes are: (a) assisting teachers through training to make HIV/AIDS related education more effective; (b) support HIV/AIDS related efforts with research and studies; (c) analysis and evaluation of teaching materials; (d) production of audiovisual materials (e.g., video film); and (e) production of HIV/AIDS Teaching Guide for Teachers.

In addition, anti-AIDS clubs have been set up in secondary schools, guidelines for their activities prepared, and various publications and video films produced and distributed. Some of these are: Know and Act: AIDS/STD Education for School Student Textbook; Life Skills Activities for AIDS/STD Education Student Book; School Health Education to Prevent AIDS and STD (Student's Activities Guide, and Teacher's Guide, 2002); and Handbook on Population and Family Life Education for Secondary School Teachers in Ethiopia.

Moreover, some studies have been carried out including: (a) Impact of AIDS/STD Education in Ethiopian Senior Secondary School (2002) the major finding of which is that there was no desirable change in behaviour; (b) Needs Assessment on HIV/AIDS Education for

Ethiopian Primary Schools the objective of which was to determine at which level HIV/AIDS education should be offered – it used to be offered at 7th and 8th grades. It was found out that teachers and community members would prefer 1st grade; (c) HIV/AIDS Baseline Survey on High School Students in Ethiopia (2002), again with a finding that even though 33% of students have awareness about the pandemic, unfortunately this has not led to positive behavioural changes; (d) Preliminary Survey of the Status and Needs of anti-AIDS Clubs in 10 Primary Schools in and Around Addis Ababa; and (e) Impact of HIV/AIDS on Education, and the Status and Problems of HIV/AIDS Education in Ethiopia, 2003.

Clearly these efforts, however important, are far less than the speed with which the pandemic has been spreading and making irreplaceable damages. More effort in the direction of mainstreaming will be necessary for an effective programming for HIV/AIDS in the education sector.

Some evidences are available to substantiate the claim that HIV/AIDS affects not only the economically active population but also those who are either better educated or are being educated. For example, according to a study (Tekeste Kebede, 2003), out of the 927 deaths reported for which the educational status was recorded, 9% received less than elementary education, 21% got elementary education, 51% got secondary education, while 19% received tertiary education. As could be seen, 70% of deaths occurred among those with secondary and tertiary education. It is important not to mistake this incidence to mean that education and HIV/AIDS infection were positively correlated[9]. First, the correlation with age is more important. The peak

[9] This finding seems to be consistent with early evidence from severely affected countries that showed a tendency for levels of HIV/AIDS infection to be higher among the more educated and better-off. Such an association was reported to have been drawn from individuals who had become sexually active in the comparatively early stages of the epidemic when the behavioural correlates of infection were less well understood and less widely disseminated. More recent evidence, however, shows a distinct change in the relationship, with more

ages for AIDS cases are 25 to 29 for both sexes. This is the period when investment in education starts to pay off. Second, education in the Ethiopian context is an urban, rather than rural, phenomenon; hence it corroborates the high incidence of infection in urban centres. Most importantly, the finding supports the evidence that professional education alone won't prevent infection from HIV; it must incorporate effective HIV/AIDS related education.

Apparently it is education and education only that is a proven means to prevent HIV/AIDS. Education provides information on protection against HIV/AIDS infection, reduces girls' vulnerability and has a comparative advantage in a sense that it offers a ready-made infrastructure for delivering HIV/AIDS prevention efforts to large numbers of uninfected persons including those who are at risk. Since the school system brings together students, teachers, parents, and the community, and preventing AIDS through education avoids the major AIDS-related costs of health care and additional educational supply, education is highly cost effective as a prevention mechanism (WB, 2002).

Higher Education and HIV/AIDS

Planning perspectives for education in the context of HIV/AIDS could be viewed from two inter-related aspects, namely (a) the impact of the disease on educational systems, and (b) the role of education in reducing the spread of the disease and mitigating its impacts, which is largely concerned with curriculum issues (Kelly 2002; UNESCO, 2002).

The impacts of HIV/AIDS on systems of institutions such as HEIs could be somewhat similar to the way in which they impact upon the systems of the individual. It has negative effects on learners, educators, managers, and on content and processes. HIV/AIDS

educated younger people emerging as less likely to be HIV infected (see UNESCO, 2002).

introduces shock and new demands on an existing organizational system directly by dwindling resources (including human resources) and indirectly through making other resources less available as well as dysfunctional. The most immediate impact of HIV/AIDS on an organization is that it forces it to operate under severe pressure.

Since HIV/AIDS is a destabilising phenomenon, changes in the system as well as in the environment within which the system operates are inevitable. Mainstreaming HIV/AIDS intervention strategies is essentially about managing such a change. It is about integrating a social message into an organization's daily activities. It requires realignment of organizational missions so that it embraces responses to HIV/AIDS. This could be through broader strategic planning and programs without neglecting ethical considerations. For these reasons, dealing with HIV/AIDS requires new ways of thinking and doing things. It requires skills that may not be amenable under ideal circumstances. Studies suggest that if the success achieved in some countries in the prevention of transmission can be expanded to a global scale by 2005, about 29 million new infections could be prevented by 2010 (Stover, Walker, et al 2002). Short-to-medium term incremental improvements in capacity to manage the change would have multiplier effects in the long term being, in a sense, a vehicle for transformation of the system as a whole.

HEIs are highly pivotal and strategic in the fight against the HIV/AIDS pandemic for a number of reasons. First, they are the single most important suppliers of trained and skilled human resources, not only for the educational sector (e.g., teachers, administrators, etc.), but also for all other sectors of the economy. They will have to come out with a critical mass of knowledge and skills on how to deal with the epidemic. Through this, future national policies and strategies will be reinforced with solid anti-HIV components to minimize and arrest the pace at which the epidemic is moving at present. The multiplier effect of this intervention, if successful, could be enormous. In short, they are centres where future educators, policy makers and advisors are generated.

Second, students in HEIs are mostly young men and women who are more susceptible to the pandemic. As mentioned earlier, the peak ages for HIV/AIDS infection are between 20 and 29 for both sexes. Most university students are within the ages of 19-24, and the extent of their susceptibility tends to increase because they leave their homes and parents for university life at that crucial and sensitive age. Hence, HIV/AIDS intervention mainstreaming could play an invaluable response function in terms of introducing them to 'life-skills'.

Thirdly and even most importantly, higher education is not there just to service the economy and society as it exists, but also to shape it into what it could and should be. Universities are expected to have social responsibility; they are also situated at a comparative advantageous position to effectively and systematically respond to the challenge of HIV/AIDS by mainstreaming interventions in their activities of teaching, research and community services. They could also play an active role in policy development process as well as ameliorating the implementation capacities of both government and non-government organizations in terms of fielding programs and projects.

HEIs in Ethiopia are currently faced with a number of serious challenges to sufficiently respond to new demands of increasing access[10], improving quality, cost-recovery, etc., even without the necessity of having to deal with HIV/AIDS. There is no doubt that HIV/AIDS is mounting a lot of pressure on the limited existing capacities by further eroding it. It threatens the goals of increasing access (e.g., dealing with problems of sickness and death of staff and students, drain and diversion of resources, etc.) and improving quality of education (e.g., loss of qualified and experienced teachers, etc.). A strategic approach is necessary to sufficiently and systematically respond to the challenges posed by the pandemic. The capacity requirements for such a strategic approach include aspects of human

[10] For example, there are plans to achieve by 2005/06 a size of student population attending tertiary level education in any one year to 150,000 (MOE, 2002).

resources development as well as organizational and systems improvement.

HIV/AIDS Prevalence and Impacts within HEIs: How much is known?

Despite the fact that Ethiopia is one of the countries that are hard hit by the pandemic, and that HIV/AIDS has been impacting negatively in more than one ways on the institutions, the society and the economy of the country, not much information is available on the capacity constraints and needs for mainstreaming HIV/AIDS intervention in the educational sector in general and in the higher education sub-sector in particular. Undoubtedly, higher education response is much below expectations.

With the exception of the recent attempt by Jimma University to estimate the prevalence rate among its students, there is no study conducted thus far either by the HEIs themselves or third parties on the prevalence of HIV/AIDS and its impacts on higher education in Ethiopia. As a result, very little is known on the prevalence and impact of the pandemic.

This is disappointing in view of society's expectation of the HEIs to come up with ways of dealing with the pandemic. Society often expects universities to champion societal concerns in terms of taking a lead in investigating developmental problems and contributing to finding workable solutions. In fact, as could be seen in the following paragraphs, the level of performance of HEIs in terms of their response to HIV/AIDS is even much below that of the secondary schools where some efforts have been made although these could also be regarded as below satisfactory levels[11].

[11] There are attempts to incorporate HIV/AIDS in secondary education curriculum and through co-curricular activities even though the curricular approach is found to be both inadequate as well as not complementing the co-curricular activities. Some of the problems emanate from deficiencies in curriculum designs that consider HIV/AIDS just as another viral infections, lack of training of staff who

The study by Jimma University suggests that prevalence rate among its students has in fact been quite high (about 12.2% in 2001). The prevalence rate was reported to be higher among males (13%) compared to females (9.6%). Also, prevalence rates among married students were found to be higher (33.3%) than those who reportedly have girl/boy friends (12.1%) or those without sexual partners (11.6%). In terms of years of university training, prevalence rate was found to be 14.3% among those in their fifth year of study, 9.1% among fourth year students, 19.5% among third year students, 12.3% among second year students, and 9.4% among those in the first year. These figures are quite alarming to the say the least. Jimma University also undertook sero-positivity test for residents of Jimma town as well as for the surrounding rural community. The results indicate that 8.9% of the rural community and 7.0% of the urban community had been infected with the virus. On aggregate, 4.5% of children and 8.5% of adults in Jimma town and its surrounding rural community are infected. Apparently the prevalence rate among university students was found to be substantially higher than for the surrounding areas, including the town in which the university is located.

Similar information is not available for the other universities. Hence, in the absence of statistical data on prevalence and impact in most cases, one has to resort to other proxy and anecdotal indicators that would suggest the tendencies. First of all, there cannot be any reason as to why the picture portrayed above should be unique to Jimma University. Students have been allocated to public universities centrally by the Ministry of Education at random. While it may be true that there could be some university students who practice sexual abstinence until later dates, are faithful to their sexual partners, or use condoms, it is however absolutely foolhardy to assume that many university students are not sexually active or do practice effective preventive measures.

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handle the subjects, and inappropriateness of the way in which the subjects are treated (e.g., peer education is not considered), etc.

For example, two separate but related studies were undertaken by the Integrated Services for AIDS Prevention and Support Organisation (ISAPSO, 1999, 2002) on knowledge, attitude, behaviour and practice on HIV/AIDS and STDs among Addis Ababa University Students. The first study (ISAPSO, 1999) indicates that knowledge of the modes of transmission and preventive methods of HIV/AIDS was universal among the students, and the sources of information on HIV/AIDS were mass media (TV, Radio, etc.). However, a substantial proportion of those who had good knowledge of the modes of transmission were not aware of preventive methods related to sexual behaviour (reducing the number of non-regular sexual partners and use of condoms) and non-sexual behaviour (avoiding the use of sharp and skin piercing instruments in common). Nearly a quarter of the respondents were reported to have been sexually active, half of whom had non-regular sexual partners during the year preceding the study period. Fifty eight students (out of 856 included in the sample) were found to be infected with STDs, of which 87.9 were males. Only few sexually active students used condoms; abstinence was reportedly low (ISAPSO 1999). The second study (ISAPSO, 2002) had an objective of measuring the effects of university based HIV/AIDS prevention intervention (which ISAPSO initiated) on students' knowledge, behaviour, attitudes and perceived risk of HIV infection. It reported desirable tendencies in terms of reduced STDs infection rates, decreased non-regular sexual encounters, increased condom use with both regular and non-regular sexual partners, reduced negative attitude towards people living with HIV/AIDS (PLWHA). However, despite widespread knowledge, a considerable number of respondents reported not to have demonstrated any significant desirable behavioural changes (ISAPSO, 2002).

Available information on sexual behaviour of secondary school students also confirms the above tendencies. One of the findings of a recent impact study (MoE, 2003) indicates that many secondary school students are exposed to the risk of HIV/AIDS infection. If at all there are differences between students in the university and those in secondary schools, it is that the former are only slightly older than the

latter and are situated in the university environment where among other things sexual initiation reaches its peak for all practical purposes. Instead of living with their parents and within the community in which they grew up, university students are now exposed to a completely new environment sharing rooms with more than five persons and that of the university campus with thousands of strangers each with diverse social and individual backgrounds. For some, the first few months of university life could be exciting; for others it could be a shocking experience altogether. Hence, if secondary school students were found to have demonstrated risky sexual behaviours, there is no guarantee that such behaviours are not carried over or even practiced at a larger scale when these students join universities.

University respondents further reported that sexual activities by and among university students are rather common; they also have legitimate cause for concern that many of those involved may not exercise preventive precautions. Student service units reported the existence of a multitude of disciplinary trespasses by a number of students involved in drinking, sexual harassment, etc. Students report that such cases are most obvious in seasons immediately after the end of semester exams. Clinical evidences also unequivocally confirm the existence of several university students with risky sexual behaviours. This is symptomatized, for example, by male students having been diagnosed and subsequently got treated for STDs such as gonorrhoea where in some cases (e.g., Alemaya University) at least three cases per week were reported. While not commonly observed, there were also reports that some female students got treatment for abortion-related complications.

Clinic staff do suspect that abortion rates could be quite high among university students. However, since abortion is not legal in Ethiopia, it does not formally take place in public health establishments including university clinics and hospitals. Those involved resort to hidden and unsafe places and practices leading to health complications and exposure to more infections. And, as elsewhere, female students

expressed their feelings of being more vulnerable through unequal power relations to unwarranted sexual advances either from other male students or some members of the academic staff in the institutions.

Moreover, more number of illnesses and deaths of students and staff have been reported more recently than before even though their causes weren't confirmed as AIDS. It is true that the size of student and staff population within the HEIs has increased tremendously over the last few years, and one may as well associate the increase in cases of illness and death of students and teachers with the increase in the total population. However, clinic staff have strong reservation about such an association and instead suspect that the problem had to do with HIV/AIDS. An apparent impact of this problem is that of loss of trained human resources which are difficult to replace in the short to medium term. There are also mounting pressures on health facilities and other resources. HEIs cover medication expenses of students while on campus.

In terms of impact, university respondents felt that HIV/AIDS has affected the functioning of the institutions. In some cases, it was reported that teachers and students who are frequently sick were found to be not strong enough to respectively teach and learn properly, and ultimately die. In all cases, it has reportedly resulted in increased dropout rate due to illness, ultimate death of students, frequent staff absenteeism from duty, loss due to terminal illness and ultimate death; and high clinical cost of treating students with various types of illnesses. In most cases the problem of loss of teachers has been rated as serious. Again, a distinguishing feature of the problem is that it couldn't be ascribed solely to HIV/AIDS since no data is available. However, the extent of the problem would suggest that HIV/AIDS might well have been the primary suspect.

HEIs' Response – what is being done and what is available in stock?

Policy, Leadership, and Advocacy

Most of those in leadership positions in the HEIs at different levels are reportedly aware of the existence of a national policy on HIV/AIDS and strategic framework for action, but a few didn't know about its specific contents. To date, none of the universities has developed HIV/AIDS policy, and with the exception of few (e.g., Jimma and Addis Ababa Universities), there isn't any intention of coming up with one in the foreseeable future. Five of the six universities, namely Alemaya, Bahr Dar, Debub, Jimma, and Mekele have developed institutional strategic plan documents.[12] Jimma, Mekele and Debub universities have identified HIV/AIDS as one of the threats (as part of the SWOT analysis). Nevertheless, with the exception of Jimma University, none of the universities including the two that listed it as one of the threats, has explicitly outlined definite strategies to respond to the challenge posed by the pandemic in their strategic plan. Jimma Univeristy has included the *'promotion of HIV/AIDS as a core strategic issue in all aspects of the university's activity'* as one of its developmental goals (*italics* added).

Clearly, and logically, a strategy of intervention could not be designed for something when it is not identified as a strategic issue in the first place. Since HIV/AIDS wasn't identified as a strategic issue by most of the HEIs, there wasn't any definite strategy of intervention and therefore no definite action plans are to be found for systematically responding to the pandemic (again Jimma University might be an exception in some fundamental sense). This could be ascribed to lack of ownership and attention given to the problem by HEIs' leadership.

[12] Alemaya, Bahr-Dar, and Jimma universities have a five-year strategic plan respectively covering 2001/02-2005/06, 2001-2006, and 2000-2005. On the other hand, Debub University has a ten-year strategic plan (2004-2013) whereas Mekele University has a twenty-year strategic plan (2002/03-2021/22) within which it encompasses rolling four five-year plans.

Lack of capacity for planning and management compounds the problem further. Absence of a dedicated unit within the university structure that is responsible for HIV/AIDS seems to affirm denial of an address of accountability. Ad hoc arrangements could serve as window dressing exercise ostensibly to portray universities' sensitivity to the issue, but they could not help achieve any tangible and concrete results that are so desired.

HIV/AIDS was not considered seriously in day-to-day activities of units including those responsible for planning. With the exception of Jimma University, there was a complete absence of effort, for instance, to initiate studies on situation and/or impact analysis within the respective institutions. Hence, there has been no system of data collection on monitoring prevalence and impact. As a result, to date, no clear picture exists on students, teachers and other educational personnel who have been infected and/or affected by the pandemic.

Hence, one would note that there is no planning in the strictest sense of the term in the HEIs as far as HIV/AIDS is concerned. Admittedly, the problem with planning is inherent and deep rooted. There seem to exist either a distorted understanding of planning altogether or an unbelievable apathy towards participating in the process. The feeling exhibited is that planning is the sole responsibility of some specialised units (e.g., planning units) with little involvement of other implementing units. The management information system normally takes care of data that are usually reported to the Ministry of Education. These include, among other things, student enrolment, attrition (dropout, etc.,) and staff size, budgets and changes in these figures. However, since the Ministry of Education does not require universities to report on HIV/AIDS issues, universities reportedly lacked the incentive to collect and analyze relevant data. As a result, the Educational Management Information System of the Ministry of Education does not include information on HIV/AIDS. What could be concluded in this respect is that universities' response to issues has generally been reactive rather than purposive.

The extent to which HIV/AIDS has imposed new demands on duties and responsibilities of key units such as personnel administration, student services, budget and finance, etc., within universities was found to be very limited. In other words, roles and responsibilities of the units and persons responsible for planning and implementation did not change to take account of HIV/AIDS. The only apparent unit that has seemingly added a new element in this regard is the universities' clinics that are run by the offices of dean of students' affairs. The clinics distribute condoms to students who might need them. Apparently, most respondents from the various units of universities have a feeling that they should be involved in HIV/AIDS related interventions, but felt that they lacked the necessary capacity for an effective response. These capacity gaps are in the areas of skills in planning, management and information handling and processing – to which practically little effort was made to address.

University governing bodies such as Boards and Senates do not generally meet quite often; and when they do, HIV/AIDS was never tabled for deliberation. University executives are bogged down with university expansion projects (infrastructure, facilities, etc.) and seem to have very little time for spearheading HIV/AIDS issues within their campuses. There is a tendency to think that the Anti-AIDS clubs, mainly a domain of students' activity, would do the trick. Staff members, with the exception of those few who are volunteers on the HIV/AIDS committees and/or Anti-AIDS activities, do not act either in groups or individually to respond to the challenges.

Heads of departments and deans of colleges and faculties do not seem to remember any instance in which they put up HIV/AIDS issues as an agenda for discussions with their respective councils (staff meetings) and academic commissions. Some of them found it difficult to give information during the interview because they were not aware of what was taking place within their respective universities as far as HIV/AIDS response is concerned. This clearly reveals the extent of apathy, denial and the seriousness of the problem at hand. Again with the exception of those in the medical/health faculties, none

of the consulted teachers reported that they discussed HIV/AIDS in classes with students or in departmental staff meetings. There is a strong feeling among student members of anti-AIDS clubs that HIV/AIDS should be discussed in classes. Organized debates and discussions, formal or informal, by staff members are the exceptions rather than the rule. This is particularly surprising in view of the fact that in most of the universities staff members and those in leadership positions normally live within university campuses as communities and thus have more chances of information exchange through informal ways.

There is no association of university teachers in the country and therefore staff members in universities lack the organizational clout to act upon any programme of intervention or demand certain collective rights. They are just there as collection of individuals who discharge their respective roles and responsibilities in an often business as usual manner. The source of information for most of these individuals, with the exception of those in the medical profession, as far as HIV/AIDS is concerned, is the media (radio, TV, newspapers, and other persons) rather than activities within the universities (i.e., workplace interventions, seminars, debates, etc.). Many reported that they actually lost their colleagues and/or students, with suspicion that the cause had to do with HIV/AIDS, but couldn't themselves take initiatives to do something about it.

With the exception of those few special cases,[13] research activities are generally not internally funded since there is no mechanism put in

[13] For example, research on agriculture has a funding mechanism in the framework of National Agricultural Research System (NARS). The new Proclamation has provisions that universities "… shall identify research areas to be prioritized on the basis of the needs of the country and in consultation with appropriate bodies, undertake research that takes into account the needs of the country and enables to equip with scientific knowledge; equips students and trainees with basic knowledge that enables them to undertake practical studies and research; … and shall allocate sufficient fund for research and study it conducts and utilize for the purpose intended (FDRE, 2003).

place to allocate budgetary resources for research. Hence, most research projects depend on external agencies for funding. Staff performance evaluation seems to take into account research involvement and community services, but the extent of staff involvement in HIV/AIDS related research[14] and community outreach is negligible. To begin with, there wasn't any attempt to study the prevalence and/or monitor the impact of HIV/AIDS on universities. Of course, there are reports of more frequent illnesses and deaths of staff and students, and that people suspect that these could be associated with HIV/AIDS, but data are not systematically and consistently collected and analysed.

Therefore, there is a legitimate concern that mainstreaming of HIV/AIDS intervention may not have been properly understood at the level of concept, let alone happening in practice. If there is an exception to this general pattern, it is Jimma University's attempt to link HIV/AIDS intervention within its innovative community based education approach. Recently, Addis Ababa University managed to train five of its faculty members on HIV/AIDS mainstreaming with possible options for implementation[15]. Several reasons were mentioned as hindrances for an effective mainstreaming of HIV/AIDS intervention in universities including lack of adequate priority given to the problem by university management, expressed apathy and lack of coordination among staff, misconception as if it were the responsibility of a specialised agency within the universities (e.g., anti-AIDS clubs) or those outside (e.g., HIV/AIDS secretariat), or those who volunteer to work (e.g., students).

[14] This does not include the activities of some university staff who take on consultancy assignments on individual capacities with external agencies. Since no system of reporting and monitoring these activities exist within the universities, it is difficult to know the extent of staff involvement in such activities.

[15] The UNDP Regional Office in South Africa organized and sponsored the training in which two institutions of higher learning from Ethiopia, namely Addis Ababa University and Ethiopian Civil Service College, benefited by sending their staff members for the training.

Extent of Factoring HIV/AIDS in the Formal Structure

Universities do not have a unit within their formal structure that is responsible for HIV/AIDS. There are committees and/or anti-AIDS clubs, but their activities are not linked with institutional plans – often they are considered as part-time, volunteer-driven activities. Where applicable, the committees in the universities are composed of teachers whereas the major participants of anti-AIDS clubs are students with few volunteering staff members providing coordination and guidance services[16]. The units organize occasional activities (dramas, cultural performances, etc.,) distribute leaflets, newsletters, etc. that are aimed at awareness creation within the respective institutions, and in some cases attempt to reach out to their surrounding community through drama and various displays. Peer education is promoted but most of them are not involved in any care and support or mitigation activities. However, there are recent attempts by the Alemaya University to start an HIV/AIDS Centre with a view to spearheading HIV/AIDS related issues within the university. The centre has a coordinator[17], who chairs a committee of seven staff members, and reports to the Academic Vice President of the university. Jimma University spearheads its HIV/AIDS response through a standing committee of staff members chaired by the External Relations Officer who reports to the President of the University.

[16] In Mekelle University all members of the university top management (president, vice presidents) participate as members of the Club. In Alemaya University HIV/AIDS committee members are composed of staff members, but the anti-AIDS clubs are the domains of students – the president of the students' union is also the chairman of the club. Similarly, in Addis Ababa University, anti-AIDS clubs are the domain of students, but a focal person (one of those who participated in the training organized by UNDP) is assigned to spearhead HIV/AIDS responses in the university. In Dilla College of Teachers Education and Health Sciences (part of the Debub University), the dean of the college is the patron of the anti-AIDS club. In Jimma University, a standing HIV/AIDS committee composed of staff members as well as students' anti-AIDS club are active players.

[17] The coordinator is a graduate of Jimma University where response to the HIV/AIDS pandemic is by far better than in any of the universities in the country.

Since HIV/AIDS was rarely considered as a planning issue within most of the universities, it wasn't integrated within institutional plans. Even where there are emergent HIV/AIDS units, planning for HIV/AIDS is considered as the sole responsibility of those units, not that of each and every department within the university. And, since the activities of anti-AIDS clubs were considered to have fallen outside of the mainstream activities of the different units of the universities, they were not involved in the planning processes either. The resort to ad hoc arrangements is a logical upshot of such a vicious circle. Because HIV/AIDS related activities are not part of mainstream functions, they are not assigned budget lines; and in the presence of other competing programs that often take priorities in the context of limited financial resources, the resources allocated to them on ad hoc basis are not commensurate with what they are expected to achieve. Hence, activities of anti-AIDS clubs within universities are funded more by external agencies such as NGOs on a piece-meal basis rather than from within the universities. Part of the problem with regard to budgeting lies in the fact that separate budget lines for HIV/AIDS was not traditionally known by the Ministry of Finance that provides funding for universities' activities. Hence, it is easily missed out. However, there are indications that some financial resources are being allocated to run occasional HIV/AIDS related activities from internally generated funds.

There is a general observation among those who participate in HIV/AIDS committees and anti-AIDS clubs that these units were unable to carry out activities according to their work-plans, let alone expectations, because of lack of financial resources, trained human resources providing leadership, adequate time, and facilities. Staff members who assume coordinating responsibilities usually carry full work-load in their respective departments (teaching, research, students' services, management, etc.). Student respondents rate the roles and influences of anti-AIDS clubs as weak within the respective universities and generally very weak outside of the universities. They express deep frustrations with the lack of management attention being given to the units, consideration of HIV/AIDS issues as side

issues, lack of mechanism for collaboration with funding organisations, and in some cases high turn over of students and coordinating staff which have reportedly contributed to low performance levels. The problem with lack of finances arises not from funding constraints at the national level as such, for there reportedly existed large sums of unutilised fund with the coordinating national body (HAPCO), but from lack of institutional framework and capacity to attract these funds.

Extent of Integration of HIV/AIDS in Content: Academic and Research Programs

There wasn't any effort to incorporate HIV/AIDS issues and information into courses, as well as in educational and training programs. In the absence of its formal incorporation, whether or not HIV/AIDS was in fact discussed in classes is left to the willingness and capacity of the individual teacher and therefore there is no way of knowing if it has been appropriately handled. Not surprisingly, student respondents confirmed that HIV/AIDS issues were not formally discussed in classes. Moreover, with the exception of those in the medical profession, not a single teacher respondent confirmed that he/she actually discussed HIV/AIDS in classes. Not a single stand-alone course on HIV/AIDS is available in any of the universities either. However, there are some intentions by a group of staff members of Addis Ababa University who received training in South Africa to initiate discussions within the university with the hope and possibilities of incorporating HIV/AIDS in courses. Jimma University has the opinion that a wider incorporation of HIV/AIDS into university curricula and programs would better be spearheaded centrally by the Ministry of Education.

A major problem that was identified with regard to embracing change among universities in Ethiopia is the limited degree of flexibility and adaptability of their systems and organisation to changing environment. The pace at which changes are introduced in the universities is not at par with the sense of urgency that the situation

calls for. The practice in most cases is that curriculum review takes place at a snail's pace and it normally takes several years before a revised curriculum is implemented. There are some cases where a newly revised curriculum awaiting approval had to be dumped altogether before it was implemented because a new curriculum was issued centrally from the Ministry of Education. Normally, university senates are the approving bodies of revised curricula, and for some reason they do not meet regularly, and when they do their preoccupation is mainly to discuss on graduation approval and staff promotion rather than more strategic issues.

The tradition has generally been that introduction of changes is faster and perhaps more successful when it is initiated top-down rather than bottom-up. This is linked with the deficiency of the planning process discussed above. One of the serious damages suffered by systems of institutions and mindset of individuals as a result of the 17 years of brutal military dictatorship and the experimentation with command economy is that it killed the tendency to take initiatives and have the feeling of responsibility. It successfully instilled in many people a sense of indifference, apathy, passivity, risk-aversion etc. Many people at the universities have developed an attitude of waiting for changes to come from above, instead of taking initiatives and responsibility for introducing changes in the system. The system does not encourage students and even teachers to suggest major changes/modifications in the curriculum or introduction of some particular issues and information. Students are expected to be passive course-and-content-takers rather than active partners in the curriculum development and learning process. It is also difficult to find a critical mass of teachers in universities who have received appropriate training and exposure that would enable them to propose changes in the curriculum they teach with a view to facilitating an active learning process.

Part of the problem arises from inadequate level of professionalism. Whereas teachers in primary and secondary schools are trained to join the teaching profession, paradoxically those in the universities,

apart from those who graduated from education faculties, are not trained as teachers. They are subject matter specialists who become instant teachers without having gone through the necessary training and skill development process. Hence, the teaching-learning process in most cases is passive and congested with content and student-participation in the education process is minimal. Under these circumstances, incorporation of HIV/AIDS issues in the academic programs might not achieve intended results unless the total approach is changed so as to design and implement a learner-centred curriculum, learning materials and methodology of training.

HIV/AIDS is conceived largely as a medical/health problem not a social and developmental problem. Hence, whenever incorporation of HIV/AIDS issues in curriculum, educational and research programs was mentioned, it was referred to the health/medical faculties[18]. Obviously, the faculties of health and medicine discuss HIV/AIDS in the various courses (communicable diseases, paediatrics, internal medicine, etc.) and also undertake clinical research (for example, the medical faculty of Addis Ababa University has a joint research project on mother to child transmission with Johns Hopkins University). The department of community health of the same faculty has been involved in KABP and surveillance studies with the Ethiopian Health Professionals Association. However, such research involvements of staff members are largely individual consultancies rather than organised through the universities' systems. HIV/AIDS appearance in the research programs of the universities is accidental rather than systematic, and externally induced rather than internally initiated.

More recently, some of the universities vow to make their curricula and research agenda relevant to the needs of the society and supportive to the development strategy of the country. They claim to have ensured that this was in fact the case through a system of

[18] This tendency is apparently persistent at all levels – for example, at a sectoral level, issues of HIV/AIDS were considered as the responsibility of the Ministry of Health.

periodic curricula revision process (making curricula dynamic) and rendering research to be participatory in processes and problem-solving in outcomes. Clearly, the extent to which this leads to integration of HIV/AIDS into the educational programs and research agenda is yet to be seen.

Human Resource Management and Development in the Context of HIV/AIDS

As explained in the foregoing discussion, data are generally not available on the current status of HIV/AIDS in the universities. Largely because people keep things confidential or demonstrate extreme denial, this contributed to the total information blackout. Absence of initiatives on the part of the universities to take proactive measures have further blocked chances of prevention, care and support for the needy and for impact mitigation.

Universities report high staff attrition and turn-over as one of the serious challenges they have been facing. In particular, they have been unable to attract and retain quality staff in sufficient numbers. There is a uniform academic staff employment policy issued by the Ministry of Education that all universities are required to implement across the board. The employment contract does not have any provision whatsoever to address the peculiarities of HIV/AIDS (see Annex).

Likewise, there has been no particular program to support terminally ill staff members – this could partly be attributed to absence of institutional policy on HIV/AIDS, but also because it is difficult to ascertain if the sickness was due to AIDS. No consistent monitoring of prevalence and impact on human resources exist, but staff deaths are reported without associating its cause to AIDS. The human resource management units do not generally see clearly how to respond to the challenges since, in their opinion, they have little chance and ability to deal with the problem, as ‘implementers of existing human resources regulations’.

The human resource management policy and practice that pertains to the administrative support personnel is subject to the Federal Civil Servants' proclamation (No. 262/2002) that is also silent on HIV/AIDS issues (see Annex). This proclamation was issued only recently (that is after the issuance of the National Policy on HIV/AIDS), and quite surprisingly makes no particular reference to HIV/AIDS as opposed to other diseases except where it excludes HIV/AIDS from the compulsory medical examination that a civil servant shall undergo when required by government office on sufficient grounds related to the service (Art. 61). Hence, it is clear that it will not help to effectively respond to the challenges that universities face in the context of HIV/AIDS. The provision on medical benefits seems to be generous; however, it does not seem to have taken note of the peculiarity of HIV/AIDS and/or the limited capacity of government medical institutions to survive the debilitating impact of the pandemic.

By and large, HIV/AIDS is considered as a problem of the individual concerned, not that of the institution. Institutional and collective responsibilities are normally not harnessed until after the event of death of a person (e.g., arranging for the funeral, transportation of the deceased to parental places, etc.). Incidentally, this is a typical feature defining the traditional prime social responsibility in Ethiopia; i.e., the fact that rendering assistance to the needy is delayed until post-mortem, despite the fact that the assistance would have made a lot of difference while the person was still alive. This episode, saddening as it is, also demonstrates the fact that HIV/AIDS is conceived just as a health/medical problem like other illnesses, not as a developmental one. Partly, this explains why health/medical faculties of universities are relatively more active in their responses than other faculties in HIV/AIDS related activities.

Also there exists no mechanism to counter the loss in productivity and quality of education as a result of teachers/workers being infected and/or affected. Other staff members would often carry more teaching load to cover for the concerned staff based on mere sympathy and understanding (not on policy). In the absence of clear policies and

mechanisms, such silent tolerance and empathy is sometimes resorted to by the universities in terms of continuing to pay salary (even when this has to go against the relevant provisions in the relevant legal documents) for staff who might fall ill irrespective of confirmed HIV/AIDS status.

As far as students are concerned, the in built health service provision enables them to have access to health facilities in general, but there is no way of knowing with certainty if the beneficiary was in fact an HIV/AIDS case or not. However, clearly, there are reports that clinical costs are rising recently. Moreover, universities have guidance and counselling units that are organized to address the general psychological and emotional problems faced by students. But, their counselling capacities could not be sufficiently utilized to respond to HIV/AIDS pandemic because students who might have been infected do not either know their status or even those who knew would not come forth seeking the service fearing possible stigma and discrimination. The fact that universities provide lodging and boarding facilities meant that a number of students would share rooms and the facilities could understandably be sub-standard in most cases. These would have impacts on care and support as well as for impact mitigation even though such efforts are lacking at present.

Extent of Collaborative Efforts and Reaching Out to the Community

The extent to which universities work with other actors in the fight against HIV/AIDS pandemic could be gauged from two angles. The first is the degree of involvement of other organisations in university-based (work place) interventions, while the second is the extent of universities' involvement in other agencies' programs and their effectiveness. As could be seen in the following paragraphs, the focus has so far been on the former even though this by itself was found to be unsatisfactory.

As regards to the involvement of external agencies in university-based workplace interventions, some NGOs were found to have

initiated some work through provision of assistance (technical, financial, material) to anti-AIDS movements within universities. A notable example is that of the Integrated Service for AIDS Prevention and Support Organisation (ISAPSO) that has peer education programs with Addis Ababa University and other colleges within the capital as well as with Debub University, though on a limited scale. The initiative started in 1997 when ISAPSO, in collaboration with the university's dean of students' office, began sensitisation work among students, which eventually led to signing of a memorandum of understanding with the university at the end of 1998. The project was initially sponsored by UNAIDS for one year and later by USAID through Path Finder International. The programme focuses on peer education (training, support), training of clinical health workers in counselling, capacitating the clinics in terms of facilities, starting information centre, and organising panel discussions, outdoor programs, mass events, etc. An attempt was made to replicate a similar approach at Debub University starting 2001, but it did not fully materialise owing to reported conflict of interests between the anti-AIDS club and the then leaders of the students' union.

Offices of deans of students' affairs have been entry points for collaborative efforts since the focus groups are students. However, the programs have reportedly faced a number of problems. First, departments or the universities at large did not often consider the problem and hence the programs as their own. Programs were often induced from outside rather than being university-driven. As a country representative of one of the NGOs tersely put it, both the initiative and the funding comes from outside, not from within the universities. Hence, sustainability of these activities is at stake. Activities lose momentum whenever there are certain disruptions in the universities caused by student unrest or with changes in the persons holding key offices. A programme that took off relatively well could be turned astray when a new disinterested official assumes position. Moreover, there were reports that some people wrongly tend to expect their involvement to carry some financial benefits. Misunderstanding between peer educators on the one hand and student councils and/or

university officials on the other could result in loss of momentum. Hence, in the absence of institutional ownership of programs and activities, individual personalities matter a great deal.

Second, programs (activities as well as focus) revolve around students and often do not involve staff and the systems at large. This is a problem which is endemic in a sense that HIV/AIDS issues have largely been construed by many university management and staff alike as belonging to others' (notably students); they have not effectively been taken home.

Third, programme designs that were meant to promote peer-education among students have reportedly run the risk of ending up being prescriptive. There are reports that some university officials tend to dictate the content and approach. This obviously limits the extent of participation by target groups in the designs of programs, hence undermining the chance of their effective implementation.

Fourth, a weak culture of communication and debates among university community on the issue has compounded the problem further.

Some NGO respondents (e.g., Pathfinder International) expressed their preference for a change in approach in such a way as to promote comprehensive programs incorporating reproductive health issues, STDs, etc. instead of trying to address HIV/AIDS in isolation or exclusively, as well as focus on general university community rather than on students alone. Student and staff attachment programs with agencies that have programs on HIV/AIDS, if encouraged, are believed to have dual roles. On the one hand, they ameliorate implementation capacities of the agencies. On the other hand, they enhance the capacities of the participants (their knowledge, skills and attitudes).

In fact, if the intervention has to be sustainable, it needs to anchor on institutional systems and sections of the university community that are

more stable and enduring. The maximum number of duration that students may stay on campus was for 4-5 years, which is now reduced to 3-4 years, and for 8-10 months within each of these years. By contrast, staff members are permanently there, with some possibly staying up to the age of retirement (i.e., up to the age of 60 years). The level of active involvement of students is also reportedly declining with years; i.e., newly enrolled students were found to be more active and interested to get involved in the programs than those who have been on campus for three or more years. Apparently, the euphoria in the former case may be associated with the hangover effects of the secondary school anti-AIDS club involvements, which tend to dissipate while in university campuses when the environment apparently turns out to be inactive and inept as far as the fight against the pandemic is concerned. So, students who started with relatively high level of enthusiasm tend to run out of their energy and motivation as they stayed longer in the universities. This is in addition to significant variations among those students in terms of their level of motivation and capacity.

What has been discussed in the foregoing paragraphs concern universities' actions within their campuses. The second aspect is related to the extent of universities' involvement with their external environment and, if so, the effectiveness of those interventions. Whereas the target group for the former is the university community (even though at the moment the domain happens to be exclusively students), that of the latter is the society at large. In fact, the degree of success/failure of university-based interventions mirror and determine the success/failure of universities' programs to impact desirable changes within the society at large.

With few exceptions, generally there was little tradition in Ethiopia's universities to make research action-oriented and impacting. Mekele University has a Community-Based Developmental Research and Practical Attachment Programme. Jimma University has a Community-Based Education and Practical Attachment Programme. More recently, there are attempts to come up with an amalgam of

these approaches so that they could be adopted by other universities (e.g., COPE – Community Oriented Practical Education). However, so far, HIV/AIDS has not been the focus of these community oriented practical education and research programs. Moreover, there was not any instance that is reported in which the universities as institutions had successfully forged partnerships with other agencies to work on HIV/AIDS.

The national HIV/AIDS Prevention and Control Office (HAPCO) coordinates, provides funding for, and monitors HIV/AIDS related programs and projects in the country. An attempt was made to know if there were projects registered with HAPCO in which universities take part. However, nothing tangible was found. The observation by HAPCO is that universities have not been sufficiently sensitised in a manner that enables them to be proactive and assume desired responsibilities. HAPCO may take its share of the blame for not having productively engaged universities as strategic partners. Other actors came up with projects and sought financial support from HAPCO. HAPCO hoped that universities would also come forward as institutions with ideas and viable projects, which apparently never happened. If anything, university students would submit research proposals as part of their theses preparation for funding, which HAPCO found difficult to entertain. This is because HAPCO's funding procedures require institutional, not individual, accountability. HAPCO encouraged these students to direct their proposals through their respective departments/universities, but the suggestion never got materialised. Lack of institutional mechanism and systems within universities to facilitate research activities tend to undermine individual initiatives and efforts.

Well over 170 various agencies[19] (government, NGOs, UN agencies, Faith Based organisations, etc.) were identified that included in their

[19] NGOs and Stakeholders HIV/AIDS Program Focus Matrix was initially prepared by Christian Relief and Development Association (CRDA) and PACT International. It is updated by NACS in collaboration with UNAIDS.

programs some HIV/AIDS related focus. Only one of the universities, namely Addis Ababa University through its medical faculty, was found to have been involved in a research and surveillance joint activity with ILO and Ethio-Netherlands AIDS Research Programme. The John Hopkins University also has an HIV/AIDS focused public health project with Addis Ababa University's medical faculty.

Moreover, an attempt to enumerate HIV/AIDS related studies undertaken in Ethiopia produced more than 80 reports. However, the only instance in which universities were mentioned concern the department of community health in the faculty of medical sciences of the Addis Ababa University in which it reportedly got involved in a surveillance project sponsored by Family Health International (FHI). In fact, some of the professional associations have served as conduits through which university faculty members could get involved in HIV/AIDS related training and research activities as consultants. Several master's theses research of graduate students also got sponsorship through such mechanisms.

Universities are reportedly lacking the necessary institutional flexibilities and administrative simplicity to sufficiently respond to training and consultancy demands of those agencies working on HIV/AIDS as well as special needs of their faculty members and students who are willing and able to engage in such activities. Most of the NGOs consulted had confirmed that they had been resorting to the expertise of individual faculty members of universities rather than working with the universities as institutions. And this is despite their preference for collaborating with universities, since such collaborations add credibility to their work for advocacy purposes as part of their efforts to influence government policy formulation process.

The reasons mentioned for resorting to individual expertise are the possibility and simplicity of directly identifying the *'right'* expert and flexibility in following up any contract awarded. Hence, some staff members have been involved with community level HIV/AIDS issues,

NGOs and Faith Based Organisations' HIV/AIDS programs, etc. And, there is no doubt that the involvement of university staff, as individuals, in HIV/AIDS related studies and consultancy significantly go unnoticed by the universities' system. There is no mechanism of knowing about the existence of such involvements let alone monitoring their impacts. While this may have arisen from weak institutional capacity, such a practice may undermine the institutional research and consulting capacity of universities if and when the latter get involved with third parties such as government, NGOs or the private sector. The practice may also be an impediment to further institutional capacity building and institutional response to issues such as HIV/AIDS.

Stakeholders' Expectations

Government ministries, major NGOs, faith or community based organizations, and major donors have been consulted to identify if they have ever run joint HIV/AIDS related programs and/or projects with universities and to determine the degree of their receptiveness to an expanded role for universities as partners in the fight against HIV/AIDS. In general, government ministries saw a more proactive role for universities than what is the case now in terms of designing focused training programs, developing effective learning materials, delivering the courses, undertaking research, and even getting involved in intervention projects. Most of the consulted NGOs have also shown a general interest to collaborate with universities, but few are rather apprehensive about the degree of flexibility, simplicity and responsiveness of the systems in universities to respond to their needs. Apparently, some have expressed their legitimate concerns that the alleged lack of flexibilities of the universities' system might as well lead to diversion of potentially collaborative programs to suit some private interests. Collaborative approaches with universities, as opposed to working with individuals, are normally considered desirable by the consulted NGOs for a number of reasons including its credibility for advocacy purposes. The tradition has so far been to involve faculty members and/or students as individual consultants or

researchers rather than work with universities as institutions. While this may be a preferable option for the concerned staff and students, it undoubtedly erodes institutional capacity. The NGOs welcome the idea of designing appropriate attachment programs for university students to work with them on HIV/AIDS related programs and projects. Student and staff attachment programs with stakeholders' programs has double blades which could be very sharp to cut both ways. On the one hand, it ameliorates the capacity constraints of implementing agencies. On the other hand, it helps enhance participants' and learners' knowledge, skills, and attitudes. For example, more number of graduate students could be enticed to undertake their masters' theses research on HIV/AIDS related issues linking with projects run by government organizations or NGOs.

Obviously needs and gaps within implementing agencies for an effective response to HIV/AIDS are numerous and large. The interest and expectation to work with universities have been immense. In fact, staff members from the medical faculties have been serving as board and/or task force members in some of the organizations such as HAPCO and PLWHAs' organisations. In addition, others serve as resources persons in the Ministry of Health (e.g., drug administration). This is to be encouraged, but also it must lead to a more proactive role on the part of the university at large (not just individuals). On the other hand, there clearly exists an idle capacity within the universities which must be tapped in an organized and purposeful manner. Faculties and departments of education, medicine/health, psychology, biology, economics, sociology, management and public administration, law, etc. have human resources that the universities could utilize in their efforts to contribute towards an effective response for combating the HIV/AIDS pandemic. Universities must be prepared to meet these needs, gaps and challenges.

Summing up – Emerging Gaps, Challenges and Opportunities

Universities need to address social concerns as affirmed in the legal documents providing for their establishments. They enjoy comparative

advantages as an effective and sustainable mechanism in the fight against HIV/AIDS since education as the most effective and sustainable cure has no substitute. After all, it is the universities that produce educators, policy makers and advisors. However, the practice leaves much to be desired. Universities have yet to live up to societal expectations.

Emerging Gaps

Ethiopian universities have yet to come to grips with addressing the demands posed by HIV/AIDS pandemic in their policies, strategies and practices. So far, they have not developed institutional policy on HIV/AIDS in terms of contextualizing and concretizing the national policy to suit their particular situations. With few exceptions, their institutional strategic plan documents do not take into account HIV/AIDS as a strategic issue. Therefore no definite strategies and action plans have been formulated. In fact, it could be said that no planning exists as far as HIV/AIDS is concerned. Hence, it does not figure in any of the major educational, research, and outreach programs of the universities. Courses and programs do not contain information on HIV/AIDS in any purposeful and organized manner. With few exceptions, university staff members did not receive training on how to introduce HIV/AIDS information in their courses and on how to effectively deliver it. In other words, there was no scope for mainstreaming of HIV/AIDS intervention. This is related to a more general problem of failure to install a system that helps make programs relevant and responsive.

At institutional level, HIV/AIDS responses lack leadership, ownership and commitment. There is inadequate understanding of the role that universities should be playing as far as responses to the HIV/AIDS pandemic are concerned. At best, HIV/AIDS responses are understood as merely ‘work place’ interventions. They have not sufficiently been considered as carrying crucial societal messages that must be addressed. The ‘work place’ interventions themselves have been found to be insufficient in many respects. Resort is made

to ad hoc arrangements that would facilitate relegation of leadership responsibilities (e.g., advocacy) to 'others' (e.g., students and/or anti-AIDS clubs) who are not only under-resourced but also lack the necessary institutional clout to effect far-reaching impacts within the respective universities, let alone with the surrounding community. The absence of a formal HIV/AIDS unit within the universities' structure effectively denied an address and sense of ownership; hence, planning for HIV/AIDS turned out to be essentially nobody's responsibility; and there exists no formal budget line for HIV/AIDS related activities. Obviously, in the absence of any HIV/AIDS intervention plans and budgets, there is no place for monitoring and evaluation.

The result is that there exists no information on the prevalence of HIV/AIDS or its impacts in the universities. The educational management information system (EMIS) includes data on many things, but not on HIV/AIDS. Hence, no systematic intervention in terms of care and support or impact mitigation has been designed. Regulations that provide for human resources management and development, students' administration and support, etc., have not been revised to take account of HIV/AIDS. Staff members do not act in any organized manner, nor do they have formal association.

Collaborative efforts with stakeholders are limited to NGOs' funding of occasional activities organized by anti-AIDS clubs within the universities, but these were rarely initiated by the universities as an institution. As a country representative of one of those NGOs who are involved in such activities succinctly put it, both the 'pushing' and the funding have been coming from outside, not from within the universities. Since interventions are not anchored on the most stable and enduring system and units of the university, ownership and sustainability of those programs are clearly at stake.

Universities are found to be not prominent in terms of their involvement in HIV/AIDS related training, research and consultancy activities as institutions. Some individual faculty members do engage

themselves in such activities as individual consultants. Lack of appropriate, flexible, simple and responsive mechanisms (systems and structures) within the universities might have contributed for the existence of such a state of affairs. Universities have yet to come up with systems that facilitate individual and/or group initiatives as well as institutional involvement in collaborative programs with other stakeholders. Various options could be suggested based on experiences elsewhere that work (e.g., Makerere University in Uganda, the University of Pretoria in South Africa, etc. where consultancy units are attached to faculties and departments). Collaborative initiatives with other African universities need to be encouraged for achieving better results.

There are a number of gaps that need to be addressed in order to enhance the capacities of universities for mainstreaming of HIV/AIDS response. These include developing shared awareness among leaders and staff of the institutions so that they appreciate that it is a priority issue to be taken seriously in the programs, skills in design and delivery of curriculum that integrates HIV/AIDS, skills on collaborative work with stakeholders and appropriate planning and allocation of resources, and institutional systems and mechanisms that encourage organized and institutionalized, as opposed to isolated and individualized, intervention.

Major Challenges

A report by the Association for the Development of Education in Africa (ADEA) has well summarized higher education's response in Sub-Saharan Africa to HIV/AIDS. According to that report, universities display characteristics similar to those shown by general education systems: considerable disarray, inadequate understanding, piecemeal response, lack of coordination, absence of well-developed action plans, minimal policy framework, and heavy reliance on the initiatives of a few interested and committed members of staff. The report concludes that the HIV/AIDS situation and responses in universities have not generated the passionate commitment that universities and

university students have historically manifested in other struggles dedicated to university advancement, national liberation, and social causes. The most striking feature of the university response to HIV/AIDS is what can only be described as the awe-inspiring silence that surrounds the disease at the institutional, academic and personal levels (ADEA, 2001).

The most fundamental challenge for universities is to live up to societal expectations. There is expectation that universities must assist the country's development process in terms of making their educational programs and curricula relevant to the country's context and render their research programs problem-solving in terms of impact and participatory in terms of process. HIV/AIDS is clearly a developmental challenge for the country. Hence, universities must respond to this challenge in a purposeful, organised (rather than piece-meal), and proactive (rather than reactive) manner.

It is also a challenge for the universities to speed up their responses at a pace exceeding (not just keeping pace with) that of the speed with which HIV/AIDS has been spreading and ravaging the society and the economy. Clearly, the way in which changes have traditionally been introduced and managed within the universities is incompatible with the required sense of urgency; it altogether requires a new approach and attitude. A good beginning would be to demonstrate in practice within their environment as a learning experience before they claim to change the outside environment. The biggest challenge seems to be to bring issues of HIV/AIDS as close to home and self as possible.

Opportunities

There are a number of opportunities that universities must seize for an effective response to HIV/AIDS. First, capacity building has been identified as a key activity of the government because of the inherent serious capacity gaps. The logic is that unless these gaps are addressed, all other efforts cannot be sustained and will not bear any

fruit. Capacity building encompasses (a) human resources development (b) systems development, and (c) organizational development. The human resources development (HRD) needs of the development strategy (in a medium to long term), and the investment that makes this happen is immense. A courageous and ambitious plan is embraced by the government to bridge the huge HRD gaps. Higher education reform is underway. There has been an unprecedented level of expansion of programs and institutions providing higher education in the country, including a national system of ICT network. In addition to the public universities, there are numerous other colleges run by government, non-government and the private sectors.

Second, government has also promulgated a legal framework by enacting a new proclamation that provides for administrative autonomy (of financial management, human resources management and development, the exercise of academic freedom) and for the necessary organisational flexibility. The proclamation also outlines the universities' responsibilities, and most importantly the need to be relevant to the country's developmental needs. There are encouraging indications in that most of the universities have indicated in their strategic plan documents the need for relevance of programs.

Third, universities are situated in a comparative advantageous position as compared to other sectors – they claim to muster best minds and facilities, are full time thinkers and not obstructed by nitty-gritty bureaucracy, and hence enjoy a congenial environment for learning, investigating and acting. They could also forge useful partnership with institutions that have expertise and experience situated locally or overseas.

Fourth, there are immense expectations from stakeholders urging universities to be more relevant and proactive in content and approach as well as more efficient and responsive in their operations. There is a widespread belief that universities can make a difference

and because of that the stakeholders have expressed their willingness to collaborate with the universities.

Fifth, some promising approaches of linking education with community outreach have already been practiced within some of the universities such as Jimma and Mekelle universities (e.g., the Community Oriented Practical Education, COPE). There is no doubt that important lessons could be drawn from such experiences for an effective HIV/AIDS response. Moreover, there are a number of promising efforts elsewhere in Africa to learn from and adapt to local situations; in a sense, there is no need for reinventing the wheel. Examples may include policy development, design and implementation of care and support programs, community engagement, setting up of units, and research in various universities including Kenyatta University, the University of Namibia, the University of Natal (see, Katjavivi and Ottala, 2003).

Sixth, more recently the Ministry of Education commissioned a task force for Higher Education System Overhaul (HESO) focussing on issues of governance, leadership and management. The analysis and the conclusion of the study clearly indicates that universities have not been giving due attention to HIV/AIDS issues. A number of useful recommendations have been forwarded including on effective HIV/AIDS response. The findings of the HESO study have been presented to higher education leaders and discussed. It is expected that concrete action plans would be developed that facilitate a proactive role by the ministry and the universities.

Recommendations – the way forward

Effective response to HIV/AIDS necessitates integrating HIV/AIDS interventions into the mainstream activities. The importance of strategic planning, definition of the roles and responsibilities of various actors and their coordination, as well as a system of monitoring and evaluation cannot be overemphasised for an effective mainstreaming. Such a planning perspective helps to automatically address the issue

of resources. Leadership needs to involve in serious planning, because that is when it becomes possible for mainstreaming and follow up and monitor implementation.

1. *Policy streamlining:* At the national level, the necessary policies and the strategic framework are in place, and they are fairly comprehensive. However, these have yet to be sufficiently streamlined at institutional level for an effective realisation of the central messages contained in those policies and strategies. Such policy gaps might have incapacitated the universities in designing appropriate strategies in dealing with the pandemic. Hence, the importance of contextualising the national HIV/AIDS policy, in terms of designing institutional policies that are consistent with and elaborative of the national policy, needs to be given utmost urgency.

2. *Incorporating HIV/AIDS issues into the universities' programs:* Universities must develop an effective 'work place' interventions for HIV/AIDS (e.g., in terms of addressing human resource management, stigma and discrimination, etc). At the moment, the 'work-place' interventions suffer from serious deficiencies. They are often student-centred and student-driven; university staff (both academic and administrative) and management do not take active part in them. There are concerns that despite their relentless efforts, the capacity of the university-based HIV/AIDS committees and/or anti-AIDS clubs to bring about a positive change in behaviour among the university communities is seriously constrained by lack of adequate support in terms of leadership, effective advocacy, knowledge and skills, facilities and financial resources. Their dependence on piece-meal external assistance limits the consistency, sustainability and effectiveness of the intervention programs. It is important that the interventions be designed in such a way as to involve all members of the university community.

Universities' responses must also transcend into addressing broader societal concerns. It is important to address HIV/AIDS issues in terms of programmatic intervention. There is a need for an increased understanding of the potential roles of universities in preparing future policy makers, opinion leaders, teachers, etc. to work within the context of the pandemic. HIV/AIDS concerns should be incorporated into teaching, research and outreach programs. It is only then that universities begin to influence government policy formulation processes at a broader level.

Universities need to carefully work out alternative mechanisms of incorporating HIV/AIDS issues in their teaching, research and outreach programs as well as administrative policies in a comprehensive manner and in a way that suits their peculiar circumstances. Provision of training of trainers (TOT) course for their staff on design and delivery of academic programs that incorporate HIV/AIDS issues should be considered as one of the priorities for successful intervention.

3. *Planning and programming for HIV/AIDS response:* The business of mainstreaming must start with serious planning. If planning does not take into account HIV/AIDS issues, then one cannot talk about mainstreaming at all. The problem is that issues related to HIV/AIDS are considered as either side-issues or as responsibilities belonging to some specialised agencies and units, hence turning the very concept of mainstreaming on its head.

As instruments of planning**,** the educational management information system must be re-examined and redesigned to take full account of HIV/AIDS issues on a continuous basis. At the moment, no data is being systematically generated on prevalence as well as on impacts – making it utterly difficult to get a clear picture of the issues to strategically and systematically respond to the challenges. Proper planning enables effective control, monitoring and evaluation during implementation and ensures

leadership commitment. It also facilitates coordination of efforts, activities and resources through systematic integration.

Budgeting should automatically follow planning, hence avoiding the chronic resource hunger that front-line units (e.g., anti-AIDS clubs) have traditionally been facing. Central to the approach is for the universities to start planning with their own available resources, however small. The advantage of having a separate budget line is, in addition to instilling a sense of ownership, reducing the vulnerability and disruption of crucial activities caused by possible dwindling of the external support.

4. *The key role of leadership commitment: W*henever a change has been introduced, success or failure of interventions is, to a large extent, determined by the degree of leadership and ownership of those programs and unwavering commitment to the cause. HIV/AIDS response is no exception. For this reason, leadership ownership and commitment must be ensured through focussed management development effort. The ministry, university boards, presidents and other relevant units need to ensure that there should be a concrete HIV/AIDS response by the universities and there needs to be a clear accountability system of regular reporting and monitoring of activities.

5. *Enhancing ownership and institutional capacity through dedicated HIV/AIDS units:* While it is perfectly appropriate to have steering committees and anti-AIDS clubs, it is also instrumental to set-up within the formal structure dedicated HIV/AIDS units staffed with adequate qualified staff and equipped with necessary facilities. The importance of having a full-time dedicated unit and personnel with clear mandates, among other things, is that it enables the institution to build its capacity so that key functions will not be susceptible to change of persons, which may apparently also cause changes in priorities, etc.

6. *The importance of organized response:* An association of university staff (teachers, workers) may serve as a useful forum for raising strategic issues such as HIV/AIDS response, take firm stand and subsequently act upon them.

7. *Proactive and purposeful institutional response:* A fundamental attitudinal change is desired among the university community and the system at large for a proactive stance as opposed to reactive attitude in the effort to address societal concerns with vigour. They need to seriously consider collaborative approaches and interventions with other stakeholders, government or otherwise.

8. *Systems development*: is necessary for motivating, streamlining and facilitating the involvement of staff and students in HIV/AIDS response. This should be possible with the issuance of the Higher Education Proclamation that provides for administrative autonomy. Institutionalized responses rather than individualized approaches, and organized responses as opposed to isolated interventions should be encouraged.

9. *The advantage of learning opportunities from promising approaches:* A lot of useful experiences abound in some of Africa's universities and even within some of the local universities. Universities must be prepared and willing to learn from these universities for a quick start. There was an initiative to form a national forum of higher education institutions against HIV/AIDS, which did not really take-off the ground. It is important that this initiative be taken on board. A useful first step would be to forge a network of partnerships among higher education institutions within the country as well as in the continent and use these networks as a forum to share experiences.

10. *The urgency to seize the opportunities created by conducive environments:* Here, one may reiterate the potential role of the national ICT capacity building initiative and the fundamental role that universities could play in effectively utilising it to advance their

HIV/AIDS response. The initiative opens immense opportunities for reaching out wider and larger audience through distance modes of delivery. It also enhances international partnerships and broadens resource envelopes through sharing. For example, universities could substantially benefit from the availabilities of online learning resources such as the UNESCO Virtual Institute for Higher Education to train their teachers. The practical usefulness of such an approach has already been tested when the Ethiopian Health Professionals Association in North America in collaboration with the Ministry of Health, Ministry of Capacity Building and the Ethiopian Civil Service College, successfully launched an online course on HIV/AIDS for health professionals in Ethiopia through video-conferencing and multi-media facilities. This needs to be expanded.

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Annexes

Annex 1a: Student Enrolment by Universities (2002/03 Academic Year, Semester I)

	Day			Evening			Summer			Total			%
University	M	F	T	M	F	T	M	F	T	M	F	T	female
Addis Abab	11161	1962	13123	7662	2895	10557	366	79	445	19189	4936	24125	20.5
Debub	4768	892	5660	2399	697	3096	1402	126	1528	8569	1715	10284	16.7
Aelmaya	3251	622	3873	1499	439	1938	1895	134	2029	6645	1195	7840	15.2
Bahr Dar	4508	688	5196	4445	1319	5764	1805	178	1983	10758	2185	12943	16.9
Mekele	3697	605	4302	2450	807	3257	388	807	1195	6535	2219	8754	25.3
Jimma	4302	818	5120	2027	622	2649				6329	1440	7769	18.5
Total	31687	5587	37274	20482	6779	27261	5856	132 4	7180	58025	13690	71715	19.1
% Female		15.0			24.9			18.4			19.1		

Annex 1b: New Admissions by Universities – Day Programme only (2003/04 Academic Year)

University	M	F	T	% female
Addis Ababa	957	283	1240	22.8
Debub	1223	316	1539	20.5
Aelmaya	1038	234	1272	18.4
Bahr Dar	1046	270	1316	20.5
Mekele	1278	255	1533	16.6
Jimma	1262	298	1560	19.1
Total	6804	1656	8460	19.6
% female		19.6		

Annex 1c: Teaching Staff in Universities

University	M	F	T	% female
Addis Ababa	693	53	746	7.1
Debub	341	35	376	9.3
Aelmaya	248	21	269	7.8
Bahr Dar	215	11	226	4.9
Mekele	194	9	203	4.4
Jimma	278	15	293	5.1
Total	1969	144	2113	6.8
% female		6.8		

Source: Education Management Information Systems, Ministry of Education. 2003.

Box. 1. Jimma University's Response to HIV/AIDS

The University has established a committee led by the External Relations Officer who is also a health specialist. This committee is a university wide committee involving a cross section of the community. In addition, there as a student anti-AIDS club under the auspices of the students' union. When the committee started its work a couple of years ago, it set out guidelines and decided to conduct base-line surveys as basis for the design of specific intervention strategies.

Subsequently, it undertook the following studies: (1) a baseline sero-positivity survey to estimate the magnitude of HIV/AIDS prevalence among the university's student population and the surrounding urban and rural areas; (2) KABP/VCT covering the student population, the nearby urban centres and rural areas; (3) a study on stigma/discrimination in Jimma town; (4) a study on the extent of effectiveness of IEC materials; (5) prevention of mother-to-child transmission around the training health centres located within 50 kilometres radius from the university, and (6) ARV therapy. Most of these studies have been completed and are in the process of getting published. The baseline surveys were financially supported by Irish AID, but most of the other studies have been covered through internal university's funds. Based on these studies, a proposal of action for the next five years is designed and submitted to HIV/AIDS secretariat for funding. Direct intervention in terms of BCC, PPMTCT and ARV are also initiated.

The care and support component aims to improve the quality of care for terminally ill AIDS patients and people living with HIV/AIDS. Twenty nursing staff members of the university hospital and nursing school were trained on quality care for that purpose.

Curricular integration is limited to those subjects within the health stream and there are concerns that unless spearheaded and coordinated centrally through the Ministry of Education, it would be difficult to integrate HIV/AIDS studies other than in health sciences. The university has been practicing an innovative approach of integrating education with practice (community-based education and research), which also helps it extend a similar approach to its response to HIV/AIDS. Graduating students have been working on KABP studies as part of their partial fulfilments for obtaining their degrees. Moreover, there are plans to share the activities and other information in an exhibition program specifically designed for that purpose.

Source: Jimma University, 2004.

Box 2. Provisions on Sick Leave in the Employment Contract for Local Academic Personnel.

"The employee shall be entitled, if the need arises, to twenty days of sick leave with pay during any academic year. The unused portion of sick leave may not be carried over to a subsequent year or used for any other purpose. Any period of sickness longer than three consecutive days must be attested by a medical certificate. It is the responsibility of the employee to give make up classes"

Box 3: Selected Provisions of the Federal Civil Servants Proclamation No. 262/2002.

On Sick Leave (Art. 36): "(1) Any civil servant shall be entitled to sick leave where he is unable to work due to sickness. (2) The duration of sick leave to be granted to a permanent civil servant in accordance with sub-Article 1 shall not exceed eight months in a year or twelve months in four years, whether counted consecutively or separately starting from the first day of his sickness. (3) Sick leave to be granted in accordance with sub-Article 2 shall be with full pay for the first three months, with half pay for the next three months and without pay for the last two months. (4) Where any civil servant is absent from work due to sickness: (a) he shall, as soon as possible, notify the government office unless prevented by force majeure, (b) he shall produce a medical certificate in case of absence for three consecutive days or for more than six days within a budget year." **(Art. 37)**: "A temporary civil servant who is unable to work due to sickness shall be entitled to sick leave in accordance with the contract he has entered into with the government office".

On mourning (Art. 39): "(1) Any civil servant shall be entitled to leave with pay for three consecutive days in the event of the death of his spouse, descendant, ascendant or any other relative, up to second degree, by consanguinity or affinity. (2) A civil servant shall be entitled to leave with pay for one day in the event of the death of his close relative or friend other than those specified in sub-Article 1, provided however that such leave shall not exceed six days within a budget year".

On medical benefits (Art. 42): "(1) A permanent civil servant shall have the right to get all medical services, free of charge, in government medical institutions. (2) A permanent civil servant shall have the right to get medical services, with half pay, in government medical institutions for his spouse and minor children".

On termination of service due illness (Art. 75): "(1) where a permanent civil servant is unable to resume work within the time specified under Art. 36(2) of the Proclamation, he shall, with no requirement of a medical certificate, be deemed unfit for service and be discharged; (2) the service of any temporary civil servant may be terminated where he is unable to resume work at the end of the sick leave granted to him pursuant to Art. 37 of the Proclamation.