AN ANALYSIS OF HIV/AIDS POLICY DEVELOPMENT AND IMPLEMENTATION AT TWO UGANDAN UNIVERSITIES

by

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DECLARATION

Student number: **3236-396-6**

I declare that **"An analysis of HIV/AIDS policy development and implementation at two Ugandan universities"** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE

(Mr TA Iraka)

18/04/2011

DATE

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- I thank the Almighty Lord God for giving me the strength and spirit to go on this journey and complete it in his honour and glory.

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DEDICATION

This work is dedicated to my wife, Ivy, and children, Namara and Elijah. Thank you for your patience, love and understanding.

Numbers 6: 24-26

"May the LORD bless you and take care of you; May the LORD be kind and gracious to you; May the LORD look on you with favour and give you peace".

ABSTRACT

The main objectives of the study were to analyse the process involved in HIV/AIDS policy development and implementation at two selected universities in Uganda.

The rationale for the study was to describe the policy development process and to identify how such institutional policies can be planned, operationalised, monitored and evaluated.

The study used a qualitative approach which involved key informant interviews and focus group discussions. The selected institutions were Makerere University Kampala (MUK) and Mbarara University of Science and Technology (MUST).

The findings show that MUST have a comprehensive HIV/AIDS Institutional Policy (HIP) which followed several stages during policy development. The basic stages identified were policy formulation, policy adoption, policy implementation and policy evaluation. The findings also show that MUST have a comprehensive implementation plan.

In contrast, MUK had no record of the HIV/AIDS institutional policy development process. However, MUK had implemented the policy successfully through the University Hospital and Gender Mainstreaming Division.

Key Terms: higher education; HIV/AIDS institutional policy development; HIV/AIDS institutional policy implementation; behaviour change; Uganda; university; qualitative research; focus group discussion; HIV/AIDS services; HIV/AIDS research.

ABBREVIATIONS AND ACRONYMS

AAU	-	Association of African Universities
ABC	-	Abstinence, Being Faithful, Condom Use
ACU	-	Association of Commonwealth Universities
AIC	-	AIDS Information Centre
AIDS	-	Acquired Immuno Deficiency Syndrome
ART	-	Anti-Retroviral Therapy
BCC	-	Behaviour Change Communication
CeSSRA	-	Centre for Social Science Research on AIDS
EAC	-	East African Community
EPRC	-	Economic Policy Research Centre
FGD	-	Focus Group Discussion
GFATM	-	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GHAIND	-	Global Health and HIV/AIDS Initiative Uganda
HCT	-	HIV Counselling and Testing
HEAIDS	-	Higher Education HIV/AIDS Programme, South Africa
HEI	-	Higher Education Institution
HIPD	-	HIV/AIDS Institutional Policy Development
HIPI	-	HIV/AIDS Institutional Policy Implementation
HIV	-	Human Immunodeficiency Virus
IATT	-	Inter Agency Task Team on Education and HIV/AIDS
IDI	-	Infectious Diseases Institute
IDP	-	Internally Displaced Persons
IEC	-	Information, Education and Communication
ISAE	-	Institute of Statistics and Applied Economics
ISS	-	Immune Suppression Syndrome
KI	-	Key Informant
LUMUST	-	Lund University Mbarara University of Science and Technology

MDGs	-	Millennium Development Goals
MJAP	-	Mulago – Mbarara Teaching Hospitals Joint AIDS Program
MoES	-	Ministry of Education and Sports
MoFPED	-	Ministry of Finance, Planning and Economic Development
MoH	-	Ministry of Health
MRRH	-	Mbarara Regional Referral Hospital
MUK	-	Makerere University Kampala
MUST	-	Mbarara University of Science and Technology
MUST HIP	-	Mbarara University of Science and Technology HIV/AIDS Institutional Policy
M&E	-	Monitoring and Evaluation
NADIC	-	National HIV/AIDS Documentation and Information Centre
NCHE	-	National Council for Higher Education
NCPI	-	National Composite Policy Index
NGO	-	Non-Governmental Organisation
NSP	-	National HIV & AIDS Strategic Plan 2007/8-2011/12
NUL	-	National University of Lesotho
NUR	-	National University of Rwanda
OoP	-	Office of the President
OVC	-	Orphans and Vulnerable Children
PEP	-	Post-Exposure Prophylaxis
PEPFAR	-	United States President's Emergency Plan for AIDS Relief
PIASCY	-	Presidential Initiative on AIDS Strategy for Communication to the Youth
PLWHA/PHA	-	People Living With HIV and AIDS
PMMP	-	National HIV/AIDS Performance Measurement and Management Plan
PMTCT	-	Prevention of Mother-To-Child Transmission
RDC	-	Resident District Commissioner
SIDA	-	Swedish International Development Agency
SRH	-	Sexual and Reproductive Health
SSA	-	Sub-Saharan Africa

STD/STI	-	Sexually Transmitted Disease / Sexually Transmitted Infection
TASO	-	The AIDS Support Organisation
UAC	-	Uganda AIDS Commission
UDSM	-	University of Dar es Salaam
UHSBS	-	Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005
UN	-	United Nations
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNCST	-	Uganda National Council for Science and Technology
UNESCO	-	United Nations Educational, Scientific and Cultural Organisation
UNGASS	-	United Nations General Assembly Special Session
UniKin	-	University of Kinshasa
UNISA	-	University of South Africa
UO	-	University of Ouagadougou
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

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CHAPTER 1: INTRODUCTION

Human Immunodefiency Virus (HIV) is the virus that destroys the body's immune system making it unable to fight infections. Without effective treatment it progresses to Acquired Immune Deficiency Syndrome (AIDS) which develops when the immune system is severely damaged (Ministry of Health 2008: 23).

The majority of people infected with HIV across the world are found in Sub-Saharan Africa (SSA). The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that approximately 67% of global HIV-infections and 75% of AIDS deaths in 2007 occurred in SSA (UNAIDS 2008: 30). The latest global report shows that in 2009 an estimated 1.8 million people became newly infected with HIV in SSA compared to the 2.2 million people in 2001, a significant decrease in the incidence of HIV. There was also a decline of AIDS-related deaths in SSA, by 20%, between 2009 and 2004 when Anti-Retroviral Therapy (ART) began to be expanded (UNAIDS 2010: 16, 19).

HIV and AIDS have transformed the socio-economic, cultural and political landscape of Africa and pose a serious threat to Uganda's future development. HIV/AIDS is the leading cause of death among adults (15-49 years) in Uganda and contributes to high morbidity and mortality (Ministry of Health 2006a: 3). The focus of the study is on HIV/AIDS policy development and implementation at two Ugandan universities.

1.1 BACKGROUND

The demographic profile of Uganda suggests that the country had a population of 29 million people in 2006; a population growth rate of 3.2%; life expectancy at birth of 48 years for men (55 years without AIDS) and 50 years for women (56 years without AIDS); an infant mortality rate of 76 per 1, 000 live births; and a generalised HIV epidemic (Uganda AIDS Commission 2007a: 5, 13). According to the 2006 Uganda Demographic and Health Survey, the maternal mortality rate was 435 per 100, 000 live births.

AIDS was first identified in Uganda in 1982 at a fishing village situated in Rakai District on the Western shores of Lake Victoria. Uganda's success story, the ability to reverse its HIV prevalence rate, was based on political leadership speaking openly about the epidemic and the Abstinence, Being Faithful, Condom Use (ABC) approach. HIV prevalence declined nationally from 21.1% in 1991 to 9.7% in 1998; and to 6.7% in 2006 (Low-Beer and Stoneburner 2004: 166; UAC 2007a: 11). It is estimated that 6.4% of the adult population in Uganda are infected with HIV (UAC 2007a: 11). However, it is emerging that HIV/AIDS is increasing among the most vulnerable groups, especially married couples, and this creates a problem for national prevention efforts.

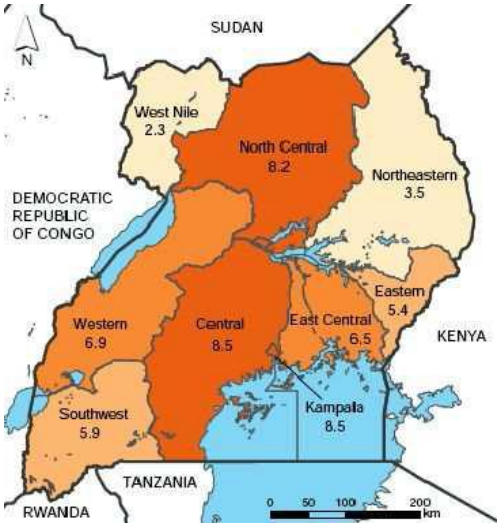

Figure 1.1 HIV prevalence in Uganda

Source: Uganda AIDS Commission (2007a)

Figure 1.1 shows HIV prevalence by geographic regions created during the Uganda HIV/AIDS Sero-Behavioural Survey (UHSBS) of 2004-2005. The Central region (8.5%), Kampala (8.5%) and North Central region (8.2%) had the highest HIV prevalence rates. The Western (6.9%) and South-Western (5.9%) regions had the second highest prevalence rates, followed by the East Central (6.5%) and Eastern (5.4%) regions. The West Nile (2.3%) and North-Eastern (3.5%) regions had the lowest HIV prevalence rates in Uganda. The regional distribution is important for this study because the

selected universities fall within the regions with the highest (Kampala) and second highest (South-Western) HIV prevalence rates in Uganda.

1.1.1 HIV and AIDS prevention strategies

The ABC approach is a strategy to prevent HIV and AIDS espoused by the Ugandan government and quickly adopted by United States (US) funding programmes. The Ministry of Health reports in the *Uganda HIV/AIDS Sero-Behavioural Survey* that government's response to the epidemic was initiating timely public health interventions that aimed at mitigating the impact of HIV/AIDS by addressing sexual behaviour risk factors. The ABC approach has formed the backbone of the national HIV prevention strategy and has subsequently been expanded to ABC Plus (+) which includes Voluntary Counselling and Testing (VCT), Prevention-of-Mother-To-Child-Transmission (PMTCT), ART, and HIV/AIDS care and support services (MoH 2006b: 3).

According to Ibembe (2009: 246), Uganda has been lauded as a success story in the fight against HIV and AIDS because in a relatively short time HIV infection rates fell dramatically in the country. This success is all the more remarkable given a lack of resources, the prevalence of poverty, mass illiteracy and the presence of war over the last two decades.

From 1991 to 2000 Information, Education and Communication (IEC) / Behaviour Change Communication (BCC) played a critical role in Uganda's prevention programme. Ibembe (2009: 248) highlights the following prevention components as crucial to the success: (1) strong political will, especially from President Yoweri Museveni; (2) interventions such as affirmative action to empower women and girls; (3) a strong emphasis on behaviour change in youths such as adoption of safer sex behaviours; (4) active efforts to give AIDS a human face and to fight stigma and discrimination, with emphasis on more open communication about the condition; (5) an involvement and engagement of the religious leadership and Faith-Based Organisations

(FBOs) in, for example, the Protestant, Catholic and Muslim communities; (6) the introduction of confidential counselling and testing facilities for HIV; (7) the emphasis on Sexually Transmitted Infections (STI) prevention and management; and (8) using drama and song, with a moral or educational message, to communicate to the local communities. Ibembe (2009: 253-254), believes that the ABC strategy will remain the cornerstone of Uganda's anti-HIV drive for some time to come but in addition, the balance and experience from different interventions will have the most impact on public health.

In addition, over the past ten years (Health Sector Strategic Plan I and II) the government has focused on mainstreaming HIV/AIDS into all sectors and decentralization of the national implementation plan (MoH 2006a: 6). Furthermore, government intervention also includes the *HIV and AIDS Prevention and Control Bill, 2008* which has been tabled in parliament with the aim to provide for the prevention and control of HIV and AIDS, protection, counselling, testing, care of persons infected with and affected by HIV and AIDS, rights and obligations of persons infected and affected and for other related matters.

The US funding programmes, the ABC approach and strong political will from President Museveni are examples of socio-economic, cultural and political factors respectively that impact on the policy-making process as environmental factors. My study will attempt to uncover some of these factors as articulated in the secondary research objectives.

1.1.2 HIV and AIDS in the education sector

The HIV/AIDS epidemic impacts the entire education sector in several ways. Sekwat and Moon (2004: 285-286) argue firstly, that it reduces the supply of teachers as a result of AIDS-related illnesses and deaths. Secondly the epidemic reduces school enrolment by forcing school-aged children to care for sick family members, work to

generate income for the family, or drop out simply because their families can no longer afford the cost of their education (due to illness or the death of a working parent). Thirdly the human resources at risk also include all individuals who have roles in the delivery of educational services, both in the private and public sectors, including those working in departments of education and those involved in the education and training of teachers. Lastly, the estimated costs of HIV/AIDS to the education sector are exceptionally high.

1.1.2.1 Policy measures for students and learners

The Ministry of Education and Sports (MoES) *citing* the Uganda Health and Household Survey of 2004/2005 reports that HIV prevalence among young people aged 15-25 was 3%. However, prevalence among girls aged 15-24 was 4% while among boys it was only 1% (Ministry of Education and Sports 2006: 10). This evidence confirms findings from other studies that young females are more vulnerable to HIV infection than young males and deserve special attention when developing policies.

(A) Prevention of HIV infection in tertiary institutions

The objectives of HIV prevention for students and learners are: (a) to improve knowledge on HIV/AIDS and promote positive behaviour change; (b) to promote access to relevant and age appropriate HIV prevention services; and (c) to equip students and learners with life skills that reduce their vulnerability to HIV infection.

Policy measures (MoES 2006: 10-13) include IEC on HIV/AIDS and the ABC+ model for HIV/AIDS prevention. In tertiary institutions, correct and consistent condom use shall be promoted as a strategy for HIV prevention in addition to abstinence and being faithful. Students in tertiary institutions shall be equipped with knowledge, skills and values that promote faithfulness as a strategy for safe transition into marriage. Special programmes to promote faithfulness as a value shall be promoted for married students.

Other measures targeting students are HIV Counselling and Testing (HCT) (Tertiary institutions shall encourage students to seek HCT services); PMTCT; prevention and management of other Sexually Transmitted Diseases (STDs); prevention of HIV infection through blood and other body fluids (First Aid training should be provided for students); zero tolerance for sexual offences; and establishment of youth friendly health services.

(B) Mitigating the impact of HIV/AIDS on students and learners

The objectives are: (a) to ensure that learners who are infected or affected by HIV/AIDS access treatment, care and support services; and (b) to ensure that learners who are infected or affected by HIV/AIDS attain quality education.

Policy measures include treatment and care; social support (ongoing counselling, psychosocial and spiritual support to learners and students including Orphans and Vulnerable Children (OVC)); students and learners living with HIV/AIDS shall be equipped with skills to avoid re-infection or spreading HIV infection to other persons; and zero tolerance for stigma and discrimination (MoES 2006: 13-16). Higher Education Institutions (HEIs) should be assessed on whether they comply with the ministry's policy measures on mitigation through evaluating the institutional HIV/AIDS policies and programmes.

1.1.3 The policy-making process

Fourie (2006: 16) argues that policy-making can be viewed as a 'process' that describes the interaction between various policy-making stages. Public policy-making can be viewed as a phenomenon with four major aspects: (1) needs and demands (societal pressures) create inputs that feed into the policy-making environment; (2) processes lead to decisions which become policy outputs; (3) policy outputs are implemented in society through different state organs to become policy outcomes; (4) policy outcomes

are evaluated via the policy environment and may lead to new policy problems that feed back into inputs at the beginning of the cycle.

The HIV/AIDS policy-making process can be viewed as a system that goes through similar policy-making stages. For example, (1) the inputs are consultative meetings and policy formulation committees; (2) outputs are the development of HIV/AIDS institutional policies; (3) policy outcomes are implementation activities; and lastly (4) Monitoring and Evaluation (M&E) of policy outcomes leads to new policy problems or desired impacts.

The main contribution of this systems model as expounded by Fourie (2006) is that it assists understanding of the complexities of the process of decision-making. Fourie (ibid: 16) points out, however, that the policy-making process is not as neatly organised as the model implies – it is a complex, elaborate, continuous and flexible process.

The systems model is ideal for describing the various processes involved in HIV/AIDS policy-making, particularly in qualitative analyses (Fourie 2006: 17). For the purposes of this study a systems model will be employed to determine the inputs, outputs, outcomes and impacts of the process involved with HIV/AIDS policy development and implementation at selected Ugandan universities.

Although various proponents of the policy cycle process have identified several pre decision-making phases such as problem identification and agenda setting; my study begins at the policy formulation stage where the problem to be solved, HIV/AIDS in Ugandan universities, has already been identified.

A structured government response to HIV and AIDS in Uganda led to the establishment of an AIDS Control Programme (ACP) in the Ministry of Health. After recognising that HIV/AIDS was not only a health issue, but also a social one with dire economic consequences, the Uganda AIDS Commission (UAC) was established in 1992 by a statute of parliament and placed in the Office of the President (OoP).

The UAC secretariat is charged with the following responsibilities: (1) policy formulation and establishment of programme priorities; (2) spearhead national joint planning,

supervision, monitoring and evaluation; (3) advocate for HIV programme implementation; (4) mobilize and monitor utilisation of resources for HIV/AIDS activities; (5) foster sectoral and district linkages; (6) disseminate HIV/AIDS information; (7) promote HIV/AIDS research; and (8) partnership development (UAC 2008a: 3).

The importance of HIV/AIDS research lies in its ability to inform policies and programmes for UAC and other state organs. The National AIDS Documentation and Information Centre (NADIC) housed at the UAC secretariat and the Uganda National Council for Science and Technology (UNCST) are responsible for collating all HIV/AIDS research taking place in Uganda. Research conducted by universities during the policy development process can be used for different purposes, e.g. to inform policy objectives, identify baseline data or for a situational analysis. Research conducted after policy development is crucial for M&E of policy implementation activities.

1.1.4 The HIV/AIDS policy at Makerere University

Makerere University drafted an institutional HIV and AIDS policy in 2005, but at the time of the study by Katahoire and Kirumira (2008: 91), it was still awaiting implementation. The university runs prevention programmes in collaboration with Office of Dean of Students, the Gender Mainstreaming Division and St. Augustine Chapel. Katahoire and Kirumira (2008: 135) revealed that more than 90% of HEIs did not have HIV and AIDS policies in place at the time of the study, but some reported having draft policies in place. After the study was completed by Katahoire and Kirumira, Makerere University approved an institutional HIV and AIDS policy in July 2008.

Principles underpinning the HIV and AIDS policy of Makerere University are: (1) non-discrimination; (2) standard procedures (concerning protection of students, staff and researchers); (3) rule of exceptions (case-by-case decision); and (4) gender mainstreaming (Makerere University 2008: 2).

Policies pertaining to students shall include: (1) admissions (HIV infection shall not be part of the admission criteria); (2) medical examination for students (no mandatory HIV related medical examination except on clinical grounds); (3) access to facilities (students with HIV shall have full access to university facilities); (4) attendance; (5) education (educational programs about HIV infection will be provided to students on an ongoing basis); (6) financial or other aid (irrespective of HIV status); (7) food services [applicable to HIV-infected students]; (8) non-discrimination [of HIV-infected persons]; (9) university approved / regulated housing (made on case-by-case basis); (10) safety precautions (of students who may be at risk of exposure to blood, body fluids or blood products); (11) off-campus study programs [information on HIV exposure and test requirements abroad]; and (12) HIV testing (no mandatory HIV diagnostic testing) (Makerere University ibid: 3-5).

Policies pertaining to Makerere University employees, in order to maintain a healthy and safe working environment, are: (1) workplace safety; (2) employment (irrespective of HIV status); (3) employment of affected persons (shall not be discriminated against); (4) employee refusal to work (with HIV-infected person shall be counselled or face disciplinary action) ; (5) HIV testing (is not mandatory); and (6) employee benefits (HIV related illnesses shall be treated as other life-threatening illnesses) (ibid: 5-6).

Policies pertaining to Makerere University HIV prevention (ibid: 6-7) shall be in-line with overall national policies and guidelines including IEC, ABC, HCT, PMTCT, gender mainstreaming policy, sexual harassment policy and any other appropriate prevention programmes.

Policies pertaining to Makerere University health services (ibid: 7-8), include (1) safe medical practices; (2) management of exposure to HIV infection; (3) counselling and other appropriate services; (4) HIV testing services; (5) provision of HIV and AIDS care; (6) confidentiality; and (7) referral.

Policies pertaining to Makerere University responsibilities (ibid: 9-10), are (1) care; (2) research; (3) education and outreach; (4) leadership; and (5) community involvement / advocacy.

Lastly implementation, monitoring and evaluation of the Makerere University HIV/ AIDS policy (ibid: 10), shall designate an office(s) to coordinate implementation of the policy by the Vice-Chancellor; raise financial resources; establish an appropriate budget and strategic work plan for the implementation of the policy. An M&E system shall be put in place to assess the university trends relevant to the policy.

Having identified principles and policies pertaining to university students, university employees, HIV prevention, health services, university responsibilities and implementation of the Makerere University HIV and AIDS policy; the information will be used to critically analyse the policy-making process at this university.

1.1.5 Mbarara University of Science and Technology HIV/AIDS Institutional Policy (MUST HIP)

The *Mbarara University of Science and Technology HIV/AIDS Institutional Policy* has as its objectives: (1) to enhance the university's capacity's to develop safety measures, information management, preventive and control measures; (2) to put in place HIV/AIDS sensitive procedures and practices in regard to: (a) admissions, (b) recruitment into university service, (c) health care for HIV/AIDS affected members of the university, (d) collaboration with neighbouring community, (e) sensitisation of the university community, (f) voluntary counselling and sero status testing, and (g) promotion of safer practices; (3) to support the national efforts to develop and communicate HIV/AIDS prevention, care and advocacy messages in the neighbouring community; and (4) to develop linkages with the local and international community, government and non-government organisations (Mbarara University of Science and Technology 2004: 3).

The policy statement addresses the issues of (1) rights and responsibilities of staff and students living / affected with HIV/AIDS; (2) recruitment; (3) admissions; (4) participation in university activities; (5) examinations for academic progress; (6) confidentiality; (7) personal responsibility; (8) responsibility of staff and students; (9) preventive care and support services; and (10) sensitisation (MUST 2004: 3-7).

The teaching hospital will continue to train staff in the comprehensive management of HIV/AIDS and the facilities of the Immune Suppression Syndrome (ISS) clinic shall be upgraded to cope with the increased people seeking services (MUST ibid: 7).

The MUST HIP (ibid: 8) covers integration of HIV/AIDS into research and teaching under (1) collaborative research on HIV/AIDS; (2) teaching; (3) peer education [MUST Peer Project]; (4) databases / knowledge bank availed in the library on HIV/AIDS; (5) advocacy and linkage with other organisations who promote the prevention of HIV/AIDS; and (6) networking with neighbouring communities and other stakeholders involved in HIV/AIDS activities.

A lecturer and research fellow of the MUST / Harvard University collaboration, Conrad, is evidence of the university's commitment to HIV/AIDS research and teaching integration. He attended two major international conferences in 2009, which were the Conference on Retroviruses and Opportunistic Infections (CROI) in Montreal Canada on 14th February and the International AIDS Society (IAS) in Cape Town, South Africa on 19th July (Conrad 2010: 6).

Policy implementation at MUST (2004: 9, 12) is under the patronage of the Vice-Chancellor; the ISS clinic extends VCT services to the community; curriculum development and teaching into service courses is offered; a coordinator was appointed to implement the policy and for M&E; the policy is periodically reviewed; and all staff members are required to support every effort taken in policy implementation. The policy implementation plan follows a multi-sectoral approach at the level of university leadership, academic and non-academic staff, students and policy makers in

government and NGOs. The ultimate aim is to make sure that the resultant policy is all embracing.

My study ascertains how the MUST HIP policy objectives; policy statement; integration of HIV/AIDS into research and teaching; and policy implementation plan were developed and whether implementation activities fall within the scope of the university policy.

1.2 RESEARCH PROBLEM

Young people (15-24 yrs), who make up most student populations, are particularly at risk of contracting HIV since the majority are sexually active, reside in communal facilities and engage in risky sexual behaviour, i.e. having multiple partners (UNAIDS 2010: 11). Staff members are also vulnerable because they fall within the adult population (15-49 yrs) that is most affected by HIV and AIDS in SSA. The higher education sub-sector is well positioned to respond to HIV and AIDS by having access to staff and students that can contribute to mitigating the impact on the sector. This can be achieved through multi-disciplinary teaching and research in HIV/AIDS; development of HIV/AIDS institutional and workplace policies; and offering care and support to those infected or affected with HIV.

A matter of concern for stakeholders in the sector is that higher education in Africa only has a participation rate of less than 45% and the enrolment rate of 2% in SSA is by far the lowest in the world (Pityana 2008: 3). This figure could be reduced even further with the onset of HIV and AIDS at higher education institutions.

Previous studies have shown that university students' knowledge, attitudes and beliefs about HIV and AIDS place them in a vulnerable position (Svenson, Carmel and Varnhagen 1997). A holistic and integrated approach is needed to prevent university students from acquiring HIV and AIDS which includes a multidisciplinary,

interdisciplinary approach involving the university academic staff, administration, student population, health education professionals and the off-campus student community (Svenson et al 1997: 61). Such an integrated approach should be contained in the HIV/AIDS institutional policy that addresses issues related to prevention, care, treatment and support.

1.3 RATIONALE FOR THE STUDY

The sole task of HEIs has generally been the conducting of HIV/AIDS research that may help inform policy. In Uganda, the Presidential Initiative on AIDS Strategy for Communication to the Youth (PIASCY) is a strategy aimed at increasing awareness of the youth in schools. There is not enough literature available which describes university policies on HIV/AIDS in Uganda.

HIV/AIDS policies at HEIs can play a decisive role in mitigating the impact of the epidemic on the sector. Institutional policies are necessary for providing norms and guidelines for the development and implementation of successful programmes for prevention, treatment, care and support of those infected and affected at HEIs. A supportive policy environment will further strengthen efforts to reduce HIV/AIDS-related stigma and discrimination at universities, while ensuring human rights are protected.

There is a need for descriptions on the way in which HIV/AIDS institutional policies are developed, according to Badcock-Walters (2006), in order to better understand the process. There is a general lack of information on university responses to the pandemic in SSA, and particularly in Uganda. The aim of this study is to analyse HIV/AIDS policy development and implementation at two selected Ugandan universities, namely Makerere University and Mbarara University of Science and Technology. This study should in some way address the gap identified in documentary analysis of HEIs

responses to HIV and AIDS in Uganda, particularly regarding the development and implementation of policy.

The final justification for the study will be to discover how HIV/AIDS institutional policies can be implemented by way of planning, costing, operationalising, reporting, monitoring and evaluating to unlock resources strategically (Badcock-Walters 2006). Focus Group Discussions (FGDs) with students help articulate some of the implementation activities.

The study adopted a qualitative approach, by conducting key informant interviews with staff and FGDs with students in order to explore the process of policy development and implementation in more detail. A qualitative approach was selected because it allows for meaningful first-hand responses regarding the process from participants who were directly involved with the phenomenon. Interviews with key informants supplemented documentary sources and provided for a triangulated approach of data-gathering.

1.4 OBJECTIVES OF THE STUDY

The primary objective of the study was to analyse the process involved in HIV/AIDS policy development and implementation at two Ugandan universities.

1.4.1 Secondary objectives:

1.4.1.1 To identify the process of HIV/AIDS policy development and HIV/AIDS policy implementation at institutional, national and international levels.

What process was involved in the development of the institutional HIV/AIDS policy? What policy framework was it based on? What process was used to implement the institutional HIV/AIDS policy?

1.4.1.2 To identify what HIV and AIDS research has been conducted at selected Ugandan universities.

What research has been conducted in the field of HIV and AIDS at the university? How does this research inform policy-making?

1.4.1.3 To identify the social, cultural and political factors that have contributed to behaviour change in Uganda.

What social cultural factors have contributed to behaviour change in Uganda? What political factors influenced behaviour change in Uganda? What efforts has the university made in terms of behaviour change communication?

Policies are made and implemented by a variety of 'policy actors', including among others private companies, NGOs, multilateral organisations such as the United Nations, universities and government (Fourie 2006: 8).

The study achieved the objectives by reviewing documents, conducting interviews with key informants at the universities and holding FGDs with students. The use of qualitative approaches was suitable for this type of study because it aimed to extract information from staff who were involved with the phenomenon and students who have benefited from the programmes.

1.5 RESEARCH DESIGN

According to Maritz and Visagie (2010: 7) qualitative research is based on the assumption that researchers are primarily focused with the process rather than the outcomes. A qualitative research design was applied to achieve the research objectives. Key informant interviews were held with staff and focus group discussions were held with students in order to obtain detailed descriptions.

1.6 DEFINITIONS OF KEY TERMS AND CONCEPTS

The following definitions are adapted from the Higher Education HIV and AIDS Programme (HEAIDS) of South Africa (2010a: 27).

1.6.1 Policy: It is a written document which sets out the organisation's position and practices around a specific matter or issue such as HIV and AIDS. It acts as a management framework to manage the impact of the AIDS epidemic on the organisation, both internally and externally.

1.6.2 Policy Objectives: Broad process actions or strategies to achieve the purpose of the policy and the SMART principles (Specific, Measurable, Achievable, Realistic, and Time-bound) used to formulate them.

1.6.3 Principles or Values: The embedded human rights and agreed behaviours and values which underpin the policy. They should be described in the context of the specific focus of the policy – in this case HIV and AIDS.

1.6.4 Advocacy and Communication: Advocacy means to campaign for the implementation of the policy by all stakeholders. Advocacy has mainly three elements: to lobby, communicate and mobilise the policy response.

1.6.5 Monitoring and Evaluation: *Monitoring* (recording and reporting) can be seen as a routine on-going assessment of implementation activities in regard to resources invested (inputs) in the activity or programme, services delivered (outputs) by the activity or programme, and the outcomes that are related to the objectives of the policy or programme. *Evaluation* (internal and external) can be seen as measuring the desired changes (impact) of the policy and/or programme related to the vision, mission and purpose of the policy and/or programme.

The remaining definitions have been adapted from Fourie (2006) and other sources as indicated.

1.6.6 Policy-Making: It is a relatively stable, purposive course of action followed by an actor or set of actors in dealing with a problem or issue of concern (Fourie 2006: 8).

1.6.7 Policy Formulation: A process in the policy design that identifies the overall mission, broadly-stated goals and prioritized objectives of the draft policy or policies (Fourie 2006: 13).

1.6.8 Policy Adoption: The stage in which a selected policy is legitimised and formalised, once formulated (Fourie 2006: 14).

1.6.9 Policy Implementation: This stage of the policy-making process entails the translation of decisions into action (Fourie 2006: 14).

1.6.10 Policy Evaluation: This is the final stage of the policy-making process in the cycle and requires learning about the positive and negative consequences of the policy (Fourie 2006: 14).

1.6.11 Risky sexual behaviour: Participating in casual sex, changing partners often and failing to use condoms (Svenson et al 1997: 62).

1.7 LIMITATIONS OF THE STUDY

The large number of public and private universities in Uganda (currently twenty-seven) could not all be captured by a dissertation of limited scope. Consideration was only given to two public universities in the country. Makerere University was selected because it is the largest university in Kampala, the capital city. MUST was chosen because it hosted a workshop on 'Dissemination and sharing experiences of HIV policy development and implementation among universities'. While the findings from the study cannot be generalised to other universities, it is assumed some general lessons can be learned from the study.

Although much has been written about Uganda's response to HIV and AIDS generally, very little is known about the response by universities and other tertiary institutions. Most international research studies use quantitative methodologies, including surveys and questionnaires, to reach a large number of respondents. For the purpose of my study, which aims to get an in-depth understanding of the process, qualitative methodologies will be used.

1.8 CONCLUSION

This chapter has provided a background to HIV and AIDS in Uganda by looking at the demographic profile, epidemiology, prevention strategies, HIV/AIDS in the education sector and the policy-making process. In addition the HIV/AIDS policies at Makerere University and MUST were summarised. The remainder of the chapter focused on the research problem, rationale for the study, objectives and research questions, the qualitative research design, definitions of key concepts and limitations of the study.

1.8.1 Chapter layout

Chapter two reviews HIV/AIDS literature from the education sector and case studies conducted in African universities. The second section is a review of the national and sectoral HIV/AIDS policy environment in Uganda. The third section then looks at HIV/AIDS responses and workshops from the two selected Ugandan universities.

Chapter three is a discussion of the research methodology employed in data collection. It uses a qualitative approach for collecting data which involved key informant interviews and focus group discussions. Ethical considerations and methodological challenges make up the rest of the chapter.

Chapter four is data analysis and interpretation. This chapter analyses the research findings which were categorised into themes ranging from HIV/AIDS institutional policy

development, HIV/AIDS institutional policy implementation, HIV and AIDS services, HIV and AIDS research and the social, cultural and political factors that contribute to behaviour change in Uganda.

Chapter five is the conclusion which is a summary of the findings of the HIV/AIDS institutional policy-making process, HIV/AIDS services, HIV/AIDS research and environmental factors. Recommendations for future action are listed at the end.

The following chapter is the literature review.

CHAPTER 2: LITERATURE REVIEW

The literature review chapter builds on from the introduction by focusing on HIV and AIDS in higher education. The review is structured into three main areas which are global responses to HIV and AIDS; national and sectoral policy guidelines; and HIV/AIDS responses from two Ugandan universities.

2.1 INTRODUCTION

The first section examines international conventions and research studies at the global level by reviewing United Nations (UN) declarations, global surveys by UN agencies and regional higher education responses to HIV and AIDS. The reason for evaluating these responses is to situate the study in the international context and to identify gaps or guidelines for the rest of the study. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) case studies and regional interventions provide a backdrop for what institutional policies should contain.

The second section analyses the national and sectoral HIV/AIDS policies in Uganda. It reviews the National HIV and AIDS Strategic Plan 2007/8-20011/12 (NSP), the National Performance Measurement and Management Plan (PMMP), and the Ministry of Education and Sports policy guidelines on HIV and AIDS. The NSP and PMMP should confirm recommendations from international conventions, whereas the MoES policy provides guidelines for the higher education sector.

The third section is a review of HIV and AIDS responses at HEIs in Uganda. In particular, it discusses materials from workshops held at Makerere University, Kampala (MUK) and Mbarara University of Science and Technology (MUST). The chapter is then summarised in the conclusion by highlighting the main outcomes of HIV/AIDS responses at these universities, particularly with a focus on the policy development and

implementation process. My study could help fill the gaps identified at these institutions or recommend activities for more effective HIV and AIDS policy-making.

2.2 THE GLOBAL RESPONSE TO HIV AND AIDS

The Millennium Development Goals (MDGs), adopted at the UN Millennium Summit in 2000, are the world's target for dramatically reducing extreme poverty by 2015 while promoting gender equality, education, health and environmental sustainability. At the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in 2001, 189 member states adopted the Declaration of Commitment on HIV/AIDS which reflects global consensus on a comprehensive framework for effective action to reduce the spread and alleviate the impact of HIV and AIDS (UNESCO 2005: 11).

Education plays an important role in achieving the MDG targets as well as the declaration of commitment on HIV/AIDS. According to Puparac (2008: 186) the 2004 report on the MDGs states that education will remain the only 'vaccine' against HIV for the foreseeable future, highlighting condom use and behaviour change rather than cure as its HIV/AIDS strategy.

This section has three sub-headings which are grouped under UN declarations; studies conducted by UN agencies; and regional higher education HIV/AIDS responses.

2.2.1 United Nations Declarations

The UN declarations reviewed below are the Millennium Declaration, with particular emphasis on MDG 6, and the Declaration of Commitment on HIV/AIDS. Uganda is a signatory to both declarations.

2.2.1.1 Millennium Declaration

The UN handbook on *Indicators for monitoring the Millennium Development Goals* contains metadata on the agreed list of quantitative indicators for monitoring progress towards the eight goals and eighteen targets derived from the Millennium Declaration (UN 2003: viii).

The goals are MDG 1: Eradicate extreme poverty and hunger; MDG 2: Achieve universal primary education; MDG 3: Promote gender equality and empower women; MDG 4: Reduce child mortality; MDG 5: Improve maternal health; MDG 6: Combat HIV/AIDS, malaria and other diseases; MDG 7: Ensure environmental sustainability; and MDG 8: Develop a global partnership for development. The Millennium Declaration was signed by 199 countries, including 147 Heads of State, in 2000 (UN 2003: x-xi).

The *Millennium Development Goals report for Uganda 2010*, lists the official MDG indicators (effective 15 January 2008) as follows (Ministry of Finance, Planning and Economic Development 2010: 25-27, 67):

Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS. The status of progress towards target 6.A for Uganda in 2010 was reversal.

Indicator 6.1 is HIV prevalence among population aged 15-24 years (In Uganda: 15-19 years, females/males was 2.6%/0.3%; 20-24 years, females/males was 6.3%/2.4% in 2004/2005).

Indicator 6.2 is condom use at last high-risk sex (Uganda: female/male – 35%/57% in 2005/2006).

Indicator 6.3 is proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (Uganda: female/male - 31%/42% in 2005/2006).

Indicator 6.4 is ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years (Uganda: 0.96 in 2005/2006).

Target 6.B aims to achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. The status of progress for target 6.B in Uganda is on track.

Indicator 6.5 is the proportion of population with advanced HIV infection with access to antiretroviral drugs (Uganda: 54% in 2009).

Target 6.C aims to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. The status of progress for target 6.C is slow in Uganda.

2.2.1.2 Declaration of Commitment on HIV/AIDS

Global commitment and action indicators for *Monitoring the Declaration of Commitment on HIV/AIDS* are: (1) international funding for HIV/AIDS; (2) public funding for research and development; (3) workplace HIV/AIDS control in transnational companies; (4) workplace HIV/AIDS control in international organisations; and (5) HIV/AIDS advocacy (UNAIDS 2003: 13-18).

National commitment and action indicators are government funding for HIV/AIDS and government HIV/AIDS policies. The National Composite Policy Index (NCPI) is used to measure progress in the development of national-level HIV/AIDS policies and strategies. The composite index covers four broad areas of policy, namely: strategic plan; prevention; human rights; and care and support. The simple quantitative nature of the NCPI does not give information on the effectiveness of national policies or strategies, therefore a separate AIDS programme effect survey is conducted in selected countries to assess the effectiveness of national policies and strategies (UNAIDS 2003: 19-21).

The national programme and behaviour indicators identified by UNAIDS are: (1) life-skills-based HIV/AIDS education in schools; (2) workplace HIV/AIDS control; (3) comprehensive management of STIs; (4) prevention of mother-to-child-transmission: antiretroviral prophylaxis; (5) HIV treatment: antiretroviral combination therapy; (6) injecting drug users: safe injecting and sexual practices; (7) young people's knowledge

about HIV prevention [which overlaps with MDG indicator 6.3]; (8) young people's condom use with non-regular partners [which overlaps with MDG indicator 6.2]; and (9) orphan's school attendance [which overlaps with MDG indicator 6.4].

The next section looks at international studies in HIV/AIDS education commissioned by the UNAIDS; UNESCO and the International Bank for Reconstruction and Development or The World Bank.

2.2.2 International studies in HIV and AIDS policy development

Here the literature review discusses studies by several UN agencies in HIV/AIDS policy development with particular reference to the education sector.

2.2.2.1 UNAIDS Inter Agency Task Team on Education and HIV/AIDS (IATT)

The UNAIDS IATT (2005: 13) commissioned the first *Education Sector Global HIV and AIDS Readiness Survey*[1] in 2004. The main purpose of the survey was to capture and calibrate qualitative and quantitative information on the state of readiness of the education sectors of those countries most at risk, to respond to, manage and mitigate the impacts of HIV and AIDS.

The final sample of the IATT Global Readiness Survey (GRS) consisted of 117 countries which were selected according to UNAIDS-reported HIV prevalence rates[2] for 2001. The response rate for the 24 high prevalence countries, including Uganda, was 83% (UNAIDS/IATT 2005: 19-20, 22).

[1] Prepared by Mobile Task Team on impacts of HIV/AIDS on education (MTT) at Health Economics & Research Division (HEARD), University of Kwazulu-Natal, South Africa.

[2] High-prevalence countries (>6%), medium-prevalence countries (2%-6%) and low-prevalence countries (0.05%-2%).

The global readiness survey was validated by a civil society survey, conducted by the Global Campaign for Education (GCE), which proved to be successful in triangulating the results for individual countries where the same instrument was used (UNAIDS/IATT 2005: 31, 36). In Uganda, the two sources of information (GCE questionnaire and GRS questionnaire) agree on: (1) the existence of a dedicated HIV/AIDS coordinator and structure; (2) the fact that the development of an HIV/AIDS policy is in process; (3) the involvement of civil society in curriculum design and general partnership; and (4) the lack of programmes that focus on children infected and affected by HIV/AIDS.

Selected key results (UNAIDS/IATT 2005: 212) for Uganda in the IATT Global Readiness Survey show that:

1.) Uganda has a single ministry and total enrolments in schools are growing[3].

2.) A national education sector coordinating management unit exists and decentralized district structures are responsible for implementing a response to HIV/AIDS;

3.) The Ministry of Education and Sports[4] has a specific HIV/AIDS policy and a workplace policy relating to HIV/AIDS which creates an enabling environment;

4.) HIV/AIDS is mainstreamed in the sector strategic plan and district level plans;

5.) Uganda is still in the process of amending Human Resources (HR) policies to minimize vulnerability and susceptibility to HIV/AIDS in the sector and developing guidelines for teachers;

[3] Uganda National Examinations Board (UNEB) official figures report that in 2008 about 755, 302 students registered for national examinations; 831, 927 in 2009 and 885, 757 in 2010 (Businge 2010: 4).

[4] Supporting Public Sector Workplaces to Expand Action and Responses to HIV/AIDS (SPEAR) is working with the ministry through policy development and access to HIV prevention, care and treatment.

6.) The MoES is in the process of ensuring awareness programmes for all employees but has a policy on non-discrimination regarding recruitment, advancement and confidentiality;

7.) A Life-skills programme has been established at primary level but still needs to be established at secondary level, for out-of-school youth, for in-service teachers and for the tertiary sector;

8.) At the time of the survey, there were no programmes by the MoES to address OVC, school feeding schemes or trained counsellors available at primary or secondary level.

9.) No partnership had been developed in relation to HIV/AIDS at the time of the report;

10.) Lastly, no research agenda was defined in the education sector but research has been commissioned to inform the sector response to HIV and AIDS.

2.2.2.2 UNESCO'S response to HIV and AIDS

UNESCO's interdisciplinary organisational and technical capacity is particularly well-suited to working on education for prevention in an effort to halt the spread of HIV and AIDS.

EDUCAIDS is the Global Initiative on Education and HIV/AIDS, led by UNESCO, and was launched by UNAIDS in 2004. UNESCO's work on HIV and AIDS is part of its contribution to Education for All (EFA) and other international goals such as the MDGs and UNGASS Special Session on HIV/AIDS (UNESCO 2005: 9, 11).

UNESCO (2005: 12) identifies the three main goals of EDUCAIDS as:

1.) Building capacity in pilot countries as they prepare a comprehensive educational response to HIV/AIDS;

2.) Mitigate the impact of HIV and AIDS on education in selected countries;

3.) Address the structural causes of vulnerability in and around the learning environment.

The UNESCO Nairobi office reports that out of the five countries that fall within its cluster (Burundi, Eritrea, Kenya, Uganda and Rwanda); four have developed education sector policies on HIV and AIDS. Uganda is one of the four and has gone even further by developing a workplace policy on HIV and AIDS for education professionals (UNESCO 2005: 28). In the section on national HIV and AIDS policy responses by Uganda, I review the education sector national policy guidelines on HIV and AIDS.

UNESCO (2006: 9) commissioned a study entitled *Expanding the field of inquiry: A cross-country study of Higher Education Institutions' responses to HIV and AIDS,* involving 12 case studies in Brazil, Burkina Faso, China, Democratic Republic of Congo (DRC), Dominican Republic, Haiti, Jamaica, Lebanon, Lesotho, Suriname, Thailand and Viet Nam. The overall objective of the study was to identify relevant and appropriate actions that higher education institutions worldwide can take to prevent the further spread of HIV, to manage the impact of HIV and AIDS on the higher education sector, and to mitigate the effects of HIV and AIDS on individuals, campuses and communities. The case studies indicated that there is little known in all of the twelve institutions about HIV and AIDS issues. Specific issues focused on Institutional HIV and AIDS policies and strategic plans; leadership on HIV and AIDS; education related to HIV and AIDS; HIV and AIDS research; partnerships and networks; HIV and AIDS programmes and services; and community outreach.

According to the report by UNESCO (ibid: 11) HIV and AIDS are placing an enormous amount of pressure on higher education institutions by weakening demand and access to education, depleting institutional and human capacity, reducing availability of financial resources and impeding delivery of quality education. In the African context it was

found that there was an overwhelming silence at institutional and individual levels regarding HIV and AIDS, a lack of information and hard data, and an imperfect knowledge of the disease and its impact on institutions.

Data collection for the institutional responses was based on methods which can be described as qualitative. These included internet searches (including institutional websites, UN agencies, NGOs partnering with the education sector and online databases and clearinghouses); document reviews (institutional policies, curriculum reviews, surveys, reports etc.); site visits (Office of the Chancellor, HIV and AIDS units, health clinics or counselling centres, libraries, student clubs, senates); and semi-structured interviews and focus group discussions based on guidelines and study protocol established by UNESCO (with administrators, faculty, HIV and AIDS focal points, staff and students). It was difficult to compare the findings of the 12 case studies due to the country-specific nature of the process (ibid: 13).

The study also noted that higher education institutions need to consider aspects of the institution that facilitate the spread of HIV, such as limited on-campus accommodation, sexual mixing between staff and students, risk of exposure to HIV-contaminated fluids in medical or laboratory environments, coercive sex, limited access to condoms, and a culture of silence that makes it difficult for people to discuss their HIV status, and put in place measures to mitigate these aspects (ibid 2006: 24). I will consider using the above findings when formulating research questions, and as a guide during data collection and data analysis of HIV/AIDS institutional policies at the selected Ugandan universities.

According to the study by UNESCO (ibid: 25), HIV and AIDS policies that provide a framework within which institutions can organise a response are the exception rather than the rule in the universities reviewed. Only one institution, the University of West Indies (UWI), had developed and implemented a policy on HIV and AIDS. The National University of Lesotho (NUL) produced a draft policy in 2002 which addresses five components, namely: (a) responsibilities of staff and students; (b) provision of prevention, care and support services on campus; (c) employment policy; (d) enrolment

policy; and (e) integration of HIV and AIDS education into teaching, research, services, and activities in all university faculties, institutes, units and other constituencies. The University of Ouagadougou (UO), in Burkina Faso, had no institutional policy although it had recently elaborated a five year plan (2005-2009) entitled 'University Strategic Plan for HIV/AIDS Control through Training and Research'.

The draft NUL policy also contains a strategic plan, which outlines actions to be taken by NUL staff for policy implementation. These actions include capacity building; information generation, dissemination and storage; fundraising; networking; care and support; and community service. Each action has corresponding objectives, activities, progress indicators, implementation timeline, and responsible persons although no accompanying budget had been developed (UNESCO ibid: 26).

At the University of Kinshasa (UniKin), in the DRC, the United Nations Population Fund (UNFPA) is supporting the integration of reproductive health issues (including HIV and AIDS) into only three faculties (under the schools of Medicine, Demography and Social Sciences). At UO, staff in Sociology and Psychology courses reported introducing HIV and AIDS on a 'voluntary basis'. At NUL, steps were taken to integrate HIV and AIDS into the curricula and five members of the academic staff were trained in 'Integrating HIV/AIDS as a social issue into university curricula' by the University of South Africa (UNISA) in 2003. This team held workshops for academic staff; however, the process was reportedly curtailed by changes in university management. In non-formal education, students are often provided with information on STIs, HIV and AIDS during student orientation at the beginning of the academic year. At NUL, for example, only 15 minutes were devoted to HIV and AIDS at the student orientation in 2004 (ibid: 28-29).

The study by UNESCO acknowledges that many of the institutions included in the review have contributed to the international understanding of HIV and AIDS. Research has covered all areas - including biomedical, scientific, health systems, sociological and ethnographic – extending to community outreach. Information on HIV and AIDS research seems to be poorly disseminated within universities. In some cases, information is housed in a specific faculty (e.g. School of Public Health library at

UniKin), while in others research results were not available in the library and only accessible on the internet (e.g. UO). Plans should include research that addresses the roots of the spread of the disease which include poverty, gender imbalances, inadequate public health protection, migration, cultural practices, joblessness and hopelessness, North-South inequalities and similar structural issues – not only the biomedical aspects of HIV and AIDS (ibid: 30-31). In chapter four, data analysis, I intend to provide a summary of HIV and AIDS research that has been conducted at MUK and MUST by analysing it according to department or faculty and identifying the main thematic area.

2.2.2.3 The World Bank studies in African universities

This section reviews literature related to university-state relations and university-policy research institutions relations. The funds received from the World Bank and international partners to eradicate poverty and combat HIV/AIDS in Uganda will also be analysed.

In Uganda, there are many government-sponsored students at universities and the government provides free primary and secondary education at schools which results in more candidates eligible for a university education. However, the higher education sector was liberalised during the 1990s and many private universities have mushroomed all over the country.

Comments made by Saint (1992: 7) almost twenty years ago still hold some truth today when he suggests that the universities of SSA face four common problems, to varying degrees. First, enrolments are often increasing faster than the capacity to plan for and accommodate this growth. Second, current patterns of higher education expenditure are unsustainable in many cases. Third, rising enrolments and reduced funding have produced general agreement that educational quality is declining. Fourth, the relevance

of universities to national needs is a growing concern for government and citizens. This is particularly true with the advent of HIV and AIDS on the higher education landscape.

In the early days of African independence, it was generally assumed that universities and their governments shared common goals in promoting national development and nation-building. As positions of the African universities began to question public policies and decisions, economically beleaguered governments frequently felt that their development partnership with universities had been betrayed (Saint 1992: 32-33).

According to Saint (1992: 37), the first step to fostering more positive university-state relations lies in more effective communication between the two parties. This can be achieved formally or informally. Formal communication mechanisms should be considered for three separate purposes, namely: policy dialogue, budget allocation and political emergencies.

A major concern recently has been the high rate of unemployment amongst university graduates in Uganda. This raises the question of whether certain academic programmes are still relevant in a rapidly changing world brought about by events in the twenty-first century, most notably globalisation. There seems to be a trend of late advocating for business, entrepreneurial, technical and vocational skills in order to secure employment.

Many public universities do not offer programmes to address HIV and AIDS. Nearly all African universities can be described as colleges of some foreign (colonial) institutions. Makerere University, one of the oldest African universities (then known as University of East Africa) was established as University College of London in 1919. The dilemma of African universities is that they cannot change the expectation of international communities which seem to determine the way they operate and hence their international aspirations outweigh local needs (Opio 1998: 1, 3).

This notion is true if we consider the heavy reliance of Sub-Saharan African countries on their more developed donor-funding counterparts, particularly from the European Union (EU) and United States of America (USA). African countries are advised to

comply with global AIDS policies developed by western-based organisations in order to keep receiving aid at the expense of local needs. This view is also true for African universities when implementing HIV/AIDS programmes.

An example to illustrate this point in Uganda is the controversial *Anti-Homosexuality Bill 2009*, which seeks to criminalize homosexuality and is currently being debated in parliament. It has been vocally supported by religious groups, academics and the general population which is homophobic. According to local culture, homosexuality is taboo but there is opposition to the bill especially from the UN Committee on the Elimination of Discrimination against Women (CEDAW). The developed countries have threatened to cut donor spending and ostracize Uganda from the international community if the bill is not amended based on international human rights principles. Ironically, HIV and AIDS prevalence in most developed countries is concentrated in the high risk populations of homosexuals, intravenous drug users and commercial sex workers.

It has been reported in *The Lancet* that David Bahati[5] prescribes prison terms and fines for people who do not turn lesbians, gays, bisexuals and transgender (LGBT) people over to the police. However, an official from the Ministry of Health acknowledged that the current draft of the bill could be problematic for HIV prevention work in Uganda (Alsop 2009: 2043).

The Economic Policy Research Centre (EPRC)[6] was established in 1994 and aims to carry out applied policy-oriented research; building capacity for policy analysis and formulation; and interfacing directly with policy-makers and government to address the problems of meeting local needs. Hence, EPRC aims at filling the gap between academic and applied research for policy analysis and building capacity for long-term policy formulation and decision-making. The role of EPRC in policy formulation

[5] Ugandan Member of Parliament and author of the Anti-Homosexuality Bill.

[6] EPRC and The World Bank jointly established the Uganda Development Information Centre (UDIC) at the premises within Makerere University campus.

depends on their capacity to undertake policy-oriented research and effective dissemination of findings and policy implications to policy-makers; and the nature of policy response needed whether short-term or long-term (Opio 1998: 4, 5).

Opio (1998: 5) acknowledges that government policies are generally made by two organs in Uganda, the cabinet and the parliament. Preliminary stages of policy formulation include several processes of basic research: (1) realising a need for policy change or designing a new one; (2) collecting necessary data; (3) analyzing the data; (4) based on research findings formulating policy alternatives which are discussed with various stakeholders; and (5) once a general consensus is reached, a policy proposal or initiative is developed. The two challenges Uganda faces in policy formulation are: first, creating effective communication means between research institutions and policy-makers; and second, strengthening linkage among research institutes which share a common goal of effectively contributing to policy formulation.

The World Bank, an institution dedicated to the reduction of poverty worldwide, was one of the first organisations to respond to the HIV/AIDS emergency. Since 2000, it has provided more than United States Dollars (USD) / US$ 1, 5 billion to more than 30 countries in SSA to combat the epidemic.

The four pillars of future actions for the bank are: Pillar 1: Focus the response, through evidence-based and prioritized HIV/AIDS strategies; Pillar 2: Scale up target multi-sectoral and civil society responses; Pillar 3: Deliver more effective results through increased country monitoring and evaluation capacity; and Pillar 4: Harmonise donor collaboration (World Bank 2008: ix, 6, 7).

The HIV prevalence, income, access to treatment, and quality of health services in Uganda are reported as follows: Gross Domestic Product (GDP) per capita US$ 326; HIV prevalence (15-49 years) is 6.7%; access to treatment is 51% for those infected; population per physician is 44, 131 units; population per nurse is 2, 729 units; PLWHA per physician is 1, 217 units; and PLWHA per nurse is 75 units (World Bank 2008: 68).

HIV prevalence and financing in Uganda was reported by the World Bank (2008: 92), as follows: HIV prevalence (15-49 years) is 6.7%; Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM) from 2003-2007 was US$ 106.7 million; United States President's Emergency Plan for AIDS Relief (PEPFAR) from 2004-2007 was US$ 645.7 million; World Bank spent US$ 47.5 million from 2001-2007; and the total funds available in Uganda during that period amounted to US$ 799.9 million.

2.2.3 Regional higher education responses to HIV and AIDS

This section investigates responses by higher education organisations including the Association of African Universities (AAU), the Association of Commonwealth Universities (ACU) and the Higher Education HIV and AIDS programme (HEAIDS) of South Africa.

2.2.3.1 Association of African Universities

The Association of African Universities (AAU)[7] has developed a multi-disciplinary HIV and AIDS Core Programme called 'African Universities Responding to HIV/AIDS'. The programme aimed to ensure that tertiary education institutions in Africa can: generate HIV/AIDS-related research - scientific, medical, socio-economic and communication - that adds to the international understanding of the disease; and continue to contribute to the production of qualified, healthy and productive graduates for the world of work in support of the continent's development (AAU 2009: 2).

HIV and AIDS programme phase I

Phase I of the Programme (2002-2007), revolved around sensitisation of African higher education leaders attending AAU modular courses as well as the funding of 20 HEIs to

[7] An international NGO set up by African universities in 1967 with headquarters in Accra, Ghana.

develop workplace HIV policies. Another major activity under Phase I was training on an AAU developed *HIV/AIDS Toolkit* which was the main instrument used in organising four sub-regional training workshops, including: (1) East Africa (2006) coordinated by Kenyatta University, Kenya; (2) Central Africa (2006) coordinated by the National University of Rwanda, Rwanda; (3) West Africa (2008) coordinated by the University of Port Harcourt, Nigeria; and (4) Southern Africa (2008) coordinated by the University of Limpopo, MEDUNSA Campus, South Africa (AAU 2009: 2).

The AAU developed an *HIV/AIDS toolkit for higher education institutions in Africa*[8]. The package comprises resource materials on HIV and AIDS in the African higher education context; advocacy strategies for use within tertiary institutions and among their constituencies / social partners; and practical guidelines for the design, management and implementation of HIV and AIDS policies and programmes in African higher education institutions (AAU 2004: 11). The toolkit is divided into the following ten modules: 1 management; 2 management structure; 3 policy development and legal issues; 4 finance; 5 human resources management; 6 student services; 7 curriculum reform; 8 research; 9 community engagement; and 10 monitoring and evaluation.

The objectives of *Module 3: Policy Development and Legal Issues* (AAU 2004: 28) are three-fold. First an inclusive process, fully supported by senior management, is established to develop a policy framework in which all institutional stakeholders have adequate involvement; second the policy is adopted by the highest governing body of the institution; and third management undertakes to implement and disseminate the policy.

The rationale for an HIV and AIDS policy are numerous such as (AAU 2004: 28-29): (1) a policy locates the institution's response to HIV and AIDS as part of its mission and core business; (2) a policy provides an agreed framework within which actions can be taken; (3) a policy on HIV and AIDS confirms the rights, roles and responsibilities of all

[8] A project initiated in 2001 with the support of the Association for the Development of Education in Africa (ADEA) Working Group on Higher Education.

institutional stakeholders; (4) a policy prepares the institution for the presence of HIV and AIDS in the classroom, workplace and in the community; (5) a policy demonstrates the organisation's commitment and concern in taking positive steps to preventing, managing, mitigating and planning for the epidemic; (6) a policy enjoins the institution to make capacity and resources available to support a response to HIV and AIDS; and (7) a policy provides partner organisations and agencies with a framework and a point of access from which to engage with your institution.

The above points clearly motivate why all HEIs in Uganda should have HIV/AIDS policies and they can follow the procedure below for developing their institutional policies. These were the steps taken by MUST when developing their HIV/AIDS institutional policy, as verified by the focal person during a workshop held in 2009.

The AAU toolkit recommends the following procedure for developing an HIV/AIDS and STD policy (AAU 2004: 30): (1) set up a small group/task team with the appropriate mix of expertise and representivity (medical, legal, students, etc.); (2) the task team should research the needs of the organisation in relation to HIV and AIDS and scan institutional policies which may already make reference to HIV and AIDS or will need to be made HIV and AIDS sensitive; (3) the task team reviews the research findings and formulates a draft policy; (4) circulate draft policy for discussion and comment; (5) revise draft policy; (6) adopt and launch the policy; (7) programme or service managers use the policy to develop implementation strategies; (8) communicate the policy and programme to determine its effectiveness; and (9) review policy periodically in light of new information about HIV and AIDS and the changing concerns of the institution.

Findings of the phase I programme, according to AAU (2009: 3) were (i) a need for continuity in curriculum integration programmes; (ii) low demand for the services of the HIV/AIDS Mobile Task Team; (iii) financial backings needed towards embracing holistic HIV/AIDS programmes in universities; (iv) increased demand for research grant on HIV and AIDS; (v) focal persons within the sub-regional network to be key prime movers to foster strong partnership among national institutions; (vi) strengthening of established

sub-regional network of higher educational institutions; and (vii) slow pace of HIV integration into curriculum.

The *HIV/AIDS control policy* of the National University of Rwanda (NUR) is based on the national HIV/AIDS policy. Surveys in the student population of the NUR showed prevalence rates of 2.7%, 2.2% and 2.8% in 1993, 2000 and 2005 respectively. University students' knowledge about HIV/AIDS is high, but their attitudes and their sexual practices need to be safer as evidenced by different student surveys. The University League for AIDS Control / *Ligue Universitaire de Lutte Contre le SIDA* (LUCS) was established by NUR on 27th November 1999 as an institutional organ. The League has as its mission to coordinate: (1) all activities of the NUR in the field of HIV/AIDS control in the university community as well as in the general population; and (2) research on HIV/AIDS within academic units or other initiatives (NUR 2007: 1, 4).

It should be noted that since the training workshops were conducted by AAU, Rwanda joined the East African Community (EAC) along with Burundi, Kenya, Tanzania and Uganda. The EAC Common Market was launched on 1st July 2010. This, according to NUR (2007: 5), should translate into better sub-regional coordination which may be useful in sharing experiences through inter-university festivals and in training of trainers.

The NUR policy is made up of the following components: (1) coordination; (2) implementation; (3) HIV/AIDS prevention among students and staff members; (4) access to treatment ; (5) socio-economic support; (6) HIV/AIDS control in the general population; (7) research and consultancy in the field of HIV/AIDS; (8) capacity building; and (9) rights and obligations of students and staff (NUR 2007: 6-16). In annexure III of the NUR HIV/AIDS control policy (2007:26) data collection in the development of the policy at NUR was undertaken by LUCS committee members including the chairperson, executive secretary, permanent secretary, IEC/BCC program officer and VCT officer.

The HIV and AIDS Programme of the AAU, with support from the Swedish International Development Agency (SIDA), conducted a survey on *HIV and AIDS and Higher*

Education Institutions in Africa: A Review of Best Practice Models and Trends from 2006-2007.

The terms of reference for the study (AAU 2007:8) identified 12 to 15 institutions which exemplified best practice in the response to HIV and AIDS in Africa in the following areas: (1) education and prevention; (2) institutional policies; (3) curriculum integration; (4) research; (5) care and support for persons living positively with HIV; and (6) others.

The best practice methodology was based on judgements that occur at either one or two levels. At the first level, the practice's accomplishments are described. At the second level, analysis is based on criteria that look at strengths, weaknesses, successes and failures. UNAIDS uses a set of five criteria as a guide: effectiveness, efficiency, relevance, ethical soundness and sustainability. The scope of the research design sought to maintain a balance between the four sub-regions, namely: West, Central, East and Southern Africa. It did not include inputs from North African and Arabic speaking countries because these are low prevalence countries. The sample used appropriate representation from Anglophone, Francophone and Lusophone institutions (AAU 2007: 9). My study will establish best practices at two Ugandan universities which both use English as the official language.

The target institutions in East Africa were University of Dar es Salaam (UDSM) (Tanzania), Kenyatta University (Kenya), Maseno University (Kenya) and NUR from Central Africa. The best practice areas identified by the report for the respective institutions were (a) Peer education at Kenyatta University; (b) VCT at Maseno University; (c) Clinical care and support at UDSM; and (d) Access to treatment and care at NUR (AAU 2007: 10, 11).

According to the AAU (2007: 16) report, the following institutions received grants for HIV and AIDS policy development: Nkumba University, Uganda, in 2004; UDSM in 2005; and NUR in 2006.

HIV and AIDS programme phase II

Phase II of the AAU (2009: 4-5) HIV/AIDS programme sets strategic priorities to be achieved in terms of HIV and AIDS mitigation, tackling prevention, treatment, care and support in HEIs in Africa. The overall goal is to improve the quality of life in Sub-Saharan Africa. The objectively verifiable indicators are: (1) reduction in the number of new infections in African Higher Education Institutions; (2) increased collaboration between AAU and regional and sub-regional networks; (3) increased participation of AAU member institutions in HIV intervention programmes; and (4) research outputs, publications and information sharing on HIV management in African higher education institutions.

Five strategic objectives (SO) have been developed to achieve phase II:

SO 1: Strengthening top leadership of AAU member institutions;

SO 2: Strengthened leadership and coordination of AAU Sub-Regional Networks (AAU SRNs);

SO 3: Strengthened and improved university training and research on HIV and AIDS;

SO 4: Strengthened HIV and AIDS Prevention, Treatment and Care among AAU members; and

SO 5: Strengthened AAU Secretariat for Improved Coordination.

2.2.3.2 Association of Commonwealth Universities

The Association of Commonwealth Universities' (ACU) involvement with HIV/AIDS began in 1999. In parallel with the Commonwealth Heads of Government Meeting (CHOGM), the ACU and the University of Natal hosted a symposium in Durban, South Africa to address higher education's response to HIV/AIDS. The ACU carried out a multi-level project with the aims: (1) to inform those in the higher education sector who are unaware of the impact and implications of HIV/AIDS; (2) to diminish the tendency

towards denial and stigmatization; (3) to motivate action that will lead towards the prevention of further infection and the appropriate care and support of those already living with, or affected by HIV/AIDS; and (4) to leave a legacy of materials that will provide clear guidance and set standards that can be used and applied in a wide variety of environments (ACU 2001: 1).

The ACU review of policy documents assessed the participation in policy development from origin of policy, enforcement as well as revision and updating.

Elements of policies (ACU 2001: 15-20) were categorized under: (1) problem statement; (2) safety procedures and preventative measures; (3) non-discrimination of staff and students; (4) legal framework; (5) support and care; (6) education; (7) curriculum; (8) research; and (9) action in the community. Policy implementation highlighted variations regarding who was responsible for implementation with reference to individuals, departments and committees.

2.2.3.3 Higher Education HIV and AIDS Programme (HEAIDS), South Africa

HEAIDS is an intervention of the South African Department of Education[9]. HEAIDS is implemented by Higher Education South Africa (HESA), an organisation constituted by the 23 vice-chancellors of South Africa's public higher education institutions (HEAIDS 2010b: 1).

The Higher Education HIV and AIDS Programme is South Africa's nationally co-coordinated, comprehensive and large-scale effort designed to develop and strengthen the capacity, the systems and the structures of all HEIs in managing and mitigating the causes, challenges and consequences of HIV/AIDS on the sector and to strengthen the

[9] Re-structured during 2009 into the Department of Higher Education and Training and the Department of Basic Education.

leadership role that can and should be played by the higher education sub-sector (HESA 2007: 1).

HEAIDS phase 1

During phase 1 of HEAIDS (HESA 2007: 7) a national programme was established in peer education, curriculum integration, voluntary counselling and testing (VCT), workplace programmes and care and support interventions. Six critical areas were identified for action, namely: (1) effective policy, leadership, advocacy and management; (2) effective treatment, care and support; (3) appropriate research/knowledge production; (4) effective prevention; (5) teaching appropriate within an HIV/AIDS context; and (6) community outreach. An audit and scan conducted in 2003 established the first baseline and situational assessment of the sub-sector. Phase 1 delivered a number of positive developments that HEAIDS Phase 2 will build upon to facilitate a more comprehensive response.

The HEAIDS Programme Framework used as the basis for this audit had a goal to mobilise the higher education sector to the HIV/AIDS epidemic through HE's core functions of teaching, research, management and community service; and through the continuum of HIV/AIDS interventions – namely prevention, treatment, care and support (HEAIDS 2004: 1). The five cross-cutting result areas of the audit were based on the six critical areas mentioned in Phase 1, except for community outreach.

The methodology used sampled all 35 of South Africa's HEIs (100% sample) at the time, comprised of 14 technikons and 21 universities (HEAIDS 2004: 2). There are currently 23 comprehensive public universities in South Africa with no more technikons, since the HEIs mergers of 2004.

HEAIDS baseline results for policy, leadership, advocacy and management indicators found that 86% had established HIV and AIDS policies and 63% of HEI councils committed to address HIV and AIDS (2004: 6-7). Baseline results for prevention

indicators showed that 443, 100 condoms were distributed during March, April and May 2003. Seventy-one percent of institutions reported quality HIV and AIDS prevention services (condom provision, VCT, STI and peer education) were available for staff and students (HEAIDS 2004: 13).

The HEAIDS (ibid: 19-20) programme baseline results for care and support show that provision of psycho-social support for students and staff was high (80%) but treatment of Opportunistic Infections (OIs), Post-Exposure Prophylaxis (PEP), palliative care, antiretroviral therapy and home-based care were very low.

HEAIDS baseline findings for clinic and health services found that a total of 86% of HEIs had an on-site health service but stockouts of drugs, contraceptive methods or general clinic supplies occur in half of all units (ibid: 22). Baseline results for teaching HIV and AIDS indicators showed that only 11% of HEIs promoted lecturer involvement in HIV and AIDS teaching (HEAIDS 2004: 26). The selected HEAIDS baseline results for research / knowledge creation indicators show that postgraduate research projects that relate to HIV and AIDS for 2002 amounted to 225, with an average of 19 projects per institution.

HEAIDS phase 2

According to HESA (2007: 2), the HEAIDS Phase 2 has identified six key result areas as being the main pillars of a comprehensive HIV/AIDS response by the HE sub-sector. These are: (1) to define the roles and responsibilities of the HEIs in addressing the pandemic; and to develop and implement appropriate policies; (2) to support the HEIs human resource capacities and systems development with respect to the challenges posed by HIV/AIDS; (3) to develop norms and standards for sustainable funding models and mechanisms at institutional level; (4) to identify and clarify the specific role to be played by educators and teacher education faculties; (5) to identify, contextualize and replicate ‘best practices’ with respect to prevention, behavioural change, care and support, gender and curriculum integration; and (6) to support and strengthen knowledge generation, assimilation and dissemination with respect to HIV/AIDS.

In order to strengthen and refine its ability to advocate for and advise on appropriate interventions, HEAIDS commissioned a national HIV prevalence survey and an associated study on knowledge, attitudes, perceptions and behaviour (KAPB) relevant to HIV and AIDS. This research was completed by mid 2009 and has fundamentally altered HEAIDS' ability to influence HIV and AIDS interventions in the sector (HEAIDS 2010b: 1).

The quantitative findings for students were reported as follows (HEAIDS 2010c: 29, 32). HIV mean prevalence for students was 3.4%. Females, with an HIV prevalence of 4.7%, were more than three times as likely to be HIV positive in comparison to males. There was not a significant difference in HIV prevalence between uncircumcised males (1.5%) and males who were circumcised below 10 years of age (1.3%).

Student behaviours and patterns related to HIV found that a similar proportion of males and females reported having sexual partners who were 10 years or older than themselves (6%, 7%). This finding relates to the issue of cross-generational sex. Among students, condom use at last sex ranges from 53% to 63%. Overall knowledge of HIV among students was high, but was inadequate on two key statements: knowledge of HIV transmission through breastfeeding, which only 66% answered correctly and the availability of PEP in case of rape which only 55% answered correctly (HEAIDS 2010c: 36-37, 39). These two indicators are also MDG and Millennium Declaration indicators discussed in the international response to HIV and AIDS. HIV prevalence was surprisingly lower for students who had reported being drunk in the last month or who had used recreational drugs such as marijuana.

The mean HIV prevalence for academic staff was 1.5%. The mean HIV prevalence for administrative staff was 4.4%; and the mean HIV prevalence for service staff was 12.2% - the highest of all four institutional categories and significantly higher than academic staff and students (HEAIDS 2010c: 48, 56, 69). It would be advantageous for Ugandan HEIs to carry out a similar HIV prevalence study in their institutions, or in the HE sector as a whole, to better inform their responses to the epidemic.

Qualitative research findings (HEAIDS 2010c: 91-100) concerning the institutional HIV and AIDS response environment noted that: (1) campus leadership and management need to take heed of the perception by students and staff that they do not take HIV and AIDS seriously; (2) there were few signs that VCT has been optimised for prevention; (3) campus security was regarded as inadequate on all campuses; (4) there were a range of student support services across campuses; (5) disclosure was deemed too risky for many HIV-positive people to consider; (6) students using sexual and reproductive health (SRH) services often felt that health service staff were critical of their being sexually active and unsympathetic to their needs; (7) most HIV and AIDS programmes were directed towards students, to the near-exclusion of staff; and (8) many students came from poor socioeconomic backgrounds and lacked adequate funding to provide for their basic needs.

Although the University of South Africa did not participate in the recent HEAIDS survey, because it only offers distance-education, it nevertheless has a comprehensive HIV/AIDS policy. The UNISA policy on HIV/AIDS has a preamble; aim; strategic objectives; definitions; and principles on general, testing, confidentiality, non-discrimination, employment and promotion, dismissal, benefits, safe working/learning environments, students, assistance and grievance procedures (University of South Africa 2006: 1-6).

HEAIDS outlines the conceptual framework for the HIV and AIDS policy development process. The first step is to plan or align, the second is to design and develop, the third is to finalise, the fourth is mainstreaming, the fifth is implementation monitoring and the sixth step is evaluation and upscale (2010a: 6). It is based on six main sections with nine corresponding actions. The first three sections relate to HIV and AIDS policy development.

The first section of HIV/AIDS policy development is *Plan* or *Align.* It consists of action 1: establish the need, roles and responsibilities; and action 2: research and analyse. The second section is *Design and Develop* which is made up of action 3: drafting; and action

4: consultation and participation. The third section is *Finalise* which consists of action 5: authorisation, communication and finalisation (HEAIDS 2010a: 7).

The next three sections relate to HIV and AIDS policy implementation. The fourth section is *Mainstreaming* which consists of action 6: align, mobilise and engage; and action 7: advocate and lobby. The fifth section is *Implementation monitoring* which is made up of action 8: implementation monitoring. The sixth and last section is *Evaluate and upscale* which consists of action 9: review and evaluate (HEAIDS 2010a: 18). The conceptual framework of HEAIDS' HIV and AIDS policy development process can provide a benchmark for HEIs in Uganda.

My recommendation is that a nationally-coordinated framework for HEIs in Uganda should be set up by the government or MoES with similar objectives of establishing structures to mitigate the impact of HIV and AIDS in the higher education sub-sector. Similar programme phases could be introduced, as those discussed above, beginning with a national situational assessment of all the universities in Uganda followed by comprehensive action plans for HIV/AIDS policy development and implementation. To the best of my knowledge, no national higher education HIV/AIDS programme exists in Uganda. Guidelines for institutional HIV/AIDS policies could be taken from the AAU, ACU or HEAIDS (supplemented by workshops) and funding for such a programme could be sought from international development partners.

2.3 HIV/AIDS POLICY DEVELOPMENT AND IMPLEMENTATION IN UGANDA

2.3.1 Background

The impact of HIV/AIDS on Ugandans has been extensive. According to the Ministry of Finance, Planning and Economic Development (MoFPED), it was estimated that, by

2003, as high as over 2.3 million people in Uganda had been infected by HIV with about 1.5 million living with the infection and about 800 000 lives already lost to the epidemic (MoFPED 2007: 2). The next sections look at some of the planning strategies adopted by the government to mitigate the impact of HIV/AIDS including the national strategic plan, the performance measurement plan and the education sector policy.

2.3.2 National HIV and AIDS Strategic Plan (2007/8-2011/12)

The Ugandan president, His Excellency Yoweri Kaguta Museveni, states in the foreword to the *National HIV and AIDS Strategic Plan 2007/8-2011/12 (NSP)* that HIV/AIDS remains high among the national development agenda priorities and, through the multisectoral approach, all government sectors are urged to effectively mainstream and scale-up HIV/AIDS programmes in their respective constituencies (UAC 2007a: i). This shows how seriously the political leader of the country tackled the epidemic and how advocacy from the highest office in the land has played a key role in mobilizing resources and communicating the prevention message to the masses.

The aims of the NSP are to reduce new HIV infection by 40%, to scale up and reach 80% of those in need of care and treatment, and to expand social support to 54% by the year 2012 (UAC 2007a: 18). In the discussion that follows, I highlight the important findings of implementing the NSP during the first year 2007/08.

The NSP has three priority thematic service areas, with corresponding goals, that relate directly to prevention; care and treatment; and social support. The *Report on implementation of national HIV and AIDS strategic plan: FY 2007/2008* documents the achievements, challenges and recommendations of each objective under the three goals which are also the main aims of the NSP. I will elaborate on a few relevant objectives below.

Goal 1 is to reduce the incidence rate of HIV by 40% by the year 2012. The first 5 objectives are found under this goal. Objective 1 is to accelerate the prevention of

sexual transmission of HIV through established as well as new and innovative strategies (UAC 2007a: 21). Findings from the report on implementation of the NSP show that during 2007 over 3, 450 teacher trainees; 18, 820 primary school teachers; 151 national facilitators; 539 coordinating centre tutors; and 6, 468 master trainers were trained to ensure that all youth in-and-out-of-school access life skills for HIV prevention. Challenges noted were that most behavioural interventions are not sufficiently grounded in behavioural theory (UAC 2008b: 8, 13). In-service and pre-service teaching courses should incorporate HIV and AIDS in the curriculum. HIV and AIDS in teacher education is an area that has been focused on by HEAIDS and there could be lessons for Uganda to learn from that programme.

Goal 2 is to improve the quality of life of People Living with HIV/AIDS (PHAs) by mitigating the health effects of HIV/AIDS by 2012. This goal is made up of objectives 6 to 10. (UAC 2007a: 24-26). Objective 6 is to increase equitable access to ART for those in need to reach 240, 000 by 2012. The MoES has a policy that was launched in 2004 and has made some progress towards implementation of the policy with support from Education Sector Workplace AIDS Policy Implementation (ESWAPI) now reaching 40 districts. In addition, many partners are training large numbers of staff in ART related services such as: Infectious Diseases Institute (IDI), Mulago-Mbarara Teaching Hospitals Joint AIDS Program (MJAP) and The AIDS Support Organisation (TASO). Challenges with this objective are understaffing, low staff motivation and high attrition (UAC 2008b: 25, 31). According to clause 4.2.2 in the policy measures of the education and sports policy guidelines on HIVandAIDS “Partnerships shall be established at all levels of the sector in the provision of treatment and care including ART for staff and their families” (MoES 2006: 20). Collaborative arrangements with other universities should ensure that adequate staff are trained and available to provide ART services, particularly in medical faculties.

Objective 8 is to scale up HCT to facilitate universal access and the MoES has integrated updated HIV training materials into the health institutions training curricular in collaboration with the various medical councils (nurses, clinical officers). A challenge

concerning this objective is that institutions of higher learning are training people in professional counselling but what is lacking is the mainstreaming of HIV counselling in these courses (UAC 2008b: 42, 44). Universities therefore need to continue providing training in professional counselling, possibly through Psychology and Social Work departments, while mainstreaming counselling in other social sciences.

Goal 3 is to mitigate social, cultural and economic effects of HIV and AIDS at individual, household and community levels. It incorporates objectives 11 to 16 (UAC 2007a: 27-29). Objective 13 is to promote sustained formal and vocational education for OVCs, and life skills development for PHAs, Internally Displaced Persons (IDPs), People with Disabilities (PWDs) and other disadvantaged groups. Recommended priority actions are to establish a national education bursary scheme and minimum education support package that includes tuition and non-tuition dues for OVC in primary, secondary and *tertiary institutions* [my emphasis] (UAC 2008b: 59). This means that the government in conjunction with HEIs should establish bursary schemes for the above-mentioned disadvantaged students at universities.

Goal 4 is to build an effective system that ensures quality, equitable and timely service delivery. It consists of objectives 17 to 21 (UAC 2007a: 30-42). Objective 19 (2008b: 75-76) is to strengthen national capacity to undertake and coordinate priority HIV and AIDS-related research and utilize outcomes. Achievements so far show that Uganda has been prolific in research outputs for HIV and AIDS. Most research is in the biomedical field with little focus on health systems and evaluation of interventions. Research in Uganda has however been a basis for policy development in other countries like for example PMTCT, discordance couples and male circumcision. Challenges include the National Documentation and Information Centre (NADIC) database, at UAC, not having a mechanism to capture, store and retrieve research outputs from the research community. Recommendations include establishing linkages of NADIC to UNCST database for efficient retrieval and developing an HIV research agenda.

2.3.2.1 National HIV and AIDS policy

The *Uganda national HIV and AIDS policy* (2008c) provides a broader framework for delivering HIV and AIDS services in the country and will inspire national action at all policy formulation, programming and service delivery levels. It also promotes a human rights-based approach as well as gender-sensitive legal and policy environment for addressing HIV and AIDS in Uganda.

2.3.3 National Performance Measurement and Management Plan

The *National HIV/AIDS Performance Measurement and Management Plan* (PMMP) is a nation-wide data collection and reporting system, which was developed to support the NSP.

According to UAC (2007b: 4-5) monthly, quarterly and annual reports as well as periodic surveys based on the workplans of the different levels and structures are the main management tools for measuring performance of the national HIV/AIDS response. The national HIV/AIDS Performance Measurement and Management (PMM) system was developed to fulfil the M&E mandate of the UAC. This HIV/AIDS PMM system consists of the following components: (1) an M&E Unit at UAC; (2) M&E system documentation; (3) one set of national HIV/AIDS indicators; (4) strategic information flow from districts to national and international levels and back to district levels; (5) an information management system; (6) supervision and data auditing; and (7) harmonized capacity building in M&E.

The benefits of the national PMM system for target users are that it enables one to (1) plan more effectively; (2) make better use of available data; (3) improve or establish monitoring systems; (4) build M&E skills; (5) improve communication with the UAC; and (6) strengthen information sharing and networking (UAC 2007b: 5-6). Universities and

other HEIs should develop their own M&E systems that are aligned to the national PMMP.

2.3.4 Education and Sports sector HIV/AIDS policy guidelines

The Ministry of Education and Sports, under the auspices of Member of Parliament (MP) Honourable Geraldine Namirembe Bitamazire, developed the *Education and sports sector national policy guidelines on HIV and AIDS,* to guide the overall response to HIV and AIDS by the sector. The education sector in Uganda is guided by the MDGs and the Education for All (EFA) goals; furthermore, it is the largest public sector employer in the country (MoES 2006: 6).

The mission of the policy is to provide a framework for responding to HIV and AIDS in the education and sports sector. The specific objectives of the policy are; (1) to raise the knowledge base of learners, students, education managers and other sector employees on HIV/AIDS; (2) to ensure that learners, students, education managers, educators and other sector employees access HIV/AIDS prevention, treatment, care and support services; (3) to eliminate all forms of stigma and discrimination in the education and sports sector; (4) to mitigate the impact of HIV/AIDS which impede access to and provision of quality education; (5) to strengthen the education and sports sector capacity for effectively responding to HIV/AIDS; and (6) to contribute to the knowledge base on HIV/AIDS through research (MoES ibid: 8).

According to the MoES (ibid: 16), sport provides an opportunity to reach out to the young population, on HIV/AIDS. This opportunity has not been fully utilized by educational institutions although MUST did make use of an inter-university female sports day with Bishop Stuart University to raise awareness of HIV and AIDS. However, contact sports, like rugby or soccer, could be an avenue for HIV infection in case of accidental contact in the case of playing with blood of an infected person. This can be

mitigated by providing PEP services at sports venues in combination with other medical services.

The policy objective is to utilize opportunities provided by sports at all levels for HIV and AIDS prevention (MoES ibid: 16).

2.3.4.1 HIV and AIDS in the workplace

Policy objectives (MoES ibid: 17-25) are the following; (a) to ensure education and sports sector employees and their families are knowledgeable on HIV/AIDS and access HIV prevention services; (b) to ensure access to treatment, care and social support services (including ART and management of OIs) for all sector employees and their families; (c) to ensure access to treatment and care literacy among all sector employees regardless of their HIV status; (d) to put in place a system for collecting, processing, analyzing and disseminating evidence based information on implementation of programmes and impact of the epidemic within the education and sports sector; (e) to facilitate the sector to actively participate in generating scientific knowledge for guiding strategic and operational planning of interventions for prevention and control of HIV/AIDS epidemic in the sector and country; (f) to ensure that the sector has at all levels skills, systems, procedures, plans, budgets and logistics that are adequate for responding to HIV/AIDS; and (g) to minimize the impact of HIV/AIDS on the ability of the sector to deliver quality education.

University Vice Chancellors, Head teachers and Principles will be responsible for day-to-day implementation of the policy in universities, schools, institutes and colleges. However, universities and other tertiary institutions may, based on this policy, develop their own HIV/AIDS policies to address their unique challenges (MoES ibid: 26). For compliance and regulatory purposes, the HEIs should be evaluated on whether they based their institutional policies on the education and sports sector HIV guidelines.

According to the education ministry (MoES 2008: 19) total student enrolment in higher education increased by 15% from 108, 295 in 2004 to 137, 190 in 2006 and universities continue to enrol the majority of post secondary students.

Of the 27 universities in Uganda, 5 are public and 22 are private universities. The five public universities are Makerere University and Kyambogo University in the Central region; Mbarara University of Science and Technology in the West; Gulu University in the North; and Busitema University in the East. The public universities continue to register more students than the private universities.

2.4 UGANDAN UNIVERSITIES RESPONDING TO HIV AND AIDS

The following sections look at the impact of HIV and AIDS in HEIs in Uganda. It then goes on to analyse the responses of the two selected Ugandan universities, namely: Makerere University, Kampala (MUK) and MUST. The discussion is supplemented with graphic illustrations and diagrams that were presented during HIV/AIDS workshops held at two of the universities.

A study on *The impact of HIV and AIDS on higher education institutions in Uganda* revealed that HIV and AIDS are a problem in Uganda's higher education institutions although their impact is unknown (Katahoire & Kirumira 2008: 21).

The study by Katahoire and Kirumira (ibid: 25-26) was designed in three phases. The first phase was based on a literature review of key themes and issues concerning HIV and AIDS in HEIs; the second phase involved in-depth qualitative exploration of two HEIs to gain an in-depth understanding of the responses; and the third phase was a cross-sectional survey of all remaining HEIs registered and licensed by the National Council for Higher Education (NCHE).

Makerere University was purposively sampled for one of the two case studies because it is the oldest and largest public university and enrols over 75% of the total students

enrolled in universities nationwide. The main data collection tools used in the case study were FGDs and in-depth interviews (Katahoire & Kirumira ibid: 27-29). According to Katahoire and Kirumira, data analysis was conducted by identifying similar themes after manually categorizing data from transcribed interviews and FGDs (ibid: 32).

2.4.1 Makerere University Kampala

Makerere University is Uganda's largest university. It was established as a technical school in 1922 and in 1963 became the University of East Africa, offering courses leading to general degrees of the University of London. It became an independent national university in 1970 when University of East Africa was split into three independent universities, namely the University of Nairobi (Kenya), the University of Dar es Salaam (Tanzania), and Makerere University. At the time of the study by Katahoire and Kirumira (2008: 59) 33, 000 students were enrolled at Makerere, nearly half of whom were evening students.

A majority of staff and students interviewed by Katahoire and Kirumira (ibid: 60-64), did not perceive AIDS as an immediate problem, except for the support staff who viewed it as a serious problem for them and the institution. In addition, most staff and students perceived university students as being at greater risk of HIV-infection; they also perceived the urban lifestyle as a risk factor; and female staff members such as secretaries, clerks and teaching assistants were said to engage in inter-generational sex to pay for the latest fashions and other forms of urban entertainment.

Katahoire and Kirumira (ibid: 65-69) identified the predisposing risk factors to HIV and AIDS at Makerere University as: (a) the attraction of urban life; (b) a growing culture of materialism; (c) risky physical environment around the university; (d) indiscipline in student's hostels; and (e) a lack of financial resources.

Staff and student attrition related to HIV and AIDS was difficult to establish but students revealed that secrecy, silence, denial and fear of stigmatization characterised HIV and

AIDS in the university. An assessment by Makerere University Hospital administration in March 2005 on student's uptake of HIV and AIDS counselling and testing services revealed that about 15% of those who had gone for VCT were HIV-positive (Katahoire and Kirumira ibid: 72-73).

2.4.1.1 Training workshop on 'HIV Prevention Strategies, Counselling and Testing'

The training workshop[10] was held at Makerere University on 1st May 2010 in partnership with the Ministry of Health. It was open to the general public but was targeted mostly at university students. A certificate was awarded to the successful participants in training and implementation of routine HIV prevention strategies, counselling and testing in clinical settings.

This verifies that the university actively supports the distribution of training materials and makes training sessions and knowledgeable speakers available to the university community as stated, in clause (ii) under 5.3 Education and outreach, in policies pertaining to university responsibilities (Makerere University 2008: 9).

The workshop was carried out by Global Health and HIV/AIDS Initiative Uganda (GHAIND) with speakers from the Infectious Diseases Institute. The training modules covered areas of: (1) basic facts on HIV/AIDS and STDs interventions strategies, (2) HIV Counselling and Testing, (3) guidelines on basic counselling techniques, (4) care for people living with HIV/AIDS, (5) psycho-social effects of HIV/AIDS, and (6) drug abuse and community basic intervention strategies. Below are a few illustrations from the GHAIND training workshop.

[10] Funding obtained from USAID, DFID and the European Union.

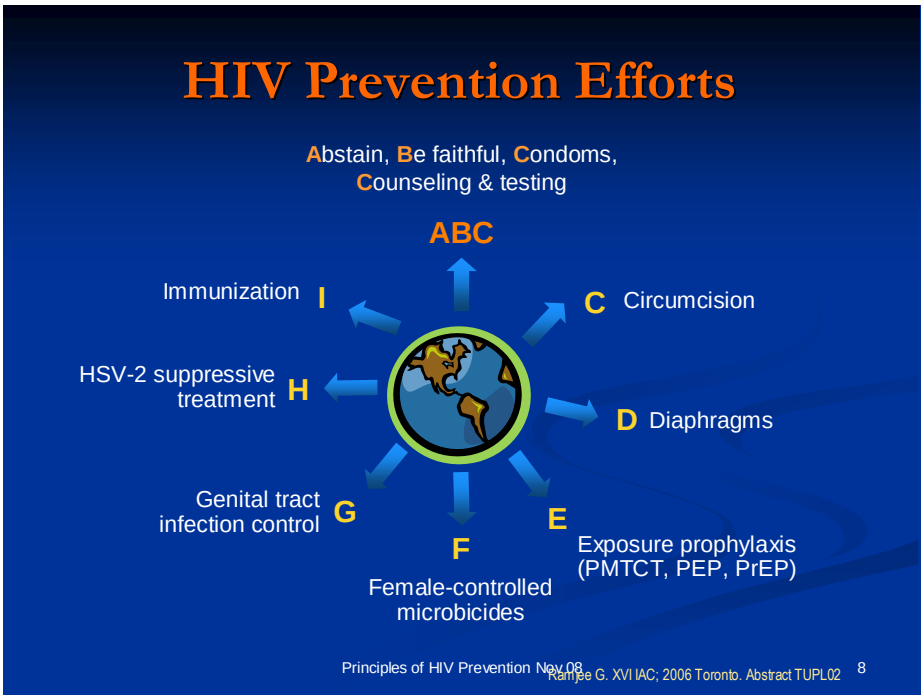

Figure 2.1 HIV prevention efforts

Source: Bahatungire (2010: 8)

The diagram in figure 2.1 lists the different HIV prevention strategies going clockwise in alphabetical order starting from letters A to I. ABC stands for Abstain, Be Faithful, Condoms, Counselling and testing. C is for Circumcision, D is for Diaphragms and E is for Exposure prophylaxis including PMTCT, PEP and PrEP. F is for Female-controlled microbicides, G is Genital tract infection control, H is Herpes Simplex Virus type-2 (HSV-2) suppressive treatment and I stands for Immunization.

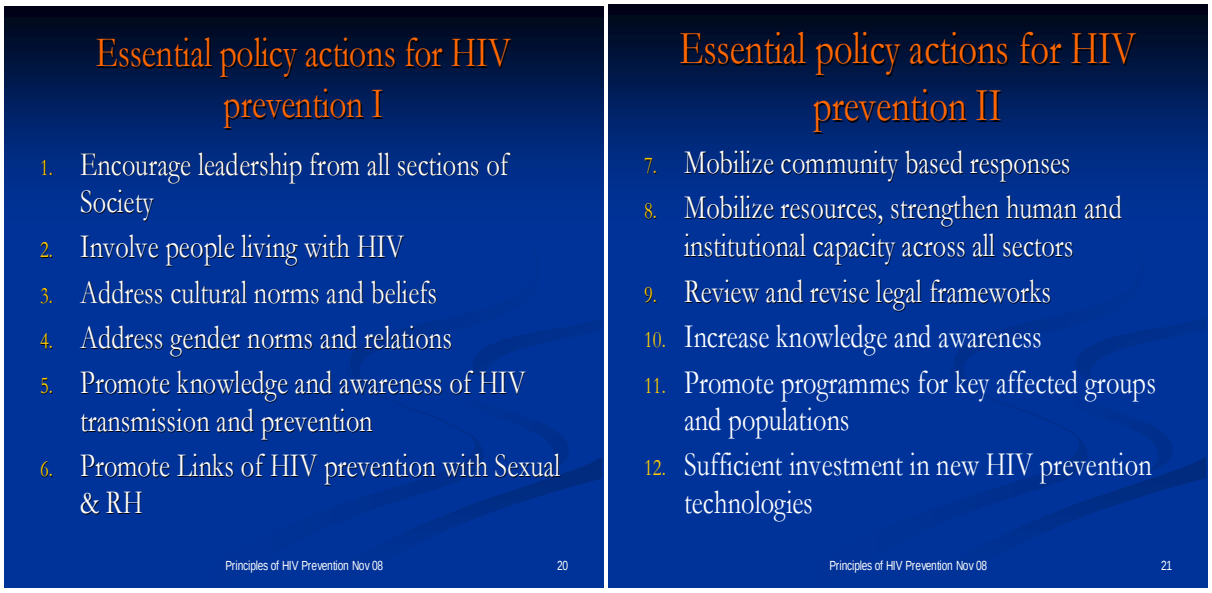

Figure 2.2 Essential policy actions I and II

Source: Bahatungire (2010: 20, 21)

Figure 2.2 lists twelve essential policy actions for HIV prevention. These are (1) leadership from all sections; (2) involvement of PLWHA; (3) addressing cultural norms; (4) addressing gender norms; (5) promoting awareness of HIV prevention; (6) promoting links with Sexual and Reproductive Health (SRH); (7) mobilize communities; (8) mobilize resources and strengthen institutional capacity; (9) review legal frameworks; (10) increase knowledge and awareness; (11) promote programmes for key HIV populations; and (12) invest in new prevention technologies. These guidelines can be used when drafting HIV prevention policies or for monitoring and evaluating existing programmes.

2.4.2 Mbarara University of Science and Technology

Mbarara University of Science and Technology (MUST) was founded by an Act of Parliament in 1989. The university started with the Faculty of Medicine and has since expanded to include the Faculty of Science and Faculty of Development Studies. The

university had a total student population of 1, 100 students in 2003/04 [now over 2, 000 students] and a combined staff of 650 at both the university and teaching hospital (MUST 2004: 10).

MUST Anti-Sexual Harassment policy

The *Anti-Sexual Harassment policy* is the university's first line of defence against sexual harassment occurring in the work and study place; it is also designed to meet the institution's HIV/AIDS sensitive and response principles aimed at ensuring a healthy workforce (MUST 2009: 3).

The goal of the policy is to create a conducive atmosphere free of sexual harassment in the MUST community. The objectives are: (1) to prepare MUST staff and students enhance their awareness of sexual harassment in the workplace; and (2) to provide a basis to prepare the MUST community for any eventualities regarding sexual harassment (MUST 2009: 4).

Annexure II of the anti-sexual harassment policy (MUST 2009: 20) contains the guidelines for Post-Exposure Prophylaxis (PEP).

2.4.2.1 Workshop on 'Dissemination and Sharing of Experiences on HIV Policy Development and Implementation among Universities'

Mbarara University of Science and Technology hosted the workshop on dissemination of HIV policy formulation and implementation experiences among Ugandan universities on 24th July 2009. Below are selected illustrations from the workshop materials.

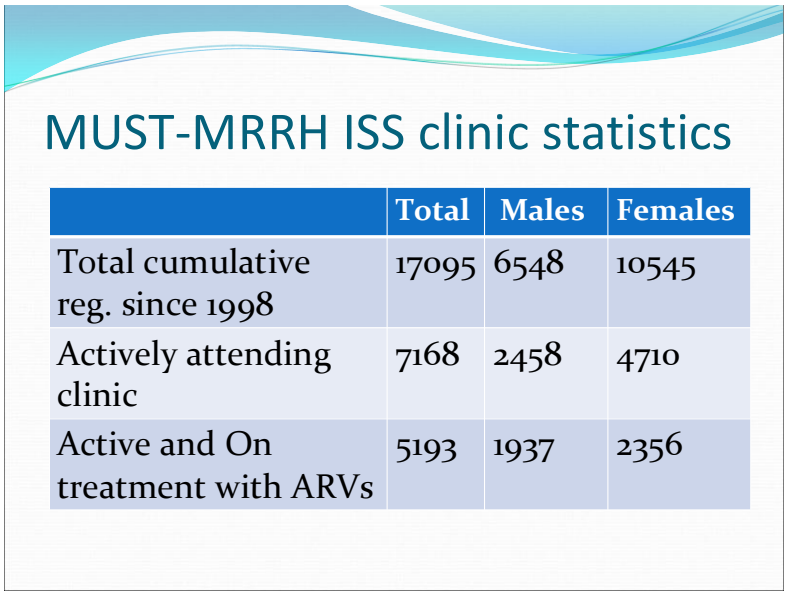

Figure 2.3 MUST-MRRH ISS statistics

Source: Bwana (2009: 8)

The Mbarara University of Science and Technology (MUST) – Mbarara Regional Referral Hospital (MRRH) Immune Suppression Syndrome (ISS) clinic data, from figure 2.3, displays the cumulative number of registered clients from 1998 to 2009; those actively attending the clinic; and those on treatment with Anti-RetroViral drugs (ARV's). A distinction is made between male and females clients and the glaring disparity between the two sexes is hard to ignore. Females account for 61.6% of the 17, 095 registered patients, 65.7% of the 7, 168 actively attending the clinic and 45.3% of those active and on treatment with ARVs. Males represent 31.3% of the 5, 193 clients active and on treatment with ARVs.

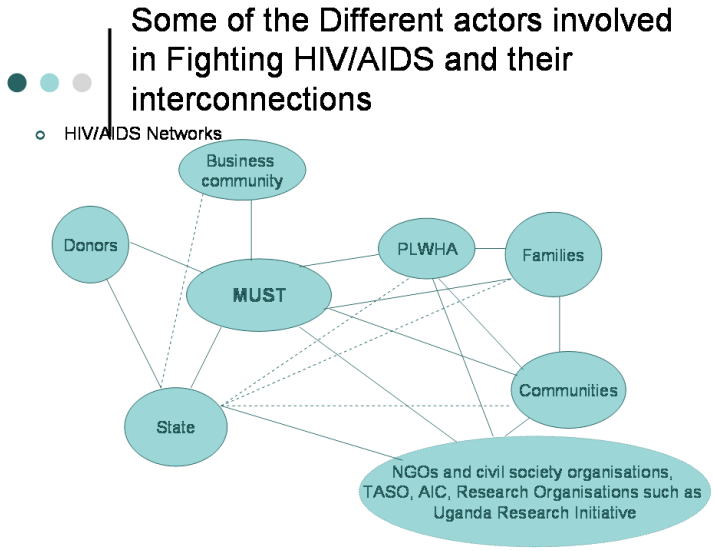

Figure 2.4 MUST HIV/AIDS networks

Source: Muriisa (2009: 8)

The diagram in figure 2.4 shows the networks involved in fighting HIV/AIDS at MUST and their interconnections. These are the business community; PLWHA; families; communities; Non-Governmental Organisations (NGOs); Civil Society Organisations (CSOs); The AIDS Support Organisation (TASO); AIDS Information Centre (AIC); research organisations such as Uganda Research Institute; the state; and donors.

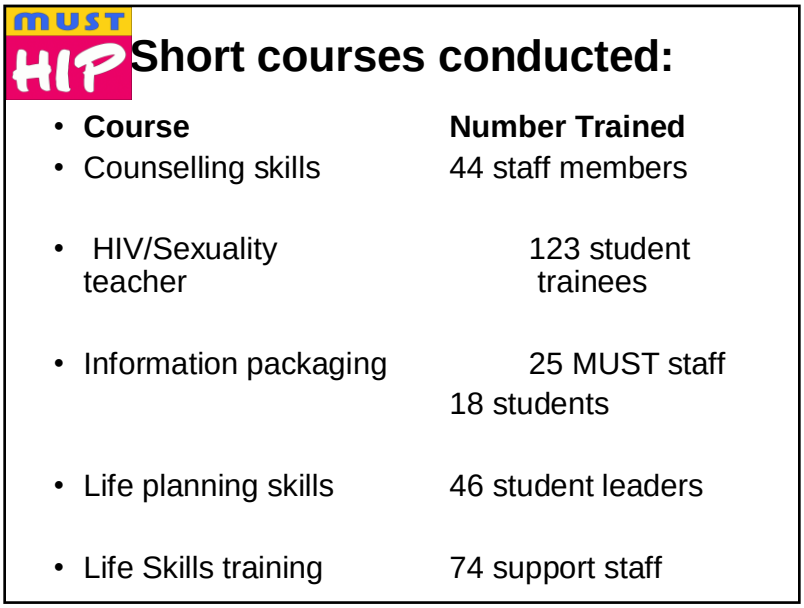

Figure 2.5 MUST HIP short courses

Source: Kyamanywa (2009: 11)

The data contained in figure 2.5 shows the short courses conducted at Mbarara University in 2009 by MUST HIP programme. These courses included counselling skills for 44 staff members; HIV/sexuality for 123 student teacher trainees; information packaging for 25 MUST staff and 18 students; life planning skills for 46 student leaders; and life skills training for 74 support staff. These courses were part of activities aimed at improving awareness of HIV and AIDS at the university.

2.5 CONCLUSION

Chapter two has reviewed literature in three main areas namely, the global response to HIV and AIDS in higher education, the national / sectoral HIV and AIDS policy environment and universities responding to HIV and AIDS in Uganda.

The global response to HIV and AIDS started with a description of the Millennium Declaration and the UNGASS Declaration of Commitment on HIV/AIDS. Studies by the UNAIDS IATT surveyed education ministry responses and Uganda performed well in mitigating the response on the education sector. This was evidenced by the development of an education sector HIV/AIDS workplace policy and an education sector workplace AIDS policy implementation programme.

UNESCO's response provided evidence that few universities, particularly from SSA, have addressed HIV and AIDS in their programmes. However, there were signs that the trend could be changing as evidenced by NUL which had a draft HIV/AIDS policy, UniKin which had incorporated HIV/AIDS into education and University of Ouagadougou which had an HIV/AIDS strategic plan. The main thematic areas covered by UNESCO's cross-country study - such as HIV/AIDS policies and plans, HIV and AIDS education, HIV and AIDS research, even data collection methods – provided thematic guidelines for my study. Certain gaps were identified, such as HIV and AIDS services and social-cultural factors, which were then added to my study at Ugandan universities. The World Bank's commitment to HIV and AIDS in Africa provided the political and economic background for the study and discussed factors related to the secondary research objectives.

Regional responses looked at two prominent associations in Africa and the Commonwealth that are involved in supporting institutional capacities to develop and monitor HIV/AIDS policies. The AAU identified best practices of Maseno University and Kenyatta University from Kenya as VCT and peer education respectively. The best practices from UDSM in Tanzania were clinical care and support, whereas for NUR it was access to treatment and care. The studies by AAU in East and Central Africa only mentioned one Ugandan university, Nkumba University. This is a gap identified in the literature review which my study aims to fill by discussing responses from other Ugandan universities. The HEAIDS programme provided information on the process of drafting HIV policies including baseline audits, sector HIV prevalence studies and a conceptual framework for policy development. UNISA also responded to HIV and AIDS

proactively by developing a comprehensive HIV/AIDS policy. HEAIDS also emphasised the importance of having a national higher education HIV/AIDS coordinating body in the country to advocate for HIV/AIDS institutional policies among other functions.

The second section reviewed the national strategic plan and monitoring and evaluation framework of Uganda's HIV/AIDS response. This part of the literature review evaluates national priorities according to goals and objectives, ensuring that sectoral and institutional responses were compliant with these goals. Furthermore, all educational institutions should comply with the education and sports sector guidelines on HIV and AIDS.

The third section of the literature review discussed HIV/AIDS policy responses by MUK and MUST. Materials from MUK and MUST workshops were used for illustration purposes to highlight the training and education taking place at these institutions. It was difficult to trace additional sources on the topic because it is a relatively new field of study.

The methodologies used by universities to assess the impact of HIV/AIDS on their institutions varied from qualitative, to quantitative and mixed methods. However, in order to gain an in-depth understanding of the policy-making process at these unique institutions it would be appropriate for my study to use a qualitative methodology. In conclusion, the literature review has attempted to provide the most authoritative scholarship on the research problem by integrating the readings of different authors. The research methodology that will be used to execute the study will be discussed in the following chapter.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter describes the qualitative methods used in the study to select data sources, elaborates on the data collection and data analysis techniques, truthfulness of the statements, methodological challenges and ethical considerations.

3.1 INTRODUCTION

The central research question was to analyse HIV/AIDS policy development and implementation at two Ugandan universities. Qualitative methods were selected as most appropriate because the researcher wanted to discover meaning and gain knowledge of the phenomenon at two unique institutions. Furthermore, general themes were identified from documentary analysis during the literature review which formed the basis of the analysis. Data from individuals, who were involved in the policy-making process had to be recorded, transcribed, assessed and finally reported in order to substantiate the findings of the study. As a result, the study was atheoretical with the intention of discovering new ways of hypothesising about the phenomenon. The data-gathering instruments were structured to guide responses in particular areas of interest.

According to Neuman (1997: 329) a qualitative research orientation should include the following aspects: (a) it should capture and discover meaning once the researcher becomes immersed in the data; (b) concepts are in the form of themes, motifs, generalisations or taxonomies; (c) measures are created in an ad hoc manner and are often specific to the individual setting or researcher; (d) data are in the form of words from documents, observations or transcripts; (e) theory can be causal or non-causal and is often inductive; (f) research procedures are particular, replication is very rare; and (g) analysis proceeds by extracting themes or generalisations from evidence and organising data to present a coherent, consistent picture.

Whereas quantitative methods allow for the clear, rigorous and reliable collection of data and permit the testing of empirical hypotheses in a logically consistent manner,

qualitative methods are more suitable for gaining access to the life-world of individuals in a short time. Reference to the life world of individuals includes motives, emotions and other subjective aspects to the lives of individuals and groups (Schwartz and Jacobs 1979: 5).

In addition qualitative research involves fieldwork; qualitative researchers are concerned with meaning; a qualitative researcher is the primary instrument of data collection and analysis; and qualitative research is descriptive, exploratory and inductive in design.

Specific qualitative data collection methods applied in the study were key informant interviews and FGDs administered to purposively selected participants. The respondents' shared HIV/AIDS policy-making experiences should translate into tentative themes that could be recommended for other interested parties.

3.1.1 Sampling

The study used a non-probability sampling technique and a total of five staff members involved with policy development at universities were interviewed, and two focus group discussions were conducted with fourteen students at the participating universities. The study sample was small because the research project was limited to those staff members who were knowledgeable of HIV policy development, which requires getting access to employees in senior positions that are not easily accessible. Participants for KI interviews were selected from those that attended the HIV Policy Development workshop held at MUST, whereas students for focus groups were volunteers from the university.

3.2 ETHICAL CONSIDERATIONS

The Uganda National Council for Science and Technology in liaison with the Research Secretariat, OoP, grants final approval and clearance for the implementation of research protocols in Uganda (UAC 2008a). An application for ethical clearance was submitted to the UNCST by me, the principle investigator, in May 2010 which included submission of the research proposal, data collection instruments and an introductory letter from my supervisor, Prof Carol Allais. The research protocol was approved on 1st June 2010 (see appendix IV) and a research administration and clearance fee was paid to the council. Furthermore, clearance was obtained from the Research Secretariat, OoP in July which resulted in access letters being issued for use in the study districts. The access letters from OoP were then submitted to the Resident District Commissioner (RDC) of Mbarara (appendix VI) in August 2010 and Kampala (appendix V) in September 2010, prior to commencing with research in those districts.

The interviews were tape-recorded in English for reliable transcription, authenticity and truthfulness. All participants who took part in the study completed the informed consent form (appendix I). The individual interviews were guided by questions found in the KI guide (appendix II) and group interviews were based on the questions found in the FGD guide (appendix III). Lastly, the access letters from Uganda National Council for Science and Technology (appendix IV), and Office of the President (appendices V and VI) are attached.

3.2.1 Informed consent

The researcher ensured voluntary participation of the participants with the option of withdrawing from the study at any time without prejudice (see appendix I).

3.2.2 Confidentiality

All participants were given the option of remaining anonymous in the report; however, some participants requested their names be recorded. For consistency purposes, none of the participant names were mentioned while reporting the findings.

3.3 QUALITATIVE RESEARCH DESIGN

The principle purpose of social research includes description and exploration (Babbie 2010: 109). The qualitative study was descriptive and exploratory in nature. Exploratory researchers are creative, open-minded, and flexible; adopt an investigative stance; and explore all sources of information. Descriptive research presents a picture of the specific details of a situation, social setting, relationship or process (Neuman 1997: 19-20). The chosen qualitative approach allowed the researcher to gain an in-depth understanding of experiences in HIV/AIDS policy development and implementation at the selected Ugandan universities by exploring and describing the process.

The epistemological approach concerning my study can be formulated as follows: (a) data are contained within the perspectives and experiences of people that were involved in HIV/AIDS policy development and/or implementation, and (b) because of this I must engage with them and their shared experiences in the process of collecting data (Groenewald 2004).

3.3.1 Key informant interviews

Sherman and Straus (2002: 47) have identified two types of interviews that sociologists conduct, firstly 'intensive' interviews seek to find out what people do or how people do things. The second type of interview is the 'structured' one in which you really need and want accurate detailed answers to specific questions and this approach is mostly used in conjunction with a survey.

In-depth, structured Key Informant (KI) interviews were held with staff members from the two universities. The two universities were MUK and MUST located in Central and South-Western Uganda respectively. Three key informants were interviewed at MUST and two informants at MUK.

A KI interview guide (see appendix II) provided the framework for questioning which would provide personal experiences from the participants. The interviews were tape-recorded in English and then transcribed for coding purposes. Additional field notes and diary entries were used to supplement data collected from the interviews. All interviews were conducted by me, the principle investigator. In addition, documentary sources such as institutional HIV/AIDS policies provided further material.

The selection of KI participants from MUST was based on their previous experience in HIV/AIDS policy development and implementation. They were members of the HIV/AIDS institutional committees and senate committees so had practical experience of the phenomenon under study. Staff members from MUK were selected because of their experience in HIV/AIDS social-cultural research and their association with Makerere University Hospital.

Key informants at the universities comprised both academic and administrative staff. Some were lecturers and others counsellors who dealt with student affairs, projects and administration. In relationship to institutional HIV/AIDS policy activities their duties involved guidance and counselling of student's, designing strategies that informed

policy activities, monitoring progress of policy activities, teaching, doing research and making laboratory requests for testing services.

Most staff members were involved with decision-making bodies at the universities including members of council, senate committees and institutional HIV/AIDS committees. The five key informants comprised of two females and three males.

3.3.2 Focus group discussions

The focus groups in the study were held with students only, excluding staff, and were meant to elicit responses that related to HIV/AIDS institutional policy implementation activities. One focus group discussion was held at each of the universities. The total number of participants in the FGDs was fourteen. The group data would supplement the key informant data and was not meant to be descriptive of HIV/AIDS policy development, as students did not know much about this process.

The first FGD at MUST, held in August 2010, comprised of four students from various disciplines including Bachelor of Medicine and Bachelor of Surgery (MBChB), Bachelor of Information Technology (BIT) and Bachelor of Business Administration (BBA). Two students failed to turn up at the scheduled time but the Guild President made an appearance at the end of the session. The second FGD was held at MUK, in September 2010, with ten second year students from the Department of Population Studies. It was held in the lecture room as part of a practical session on methodology after getting permission from the course facilitator.

Focus groups maximise 'breadth' of understanding compared to individual interviews that maximise 'depth' of understanding. Furthermore, focus groups enable the researcher to explore what is common to or different within or across social groups, explore areas of consensus or its lack, or harness group dynamics to brainstorm new ideas or solutions (Sherman and Strauss 2002: 56). The FGDs held with university students achieved these objectives including identifying HIV/AIDS-related services and

research taking place at the respective institutions. In addition new ideas and solutions were suggested for effective HIV/AIDS policy implementation by the students.

The FGD questioning guide (see appendix III) had fewer questions than the KI interviews and this was done to save time. I was the principle investigator and moderator of the student focus groups and facilitated discussion among group members to make more specific (focus) their generally held opinions on HIV/AIDS issues at the university. An important point to be noted is that group interviews were used as a setting in which to conduct research, not a kind of research; and they were a strategy for questioning. Findings from the group discussions point to effective HIV/AIDS policy implementation at both universities with services and information readily available. The data from FGDs supported narratives of staff members' comments during the informant interviews.

There was a multi-disciplinary mixture of students in the first FGD at MUST and a second homogeneous FGD at MUK. The second homogeneous group comprised of five males and five females all students in the Department of Population Studies. In total there were fourteen students who took part in the FGDs, six females and eight males.

3.4 DATA SOURCES

The sources of data for the study included both primary and secondary sources. The primary sources of data in this study were qualitative interviews with academic and administrative staff. FGDs were held with students from the selected universities. The study population comprised of five academic / administrative staff and fourteen students. In total, nineteen people were interviewed for the study.

The secondary sources were official government documents, national and sectoral HIV/AIDS policy frameworks, HIV and AIDS legislation, workshop presentations, institutional HIV/AIDS policies, field notes and other unpublished research reports.

While the approach will be mainly qualitative in nature, some quantitative statistics were used for illustrative purposes to enlighten the argument. To be precise I created graphs and pie charts, to showcase the different categories of HIV/AIDS research that was conducted at both universities. In addition quantitative statistics, produced in the form of bars, were presented during the policy formulation workshop at MUST.

Hence the study applied data triangulation methods by using both primary and secondary data sources. This will be explained further during the next chapter on data analysis and interpretation.

3.5 DATA COLLECTION TECHNIQUES

Data collection interviews were held with participants until the topic was saturated, that is when interviewees are not introducing any new perspectives on the topic (Groenewald 2004: 11). However, in some instances, respondents did not have sufficient information to answer all the questions.

The data collection methods of my study included internet searches (major line ministries in Uganda including Ministry of Health, institutional websites, UN agencies and other relevant websites) and document reviews (institutional HIV/AIDS policies, surveys and research reports). My site visits at MUK were the Office of the Academic Registrar, Centre for Social Science Research on AIDS (CeSSRA), Institute of Statistics and Applied Economics (ISAE), the library and the Economic Policy Research Centre (EPRC). At MUST, I visited the library and offices of the Dean of Students and MUST HIP programme. In addition Mulago National Referral Hospital (including TASO headquarters) and Mbarara Regional Referral Hospital, where medical students

practice, were also visited. The UNCST office was visited for ethical clearance. Furthermore HIV and AIDS-related workshops were attended at both universities which yielded useful materials.

The key informants from both universities were interviewed in their offices. The first focus group in Mbarara was held at the MUST HIP office and the second focus group in Kampala was held in a lecture room. The data collection instruments were developed for an assignment in another coursework paper on the history and ethics of HIV/AIDS. After passing the paper with distinction, I assumed that my questions were appropriate. The data collection instruments were tested on 'guinea pigs', e.g family members, that choose to remain anonymous.

3.5.1 Qualitative data collection

The participants were asked two central questions: 1) what process was involved in HIV/AIDS policy development and implementation at this university? and 2) how was this achieved?

The individual and group interviews were conducted in English and tape-recorded. The qualitative approach was also used to identify HIV and AIDS related services at the universities and some of the social, cultural and political factors contributing to behaviour change. All interviews were guided by questions from the same interview schedules, either appendix II or III.

Responses obtained from participants contributed towards realisation of the research objectives. The primary objective was to understand the process involved in HIV/AIDS policy development and implementation. The secondary objectives aimed to identify the HIV/AIDS services and the HIV/AIDS research at the universities in relation to policy implementation. Using qualitative data collection techniques (interviews, FGDs and document reviews), descriptions and illustrations were presented in data analysis to support the objectives.

3.6 DATA ANALYSIS AND INTERPRETATION

Data analysis was achieved through data management by creating separate files for each institution; transcribing the interviews; classifying responses according to themes; interpreting the description of 'what' happened; interpreting the description of 'how' HIV/AIDS policy development and implementation was experienced; reflecting the core aspects by identifying a process; and visually representing findings in a process model.

There is a distinction between explicitation of data, discussed below, and data analysis. Data explicitation implies an investigation of the constituents of a phenomenon while keeping the context of the whole whereas data analysis usually means breaking into parts and therefore often means a loss of the whole phenomenon. Hycner's (1999) explicitation process (*cited* in Groenewald 2004: 17) has five steps, namely: (1) bracketing and phenomenological reduction; (2) delineating units of meaning; (3) clustering units of meaning to form themes; (4) summarising each interview, validating it and where necessary modifying it; and (5) extracting general and unique themes from all the interviews and making a composite summary. I applied data explicitation during the study by identifying the stages of HIV/AIDS policy development and implementation, while keeping the context of the whole intact knowing that each stage contributes equally to the entire process.

By using data explicitation I was able to identify four minimum stages in the HIV policy-making process which are described in the next chapter.

3.7 TRUTHFULNESS AND TRANSFERABILITY

Data triangulation was used to confirm that tentative themes identified in secondary sources corresponded with comments made by primary sources in order to strengthen the methodological choice and argument for the study. Data triangulation was used to contrast the data and 'validate' the data as it yielded similar results. Themes from

descriptions obtained during the interviews corresponded to themes from the HIV/AIDS institutional policies.

Research participants were issued with copies of interview texts to validate that they, in fact, were a true reflection of what transpired during the interviews. In addition, cassette recordings of interviewees are available for verification purposes to support claims made by the researcher. This contributed towards truthfulness in the qualitative research study.

Transferability, a term used in qualitative research designs, implies that the individual researcher did his best in the study to present the facts as a true reflection of life. This is done in such a way that the data is as accurate as possible and perhaps, given similar circumstances, the research approach can be deployed by other researchers.

3.8 METHODOLOGICAL CHALLENGES

Locating participants who had experience in HIV policy making was difficult. This was particularly challenging at Makerere University because the HIV/AIDS institutional policy has not yet been fully implemented. On several occasions interviews had to be re-scheduled due to unforeseen circumstances, for example, a key informant at MUK could not be interviewed on two occasions on the agreed dates due to personal circumstances and a replacement was found instead.

3.9 CONCLUSION

This chapter addressed the qualitative research design by describing research participants who were interviewed, access, informed consent and ethical

considerations. It also discussed key informants and focus group interviews, sampling methods, data collection techniques, data analysis, interpretation and triangulation.

The research design used a qualitative approach and sought to investigate the experiences of key stakeholders involved in HIV/AIDS policy development and implementation at MUK and MUST. The research findings and interpretation are dealt with in the next chapter.

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CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter is a qualitative analysis of the data that was collected during the individual and group interviews held at Mbarara University of Science and Technology and Makerere University, Kampala. In total five key informant interviews were held with staff members, three at MUST and two at MUK. Two focus group discussions were held with students. The data analysis method involved identifying main themes from the interviews which were then manually coded. The main aim of data analysis was to describe the process involved in HIV /AIDS policy development and implementation. HIV and AIDS related services; HIV and AIDS research; and the social, cultural and political factors that contribute to behaviour change were also explored as secondary objectives. I tried to remain reflexive throughout data analysis by distancing myself from the research participants and institutions both emotionally and culturally.

4.2 RESEARCH FINDINGS

The research findings are reproduced in the following sections and are grouped according to themes identified during manual coding. Five main themes were identified, namely: (i) HIV/AIDS institutional policy development; (ii) HIV/AIDS institutional policy implementation; (iii) HIV and AIDS services; (iv) HIV and AIDS research; and (v) social, cultural and political factors contributing to behaviour change.

It should be noted that two terms were identified during data analysis and will be used as themes throughout the chapter. These terms are HIV/AIDS Institutional Policy

Development (HIPD) and HIV/AIDS Institutional Policy Implementation (HIPI) which originate from HIV/AIDS Institutional Policy (HIP).

It was important to get key informants who were easily accessible, knowledgeable and involved with HIV/AIDS institutional policies. I interviewed informants to get a variety of perspectives as information collected from interviews would provide me with first-person accounts compared to simple document analysis.

MUST, established in 1989 by an Act of Parliament, can be described as a science-based university, a community-based university and a small university in terms of numbers (approximately 2, 000 students).

Makerere University was established in 1922. It was described as a prime university in East Africa. It is the largest university in Uganda and offers both secular and religious courses.

The prestigious position of Makerere University was described by one respondent as follows:

> The very first one in East and Central Africa. It has trained many leaders, people like Nyerere, Kibaki, Obote some of the major leaders of our region have been trained at Makerere. It has been ranked the best university in this sub-region and 13th best university in the whole of Africa. It's actually the best university in black Africa; the universities that are ranked higher than it are either from Egypt or South Africa.

Makerere University informants were less knowledgeable in the area of HIV/AIDS policy development compared to MUST staff. The MUK respondents were found wanting and provided inadequate data, or no data at all, in certain key areas of the study. Consequently their comments diluted the richness of information on the phenomenon but were helpful in other areas. Their main focus was in the areas of HIV/AIDS services and research.

The next section discusses findings of HIV/AIDS Institutional Policy Development (HIPD) under the sub-headings sectoral, national and international policy guidelines; HIPD at MUST and challenges of HIPD at MUST.

4.3 HIV/AIDS INSTITUTIONAL POLICY DEVELOPMENT (HIPD)

The following findings addressed research questions related to international, national and institutional HIV and AIDS policy development. They have been covered under separate headings.

4.3.1 International and national HIV/AIDS policy guidelines

MUST has a cross-cutting HIV policy called the Mbarara University of Science and Technology HIV/AIDS Institutional Policy, also abbreviated as MUST HIP. Findings from the interviews indicate that the policy deals with all issues of HIV and AIDS including raising awareness, prevention and care, even mainstreaming HIV in the curriculum. In addition, it was discovered that other documents like the Anti-Sexual Harassment policy found in the Human Resources manual are related to HIV and AIDS issues at MUST. International and national policy guidelines that informed MUST HIP were the Association of Commonwealth Universities (ACU), the national HIV/AIDS policy and the Ministry of Education and Sports HIV/AIDS policy.

A respondent explained the role of the ACU in providing international guidelines:

> The initial idea to have such a cross-cutting policy was borrowed from the Association of Commonwealth Universities. Needless to say, Uganda has had its rightful share of the HIV/AIDS pandemic so, the HIP was also borne out of a dire need to mitigate HIV/AIDS issues at work and study place.

The importance of aligning the institutional policy with the education sector policy guidelines was highlighted by one respondent:

> The initial idea to develop an institutional policy was an appeal from the Ministry [of Education and Sports] that institutions with over 100 employees should develop an institutional HIV/AIDS policy. The university acted on that affect. The national HIV/AIDS guidelines [NSP], we also fit within those. Definitely, you think of the Ugandan constitution and the human rights issues. HIV/AIDS is a human rights issue and they fit within those parameters.

A respondent from MUST mentions the national HIV/AIDS policy:

> When the institutional policy was being developed they had to comply with the national policy on HIV and AIDS.

A staff respondent from MUK refers to the National Strategic Plan:

> I remember we approved [an] HIV/AIDS policy some years back in senate…Well I know Uganda has a national policy. It has a National Strategic Plan on HIV/AIDS. I'm sure those that drafted the university policy must have consulted the NSP framework.

The above comments by staff members highlight the essential role played by international associations and national plans in providing guidelines for their HIV/AIDS institutional policies. The comments also confirm the consultative process involved when drafting institutional policies in HIV and AIDS. The ACU provided a strategy for Ugandan universities during the development of their HIV/AIDS policies, as evidenced by MUST. Makerere University also referenced the ACU as one of the sources in their HIV/AIDS policy (Makerere University 2008: 11). The Association of African

Universities (AAU) HIV/AIDS toolkit was another useful reference used by staff members of MUK and MUST during the policy formulation process.

The MoES HIV/AIDS policy guidelines were mentioned as a source by staff members of MUST in their interviews. The draft national HIV/AIDS policy and the NSP were also mentioned by respondents from MUST during the individual interviews. These sources, and others, were discussed in detail during the literature review of the study. In addition the Ugandan constitution, which contains human rights principles, was also fundamental during the drafting of the institutional policy at MUST. The Ministry of Health is mentioned as a key stakeholder in the entire policy-making process.

Hence these findings partly address the primary research objective of the study. The aim of which was to identify the national and international policy guidelines that assisted selected Ugandan universities to develop their HIV/AIDS institutional policies.

4.3.2 HIPD at MUST

The process of developing the HIV/AIDS Institutional Policy at MUST is described by participants below. It was a process that went through various stages of the policy-making cycle from formulation right through to implementation. A policy formulation committee was established in 2003 thereafter they held a policy formulation workshop where they developed a draft policy. The draft policy was approved by council in 2004 and after three years funds were raised for the implementation of policy activities. In addition the Lund University Mbarara University of Science and Technology (LUMUST) cooperative project helped to start off the MUST HIV/AIDS policy activities.

A respondent describes the process of policy development from approval to implementation as follows:

> The development of the HIV policy was approved by council in 2004. It was spearheaded by the Dean of Students, a number of stakeholders in departments and

> faculties, and brought in people from the Ministry of Health. From 2004, it took three years for it to be implemented. In 2007, we got funding from SIDA project. That was when we were able to start the implementation. Actually, right now the project has come to an end, but our university has set aside funds to continue with the implementation.

Senior members of the Policy Formulation Committee (PFC) were named in appendix II of MUST HIP as: Chairperson (Medical Superintendent of Teaching Hospital) and Secretary (Dean of Students). Other committee members were the Academic Registrar; University Secretary; Deans of Development Studies, Medicine and Science; Heads of Department for Community Health and Nursing; Associate Dean of Medicine; student Guild president and the Workers Union chairman. Co-opted members were from the STD/AIDS Control Programme in the Ministry of Health; HIV/AIDS Hope Initiative, World Vision International; Nkumba University; MUST planning unit; and MUST public relations officer (Mbarara University 2004: 11). The committee comprised of administrators, academic and non-academic staff, students and external stakeholders.

A response by a staff member from MUST described the steps taken in HIPD as follows:

> Step 1: The users of Mbarara University who are students, staff and also major line ministries in the country and the Ministry of Health held consultative meetings. Step 2: To write down the issues that were pertinent to MUST involvement. Step 3: To have a policy document. Step 4: To see whether policy can stay on shelf or can we have hand-made activities, so we looked out for funding to address the challenges identified. Step 5: To design strategies to address the challenges so we carried out a baseline. The baseline brought out priorities that needed to be addressed. Step 6: Next, was implementation of initial activities. A policy is not cast in stone, so the policy must evolve, must grow; it must be responsive to the daily changing needs. Ofcourse, HIV/AIDS as a health problem is also not static. It evolves, it changes, and it's alive and well.

When asked to elaborate on the baseline study, the staff member added on:

> It was a mixed-methods study because we wanted to reach all aspects, all stakeholders involved in the HIV/AIDS business. We had focus group discussions among students. We had a survey with the hostel owners, where students reside off-campus. We had to look at student's life, outside class hours; where they spend their time off-campus, i.e. recreational centres. We also carried out observations. We carried out document reviews. So a mixed-methods comprehensive study. Of course cross-sectional by the nature of a baseline. So, both quantitative and qualitative.

Another staff member from MUST revealed that they were not involved in policy development. However, their information correlated with what the other participants had said about consultative meetings.

> There were several consultative meetings with Ministry of Health [officials] who have experience in policy formulation; reviews; committee sittings; and workshops. That's when they developed the policy.

According to MUST HIP (Mbarara University 2004: 12), in appendix III, a policy formulation workshop was held with a mixed representation of people from the university community including staff and students. The workshop addressed the following key areas:

1. Basic principles in policy formulation;
2. Health care and use of ARVs for HIV/AIDS patients;
3. Gender and HIV/AIDS;
4. Voluntary Counselling and Testing; and
5. Challenges in policy implementation.

The points raised by MUST staff on HIPD have been informative and descriptive. The participants mentioned several steps involved in HIV policy development. These can be summarised as follows: (1) consultation with all stakeholders at MUST; (2) establishment of a policy formulation committee; (3) hosting a policy formulation workshop; (4) drafting an HIV/AIDS institutional policy; (5) approval of the policy by council; (6) raising funds for policy activities – achieved through SIDA; (6) conducting

baseline studies; (7) implementation of policy activities; and (8) monitoring and evaluation of policy activities.

Officials from the Ministry of Health have been instrumental in guiding the MUST HIP development process because they were mentioned by all respondents. A baseline study was carried out to identify what priorities the policy should address. It entailed mixed research methods including surveys, focus group discussions, document reviews and observations.

Management's role

The role of management is critical in the development process. The positive support by the management of MUST was expressed by several participants:

> Top management and the university council have been very positive about it. I think that has helped.

> Involvement by all stakeholders. Involvement and support by politicians and political actors. Involvement at top level, top management of the university. Involvement by all institutes and departments. Having MUST HIP committee that ensures monitoring and evaluation. Good coordination mechanisms in place and also strong collaborative efforts at inter-university and NGO level.

> The university embraced the idea of having a policy, owned it and [management] supporting the idea of having an institutional policy is very key.

The following comments introduce the next topic on residential students and why they should be considered in HIV policy development.

Residential students

Baseline studies conducted at MUST identified residential students as a vulnerable group of students because of their versatility and greater social networking.

A number of staff identified students in residential halls and hostels as a vulnerable group. The following respondent explained why:

> The residential students are more vulnerable because they're more versatile. They link up with more people, their social interconnectivities are higher therefore in the case of HIV/AIDS they are more at risk. We target them directly and indirectly. Directly, with other students in class, for example, if you talk about the HIV/AIDS curriculum that tackles all students. Indirectly, they have been talked to through mobilisation and involvement of hostel owners in HIV/AIDS mitigation. Also student groups have door-to-door interventions in hostels.

Students living in digs are the majority, as a staff member attests to, and they were taken into consideration when developing MUST HIP:

> Eighty percent of the MUST community stays outside MUST campus. We have worked with hostel owners, local council leaders to ensure student's welfare is guaranteed. Residents on campus have associations and peer educators that conduct activities at hostels.

These comments suggest that students living in residences and hostels are more vulnerable and should be addressed as a key population at universities. At MUST, it was found that the majority of students reside near campus therefore community mobilisation was necessary to support this group.

Makerere University HIPD

Neither of the staff respondents from Makerere University could provide information on the policy making process. For a prime university of East Africa, the largest and oldest in Uganda, it was of concern that the HIV/AIDS policy was only approved recently in 2008.

In contrast to MUST, a staff member from Makerere University admitted no knowledge of the policy development process.

> To tell you the truth I don't know of the process involved. What I think must have happened is the university got an expert to draw it then presented to senate.

While MUST is a smaller new entrant in the sector, it had an approved HIV/AIDS institutional policy in 2004 and had an efficient reporting system in place.

4.3.3 Challenges of HIPD at MUST

Two major challenges were faced when developing the HIV/AIDS institutional policy at MUST, namely the sensitive nature of sex and budgetary constraints.

Sexuality is core to the HIV/AIDS problem and the cultural sensitivities around talking about sex presented a number of challenges.

The difficulties in talking about sex with students were expressed by one respondent from MUST:

> HIV/AIDS is an illness that is transmitted in Africa mainly through heterosexual sex, and sex culturally in Africa is not something that has been talked about freely throughout. So, it is like breaking ice, it's not easy. To do this, we had to delve into lived experiences by students. We had to use research assistants who could more easily understand the language and aspirations of younger people.

Another challenge identified during the policy formulation process was raising funds for the activities and budgetary constraints. More comments related to budgetary constraints are discussed in challenges of policy implementation.

The implications of budgetary constraints were expressed by a respondent from MUST:

> Like I said I wasn't involved in the development process. However, from experience in the implementation of the policy, the challenges they could have met were issues at setting up a strategy for implementation of policy without readily available source of funding; to envisage what's in the future. The budget usually reflects the resources you have, in terms of human resources, knowledge resources, etc.

4.4 HIV/AIDS INSTITUTIONAL POLICY IMPLEMENTATION (HIPI)

HIV/AIDS Institutional Policy Implementation occurs during the later stages of policy development. It takes place after policy formulation and policy approval stages have been achieved and it entails activities of implementing the institutional policy objectives, mission and goals.

HIPI at MUST was carried out according to activities under the supervision of staff who were coordinators of the activities. Examples of activities are baseline studies, eliminating stigma and discrimination, raising awareness, peer education and VCT.

4.4.1 HIPI at MUST

The implementation activities of HIPI at MUST were described by one respondent as follows:

> The implementation activities that have been identified…have had activity heads, for example, baselines. Baselines need to have periodic reviews. We also identified, for example, mainstreaming HIV/AIDS into the curriculum a key activity with an activity head. Then there is addressing stigma through free sharing of information. There is an activity head there. Then there is HIV/AIDS interventions, like the clinic that does voluntary counselling and testing that also has an activity head. So, we see that HIV/AIDS is multifaceted. The key aspects of the health problem require having focal point persons who further spearhead and further develop these aspects. So that is the process which has periodic reviews, through meetings with activity heads at Mbarara University. There is someone who is in charge of student welfare services, the Dean of Students, this is the overall focal point person for MUST HIV/AIDS activities. He is really chairperson to sub-focal point persons for HIV/AIDS.

Data from the interviews and data from MUST HIP confirm that voluntary counselling and testing services are provided by the clinic. A focal point person was appointed by the university to coordinate the institutional response to HIV and AIDS activities.

A staff respondent commented further on the multi-disciplinary nature of HIPI at MUST:

> Initially, more was done regarding student peer education. The real visible aspect of peer education was a project funded by SIDA and it has grown. When MUST HIP got funding, we had networks and collaborations with HIV/AIDS external organisations with the university as a study and work place. Sensitisation workshops on different matters, service provision like condom distribution, VCT and counselling itself. We have a multi-disciplinary approach because the university has several disciplines (students, lecturers of medicine, education and so on).

From the above comments by staff members at MUST it is apparent that the HIV/AIDS institutional policy was implemented through several activities. Examples of these activities were baseline studies, mainstreaming HIV/AIDS into the curriculum, addressing stigma through IEC, and VCT at the ISS clinic. In addition student peer education, networks with external organisations, sensitisation workshops and service provision including condom distribution were also identified as key activities. All these activities had activity heads who met regularly with the focal point person.

Another staff member described the activity area of raising awareness:

> Duties were separated and mine was to raise awareness. In raising awareness we had some courses to ensure that students and staff were trained. Amongst those for the staff members, we gave them a lot of counselling skills. We also gave students, especially second and third year education students, we gave them sexuality courses. During teaching practice, or when they start jobs to know that when they face challenges with sexuality, they are able to disseminate information they have. It was a good course; students come from different backgrounds so when trained with this information, they go out to the nation and also spread the word. Apart from that, we also have in the curriculum; we had to make sure HIV/AIDS is inclusive in whatever courses are being trained – whether you're doing development studies, business administration. We also have medical students that go out into the community and they also already have that knowledge.

From the above quote it is clear to see that HIPI at MUST involved a lot of training and creating awareness as well. A cross-section of staff members were trained in counselling skills, students were trained in sexuality courses and HIV/AIDS was mainstreamed into the curriculum within a compulsory service course. These activities

in raising awareness correlate with information obtained from the MUST workshop on 'Dissemination and sharing of experiences in HIV policy development and implementation among universities'. Furthermore, paragraph 2.5.2, under integration of HIV/AIDS into research and teaching, states that information on HIV/AIDS, counselling and guidance will be included on the service course to be given to all students enrolled at MUST (Mbarara University 2004: 8).

Effective policy implementation was highlighted by students from MUST:

One student from MUST said:

> I think it's a great initiative by the university. The way they have thought about introducing the MUST HIP Implementation Project and the way they have implemented it is fantastic!

Another MUST student added on:

> My opinion is that really good work is being done and has already been done. The fact that MUST HIP offers voluntary and free services given to students is a lot. The fact that I'm capable of knowing my sero-status, I'm counselled and I have protection, that's great.

4.4.2 HIPI at MUK

It is evident from the responses received from MUK staff members that they are not aware of HIV/AIDS policy implementation activities at campus. However, student participants in the FGDs were more knowledgeable of activities that supported HIPI as evidenced from their responses below. The students gave examples of VCT services and condom distribution as forms of HIV and AIDS services available in halls of residences (e.g. Lumumba Hall and Mary Stuart Hall) and also via the personnel at Makerere University Hospital and the Gender Mainstreaming division.

The staff member from MUK could not comment on HIPI:

> After the policy is approved, I expect them to come up with programmes to support the implementation.

A student from MUK recalls getting condoms from Lumumba Hall and responded to whether implementation of the policy was successful:

> The services are being implemented because, for example, supply of condoms. At Lumumba Hall there are boxes of condoms so that policy is successful.

Another student commented on voluntary counselling and testing:

> Yes, policy is being implemented through VCT. They come; they test and give a free t-shirt.

A third student from MUK supported the statement on counselling and testing:

> I think the policy has really been implemented because they've tried to carry out regular testing, counselling and even the fresher's awareness.

It would appear from these comments that the management of MUK have infact began implementing the HIV/AIDS policy particularly through the university hospital which provides services such as VCT, care and treatment.

The Makerere University (2008: 8) HIV/AIDS policy, in paragraph 4.4, confirms that confidential, inexpensive diagnostic testing for HIV will be offered to students by University Health Services. No test will be given without informed consent, and results cannot be released to third parties without the specific and express prior authorization of the patient unless otherwise required by law. Information from the group interviews corresponds to information in the HIV/AIDS policy.

4.4.3 Challenges of HIPI at MUST

Interviews with respondents revealed that the implementation of the HIV policy at MUST presented numerous challenges. These ranged from complacency from academic staff,

difficulty in following up information, time available for implementation, funding and service provision.

A respondent narrated some of the challenges:

> Challenges were usually… mobilisation of academic staff. They were difficult to do. Support staff was okay and maybe the challenges with students when inviting them for a workshop / seminar, the semester runs concurrently. The time we had to implement was not enough. They also have so many other extra-curricular activities. The academic staff don't see a need to come attend those seminars, so they are the most hard to reach. We attract them with renowned speakers from outside, somebody they respect to talk to them about it.

In addition to complacency regarding HIV/AIDS activities, another staff member comments on the problem of funding:

> Challenges we experienced and are still experiencing are: No.1 complacency to HIV/AIDS-related activities and information. It's reflected in response to activities. We have challenges in mobilisation as well, few people turn up. Forty percent of students are doing courses in medicine. No.2 is a funding problem. We are in a phase-down stage after being funded by SIDA from 2007 to 2010. Our activities are thinning down. The university has come aboard but not as much as SIDA. Financial assistance is a problem. No.3 is service provision. We don't have a hospital as a university. We're attached to Mbarara Regional Referral Hospital. We rely on referrals. Formerly it was the [Mbarara] University Teaching Hospital now the [Mbarara] Regional Referral Hospital.

The challenges identified are thus mobilisation of academic staff, planning for student workshops, external sources of funding, creative marketing of implementation activities and information gathering. Another important challenge identified is the lack of a functional clinic on main campus. There is too much reliance on Mbarara Regional Referral Hospital, which was formally Mbarara University Teaching Hospital.

The policy implementation plan[11] of MUST HIP, found in appendix IV, shows the resources and budget required for implementation (Mbarara University 2004: 13).

The MUST HIP implementation budget[12] is a useful guide for costing other higher education institutional policies. The total budget of US$ 75, 000 explains why the university had challenges in raising the funds and why a partnership was formed with an international donor agency.

Challenges of HIPI at MUK

The staff members interviewed at MUK could not comment on the challenges faced during HIV policy implementation. This highlights the difficulty in securing access to personnel who were knowledgeable of the topic and were willing to discuss issues openly. A potential respondent replied to my request for an interview with the reply that he does not fall within my study population. In other cases, I was referred to the Human Resources Manager or the University Hospital Director who were not available for interviews.

The main challenge identified at MUK was securing time with staff members who were knowledgeable of HIPI. At the same time it should be noted that the response to HIV and AIDS at MUK was slow, cumbersome and poorly coordinated.

[11] The total budget was one hundred and fifty million Ugandan shillings (UGX) (150, 000, 000/=) or approximately seventy-five thousand United States (US) dollars (US$ 75, 000).

[12] Recruitment and Admission: Cost 5, 000, 000/= (US$ 2, 500); Teaching Initiate: Cost 5, 000, 000/= (US$ 2, 500); Research Initiate: Cost 50, 000, 000/= (US$ 25, 000); Health Services: Cost 50, 000, 000/= (US$ 25, 000); Peer Counselling: Cost 10, 000, 000/= (US$ 5, 000); Reading materials for library: Cost 5, 000, 000/= (US$ 2, 500); Newsletter and posters: Cost 10, 000, 000/= (US$ 5, 000); Crusades, orientation programmes, student assemblies, staff meetings, workshops: Cost 5, 000, 000/= (US$ 2, 500); Administration and coordination: Cost 10, 000, 000/= (US$ 5, 000).

4.4.4 Suggestions for more effective HIPI

Students from both higher education institutions were asked to give their suggestions on new ideas or solutions for better policy implementation during the FGDs. The students from MUK mentioned a few innovative ideas like provision of stronger ARVs for treatment, creating HIV/AIDS clubs and promoting exchange programmes. They also emphasised the need for guidance, counselling and sensitisation of the community.

The following comments from MUK students exemplify their concerns for better HIPI:

> I think they should increase on the provision of medicines like ARVs.
>
> I think they should improve on bringing drugs that are powerful than those they bring. For example, they supply septrin and this septrin does not work very well. I think they can bring more drugs since we have students studying sciences, we have the hospital experts, and they can bring powerful drugs.
>
> I think they have to sensitise more on guidance and counselling. Since most students who are [HIV] positive and have social stigma, it affects them very much. It affects students so they have to work more on that part.
>
> I think they should also introduce exchange programmes because we have not had exchange programmes…that would be good.
>
> Increase sensitisation, HIV/AIDS clubs and seminars.
>
> The community should respond positively to the policy and implementation of policy as AIDS is caused by different factors. It should be multi-disciplinary. The social-cultural factors should also be considered.

Students from MUST had different ideas for effective policy implementation. These included greater community involvement by targeting schools and rural areas. Home-based education surrounding sexuality and greater parental involvement was also encouraged. It was felt that these aspects would support the efforts being made at universities. Typical comments were:

> Before thinking of coming to tertiary institutions, we ought to go back to grassroots level because there's so much that can go wrong between primary education and university… So, if someone had the foundation, a good background right from the start this would help the children themselves realise who they are, help them boost their self-esteem and their self-awareness and get to know this. Secondly, I think we need to reach out more to the village communities because most of them don't have these facts about HIV; most of them are kept in the dark about this. If we could reach out to the schools and to the communities it would be a better way to fight HIV because it is better to prevent than to cure because we don't have a cure.
>
> While in school they go through many temptations at primary and secondary level, then coming to campus students will feel they are now free to do anything. So, in other words, people need to know from way back even from home parents should be free to inform their children about HIV/AIDS. Actually, if it's put to parents that it's your role to ensure your child has known what it is about HIV/AIDS… if a lady comes to campus she is not surprised to hear about HIV/AIDS. You need to know it right from home.
>
> Some of my colleagues have said and almost exhausted everything. Before telling the child about HIV/AIDS it would be good first to inform the parents what is taking place around the world about HIV/AIDS. A word from parents would sound more than from a different person. Parents can be counselled first to counsel their children that would be of great importance.

It was clear from the discussion held by MUST students that policy implementation should take cognisance of the important role played by parents (caretakers) in educating their children on the issue of sexuality and HIV/AIDS.

4.5 HIV AND AIDS RELATED SERVICES

The next theme discussed is HIV and AIDS services. It shows the relationship between services offered at the respective universities and HIV policy implementation activities.

4.5.1 HIV and AIDS services at MUST

The HIV and AIDS related services available at MUST were quite diverse but reflected activities discussed under HIPI. According to staff these encompassed VCT, condom distribution, workshops, seminars and IEC strategies. In addition provision of ARVs for treatment of HIV infection is a key service offered.

A staff member explains the university's position on VCT:

> We have counselling, voluntary counselling and testing, once a month. An understanding with the hospital next door for staff members who need care can access treatment from there; it's called the ISS clinic. We also have workshops and seminars which educate staff members and students. We also have IEC materials which we distribute targeting students and staff according to what the organisations have and approach them. The VCT is done by AIDS Information Centre (AIC); they come in once a month. We need privacy and being anonymous so preferred an outside person to provide the service.

Another staff respondent said that services were both direct and indirect:

> Key aspects to services are even indirect. Direct services are health promotion through awareness. 1. Raising information accessibility and availability. 2. Other services encourage people to know their status, through voluntary counselling and testing. 3. Availability of interventions, ARVs (antiretroviral drugs). All these have been done at different levels of magnitude. For Uganda there is the strategy Abstinence, Being faithful and Condom use (ABC). We also support parallel strategies and policies.

A student from MUST recalls the communication strategies and services available in the university community:

> One is dissemination of information through billboards all over town in both English and local languages. There are counselling services available from TASO [The AIDS Support Organisation], AIC and MJAP [Mulago-Mbarara Teaching Hospitals Joint AIDS Program].

Condom distribution was found to be another major service being offered at the university. The MUST Peer Project (MPP) was responsible for condom distribution to the different hostels. There was a concern that the university clinic did not adequately address SRH issues besides condom distribution. A staff member comments on condom distribution:

> At the university we mostly have condom distribution and the rest…since there's the hospital next door that they can access. The MPP group also distribute the condoms from hostel to hostel.

A MUST HIP staff member spoke about the communication strategies:

> We distributed a number of things. MUST HIP did something on the meal cards of students about HIV or helping them to help themselves. Then when we get fresher's, first years, we also distribute that information to them. Even we have notice boards which are purely for MUST HIP all around the campus.

Responses from MUST staff and students indicate that the university is working in unison with community organisations like AIC, which provides VCT, to implement the institutional policy activities. Other organisations include TASO, Mbarara Regional Referral Hospital, ISS clinic and MJAP which are all adjacent to the university. The major services offered at MUST were (a) personal through voluntary counselling and testing, blood donations and condom distribution; (b) educational services via IEC materials (posters, notice boards and billboards) and audio-visual media such as plays, radio and television programmes.

4.5.2 HIV and AIDS services at MUK

The HIV and AIDS services offered at MUK varied from community outreaches, a university health week, VCT in halls of residences, condom distribution, SRH, family planning and ART (including PEP). The university hospital was a major service provider for students and employees of MUK.

The comprehensive services offered by MUK were described by one respondent:

> Outreach, by that we do VCT at nearby communities, for example, Kangugube parish. Within the university, we have a health week where we carry out general health check-up of the students. Also in the halls of residences, we carry out VCT. Each hall of residence is allocated a day, we visit each hall during that day of the week. We have health ministers in each hall. Since we have a national strategy of ABC, we get condoms by Ministry of Health which are picked by the health ministers. In addition we have the ART clinic… In case someone has been exposed to HIV, this person can receive treatment through Makerere University Hospital; but priority is given to students. We have emergency treatment in antiretroviral therapy which is called post-exposure-prophylaxis (PEP). That treatment is provided to students or our private patients.

There was a drive by hospital staff during the health week to promote VCT services through the respective health ministers of each hall. These health ministers were responsible for collection and distribution of condoms supplied by the Ministry of Health. The ART clinic located at the university hospital provided treatment, including PEP, to students and private patients who were HIV infected.

According to paragraph 4.2 (Management of exposure to HIV infection) under policies pertaining to health services, the Makerere University HIV/AIDS policy states that post-exposure prophylaxis for those who get accidentally exposed to the virus for example through needle stick injuries or rape will be provided by university through the University Health Services or appropriate referral services (Makerere University 2008: 7). Furthermore, paragraph 5.5 (community involvement / advocacy) under policies pertaining to university responsibilities, states that the university recognizes that the struggle against HIV and AIDS is not restricted to the University campuses and employees or students, but that wider community involvement and participation is required to control the spread of the disease and mitigate its impact (ibid 2008: 10). The scope of HIV/AIDS services offered at MUK has covered the full spectrum of the major thematic areas of the NSP of Uganda which are prevention (VCT), care and treatment (ART and PEP), and social support (community outreaches). In my opinion, HIPI has been very successfully executed at MUK.

SRH services and family planning are also part of the services provided:

> We provide SRH guidance and counselling for students. We provide family planning services to students. In family planning, we discuss contraceptives and these are provided at a fee.

Residential students, in halls and hostels, were encouraged to visit the hospital anytime for HIV/AIDS related services. Prevention strategies at MUK included the national ABC strategy, but they emphasised the AB approach of abstinence, being faithful or behaviour change. Responses from a staff member who works at the university hospital acknowledged they have married couples on campus and so stressed the AB approach.

IEC materials are received from the Health ministry and distributed to students. In addition responses from the hospital staff member claimed they were distributing fliers, posters and stickers but mainly during the health week.

Students in halls of residences believe that the university is making good progress as the following remarks suggest:

> They have given out condoms to different halls and hostels. Maybe after every week.

> There's also access to HIV/AIDS information to all university students and it's free. It's at Gender Mainstreaming and also at Makerere University Hospital.

> There has been free counselling and testing at Makerere University. For example, last semester it was at Mary Stuart Hall and also at Nkrumah grounds.

> Counselling and guidance services have been brought up in the university in addition to gender mainstreaming which has helped to explain to the students, encourage them and discourage them from contracting AIDS. Gender Mainstreaming is under a faculty and it helps ladies learn about how to protect themselves, to avoid men.

> The University has put up seminars and conferences where they sensitise students on how to protect themselves. They also teach students not to stigmatize those who are infected with the virus.

From the examples given by these students, it is evident that HIV/AIDS services are being implemented by university health services at places of residence and are held regularly.

MUK students made reference to Gender Mainstreaming and counselling services available. This shows that what is stated in the MUK HIV and AIDS policy is actually being implemented on campus and as a result makes a good argument for successful HIPI. Major service providers of HIV/AIDS services are Gender Mainstreaming Division and Makerere University Hospital. The lack of attention towards academic and support staff is a cause for concern and the implementation of the policy needs to address this weakness.

In summary, it can be noted that the major HIV and AIDS services at MUK are (a) personal through condom distribution and VCT, (b) educational (to a limited extent), and (c) community-based through outreaches, gender mainstreaming, university hospital and health weeks for residential students. Gaps identified in policy implementation and services are complacency from academic / support staff that are not being targeted by university health services. The following section is the theme on HIV and AIDS research.

4.6 HIV AND AIDS RESEARCH

The purpose of the theme on HIV and AIDS research was to identify what research was conducted at the universities and how this research contributed to policy development and implementation. By identifying the main research categories, NSF themes, faculties and departments/courses one has a better understanding of the research focus at the respective HEIs. This theme also addressed one of the secondary research objectives.

The following excerpts describe the HIV/AIDS research taking place at both universities. It was discovered that research at MUK is multi-disciplinary but from the analysis that

follows the bulk of the research takes place in the College of Health Sciences situated at Mulago National Referral Hospital. Research at MUST was carried out in the Faculties of Development Studies, Medicine and Science. In addition MUST HIP spearheaded a number of HIV/AIDS research projects.

4.6.1 HIV and AIDS research at MUK

Research is important during the policy cycle for various reasons. In policy development, baseline research studies are carried out to define the initial situation from which to compare future reports. Research also helps to identify key priority areas. During policy implementation, the research strategy ensures the policy is evaluated through M&E.

Information provided by the respondent was not conclusive of all research conducted at MUK but reference was made to studies done in Statistics and Population Studies. As a result documentary evidence was introduced to corroborate interviewee comments.

A respondent mentioned that the Institute of Statistics and Applied Economics had conducted research on HIV and AIDS.

> Well, the research in HIV/AIDS is conducted by different departments at the university. Like in our Institute of Statistics [and Applied Economics], we conduct research on HIV/AIDS especially our student's at undergraduate level who have to do a project and write a report. I've been supervising some of these students. At the postgraduate level as well, some masters and PhD students have been doing some research in HIV/AIDS. Research is also going on in the Faculty of Social Sciences. There is a lot of research going on in the medical school, College of Health Sciences, under the School of Public Health. There is a lot going on there, they have major institutional projects.

The following research was carried out at Makerere University between 1997 and 2006. The documentary source used was the *Annotated inventory of HIV/AIDS research* published by Uganda AIDS Commission (2008d). The data was entered into a

spreadsheet using Microsoft Excel 2007. Information was captured under the following headings: research category, National Strategic Framework, journal, centre / department / institute, university, date published, topic, author, abstract and acronyms.

Data analysis took shape by creating graphs from several groups and the ones presented below are for department, research category and National Strategic Framework. The data from figure 4.1 below corresponds to information provided by the respondent during the interview. The initial coding analysed 71 articles that provided sufficient quantitative data that would have a greater impact on the theme if expressed visually. This is contrary from qualitative data, collected from field interviews, which gives meaning to the study when expressed through descriptions and narratives from participants who experienced the phenomenon.

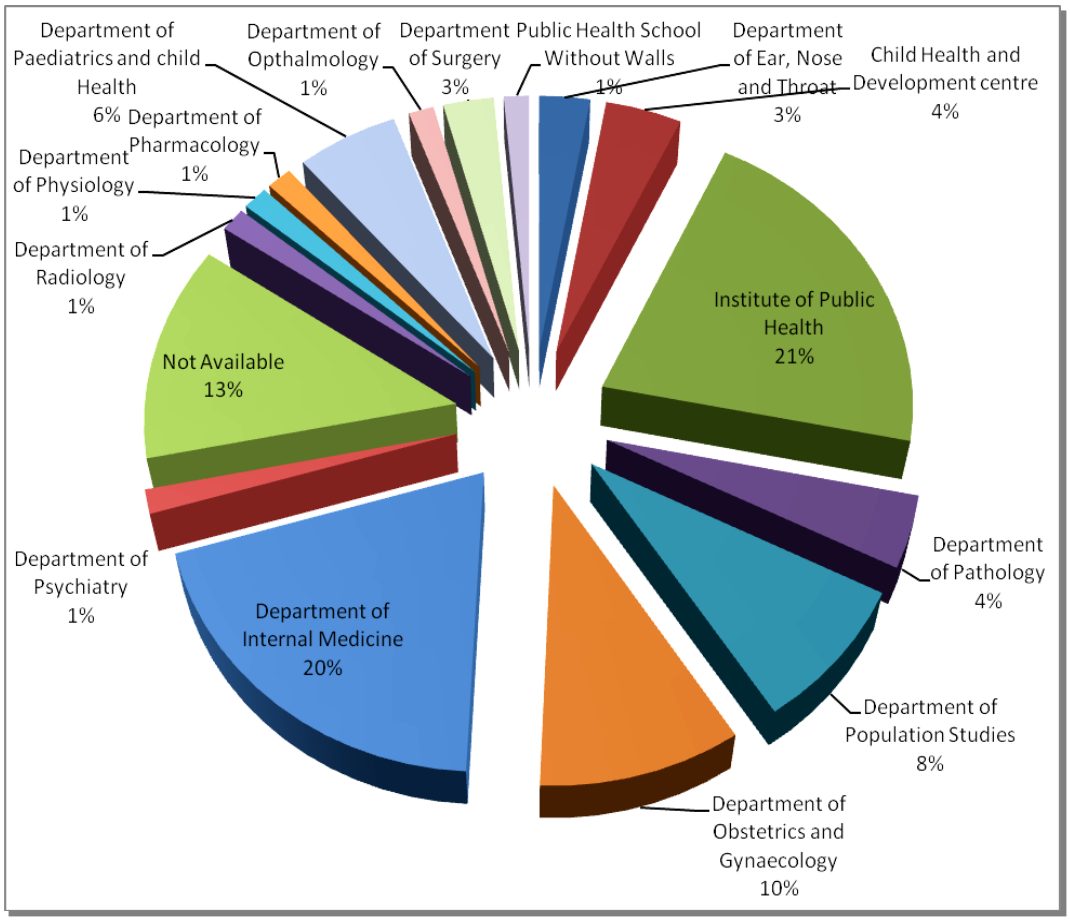

Figure 4.1 Departmental research at MUK

Source: Uganda AIDS Commission (2008d)

Data from figure 4.1 shows that the Institute of Public Health (School of Public Health) produced the most reports at Makerere University accounting for 15 articles (21%) of the 71 recorded. This was closely followed by the Department of Internal Medicine with 14 articles (20%). Nine reports (13%) were unaccounted for and are classified as Not Available. Next is the Department of Obstetrics and Gynaecology which produced 7 reports (10%) and the Department of Population Studies followed with 6 reports (8%). The Department of Paediatrics and Child Health produced 4 reports (6%), whereas the Child Health Development Centre and Department of Pathology produced 3 reports each (4%). The Departments of Surgery; and Ear, Nose and Throat produced 2 reports each (3%). The departments with the fewest research reports in HIV/AIDS at Makerere University between 1997 and 2006 were Psychiatry, Radiology, Physiology,

Pharmacology, Ophthalmology and the Public School without Walls accounting for 1 report each (1.4%).

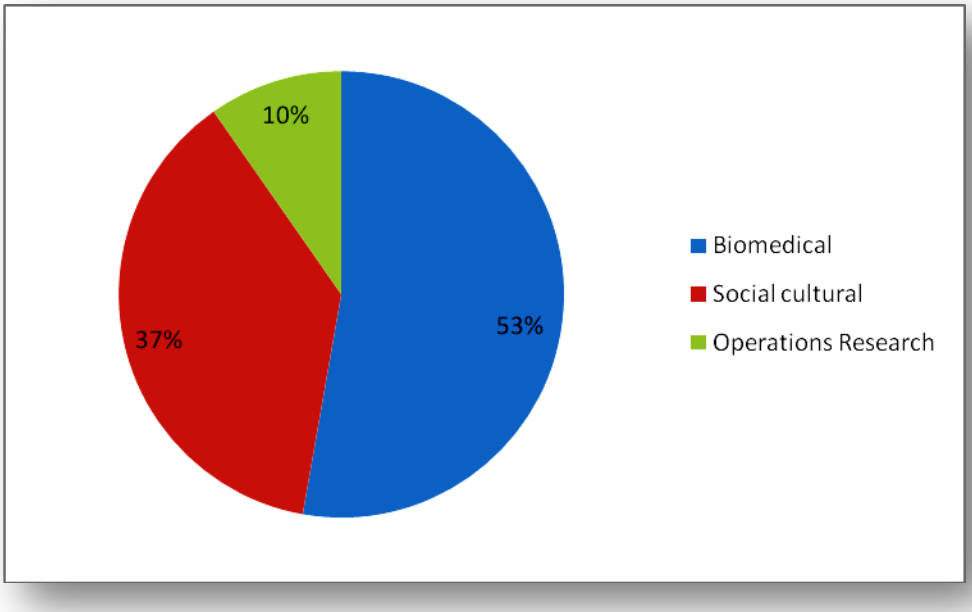

Figure 4.2 HIV/AIDS research categories

Source: Uganda AIDS Commission (2008d)

The majority of research carried out at Makerere University was in the Biomedical category (53%), followed by the Social-cultural category (38%) and the least amount was conducted in Operations Research (9%).

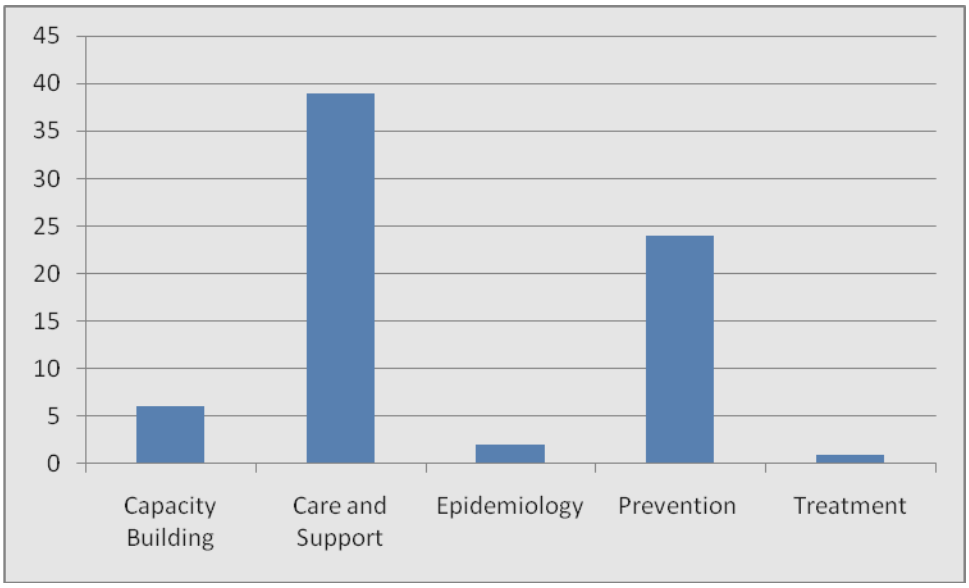

Figure 4.3 NSF themes at MUK

Source: Uganda AIDS Commission (2008d)

The data in figure 4.3 displays research reports from Makerere University according to the National HIV and AIDS Strategic Framework (NSF) 2000/1-2005/6, which preceded the National HIV and AIDS Strategic Plan (NSP) 2007/8-2011/12. Thirty-nine reports were under Care and Support (54%), twenty-four reports were grouped under Prevention (33%) and Capacity Building accounted for six reports (8%). Two reports were in the field of Epidemiology (3%) and one report under Treatment. The current NSP has identified three thematic areas which are Prevention, Care and Treatment and Social Support.

MUK had not mainstreamed HIV/AIDS in the curriculum as prescribed by the institutional policy. The respondent said HIV/AIDS was covered as a topic in most faculties although it was not mainstreamed at the university. MUK have mainstreamed gender issues at the university. The staff member mentions courses like Reproductive Health and Population Studies where HIV appears as a topic:

> I don't think it's been mainstreamed but many faculties must have it as a topic in their courses. In our department we have it as a topic in our courses like Reproductive Health, Introduction to Population Studies. We also have it as a whole semester course for some of our students who are doing Masters in Population Studies.

4.6.2 HIV and AIDS research at MUST

When asked about HIV/AIDS research studies taking place at MUST, the respondents acknowledged several studies and gave examples. These included studies in gender and HIV/AIDS, cross-generational sex and the sero-status of students at universities. Research centres conducting such studies were the ISS clinic, MUST HIP and all three faculties at MUST.

A respondent participated in a study on 'Gender and HIV/AIDS at the university':

> That's a lot. The recent one I know of and took part of is 'Gender and HIV/AIDS at the university' and its implications on implementing the policy.

When asked about the research centres and institutes that conduct studies in HIV/AIDS at the university, a respondent mentioned the ISS clinic:

> Specific centres are the Immune Suppression Syndrome (ISS) clinic. There are inter-university collaborations, which take specific aspects of HIV/AIDS. ISS clinic deals with intervention and also data bank resource, pertaining to incidence, prevalence those things. Now much more than before the policy was put in place.

Another respondent mentioned inter-university collaborations with an American university and MUST:

> The university has different collaborations with University of San Francisco; Mulago-Mbarara Teaching Hospitals Joint AIDS Program (MJAP); and MUST HIP programme to explore studies on behaviour and practices with over twenty reports within the university.

Students from MUST had participated in several HIV/AIDS studies but none had actually conducted any.

One student participated in a cross-generational sex study:

> I haven't done research but I have participated in one which was about cross-generational sex. I was a respondent.

Another student confirmed participating in HIV sero-status studies:

> I have participated in two or three. Two were voluntary blood testing, they were getting the sero-status of students from different courses, and there was a general testing for all university students in Uganda. And I participated in conferences that were about sexuality, HIV/AIDS bringing back research findings about tertiary institutions and other places.

A third student confirmed the study on the sero-status of university students and mentioned another study on alcohol and HIV/AIDS:

> Actually, last semester I participated in two of them. One was about the sero-status of students in the university. I also participated in another one not carried out at the university; it was about the effect of alcohol in causing HIV/AIDS.

Judging by what the students said, research was conducted at MUST to determine the sero-status of students which will probably inform results of HIV prevalence at MUST. A similar study was conducted by HEAIDS in South Africa and the results were released in March 2010. If similar studies are taking place at other Ugandan universities, the results would determine the overall HIV prevalence at HEIs and this will enable them to develop more effective activities for HIV policy development and implementation.

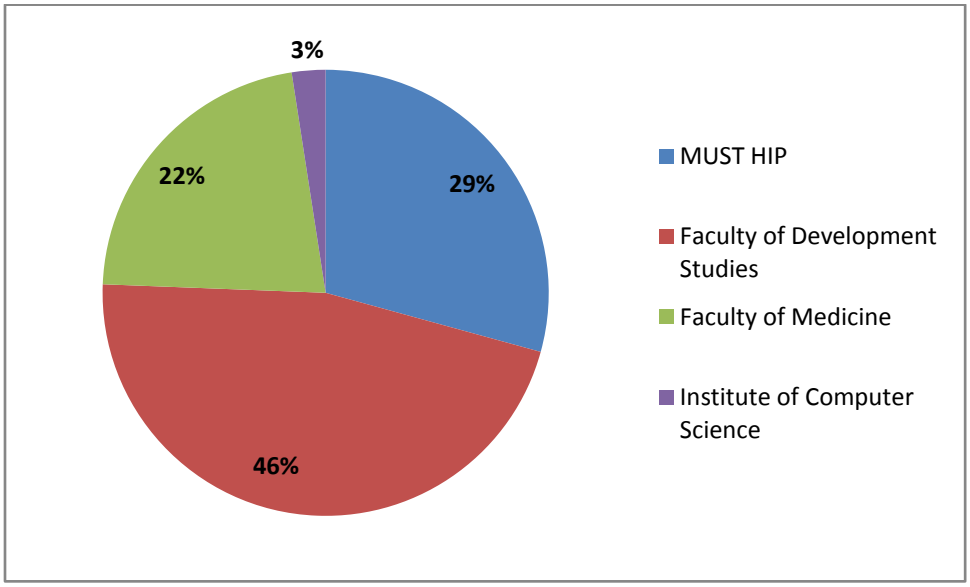

Figure 4.4 HIV/AIDS research at MUST

Source: Muriisa (2008); Nakakeeto (2009).

The diagram in figure 4.4 displays the research conducted at MUST according to faculty, programme and institute. Of the 41 reports gathered for analysis, the Faculty of Development Studies had the most with 19 (46%). The MUST HIP Implementation Programme had the next highest number of reports with 12 (29%), followed by the Faculty of Medicine with 9 reports (22%). The Institute of Computer Science produced 1 report (3%) on an HIV/AIDS information system. The research reports at MUST were produced between 2000 and 2008.

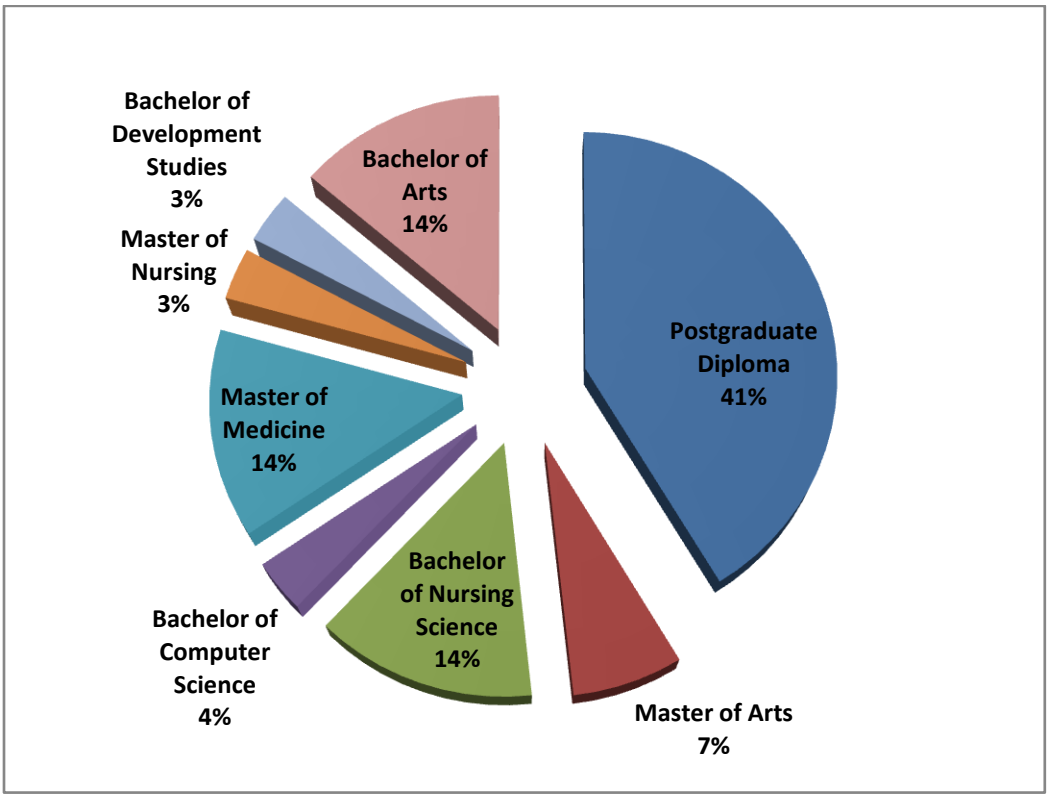

Figure 4.5 HIV/AIDS research by qualifications

Source: Muriisa (2008)

The above diagram displays courses undertaken by MUST students while conducting HIV/AIDS research. The Postgraduate Diploma in Development Studies produced the most reports representing 12 dissertations (41%). The Faculty of Medicine had the second highest research output with 4 reports each for the Master of Medicine (14%) and the Bachelor of Nursing Science (14%). The Bachelor of Arts (14%) and Master of Arts (7%) in the Faculty of Development Studies accounted for 6 dissertations. The remainder of the dissertations were for Master of Nursing Science, Bachelor of Development Studies and Bachelor of Computer Science. The data above does not include reports from the MUST HIP Programme.

A staff member confirmed the multi-disciplinary research approach:

> Each faculty carries out its own research. Also MUST HIP carry out research, we carried out a baseline survey where after we implemented using these findings. We encourage research; some money is set aside in MUST HIP to carry out research.

Dissemination of research findings is an important activity at MUST. The following staff member explained how this is achieved:

> A number of research projects and critical findings from HIV/AIDS policy implementation, in the form of 'abstracts,' were hanged up at certain locations. We have notice-boards placed strategically in main areas of campus. These have been main avenues of dissemination and information. Also we have disseminated research findings at research conferences. There's an annual university research conference. We also disseminate findings on HIV/AIDS Day, 1 December. The World AIDS Day is also commemorated at this university. We used the former World Health Organisation (WHO) approach, wherever people are when you are a community organiser then you try to intervene.

4.6.3 Mainstreaming HIV and AIDS at MUST

MUST have mainstreamed HIV/AIDS in the curriculum for all students. This shows that MUST HIP has successfully achieved their objectives set in the policy implementation plan of integrating HIV/AIDS into research and teaching. A staff member elaborates on the service course:

> They mainstreamed AIDS through a service course in development studies taken by all students. Lecturers look at Politics and HIV/AIDS or Sociology and HIV/AIDS.

In addition, one student related the same point:

> The university has integrated a programme in HIV/AIDS in the Development Studies service course which is taken by all the students who go through the university. Apart from that there have been several trainings. I participated in information-packaging which focused on how to develop IEC material and how to disseminate information to

> the intended recipients. I also participated in a counselling course which ran for two weeks.

Another student spoke about training to become a peer educator at MUST:

> I took two weeks training certification course in HIV/AIDS counselling and guidance and at the university the MUST Peer Project trained us as peer educators.

A third student spoke about student associations at the university that provided HIV/AIDS training. An interesting group called the Go-Getters had a gender aspect to it:

> Then also at the university the students get an opportunity to know about HIV/AIDS through the different associations or groups, we talked of Peer Project and Go-Getters. The Go-Getters was initiated due to cross-generational sex so it's empowering the ladies. If it's a 'no' let it be 'no'. It's being focused on what you really want. Would you risk your life for something small like a gift or something? It's one way of raising the esteem of ladies or girls to say 'no' instead of ruining your future.

These extracts from students at MUST show that HIV/AIDS has been mainstreamed externally, with the provision of open training courses and student AIDS clubs. However, the important finding from this section is that HIV/AIDS is being mainstreamed internally at MUST through the compulsory service course offered through the Faculty of Development Studies.

4.7 SOCIAL, CULTURAL AND POLITICAL FACTORS THAT CONTRIBUTE TO BEHAVIOUR CHANGE

Numerous social, cultural and political factors have contributed to behaviour change practices in Uganda. Some of the social-cultural factors addressed relate to safe medical male circumcision, cross-generational sex, alcohol / drug abuse and HIV/AIDS in married couples. These environmental factors could also have contributed to increased HIV infection rates. The political factors are then addressed separately and take into consideration the role played by Government of Uganda and donor agencies.

4.7.1 Social-cultural factors contributing to behaviour change

A respondent from MUK explained some of the social-cultural factors that contributed to the spread of HIV/AIDS in Uganda.

> The cultures of our societies here, some of which have been abandoned like widow inheritance, that was a problem. The male circumcision in Bagisu has been a problem. After the circumcision, they feel they are now free to enjoy sex. Even during circumcision there is a lot of sexual activity. In Buganda, the funeral rites used to be a problem. In funeral rites, if your relative dies sometime after the burial there is a ceremony, the extended family would get together and have an 'occasion'. Some of the activities involved a lot of sexual activity. In Ankole, in the past especially among the Bahima, if you have a wife and your brother visits you he can share the wife with you; if you had two wives you would ask him to go to the second bed. All these things are a problem, were a problem in the past.

The respondent gives vivid examples of cultural practices by ethnic groups in Uganda that were a problem. He mentions the Bagisu circumcision ceremony, the Baganda funeral rites and the Ankole wife-sharing rituals. These social-cultural factors could have contributed to increased HIV infection rates. However, since the introduction of the ABC strategy, some of these cultural practices have been abandoned in order to curb the spread of HIV among Ugandans.

A staff member from MUST explained some of the other social-cultural challenges such as talking about sexual relations:

> Social-cultural factors in Uganda are that sexual relations issues are private. Silence is a challenge. Research was done called the 'Culture of Silence on Sexuality' and it's interesting… cultural and complacency, too much information and it's the same. In 1980s when HIV/AIDS came to Uganda it's only breaking of silence that helped us come up and talking about it dealt with the problem.

The respondent makes an important point that by breaking the silence on sexuality and openly talking about HIV/AIDS, Ugandans managed to deal with the problem.

4.7.1.1 Male circumcision

Some measures have been put in place at Makerere University to address recent research findings that Medical Male Circumcision (MMC) reduces the risk of HIV transmission by up to 60%. In addition, the Ministry of Health recently launched a national policy on Safe Male Circumcision (SMC) in 2010. This intervention targets males and has recently been rolled out at all regional hospitals in Uganda with an emphasis on newborns.

At MUK the hospital was providing this service to students at a cost. However, at MUST the issue still had to be addressed.

A staff member from MUK elaborates on male circumcision:

> Some students do go for medical male circumcision (MMC) at the university. MMC is carried out at the university [hospital] at a given fee. The fee ranges from 70, 000 to 100, 000 shillings.

At MUST steps were in place to introduce MMC as an added benefit but it had not yet been addressed at policy level.

A MUST staff member commented:

> We have not yet embraced this as part of the policy. We think the science available provides better strategies for mitigation than MMC, so that is an additional cultural aspect that needs to be addressed.

The responses from other staff were similar:

> MMC has been addressed in HIV prevention strategies. It is under study, not yet confirmed. It has not yet been implemented.

4.7.1.2 Married couples

Strategies were also in place that targeted married couples who are at high risk of HIV infection in Uganda.

A staff member from MUK mentions strategies targeting married couples at the university such as couple counselling and testing:

> As far as marrieds, we were reluctant to carry out couple testing. It was more individual testing and counselling. We are [now] encouraging married couples to come with their spouse such that we address HIV/AIDS related matters to both of them. If you've heard of Pastor Sempa (a renowned pastor at the university); every Saturday he meets students at the poolside to address HIV. People have concerts, give testimonies and he has been addressing this issue of married couples getting tested for HIV.

A staff member from MUST also commented on couple testing:

> With staff members, we have actually tried and agreed to target the spouses or partners of staff members to also involve them. So that's what we're planning to do. The outcome is that support groups, called post-test clubs, come in and help each other and that is the group which is married.

A MUST respondent acknowledged that staff couples were recognised:

> We have put in place strategies that try to target the couples. The MUST HIP has been trying to emphasize that this is an area we need to address. Even with staff, irrespective of whether both of them are staff at Mbarara University that are married couples, this is an aspect that is recognised. An issue we are looking for solutions and an area we need to look at much more.

Another respondent from MUST commented on married couples:

> Married couples issues came up in a meeting with support / administrative staff to invite spouses for testing. We encourage married persons to be faithful to partners and if not faithful to use condoms.

To summarise the comments made by staff of both universities, married couples are encouraged to go for testing together since they are a vulnerable group in Uganda. This implies that when a male or female staff member goes for VCT they should bring their spouse along with them. Post-test clubs of married persons are being introduced so as to offer support from peers. In addition, it can be implied that when students go for testing they should bring their partners along with them.

MUK is now moving away from individual testing to Couple HIV Counselling and Testing (CHCT). At MUST efforts are still underway to target married and cohabiting partners of staff, particularly the administrative and support staff, so as to change their behaviour positively. It has also been discovered that the BC approach, of the national ABC strategy, is applicable to married couples. That is Being faithful or using Condoms especially for discordant couples.

4.7.1.3 Cross-generational sex

With regard to cross-generational sex (CGS), research findings showed that a small percentage of students are involved with this activity at MUST. Such behaviour can be classified as negatively contributing to behaviour change programmes. The following staff member elaborates:

> Some research findings sometimes talk about it. A number of studies from both the university and other different organisations like Go-Getters, PSI did research and found a small percentage. Sugar mummies, sugar daddies are sensitised about it. However, it's up to them to make the decisions on which way to go.

Another participant commented on CGS as follows:

> Research was done on cross-generational sex. It boils down to a lack of life skills. So, life skills development, talk about it. Research done in 2008/09 was to form a way forward to the next phase. We are addressing it on a low-scale level.

Another respondent made reference to the Anti-Sexual Harassment policy at MUST:

> This was an aspect discussed at policy implementation. Within the policy framework, they developed an Anti-Sexual Harassment policy which is so much related to the cross-generational aspects. In view of facts that lecturers are much older than the students; these issues have been presented as aspects. Student-lecturer relationships, we embraced anti-sexual harassment policy that's directly related to this otherwise there would be aspects of cross-generational sex matters.

It stems from the above statements that cross-generational sex has been researched at MUST and findings show that it was not such a big problem. However, an Anti-Sexual Harassment policy was developed at MUST in 2009 to address sexual harassment issues at the workplace and student-lecturer relationships. Respondents from MUK did not comment on CGS.

4.7.1.4 Alcohol and drug abuse

Regarding alcohol and drug abuse neither issue was seriously addressed by either policy of MUST or MUK. Yet studies in other countries suggest that these substances contribute to loss of clear thinking and reasoning which would inevitably lead to poor decision-making. As a result this leads to risky sexual behaviour including having unprotected sex. A report recently cited Uganda as the country with the highest alcohol consumption per capita in the world and this needs to be taken into consideration when developing and implementing HIV/AIDS institutional policies.

A participant acknowledges the potential danger of substance abuse:

> We haven't really gone out to discuss drug abuse, it somehow comes up but it's not highlighted. In capacity of being in Dean of Students office we note that alcohol and drug abuse is becoming a challenge to our students and we must help them out.

Another respondent explains the role of MPP:

> Not directly covered but we know that student programme MUST Peer Project has as its main concern drug and alcohol abuse. MUST HIP supports student based organisations that are supportive to HIV/AIDS aspects and vulnerability. Alcohol and drug misuse is an aspect that predisposes one to HIV/AIDS.

A respondent highlighted the role of peer education in addressing alcohol abuse:

> Drug and alcohol abuse cases have been raised. Not very much drug abuse but alcohol abuse is a challenge with students who are above 18 (adults)… to be responsible and sensitised about staying awake during lectures. Peer education groups sensitise them to eventually get their degrees. At the end of the day it relies with the individual. MUST HIP committee recommend peer education as important support.

These staff members have raised concerns that alcohol abuse is a problem with the students and it predisposes them to HIV/AIDS. A recommendation from MUST HIP was to provide support through peer educators. Drug abuse was not identified as a major problem at MUST.

The training workshop at MUK 'HIV Prevention Strategies, Counselling and Testing' addressed the topic of drug abuse and community basic interventions in some detail. The module covered the definition of drug abuse, different categories of drugs (stimulants, depressants, opiates and hallucinogens) and the effects of drug abuse. The relationship between drug abuse and HIV/AIDS and community interventions were also discussed. Research showed that drug abusers are more susceptible to HIV/AIDS and may trade sex for drugs or money for drugs. Drug abuse is one of the factors in the spread of HIV/AIDS especially in the shared equipment of injecting drugs into one's body. Drug use increases the chances of acquiring HIV/AIDS and can reduce people's commitment to use condoms. Furthermore, it was found that substance users often have multiple sexual partners.

4.7.2 Political factors contributing to behaviour change

Political leaders in the country have been credited with mobilising the masses to become more aware of HIV/AIDS and hence change their behaviours positively to reduce the incidence rate. The president of Uganda and ministers were given as examples.

4.7.2.1 The president's role

A respondent from MUK said political leadership was positive:

> Some of the factors have been positive. The positive political factor has been leadership. The president has been open and forthright about this and helped fight HIV/AIDS. At the same time he stigmatised his opponent during presidential elections.

Another staff member from MUK gave examples of respected leaders:

> …Major Rubaramira Ruranga who has come out openly to address the issue of HIV/AIDS. We also have the former Minister of Ethics and Integrity, Miria Matembe, to address the issue of HIV.

At MUST it was mentioned that the president and politicians should be credited with leading the fight against HIV/AIDS.

A respondent sums up the role played by the president:

> The government in place, the president, took it upon himself realising that HIV/AIDS also affected the soldiers. He put it upon himself to speak out against HIV/AIDS, particularly since he realised it was leading to dwindling of resources. Government was losing money and people, and the politicians could not keep quiet. Other players, academicians inclusive, NGOs inclusive followed but I think the initial credit goes to the politicians and the political framework and organisation of the country.

Another respondent from MUST highlighted particular preferences of politicians:

> Politicians have particular preferences. The First Lady focuses on abstinence. The Gay Bill presented to parliament…foreigners refused to fund activities on that bill…men having sex with men (MSM) as an issue on HIV/AIDS, Uganda is against it. Religious organisations are more outspoken about AIDS and thus more political.

Respondents from MUST have also described the political factors that contributed to positive behaviour change in Uganda. Of significance was the leadership role played by the president supported by preferences of politicians in areas such as abstinence and gay issues. Religious organisations were mentioned as another active political voice.

4.7.2.2 Donor agencies

Other political actors that have been influential in supporting MUK's efforts to mitigate the impact of HIV/AIDS have been international donor agencies and advocacy from the Ministry of Health. These agencies have contributed to the struggle for positive behaviour change.

A staff respondent from the university hospital elaborates:

> Government, through Ministry of Health, provides health materials to us. Secondly, we have partners such as HIPS [Health Initiatives for the Private Sector], United Insurance Fund from Canada and USA. We have partners such as TASO. We have partners such as AIC. Of course, Uganda AIDS Commission. Through Ministry of Health, National Medical Stores (NMS) provides drugs to the hospital. Then we have JCRC [Joint Clinical Research Centre]. We also have Joint Medical Stores.

Another staff member from MUK mentioned the financial contribution of international donors:

> On a national scale the international donors PEPFAR; Global Fund and many others have been very influential. Maybe 85% of aid comes from outside.

Partners such as GFATM and PEPFAR have been crucial to the success of behaviour change campaigns by contributing financial and technical resources to universities and other organisations in Uganda.

At MUST donor funding was received from SIDA and other university colaborations.

A staff member elaborates on funding from SIDA:

> The project that helped support the start of policy activities was funded through the Swedish International Development Agency. Other research collaborations like Harvard University / MUST collaboration carrying out a lot of HIV/AIDS-related work. So HIV/AIDS continues to be tackled through networking mechanisms and approaches.

A different staff member explains the collaboration with Lund University, Sweden:

> MUST has a collaboration with Lund University (LUMUST) and through which SIDA funded the HIP from 2007 to date. SIDA funding came in when the university had already started implementing activities like peer education, commemoration of World AIDS Day and the health week.

These concluding comments from the participants have shown how support from international donor agencies and inter-university research collaborations can contribute to more successful development and implementation of HIV/AIDS policies. By taking cognisance of the positive and negative practices that contribute to behaviour change in Uganda, these environmental factors cannot be ignored any longer by institutions involved with HIV/AIDS policy-making.

4.8 CONCLUSION

The chapter has described, analysed and interpreted data obtained from key informants and group interviews. It used a qualitative approach which entailed grouping the responses according to themes in order to clarify meaning. The themes identified were HIV/AIDS Institutional Policy Development (HIPD); HIV/AIDS Institutional Policy

Implementation (HIPI); HIV and AIDS services; HIV and AIDS research; and social, cultural and political factors contributing to behaviour change. In addition sectoral, national and international frameworks that contributed to developing the policies were mentioned.

The next chapter summarises the research findings according to themes. It goes further by identifying best practices in the two HIV/AIDS institutional policy responses. It concludes by making recommendations for successful HIV/AIDS institutional policies at selected universities.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

This chapter summarises the conclusions drawn in chapter four. The themes discussed were HIPD, HIPI, HIV/AIDS related services, HIV/AIDS related research and social, cultural and political factors contributing to behaviour change in Uganda. The chapter concludes with recommendations for each of the themes identified during the research project.

5.1 SUMMARY OF FINDINGS

MUST has a well-defined HIV/AIDS Institutional Policy Development (HIPD) process on record. It has been summarised and produced as a theoretical framework in Figure 5.1 and as a result it has been identified as a best practice when compared to MUK. The HIV/AIDS Institutional Policy Implementation (HIPI) process at MUST was well reported, costed, monitored and evaluated; it too, has been identified as a best practice and grouped into a conceptual framework in Figure 5.2. The HIV and AIDS services available at MUST were mainly outsourced to external organisations which required good financial planning and budgeting. HIV and AIDS related research at MUST was carried out in the Faculties of Development Studies, Medicine and Science. MUST HIP programme also carried out research that informed HIP activities.

MUK respondents did not participate in the process of HIPD, neither were there any records available that documented the process. Some respondents provided examples of HIV/AIDS activities taking place on campus and when compared to the institutional policy, using triangulation, were found to be evidence of policy implementation. HIV and AIDS related services at Makerere University Hospital covered the entire spectrum from prevention, treatment, care and psychosocial support and were consequently given the best practice award in this category when compared to MUST. HIV and AIDS research at MUK was multidisciplinary but mainly focused on the biomedical category,

spearheaded by the College of Health Sciences. The volume of research conducted at MUK also ensured it was a best practice area when compared with MUST research.

The social, cultural and political factors that contribute to behaviour change in Uganda were numerous. The factors discussed by the participants were circumcision, discordance in married couples, cross-generational sex and alcohol/drug abuse. The positive political factors were advocacy from the president at national level and advocacy from donor agencies at the international level.

5.1.1 HIPD process

MUST respondents described the process of HIV/AIDS policy development in detail. The findings from MUST can be summarised in a model based on systems theory which has four stages namely: inputs, outputs, outcomes and impacts. Consultative meetings, policy formulation committees and policy formulation workshops constituted the policy inputs. The development of a draft HIV/AIDS policy and undertaking research to inform policy activities were policy outputs. Raising funds and implementing MUST HIP activities were the policy outcomes. The fourth stage involved M&E of policy activities and holding regular committee meetings with feedback that become policy impacts. Surprisingly, these four stages of a policy development model correspond to four levels of a M&E framework, namely: inputs and outputs (monitoring); and outcomes and impacts (evaluation).

Based on the findings from paragraph 4.3.2 in data analysis, four basic stages have been identified in the process of HIPD at MUST, namely: (1) policy formulation, (2) policy adoption, (3) policy implementation, and (4) policy evaluation. The process is illustrated in Figure 5.1 below.

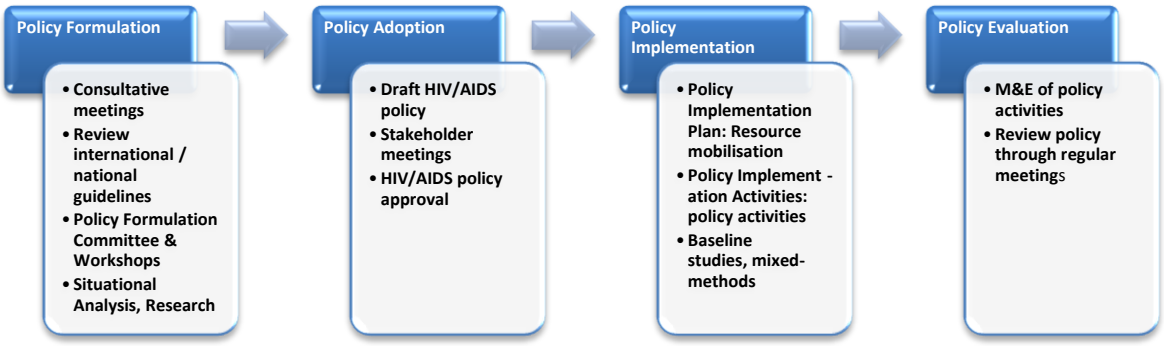

Figure 5.1 HIV/AIDS Institutional Policy Development process

The roles of top management and residential students were discussed and these people were identified as key stakeholders who should be consulted during the policy-making process. The major challenges identified at MUST in HIV/AIDS policy development were difficulty talking openly about sex and budgetary constraints.

5.1.2 HIPI process

The second important theme unpacked by the study was HIPI. MUST participants describe several key implementation activities with activity coordinators (sub focal persons) for example baseline surveys, raising awareness, mainstreaming HIV/AIDS, peer education and VCT. A coordinator (Focal Point Person) was responsible for the overall management of MUST HIP activities. Challenges of HIPI at MUST were complacency from staff, budgetary constraints and service provision. The policy

implementation plan was available in the policy document and it had an allocated budget of 150 million UGX or US$ 75, 000. The figure 5.2 below provides a summary of HIPI according to three stages, namely: (1) policy implementation plan; (2) policy implementation activities; and (3) policy evaluation.

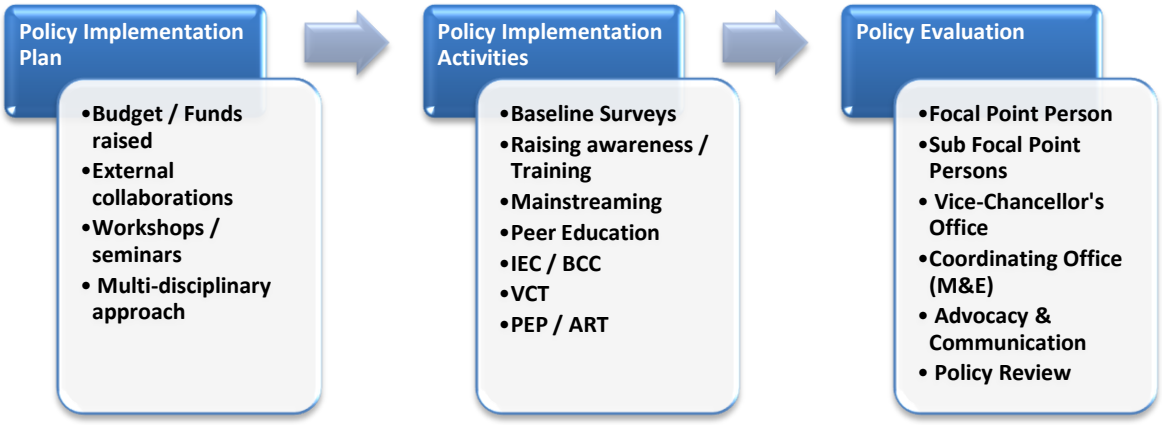

Figure 5.2 HIV/AIDS Institutional Policy Implementation process

Students from MUK commented on implementation activities at the university but their findings could not adequately delineate the process in clear stages like MUST respondents. Therefore, it was difficult to establish when, where or how policy implementation was planned, implemented and evaluated at MUK. However, analysis of the interview transcripts identified Makerere University Hospital and Gender Mainstreaming Division as facilities leading service delivery and partial implementation of HIV/AIDS activities. VCT and condom distribution were regular activities that resulted in behaviour change of students.

Suggestions for more effective HIPI from MUK students were providing stronger drugs, starting HIV/AIDS clubs, promoting inter-university exchange programmes and greater

community involvement. MUST students suggested more home-based sexuality education and greater parental involvement.

5.1.3 HIV and AIDS services

HIV and AIDS services have an important role to play in HIV/AIDS institutional policy implementation. They provide measures for assessing whether services stipulated in the policy document are being provided, by whom, to whom, when and how often.

The third theme of the study was the availability of HIV and AIDS services at both universities and how these services reflect on implementation of HIV/AIDS policies. MUST HIP services include VCT, condom distribution, peer education, ARV treatment and IEC through workshops and seminars. The MUST HIP programme was instrumental in providing guidance, counselling, condom distribution and peer education. Networks with external organisations such as AIC, TASO and MJAP contributed to providing VCT and treatment services. Services were both directly targeting students in the curriculum and indirectly targeting all stakeholders by promoting the national ABC approach.

MUK services involved community outreaches, health weeks and a plethora of HIV and AIDS services provided by the Makerere University Hospital. Some of these were VCT, SRH, family planning and ART. Students in halls of residences and hostels were more easily accessible and their anecdotes confirmed availability of these services on campus.

5.1.4 HIV and AIDS research

HIV and AIDS research relates to institutional policy development and implementation in several ways. For example, during the policy formulation stage, a situational analysis

should be conducted. During the policy implementation stage, additional research studies should be conducted to determine the effectiveness of existing programmes and to identify areas of priority.

The fourth theme addressed by the study related to HIV and AIDS research. MUK had conducted multi-disciplinary research though most of the records available were from the College of Health Sciences. Figures 4.1 to 4.3 presented charts and graphs of research conducted at Makerere University from 1997 to 2006 and were categorised into departmental research, research category and NSF themes. The Institute of Public Health and Department of Internal Medicine produced the most reports. The biomedical category accounted for 53% of research, followed by the social-cultural category with 37% and operations research with 10%. Further analysis showed that most research took place under NSF theme care and support (54%), followed by prevention (33%) and capacity building (8%).

HIV/AIDS research analysed at MUST was conducted in all three faculties and by the MUST HIP programme, between 2000 and 2008. The Faculty of Development Studies had produced the most reports (46%), followed by MUST HIP programme (29%), the Faculty of Medicine (22%) and Institute of Computer Science (3%). MUST HIP was instrumental in HIV/AIDS research that directly informed the HIV/AIDS institutional policy. This was another method of evaluating the policy and implementation programme. Similarly, when it came to courses conducting research in HIV and AIDS the Faculty of Development Studies had produced the most dissertations. Furthermore, MUST have mainstreamed HIV and AIDS internally through a compulsory service course in the Faculty of Development Studies, and externally through partnerships with external service providers.

5.1.5 Environmental factors contributing to behaviour change

The final theme of the study addressed social, cultural and political factors contributing to behaviour change in Uganda. The main social-cultural factors discussed were MMC, HIV/AIDS in married couples, CGS and alcohol and drug abuse. These environmental factors were found to either contribute to spreading HIV and AIDS (e.g. CGS, cultural practices and alcohol abuse) or were found to mitigate the impact of HIV and AIDS at Ugandan universities (e.g. MMC, CHCT). Some of the cultural factors were attributed to ethnic beliefs and tribal practices which are difficult to change but were being abandoned. Male circumcision services were available at Makerere University Hospital but MUST HIP had not addressed it yet. Married couples were targeted through Couple HIV Counselling and Testing at MUK and post-test clubs at MUST. A number of studies were conducted in CGS at MUST while MUK was still silent about it. Alcohol and drug abuse were raised as concerns at MUST and training was conducted at MUK on drug abuse, however, neither policy had addressed it as a priority area.

Political factors contributing to positive behaviour change in Uganda were the outspokenness of the president on the matter along with several politicians and religious leaders. International donor agencies were also instrumental in providing aid for many of the services offered and international inter-university collaborations facilitated the policy-making process.

5.2 RECOMMENDATIONS

The findings of this study have identified the stages through which HIV/AIDS institutional policies should be developed and implemented. The research also outlined what each stage of the policy cycle should be comprised of for each category of policy formulation, policy adoption, policy implementation and policy evaluation as described in figures 5.1 and 5.2. The following recommendations are made in fulfilment of the findings of the research.

5.2.1 Recommendations for policy development

The following recommendations are made by the principle investigator for HIPD as highlighted by the research findings.

1. MUK should record an HIPD process like the conceptual framework described in Figure 5.1 that follows the basic stages of policy formulation, policy adoption, policy implementation and policy evaluation. This was a huge gap identified by the study since there was no policy-making process on record.
2. **Policy Formulation** should encompass the following aspects: consultative meetings with all stakeholders; review institutional, sectoral, national and international policy guidelines; establishing policy formulation committees; holding policy formulation workshops with stakeholders; and a situational analysis.
3. **Policy Adoption** should include developing a draft HIV/AIDS institutional policy; communication the draft policy to stakeholders; and approving the HIV/AIDS institutional policy by appropriate decision-making bodies.
4. **Policy Implementation** should consider developing an implementation plan; mobilising financial and human resources; operationalising policy activities; and regularly reviewing the implementation plan from baseline studies and other research.
5. **Policy Evaluation** should be assigned a coordinating office; report to the Vice-Chancellor at universities; develop a M&E framework; and regularly review the policy.
6. There is a need to document, report, monitor and review the HIPD process (mentioning stakeholders, committee members, budgets, etc.) at MUK in order to ascertain whether policy objectives are being met.
7. There are several international associations and organisations that provide guidelines for institutional HIV/AIDS policy development for example the AAU,

the ACU and HEAIDS South Africa. These regional frameworks can be consulted by HEIs intending to develop and implement HIV/AIDS policies.

8. The basic four-stage framework provided in Figure 5.1 can be used as a benchmark for other universities in Uganda, including MUK, who wish to develop HIV/AIDS institutional policies.

5.2.2 Recommendations for policy implementation

The following recommendations are suggested for HIPI as supported by the research findings.

1. MUK should adopt the HIPI process as described in Figure 5.2 with the minimum stages of a policy implementation plan, policy implementation activities and policy evaluation. This framework should be modified to suit the particular needs of MUK.
2. A **Policy Implementation Plan** should cover, at the minimum, the budget or fundraising initiatives; collaborations with external stakeholders; holding implementation workshops and seminars; and it should have a multi-disciplinary approach.
3. **Policy Implementation Activities** should include, but are not limited to, baseline studies using mixed-methods; efforts to create awareness; mainstreaming HIV/AIDS internally and externally; peer education; IEC and BCC; VCT; ART and PEP.
4. **Policy Evaluation** should be assigned a coordinating office; a M&E framework; a focal point person; sub focal point persons; be situated in the Vice-Chancellor's office at universities; include advocacy and communication; and regular policy review through committee meetings.
5. At MUST, policy implementation should take cognisance of the important role played by parents and caretakers in educating their children on the issue of sexuality and HIV/AIDS.

6. Renowned speakers should be considered for attracting academic staff to activities at both institutions.
7. Planning for student workshops should be done to avoid clashing with academic / extra-curricula programmes.
8. Activities need to be creative and data should be supported by efficient information systems.

5.2.3 Recommendations for HIV and AIDS services

These recommendations concern HIV and AIDS related services that support HIV/AIDS policy implementation at two Ugandan universities.

1. HIV and AIDS services at MUK should be regularly provided and IEC materials disseminated more often than just during the health week.
2. HIV and AIDS services at MUST need to be regulated by the university clinic which is understaffed and under-stocked. More efforts must be made to become self-sufficient as MRRH has other patients to serve.
3. HIV and AIDS services provided should be related to policy implementation activities and reported to the coordinating office.

5.2.4 Recommendations for HIV and AIDS research

The following recommendations address HIV and AIDS research priority areas and financing from donors in fulfilment of the research findings.

1. A policy shift is required for HIV/AIDS research to focus on social, cultural and behavioural studies in the next ten years targeting prevention efforts at MUK. This stems from the fact that most of the research is conducted in the biomedical category.

2. More research funds should be invested towards Social Sciences/Development Studies project collaborations and the prevention theme of the NSP.
3. HIV/AIDS behavioural scientists should be afforded more grants and opportunities to conduct research in prevention categories and operations research. Uganda has shown that behaviour change can greatly reduce the rate of HIV infection, while a search for a vaccine continues.
4. Measures must be put in place to mainstream HIV and AIDS in the curricula at MUK as this had not yet been achieved.

5.2.5 Recommendations for environmental factors that contribute to behaviour change

These recommendations under environmental policy factors should be considered by the institutions as evidenced from research findings.

1. Medical male circumcision should be encouraged as an HIV prevention strategy that targets men. It should be incorporated in institutional policies on HIV and AIDS.
2. Couple HIV/AIDS Counselling and Testing should be included in HIV/AIDS Institutional Policies in Uganda as it targets married /cohabiting couples who are most at risk. It should encourage both students and staff to attend testing with their partners.
3. Anti-Sexual Harassment clauses or separate policies should be developed to address the issue of cross-generational sex at universities and similar institutions.
4. Alcohol and drug abuse should be incorporated as a key factor of institutional policies that predisposes students and staff to HIV infection at universities and other higher education institutions.

5. Political support from local district councils to the president's office should be considered with regard to consultations at the policy formulation stage of policy development.
6. The support of international donors and networks should be encouraged to provide technical expertise and funds during the HIV/AIDS institutional policy-making process.

5.3 CONCLUSION

Suggestions for further research are:

- Studies on HIV prevalence and behavioural surveys in higher education institutions of Uganda, incorporating all public and private universities.
- Research on the establishment of a national higher education HIV and AIDS programme in partnership with the MoES.
- HIV/AIDS studies on social-cultural factors and prevention strategies that contribute to behaviour change.

The study has identified and described the process of HIV/AIDS institutional policy development and implementation at MUK and MUST. The study found that HIV/AIDS related services and research contribute to the effectiveness of these policies. Environmental factors should be taken into consideration during the policy-making cycle to help make more meaningful and insightful policy decisions.

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APPENDICES

Appendix I: Informed consent form

Introduction: Good day sir/madam. My name is Timothy Iraka and I am a master's student in the Department of Sociology at the University of South Africa. I am carrying out a study to get views on HIV/AIDS policy development and implementation at selected Ugandan universities.

You have been purposively selected to participate in this study either because of your expertise knowledge in the field of HIV and AIDS research, policy analysis or HIV/AIDS policy development and implementation. As part of this study I would like to ask you a few questions. Any information provided will be treated as confidential, comply with research ethics and be used for research purposes. If you choose to remain anonymous, do not write your name on the form.

The information being collected will be extremely useful in helping to understand how to develop and monitor effective HIV/AIDS policies for universities in African contexts.

Institution: 1.) Mbarara University of Science and Technology (MUST)

2.) Makerere University Kampala (MUK)

Name of Interviewee (optional): ……..

Signature: ……

Witness: …….. Signature: ……

Name of Interviewer: Mr TA Iraka Signature: ……

Date of Interview_____/_____/2010

Appendix II: Key informant interview guide

Title of study: A critical analysis of HIV/AIDS policy development and implementation at selected Ugandan universities.

Name of university: _____

Date of Interview: _____/_____/2010

1. What is your title and job description?
2. Are you involved in the decision-making process at the university?
3. How would you describe your university? (Is it a science and technology, distance learning, small or mega university?)
4. Can you briefly tell me what policies exist at the university related to HIV and AIDS?
5. What are some of the national and international policy guidelines that have informed your institutional HIV and AIDS policy?
6. What process was involved in the development of the institutional HIV/AIDS policy?
7. What challenges have you experienced in developing the policy?
8. What process was involved in implementation of the institutional HIV/AIDS policy?
9. What kind of challenges did you experience in implementation the policy?
10. What other mechanisms are used to implement the institutional policy on HIV and AIDS?
11. How has HIV/AIDS policy implementation been monitored by the university?
12. What services related to HIV and AIDS are available at the university and in the local community?
13. What kind of HIV/AIDS prevention strategies are used in the university community (students and staff)?
14. What, if any, specific strategies target the residential students or hostel dwellers in terms of HIV/AIDS prevention?

15. What Information, Education and Communication (IEC) / Behaviour Change Communication (BCC) materials related to HIV and AIDS are available for university students and staff?

16. What are the research centres and/or institutes that conduct studies in HIV/AIDS at the university?

17. What are the benefits, if any, of research findings **/** reports for the university in terms of the institutional HIV and AIDS policy?

18. How has research in the field of HIV and AIDS contributed to implementation of the institutional policy? (monitoring and evaluation)

19. What kind of research was undertaken lately in HIV/AIDS at the university?

20. What training is available in HIV and AIDS at the university?

21. What measures has the university taken to mainstream HIV/AIDS in its academic programmes concerning teaching and learning?

22. What sexual and reproductive health (SRH) services are available for university students?

23. Is Antiretroviral Therapy (ART) available at university clinics or hospitals?

24. How effective have HIV Counselling and Testing (HCT) services been in the prevention of HIV infection at the university?

25. How does the institutional policy address the employment issues of HIV and AIDS affecting staff members in the workplace?

26. How often is the HIV/AIDS institutional policy evaluated?

27. What measures have been put in place to address the research findings that medical male circumcision (MMC) reduces the risk of becoming infected by HIV/AIDS?

28. What measures are in place to address the increase of HIV/AIDS in married couples at the university?

29. How does the university policy or HIV/AIDS committee address the issue of intergenerational / cross-generational sex?

30. How has drug abuse or alcohol abuse been covered by the institutional HIV and AIDS policy?

31. How effective has the ABC (abstinence, being faithful and condom use) approach been in behaviour change communication (BCC) at the university?

32. What social and cultural factors contribute to achieving behaviour change in Uganda?

33. What political factors have influenced behaviour change in Uganda?

34. What efforts has the university made in terms of behaviour change communication?

35. How important have donor agencies and government departments been in the development or implementation of the institutional HIV/AIDS policy?

36. What other organizations were helpful in the development or implementation of the university HIV/AIDS policy?

37. What other factors have contributed to the effective development and implementation of the institutional HIV/AIDS policy?

Appendix III: Focus Group Discussion guide

Title of study: A critical analysis of HIV/AIDS policy development and implementation at selected Ugandan universities.

Name of university: _____

Date of Discussion: _____/_____/2010

Introduction: Welcome all participants. My name is Timothy Iraka and I am a master's student in the Department of Sociology at the University of South Africa. I am carrying out a study to get views on HIV/AIDS policy development and implementation at your university.

This Focus Group Discussions (FGD) will take place between…… people who are gathered together in …….. room to discuss issues that maximize 'breadth' of understanding around the university HIV and AIDS policy. I, being the moderator, will ask questions and encourage discussion on specific issues. Responses will be tape-recorded in English. You will be provided with soft drinks during the discussion.

1. What courses are you studying?
2. How serious do you think the effects of HIV and AIDS are on higher education institutions in Uganda?
3. What steps has your university taken to respond to and mitigate the impact of HIV and AIDS on the campus community?
4. What have been the effects of the HIV/AIDS Institutional Policy on you, as students, during your years at the university?
5. What are some of the HIV and AIDS research studies that you have conducted or participated in at the university?
6. What courses / training related to HIV and AIDS did you take while studying at the university?
7. What specific HIV/AIDS prevention campaigns have successfully made you change your behaviour towards sexuality?
8. What HIV/AIDS services are currently available at the university or in neighbouring community?
9. What are your opinions on the HIV/AIDS Institutional Policy implementation process?

10. What new ideas or solutions would you recommend for better policy implementation?

Thank you

Appendix IV: Uganda National Council for Science and Technology approval letter.

Uganda National Council For Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Your Ref:.....
Our Ref:..... SS 2359

Date:.....29/07/2010

Mr. Timothy Atwine Iraka
Q-Sourcing Ltd
Plot 29, Bukoto Street, Kamwokya
Kampala

Dear Mr. Iraka,

RE: RESEARCH PROJECT, "A CRITICAL ANALYSIS OF HIV/AIDS POLICY DEVELOPMENT AND IMPLEMENTATION AT SELECTED UGANDAN UNIVERSITIES"

This is to inform you that the Uganda National Council for Science and Technology (UNCST) approved the above research proposal on **June 01, 2010.** The approval will expire on **June 01, 2011.** If it is necessary to continue with the research beyond the expiry date, a request for continuation should be made in writing to the Executive Secretary, UNCST.

Any problems of a serious nature related to the execution of your research project should be brought to the attention of the UNCST, and any changes to the research protocol should not be implemented without UNCST's approval except when necessary to eliminate apparent immediate hazards to the research participant(s).

This letter also serves as proof of UNCST approval and as a reminder for you to submit to UNCST timely progress reports and a final report on completion of the research project.

Yours sincerely,

Leah Nawegulo
for: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

LOCATION/CORRESPONDENCE

Plot 3/5/7, Nasser Road
P.O. Box 6884
KAMPALA, UGANDA.

COMMUNICATION

TEL: (256) 414-250499, (256) 414 705500
FAX: (256) 414-234579
EMAIL: uncst@starcom.co.ug
WEBSITE: http://www.uncst.go.ug

Appendix V: Access letter (Kampala District)

THE REPUBLIC OF UGANDA

OFFICE OF THE PRESIDENT

PARLIAMENT BUILDING P. O. BOX 7168 KAMPALA, TELEPHONES: 254881/6, 343934, 343926, 343943, 233717, 344026, 230048, FAX: 235459/256143
Email: secretary@op.go.ug, Website: www.officeofthepresident.go.ug

ADM 154/212/01

July 8, 2010

The Resident District Commissioner
Kampala District

This is to introduce to you **Mr. Atwine Timothy Iraka a** Researcher who will be carrying out a research entitled **"A critical analysis of HIV/AIDS policy development and implementation at selected Ugandan universities"** for a period of **01 (one) year** in your district.

He has undergone the necessary clearance to carry out the said project.

Please render him the necessary assistance.

By copy of this letter **Mr. Atwine Timothy Iraka is** requested to report to the Resident District Commissioner of the above district before proceeding with the Research.

Alenga Rose
FOR: SECRETARY, OFFICE OF THE PRESIDENT

Copy to: Mr. Atwine Timothy Iraka

Cleared

THE RESIDENT DISTRICT COMMISSIONER P.O.BOX 352 K'LA 20 SEP 2010 KAMPALA OFFICE OF

Appendix VI: Access letter (Mbarara District)

THE REPUBLIC OF UGANDA

OFFICE OF THE PRESIDENT

PARLIAMENT BUILDING P. O. BOX 7168 KAMPALA, TELEPHONES: 254881/6, 343934, 343926, 343943, 233717, 344026, 230048, FAX: 235459/256143
Email: secretary@op.go.ug, Website: www.officeofthepresident.go.ug

ADM 154/212/01

July 8, 2010

The Resident District Commissioner
Mbarara District

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He has undergone the necessary clearance to carry out the said project.

Please render him the necessary assistance.

By copy of this letter **Mr. Atwine Timothy Iraka is** requested to report to the Resident District Commissioner of the above district before proceeding with the Research.

Alenga Rose
FOR: SECRETARY, OFFICE OF THE PRESIDENT

Copy to: Mr. Atwine Timothy Iraka

Recieved by
Sec RDC Mbrara
Kengabirano Consider
10/08/2010