KNOWLEDGE, PERCEPTION AND PARTICIPATION IN HIV AND AIDS POLICY-RELATED ACTIVITIES AMONG STAFF AND STUDENTS OF UNIVERSITY OF IBADAN, NIGERIA

BY

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DEDICATION

To the Alfa and Omega, the One who saw me through to the end of this work, my maker, my refuge, my ever present help in times of trouble – God the Almighty.

To my late parents Elder Joseph Adebola and Mrs (Princess) Rachael Adeyeluwa Adebusuyi, both of whom went to be with the Lord during the course of this programme. How I wish you were around to see your beloved daughter achieve this feat. But thanks be to God who has given me victory. Continue to rest in the bosom of our God. I am forever grateful for the values you instilled in me.

CERTIFICATION

I certify that this study was carried out by ANIAGWU Toyin Ibironke Grace in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan.

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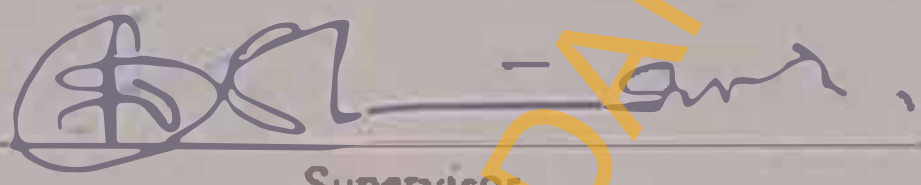

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ABSTRACT

HIV and AIDS Policy (HAP) of the University of Ibadan was formulated to facilitate HIV prevention on campus. However, a systematic appraisal of the knowledge, perception and practices related to the policy among staff and students, needed for possible policy reforms, has not been adequately explored. This study was designed to investigate the knowledge, perception and participation of staff and students of the university in activities related to the HAP.

A two-stage sampling technique was used to select 59 Academic staff (AS) and 146 Non-teaching staff (NS) from Faculties and Departments. A three-stage sampling technique was used to select 1001 students from halls, blocks and rooms. A semi-structured questionnaire which included questions on socio-demographic characteristics, 38-point knowledge and 17-point perception scales, and questions on HIV-related activities were used for data collection. Knowledge scores of <20, 20-28 and >28 were rated poor, fair and good, respectively. Perceptions scores of <7 and ≥7 points were categorised as unfavourable and favourable respectively. Twenty key informant (KI) interviews were conducted among Principal Officers, religious, staff and student leaders of the University. Quantitative data were analysed using student t-test and Chi-square test at 5% level of significance. Thematic approach was used to analyse qualitative data.

The ages of AS, NS and students were 39.5±9.3, 44.0±7.9 and 24.5±6.0 years, respectively. Majority of AS (83.1%), NS (60.3%) and students (65.4%) were males. Only 40.7% of AS, 15.8% of NS and 14.5% of students had heard of the HAP and of these AS (44.4%), NS (31.3%) and students (35.6%) had copies of the policy. Knowledge scores of AS, NS and students were 29.1±6.7, 23.2±7.0 and 23.4±7.1, respectively. Respondents with good knowledge were AS - 57.1%, NS - 30.0% and Students - 23.4%. Few AS (14.3%), NS (30.0%) and students (14.9%) stated that the policy recommends compulsory HIV screening for prospective employees and students which was incorrect. Knowledge scores by sex among the three categories of respondents were not significantly different. Respondents with favourable perception of the HAP were AS (85.7%), NS (70.0%) and students (46.7%). Majority of AS (85.7%), NS (80.0%) and students (66.0%) who had ever read the policy had favourable perception regarding allowing persons with HIV to

continue working or studying. A few AS (13.9%), NS (23.4%) and students (30.9%) had ever received HIV counselling and testing on campus. Other HAP .related activities participated in by respondents included training (AS--88.9%; NS--44.6%; students-68.1%) and sessions of HIV and AIDS orientation for fresh students (54.0%). Respondents' knowledge of HAP was not significantly related to their participation in HIV-related activities. Some KIs were aware of the HAP and majority had not read it. Inadequate collaboration among stakeholders was a perceived major barrier to the policy implementation.

Respondents' knowledge of the HIV and AIDS policy was not adequate among the three groups while the perception of the policy was most unfavourable among students. Access to copies of the policy among staff and students and public enlightenment programmes are recommended to address the situation.

Keywords: HIV and AIDS Policy, HIV prevention, HIV-related activities

Word count: 496

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ACRONYMS

AAU	Association of African Universities
ACU	Association of Commonwealth Universities
ADEA	Association for the Development of Education in Africa
AWSE	African Women in Science and Engineering
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
CEHAIN	Centre for HIV/AIDS Intervention in Nigeria
CHGA	Commission for HIV and Governance in Africa
CUAHA	Churches united against HIV and AIDS in Eastern and Southern Africa
EDC	Education Development Centre
FGN	Federal Government of Nigeria
FMoE	Federal Ministry of Education
FMoL&P	Federal Ministry of Labour and Productivity
HIV	Human immunodeficiency virus
HEAIDS	Higher Education HIV/AIDS Programmes
HESA	Higher Education South Africa
IEC	Information Education and Communication
IFC	International Finance Cooperation
IIEP	International Institute for Educational Planning
ILO	International Labour Organisation
IOE	International Organisation of Employers
ITPC	International Treatment Preparedness Coalition
KFF	Kaiser Family Foundation
KIIs	Key Informant Interviews
KNUST	Kwame Nkurumah University of Science and Technology
OECD	Organisation for Economic Co-operation and Development
PABA	People Affected by AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV and AIDS
NACA	National Action Committee on AIDS
NACZ	National AIDS Council Zimbabwe

NGOs	Non-governmental organizations
NEACA	National Expert Advisory Committee on AIDS
NCDDR	National Center for the Dissemination of Disability Research
NIH	National Institute of Health
NUSTZ	National University of Science and Technology Zimbabwe
REACH	Research Alliance to Combat HIV/AIDS
SACA	State Action Committees on AIDS/State AIDS Control Agencies
SADC	Southern Africa Development Conference
SADE	South African Department of Education
SADH	South African Department of Health
SARUA	Southern African Regional Universities Association
SIDA	Swedish International Development Agency
SMEs	Small and medium-sized enterprises
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and cultural Organisation
UNDP	United Nations Development Group - UNDP
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNPF	United Nations Population Fund - UNPF
USAID	US Agency for International Development
VCT	Voluntary Counselling and Testing
WGHE	Working Group on Higher Education
WHO	World Health Organisation
YFC	Youth Friendly Centre

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CHAPTER ONE

INTRODUCTION

1.1. Background Information

AIDS caused by the HIV is one of the leading causes of death in Africa (KFF, 2013; Timko, 2010; Bakilana, Bundy, Brown and Fredriksen, 2005; Otaala, 2003). The disease condition constitutes a major barrier to economic and social development (UNESCO, 2006a; Ndongko and Oladepo, 2003; Patel, Buss and Watson, 2003). The pandemic is one of the most serious threats to global progress (UNESCO, 2008a) affecting key sectors of the economy. These sectors are health (Dageid, Seidumedi and Ducken, 2009), education (Sibiya, 2008; Ambe-Uva, 2007), agriculture (Parker, Jacobsen and Kanwa, 2009; Bollinger, Stover and Nwaorgu, 1999) and industry in both low and high prevalence settings thereby placing obstacles on human development (FMoL&P, 2005; Patel et al 2003). The pandemic disproportionally affects people during their most productive years (WHO/UNAIDS/UNICEF, 2011). For instance, more than 90% of HIV infections have been reported in the most productive age group of 15-49 years (IOE/PAEC, 2005; Dibua, 2009; ILO, 2002). This has great implications on the economic and social value of contemporary society (Hannan, 2002). Therefore workplace health promotion is very essential in the promotion of the health of the public (WHO, 2010; Goetzel, Roemer, Liss-Levinson and Sarnoly, 2008).

The CHGA/ILO, (2004) has stated that the impact of the HIV pandemic cuts across all sectors of the economy and all areas of social life. The workplace, which include schools, hospitals, industries and marketplaces is one of the priority settings for health promotion in the 21st century (WHO, 2005a). The educational sector particularly touches all cadres of the society (Bakilana, et al, 2005). The people in the educational sector especially teachers and students are vulnerable to HIV (Nzioka and Ramos, 2008). The non-teaching staff are also vulnerable (UNESCO, 2008a). The impact of HIV is therefore of great concern in the sector. This scourge of HIV is so severe on educational sector such that it affects demand, supply, quality, content, process, organization, planning and management of the system (UCN, 2006; UNAIDS/IOE/ILO, 2005).

The education sector has a critical role to play both in preventing HIV and in building capacity to respond to the pandemic. This it can do by promoting human rights, gender equality, knowledge and skills, the participation of young people and people living with HIV, and by reducing stigma and discrimination (UNESCO, 2006a). Workplace programmes have several benefits, they facilitate the sharing of information, influence attitudes and facilitate behavior change (Harrison, 2013). Beneficiaries of these programmes bring what they have learned at work home to their families and communities.

The need to prevent and curtail the pandemic of HIV has led to the development of national, organisational or institutional policies on HIV and AIDS (UNESCO, 2008b; ILO, 2005). These policies dwell on the rights and responsibilities of both the employers and the employees. There are institutional policies relating to comprehensive programs that combine peer education with care and support interventions, including provision of antiretroviral drugs and non discrimination of HIV positive workers (UNESCO, 2008b). According to ILO (2002), the development of a workplace policy is the single most effective and important action an institution can initiate in the fight against HIV. Workplace policy provides the framework for action to reduce the spread of HIV and manage its impact (NACZ, 2010). The policy therefore provides a clear statement about non-discrimination (ILO, 2005) and ensures consistency with appropriate national laws (Bickel, Corley, Hamilton, and Mazzone, 2005). It also lays down a standard of behaviour for all employees (whether infected or not) and give guidance to supervisors and managers. The institutional policy according to ILO (2005) helps employees living with HIV to understand what support and care they will receive, thus motivating other staff to come forward for voluntary testing (NACZ, 2010). The spread of the virus is also curtailed through prevention programmes as well as providing an enterprise in planning for HIV and managing its impact.

Policies are specific and implied statements of organizations and governments concerning their goals and objectives as well as the means by which they intend to achieve such goals and objectives (Aminu, Tella and Mbaya, 2012). They are a set of decisions which are oriented towards a long-term purpose or to a particular problem, not just an ad-hoc

intervention. Torjman (2005) stated that a public policy is a deliberate and careful decision that provides guidance for addressing selected public concerns and that it represents the end result of a decision as to how best to achieve a specific objective. Public policy seeks to achieve a desired goal that is considered to be in the best interest of all members of society (Mobility Foundation, 2013; Smith, 2003). One of the action areas of health promotion is building healthy public policy (Kumar and Preetha, 2012; WHO, 2009). Health promotion thus goes beyond health care (WHO, 2009; WHO, 2005a). It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health (Krech, 2011; Intachol, 2007).

Implementation is crucial to effectiveness, efficiency and consistency of a public policy. A plan that may be excellent on paper could end up being very different from its intent if not properly implemented (Torjman, 2005). Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of overcoming them (Krech, 2011; Kessler and Renggli, 2011). In the case of HIV and AIDS control, the central assumption according to Ennosho and Tenuche (2008) is that the disease cannot be successfully tackled in the absence of policy and programmes. This is particularly at the sectoral levels of which the education sub-sector is an example. They also stated that the development of policy and programmes including commitment to their implementation are required in order to reduce the impact of within each of the sectors/sub-sectors as well as in the society at large. Strategic plans that are costed and funded are needed to implement, enforce, and monitor institutional policies (University of Nairobi, 2003). These plans therefore should be understood and used at all levels (SARUA, 2005).

The ILO had been spearheading policies to guide workplace activities in the education sector (USAID, 2008). In Nigeria, the National Health Policy identifies the adoption of measures to prevent the spread of HIV and promotes reproductive health (FMoE/FGN, 2005). Recognizing that the worker is the most important factor in production, the FMoL&P in collaboration with its social partners, development partners, NGOs, PLWHA, developed and produced a policy. This was aimed at providing a guide for the prevention of HIV in the workplace (FMoL&P, 2005). The National Workplace Policy commits the stakeholders in

the workplace to take actions based on laid down minimum standard of practice for employers and workers. The policy also gives guidance on implementation of the standards and assists the enterprise to put in place a workplace response to HIV and AIDS and thus reduce its impact in the workplace. The National Workplace Policy is rights-based and premised on the ILO Code of Practice in the world of work as well as the Nigeria National Policy on HIV/AIDS. It provides guidelines for government, employers, workers and other stakeholders in the workplace.

Universities as workplaces and learning institutions are particularly concerned with responding to the scourge of HIV and AIDS. It is also because they are part of the larger community (SARUA, 2008). In 2007, the Ministry of Education in Nigeria held a two day consultative meeting in collaboration with the NACA. The meeting appraised the state of national response to the disease in the tertiary institutions. The general assessment of the state of response of stakeholders to the disease in the tertiary education sector has been adjudged to be below average despite the fact that the prevalence rate of HIV in Nigeria was then about 4.4% (AVERT, 2008; Ezekwesili, 2007). According to Ezekwesili, the HIV prevalence among the youth far outstrips the stated prevalence in some cities in the country. The conclusion at the consultative meeting included that an policy be developed by every institution and that the process should be guided by the National Policy Framework to fashion out policies for protecting HIV positive staff and students and PABA. It was recommended that tertiary institutions should establish HIV Research Centers and integrate issues into the General Studies courses and other relevant courses at undergraduate and post graduate levels. Heads of tertiary institutions were saddled with the responsibility of ensuring cordial students-management relationships with a view of creating an enabling environment for effective programme implementation.

Having documented that one university from Southern Africa has reported spending 10% of its recurrent budget on AIDS-related expenses such as funerals, death benefits and health care (ACU, 2001; Saint, 2004), the ACU observed that practical financial reasons should motivate institutional managers to recognize and tackle the threat of HIV and AIDS (Gobind and Ukpere, 2014). The development of HIV and AIDS policy by tertiary institutions was

addressed and substantially boosted by the 'Tertiary Institutions Against AIDS' conference, held on 1 October 1999. This came after the ACU was challenged to take heed of and respond to the impact of the HIV and AIDS pandemic on the universities in southern Africa and elsewhere in Africa at a meeting in London in 1998.

Later on, the AAU also called for the development of institutional HIV and AIDS in higher institutions in Africa as part of their response to the pandemic and African Universities have started responding (Inkoom, 2007). The University of Ibadan (UI) has developed its policy to form part of the national response to fight the pandemic. There is the need to appraise the effect of the UI HIV and AIDS policy with special reference to the determination of knowledge and perceptions of staff and students level relating to the policy as well as their participation in the its related activities. It is this need that largely constitutes the focus of this study.

1.2. Statement of the problem

The global epidemic of AIDS has caused widespread concern because of its associated high morbidity and mortality rates as well as the difficulty involved in its control (Tan, Lin, Wan, Luo, Luo and Wu, 2007). Globally, there was an estimated 33 million people living with HIV in 2007 (UNAIDS, 2008). Ninety percent of the 40 million people who are living with were aged 15 – 49 years (UNAIDS, 2012a) and were in their productive and reproductive ages (Fobil and Soyiri, 2006; ILO 2001). The ILO has estimated that by 2020 HIV will be expected to cause a 10% to 30% reduction in the labour force in high-prevalence countries. Nigeria qualifies as one of such countries with adult seroprevalence of 3.6% in 2010 (UNAIDS, 2011) to 3.4% in 2012 (FMoH, 2014; FMoH, 2013). Nigeria has the second-largest number of people living with HIV globally (WHO/UNAIDS/UNICEF 2011; USAID, 2011). Nigeria is thus classified as having a generalized epidemic (SARUA, 2008).

The effects of HIV and AIDS go beyond the simple calculation of labour losses and have deeper implications for the structure and functioning of families (FAO/UNAIDS, 2003). It has social, economic and psychological impacts on members of the University community. (SARUA, 2008). It can lead to a depleted pool of staff and students (Phuswana-Mafuya and

Peltzer, 2005). This ultimately reduce capacity to work and study to cause a fall in Gross Domestic Product (GDP) as well as a decline of quality education. Suffice to say that it has been documented that students in tertiary institutions generally still engage in risky sexual behaviour (Owuamanam, Ogunsanmi and Osakinle, 2008). Available data indicate that the prevalence rate of HIV in the educational subsector which accomodate persons between 15 and 45 years old who are presumably the most vulnerable subgroup in society is always higher than in the general population in Africa (Owuamanam et al, 2008). It has been documented that HIV prevalence of the Nigerian educational sector is between 6.5 per cent and 6.8 per cent in contrast to 4.4 per cent in the general population according to Ohiri-Anichi and Odukoya, (2004).

In recent years, there has been a proliferation of workplace HIV programmes throughout the world. Some of these programmes look very impressive on paper and they are launched with great promise but the reality is that very few workplaces have implemented well coordinated HIV and AIDS interventions (Ndanibuki, McCretton, Rider, Gichuru and Wildish, 2006; Zuccarini, 2005). According to Crewe and Nzioka (2009), for tertiary institutions to respond effectively to the pandemic, they need to develop institutional policies that establish appropriate internal programmes for mainstreaming into institutional life. The provisions of such a developed policy have to be communicated to all stakeholders so as to be well informed of their rights, roles and responsibilities in controlling it (Stellenbosch University, 2011). This requires that HIV education should be incorporated into academic and co-curricular programmes of their institutions (Crewe and Nzioka, 2009).

Institutional policies are critical to addressing the impact of HIV on students, teaching and non-teaching staff of any institution to ensure prevention and mitigation of HIV (UNESCO, (2006b; Rembe, 2006). The need has therefore arisen for complete ownership and commitment of the policy and programmes not only by the leadership but the entire population of students and staff of the University (SARUA, 2006). This will bring about effective implementation of the response strategies.

As part of the commitment to prevent and control HIV on campus, the University of Ibadan has formulated its policy targeted at members of its community. The level of awareness and

knowledge of members of the community relating to the policy has not however been systematically explored. There has not been an appraisal of the effect of the policy needed for its reforms since it was formulated and published in the year 2008. In addition, there is a dearth of information about members of the community's knowledge, perceptions of the policy and participation in HIV prevention and control activities. Tolman (2005) has opined that ideally, all policies and programmes should continually be assessed and corrected or modified. This study is therefore designed to assess the awareness as well as determine the knowledge, perception and practices of the students and staff of the University of Ibadan relating to the provisions of the formulated policy.

1.3. Justification of the study

Given the very little available literature on knowledge and perceptions of HIV Policies and Programmes in higher educational institutions, it is envisaged that this study has the potential in contributing to the body of knowledge regarding the alignment of HIV and AIDS policies and programmes to the core educational response strategy.

The findings of this study will be useful in revealing the factors which are influencing the implementation of the policy. The findings of this study will constitute a data bank for evidence-based actions and reforms aimed at modifying the policy if the need arises.

1.4. Research Questions

1. What is the level of awareness of the staff and students of University of Ibadan on the institutional HIV and AIDS policy?
2. What is the level of awareness of staff and students to specific HIV control activities within the University?
3. What is the level of knowledge of staff and students of University of Ibadan on the provisions of the HIV and AIDS policy?
4. What are the perceptions of both staff and students of the institution regarding the provisions of the UI HIV and AIDS policy?
5. What are the stakeholders perceived challenges to the implementation of UI HIV and AIDS policy?

6. What is the level of participation of staff and students of University of Ibadan in HIV-related activities in the University ?
7. What are the contributions of the key stakeholders in the University relating to the implementation of the HIV and AIDS policy?

1.5. Broad Objective

The broad objective of this study was to investigate the level of awareness, knowledge and perceptions of the students and staff of the University of Ibadan relating to the provisions of the institution's HIV and AIDS policy and to determine the extent the policy influences related actions or programmes through their participation.

1.5.1 Specific Objectives

The specific objectives are to:

1. Assess the level of awareness of staff and students of University of Ibadan concerning the HIV and AIDS policy;
2. Assess the awareness of staff and students relating to HIV prevention and control activities within the University.
3. Measure the knowledge of staff and students of the institution on the provisions of the institutional policy.
4. Identify the perceptions of both staff and students of the institution regarding the provisions of the policy;
5. Identify the stakeholders perceived challenges to the implementation of UI HIV and AIDS policy;
6. Determine the level of participation of staff and students of UI in HIV prevention activities related to the provisions of the policy
7. Identify the contributions of the key stakeholders in the University relating to the implementation of the HIV and AIDS Policy.

1.6. Operational definition of terms

a. Academic staff – Members of staff who are actively involved in the teaching of students and conduct of research in the University.

b. Health Personnel – Men and women working as senior members of staff at University Health Service and other facilities targeted at the youth within the campus; who are in involved in HIV programmes and other related activities on campus.

c. Key Informants – All the persons who are important in the decisions that concern the welfare of students and members of staff in the University of Ibadan who can also say much about the group they represent.

d. Non-teaching staff – Members of staff of the university who are involved in other duties aside from teaching of students for academic work. The duties include administrative, secretarial, accounting, technical, laboratory technology, sports, health provision, support and domestic functions.

e. Student leaders – Any University students who serve in leadership position for students on campus either at students' Union or Hall Chairman level.

f. University Administrators – Employees of the University who are academics but have responsibilities for the maintenance and supervision of the institution in issues that concern staff, students, research, funds, welfare, safety and security of all in the institution.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction and conceptual clarifications

2.1.1. HIV infection has now spread to every country in the world although the number of new infections have fallen by 19% (UNAIDS, 2010a). Statistics show that 34.0 million people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions (UNAIDS, 2012).

Globally, 85% of HIV transmission is through heterosexual intercourse (Painter, Herbst, Diallo and White, 2014; Roberts, 2008). In the United States of America, approximately one-third of new diagnoses appear to be related to heterosexual transmission (Sharma, 2015, UNAIDS, 2012a). Male-to-male sexual contact still accounts for more than half of new diagnoses in the U.S. Intravenous drug use contributes to the remaining cases. Infections in women are also increasing. Worldwide, women represent half of all adults living with HIV and AIDS (UNAIDS, 2012b). Over the past two decades there has been an increase in the proportion of women living with HIV/AIDS in 57the United States. (Squires, Hodder, Feinberg, Bridge, Abrams, Storfer, and Aberg, 2011).

Sub-Saharan Africa still bears a large share of the global HIV burden (Oluwabamide, 2014). The Sub-Saharan Africa provides home to about 12% of the world's population but has two thirds of the HIV and AIDS burden globally (KFF, 2013; UNAIDS, 2012b; Vitoria, Granich, Gilks, Gunneberg, Hosseini, Were, Raviglione, and De Cock, 2009). At least 1-2 people are infected with HIV every minute in Sub-Saharan Africa (Adeyipo, 2007). There was an apparent drop in the figure due to advances in the methodology of estimation of HIV epidemics, which resulted in adjustments to the data from a number of countries, particularly India, and countries in sub-Saharan countries of which Nigeria is one (UNAIDS/WHO, 2009). Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. The largest epidemics in sub-Saharan Africa—Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe have either stabilized or are showing signs of decline. The estimated 1.3 million [1.1 million–1.5 million] people

who died of HIV related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global total of 1.8 million [1.6 million–2.0 million] deaths attributable to the epidemic. (WHO/UNAIDS/UNICEF, 2011; Khamsawanle, 2010; UNAIDS 2010b).

2.1.2. Situation of HIV in Nigeria

Nigeria is Africa's largest nation, with up to 158 million people; it is home to 47% percent of Africa's population (The World Bank, 2013). It has the second-largest number of people living with HIV in the world and the highest number of HIV infected adults in West Africa (USAID, 2012; NACA, 2011). Although Nigeria's infection rate is lower than that of some of its neighbors, its large population translates into a higher number of infections. Since recording her first case of AIDS in 1986, Nigeria's HIV prevalence rate increased steadily from 1.8% in 1991 to 5.8% in 2001 (Ebeniro, 2010, Entonu and Agwale, 2007) but with a gradual decline to 5.0% in 2003 and 4.4% in 2005 (FRN, 2008). According to Sufian (2005), low prevalence does not equate to low risk or low priority. Although the prevalence rate appears low, Nigeria ranks second in terms of the actual number of people infected with HIV after South Africa (Ploch, 2013; NACA, 2012). 3.6 million Nigerians are estimated to be living with HIV (UNAIDS, 2013) and life expectancy has been reduced from 53.8 years for women and 52.6 years for men in 1991 to 46 years for women and 47years for men in 2007 (Odoemelam and Nwachukwu 2011; Yahaya, Jimoh, and Balogun, 2010; AVERT, 2008) which is not unconnected with HIV/AIDS pandemic (Onorkerhoraye, Matlcka-Tyndale and the HP4RY Team, 2012; Pennap, Chaanda and Ezirike, 2011). The country accounts for 11 percent of all infections worldwide (UNAIDS, 2006).

However, the WHO put the adult prevalence rate at between 3.6% to 8.0% and that more women are more affected than men with a female ratio of 1.3:1 (WHO, 2004) and a median prevalence of 4.1% in pregnant women. On the other hand, the fall in prevalence from 2001 to 2005 cannot be said to be a true decline as review of trends in 81 sites consistently used from 2001 to 2005, done by WHO, showed that 77% did not show any declining trends (AVERT, 2011).

2.2. Burden of HIV among workers and students in educational Industries

HIV is having a devastating effect on the world of work and the impact of the epidemic is being felt at all levels (ILO, 2008). Pennap, Chaanda and Ezinke (2011) stated that the International Labour Organization estimated in 2005 that 2 million workers globally were unable to work due to HIV and AIDS and related illnesses and that this figure is expected to double to 4 million by 2015. The impact of HIV on the education sector in Africa is also of great concern. The sector in many countries is already severely negatively impacted by HIV (Kelly, Desmond and Cohen, 2006; Wirak, 2005; Coombe, 2002). This is because, the extent to which schools in general, and tertiary institutions in particular, are able to continue functioning would affect the recovery of African societies from the pandemic (AAU, 2007a). Schools are both educational environments and workplaces that employ thousands of people (EDC, 2012). Higher education institutions educate and train the most sexually active young adults who are most vulnerable to contracting HIV due to their risky social and sexual behavior especially as they live in residential campus settings (Chetty, 2003).

Institutions of higher education over the past decade have become increasingly aware of the negative impact of the HIV and AIDS epidemic on their core business areas of teaching and learning, research and community engagement (HEAIDS, 2012), hence the need to respond forcefully and decisively. As the number of HIV infection increases, the burden also increases considerably. Although the United Nations AIDS Department has reported that the HIV prevalence is leveling off and there is a fall in the number of new infections globally (UNAIDS/WHO, 2009), it remains one of the leading obstacles to health and development for poor countries. This is especially true in the educational sector (IIEP/UNESCO, 2002). A national survey found in South Africa revealed that within the public and private health care system, 28 % of patients seeking health care services were HIV positive. Almost half of the patients in public hospitals, and an alarming 15.7 % of the health care workers were HIV positive (Dageid et al, 2009). These health institutions are training facilities of higher institutions that train medical, nursing and other allied health professionals (Lui, Musson, Kishore and Ram, 2010).

Statistics show that the most affected group of people is the adolescents, most of whom are students (Yahaya, 2009). This could be attributed to the social and physical developments which they experience (Adeyipo, 2007). In general, due to the very nature of the students because of their age, ambition to experience new events, location of the university and other factors, students of higher education are at risk of HIV and AIDS (Regassa and Kedir, 2011). At least 12% of South African education administrative staff and educators are said to be infected by HIV (Bank, 2002) as evident by the mortality rates of female educators between the ages of 30 and 34 increasing by 70% between 1999 and 2000 (Theron, 2005).

2.2.1. Physiological effects

Kelly, Desmond and Cohen, (2006) concluded that the most immediate impacts of HIV lie in the infection, illness or death of individuals. When infection becomes widespread in a community, it constitutes an epidemic. HIV infection, the likely ensuing illnesses and the possibility of a premature and distressing death have immediate and devastating consequences for the person concerned and for his/her immediate family. Opportunistic infections become burdensome to care givers (Commonwealth of Learning, 2005). These often result in death. Also, as a health concern per se, HIV is linked with other infectious diseases, such as tuberculosis and sexually transmitted diseases. As a result, the prevalence of these diseases has increased in recent years, adding greatly to the strain on health care systems (The ITPC, 2008).

In some African countries, it was estimated that by 2010 two thirds of educators would be substitute educators for those who would have died from AIDS (Development Gateway, 2003). Unfortunately, the problems children face as a result of HIV and AIDS would have started long before their parents die, as they live with sick relatives in households that already have dwindled resources. Children are left emotionally and physically vulnerable by the illness or death of one or both parents (Doku, 2009).

2.2.2 Psychological effects

According to Coombe, (2002), HIV/AIDS is impacting on the emotional status of educators and young people bringing about low morale of teachers where impact is high and teachers

who have generally resisted voluntary testing and counselling may be uncertain and anxious about their own HIV and AIDS status. Both educators and learners have difficulty concentrating in the face of illness, death, mourning, and dislocation (Chinsembu, Kasanda, and Shimwooshili-Shaimemanya, 2011; Rena, 2007). Learners observe HIV positive educators' health decline, absenteeism and their eventual death which is saddening. Many learners affected by the presence of HIV and AIDS ,also have a widespread sense of anxiety, confusion and insecurity (Chinsembu et al, 2011; Ebersohn and Eloff, 2001).

Rens, Meyer, Kwatubana and Modisane (2012) and Gachuhi (1999) stated that children who have lost parents are more likely to be removed from school and pulled into the informal economy to supplement lost income. This is especially the case for girls. A study in Uganda on the impact of HIV and AIDS in higher institutions of learning however revealed that lack of information on the occurrence of AIDS-related illnesses, absenteeism or death among staff and students has perpetuated the silence that surrounds within higher education institutions. This has created a misplaced view that do not constitute a serious problem. It has also resulted in inadequate institutional responses to HIV (Katahoire, Kinyanjui, and Caillods, 2008). Evidence suggests that AIDS orphans are more likely to die from preventable disease because of the mistaken belief that their illness must be due to AIDS, and that medial help is thus pointless (Carr-Hill, 2007; UNICEF, 2004) which may result into low esteem and depression.

For infected educators, frequent absence happens and they have approximately 6 months of professional time before developing full-blown AIDS (Bank, 2002; Goliber, 2000). Many educators choose to relocate once they are visibly ill, or simply disappear, leaving classes without educators and affecting the education of school children (Theron, 2005). Absenteeism is not restricted to infected educators: educators who have infected family members have higher rates of absenteeism too as they are engaged in caring for ill relatives or burying them (ADEA, 2003; Fredriksson and Kanabus, 2002). On the other hand, healthy educators prefer to avoid densely populated AIDS infected areas, increasing educator mobility and decreasing educator learner ratios. Temporary educators without adequate

experience or scanty training may then be lured. This will do havoc to the quality of education (Theron, 2005; Coombe, 2000).

The implications for remaining educators are also bleak. Healthy educators will have to contend with augmented workloads and heightened responsibility (Theron, 2005). Their psychological wellness will be taxed as work demands escalate, and as they witness HIV positive colleagues and/or relatives die (Shunmugam, 2012; Bmaf, 2012). The stigma of AIDS causes social isolation which heightens trauma and decreases effective teaching (Shumnugan, 2012; Bank, 2002). Students may face formal suspension by the system or be pressured to leave school if they have not already been pushed or dropped out (Carr-Hill, Katabaro, Katahoire and Qulai, 2002). Moime (2009) and Lee (2007) emphasised that the school itself may also be affected by the psychological effects of having infection, illness and death in its midst. There is likely to be discrimination, ostracism and isolation in the classroom and school of those students and teachers who are infected or ill or are members of affected families (Kwadwo, 2012). Teachers may face the suspension of social and health benefits and/or dismissal from the system (Shaeffer, 2013).

The stigma surrounding AIDS is complex (Caillods, Kelly and Toumier, 2009). It is primarily caused by inadequate knowledge of the disease and fear of death (Mnyanda, 2006). Stigma and prejudice lead to social isolation (Tomaszewski, 2012) and in addition to stigma, orphans have to overcome many barriers if they are to continue schooling (Johnson, 2011). A contemporary study of African universities noted an "... overwhelming atmosphere of ignorance, secrecy, denial and fear of stigmatization and discrimination in relation to AIDS" (Bank, 2002).

2.2.3. Socioeconomic effect

The total estimated loss to the educational system arising from HIV is enormous (Drimie, 2002) up to US$110 million in Mozambique (Government of the Republic of Mozambique, 2001). This represents additional costs to the system of 6.9% just due to the condition. It should be noted that this is an underestimate of the actual costs because some costs cannot be quantified based on available data. HIV and AIDS will continue to cause fundamental social and economic changes in the affected countries that will affect educational

opportunities and the demand for labour (Lisk, 2002). It causes illness and death among adults in the most productive age groups.

HIV will significantly slow down the growth of the labour force and will create labour shortages in several sectors including the education sector (Azuh, Osabuohien, Nwaubani, and Ugwuanyi, 2014; Carr-Hill et al, 2002). The loss of women's labour in the home and in agriculture will create critical deficits in food supplies. (Carr-Hill et al, 2002). The pandemic will continue to have a profound impact on families and communities, on the availability of social services, access to health services and the rate of poverty at the household level (International Federation of Social Workers, 2012). Children will be the most affected since they will be required to take the place of adults in the labour market, particularly in households that are highly dependent on subsistence farming (UNESCO 2006b; FMoE, 2006). Inkoom (2007) submitted that the education sector in general is being hit several-fold by the HIV pandemic, majorly by threatening the supply, demand and quality of education at the very moment Africa is striving to achieve Education for All (EFA) by the year 2015.

Kelly, Desmond and Cohen (2006) listed economic effects of HIV on the education sector as reduced labour supply in education with a different age and gender composition and loss of skilled and experienced staff of all categories including, professional and manual workers across the education system. Others are disruption of educational activities and increased costs for the education system due to increased levels of staff absenteeism and morbidity and early retirement of experienced staff (Booysen, Geldenhuys, and Marinkov, 2003) stigmatization and discrimination against staff with HIV or AIDS and losses of staff performance. As a result, effects on system performance and on staff morale show increased labour costs for the education system as a whole due to reduced labour productivity (Tawfik and Kinoti, 2006), and higher costs due to healthcare expenditure, absenteeism and covering for workers that are sick, funeral costs, pension and other termination payments etc (IFC, 2002).

The Zimbabwean National University of Science and Technology (2005) summarized the economic effects as direct which means both academic and non-academic staff and students

are affected by HIV and AIDS. This lead to loss of trained /skilled, competent personnel especially those who would have served the university for a long time. Their skills which are an integral part of the development of the institution are thus lost. It is necessary for the institution to try as much as possible to ensure that affected individuals are able to continue working for as long as possible before succumbing to the debilitating effects of the illness.

The indirect impacts are during the primary HIV infection period when affected members of staff and students tend to be off-sick, on and off, for several months (Reinhart, Given, Pellick and Bemis, 2008). Their performance while at work or in their studies is grossly compromised by the illness. (Suarez, Givah, Storey, and Lotsch, 2008). Without supportive services their condition deteriorates and their productivity becomes minimal. Usually the affected individuals are breadwinners hence the implications on their families makes it even more difficult for them to work competently (Ahmad, 2012). Eventually they succumb to AIDS, at the terminal stage and go off work permanently until their death (Cichocki, 2013).

In Nigeria, Universities have come under serious attack of the pandemic (Ambe-Uva, 2007) and this undermines the very institutions that are designed to protect communities (Chikaire, Ojuegbuchulam, and Osuagwu, 2010) including educational institutions. The World Education Forum, held in Dakar in April 2000, noted that a key objective of any international strategy must be to realize the enormous potential that the education system offers as a vehicle to help reduce the incidence of HIV and AIDS and to alleviate its impact on society (Komunda, 2007).

2.1. Policy Concept

A policy is defined according to Simmons (2012) as a definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions or a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body. A policy is also a definite goal, course or method of action to guide and determine present and future decisions (Government of Canada, 2013). Policies are a set of rules to administer, manage, and control access to network resources (Westerinen, 2003). Policies are not just a decision but a

product of negotiations between those concerned (Stahl, Rutten, Nutbeam and Kannas, 2002).

Torjman (2005) explains that there are two main categories of policy. *Substantive* legislation and policy leading to programmes such as income security, childcare services, and employment initiatives, while *administrative* policy constitutes the gathering and evaluation of information in society. Both substantive and administrative policy can be either vertical or horizontal. *Vertical* policy is the traditional process within a single organizational structure or governmental department, where a broad framework policy is created at the head office to guide subsequent decisions down the chain to those implementing policy in the creation of programmes. *Horizontal* or integrated policy is developed and implemented across two or more departments at a similar hierarchical position facilitating their co-ordination and co-operation to better address complex matters that are beyond the scope of a single department or jurisdiction.

Policies must be formed based on evidence as policy formulation is a central function of government (Brownson, Chriqui and Stamatakis, 2009) and the quality of the policies therefore depends on the capacity of government to manage policy-making processes (Sutcliffe and Court, 2005). Without evidence, policy makers would have to rely on intuition, ideology or conventional wisdom and theories (Van Bavel, Herrmann, Esposito, and Proestakis, 2013). Many policies developed in isolation from the available evidence, or initiated and continued in the absence of monitoring and formal evaluation of impact and effectiveness, may well be ineffective in meeting their primary or secondary policy objectives (Gluckman, 2011). Policy decisions emerging from such a process are likely to set off a chain of unanticipated actions which, in turn can seriously go astray (Banks, 2009). Also, according to NCDDR (2009), policies serve as a foundation for the implementation of procedures and often address areas that are regulated by legal requirements.

The importance of a policy in HIV mitigation according to James, Dipo-Salami, Salali, and Nairesiae, (2009) is for ensuring fairness and consistency in how individual staff are treated, making budgeting easier and enhancing continuity. It also gives room for accountability for funds spent, raises awareness about HIV, addressing gender issues and demonstrating care

for staff welfare. In summary, according to the authors, it gives clarity to managers and employees on what to do.

2.4. Response to HIV

The ILO has developed a code of practice in consultation with its tripartite constituents that is, governments, employers, labour. The International Labour Congress has proposed fundamental principles for policy development and practical guidelines from which concrete responses can be developed (ILO, 2009a). This is aimed at enterprise, community and national levels in the key areas of prevention of HIV, management and mitigation of the impact of HIV in the workplace, care and support of workers infected and affected and elimination of stigma and discrimination on the basis of real or perceived HIV status.

Similarly, the UNAIDS has put forward a set of guiding principles and leadership commitments that together are meant to form the basis for successful responses to the epidemic (UNAIDS, 2010a). The Global Strategy Framework is guided by fundamental principles one of which says is the role of national governments, working with civil society, to provide leadership, means and co-ordination for national and international efforts to respond to country and community needs. Secondly, in countries around the world, support for the active engagement of people living with and affected by HIV/AIDS is central to the response. Thirdly, gender inequalities fuelling the epidemic must be explicitly addressed.

The education system ought to be strongly involved in actions against the epidemic (Wirak, 2003). This is because the education system in all countries plays a significant role impacting on people behaviour, norms and values directly and indirectly, institutionally and otherwise, (Wirak, 2003). The important role of education has been highlighted in the need for cross-sector and holistic planning and action against (Carr-Hill, Katabaro, Katahoire and Qulai, 2002). Particularly helpful is the Global Strategy Framework's recognition of the interrelationship of the basic dynamics of the epidemic, and hence that an expanded response to the epidemic is one that simultaneously acts on reducing risk, reducing vulnerability and educing impact of the epidemic.

According to Government of Jamaica (2005), important actions, principles and norms that will be highly relevant for any anti-HIV strategy and plan need to be developed in the education sector. These include financial resources needed for sustainability of the plans, strategies that indicate how and when prevention and care are mainstreamed into existing planning and development efforts (Republic of Namibia, 2008, UNAIDS/UNDP, 2005). Others of particular importance are strategies to reduce the stigma associated with HIV and AIDS (Mahajan, Sayles, Patel, Remien, Ortiz, Szekeres and Coates, 2008) while particular emphasis is needed to empower local communities, schools and districts (Pervilhac, 2003). Life-skills education approaches for in-school and out-of school youth, which are free of harmful gender stereotypes and include sexuality education and the promotion of responsible sexual behavior are also paramount to meet the HIV/AIDS-related needs of girls and women. Partnerships (Szekeres, Coates and Ehrhardt, 2008, CIDA, 2004), human resources (SADC, 2012) and institutional capacities (Piot, 2002) are required to properly address the pandemic.

2.4.1. Response to HIV in the workplace

Workplace HIV responses rely on two inter-related pillars which are policy development, and the actual programme (SAfAIDS/ILO 2010). Universally, there had been responses to the HIV epidemic although the World Economic Forum (2006) reported that globally, few firms have developed responses to HIV and AIDS with 6% having formal written policies and 14% having informal programmes. The reports further revealed that facilitating access to AIDS treatment and care is part of the response. According to Kumar, Chaudhury and Vahidev (1997), workplace programmes traditionally focused on raising awareness about HIV and on preventing transmission (UNAIDS, 2012a).

However in the Nigerian political sphere, there has been more concerted and higher-level action than ever before. President Obasanjo of Nigeria in April, 2001 hosted a special summit of the Organization of African Unity in Nigeria to focus African leadership on the response to HIV and AIDS. This resulted in the Abuja Declaration on HIV and AIDS, Tuberculosis and Other Related Infectious Diseases, which called the AIDS situation a "state of emergency" facing the continent. Governments committed themselves to

allocating at least 15% of their national budgets to the health sector to assist in the fight against HIV/AIDS, tuberculosis and other related infectious diseases (Piot and Seck, 2001). This later led to the development of the National HIV policy and subsequently the National workplace policy on HIV and AIDS.

The goal of the National workplace policy on HIV of 2005 is to provide guidelines to government, employers, workers and other stakeholders about workers infected and affected by HIV and AIDS (FMoL&P, 2005). It was also formulated to identify strategies and programs for promoting and protecting the rights and dignity of workers as well as providing access to HIV and AIDS information and services for them. This will enable them take appropriate actions to protect themselves and mitigation of the impact of HIV and AIDS within the workplace. The objectives are to provide guidelines and policies to facilitate the establishment of workplace responses in all the formal and informal sectors as well as create an enabling environment and provide strategies for technical support for HIV and AIDS intervention in the workplace. Others are to improve the knowledge of workers on HIV, protect the right of the those affected by HIV and AIDS and facilitate review of appropriate laws and statues to incorporate HIV and AIDS issues.

Otaala (2003) opined that in each undertaking, policies are needed to guide the vision and goals of the enterprise before strategic planning and implementation are begun. In the area of HIV and AIDS, institutional policy development has been slow, particularly within tertiary institutions where AIDS is often viewed as a private matter. A well-conceived policy however, when translated into activities and fully implemented, will result in behavioural change and use scarce resources effectively (Hunter and Killoran, 2004). It also can lead to a drastic reduction in the sero-prevalence rate within each of the sectors, sub-sectors and institutions pave the way for implementation of policies related to improved care and treatment (Tawfik and Kinoti, 2006). Achieving the twin goals, however, will depend on the zeal and commitment of the leadership in the various sectors/institutions in society (Ennosho and Tenuche 2008). Therefore, every workplace policy should conform to international and national laws, policies and agreements. (Arya Mzuri, 2006).

Political response is a determinant of the effectiveness of other responses to HIV and AIDS as they can exert great influence on resource allocation to HIV and AIDS Programmes (Ndongko and Oladepo, 2003). Policies are developed in response to the HIV pandemic by the government of different countries as they recognize it to be a looming doom for the health of the citizens as well as for the economy. The implementation however, still faces challenges. Policies are implemented by creating policy awareness, capacity building, peer education, care and support of HIV positive workers and interventions designed to address concerns on stigma and discrimination (Esu-Williams, Motsepe, Pulerwitz and Stewart, 2005).

2.4.2. HIV Policies in the workplace

One of the health promotion action as declared in the Ottawa Charter of 1986 is developing healthy public policy. This also applies to HIV workplace Policy, which is rights based and premised on the ILO Code of Practice on HIV/AIDS (ILO, 2001) in the world of work and National Policy on HIV/AIDS (FGN, 2009; FGN, 2006). It provides guidelines for government, employers, workers and other stakeholders in the workplace. The policy identifies strategies and programmes for protecting the rights and dignity of workers infected or affected by the disease. It provides HIV and AIDS information and services to workers, prevention, impact mitigation, care and support within the workplace and reducing stigma and discrimination based on real or perceived HIV status.

The erstwhile Obasanjo administration adopted and implemented a proactive HIV and AIDS control policy after years of inaction by its predecessors. The effort of the Administration seems to have been paying off because there is now a heightened level of awareness on the aetiology and consequences of the disease in the population (NACA, 2011). In Nigeria, the public - government agencies that are responsible for the prevention and mitigation of HIV are NACA, SACA and Local Action Committee on HIV/AIDS (LACA). The NACA operates at the Federal level and the SACA exists at the State levels, while LACA functions at the grass-root administrative level (NACA, 2001). The NACA, SACA and LACA often work in the area of policy design, planning, funding, monitoring and evaluating projects supported by government and development partners, like UNAIDS, US President's

Emergency Plan for AIDS Relief (PEPFAR), USAID, Family Health International (GHAIN, 2008).

The ILO has recommended some key points which builds on and reinforces the ILO Code of practice of 2001. Key points which policy and decision makers should consider in the development of national policies and programmes on HIV and the workplace are:

1. The response to should be recognised as contributing to the realisation of human rights and fundamental freedom and gender equality for all, including workers, their families and their dependants.
2. Workers should not be subjected to HIV-related stigma and discrimination in any aspect of the employment relationship, including selection and recruitment and terms and conditions of employment. Measures should be in place to ensure the application of the principle of non-discrimination. HIV status alone should not be a ground for termination of employment, denial of access to a job or occupation, or a ground for a medical finding of lack of fitness for work. The promotion of equality of opportunity and treatment must include respect for workers' human rights, ensuring gender equality and the empowerment of women, and measures against violence and harassment in the workplace, empowerment of workers regardless of their sexual orientation, promotion and protection of reproductive health; and support for the confidentiality of workers' personal medical data.
3. Prevention programmes and strategies should be adapted to workplace and national situations, and be sensitive to gender, cultural, social and economic concerns. Programmes should include access to comprehensive prevention packages such as availability of supplies (e.g. condoms, post-exposure prophylaxis, and other harm reduction tools), accuracy of information, provision of comprehensive education to reduce risk of transmission, promotion of voluntary testing to know one's HIV status, and reduction of high-risk behaviors.
4. Workplaces should facilitate access to a broad range of HIV treatment, care and support services, including appropriate and effective prevention interventions, access to health care for workers and their dependants who are living with HIV, and

education or awareness interventions to facilitate workers' access to available services both within and outside the workplace.

5. Care and support services in the workplace should include measures of reasonable accommodation such as providing a worker living with HIV time off or working hours that are flexible to accommodate his/her needs to seek medical services, counseling, and other needs. Any kind of reasonable modification or adjustment to a job should enable a person living with HIV to have access to, or participate or advance in employment.
6. Workers should not be required to undergo compulsory testing and disclosure of their HIV status for purposes of recruitment and employment. Testing should be free from any forms of coercion and must be genuinely voluntary. For instance, workers should not be subjected to HIV testing unless they freely give their informed consent. Moreover, the confidentiality of the test results must be ensured.
7. Workplaces should be safe, healthy and protect workers from the risk of HIV transmission through appropriate measures to prevent workers' exposure to HIV at work. Measures include the adherence to universal precautions such as strict adherence to safe use of needles and syringes, prevention of accidents and hazards, and education and training on all modes of HIV transmission, emphasising that casual physical contact in the workplace cannot transmit HIV.
8. The vulnerability of children and young workers to HIV should be reduced by combating child labour and child trafficking, preventing sexual exploitation, and implementing protective measures for young people such as the inclusion of sexual and reproductive health education in programmes and services in the workplace.

The ILO 2001 Recommendations also provide guidance on the implementation and monitoring of workplace HIV policies and programmes (ILO, 2010a). It emphasises the need for putting such HIV workplace policies and programmes into action and campaigning against inequality and the need to mainstream gender and cultural concerns. Implementation and follow-up is done through informed consultations with relevant institutions and actors, including governments, employers' and workers' organisations, the health sector, networks of people living with HIV and the labour administration and judicial authorities. Provision

of easily accessible dispute resolution procedures to address violations of workers' rights such as breaches of privacy and confidentiality. Coordination and collaboration among the national AIDS authorities and relevant public and private entities are also advocated.

2.5. The response of educational sector to HIV and AIDS

Educational systems can play an important role in protecting the health of those who work within them and the students who learn and play there (AAU, 2010). .As HIV infection itself is not a barrier to recruitment or career advancement (International HIV/AIDS Alliance, 2004), policies within the education sector and workplace must therefore address the pandemic. HIV and AIDS are a systemic problem for the education sector and hence require a systemic response (Kelly, 2006).

The education facility is a risk environment for HIV as high-risk sexual activity between students or between students and others may occur there (Mutinta and Govender, 2012). This may happen at all levels of education, not just higher levels (Badcock-Walters and Whiteside, 2006). At the University of Nairobi, it was reported that there was pressure on female students by male students and faculty members to consent to sexual intercourse among both educators and students (Katahoire, 2004). Higher education institutions (HEIs) are potential breeding grounds for HIV infection due to the close physical proximity of a large number of young adults at their peak years of sexual activity and experimentation devoid of systematic supervision, combined with the availability of alcohol and perhaps drugs (Saint, Otaala, Chetty and Ojwando, 2004).

Key findings of the South African Educators Survey showed that there were HIV prevalence of 12.7% among educators, 3.9% among further education and training (FET) lecturers and 8.2% among third and fourth year teaching students (Rispel, Letlape and Metcalf, 2006). While university students seem to be generally aware of the existence of HIV and AIDS and to know the basic facts about its transmission, they do not seem to generally regard themselves as being seriously at risk of HIV infection (Katahoire, 2004). It was noted that the culture of campus life appeared to be ambivalent about or open to "sugar daddy" practices, sexual experimentation, prostitution on campus, unprotected casual sexual

intercourse, gender violence, multiple partners, and similar high-risk activities (Kelly, 2001)

The education sector has a critical role to play both in preventing HIV and in building capacity to respond. This is done by promoting human rights, gender equality, knowledge and skills, the participation of young people and people living with HIV, and by reducing stigma and discrimination (UNESCO, 2008h). In the light of this, the Federal Ministry of Education of Nigeria in 2005, responded by developing the National Policy on HIV in the education sector which also based its guiding principles on the recommendations of the ILO. The policy recognises it as a development and workplace issue as well as make important the non-stigma and non-discrimination in the recruitment, employment, admission and termination of staff and students. It also considered confidentiality of all HIV related information, gender sensitivity, equity and respect for fundamental human rights of the people. It also recognizes the multi ethnicity and cultural diversity of the country, places great attention to the people living with HIV and partnership with relevant organizations

2.6. The Response of Universities in other continents of the world to HIV and AIDS

AIDS was first recognized as a new disease in the United States when clinicians in New York, Los Angeles, and San Francisco began to see young homosexual men with *Pneumocystis carinii* (now *P. jirovecci*) pneumonia (PCP) and Kaposi's sarcoma (KS), unusual diseases for young adults not known to be immunosuppressed (Osmond, 2003). Over the years several strategies have been adopted in the response to the pandemic in the United States of America which includes the PEPFAR (Milbank Memorial Fund, 2004).

Previous studies with African American college students have reported that, like college students from other racial/ethnic minority groups, behaviors that can increase the risk of HIV acquisition and transmission such as multiple, congruent sex partners and inconsistent condom use do occur (Sutton, Hardnett, Wright, Wahi, Pathak, Warren-Jeanpiere, and Jones, 2001). They further stated that additional studies with college students and African Americans have shown that some young adults continue to participate in high-risk sexual behaviors even after previous exposure to general HIV educational messages. In view of this, the American College Health Association (ACHA), with the assistance of the American

Council on Education (ACE) and the CDC, has recommended that institutions not adopt blanket policies concerning students with AIDS or AIDS-Related Conditions (ARC). Instead, it suggests that the institution analyze and respond to each case as required by its own particular facts (Pace University, 2011). The ACHA has linked college health professionals throughout the United States forming a powerful, collaborative networking base. This unique synthesis of vision and knowledge, of practice and policy, guide and support health service, health programmes, and professional development in colleges and Universities.

The American Association of Community College (AACC) also stated that thorough policy, programmes and services are success factors for healthy campuses (Ottenritter and Barnett, 1998). It was reported by the AACC that more than half of the colleges have a nondiscrimination policy toward HIV-infected employees and students, but only 17 percent have a campus HIV task force or similar group as at then. The Pace University (USA) has adopted the recommendations of the Public Health Service in the response to HIV on its campus which includes education about HIV, the promotion of condom use in HIV prevention, universal precautions and health services regarding HIV (Pace University, 2011). The Syracuse University (USA) formulated its HIV and AIDS policy in 2005 and amended it in 2013 (Syracuse University, 2013). The policy emphasises that the University does not discriminate against individuals on the basis of diagnoses of HIV infection or AIDS and that knowledge of a person's HIV status should be treated in a confidential manner by all members of the University community.

The Syracuse University HIV policy also stated that no restrictions will be automatically placed on students, staff, or faculty who are known to have HIV infection in terms of their abilities to work, study, or take part in activities on campus. This policy is based on current scientific and medical information which indicates that persons with HIV infection do not necessarily pose a health risk to others in a campus setting. The University therefore urges that all members of the University become informed about the infection in order that each person may take precautions as appropriate. Although HIV testing is not mandatory, Health Services provides confidential testing for the University student population in accordance with the New York State Department of Health guidelines specific to the provisions of pre-

and post-test counseling and consent for testing. Information regarding other testing sites within the Syracuse community is available at the center for all members of the University community (Syracuse University, 2013). The policy is available in the students' handbook and on the University's website.

The Emporian State University (USA) stated the purpose of its HIV and AIDS policy as to prevent the further spread of the HIV to reduce fears and dispel myths, to protect the rights of persons with AIDS or HIV infection, and to create an informed and supportive university community (Emporian University, 2014). As a Catholic University, Seton Hall (USA) strives to enhance the well-being of all members of its community. The University is committed to providing an open forum for ongoing education on a broad range of topics, as well as appropriate counseling and pastoral support for those with special needs. (Seton Hall University, 1995). The University's HIV/AIDS policy was formulated in 1995 based on the suggested guidelines by the ACHA and CDC which covers non discrimination of persons within issues relating to admission and employment and access to facilities. Also, the policy emphasized voluntary HIV testing, confidentiality of HIV status, medical care and support care for affected individuals.

In the Caribbean the spread of the HIV virus leading to the dreaded disease of AIDS is second only to what is occurring in southern Africa, the epicentre of the malady. The social and economic implications are far reaching since the disease threatens to deprive the entire region of much of its youth population who are the heirs to the legacy of achievement over generations and of the meaningful development now demanded of those very youths. (Kelly, and Bain, 2003). According to the authors, Barbados and Jamaica have both developed HIV and AIDS resource materials for those with learning difficulties or special needs. Guyana has established a 'Youth Challenge and HIV and AIDS' programme that seeks to increase the level of information and knowledge on HIV and AIDS among 12 to 15 year-old youth through music, dance and the arts.

The University of West Indies' HIV and AIDS Response Programme (UWI HARP) is an accelerated institutional response to the epidemic across the entire University - on the campuses in Barbados, Jamaica and Trinidad and Tobago as well as in the extramural

centres scattered throughout the English-speaking Caribbean. A multidisciplinary group, UWI HARP is dedicated to using the expertise of the University to work with other committed partners in combating and mitigating the impact of HIV (University of West Indies, 2014). UWI HARP was established in August 2001 and consists of a multidisciplinary, cross-faculty team of staff and students, with invited membership form governments and non-governmental organizations. Task forces have been established on the three campuses to tackle areas including research, updating of an HIV/AIDS policy for the University community, curriculum review and development, and social marketing.

In Europe, the University of Nottingham regards adherence to the upholding of basic human rights and human dignity as of fundamental importance, in accordance with the European Convention of the Protection of Human Rights and Fundamental Freedoms (ECHR) and the International Covenant on Civil and Political Rights (ICCPR) and the Universal Declaration of Human Rights. (University of Nottingham, 2011). The University accepts that it has a role and responsibility to make available education, information and advice on HIV/AIDS. This would be achieved by making information about University as well as the University's Policy available to all existing and new officers of the University, members of staff and students in clear non-prejudicial language.

2.6.1. Involvement of Association of Commonwealth Universities in Response to HIV and AIDS

The ACU in its overview of activities and reports 1998 – 2002 at a meeting in London in November 1998. ACU was challenged by Professor Brenda Gourley, at that time Vice-Chancellor of the University of Natal and Immediate Past Chair of the ACU Council, to take heed of and respond to the impact of the HIV/AIDS pandemic on the universities in southern Africa (and elsewhere) (ACU, 2002a; ACU, 1999).

Accordingly, ACU organised in conjunction with the University of Natal a 2-day symposium tagged 'Durban symposium' immediately to precede the November 1999 CHOGM (Commonwealth Heads of Government Meeting) in Durban. The symposium was entitled The Social, Demographic and Development Impact of AIDS: Commonwealth Universities Respond (ACU, 2002b). A draft of policy for students and staff emerged after

the symposium. The draft Copies of the draft Policy was then made available for staff and students of Commonwealth Universities mapping survey to establish the extent to which HIV/AIDS is, or is recognised as, a problem in the universities around the Commonwealth, to identify some of the strategies that are in place for dealing with it, and to give examples of some of the policies that already exist. A one-day conference, immediately preceded the 6th International Congress on AIDS in Asia and the Pacific (ICAAP) in Melbourne, Australia, to explore and debate what constitutes successful strategies in a wide variety of sectors including higher education, the private sector, the trades unions and a wide variety of NGOs the development of a new initiative - the Commonwealth Award for Action on AIDS - which held its first Awards Ceremony in Melbourne just after the one-day conference.

2.6.2. The Association of African Universities and response to HIV in Higher educational institutions across Africa

The AAU is the apex organization and forum for consultation, exchange of information and co-operation among institutions of higher education in Africa (AAU, 2007b). This organization had been in the forefront coordination the efforts of universities in Africa on the response to the scourge of HIV at institutional level (AAU, 2007c). In the higher education sub-sector, several universities in Africa are generating HIV and AIDS-related research covering all areas, including scientific, medical, socio-economic and communication that has added considerably to the international understanding of the disease (AAU, 2007d). The AAU collaborated with several of its partners to document the role and contribution of its members to the fight against the pandemic. A major gap revealed by the studies is the virtual absence of institution-specific targeting and action which emerged from the set of nine case studies of and African Universities commissioned by the WGHE of the ADEA and disseminated in collaboration with the AAU at the Nairobi meeting of the Working Group in 2001 (AAU, 2004). The AAU represents institutions across the continent with a membership of 199 institutions as at 2006 (AAU, 2007b).

The AAU in order to coordinate and scale up the efforts of universities to produce AIDS-competent graduates, developed a multi-disciplinary HIV and AIDS Core Programme

dubbed 'African Universities Responding to HIV/AIDS' (AAU, 2011a). This aimed to ensure that tertiary education institutions in Africa can continue to contribute to the production of qualified, healthy and productive graduates for the world of work. Phase one of the programme was from 2002 to 2007 while phase two commenced in 2009 to 2013 (AAU, 2013; AAU 2009). Under Phase 1 of the Programme, which revolved around four major components, a growing number of institutions, particularly those in high HIV prevalence areas, responded positively. Advocacy, a component of Phase 1 of the Core Programme, revolved around sensitisation of African higher education leaders attending AAU modular courses as well as the funding of 20 higher education institutions to develop workplace HIV policies. Some of these policies are available on the internet. (AAU, 2012). The formulation of an institutional policy was another strong point the AAU encouraged and supported its member Universities to adopt and enforce (AAU, 2010a; Inkoom, 2008).

Along the line, a tool kit for proper response was put together by the AAU aimed primarily at supporting the efforts of African universities to develop and initiate or improve their institution-specific HIV and AIDS prevention programs. It is intended to fill the gap in the availability of trained personnel by giving training to academic staff, students and support staff of the institutions to work with their peers to reduce personal risk and to engage with families and communities.

At a meeting of the AAU conference of rectors, vice-chancellors and presidents of African Universities held in Stellenbosch, South Africa in 2011, it was reinforced that the burden of fighting cannot rest only with national governments, therefore Universities must make a difference (AAU, 2011b). The report at the Stellenbosch meeting observed that the response of many African universities to the pandemic was more of an internal, *ad hoc* activity than a coordinated one. (AAU, 2011b). This is sequence to the publication of a review of best practices in African higher institutions of learning (AAU, 2007a). The meeting of AAU leaders further builds on the submission of Erinoso a Tenuche (2008) that the stronger the response of educational institutions to HIV and AIDS, the higher the chances of behavioural change and low sero-prevalence rate in the general population. By and large, HIV and AIDS cannot be successfully tackled in the absence of control policy and programmes at the

sectoral levels of which the education sub-sector is an example. (USAID, 2005; Partners for Health Reformiplus, 2004).

African tertiary institutions face a number of challenges, with globalisation and information and communication technology (ICT) development among them (Otaala, 2006). Notwithstanding, the AAU has collaborated with several of its partners to document the role and contribution of its members in the fight against the pandemic. The association also tried to identify the strengths, constraints and opportunities of its member Universities for addressing the human resource and policy challenges occasioned by the pandemic (AAU, 2007b).

2.7. The University campus and HIV

It is an educationally purposeful community, a place where staff and students share academic goals and work together to strengthen teaching and learning on campus. It is an open community, a place where freedom of expression is unconpromisingly protected and where civility is powerfully affirmed (Bryd, 2007). It is a just community, a place where the sacredness of the person is honoured. It is also a caring community, a place where the well-being of each member is sensitively supported and where service to others is encouraged (Elkins and Forrester, 2011). Bryd, 2007 also stated that a university campus is a celebrative community, one in which the heritage of the institution is remembered and where rituals affirming both tradition and change are widely shared Given such a community, one would expect it to rise to the occasion, by "challenging the challenger" (Otaala, 2006). Universities have a role in promoting societal change and in many cases their first responsibility is to the university population i.e. students and staff (SARUA, 2008).

Saint (2004) opined that developing an institutional policy on HIV and AIDS is the first action that tertiary institutions should take. He identified the challenges of the pandemic as a development issue, not just a health issue; a legitimate topic for university inquiry as it affects not just individuals, but institutions (Parker, Jacobsen and Komwa, 2009). Tertiary education institutions are vulnerable to the negative impact of HIV on their core operations of management, teaching, research, and community outreach (Saint, 2004); tertiary level

educators are among the most skilled individuals in most economies (OECD, 2012; Earle, 2010), and tertiary students are particularly vulnerable to infection (Balogun, 2012). The fight against HIV and AIDS requires leadership (Campbell, 2010). Tertiary level staff and students are traditionally among the leaders of their societies, and their active commitment is essential to the development of action and responses related to the HIV and AIDS pandemic (UNESCO, 2012).

A deeper understanding of the pandemic and its implications for higher education institutions is hereby needed as a basis for advocacy as well as for designing comprehensive policies and programmes in response to HIV and AIDS at institutional level (Kalahoire, Kirumira and Calloids, 2008). The authors further stated that the understanding also forms the basis for strategic planning, which incorporates policy and curriculum development, capacity building, identification of implementation mechanism and resource assessments.

The idea of institutionalizing a response in higher education institutions seems to be a relatively new, and often poorly-understood in its way of operating (UNESCO, 2006b). As higher education institutions are centres for the development of intellectual and human potential, other studies have noted pressure exacted on students or colleagues by University staff for sexual favours in return for good grades or promotions. (UNESCO, 2006b) Anecdotal evidence suggests that a number of institutions are experiencing staff and student deaths from HIV related causes. In the last decade, staff at the University of Ouagadougou (UO) in Burkina Faso believed it has lost at least six permanent lecturers to AIDS, and in the past year alone, one professor and two technical staff. At the University of Quisqueya (UniQ) in Haiti, a staff member in the Department of Academic Affairs recalled a suspected case of AIDS, saying that the person chose to resign when opportunistic infections became too frequent. One way of addressing the impact of the epidemic on HEIs is by allowing institutions to take a position on the subject and taking action to reinforce that position. However, an HIV and AIDS workplace programme enables an institution, an organization or a ministry to make a statement about its role in protecting the legal rights and wellbeing of its employees whilst diminishing the impact of HIV and AIDS within the workplace

(HEAIDS. 2011; Marwitz and Were-Okello, 2010; Crewe and Nzioka, 2007; Mutin and Alexander, 2006; Saint, 2004).

2.8. Overview of Institutional Policies in African Universities

HIV has had a significant impact on higher education institutions as the pandemic had affected students, their lecturers and non-teaching staff (EAC/EALP, 2010). Therefore significant stukeholders have responded actively to the threats posed by the epidemic, by developing sector specific policies in some cases, and generally introducing prevention programmes and new courses in their curriculum (Kelly, Desmond and Cohen, 2006). Smart (2004) opined that developing an institutional policy on HIV and AIDS is the first action that tertiary institutions should take. A written institutional policy provides explanation for internal decisions and legitimacy for actions taken in the process of AIDS control and prevention. Otaala, (2003) indicates that a tertiary institution's HIV and AIDS policy is generally comprised of four main components: the rights and responsibilities of staff and students; integration of HIV and AIDS into teaching, research, and community service; preventative services and supportive care on campus; as well as structures for policy implementation, monitoring, and review.

The institutional HIV policy is usually made up of these elements - a statement of the problem; a commitment to non-discrimination and confidentiality; safety procedures for staff and students; services and resources; legal aspects of HIV and AIDS; conditions of service; issues related to teaching and research; and a commitment to community action (ACU, 2002b). Policy is relevant to managing corporate entities, educational establishments, corporate societies communities and any form of social organization (USAID, 2010). Otaala (2003) explained that at the University of Namibia (UNAM), the move to develop HIV policy dated back to 1997 when the guidelines were approved by the University Senate. But it was not until they visited other sister institutions in the Southern Africa region (University of Botswana; University of Natal; University of Pretoria) and numerous exchanges on issues with several Universities under the South African Vice Chancellors' Association (SAUVCA), that UNAM began to actively develop its own policy.

The UNAM policy drew heavily on its 1997 guidelines, as well as liberally from other policies which had been adopted then or which were in draft form. This is in conformity with the submission of MacDonald and George, (2002) that a policy must be aligned with international codes of good practice or other policies of the same interest. Otaala (2003) further said that most of the universities and technikons in South Africa have policies and that the few that did not have, are in the process of developing them which is often with financial support from international organisations. In other Anglophone countries, many tertiary institutions do not yet have HIV and AIDS policies. More recently, however, many more institutions have either developed or are in the process of developing such policies (HESA, 2008; Saint, 2004). These include the Mombasa Polytechnic and Highridge Teachers Training College, in Kenya; Nkumba University in Uganda, and the University of Botswana, Gaborone, Botswana.

The report at the conference of rectors, vice-chancellors and presidents of African Universities in Stellenbosch, South Africa in 2011 revealed the findings of a survey the AAU conducted in 2008 and 2009 at 35 Universities in 19 countries in Sub-Saharan Africa with regard to their responses to HIV. Twelve of the institutions were from eight Southern African countries, eleven Universities were from five countries in East Africa, seven were from two countries in Anglophone West Africa and five were from four countries in Francophone West and Central Africa. According to the report,

> "80% of surveyed institutions had policies to respond to the pandemic. All Southern African institutions had policies. West Africa had the bulk of no-policy and policy-in the-pipeline institutions."

Many African and Caribbean universities have learnt from the University of West Indies institutional policy (Crewe and Maritz, 2005) which was developed in 1995 and redrafted in 2004. It covers the areas of rights of affected persons, confidentiality, staff and students' responsibilities, prevention strategies and management of HIV within the university. It is also important to note that the University of West Indies policy reflected a need of for the mainstreaming of into the curricula, or for the development of research agendas or community outreach (The University of West Indies, 1995; Crewe and Maritz, 2005). Since

policies are a course of actions or set of programs adopted by an organization based on a set of principles it suggests to assume that not having a policy at tertiary education institutions means a lack of commitment to HIV and AIDS. This is because a good policy provides persuasive leverage to introduce or improve existing education (Lui, et al, 2010). The HIV policy therefore guides managers and supervisors on how to manage HIV in a consistent manner and informs employees about their responsibilities, rights and expected behaviour (Laas, 2009; Rau, 2002). It further sets standards for communication about HIV and let employees and students know what assistance is available to them (Department of Labour, 2012).

In West African subregion, KNUST (Ghana) formulated a policy as advocated by the National Tripartite Committee (NTC), in collaboration with the Ghana AIDS Commission (GAC) in 2011. According to the then Vice Chancellor, the policy was the university's contribution to the fight against the spread of the disease and prevention of stigmatization and discrimination of those living with the disease. The policy document seeks to incorporate into the University curriculum the following: peer counselling; blood safety; occupational health and safety; as well as the impact of incidence of HIV/AIDS on human resource capacity, medical coverage, anti-retroviral therapy and adjunct treatment, among others. The basic idea in formulating the policy was to assist with the education and prevention efforts of the GAC and to enhance the knowledge of staff, students and the wider community of KNUST for their safety and protection (KNUST, 2011).

Similarly, the University of Dschang, Cameroon in 2007 has developed its HIV and AIDS policy with the financial assistance of the AAU following a workshop in 2006 organised by AAU in Kigali to accelerate the response of Higher Institutions to HIV/AIDS. The policy was borne out of the university's recognition of HIV and AIDS as both a health and developmental issue, which concerns the entire University community and the Cameroonian society as a whole. The policy emphasized that tertiary institutions have the ethical and intellectual responsibility to set examples in the response to the scourge of HIV/AIDS being directly responsible for physical welfare and orientation of large numbers of very intelligent young men and women (University of Dschang, 2007).

In Nigeria, many Universities still have not developed an institutional policy (AAU, 2007a) but some of the Nigerian Universities have started developing theirs (AAU, 2007b). There is the likelihood that the other institutions can develop their HIV and AIDS policies quickly as a result of the availability of other policies to serve as yardsticks. It is important, however, to ensure that the policies are prepared in a participatory way to ensure that all stakeholders- students, academic and non-academic, support staff and communities living around institutions are involved in the policy development process. In February, 2006, a workshop was organized to train University representatives in the development of institutional policy.

2.9. Development of an Institutional HIV and AIDS policy and its Importance

AAU (2004) outlined the importance of an policy within an institution. An institutional HIV and AIDS policy helps to prepare the institution for the epidemic in the lecture rooms, the workplace and its community in order to make a decision for a response to it. SAFAIDS/ILO (2010) workplace HIV policy defines it as an organisation's core collaboration's position and practices for preventing the transmission of HIV and for handling cases of HIV infection or AIDS among employees. The policy demonstrates the institution's commitment and concern in taking positive steps towards prevention, managing and mitigating the impacts of the epidemic (Government of Kenya, 2005). It also confirms the rights and responsibilities of all the stakeholders as well as compels the institution to provide all the support and resources towards the response to HIV (ILO, 2007). The policy will also provide a framework for partnership with other organizations and agencies in the response (Ghana AIDS Commission, 2004). A well planned HIV and AIDS policy outlines or describes how a particular organisation, institution or business is going to manage HIV/AIDS within the workplace (Gobind and Ukpere, 2014).

Reimer, Simpson, Hajer and Loxley (2009) outlined the Torjman process of developing a policy as selecting the desired objective. This typically results from priorities and imperatives set at the political level or policy conference, through negotiations with provinces/territories. Once a policy issue has been identified, the next step is to analyze it so that the extent and nature of the problem can be understood (UNICEF, 2008). Objective setting then follows which often requires asking the right questions particularly from the

people targeted by the policy (Fukuda-Parr, 2013; Hollander, Miller and Kadlec, 2010). The target of the objective is also determined. (Fukuda-Parr, 2013). Research is most likely to influence policy development through an extended process of communication and interaction (Brownson, et al, 2009).

Determining the pathway to reach that objective will follow identifying the targets. This is a difficult and contentious process of selecting the best policy package to achieve the goal (Dimitrova, Hollan, Laster, Reinstaller, Schratzenstaller, Walterskirchen & Weiss, 2013) When there are many possible policy options, this will likely include much discussion, consultation, and research prior to a decision. A policy target must be considered again with a greater focus on the details of whom the measure is intended to affect and how large a group they represent (Olivier, Leiter, and Linke, 2011). Other key decision-making factors include the efficiency of resource allocation and the consistency with the broader goals and strategies of the government and society (Bekefi, 2008, Smith, 2003). The goal needs to have a designed specific program or measure which concerns how best to implement the chosen pathway (Cogliandro, 2012). Consideration is also given to any particular population that might "lose out" or be adversely affected by the policy (Reimer et al, 2009).

Cost and financing must also be considered at this stage. If a proposed plan is prohibitively expensive or difficult to pitch to financers, a plan may be scrapped or sent back to be redesigned (Reimer et al, 2009). Often there is jurisdictional overlap and programs from different levels of government can work against each other, but ideally, policy will be designed to be complimentary across all levels of government (Rodrigo, Allio and Andres-Amo, 2009).

The development of national policy and programme frameworks are key instruments for achieving a single approach to HIV and AIDS across the higher education sector and attaining greater equity among institutions (HESA, 2011). There is a need to set up a task team or committee with appropriate mix of technical expertise and representation of all the concerned groups within the University e.g medical, legal, union leaders, student representative (AAU, 2004). It is important, however, to ensure that the policies are prepared in a participatory way to ensure that all stakeholders-students, academic and non-

academic, support staff and communities living around institutions are involved in the policy development process (Inkoom, 2008). This task team or committee will then do a need assessment of the university community in relation to . (HESA, 2011; AAU, 2004). This research findings are reviewed and draft policy is made (Stover and Johnston, 1999) based on the guidelines of some organizations like the ILO (ILO and UNESCO, 2006) or other national policies or frameworks on (Chetty, 2003).

The draft policy is then circulated for discussion and comment which leads to a revision of the draft policy by the committee (ILO, 2002). The final policy is passed to the appropriate body of the institution for approval, adoption and launching. The procedure continues by the managers and service providers using the policy to develop implementation strategies (AAU, 2004; Stover and Johnston, 1999). The policy and the ensuing programmes must then be communicated by a wide dissemination to the entire community as a policy developed to address HIV and discrimination (UNESCO, 2011) for ownership. The effectiveness must be determined by monitoring and evaluation of the policy. (SHARe, 2010; Republic of Namibia, 2008). This must be followed by a periodic review of the policy (Chetty, 2003).

Lastly, there must be a plan for the implementation of the measure and assessment of its impact (Victorian Quality Control, 2006). Often a policy that works well on paper will not function as expected when implemented and ideally, policies should be assessed and corrected as they unfold and fail or surpass the intended goals (Reimer et al, 2009). Policy should be written down in order to avoid misunderstanding of the provisions. With a written policy manual, managers and supervisors will be able to act decisively, fairly, legally and consistently (Michigan Municipal League, 2006). Unwritten policies often will lead to confusion and conflicts (Accuracy, 2013).

2.10. Creating awareness and communicating the HIV and AIDS Policy to the Beneficiaries

Literature on communication of the HIV policy to the beneficiaries are not many but the few found did justice to the topic. Communication is an essential ingredient for effective implementation of public policies (Makinde, 2005). Through communication, orders to

implement policies are expected to be transmitted to the appropriate personnel in a clear manner (Hughes, 2008; Makinde, 2005). There is often a gap between policy and practice as failure to communicate departmental policy to schools which hinder the awareness of it (UNESCO, 2008a). In order to increase effectiveness of the policy, it is good to make it available and known to all staff (irrespective of job category) in an organization (Neema & Koster, 2008) including the school administrators and to all students in an educational institute (UNESCO, 2008b). Though a policy is a formal document, wording should be simple enough for everyone within the workplace or institution to understand it easily (Stop AIDS Now!, 2010). There is also need to keep discussing the policy in routine meetings so as to keep all involved informed and up to date, and increase understanding of the contents (Neema and Koster, 2008).

At the University of Florida, policies of the institution including HIV policy with other policies have been put on the university website captioned 'Policies you should know'. The HIV policy gives clear direction to students, academic and other staff on issues related to HIV in the University community (University of Florida, 2013). This is true for most Universities in the USA. In order for their students and staff and others in the university to be aware and have knowledge of the policy, the Stellenbosch University (SU) (2011) in its policy for HIV and AIDS clearly stated that as policy development and implementation is a dynamic process, that the HIV and AIDS policy should be communicated to all existing students and staff, as well as to all new students and staff on admission to SU. Also it should be routinely reviewed in the light of emerging epidemiological and scientific information and be monitored on an ongoing basis in order to ensure its successful implementation.

One of the actions of improving the lives of people in the workplace is to inform them about existing HIV related policies and programmes (ILO, 2009b). It is generally assumed that working on policy involves the creation of a new measure. However, significant policy work is carried out by ensuring that individuals who will benefit from the services actually know about them and receive them as their own. A major problem arises from the fact that potential beneficiaries of programmes may not be aware of them (Tolman, 2009). Awareness-raising measures should be emphasised among members of the community and

labour unions can offer support in raising awareness, promoting healthy workplaces and providing good sources of information (ILO, 2009b).

Disseminating the policy plans should be made as early as during the policy development process with questions about goals, objectives, users, content, sources(s), medium, success, access, availability and barriers that may be encountered (NCDDR, 2009). In the planning process, it is important to remember that training events, such as conferences, workshops, academic courses, meetings, computer-based discussion lists, and products, such as reports, journal articles, video tapes, newsletters, and websites are primary tools that may or may not help reach the set dissemination goals with certain target audiences. It is then important to identify "best practice" models in dissemination and utilization to help in putting in the most appropriate strategies in disseminating information for utilization. Success in dissemination is more likely to occur when the "packaging" and overall nature of the information has been influenced by appropriate input from the potential recipient/user audience (NCDDR, 2009).

Afya-Mzuri (2006) proposed that the HIV policy of an organization has to be communicated to the people involved in the workplace and that preparing a workplace policy briefing paper is necessary. The template as proposed should include epidemic in the particular country or institution, facts about the extent and distribution (geographic, age and gender) of the epidemic and what this means for the organization. Also, it should include why it is important to develop and implement a workplace policy as well as what the policy addresses. The access strategy to get the policy information across to the recipients must particularly consider alternate formats that are accessible to all members of the intended user group(s), share and allow requests for information through multiple means, for example, telephone, fax mail, e-mail, and other modes upon request as well as make the policy/project information available in full-text format through the Internet (NCDDR, 2009). Also, how the disseminated information will be evaluated by users in terms of its ease of use and the description of a strategy to conduct personal follow-up with users to assess customer satisfaction and usefulness need to be considered.

2.11. Stakeholders inclusion in policy development

Stakeholders must be included in the development, the public interest must been given a high priority (Mayers, 2005; Bryson, 2004) and organisational expectations be met with the assurance that the policy is likely to be both efficient and effective (Eurydice, 2008, Smith, 2003). Part of the policy development process therefore is to clearly identify who all the stakeholders are (Preskill and Jones, 2009; Griffiths, Maggs and George, 2008). Also, an appropriate consultative strategy needs to be implemented as part of the policy development process. Oftentimes it is difficult to achieve all the desired outcomes from each stakeholder group but it is key to discuss with each of the stakeholder groups the policy outcomes that are going to be implemented (Griffiths et al, 2008). Where these outcomes clearly do not meet the stakeholders expectations it is imperative that the organisation identifies these issues and resolve the conflicts as much as possible.

The policy statement must clearly express why the policy has been written and what is hoped to be achieved by its implementation. Part of the consultative process prior to the implementation of policy needs to be a testing of the process and ideas (Mawhood, 2008). The assumptions that have been made about why policy needs to be implemented must be tested within the organisational context. Questions must be asked relating to whether a perceived problem in one department the problem that needs to be addressed from an organisational point of view.

Policy should be seen as pillars supporting the structure of an organization (Shih, Davis, Schoenbaum, Gauthier, Nuzum and McCarthy, 2008). Policy makers must ensure that policies are linked to the overall direction and goals of the organization (WHO 2009). The overall framework of the business will provide some strategic direction, and will be important in assessing the direction of the organisational policies (Bonchill, 2007). In writing policies, process must be observed, organisational rules and principles must be established and clearly understood as part of the policy development process. It is crucial that all components of the organisation have some input into the policy development (Bonchill, 2007). Policy writers must ensure that the policy supports existing policies and procedures within the organisation.

The intended policy is to achieve a specific outcome which needs to be effective in terms of the impact that it has on the organisation. Part of the consultative process undertaken appropriately will be to help identify areas where the policy may not be effective within the organisation. The policy should also be both efficient and cost effective (Bacchus, 2001). The policy should be measurable based on indicators that will provide proof that it is having a desired effect (Jacobs, Jones, Gabella, Spring and Brownson, 2011). This is especially useful for the evaluation stage of the policy cycle. The ability to measure the effectiveness of any policy gives it capacity to be evaluated. Evaluation of policies helps an organization determine effectiveness and possible areas where change is needed, enabling that particular organization to work at its' most efficient level (UNDP Evaluation Office, 2002). Policy directives must ensure that organisational resources are being used in an appropriate manner.

A policy initiative is more likely to achieve the best possible outcomes when the question of how the policy is to be implemented has been an integral part of policy design (Commonwealth of Australia, 2012). When this does not receive sufficient and early attention, problems may arise during subsequent implementation. These problems may include: sub-optimal delivery methods, unrealistic timeframes and resources not being available when required (Australian Government, 2012). An organisation must ensure that its policies, and policy development initiatives, are properly and appropriately funded (The Economist, 2010). It is also imperative to identify and set aside the necessary funds for its implementation (WHO, 2012). Organisations should budget for these initiatives and stay within budget. It should be easily apparent in the policy which persons and departments are accountable for what actions, and within what time frame (Department of Health, 2010). Everyone, from the policy officers to the direct worker are accountable for some part of the policy, be it proper use of funds, proper protocols for developments, or the recommended implementations.

2.12. HIV Policy Implementation

It is important to manage HIV effectively in the workplace in order to reduce the negative impact it has on the economy (Vass, 2004). This is achieved with the comprehensive

workplace response to HIV/AIDS and it should begin by implementing an HIV and AIDS workplace policy (MacDonald and George, 2002). This is because a supportive policy environment is crucial to the implementation of successful programs that it provides for in order to prevent the spread of HIV, deliver care to those infected, and mitigate the impacts of the epidemic (Hardee, Feranil, Boezwinkle, and Clark, 2004; Stover and Johnson, 1999). The HIV and AIDS workplace programme, outlines how the different principles of the policy will be translated into practice (Africa Centre for HIV/AIDS, 2007). The intention of the HIV and AIDS workplace programme is to implement an action plan within an organisation to prevent new infections, provide care and support for infected or affected employees, and manage the impact of the pandemic on organisations (Africa Centre for HIV/AIDS, 2007).

Bhuyan, Jorgensen and Sharma (2010) referred to policy implementation as the mechanisms, resources, and relationships that link health policies to program action. Policy implementation is the set of activities and operations undertaken by various stakeholders toward the achievement of goals and objectives defined in an authorized policy. It is important to understand the nature of policy implementation because international experience shows that policies, once adopted, are not always implemented as envisioned and do not necessarily achieve intended results (Bhuyan, Jorgensen, and Sharma, 2010). The effective implementation of HIV policy according to KNUST (2011) requires human, financial and material resources. These include trained technical and administrative personnel, professional counselling staff, infrastructure such as a furnished secretariat conducive for effective work and equipment for publication and communication. Others include setting up an HIV/AIDS fund, providing facilities for diagnosis, treatment and research as well as making transport available for mobility (KNUST, 2011).

In order for the HIV policy to be implemented, the responsibilities must rest on some group of stakeholders (Government of Jamaica, 2011). The responsibilities for implementation of this policy may rest with regard to the University community as a whole, the Task Committee and with regard to the staff, the Human Resources Division, in accordance with legal requirements. As regards the student community, the implementation responsibility rests with the Dean of Students Division, Board of Residences, Healthcare Centre and

Counselling Centre and the Registrar's Division. The Deputy Vice Chancellor Research & Development are involved and with regard to sporting activities on campus, the Sports Union administration structure (Rhodes University, 2008). WHO (2005c) stated that involving people with HIV, communities and other key stakeholders in planning, implementing, monitoring and evaluating HIV testing and counselling services is critical for ensuring appropriate and effective services and achieving engagement in services being offered.

2.13. Benefits of HIV Policy Implementation

An appropriate policy is essential in supporting efforts to ensure that human rights are respected and eliminating stigmatization and discrimination associated with HIV/AIDS. An HIV & AIDS policy defines an organisation's position and practices in relation to employees with HIV & AIDS and to preventing the spread of HIV (AAU, 2007b; Rens, Meyer, Kwatubana and Modisane, 2012). Experience shows that having a written policy assists in ensuring that all employees are treated fairly and with consistency (Neema and Koster, 2008). The authors also submitted that having a written document also helps to integrate the HIV response with other systems and policies, and that it enables legal compliance with national legislation. It also provides an accountability framework for funds received from donors to finance HIV responses. It enhances the possibility of continuity in response and encourages better planning and therefore budgeting of response (Neema and Koster, 2008). But for the policy to achieve its goals, it must be implemented. One of the most critical aspects of the workplace response to HIV is the ability to operationalise the policy and make it work (SAFAIDS/ILO 2010).

The implementation of any HIV and AIDS policy will bring about the establishment of programmes on HIV prevention, treatment, care and support which in turn will boosts the morale of the company and has a positive impact on the surrounding community (IFC, 2012). He referred to financial benefit reported by the Polaroid Corporation that the out-of-pocket workplace program that one-third the cost of the entire workplace HIV and AIDS program over the last nine years is equivalent a case of HIV infection. Also, businesses that employ workplace HIV and AIDS programs are likely to enjoy intangible benefits that will

increase their employees' productivity and the harmony of their work environment (KNUST, 2011). The early awareness and education of HIV and AIDS in the University and an educational curriculuin would reduce the incidence of the disease among students and staff (KNUST, 2011) as well as preserve the human capital of the country (IIEP, 2007b).

2.14. Challenges of HIV policy implementation

Implementation problem occurs when the desired result on the target beneficiaries is not achieved (Makinde, 2005). A model was identified by an activity team for policy implementation which is the Contextual Interaction Theory (CIT) Spratt (2009). Contextual Interaction Theory is a simplified model provides a framework for systematically identifying and addressing factors that implementers have some chance of influencing. CIT uses a deductive, social process approach that employs explicit consideration of several variables, including the policy tools and the strategic interactions between implementers and target groups over extended periods of time.

The theory makes use of constructs such as motivation, information and power. Motivation is how much importance those who are involved with implementation place on the policy or program (Bessell, Dicks, Wysocki and Kepner, 2009) and the degree to which the policy or program contributes to their goals and objectives. If implementers' motivation is low regarding a specific issue, they may ignore the policy or may not supported by a serious commitment of resources (Substance Abuse and Mental Health Services Administration (US), 1999). If motivations are examined, stakeholders will understand the perspectives of implementers in knowing their value priorities, and perceptions of the importance and magnitude of specific problems and policy (Morcom, and MacCallum, 2010; Spratt, 2009). On other hand, sufficient information is required by those involved in the policy's implementation to achieve success (Victorian Quality Council, 2006; Economic Policy Unit, 2004). Information includes technical knowledge of the matter at hand and levels and patterns of communication between actors (Jones, Datta, and Jones, 2009).

Those responsible for implementation should know with whom they should be working and who the policy is supposed to benefit (Australian Government, 2006). They need to know which department is assigned to lead the implementation and how the program will be

monitored. They need to know the culture and processes of other organizations in their network. The beneficiaries also must have sufficient and appropriate information to benefit from the program (The White House, 2011; WHO, 2005b).

It is important to understand who is empowered to implement a policy and to what degree they can implement it (Sultana, 2008; Honig, 2006). Power may be derived from formal sources (such as legal or regulatory systems) or informal sources (such as being dependent on another party for the achievement of other objectives (OECD, 2000). Interactions between actors must be considered to further analyze barriers to implementation (Spratt, 2009) as the motivation, flow of information, and balance of power and resources among stakeholders influences policy implementation processes (USAID, 2010). Interaction predicts the level of collaboration among actors, which, in turn, influences policy implementation (Spratt, 2009).

In Kenya, it was reported that students-teachers sexual relationships, inadequate skills to provide psycho-social support to positive learners by care givers and teachers, stiff resistance to sexuality education by faith based organizations, are some of the challenges of HIV in education sectors (Government of Kenya and UNICEF, 2000). Studies have revealed gaps in the current Education Sector Policy on as some emerging issues had not been provided for in the policy, e.g. on how to attend to learners who are HIV positive.

It was relatively easy to argue, at the level of theory, about the 'development challenge' posed by HIV. It was a rather different task to elaborate the challenge in the functional and institutional context of university management and operations. There was evidence of a range of work already being carried out, mostly in the realm of research, prevention education and social mobilization. However, a picture emerged through the surveys which found that the higher education community was lacking on many fronts, including uneven responses (often a strong research focus at the expense of internal programmes and services), silence or denial, stigma, focus only on prevention and education, poor co-ordination within institutions, persistence of risky social and sexual behavior and lack of a relationship to government and non-government organizations in terms of policy, plans and

programmes. Others are constraints on operations and resources leading to a 'short-term' mentality, poverty as the root cause of vulnerability and low priority of the response to HIV (AAU, 2007b; Torjman, 2009). Funding is of a huge importance for starting and sustaining policy implementation (The Economist, 2010).

Also, the ideas, values and morals of implementers may affect HIV policy implementation at service delivery level (Dickinson and Buse, 2008; Makinde, 2005). The authors reported that in a study of nurses' motivations in implementing the government's ARV policy in South Africa's Free State province, some nurses were found to use religious metaphors alongside medical ideas of effective treatment to help themselves and their patients involved in ARV programmes (Dickinson and Buse, 2008). The way the implementers exercise their discretion depends, to a large extent, on their disposition toward the policy (Makinde, 2005). Therefore the level of success will depend on how the implementers see the policies as affecting their organizational and personal interests. Therefore an institutional policy will only be effective just as the leadership that owns it if vice-chancellors, principals and other senior managers and staff unions (Saini, 2004) would give it their support.

In a report of the Stop Aids Now project (2009) of Uganda, findings revealed challenges to implementation of HIV policy and programme to include lack of or late funding, high turnover of staff trained in workplace policy and programme and negative stand on condoms by religious organizations. Although policies and activities aimed at promoting condom use as a method of HIV prevention have noticeably increased in Africa, policies often avoid addressing condom use among adolescents because of moral, religious or other reasons (Population Division, 2003). As a result of this many adolescents therefore do not have access to information and services concerning the use of condoms in prevention. Programmes that adopt condom promotion and distribution have often had to deal with inadequate supply (United Nations Population Fund, 2002). Policies and programmes that de-emphasize the importance of condom-promotion in HIV prevention have been criticized. (United Nations Population Division, 2003).

2.15. Monitoring and Evaluation of HIV and AIDS Policy and Programmes

As support to plan and implement HIV interventions in tertiary educational institutions is critical (UNESCO, 2011), so also is monitoring and evaluation of the policy implementation. Officials in institutions with preexisting HIV-related policies need to know if their policies are defensible in the light of the whether the policies are understood by everyone who need to follow them or that the policies are in the hands of everyone who need to follow them (King and Muthen, 1992). It is also to determine whether the policies have met the needs of the people within the institution.

Monitoring is the routine tracking of priority information about a programme and its intended outcomes (WHO, 2004). It includes the monitoring of inputs and outputs through record-keeping and regular reporting systems as well as health observation and client surveys. It can be called programme monitoring, process monitoring or output monitoring. Evaluation on other hand is a collection of activities designed to determine a programme's effect or value. Evaluation focuses on whether the programme has had the intended effect on specified outcomes.

Monitoring of HIV policy implementation will according to WHO (2004) include provision of life-skills-based education in schools, institutionalizing youth-friendly health services, use of specified health services by young people, condom availability and young people's participation in HIV prevention programmes. Other indicators are knowledge of HIV prevention among the population, sexual decision-making among young people, perceptions of peers' sexual activity, HIV testing behaviour among young people and safe sexual behaviour among young people. Percentages and proportions of the people involved in the programmes and specific knowledge and behavior expected are also indicators for monitoring (UNAIDS, 2009; ILO, 2004).

According to HEAIDS (2004), the benefits of having and implemeoting a successful HIV and AIDS workplace programme are significant. However, evaluating such programme is equally important. Having HIV and AIDS programme in place is the first step; implementation should be followed by evaluation. By systematically evaluating HIV policies which, educators can see whether their policies are well conceived and have been

effective. If the policies fall short of expectations, they can be improved through revision. Afya Mzuri (2006) proposed using a questionnaire or survey tool as a way to conduct an evaluation of HIV policies and programmes. Other methodologies for conducting the analysis include interview with a contact person, key informant or group; informal meeting with a group of employees or union representatives; a needs assessment survey and analysis of documentation from the organisation, such as a company information flyer, newsletter, website, organogram, annual report, etc. (Afya Mzuri, 2006).

2.16. Awareness, Knowledge and Perceptions of Staff and Students on their Institutional HIV and AIDS Policy

2.16.1. Awareness and Knowledge

UNESCO 2008 concluded that schools are not always aware of national policies established by education ministries which often causes a gap between policy and practice. However, these days, employees in particular are becoming more outspoken about their desire to know what regulatory agencies require of their employers (Michigan Municipal League, 2006). Failure to communicate departmental policy to schools, educators and learners, lead to problems therefore governing bodies and school administrators need to be made aware of policies and legal issues related to HIV and individuals, including laws that prohibit discrimination in the workplace in order to promote ownership and ensure that policies are put into practice (UNESCO, 2008a).

UNDP staff strengthened their knowledge on the UN's workplace policy and programme on HIV and AIDS at a recent UN Cares awareness session organized by the UNDP country office (UN, 2012). The session was where participants were briefed on the objectives of UN Cares programme and learned the epidemiology of in the world, Eastern Europe and Central Asia region, and situation in the country. The session was held for the first group out of 75 staff in Turkey. Through understanding the modes of HIV transmission, prevention, symptoms and treatment, sexually transmitted infections and drug prevention issues, the staff learned how to protect themselves and their families. The session helped participants to improved their awareness on stigma and discrimination issues with regard to UN policy and standards as regards HIV.

There has been a lot of focus and studies in the knowledge and perceptions of the University community on HIV but there is a dearth of information on awareness and knowledge of staff and students of Universities of the HIV policy of their institutions. Hence, inference will be made from findings from Kenyan education sector and other workplaces. Kenya has been in the vanguard of developing and supporting various teacher training policies of which a comprehensive guideline of policies and procedures for HIV issues for teachers and pupils is one (Kiragu, Mackenzie, Weiss, Kimani and Gachuhi, 2008).

Centre for British Teachers (2006) reported in an analysis of HIV and AIDS policy formulation and implementation structures, mechanisms and processes in the education sector in Kenya that there was lack of awareness and ownership of the HIV and AIDS policy. The report highlighted that the Education Sector policy lacked adequate support among the key stakeholders. The distribution and dissemination was limited and fragmented and that there was no evidence of a strategy for ensuring that all the stakeholders are adequately briefed on the content and use of the HIV and AIDS policy. A few of the participants said that they were aware of the existence of the policy through information and guidance-circulars and other avenues such as in-service workshops but the majority had not seen the policy booklet. Only a few head teachers who had attended the secondary schools heads association annual meeting had received a copy each of the policy document. However, according to the report, those who received the policy documents said that no information, guidelines or sensitisation was done following the distribution of the policy documents. The stakeholders also confessed that they had not made use of the document since they were not given any information on its content, their role in disseminating the information and their role in its implementation.

A study of physicians at an Academic Medical Center revealed a mean survey score of 51.2% indicating that respondents had relatively limited knowledge regarding state law and institutional policies and procedures on issues of confidentiality specific to patients with HIV or AIDS. (Thomas, Rogers and Maclean, 2003). Laas (2009) in a study of a selected organizations in South Africa found that only a small percentage of respondents confirmed the existence of an HIV/AIDS workplace policy at their respective workplaces. A reason for concern according to Laas (2009) is that almost a quarter of the respondents were not

sure whether their workplace had a policy or not. In a study to explore the knowledge of managers of a freight company in a southern African country, the knowledge of the workplace's Policy was found to be poor as well as the fact that there was lack of ownership of the firm's programmes by the employees (Mabuza, 2010).

A study of the University of Malawi (UNIMA) also revealed that majority of staff and students respondents were not aware of the UNIMA HIV and AIDS policy or any HIV and AIDS activities that are guided by the policy (Soko, Umar, Nonwa and Lakudzala, 2012). This is due to lack of interest on their part or lack of knowledge on the existence of the workplace programme in the University. It was also noted that the respondents' knowledge of HIV and AIDS policy depended on how active they are either in the HIV and AIDS committee or student club and how long they have been with College of Medicine. The members of staff who had been with College of Medicine for more than five years and was present when the policy was being launched, had a chance of patronizing it earlier on, were aware of the policy. Others were in leadership position within the institutional hierarchy as well as in the HIV and AIDS committee and were involved in the policy formulation and implementation. The student's awareness of the policy also depended on how active they were in organizations and the students union.

Since the inception and adoption of UNIMA HIV and AIDS policy in 2003 and follow-up baseline HIV and AIDS study in 2007, changes have taken place in individual institutions under UNIMA and in particular, the College of Medicine as regards the management of HIV and AIDS. New members of staff have joined in, student numbers have doubled or even tripled. Some members of staff felt that the environment at COM does not facilitate access to HIV and AIDS information due to lack of forums where issues as such as this could be discussed as alluded to by these members of staff (Soko et al)

2.16.2. Perception

There is very little research available which had explored the perceptions of staff about policies and programmes at the workplace (Mabuza, 2010). This is equally so for staff and students in higher educational institutions. Perception can be broadly defined as the manner in which meaning is made. Meaning in turn impacts on attitude and behaviour (Donald,

Lazarus and Tolwana, 2002). The perception that an employer cares for its employees can help the company avoid possible litigation costs due to discrimination against HIV status (Petesch, 1996). It is important that staff and students recognise the HIV problem that is being addressed through the policy and its implementation. This is because it is extremely difficult to implement policy in a situation where people do not perceive a need for it (Plant, and Scott, 2004) because of many plausible and equally legitimate interpretations and perspectives (Jones, 2011). One of the common problems within an organisation is that people of different levels in such organisation may not believe a policy meant to resolve a specific problem (OECD, 2006). People cannot comply with regulations if they do not understand what is required (OECD, 2000). Although a number of firms have increasingly implemented policies and programmes to address the risk posed by, most of these policies and programmes have not been successful, largely due to a lack of complete ownership by the leadership of these firms (SAfAIDS/ILO, 2010).

The findings of the study conducted by Mabuza (2010) among the freight company managers also showed that their perceptions were varied among the few that had knowledge of their company's policy and programme. Some managers felt indifferent about the firm's HIV/AIDS Policy and some managers who were aware of the policy felt unhappy about the manner in which the firm's Policy was implemented. Some managers' perception was that the firm's programme is the responsibility of the Human Resources department through the Employee Assistance policy and programme or the clinic. Only a few managers had a perception that the firm's HIV and AIDS policy and programme has added value to the business (Mabuza, 2010).

2.17. Activities related to HIV and AIDS policy in Universities

Action in response to HIV and AIDS as part of the mission and core business of tertiary institutions should include the development of policy frameworks and programmes, including services (ILO and UNESCO, 2006). Case studies that have been carried out in a number of African universities point to the fact that HEIs have responded in diverse ways to HIV/AIDS. These responses range from complete silence to systematically developed HIV/AIDS-related policies and programmes, research, service provision, peer education,

and various academic responses, including the integration of HIV/AIDS into the curriculum (either as part of a course or module, as a set of assignments, or as stand-alone -focused modules) (HEAIDS. 2010). There should be more effective focus on education, integrating it into formal education programmes, research, pre and in-service programmes for teachers and students (Komunda, 2007). Also, non-formal educational activities should be strengthened, along with community outreach. The role of an HIV programme in the Higher Education sector is hence to provide that voice which not only influences policy but also educates the wider community (SARUA, 2006).

Abebe (2008) stated that where active response exists, it is also reflected in the research agenda and activities of the institutions. For example, eight universities and six Technikons in South Africa have specific units that deal with research. Apart from mainstreaming and gender in the main activities of research, HEIs need to conduct assessment to know the status and respond accordingly. Mainstreaming in Higher Educational Institution (HEI) requires having a critical mass of well-informed staff about the concepts and the essential actions. This includes conducting regular mainstreaming discussions among the key stakeholders of the HEIs university officials, administrative and academic staff members as well as students (Ministry of Education, Ethiopia, 2012). Despite the very important gains in treatment, prevention remains key (NACA/REACH, 2010).

2.17.1. Integration of HIV courses

Out of those with staff trained on mainstreaming HIV, some Ethiopian Universities are offering HIV and AIDS as a stand-alone course in teaching and learning program and ensuring the development of core competencies according to the professional specific requirements developed as part of the policy framework and strategy document (Ministry of Education Ethiopia, 2012). Forming a curriculum design team and conducting trainings to the team, developing standalone course curriculum and course syllabus, conducting workshop for validating curriculum and syllabi availing teaching and resources materials are the key activities that each of the HEIs are expected to carry out as part of the mainstreaming process. An evaluation of a stand-alone module on HIV and AIDS for all

first year students at the University of Namibia suggests that timing, personal relevance, levels of practicality and so on are all vital (McGinty & Mundy, 2009).

Academic responses to addressing can be looked at in a variety of ways and can include the development and provision of credit-bearing stand-alone modules, online or direct delivery modules (Webb and Gripper, 2010). It can also include the development (or adaptation) of courses or modules to include some components of HIV education (Miedema, 2007). Integrated courses or modules can include various models of integration and infusion. This may be infusing HIV throughout the module, or taken as a one or two units course (HEAIDS, 2010). Stand-alone modules refer to those modules that focus primarily on HIV. They may be part of the curriculum of a particular disciplinary area (HEAIDS, 2010). On the part of the staff, awareness of can be raised through training because safety or technical briefings and new employee induction programmes present a good opportunity to provide AIDS education for staff (IFC, 2002). If these programmes are to be implemented effectively teachers need to be empowered, trained and supported to meet the requirements of the adapted curricula and new didactic material (Programme for HIV and AIDS education, 2006).

2.17.2. HIV Education

The prevention key performance areas outlined in the Ethiopian HEIs Policy and Strategic Framework document cover the HIV prevention components including information or education, testing services and condom promotion and distribution (Ministry of Education Ethiopia, 2012). This include ensuring that all the target communities of the HEIs have access to up-to-date information on HIV and AIDS and receive regular and consistent training and education on HIV and AIDS are the key strategic objectives outlined in the policy framework and strategy document. Moreover, establishing information/resource centers, conducting small/large group peer group trainings, adaptation and production of training materials, organising 'edutainment' sessions, drama group, sport festivals and organizing and conducting regular awareness raising sessions: debate forum, questions and answers sessions are the key programmatic activities that the HEIs need to be engaged to achieve the stated objectives.

The study of HIV response of Universities in Ethiopia by the Ministry of Education, Ethiopia. (2012) reported that in Atba Minch University, the peer education and community conversation related activities taking place in university campuses are jointly coordinated by the units and clubs of the university. Up to 1000 students and university staff are reached with peer education sessions every quarter. Also in Mada Welabo University thirty peer educators were trained during one academic year. The peer education programmes are conducted in dormitory blocks and coffee ceremonies organized by the clubs and the peer educators are used as facilitators to bring the students together. The peer education programme is financially supported by an NGO called Integrated Family Health Project (IFHP) and coordinated by the HIV coordination unit of the university.

It was also reported by the Ministry of Education, Ethiopia (2012) that officials and leaders of student council and HIV and AIDS clubs as well as the clinic staffs are trained on different issues including basic HIV and AIDS awareness, HIV and AIDS mainstreaming, gender-based violence and sexual harassment. In this regard, Universities like Debre Birhan trained top level management and clinic staffs were trained on basic HIV and AIDS awareness and counseling. In Adama, Bahir Dar and Jijiga Universities student deans, leaders of the student council and others working in the student guidance and counseling services were trained on VCT. In Wollega University, representatives from the student service, librarians, and the University security were trained. Some universities like Axum reported that staff members in the university clinic got training on youth-friendly services.

2.17.3. AIDS Resource Center

Reaching people with related HIV and AIDS messages is one of the key strategic interventions of the national response to HIV and AIDS (National Strategic Framework, 2010). Access to information is a very important aspect in any person's life and generally, information is important for use in planning programmes intended to spread knowledge about health and other issues through various media messages (Chisanga, 2011). Establishing stand-alone AIDS resource centers (ARC) and allocating designated corners in the existing libraries are the two most widely practiced approaches employed by the HEIs to

ensure students and the rest of the university community have access to different related information (HEAIDS, 2010).

Universities with AIDS Resource Centres reported that in most cases the centers have computers with free internet access, books, publications, research works, IEC/BCC materials including audiovisuals, leaflets and brochures on related issues (Ministry of Education Ethiopia, 2012). The centers are accessible for students (Van Deuren, Kahsu, Ali, and Woldie, 2013) researchers, and academic and administrative staff of the universities.

2.17.4. University's Health Facilities in the HIV and AIDS Response of the HEIs

University Health Facilities facilitate access to medical care for students and academic and non-academic staff living with HIV in HEIs (University of Capetown, 2006). The University clinics play significant role in the implementation of HIV programmes (Chokwe, Naidoo, Manana, Mbatha, & Muchengetwa, 2013; AAU, 2007a). In the regards, fourteen clinics in Ethiopian Universities were reported to be involved in the HIV/AIDS program and eleven (61.1%) work with the gender programmes of their respective universities. In this regard, those health facilities owned and run by the HEIs are expected to play significant role in the prevention care and support aspect of the HIV and AIDS and related gender response of the HEIs. All the eighteen health facilities owned by the public HEIs in Ethiopia were reported to providing twenty-four hours clinical care services to students at the outpatient department level (Ministry of Education, Ethiopia, 2012). Five of the HEIs have in-patient beds and admit students for basic emergency care, five also reported to be providing basic emergency care to the staffs of the university. Thirteen health facilities have basic laboratory services. Condom supply, voluntary counseling and testing, treatment for STIs and supply of IEC/BCC materials are some of the HIV/AIDS related activities carried out by the university clinics.

The HIV and AIDS services rendered in the University Health facility should include mobilizing students and staff members for VCT and providing trainings on issues like HIV/AIDS, STIs and RH (O'Malley, 2010). Others are supporting the HIV units and the HIV and gender clubs of their respective university in organizing successive peer education

sessions for students, providing counseling and other clinical care service for rape victims, referring HIV positive students to other health facilities for better care. Only two of the twelve health facilities in Ethiopian Universities with VCT service have trained VCT counselors who work on full-time basis while ten health facilities reported that though there are trained counselors, the VCT service is provided as part of the routine service of the health facility (Ministry of Education Ethiopia, 2012). Practically, all the health facilities reported to have an established referral linkage with the nearby public hospitals and health centers for different HIV and AIDS and RH related services and refer AIDS patients and students with different RH problems for better care.

2.17.5. HIV Counselling and Testing (HCT)

The campaign across South Africa targets the testing of at least 35,000 people from all sections of the Higher Education community, including students, academics and service and administrative staff. In 2011, the campaign achieved testing of 22,000 students at 17 universities. 58% of these students had never been tested before (HEAIDS, 2012). HIV Counselling and Testing (HCT) and knowledge about HIV are some key strategies in the prevention and control of HIV/AIDS in Ghana but utilization of HCT services among university students is low (Asante, 2013). When HIV testing policies and strategies are not in place or poorly implemented, this presents a barrier to testing (European Centre for Disease Control, 2010).

HIV Counselling and Testing service is offered to students on campus at the University of Witwatersrand. The testing process involves pre-test counseling which prepares the client for the possible outcomes of the test and possible emotional responses looking at risk factors, exposure and positive living. The test is done using a rapid test kit which takes about 5-10 minutes. It requires a few droplets of blood which is obtained from one of individual's fingertips through a pinprick. The blood is then fed into a testing kit and the results obtained after a few minutes. Post-test Counseling is offered after the test in a supportive counseling context also exploring the option of confirmatory tests if positive or re-testing after a 3 month period (window period) to validate a negative result. Campus Health will do the rapid test for free (University of Witwatersrand, 2014). The matrix

basement office address is given to individuals on campus that want to do the test with the option of regular mobile testing campaigns around campus.

Student Wellness Service which is part of campus health service of the University of Capetown, provides students with HCT and clinical management of HIV, including treatment of opportunistic infections and referral for ARVs. This free confidential service is open Monday to Friday, from 08h30 to16h30, except Thursdays, from 09h30 based on appointments (University of Capetown, 2014). There are also mobile testing unit which visits different campuses of the University. Lack of funding, staff and office space, as well as lack of training of the staff were identified as main barriers to offering on-site HIV testing and counselling in drug treatment programmes in a Grade III study from Hungary (ECDC, 2010). Also, low uptake of HCT by Nigerian youths in HEIs despite their possessing of high knowledge of HIV and AIDS has been established (Katibi and Adegoke, 2013). Students are not particularly interested in HIV counselling despite the high awareness of availability of HIV counselling and testing centre located within their educational institution (Akodu, Diaku-Akinwumi and Njokannia, 2012). Some students however claim that obstacles abound militating against uptake of HIV test on their campuses which were accessibility, including availability and distance to a facility, cost of services, transportation and time constraints (Daniel, 2014).

2.17.6. HIV and AIDS Research

Universities and other tertiary institutions with HIV/AIDS programs are expected to undertake baseline assessments and operational researches on HIV/AIDS and generate area specific data that would inform the planning, implementation and monitoring and evaluation aspects of their programme (Chebet, 2010). There have been so many research on awareness and knowledge of HIV in African Universities but a lot more need be done in respect to prevention, care, treatment and support of PLWHA in Universities.

2.17.7. Coordinated Institutional HIV and AIDS programmes

A number of the case studies conducted in higher education institutions show that students are more active in response initiatives than members of staff (HEAIDS, 2010). Abebe (2004), for example, observed that staff involvement particularly among the academic staff

in HIV/AIDS response initiatives is almost invisible. This would suggest that the bulk of initiatives are extra-curricular rather than curricular in nature. Student-based activities are more dominant on the scene and staff involvement is the exception rather than the rule, hence undermining effectiveness and sustainability of intervention programmes.

There is the need to commit resources from the University budget and other sources to ensure that there is coordinated and sustained action on the various campuses against HIV and AIDS (Inkoom, 2008). Katahoire (2004) highlights the fact that institutions such as the University of Botswana, the University of Pretoria, the University of Cape Town, the University of KwaZulu-Natal, Kenyatta University and the University of Namibia have established units to coordinate activities across the institutions and to prevent ad hoc approaches to programmes and to ensure institutional involvement in HIV/AIDS prevention. According to Saint et al (2004), institutions that establish AIDS coordination units have better organised programmes for addressing HIV and AIDS. Coordination among programmes can also be strengthened. In order to be maximally effective and efficient, programmes must be harmonized with each other to a greater degree (Szekeres, Coates and Ehrhardt, 2008).

2.18. Rights and Responsibilities of Staff and students within the context of an Institutional HIV and AIDS Policy

The workplace is a strategic location to advocate for the rights of workers (ILO, 2009a). Therefore in every institutional HIV policy the rights and responsibilities of those the policy is targeted at are spelt out. Teachers and other employees and their representatives are expected to respect and protect the rights and dignity of all learners, students and other education sector employees, regardless of their actual or perceived HIV status (Namibian Ministry of Health, 2007). The rights usually are premised on issues regarding HIV testing in relation to conditions of employment or admission of students, non discrimination of People living with HIV and AIDS (PLWHA), right to safe working or learning environment and protection from risk of exposure to the infection. Others are rights on issues like access to facilities, confidentiality and disclosure of HIV status and issues about termination of appointment or studies on the basis of their HIV status (Highridge Teachers College, 2003).

2.18.1. Rights of students and staff

Students and staff are not required to undertake a mandatory HIV test before being considered for admission or before being offered an employment (Makerere University, 2006) but they are encouraged to do so on their own (University of Nairobi, 2003). Although medical examinations are basic and routine for students and staff when they resume newly, continuing students may undergo HIV related medical examination on clinical grounds and as determined by a health care provider (Makerere University, 2006). All members of the university community must be accepted, regardless of their status, in an environment free of prejudice, stigma and discrimination.

For staff, HIV status will not be used as a justification for the non-performance of duties in terms of the employment contract, employees living with HIV will have equal opportunities for job assignment, salary and promotion based on without consideration of HIV status. No employee will be dismissed or have their employment terminated merely on the basis of HIV and AIDS, nor will their status influence retrenchment procedures (University of Zululand, 2010).

Within the limits of the law the University will respect the right of staff and students to confidentiality of the HIV status of students and staff. (University of Rhodes, 2008). This is in relation to the legal requirement of keeping information on HIV status disclosed as a member of the university community confidential (National University of Rwanda, 2007) provided such does not pose risks to others as no employee will be under any obligation to inform the employer about his/her sero-positive status (University of Nairobi, 2003). The University of Botswana, (2002) added that HIV status of a student or staff may not be disclosed without their written informed consent.

However, there is equal access to all service places for all members of staff without considering their HIV status while students access to infrastructures including classrooms, hostels, restaurants, rest rooms and other places for academic and para academic activities (e.g. social, cultural, and athletic events) is unhindered (Makerere University, 2006; Ukuniba University, 2002). There will not be discrimination against anyone living with HIV and this status will not be reflected in the personal files of employees or students (National

University of Science and Technology Zimbabwe, 2005). HIV-related illness will not be treated differently from other comparable chronic or life threatening conditions with respect to the rights of members of staff and students (University of Agriculture, Abeokuta, 2006)

In regard to risks of exposure of HIV, all members of staff and students have the right to be made aware of the risks of exposure and work in an environment in which occupational exposure to HIV is minimized by providing appropriate protective methods and post exposure counseling, diagnosis, prevention and treatment, where applicable, (University of Nairobi, 2003). They must be made aware of and have access to preventive and supportive care services available in the institution (University of Kwazulu Natal, 2005).

2.18.2. Responsibilities of staff and students

According to the University of Port Harcourt (2008) every member of the university community shall have an individual responsibility to protect himself/herself against HIV infection. Those living with HIV/AIDS have the added obligation to ensure that their behaviours do not pose a threat of infection to other persons. Every member of the university community must respect the rights of, members of staff and students living with or those affected by HIV/AIDS and provide support and care for them. They must also accept, support, and participate in Voluntary Counseling and Testing (VCT) services (University of Agriculture, Abeokuta, 2006).

Medical personnel living with HIV must practice their professions in such a manner that eliminates the risk of transmission to their patients or colleagues. Staff and students have the responsibility not to discriminate in whatever form against or stigmatize infected members of the university community (University of Port Harcourt, 2008). Unless medically justified, no staff of student may use his/her HIV/AIDS status as a reason for failing to carry out his/her responsibilities such as statutory work obligations, assignments, attendances at lectures, field trips and sitting for examinations. (Muhimbili University, 2008; University of Kwazulu-Natal, 2005). All individuals administering first aid should adopt universal precautions. The University undertakes to educate all first aid officials in universal precaution techniques and to equip all first-aid kits with the appropriate equipment. (University of Capetown, 2006)

2.19. Participation of staff and students in HIV and AIDS Response Initiatives

Evidence has shown from the studies that have been carried out in higher education institutions that students are more active in HIV/AIDS response initiatives than members of staff (Katahoire, 2004). Abebe (2004) also observed that staff involvement particularly among the academic staff in HIV and AIDS response initiatives is not significant. Student-based activities are more dominant on the scene and staff involvement is the exception rather than the rule, hence undermining effectiveness and sustainability of intervention programmes. Academic staff involvement, however, is more common in consultancy activities that have little or no involvement within the university's HIV and AIDS intervention programmes (Abebe, 2004).

While students in higher education institutions have generated a creative array of activities in response to the HIV crisis their response initiatives are widely divergent. Some institutions have reported a persistent difficulty in mobilizing students beyond one-off activities, and a low level of interest from student organizations while others have been able to engage students through their professional interests and volunteer projects (Ennals and Rauan, 2002; Chetty, 2001; AWSE, 2001).

University of Nairobi students have organized AIDS Awareness Campaigns, featuring events including a beauty contest to attract interest, and combining this feature with AIDS talks and dissemination of educational materials. The students coordinate their activities through a variety of student groups that do not necessarily focus exclusively on AIDS, but incorporate an HIV and AIDS focus into their particular group activities, for example by holding a competition among the groups for best AIDS campaign (Makerere University, 2006). Reportedly, more than 50% of youth in six South African communities have a high interest of involvement with HIV and AIDS response initiatives (Department of Health, South Africa 2005).

2.20. Response to HIV and AIDS in the University of Ibadan, Nigeria

The University of Ibadan is the oldest among Nigeria's federal Universities and is one of the continent's most widely recognized (AAU, 2007a). In 2006 its enrolment stood at 24,000 students with a strong emphasis on post-graduate education. This trend will be strengthened

over the coming years to reach a 60/40 ratio between under-graduate and post-graduate. (University of Ibadan, 2013). As a federal institution, its student body is drawn from across Nigeria as well as elsewhere in Africa.

The initial attempts at co-ordination of the response at Ibadan were focused on prevention and driven by the University of Ibadan's Committee on Prevention (UNICAP) based at the University's College of Medicine (AAU, 2007a). The College of Medicine has anchored the university's response since its inception in 1998, mostly through its research and teaching activities in a range of disciplines in the health sciences. A University of Ibadan team participated in the UNDP's 2003 training programme which was aimed at mainstreaming in the curriculum. Subsequently, with the support of the MacArthur Foundation, a team took the process two levels further with capacity building sessions for academic staff interested in teaching related issues which involved 112 people, with one of the sessions funded by AAU itself.

The second level was the development of a general studies core course which is a requirement for all incoming fresh undergraduate students. The course involves four hours of contact time focused on related content as part of a larger programme, including: the epidemiology of HIV, the natural history of HIV infection, transmission and predisposing factors to HIV infection, impact of on society, management of HIV infection and prevention. Three thousand copies of a resource booklet have been published and implementation of the course was planned for January 2007. The University is keenly pursuing opportunities to replicate the course elsewhere in higher education. The course has now been properly organised into a general studies (GES) course titled Reproductive health, Sexually transmitted infections and HIV/AIDS by the General Studies Programme of the University, (University of Ibadan, 2012).

2.20.1. HIV and AIDS Policy of the University of Ibadan

The policy was developed by a team of Policy Development Committee and Steering Committee as a step in the institutional response to the pandemic. The process started in 2006 and the approved policy was published in 2008 (University of Ibadan, 2008). The AAU in 2007 referred to it in the review of best practices and models in African higher

institutions of learning (AAU, 2007a) as being underway. The objective of this policy is to provide a set of guidelines for addressing issues related to HIV and AIDS at the University of Ibadan. The guidelines cover the following key areas of action like prevention of HIV among staff and students, management and mitigation of its impact on the staff and students, care and support of staff and students infected and affected by , prevention of stigma and discrimination research on HIV and AIDS. It is for use in developing specific institutional responses, promoting processes of dialogue, consultations, negotiations and all forms of cooperation among all concerned parties like the Federal Ministry of Education, staff of the University and their associations, the University Health Services personnel, other health personnel specialists on issues, and all relevant stakeholders.

The University of Ibadan HIV and AIDS policy applies to staff of the University, students of the University, all support staff of the University, including cleaners, and contract staff as well as other groups of persons in the University community. These including staff dependants and students of primary and secondary schools within the campus. The Vice Chancellor at the time of its publication in his foreword corroborated all by saying:

" The large work force and student population are not inimune to HIV infection, this makes it imperative that the University of Ibadan positions itself in forefront in the light against this deadly enemy that has the potential to claim the lives of members' of its community. The formulation, implementation, evaluation and widespread distribution and acceptance of this policy by the University of Ibadan is definitely a bold step in the right direction. The policy document will guide the development of a strategic institutional response to HIV and AIDS by our University".

The policy made a provision for the University to successfully collaborate with the community in training and research on HIV by mobilizing its members in and around the University to participate fully in the programmes. This is in order to allow for the effective flow of support between the University and various communities and community structures. Also the University's intervention is stipulated to include information outreach to employees and their dependants on issues and that the University will share its experience of best

practices and, where applicable, its skills and resources with other government agencies, NGOs and Community Based Organisations.

According to the policy, the University of Ibadan shall establish a committee on which shall be responsible for coordinating the timely and effective development, implementation, monitoring and revision of the HIV Policy. This committee shall advise appropriately on matters relating to the implementation of the policy. It says further that each relevant faculty/institute/department/unit shall have a standing coonlinating committee which will plan and implement the University's programmes. This shows an intention which cannot be substantiated and measured unlike the mechanism of implementation of some other Universities . For example, the University of Zambia, (UNZA) Lusaka in their HIV and policy, stated specifically that the Vice-Chancellors's standing Committee on HIV and AIDS shall have the overall responsibility to support and lead the implementation of the HIV and AIDS policy for UNZA. The process would be achieved by establishing a strategic work plan to guide the implementation, establishing a budget line for implementation and making available the policy to all the stakeholders in the institution. Others were briefing Deans of Schools, Heads of Academic and Non-Academic Department, and other Units, Student Clubs and Associations as well as Unions on the contents of the policy (University of Zambia, 2006).

The policy adopts many strategies and interventions in its response to mitigate HIV in the University community. Accordingly, the University of Ibadan policy shall promote and support activities that ensure that members of the community do not become infected with HIV. It shall also make conscious efforts at reducing the risk of transmission through promotion of behavioural change through acquisition of abstinence skills, promotion of quality human sexuality and sexual interactions though education, promotion of safe sexual behaviour based on 'safer-sex' education, with emphasis on women empowerment and prevention of HIV transmission.

Prevention strategies include safe blood and blood products by enacting and enforcing; and blood banking and blood transfusion laws, and the adoption and enforcement of strict, thorough and rigorous blood transfusion practices, education of all concerned,

with emphasis on those likely to have the repeated need for blood or blood products. Other prevention strategies include prevention of mother-to-child transmission which the policy said shall be vigorously pursued and promotion of HIV counselling and testing in the University community. The policy says that attention will be given to staff's family members, with respect to proper education on HIV and AIDS through formal and informal media.

According to the policy, universal precautions shall be adopted in the course of health care service delivery to ensure the safety of health care providers. However, in the event of accidental exposure to HIV, the University shall provide access to post-exposure prophylaxis for staff and students. Students and staff shall be provided access to HIV counselling and testing services in various sites on campus, including the University Health Centre and the Youth Friendly Centre. The University College Hospital (UCH) shall offer routine HIV testing (with an opt-out option) to provide access to treatment and care for those who are infected. Other aspects of HIV counselling, such as nutritional counselling, safe sex and prevention of mother-to-child transmission, will be provided in a user-friendly atmosphere.

The University shall periodically organize educational and training workshops for health workers within the University Health Services (UHS) on HIV-related issues, such as universal precautions, post exposure prophylaxis, HIV counselling, stigma and discrimination and other relevant matters on prevention, care and treatment for persons living with HIV (University of Ibadan, 2008). The policy provides for the rights and responsibilities of students as well as staff of the university. The rights include no discrimination against people living with or affected by HIV in terms of employment and admission, access to the same facilities as those who are not infected and no compulsion to test for HIV or disclose their status (University of Ibadan, 2008).

2.21. Programmes and activities on HIV and AIDS in the University of Ibadan

An array of HIV/AIDS student-led, institution-led and staff-led activities and programmes have been introduced in tugher education institutions in response to HIV/AIDS (Kelaheire, 2004). This also applies to the University of Ibadan. The University of Ibadan HIV and

AIDS policy has provided for several programmes in the mitigation of HIV in its community.

Saint (2004) argues, however, that the weakness of most current tertiary institutions' responses to AIDS is that they tend to be one-dimensional. They often concentrate on awareness campaigns and do not do enough in terms of voluntary testing, counselling and support, care and treatment, curriculum integration, community outreach, research, and the creation of external partnerships. He suggests that an institutional response strategy to AIDS should be based on a continuum of prevention, treatment, care, and support. HIV and AIDS activities planned and executed with student involvement are reportedly more effective because students generally have an understanding of their social environment that older adults often lack (Kelly, 2001; Otaala, 2003; Saint, 2004). Peer education programmes are cited as being particularly successful. The programmes currently in place need to be evaluated and their contribution to the mitigation of HIV and AIDS in their respective institutions documented, so that this information can be shared with other higher education institutions on the continent.

While many may argue that an educational institution's response to HIV and AIDS should be limited to education about HIV prevention, the effect is more. It plays a significant role in sorting all the dimensions of a comprehensive response to including prevention, treatment, care and support (UNESCO 2008). Officials in school communities with preexisting HIV-related policies thus need to know if their policies are defensible in light of current knowledge, are understood by everyone who might need to follow them, are in the hands of everyone who might need to follow them, and have met the needs of the people affected by them. By systematically evaluating HIV policies, educators can see whether their policies are well conceived and have been effective (UNICEF, 2008; Ellis, Barnett-Page, Morgan, Taylor, Walters, and Goodrich, 2003). If the policies fall short of expectations, they can be improved through revision.

In view of the University of Ibadan HIV and AIDS policy, the following are the main intervention programmes - integrating HIV education into academic programme, and on-campus HIV information and awareness campaigns including peer education, research,

prevention of HIV e g VCT, HIV orientation and provision of care support and ARV in the UI health service (University of Ibadan, 2008). The University's intervention strategies were established, based on the understanding that HIV and AIDS was both a health and a developmental issue that concerned the entire community. Hence the intervention programmes are aimed at furthering the commitment of the institution, to actively mitigate the impact of HIV and AIDS within the University community by both students and staff. Some of the programmes which include curriculum integration with HIV courses, HIV preventive services, research and students' involvement including peer education have been in existence before the policy (AAU, 2007a) but the policy further strengthened the University's commitment to them.

2.21.1. Curriculum Integration

The integration of HIV/AIDS into the curricula has taken on various forms which include incorporating issues within existing courses and or designing stand-alone courses that are either optional or compulsory (Abebe, 2004). According to the AAU (2007a), a University of Ibadan team participated in the UNDP's 2003 training programme which was aimed at mainstreaming in the curriculum. Subsequently, with the support of the MacArthur Foundation, a team proceeded to organise capacity building sessions for academic staff interested in teaching related issues which involved 112 people, with one of the sessions funded by AAU itself. The team also developed general studies core course which is a requirement for all incoming students.

The course involves four hours of contact time focused on -related content as part of a larger programme, including: the epidemiology of HIV, the natural history of HIV infection, transmission and predisposing factors to HIV infection, impact of on society, management of HIV infection and prevention. Three thousand copies of a resource booklet have been published at first and implementation of the course started in 2007. As a follow up to the UNDP course, Ibadan was allocated $10,000 which was used to fund seven research sub grants and a further $3,000 for books and materials. There are other significant curriculum-based efforts at making students 'AIDS competent' in terms of personal and professional skills

The inclusion of HIV in the General Studies course marks significant progress over four years (2003-2006) during which academics and the institutional as a whole has become more receptive to the idea of an institution-wide response to HIV. HIV- related GES courses have now increased to two with a plan to bring in more of such courses as integrated or as stand alone. Subsequently, another organization MEPIN organised a training programme for the lecturers to teach the HIV related courses integrated into the general studies. The core course is called Reproductive Health and Sexually Transmitted Infections including HIV/AIDS with the code GES 107 (University of Ibadan, 2012) and another that talked about HIV infection briefly in Science and Mankind with the code GES 104.

2.21.2. Research

As a result of the activities of the AAU, the Social Science Faculty of the University of Ibadan was selected to conduct a Nation-wide survey under the REACH programme which was in collaboration with the MacArthur foundation (Inkoom, 2008). The University of Ibadan is a major research institution in the region and its flagship programmes include the REACH Programme (AAU, 2007a). Launched in 2006, the Research Alliance to Combat HIV/AIDS (REACH) with support from the Bill and Melinda Gates Foundation is a collaborative programme between the Programme of African Studies and the Buffett Center, Northwestern University and the University of Ibadan, Ibadan, Nigeria. It was aimed at producing knowledge and recommendations for the development of more effective HIV/AIDS prevention strategies in specific Nigerian communities. Also, it aimed to increase the quantity and quality of information available to policymakers, practitioners, activists, researchers, and communities on the factors driving HIV transmission, while building the capacity of Nigerian AIDS researchers (REACH, 2010; AAU, 2007a).

REACH was aimed at examining why prevention efforts fail and how they can be improved using social science expertise and community-based approaches. The outputs of the programme are directed at policy makers, practitioners, activists and those communities most in need of better programming. According to AAU (2007a), the REACH programme was a new initiative that merited best practice recognition on a number of counts. Firstly, it represents a major departure from the tradition of health and biomedical sciences being the leading edge of research on HIV in higher education. This time it's the social sciences

Secondly, it is located within a faculty which has a demonstrated commitment to working on HIV as both an academic pursuit and as part of an institutional response. Thirdly, the research agenda is aimed at using research to influence and support decision making in policy the most use of social science research. Fourthly, this programme builds on the University's reputation for partnerships in high level research and contributes towards its strategy of becoming a premier post graduate teaching and research institution.

2.21.3. Prevention services

The University Health Centre (Jaja Clinic) now referred to as the University Health Service operates as a primary health care centre handling all prevention services (AAU, 2007a) and refers all secondary matters to the University Teaching Hospital. The centre conducts all investigations and is a major treatment access facility. It has since then regularly paid faculty Health visits aimed at providing works place wellness as well as disseminating information on prevailing public health problems. The clinic initiated counselling and testing services in 2002 for students and staff and by 2004, it had tested three hundred and five. A significant number of those tested were positive (13%) but never returned to the centre for any follow up investigations, care or support (AAU, 2007a). Students' perceptions of HIV VCT testing and the delivery of the service are clearly a challenge, as is the case in other institutions profiled in the AAU report (AAU 2007a).

2.21.4. Condom promotion and distribution

A cardinal strategy in the prevention of STI/HIV is the promotion of the use of condoms during sexual intercourse among those who find abstinence difficult (Asekun-Olarinmoye & Oladele, 2009). The correct and consistent use of condoms has been proven to be effective in preventing most STIs including HIV (amFAR AIDS Research. 2005). There is significant debate at the university on the merits of condom distribution and no agreement has yet been reached on distribution at the student residences or the clinic. Condoms are typically available through vendors and shops operating on the campus. (AAU, 2007a). The University of Nairobi in its HIV and AIDS policy stated that staff and students will be advised on condom use on campus (University of Nairobi, 2003). At the University of Capetown, the HIV/AIDS Unit was responsible for distributing approximately 45,000 condoms per month in 2005 as an on-Campus condom distribution. This was a considerable

rise from 14,000 per month in 2004, and included provision for staff (previously, only students were reached). Additionally, over 100 condom vending machines were installed on campus, in both male and female toilets in academic buildings and in the UCT residences. The responsibility for condom distribution was reassigned to Student Health Services in December 2005 (University of Capetown, 2006).

2.21.5. Students' Involvemcot

Saint (2004) stated that AIDS activities planned and executed with student involvement are far more effective as students generally have an understanding of their social milieu that older adults often lack. According to AAU (2007a), the University of Ibadan's primary platform for student involvement is through its peer education project under the umbrella of the CEHAIN programme. Typically, the peer education strategy often involves the use of group members to effect change at the individual level by attempts to personal knowledge, attitudes, beliefs, or behaviour modification (Okello, 2008). Starting in 2001, the peer education project trained 40 students and continued over a three year period on internal resources. In 2005, using additional support from the MacArthur Foundation, the project expanded and has managed to train a total of 389 peer educators. Interestingly, the project managers note that a small percentage of peer educators are willing to test (30% estimated) and an even smaller number (10%) are likely to have tested in the past (AAU, 2007a).

2.21.6. Action Group on Adolescent Health (AGAH)

The Action Group on Adolescent Health (AGAH), established in 1997, is another important student initiative, primarily because it is managed by students themselves. The group's plans were focused on the establishment of a Youth Friendly Centre. It is envisaged that the centre will offer services for: STI treatment and management, counselling including rights and sexual and reproductive health, essential drugs and VCT. AGAH's campaign in June 2006, netted 200 students who tested (AAU, 2007a).

2.21.7. Youth Friendly Centre

The YFC was established in October 2007 by the College of Medicine, University of Ibadan. It is located in the former Laboratory Training building behind the Zoological

garden along Technology or Appleton road in the University of Ibadan campus. It offers recreational services for students and staff alike. The centre also offers general counseling, intervention on health issues and library information services. It provides HIV counseling and testing as well as referral of anyone who tests positive. The centre refers the individual that tests positive to the appropriate facility in the teaching hospital of the University for confirmation and subsequent care and support. The YFC also conducts HIV orientation for first year students of the University and trains peer educators. The centre works with AGAH which refers fellow students for HIV counseling and testing. The Center is manned by professional counselors in STIs prevention and control.

2.22. Role of Health Promotion and Education in the development and implementation of HIV and AIDS Policy

Health promotion and education play a significant role in the total health of every community. The Ottawa Charter of health promotion according to Kessler and Renggli (2011) outlined five strategies for ensuring that all people have the right to health resources. UNESCO (2010) stated that this is achieved by the actions of developing healthy public policies which builds co-operation of all governments and policy makers across all sectors and at all levels to consider the health consequences of their decisions and to accept their responsibilities for health. Other actions include creating supportive environments which leads to the responsibility of people in communities to take care of themselves and generating safe, satisfying and enjoyable living and working conditions. Another one is strengthening community action empowering them and strengthening public participation and community ownership and control over the direction of health matters. Developing personal skills and reorienting health services are the last two actions. Reorienting health services will broaden the role of health services to shared responsibilities and partnerships for health (Ziglio, Simpson and Tsouros, 2011). This will be a shift from a dominant clinical and curative orientation to one that emphasises prevention with a focus on the social, political, economic and environmental components connected to health. The Ottawa Charter's calls for development of healthy public policies however has been regarded as essentially one of the many roles of the health promotion professional (WHO, 2001).

A University is both a school and a workplace therefore the principles of school health promotion and workplace health promotion apply (Ministry of Health Promotion, 2010). Health promotion in a school setting could be defined as any activity undertaken to improve and/or protect the health of everyone in the school community (Young, St Leger and Buijs, 2013) Health education in a school is a communication activity and involves learning and teaching pertaining to knowledge, beliefs, attitudes, values, skills and competencies (WHO, 2012c). It is often focused on particular topics, such as tobacco, alcohol, nutrition; or it may involve reflecting on health in a more holistic way (St Leger, Young, Blanchard and Perry, 2010) These authors continued to list the principles of health promoting school which is based on the aforementioned Ottawa Charter's health promotion actions. Evidence has shown that both education and health outcomes are improved if the school uses the health promoting school approach in addressing health related issues in an educational context (Whitman and Aldinger, 2009; Stewart-Brown, 2006).

In workplace health programme, health promotion and education actions are applied for intervention and policy development and implementation have become significant (Heuning, Warren, Roberton et al, 2009). The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) Kenya has remarkably marked out the roles of health promotion focal persons in the programme in planning and implementing the HIV and AIDS and Workplace Health Promotion programme for the national GTZ staff (GTZ, 2012). The Focal Person initiates and participates in the development of a programme and project based annual plan of action. This including assisting to adapt a workplace health promotion (WHP) and HIV and AIDS workplace policy for Kenya offices and organise information material (IEC) on WHP and HIV and AIDS to be placed and distributed at the offices (GTZ, 2012).

Health education and promotion will assist in the programmes that are needed to provide technical assistance to universities (Szekeres, Coates, and Ehrhardt, 2008) in the development and implementation of HIV policy. Effective leadership development is also required for a sustained commitment of resources, mentorship and ongoing programme evaluation which is one of the efforts of health education (Szekeres et al, 2008). The

competencies of health promotion also come into play in implementing the HIV policy in an institution (Kulbok, Thatcher, Park, and Meszaros, 2012; Jacobs, Jones, Gabella, Spring, and Brownson, 2012). For example, creating tailored messages and using the most effective media channels are crucial for reaching workers and persuading them to change their behavior (ILO, 2008). Chetty (2003) highlighted roles of the focal person in the development and implementation of policy which includes advocacy, sensitization, resource mobilization, partnership development and management, policy development and programme design. Others are implementation support for projects, co-ordination, stakeholder liaison, networking, research and evaluation.

All these are core competencies of specialists in health promotion and education (Dempsey, Batel-Kirk, Barry and the CompHP Project Partners, 2011; Ramsden, McKay and Crowe, 2010). Health promotion and education contributes greatly to the conception, development implementation, monitoring, evaluation and review of policies and programmes (SafAIDS/ILO, 2010; Dempsey et al, 2011). According to Sills (2011), health promotion and health education cannot be separated from related issues arising in the school setting where efforts to protect the future generations are concentrated. Health promotion and health education in schools are also dealing with prevention, education, dissemination of information, skill development (Navarro, Voetsch, Liburd, Bezold & Rhea, 2006), elimination of risk in a case of emergency, allaying anxieties of teachers, students and the community. There is also the provision of social support, referrals to appropriate practitioners and advocating appropriate policy development (Sills, 2010).

Appropriate training and capacity building in health promotion and health education are required in general but more specifically the attitudes, skills and knowledge required to address related issues are crucial (Sills, 2011). Health promotion particularly uses the strengthening of community action in interventions. Community level interventions aim to support the effectiveness of such by risk reduction through the diffusion of messages and norms (Cohen, Chavez and Chehimi, 2007). The authors also submitted that rather than trying to reach every individual in the community, opinion leaders are often involved who will in turn diffuse the message or norm to the rest of the community. Such messages or norms could be structural which includes policy, technology, or environmental.

2.23. Role of Leadership in the development and implementation of HIV and AIDS policy

Leadership can be defined as the capacity to inspire others to action and it is critical for the development of individuals, organizations and societies (UNDP, 2005). Despite the many strategies mitigating the impact of HIV in the education sector, there is still a gap. The multiple sexual partnerships, sexual exploitation of female students and sexual relationships between staff and students placed students at high risk of HIV infection (Baba Djara, Brennan, Comeliess et al, 2013; Shumba, Mapfumo, and Chademana, 2011). Therefore support to plan and implement HIV interventions in tertiary educational institutions is critical (UNESCO, 2011). Stakeholder awarencss is imperative, because by empowering stakeholders who are leaders with information pertaining to HIV and AIDS programme content, stakeholders would be equipped with a resource that informs them as to the consequences of the disease and support structure available within the university. Improving stakeholder awareness as to HIV/AIDS programme would facilitate stakeholder awareness as to possible recourse in the event of infection (Gobind and Ukpre, 2014).

Policy-making is not just about a particular decision made at a certain point in time but needs to be understood in the context of ongoing interactions and conflicts among institutions, interests (the groups and individuals who stand to gain or lose from change) and ideas - discourses, arguments and evidence (Dickinson and Buse, 2008). HIV and AIDS strategies and actions, if they are to be successful, require not only an unprecedented social and political mobilization across all sectors, but also a deep transformation of norms, values and practices (UNPD, 2005). Thus the need for good leadership in the tertiary institutions for influencing HIV policy formulation and implementation (HESA, 2008).

National authorities demonstrate genuine ownership and leadership in transforming the response to the epidemic by strengthening partnerships with key stakeholders (UNDP, 2005), achieving exceptional implementation at a sub-national level, and continuously creating innovations and new strategies (UNDP, 2005). To demonstrate leadership is to develop socially responsible initiatives that are directly related to protection of a company's core-competencies (Asian Business Coalition on AIDS, 2002). To this effect, there exist four potential threats to sustainability of workplace programmes (Asian Business Coalition

on AIDS, 2002). These include lack of top-management commitment, employer's belief that HIV and AIDS is not a corporate responsibility, perception that HIV/AIDS prevention is expensive and lack of knowledge of care and support issues (UNDP, 2005). It is therefore important to secure the commitment of top management (UNAIDS, 2012a; Asian Business Coalition on AIDS, 2002) to be able to take care of the threats.

Major role players in the wider institution community for example religious and traditional leaders, representatives of the medical or health care professions should be involved in developing an implementation plan on HIV and AIDS for the institution (South African Department of Education, 1999). Preparing for policy development requires a broad-based participatory process, including a situation and response analysis. The strategies employed include rapid assessment, programme review, and independent consultations with input from all stakeholders (Obasanjo and Odowole, 2006).

Religious leaders are in the unique position of being able to alter the course of the HIV pandemic because they can shape social values, promote responsible behaviour that respects the dignity of all persons and defends the sanctity of life, increase public knowledge and influence opinion (CIJAHA, 2009). They can also support enlightened attitudes, opinions, policies and laws, redirect charitable resources for spiritual and social care and raise new funds for prevention and for care and support and promote action from the grass roots up to the national level (UNICEF, 2003). Religious leadership in the response to HIV provide moral guidances with regard to ensure that sexual abstinence and mutual fidelity are cornerstones of HIV prevention (The Juridical Society, 2008; Green, 2003). In this regard, religious group must face the reality that there will always be people who are not willing or able to conform to these teachings and standards of behaviour, thus placing themselves and others at risk (UNICEF, 2003).

Faith-based organizations responding to HIV need to provide clear and accurate information on ways to avoid contracting and spreading HIV, including the use of condoms which is an emotionally charged issue (Kelly, 2003; World Council of Churches, 1996). The condom use could be tackled by including scientific information on the proven effectiveness of condoms in preventing HIV transmission, presented in the context of relevant doctrines and

religious teachings (UNICEF, 2003). Many religious organizations, while promoting the sanctity of sexual relationship within marriage and providing abstinence and fidelity education, are in a good position to promote condoms in an appropriate, targeted and sensitive manner as one part of an overall prevention strategy (Government of Rwanda, 2005). Obasanjo and Oduwole, (2006) however concluded that according to studies that have provided ample evidence, broad-based stakeholder participation in policy design and implementation leads to increased effectiveness of programmes.

2.24. Unions and Bodies in the University

In order to strengthen the capacity, system and structures responding to HIV and AIDS on University campuses, the unions, bodies and their leaders are relevant. Trade union and other union leaders representatives of bodies are very influential and they promote the interest of their members (Fasboyin, 1998). The unions in the Universities are basically for academic staff, non teaching staff and students. The union and youth leaders can help promote the HIV policy as well as motivate their members to participate (Szekeres, et al, 2008) and utilise the programmes on HIV control on campus. They can also ensure commitment to and participation in HIV and AIDS institutional programmes such as hold regular HIV and AIDS awareness programmes, encourage HCT, conduct education and training on HIV and AIDS, promote condom distribution and use and encourage health-seeking behaviour for STIs among their members. They can also establish Peer Education or support groups, enforce the use of universal infection control measures and promote education and awareness about antiretroviral and treatment literacy programmes, counselling and other forms of social support for infected employees (HEAIDS, 2012).

Saint (2004) stated that the fight against HIV and AIDS requires leadership. Tertiary level staff and students are traditionally among the leaders of their societies, and their active involvement is essential to the development of open national debate and action responses related to the HIV/AIDS epidemic. The author submitted that among the issues that should interest the union leaders should be measures to prevent the sexual harassment of union members, prevention of infection among union members, ensuring that union members living with AIDS are treated fairly (Saint, 2004). Also, protection of union members from discrimination and recourse to redress when discrimination occurs and shielding of

employee benefits from dilution in the face of AIDS are what they (union leaders) must take serious (Holdemess. 2012).

2.25. Conceptual Framework

For this study, the PRECEDE Model and the Transtheoretical Model were used.

2.25.1. PRECEDE Model

Theories are important in the planning and delivery of health improvement services as health promotion needs to be carefully planned to be efficient and effective (Araujo, 2009). Theory can guide practitioners during the various stages of planning, implementing, and evaluating an intervention (NIH, 2005) to ensure that interventions actually reach and have a demonstrable impact on individuals, communities and organizations. Theory provides an essential framework for studying problems, developing appropriate interventions, and evaluating their successes (Araujo, 2009; Green, 2000). Different theories and models are used based on the targets which may be individual groups, organization or communities as well as the health problem. For this study, the PRECEDE MODEL was used which provided a framework for identifying the factors that are linked to the knowledge, perceptions and involvement in activities relating to the institutional policy among students and staff of the University of Ibadan. PRECEDE is an acronym which stands for Predisposing, Reinforcing and Enabling Constructs in Educational Dingnosis and Evaluation (Green, and Kreuter, 2005; Green, 1974).

The PRECEDE framework or model was developed by Lawrence Green and associates to provide a road map for designing health education and health promotion programs (NIH, 2005. Hazavehei, 2003). It offers a framework for problem solving (Parent, Kahombo, Bapitani, Garant, Coppieters, Leveque and Piette, 2004) and guides planners through a process that starts with desired outcomes and works backwards to identify a mix of strategies for achieving objectives (NIH, 2005). Developing in the 1970s, this component of the model posits that an educational diagnosis in this context refers to the determination of the factors which influence people's behaviours or practices. It further emphasizes planning interventions by focusing on the expected outcomes of action based on epidemiological, social, behavioural, environmental, educational, organisational, administrative and political diagnoses of a social, health and/or educational situation.

According to the framework, any behaviour is caused by some behavioural antecedents. The antecedents could be categorized into three groups of factors - predisposing, enabling and reinforcing factors (NIH, 2005). The predisposing factors which influence behaviour include awareness, knowledge, attitude, interest, beliefs, perceptions, norms, values and culture. Within the context of this study, level of awareness about the policy of the University of Ibadan, knowledge of its provisions and perceptions of both students and staff can influence the way they perceive HIV issues within University community. These factors can also influence the implementation of the intervention programs put in place towards control as provided by the policy.

The enabling factors refer to presence or absence of information. Source of information for becoming aware of the policy and programmes include workshops and seminars, HIV sessions at the orientation for new students, screening outreaches, departmental briefing, hall meetings, GES courses on HIV, Information on the internet and newsletter or bulletin of the University. These factors have the potential for influencing the perceptions and behaviour of students and staff of University of Ibadan in relation to becoming aware of their rights, roles and responsibilities leading to action on improving their health based on the provisions of the policy. The reinforcing factors refer to the influence of significant others These include stakeholders such as the University authority, union leaders, students leaders, policy development committee, hall wardens and campus based organizations and health service providers. These stakeholders have the potential to influence the University community to be fully aware of the provisions of the policy by providing support thus facilitating ownership and proper implementation of the policy.

The PRECEDE framework was used in this study in the selection of variables for assessment. The variables include awareness, knowledge, beliefs, attitudinal perceptions, and or involvement in activities related to the provisions of the university policy.

Figure 2.1: PRECEDE framework adapted to explain awareness and uptake of the HIV and AIDS policy provisions by the staff and students of the University Ibadan Community

Administrative diagnosis

Educational diagnosis

Behavioural Diagnosis

Quality of Life

Planning
- Policy formulation
- Training
- Public enlightenment

PREDISPOSING FACTORS
- Awareness
- Knowledge
- Perceptions
- Interest
- Intentions
- Beliefs

About HIV and AIDS Policy of the institution

Developmental strategies
- Establishing services
- Training providers
- Linkages with other agencies

ENABLING FACTORS
- HIV sessions at orientation for new students
- Screening Outreaches,
- Workshops/ seminars
- Departmental briefings
- Hall meetings
- GES courses on HIV
- Information on the internet,
- Newsletter or bulletin of the University

- Owning a copy of the HIV/AIDS policy
- Reading and understanding the provisions
- Knowledge of the rights, roles and responsibilities
- Practices based on the policy (participating in the HIV activities

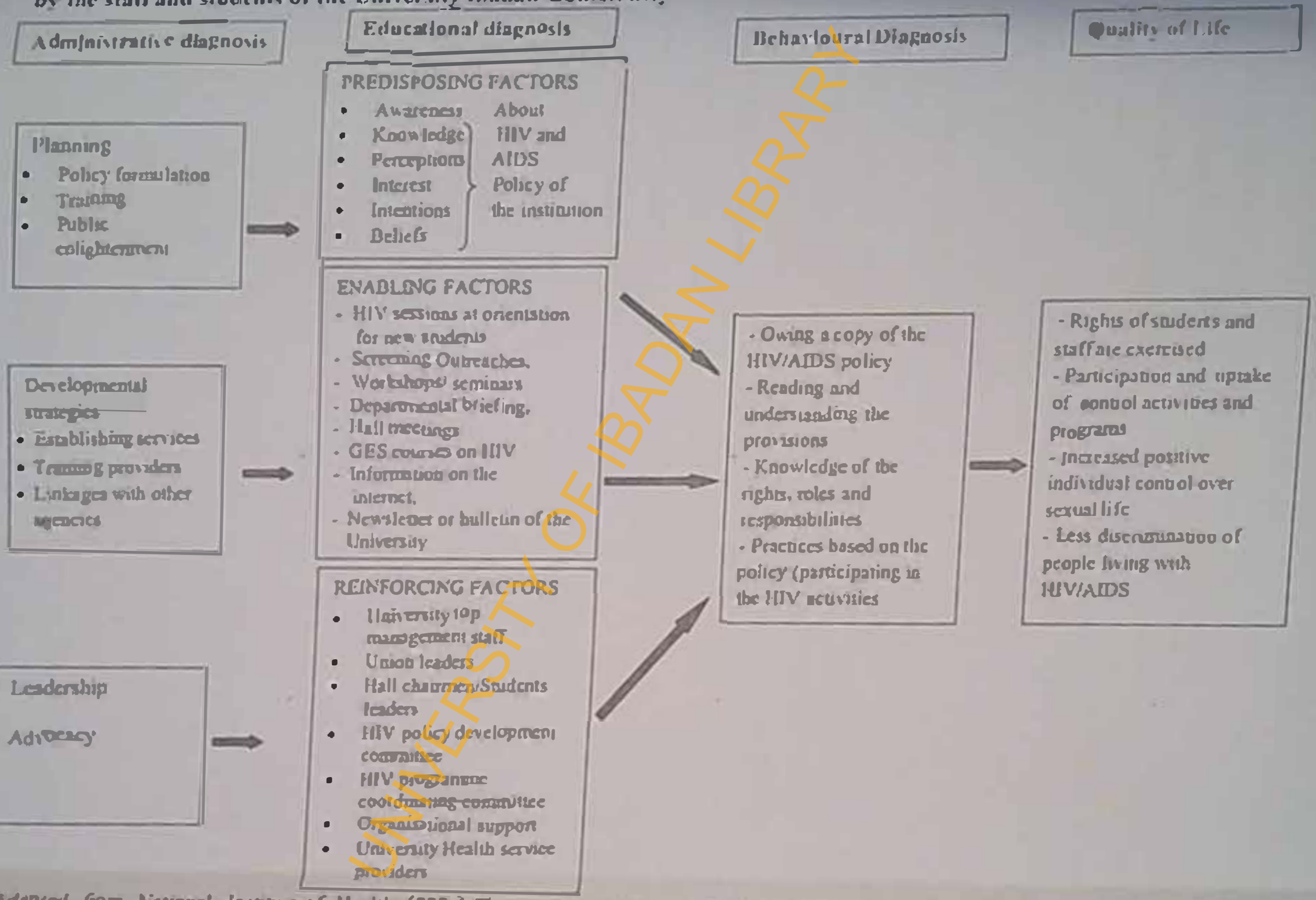
- Rights of students and staff are exercised
- Participation and uptake of control activities and programs
- Increased positive individual control over sexual life
- Less discrimination of people living with HIV/AIDS

Leadership

Advocacy

REINFORCING FACTORS
- University top management staff
- Union leaders
- Hall chairmen/Students leaders
- HIV policy development

Figure 2.1: PRECEDE framework adapted to explain awareness and uptake of the HIV and AIDS policy provisions by the staff and students of the University Ibadan Community



Adapted from National Institute of Health (2005) Theory at a glance: A guide for health promotion practice. National Institute of Health U. S. Department of Health and Human Services

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Leadership

Advocacy

REINFORCING FACTORS
- University top management staff
- Union leaders
- Hall chairmen/Students leaders
- HIV policy development committee
- HIV programme

2.25.2. TRANSTHEORETICAL MODEL (Stages of change model)

The Transtheoretical Model (TTM) also called The Stages of Change Model was presented in the 1980s by James O. Prochaska and Carlo C. DiClemente. The model evolved from work with smoking cessation and the treatment of drug and alcohol addiction and has recently been applied to a variety of other health behaviours. The basic premise is that behavior change is a process and not an event, and that individuals are at varying levels of motivation, or readiness, to change. People at different points in the process of change can benefit from different interventions, matched to their stage at that time.

Five distinct stages are identified in the Stages of Change Model: pre-contemplation, contemplation, preparation (decision/determination), action, and maintenance. People do not go through the stages and "graduate"; they can enter and exit at any point, and often recycle. Studies have shown that individuals go through the same changes when using self-help or self-management methods, or when they seek professional help or go to organised programmes. Also, there appear to be differences in how the stages fit the situation for different problem areas (NIH, 2005)

Table: 2.1 **Transtheoretical Model applied to the intention of students and staff of University of Ibadan to be involved in the HIV control related activities on campus**

Stage	Definition	Potential change strategies
Pre-contemplation	Staff and students have no intention of involving in HIV voluntary counseling and testing	Enlightenment through distribution of copies of policy Effective awareness programmes
Contemplation	Staff and students who have become aware of VCT and where to do it on campus and have started thinking about it	Campus awareness GES HIV course Seminar HIV orientation Social marketing Peer education
Preparation	Staff and students who have the intention to go for HIV screening have identified the centre and is preparing to visit	Training Social support Policy intervention
Action	Staff and students who have visited any screening centre on campus for VCT	Training Counselling Social marketing
Maintenance	Staff and students who have tested for HIV and are discharging their responsibilities in prevention of HIV on campus	Public enlightenment Peer education Enforcement of policy

Adapted from National Institute of Health (2005) Theory at a glance: A guide for health promotion practice. National Institute of Health U. S. Department of Health and Human Services

CHAPTER THREE

METHODOLOGY

This chapter starts with a description of the study setting, study design and scope. The chapter also included the following methodological elements: the study population, sample size and sampling technique, methods of data collection, validity and reliability, data collection process, data management and analysis, ethical consideration and limitations of the study.

3.1. Study design and scope

This study was a descriptive, cross-sectional survey. It was limited in scope to the determination of the awareness, knowledge, perception and involvement of staff and students of the University of Ibadan in HIV-related activities or practices in line with the provisions of the institutional HIV and AIDS policy of the University of Ibadan.

3.2. Description of the study area

This study was carried out at the University of Ibadan (UI) which is located in Ibadan North Local Government Area of Oyo State. The University was first founded as a College of the University of London in 1948. It covers over 1,032 hectares of land (University of Ibadan, 2013). It is the oldest and most reputable tertiary institution in Nigeria. The vision of the founding fathers was to make the academic institution a centre of excellence as well as the foremost institution for the provision of human resources required for Nigeria's socio-economic, physical growth and development (University of Ibadan, 2013).

There are 13 faculties in the University which offer undergraduate and post graduate courses (See Table 1). They are the Faculties of Arts, Social sciences, Law, Science, Technology, Pharmacy and Education. Others are the faculties of Basic Medical Sciences, Clinical Sciences, Dentistry, Public Health, Agriculture and Forestry and Veterinary Medicine. The 13 Faculties have a total number of 94 Departments. There are also four Institutes and two Centres in the institution. The University has a total of 4,264 staff comprising 1217 academic staff (Female – 322, Male – 895) 3,047 non- teaching staff (Female – 941, Male – 2106) as at 2010 (University of Ibadan, 2010).

The Total students population was 20,715 as at 2010 with postgraduate students accounting for 8208 (full time – 7280, part time- 928) while the undergraduate students constituted 12,507. Female students were 8,394 while male students were 11,781. The total population of students accommodated on campus was 8,743 as at the time of this study. Other students live in private halls of residence and off-campus residences in the city. There were twelve halls in residence of the University with eleven located within the main campus and one at the University College Hospital (UCH), an affiliate Teaching Hospital of the University.

3.3. Study population

The study population comprised students (undergraduates and postgraduate students) who officially reside in various halls of residence of the University and members of academic and non-teaching staff. The distribution of the academic and non-teaching staff is presented in Table 3.1.

Table 3.1: Distribution of academic and non-teaching staff of UI by Departments

	Faculty	Number of Department	Academic staff	Non-teaching staff	Total
1.	Faculty of Arts	10	134	52	186
2.	Faculty of Social Sciences	7	107	55	162
3.	Faculty of Law	2	24	16	40
4.	Faculty of Science	9	192	157	349
5.	Faculty of Technology	7	77	76	153
6.	Faculty of Pharmacy	5	32	46	78
7.	Faculty of Education	9	115	78	188
8.	Faculty of Agriculture and Forestry	7	117	106	223
9.	Faculty of Basic Medical Sciences	9	77	96	173
10.	Faculty of Clinical Sciences	14	143	107	250
11.	Faculty of Dentistry	5	21	25	46
12.	Faculty of Public Health	3	28	38	66
13.	Faculty of Veterinary Medicine	7	80	89	169
14.	Other Academic Institutes	4	36	78	114
15.	Teaching Support Units	8	1	112	113
16.	Organised Research Unit	1	8	5	13
17.	Public Service Units	6	4	71	75
18.	Other Academic Units*	2	21	88	109
19.	College of Medicine (Administrative Units)	4	0	129	129
20.	Non-teaching Units	40	0	1628	1628
	Total	159	1217	3047	4264

(Source: Planning Unit Information, Office of the Vice Chancellor, University of Ibadan, 2010)

* African Regional Centre for Information Science, Abadina Media Resources Centre

The faculties and other service units were grouped into clusters based on similarities in the areas of studies as shown in Table 3.2

Table 3.2: The clusters of the Faculties/Department/academic/service/nonteaching units

	Cluster	Faculties/Service Units	Total no of Faculties (F)/ Departments (D)/others in a cluster		Number of staff (academic – A, non-teaching – N)		
			F	D	A	N	TOTAL
1.	Medical/Health Sciences	Basic Medical Sciences, Clinical Sciences, Public Health, Dentistry, Pharmacy	5	36	301	312	613
2	Science and Technology	Science, Technology	2	16	269	233	502
3.	Agricultural and animal health sciences	Agriculture and Forestry, Veterinary Medicine	2	14	197	195	392
4.	Arts and Social sciences	Law, Social sciences, Arts and Education	4	28	380	201	581
5.	Postgraduate programs	Post graduate School, IMRAT, Institute of Education, Institute of African Studies, ARCIS		5	44	83	127
6.	Teaching support and public service	University Media Centre, Biomedical Communication, Animal House (College), Ibarapa Programme, Computing Centre, Industrial					
7.	Teaching support and public service	Training Coordinating Unit, Teaching and Research Farm, Central Animal House, Abadina Media Resource Centre, Botanical Garden, Zoological Garden, Publishing House, Equipment Maintenance Centre, Veterinary Teaching Hospital		14	5	183	188
8.	College of Medicine and other academic units	College Office, Provost's Office, Internal audit, Finance Office, Library (Main), Library (Medical)		6	21	217	238
9.	Non-teaching Units	Vice-Chancelor's Office, Registrar's Office, Student Affairs Div, Bursary, Works and Maintenance, Health Services Centre, GSP, Registry (Admin), Admissions, CEPNAR, Council, Establishments, Academic Affairs Div, Industrial Relation Office, Publications Unit, Students Records, Internal Audit, Legal Office, MIS/ICT, Planning Office, Public Relations Unit, Physical Planning Unit, Multi-disciplinary Central Research Lab, Security, Central Catering Service, Sports Council, Estate, Staff School, Halls - Alexander Brown, Nnamdi Azikwe, Tafawa Balewa, Queen Idia, Independence, Kuti, Mellanby, New PG, Queen Elizabeth, Sultan Bello, Tedder, Awolowo		40		1628	1628
		GRAND TOTAL			1217	3047	4264

(Source: Planning Unit Information, Office of the Vice Chancellor, University of Ibadan, 2010)

3.3 Sampling procedure

3.3.1 Sample size determination

It is often impracticable for investigators to study the entire target population (Burns, Duffett, Kho, Meade, Adhikari, Sinuff and Cook, 2008). This is often and as a result of lack of resources. Consequently, samples of the population are often selected and used. When this is scientifically done, the results can still be generalized. It is a sample of the academic staff, non-teaching and accommodated students that were used in this study.

The formula used to calculate the sample size was as follow:

$$n = \frac{z^2(p(1-p))}{d^2} \quad \text{(Cochran, 1963)}$$

Where:

n = Sample size

z = Level of degree of confidence at 95% = 1.96

p = An estimate of the proportion of staff and students aware of the HIV policy = 50%

d = Level of precision (the proportion of error to accept) = 3%

$$= \frac{1.96^2 \times (0.5(1-0.5))}{0.03^2}$$

$$= \frac{3.8416 \times 0.25}{0.0009} = 1067$$

Attrition and incomplete responses were expected so, the 10% (107) of the calculated sample size was added, giving the sample size of 1174. This frame was rounded up to 1200 for better precision. Proportional sampling method was therefore utilised to arrive at the samples of size to each subgroups to be studied. Official records of the University of Ibadan for 2010 was used to facilitate the calculation of the proportions. The proportions were calculated using the following formula.

$$\text{Sample size for each group} = \frac{\text{sample population of group} \times \text{calculated sample size}}{\text{Total sample population}}$$

$$\therefore \text{Sample size for the proportion of staff} = \frac{4264 \times 1200}{24979} = 204.84 = 205$$

For academic staff = $\frac{1217 \times 205}{4264}$ = 58.51 ≈ 59

For non-academic staff = $\frac{3047 \times 205}{4264}$ = 146.49 ≈ 146

Sample size for the proportion of students = $\frac{20715 \times 1200}{24979}$ = 995.15 ≈ 995

For undergraduate students = $\frac{12507 \times 995}{20715}$ = 600.74 ≈ 601

For postgraduate students = $\frac{8208 \times 995}{20715}$ = 394.25 ≈ 394

3.3.2 Sampling procedure

In order to select a sample of the population to be studied, a multi-stage sampling technique involving two stages for staff and three stages for students was employed. For each study group, the study community was divided into various strata (stratified sampling).

Stages of sampling – For Staff

Stage 1

Selection of the faculties

Four clusters out of the eight clusters (Medical/Health sciences, Science and Technology, Arts, Postgraduate program, Teaching support and public service, College of Medicine, other academic units and Non-teaching units) were selected using balloting. Two faculties were then randomly selected from each of the clusters by balloting. Two units also from the non-teaching clusters were selected using the same method to make a total of six faculties and two non-teaching units. For the selected clusters with not more than two faculties, all were included in the sample for the study. The clusters are presented in Table 3.3

Table 3.3: Selection of Faculties from the cluster chosen

	Selected clusters	Two selected faculties/units
1.	Medical/Health Sciences	Clinical Sciences, Pharmacy
2.	Art	Social Sciences, Education
3.	Science and Technology	Science, Technology
4.	Non-teaching	Establishments, Sports Council

Selection of departments from faculties

In each faculty, three departments were selected using the simple random sampling technique (balloting) to make a total of six departments in addition to the two non-teaching units already selected. Balloting method was employed in the selection. The departments selected cluster are presented in Table 3.4.

Table 3.4: Selection of Departments from the faculties chosen

	Selected cluster	Selected departments/units
1.	Clinical Sciences	Radiotherapy, Medicine, Peadiatrics
2.	Pharmacy	Pharmaceutical Chemistry, Pharmacognosy, Pharmaceutical Microbiology
3.	Social Sciences	Geography, Psychology, Political Science
4.	Education	Guidance and Counselling, Special Education, Social Work
5	Science	Statistics, Computer Science, Geology
6	Technology	Civil Engineering, Petroleum Engineering, Food Technology
7	Non-teaching	Establishments
8.	Non-teaching	Sports Council

Stage 2

Based on the staff strength of each selected department, calculated proportion of staff (academic and non-teaching) was selected using a simple random sampling method. (Table 3.5 shows the details).

Table 3. 5: Proportions of academic and non-teaching staff to be selected for the study

	Selected Department/Unit	Total Number of Academic staff	Proportion of academic staff selected	Total number of non-teaching staff	Proportion of non-academic staff selected	Total selected
1	Radiotherapy	7	2	3	2	4
2	Medicine	16	5	8	6	11
3	Paediatrics	12	3	13	9	12
4	Pharmaceutical Chemistry	6	2	9	6	8
5	Pharmacognosy	6	2	9	6	8
6	Pharmaceutical Microbiology	8	2	6	4	6
7	Geography	18	2*	13	9	11
8	Urban and Regional planning	7	5**	3	2	7
9	Political Science	16	5	4	3	8
10	Guidance and Counselling	15	4	5	4	8
11	Social Work	66	2	5	4	6
12	Special Education	11	3	10	7	10
13	Statistics	16	5	5	4	9
14	Computer Science	17	5	12	9	14
15	Geology	19	5	10	7	12
16	Food Technology	7	2	9	4	6
17	Civil Engineering	13	3	9	6	9
18	Industrial Engineering			7	2***	3
19	Petroleum Engineering	7	2	5	3	5
20	Establishment			39	28	28
21	Sports Council			30	21	21
	Total	209	59	214	146	205

* *Number selected not complete because staff were on leave*

** *Addition to make up for the shortage in Geography*

*** *Make up for non-teaching staff in Food technology (2) and Petroleum Engineering (1)*

Stages of sampling – For Students

All the 12 halls of residence for students were listed based on male and female accommodation facilities provided by the University of Ibadan. Eleven Halls are located within the campus of the University of Ibadan while the remaining one is located within the University College Hospital. All the University halls of residence were used for the study. (Table 3.6 shows details)

Table 3.6: The Halls of Residence with the students distribution

	Halls of Residence	Undergraduate (UG)/Postgraduate (PG)	Male/Female/Mixed
1	Queen Idia Hall	UG	Female
2	Queen Elizabeth Hall	UG	Female
3.	Nnamdi Azikwe Hall	UG	Male
4.	Independence Hall	UG	Male
5.	Kuti Hall	UG	Male
6.	Mellanby Hall	UG	Male
7.	Sultan Bello Hall	UG	Male
8.	Tedder Hall	UG	Male
9.	Alexander Brown Hall*	UG	Mixed
10.	Obafemi Awolowo Hall	UG/PG	Mixed
11.	Tafawa Balewa	PG	Mixed
12	New Postgraduate Hall	PG	Mixed

* *Hall for Medical students is located within the University College Hospital (UCH), Ibadan*

Stage 1

Number of student participants to be used for the study in each hall of residence was determined by proportionate sampling using all the blocks within each hall of residence to ensure fair sampling. Total population of students in the undergraduate halls of residence was 7440 while total for post graduate students population their three halls of residence was 1393. Table 3.7 presents the number of students selected in each hall of residence and other details

Table 3.7: Number of students selected in each hall

Hall of Residence	Type of hall	Number of blocks in the hall	Number of students in the hall	Number of respondents selected in each hall
Alexander Brown	Undergraduate	7	693	56
Tedder	Undergraduate	4	549	45
Mellanby	Undergraduate	4	565	46
Kuti	Undergraduate	5	557	45
Sultan Bello	Undergraduate	5	422	35
Nnamdi Azikiwe	Undergraduate	4	940	76
Independence	Undergraduate	4	956	79
Obafemi Awolowo	Undergraduate	9	1222	125
	Postgraduate		396	97
Queen Idia	Undergraduate	4	956	79
Queen Elizabeth	Undergraduate	4	580	47
New PG Hall	Postgraduate	4	700	211
Tafawa Balewa	Postgraduate	5	207	60
Total		59	8743	1001

Stage 2

Systematic sampling was used to select student participants at the room level of each block using a sample interval based on the ratio of the student to the allocated sample for that Hall. This ensured that a representative is captured from each block from all halls of residence.

Stage 3

In each room selected, simple balloting procedure was used to select a participant.

3.4 Instruments for data collection

Data for the study were collected using a combination of quantitative (Semi-structured questionnaire) and qualitative (Key Informant Interviews, KII) methods.

The instruments (semi-structured questionnaire and KII guide) were designed after reviewing the policy of the University of Ibadan, related literature and extracting pertinent variables relating to university policies. These were used to tease out knowledge, perceptions and involvement or practice variables for measurement relating to the U.I policy on HIV and AIDS. The validated questionnaire used for collecting the quantitative data included a 38-point knowledge scale, 17-point perception scale and 8-point participation scale

- Semi-structured questionnaire: A semi-structured, self-administered questionnaire which consisted of five sections labelled A-E, was used to collect quantitative data from respondents. The design of the questionnaire was facilitated by use of the research questions, study objectives and the reviewed literature. Section A focused on the socio-demographic characteristics of the respondents while section B contained questions on awareness of the University's policy. Section C contained questions used to assess the knowledge of respondents relating to the provisions of the policy, section D had questions related to the respondents' perception of the University's policy. Section E focused on awareness and participation of staff and students in HIV control activities and programmes within the University (Appendix 1).

3.4.1. Scales for knowledge, perception and participation

The instrument also included three scales; these were knowledge, perception and participation/involvement scales.

38-point knowledge scale was used to determine the level of knowledge of respondents related to the provisions of the HIV and AIDS policy of the University of Ibadan (Appendix 2). The knowledge scores were categorised as poor, fair and good (Appendix 3).

The 17-point perception scale was used to rate the perception of respondents related to the provisions of the HIV and AIDS policy of the University of Ibadan (Appendix 4). The perception scores were classified as unfavourable and favourable (Appendix 5).

8-point participation scale was used to rate the participation of respondents in programmes and activities related to HIV control on campus (Appendix 6). Participation was ranked as low, moderate and high participation (Appendix 7). The administration of the questionnaire which took place after obtaining consent from the participants was coordinated by the researcher and the research assistants.

ii. **Key Informant Interview Guide:** Key Informant Interview (KII), was used as a diagnostic tool to have an insight into the stakeholders' involvement and support for the policy and programme implementation in the University. The KII sought to determine the extent of stakeholders' input in the policy formulation, dissemination and implementation. The KII interview also captured the challenges which characterise the policy implementation and to document suggestions for the way forward. A KII guide consisting of 13 items with probes was used to facilitate the interview process (Appendix 8).

In all, 20 KIIs were conducted and they were conducted simultaneously with the main survey. Convenience sampling was employed to select the key informants for the study. The key informants are presented in Table 3.8.

Table 3.8: Selected Key Informants

	Category	Number
1.	Member of the policy development committee	1
2.	Member of the policy steering committee	1
3.	Managerial staff of the University Health Service	2
4.	University Administrator (Dean, student affairs)	1
5.	University Administrator (Deputy Vice-Chancellor)	1
6.	ASUU leader	1
7.	SSANU leader	1
8.	NASU leader	1
9.	Student Union leader	1
10.	Hall chairmen (Students)	6
11.	Religious leaders	3
12.	Coordinator Youth Friendly Centre	1
	Total	20

3.5. Validity of the instrument

Validity is a measure of the ability of an instrument to measure what it is designed to measure (Burns, Duffett, Kho, Meade, Adhikari, and Cook, 2008). The validity of the KII guide and the questionnaire was conducted. The instruments were reviewed by the researcher's supervisor and other experts in the field of public health; their inputs were incorporated into the instruments. This made it possible to ascertain whether the content of the instrument was appropriate enough to assess the issues under investigation. This was necessary for face and content validity of the instrument.

The questionnaire and the KII guide were pre-tested. The pre-test enabled the researcher to assess the pattern of responses of participants, their level of understanding of the items in the instruments and the duration of time it would take to administer the instruments. The questionnaire and KII guide were pre-tested among staff and students at Obafemi Awolowo University (OAU), Ile-Ife, Osun State. This involved administering the questionnaire to 115 staff and students of the OAU; the KII guide was administered on a member of the HIV Policy committee of the University.

The OAU shares sinular characteristics with the University of Ibadan in terms of their ownership and the diversity of the population as regards structure, composition and organisation. It is, like U-I, one of the first generation Universities in Nigeria. OAU at the time of the pre-test had a policy which was awaiting approval by the University Council. It also had several activities and programmes in place. After the pretest, appropriate modifications based on the pretest outcome, were effected on the research instruments

3.6. Reliability of the Instrument

Reliability refers to the consistency of the measuring instrument over time (Ibrahim, Landu, and Opadokun, 2004). Reliability determination helps to assess whether the designed instrument is accurate and consistent in measuring the variables it is designed to measure (Trochim, 2006). The pre-test conducted was aimed at ensuring that the instruments fulfill this quality. The pre-tested copies of the questionnaire were cleaned, coded and entered into a computer facilitated by the use of the SPSS. A statistical reliability analysis was conducted to test the reliability of the questionnaire and to measure its internal consistency (r) using the Cronbach's Alpha co-efficient. The nearer r is to 1, the more reliable the instrument (Knapp, 2009). The obtained value thus indicated that the instrument was highly reliable. In this analysis, a result showing a correlation coefficient greater than 0.5 is said to be reliable. The value of the reliability analysis obtained was 0.96.

3.8. Training of Research Assistants

Four Research Assistants who are fluent in English language were recruited and trained to administer the questionnaire and work with the investigator in conducting the KIIs. They were trained on the procedures for questionnaire administration, objectives and importance of the study, sampling processes and how to obtain informed consent from the participants. Their training also included the importance of valid data, review of questionnaires to ensure completeness and general interviewing instructions. The questionnaire and the KII guide were discussed in detail during the training. Role plays and simulation were used to practice the interview processes. The trained field assistants were involved in the pretest of the instrument which gave them an ample opportunity to acquire and improve on their questionnaire administration competencies.

The four RAs were also trained on salient ethical issues which include confidentiality of data and respect for the persons they were to interview. They were instructed to treat participants with the utmost respect. They were instructed to report any matter which they would not be able to resolve in the course of collecting data to the investigator. The investigator paid several impromptu supervisory visits to the RAs to monitor the conduct of the RAs and to correct when necessary.

3.9. Data Collection Procedure

Data were collected for the study from May to December, 2012. The data collection processes were as follow:

3.9.1. *Quantitative data*

For staff, data were collected with the aid of the questionnaire in their various departments. Some of the staff returned their answered questionnaires immediately while others gave an appointment for the retrieval of the questionnaire later in the day. When a staff was not willing to answer the questions, another member of staff was selected in his or her place. In some selected departments, some of the staff were not available due to annual or sabbatical leave, therefore members of staff in some other departments within the same faculty were selected to make up for the proportion of staff.

For students, a hall-based approach was used in collecting data in order to be able to achieve a wide range of students at all levels and from different faculties in an atmosphere that is more relaxed and less tension soaked. The students were met in their rooms after permission to gain access to such rooms had been obtained from the Hall wardens. The stipulated sampling technique were adhered to in selecting the calculated sample size. When a student was not willing to complete the questionnaire, another student was selected in his or her place. Students who consented to participate in the study were encouraged to answer the questionnaire immediately so that they can be retrieved on the spot. Copies of the questionnaires were reviewed for completeness and consistency by the researcher.

3.9.2 *Qualitative data*

The Key Informants for interview were contacted for permission to interview them with a letter of introduction from the researcher's Department, the Department of Health Promotion and Education. A total of twenty KIIs were conducted. The sessions were conducted in the key informants' offices or in their halls of residence at a time when there were no distractions. All the key informants were visited and interviewed based on appointments earlier made with them.

The researcher and one research assistant (RA) at a time conducted the interview using the KII guide after obtaining their consent. The researcher introduced herself and the RA. She briefly mentioned the purpose of discussion and obtained verbal consent to record the discussion on tape. The Key Informants were assured of confidentiality, that their names would not be mentioned during and after the interview. The RA was an observer and recorder who took notes during the interview. Each interview session lasted for an average of 35 minutes. The responses of the key informants were recorded verbatim using a tape recorder and supplemented the observer's notes. The language of interview was English. Thereafter, the discussion recorded on tape was replayed, carefully listened to and then transcribed. Themes were then raised from the transcripts for results.

3.10. Data Management and Analysis

Proper data management is important in order to obtain credible results. The following processes were used for data management and analysis.

For quantitative data

1. The questionnaires were serially numbered for control and recall purposes
2. All the problems noted during data collection were resolved immediately. There was difficulty in collecting data from majority of the academic staff and in certain departments; they were almost inaccessible. The challenge was overcome with the proper explanation of the purpose of study and the booking of appointment with the participants. In some departments, their members of staff were not available, so other departments within the cluster of faculties were used to make up the shortfall.
3. Questionnaires were manually sorted and collated

4. A coding guide was developed and used to facilitate the coding and entry of data into the computer.
5. The data entry was done using Statistical Package for Social Sciences (SPSS) and the analysis was done using the Epi info package software after data cleaning.
6. The frequency distribution of each category of respondents were generated and analysis was done using the descriptive statistics, t-test, F-test and Chi square test.
7. The questionnaires have been properly stored in a safe place until the dissertation is defended.

For qualitative data

1. A coded number was used to identify the key informants as there was no identifier for each of them.
2. Each KII was transcribed verbatim and subjected to content analysis. Points of agreement and disagreement among the key informants were noted.
3. Themes were raised from the responses of the key stakeholders.
4. The responses of the key informants have been kept away from the reach of unauthorized persons. The qualitative results are integrated into the quantitative results in chapter four.

3.11. Ethical Consideration

The proposal for the study was submitted to the UI/UCH Ethical Review Committee for review and approval (Appendix 9). Letter of introduction for permission to collect data was collected from the Department of Health Promotion and Education and presented to Heads of Departments and Units where participants for the study were selected. (Appendix 10). Informed consent was duly sought and obtained from the participants before embarking on data collection (Appendices 11 and 12). Participants were assured of utmost confidentiality and anonymity of their responses to protect their interest. There was no identifier on the questionnaire and the Key Informants were not required to mention their names. Any participant that did not wish to take part in the study was excused in order to observe the principle of autonomy. Research participants who wish to withdraw from study were free to do so, at any point in time as participation in the study was voluntary.

Data collected were accessed only by the researcher and the data analyst (during analysis of the data). It was transferred to an electronic data file using the researcher's personal computer with an individual and unshared password. A secondary backup was used as a precautionary measure against complete loss of data.

3.12. Limitation and challenges of the study

The study focused on students and staff of the University of Ibadan. The students for the study were only those residing in Halls of residence. The knowledge, perception and participation of students who did not reside on the campus were not documented. It is hoped that further research on the implementation of the policy in the institution will take those students who do not reside within the University into consideration.

The key informant interview was not extended to other stakeholders because of the challenge of meeting with them individually for interview. In order to have a wide coverage of information about the institutional policy, a fairly large proportion of the stakeholders were interviewed. Many of the study participants who consented especially the University management staff, members of policy development and steering committees, union leaders and the Health Personnel gave several appointments which they (the key informants) were not able to keep due to one reason or the other. The KII was more challenging than the quantitative date because it more time than the time for collecting the quantitative data. This was because of the status of people involved. It was easier getting the stakeholders who were students to interview once an appointment was fixed with them than those who were staff. The challenge of meeting some of the key stakeholders especially the staff member was so enormous. This was responsible for not been able to interview more KIs as the investigator paid numerous visits to their offices over a period of many weeks without meeting them. The researcher had to persevere and was consistently visiting their offices to reschedule in order to conduct the interviews. The interviews were conducted after a long period of persistently visiting on the rescheduled appointments.

There was also the challenge of getting the staff to complete the questionnaire. This applied to both academic and non-teaching staff. It was particularly very challenging to obtain

informed consent to complete the questionnaire from academic staff. Some of them claimed they did not have time to do the completion of the questionnaire, while in some departments, the academic staff refused to give audience to the researcher. The researcher and the assistants had to keep going to the department for weeks to seek for the staff's consent when eventually they were available. For the ones that were not available after a long time of visiting their offices, the researcher had to switch to other departments to make up for the deficiencies.

Interviewing the students was not as challenging. Initially, there was a disruption in the data collection because of the students' unrest that led to their being sent home for almost two months by the University authority. The data collection resumed as soon as the students came back to the campus. The other challenge worthy of note was from postgraduate students from a particular hall of residence who were not ready to participate in the study. The research team was able to explain to them and got the consent of a little above two thirds of the proportion that was supposed to be selected from the Hall.

CHAPTER FOUR

RESULTS

The findings of this research are presented in this chapter under the following subsections: socio-demographic characteristics, respondents' awareness of HIV and AIDS policy of UI, respondents' awareness of HIV control programmes in UI, knowledge of staff and students on the features of the University's HIV and AIDS policy, participation of staff and students in HIV control programmes on UI campus and stakeholders support of the HIV and AIDS policy of UI

4.1 Respondents' Socio-demographic characteristics

The 1206 respondents consisted of 4.9% AS, 12.1% NS and 83.0% students. Table 4.1 shows the basic socio-demographic characteristics of the respondents. Their ages ranged from 30 – 63 years for AS with a mean age of 39.5 ± 9.3. The age range for NS was 20 – 60 years with a mean age of 44.0 ± 7.9. The students' age range and mean age were 17 – 54 and 24.5 ± 6.0 years respectively. Majority of the AS (72.9%) were within the very active age group of 30 – 49 years while a majority of NS (80.8%) fell within 20 – 49 years age groups. Overall, students aged ≤ 24 years (i.e young persons) constituted the majority (90.6%). A majority of AS (83.1%), NS (60.3%) and students (65.4%) were males. Majority of AS (89.8%) and NS (75.3%) were married while most students (90.6%) were never married. The other details of the socio-demographic information are contained in the table under reference.

The educational qualifications of staff are shown in table 4.2. Majority of the AS (62.7%) were doctorate degree holders while slightly over half (52.8%) of the NS had either bachelor or masters' degree. Table 4.3 highlights the official designation of the staff respondents. Majority of the AS (76.3%) were Lecturers of the Lecturer II, I and senior Lecturership cadres. The administrative staff among NS constituted 21.2%. Secretarial officers, technologists and clerical officers were 16.9%, 11.3% and 15.5% respectively. (See the table for other details)

The working experiences in years of AS and NS are presented in Table 4.4. The mean working experiences (in years) for AS and NS were 9.53 ± 7.76 and 11.23 ± 8.56 respectively. Most of the AS (61.0%) had worked for less than a decade while about a quarter (25.4%) had worked for over a decade. Among the NS, those who had worked for less than a decade topped the list (43.1%). This was followed closely by those who had worked for 10 -19 years (42.5%). The details are shown in the table under reference.

Table 4.5 presents the faculties and departments to which the AS and NS were affiliated. The Faculty of Science had the highest proportion of AS (25.4%), followed by the Social sciences (20.3%), and Clinical sciences (16.9%), Education (15.3%), Technology (11.9%) with Pharmacy being the lowest (10.2%). For NS, the highest proportion was in the non-teaching departments – Sports Council and Establishment (14.4%). The NS in the Faculty of Science were 13.7%, those in Clinical sciences were 11.7% while those in Pharmacy were 10.9%. (See the table concerning the remaining faculties).

Majority of the students were undergraduates (62.4%) while students undergoing masters' programme constituted 30.7% (Figure 4.1). Students in the doctorate and sub-degree programmes were 6.1% and 0.8% respectively. The students' length of stay (in years) in the University is shown in Table 4.6. Students who had just spent two years (34.5%) topped the list, followed by those who had spent one year (26.2%). The distribution of the students studied by faculty is summarized in table 4.7. Students in the faculty of science accounted for 19.0% followed by those in the faculty of the social sciences (16.3%). For details, see the table under reference.

Table 4.1: Distribution of respondents by age, sex, marital status and religion

Variables	AS* n=59 No (%)	NS** n=146 No (%)	Students n=1001 No (%)	N=1206
Age in years* **				
17-19	0 (0.0)	0 (0.0)	202 (20.2)	
20-29	0 (0.0)	23 (15.8)	652 (65.1) †	
30-39	19 (32.2)	50 (34.2)	111 (11.1)	
40-49	24 (40.7)	45 (30.8)	29 (2.9)	
50-63	16 (27.1)	28 (19.2)	7 (0.7)	
Sex				
Male	49 (83.1)	88 (60.3)	655 (65.4)	
Female	10 (16.9)	58 (39.7)	346 (34.6)	
Marital status				
Never married	6 (10.2)	32 (21.9)	907 (90.6)	
Married	53 (89.8)	110 (75.3)	93 (9.3)	
Divorced	0 (0.0)	0 (0.0)	1 (0.1)	
Separated	0 (0.0)	2 (1.4)	0 (0.0)	
Widowed	0 (0.0)	2 (1.4)	0 (0.0)	
Religion				
Christianity	49 (83.1)	129 (88.4)	863 (86.2)	
Islam	9 (15.3)	17 (11.6)	130 (13.0)	
Traditional	1 (1.7)	0 (0.0)	4 (0.4)	
Others††	0 (0.0)	0 (0.0)	4 (0.4)	

* *AS – Academic staff*

** *NS – Non teaching staff*

*** *Mean ages for AS, NS and Students = 39.5 ± 9.3, 44.0 ± 7.9 and 24.5 ± 6.0 years respectively*

† *Students aged ≤ 24 years = 566 (90.6%)*

†† *Refers to Eckankar and Atheist*

Table 4.2: Staff respondents' highest educational qualification

Highest educational qualification	AS n=59 No (%)	NS N=205 n=146 No (%)
Secondary school leaving certificate	0 (0.0)	12 (8.2)
Diploma – OND	0 (0.0)	31 (21.2)
Diploma – HND	0 (0.0)	22 (15.1)
Bachelor degree	5 (8.5)	41 (28.1)
Post graduate degree – Masters	17 (28.8)	36 (24.7)
Post graduate degree – Ph.D	37 (62.7)	2(1.4)
Post graduate Diploma PGD	0(0.0)	2(1.4)

Table 4.3: Position/Official designation of staff respondents

N=205

Category	Rank	Number	%
Academic staff (n =59)	Professors	6	10.2
	Lecturers*	45	76.3
	Assistant Lecturers	8	13.5
Non-teaching staff ** (n=142)	Administrative Officers	30	21.2
	Secretarial Officers	24	16.9
	Technologists/Technical staff	16	11.3
	System/Data analysis	5	3.5
	Laboratory assistants	11	7.7
	Sports Officials	21	14.8
	Clerical officers	22	15.5
	Special education officials	6	4.2
	Domestic staff	7	4.9

* *Includes Lecturer I, II and Senior Lecturers*

** *The four "no responses" were excluded from the calculation*

Table 4.4: Staff respondents' working experiences in years

Category	Years of experience*	No	N=205 %
Academic (n=59)	1-9	36	61.0
	10-19	15	25.4
	20-29	8	13.6
Non-teaching (n=146)	1-9	63	43.1
	10-19	62	42.5
	20-29	12	8.2
	30-39	9	6.2

* Working experience at the University of Ibadan

Table 4.5: Faculties and Departments of staff respondents

Faculty/ Department	AS n=59 No (%)	NS n=146 No (%)	N=205
Clinical sciences			
Radiotherapy	2 (3.4)	2 (1.4)	
Medicine	5 (8.5)	6 (6.1)	
Paediatrics	3 (5.1)	9 (6.2)	
Pharmacy			
Pharmaceutical Chemistry	2 (3.4)	6 (6.1)	
Pharmacognosy	2 (3.4)	6 (6.1)	
Pharmaceutical microbiology	2 (3.4)	4 (2.7)	
Social sciences			
Geography	2 (3.4)	9 (6.2)	
Political science	5 (8.5)	3 (2.1)	
Urban and regional planning	5 (8.5)	2 (1.4)	
Education			
Guidance and Counselling	4 (6.8)	4 (2.7)	
Social work	2 (3.4)	4 (2.7)	
Special Education	3 (5.1)	7 (4.8)	
Science			
Statistics	5 (8.5)	4 (2.7)	
Computer Science	5 (8.5)	9 (6.2)	
Geology	5 (8.5)	7 (4.8)	
Technology			
Civil Engineering	3 (5.1)	6 (6.1)	
Food Technology	2 (3.4)	4 (2.7)	
Petroleum Engineering	2 (3.4)	3 (2.1)	
Industrial Engineering		2 (1.4)	
Non-teaching Departments			
Establishment	-	28 (19.1)	
Sports Council	-	21 (14.4)	

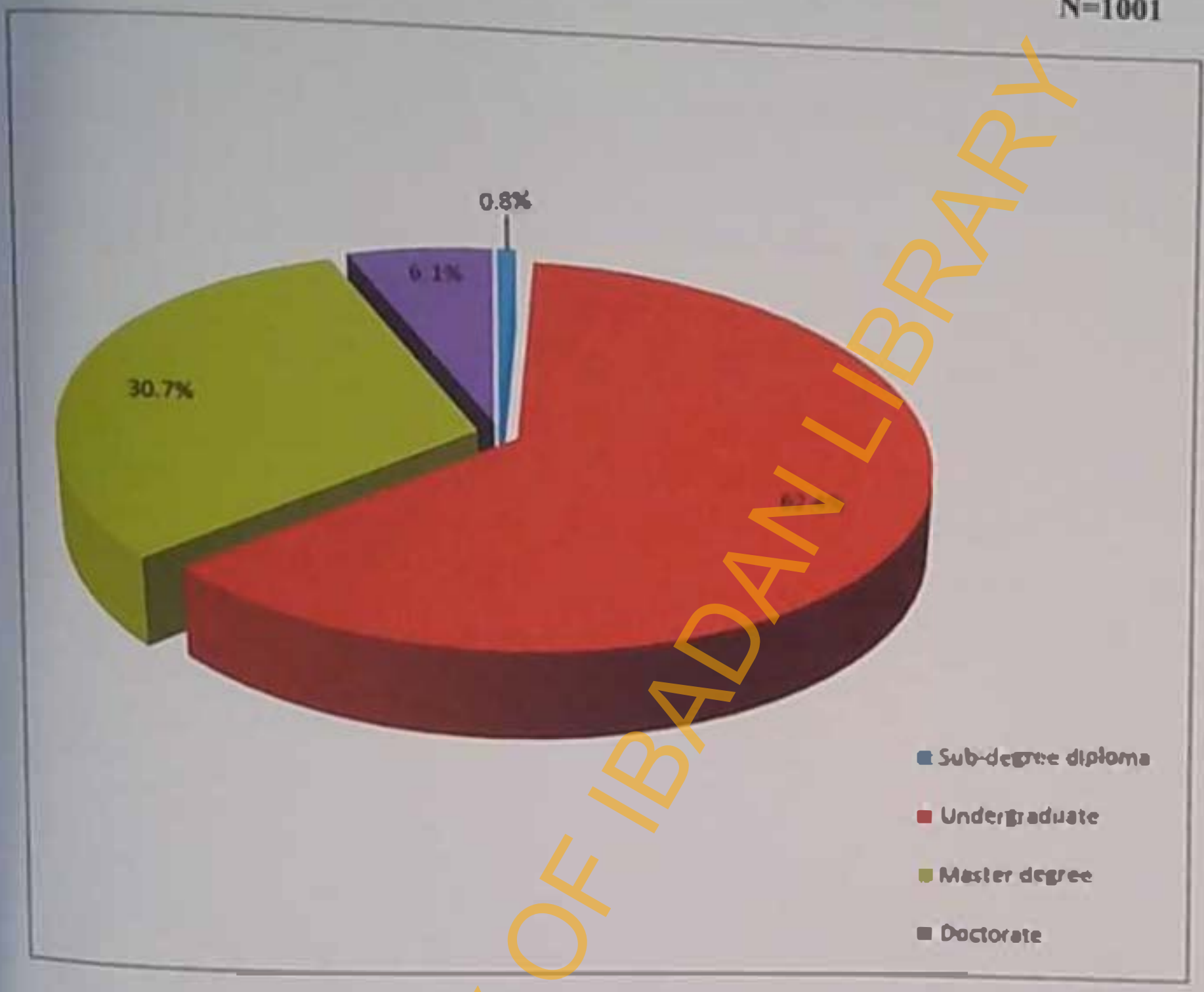

Figure 4.1: Categories of student respondents by type of academic programme

Table 4.6: Length of stay of students (in years) in the University

N=962

Length of stay in years*	No**	%
One	252	26.2
Two	332	34.5
Three	192	20.0
Four	123	12.8
Five	31	3.2
Six	27	2.8
Seven	5	0.5

* *Mean = 2.0 ± 1.3, Mode = 2, Range = 6*

** *The 39 'no responses' were excluded from the calculation*

Table 4.7: Faculties of student respondents

Faculty	Number	N=998* %
Arts	131	13.1
Law	29	2.9
Social sciences	163	16.3
Science	190	19.0
Technology	67	6.7
Pharmacy	13	1.3
Education	111	11.1
Basic medical sciences	50	5.0
Clinical sciences	71	7.1
Agriculture and Forestry	88	8.8
Dentistry	18	1.8
Public Health	31	3.1
Veterinary Medicine	15	1.5
Other academic Departments**	21	2.1

* A total of 3 (0.3%) did not respond to the question and the calculation was therefore based on 998

** These consists of the following: Institute of African Studies, Institute of Education, African Regional Centre for Information Science, Ibadan Media Resources Centre

4.2. Awareness of staff and students of University of Ibadan on the institutional HIV and AIDS Policy

Table 4.8 presents results relating to respondents' awareness of the HIV and AIDS (HA) policy of the University of Ibadan. Most of respondents - AS (98.3%), NS (97.9%) and students (98.2%) had heard of AIDS. Majority of AS (71.2%) and most NS (979) had heard of an HA policy. The proportion of students who had heard of any HA policy was 52.5%. Many of the AS (40.7%) few NS (15.8%) and students (14.5%) had heard of the HA policy of the University of Ibadan.

Out of the 192 respondents who were aware of the HA policy, AS (37.5%), NS (696.0) and students (50.3%) had ever seen it (See figure 4.2 for details). Figure 4.3 shows that many AS (44.4%), and some of NS (31.3%) and students (35.6%) who were aware of the HA policy of the University of Ibadan had copies. However, out of the few respondents that were aware of the HA policy of the University of Ibadan and those who had seen it whether they had a copy or not, majority of AS (77.8%), NS (62.5%) and students (64.4%) had read it (See figure 4.4 for details). Reasons provided for not reading the HA policy by the respondents that were aware of the policy but did not read it included no time to read it among AS - 11.1% and students - 4.1%. Lack of personal copy was the reason given by few NS (6.3%) and students (12.3%). (See figure 4.4 for details).

Table 4.9 presents respondents sources of information on the HA policy of the University of Ibadan. The sources among those who had heard of the HA policy included bulletin/leaflet (45.0%), workshop/symposia (25.0%), and friends (15.0%) for AS. Similarly among the NS, the sources of information included workshop/symposia (37.5%), bulletin/leaflet (31.2%) and friends (18.7%). Furthermore, the sources of information of the HA policy of University of Ibadan among the students included workshop/symposia (27.1%), bulletin/leaflet (24.3%), lecture rooms (12.1%) and friends (12.1%). (See table 4.9 for details). The identified opportunities and fora which were deliberate efforts at increasing the level of awareness for the HA policy of the University of Ibadan among staff and students are summarized in table 4.10. These fora as part of the HA policy dissemination activities included the university bulletin/leaflet which topped the list among the AS (45.0%) while workshop/symposia topped for NS (37.5%) and students (27.1%). All AS (100.0%) who

read the policy got enlightened about it during departmental meetings, on the internet or on special occasions. A majority of NS (60.0%) did so through their union meetings or through the University Health Service (UHS). Seminars or workshops were reported channels for raising the level of awareness of 42.6% students about the HA policy of the University.

Reasons for not reading the HA policy among AS, NS and students that were aware but did not read it were: no time to read - AS (11.1%) and students (4.1%), lack personal copy – NS (6.3%) and students (12.3%) and negligence – students (4.1%).

Table 4.8: Awareness of AIDS, any HIV and AIDS (HA) Policy, and HA Policy of University of Ibadan

Variables	AS n=59 No (%)	NS n=146 No (%)	Students n=1001 No (%)
Ever heard of AIDS:			
Yes	58 (98.3)	143 (97.9)	983 (98.2)
No	1 (1.7)	3 (2.1)	12 (1.2)
Awareness of any HA HIV and AIDS policy:*			
Yes	42 (71.2)	143 (97.9)	526 (52.5)
No	17 (28.8)	3 (2.1)	475 (4.5)
Awareness of UI HA HIV and AIDS policy:			
Yes	24 (40.7)	23 (15.8)	145 (14.5)
No	35 (59.3)	141 (84.2)	856 (85.5)

* *Any HIV and AIDS policy apart from that of UI*

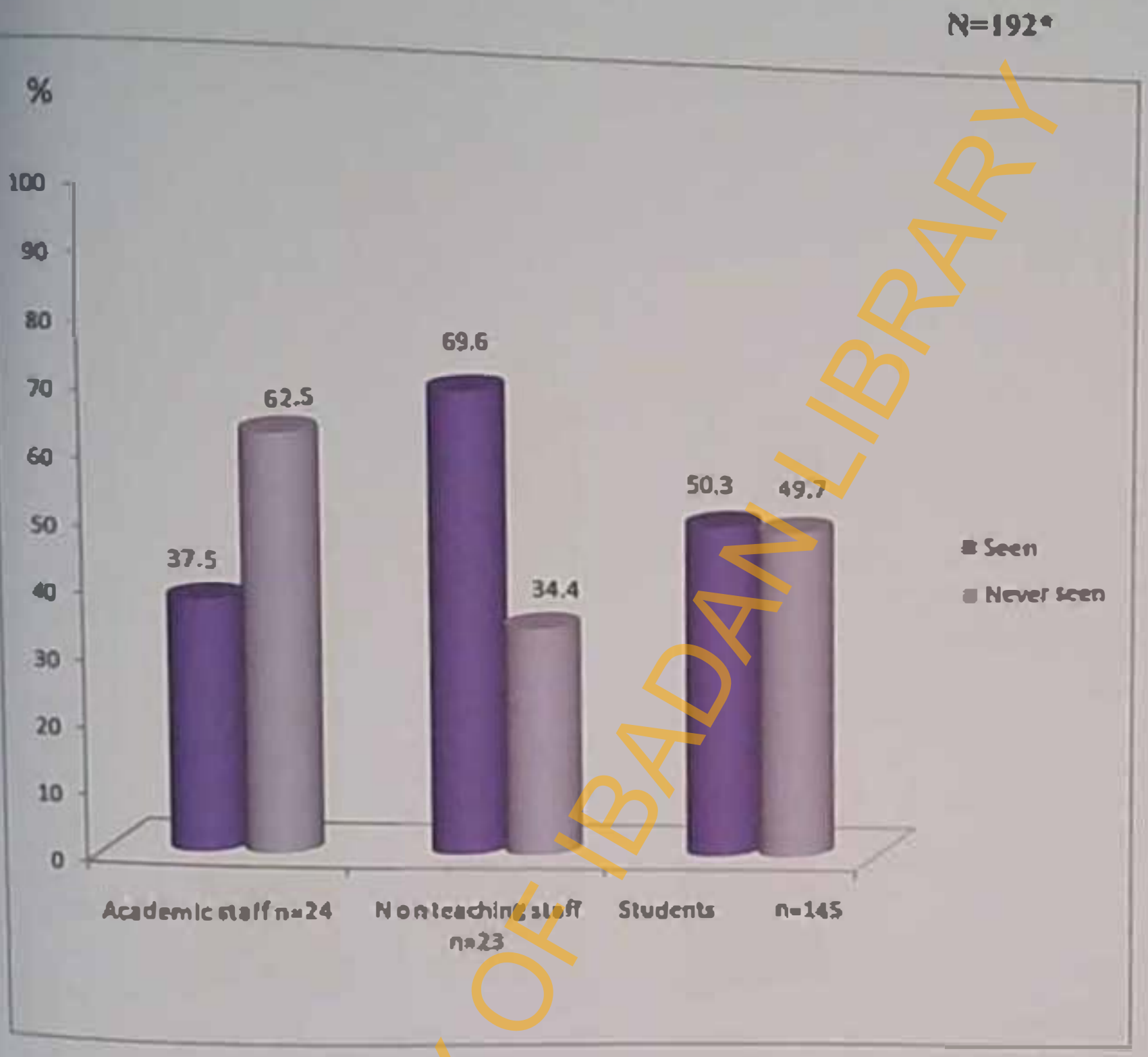

Figure 4.2: Respondents who had ever seen the HIA policy of UI

* *The total number of respondents who were aware of the UI HIV and AIDS policy, out of this, 98(51.0%) had seen the HIV and AIDS policy. (AS = 9; NS = 16; Students = 73)*

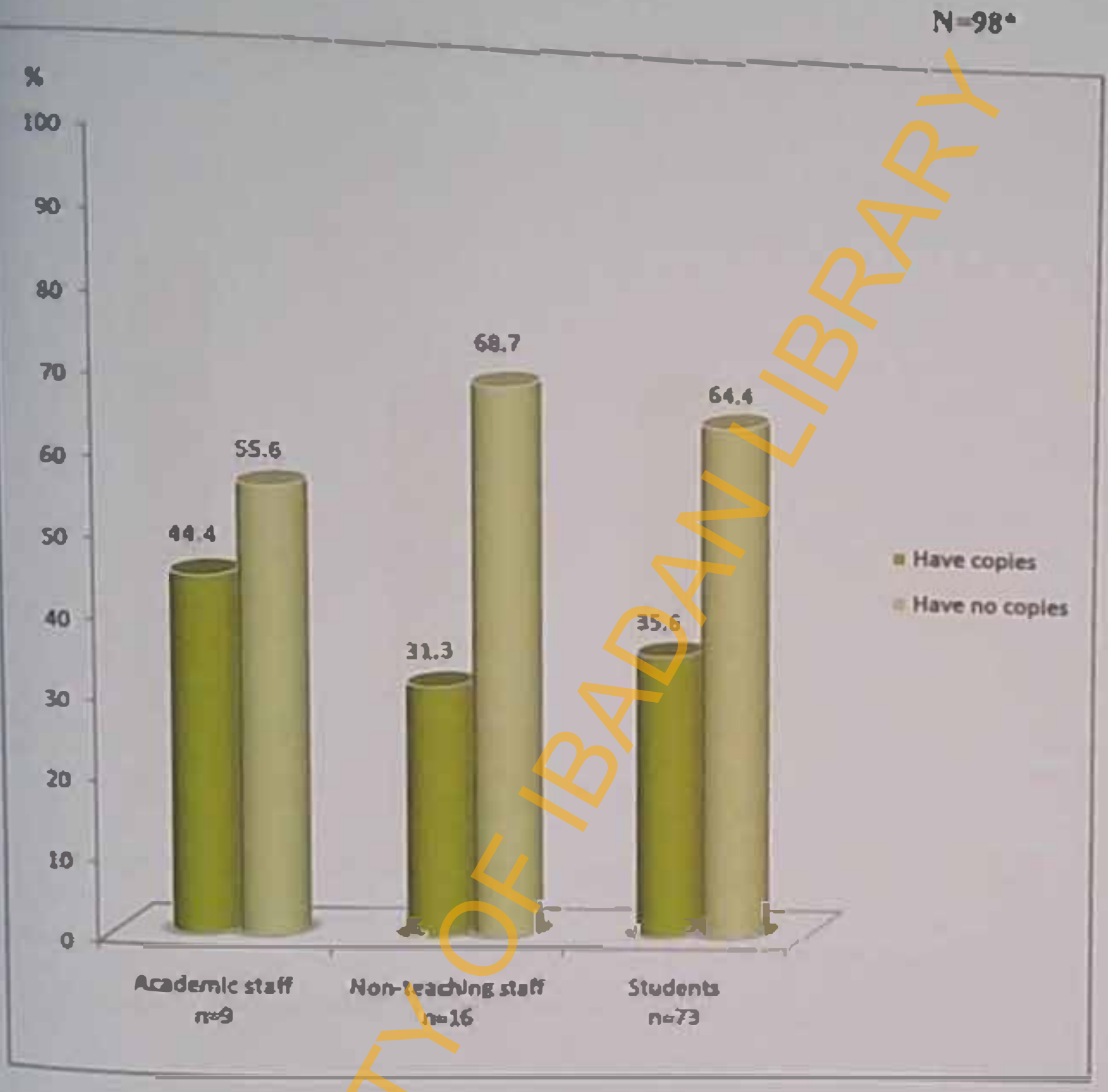

Figure 4.3: Respondents who had a copy of the HA policy of UI

** Total number of those who have seen the UI HIV and AIDS policy, out of this, 35 had copies (AS = 4, NS = 5, Students = 26)*

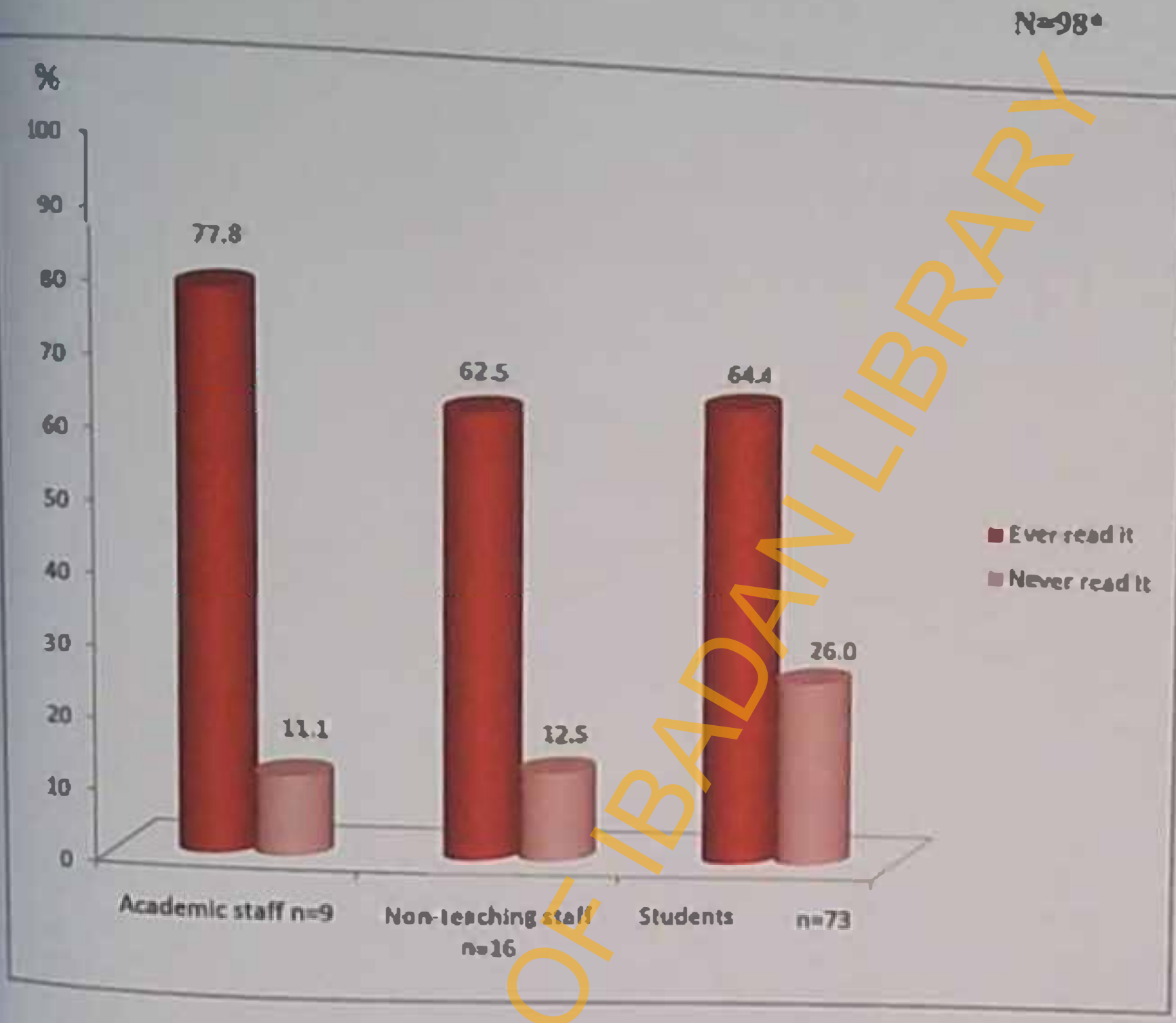

Figure 4.4: Respondents who had ever read the IIA policy of UI

* *Total number of respondents who had seen the IIA HIV and AIDS policy of UI out of which 64 had ever read it. (AS =7; NS =10; Students = 47)*

Table 4.9: Respondents' sources of information on the HIV and AIDS Policy of University of Ibadan

Category	Sources*	No	%
Academics staff n=20**	Bulletin/Leaflet	9	45.0
	Workshop/Symposia	5	25.0
	Friends	3	15.0
	UI Radio	1	5.0
	Internet	1	5.0
	As member of HA Policy Development Committee	1	5.0
Non-teaching Staff n=16**	Workshop/Symposia	6	37.5
	Bulletin/Leaflet	5	31.2
	Friends	3	18.7
	During HIV screening	1	6.3
	UI Radio	1	6.3
Student n=140**	Workshop/Symposia	38	27.1
	Bulletin/Leaflet	34	24.3
	Friends	17	12.1
	Lecture halls	17	12.1
	UI Radio	9	6.4
	Peer educators	7	5.0
	Youth Friendly Centre	7	5.0
	Internet	6	4.3
	During HIV screening	2	1.4
	Department/Faculty	2	1.4
	Student affairs Unit	1	0.7

* *Multiple responses were included*

** *'No responses' have been removed*

Note: Percentages were based on the n for each of the categories

Table 4.9: Respondents' sources of Information on the HIV and AIDS Policy of University of Ibadan

Category	Sources*	No	%
Academics staff n=20**	Bulletin/Leaflet	9	45.0
	Workshop/Symposia	5	25.0
	Friends	3	15.0
	UI Radio	1	5.0
	Internet	1	5.0
	As member of HA Policy Development Committee	1	5.0
Non-teaching Staff n=16**	Workshop/Symposia	6	37.5
	Bulletin/Leaflet	5	31.2
	Friends	3	18.7
	During HIV screening	1	6.3
	UI Radio	1	6.3
Student n=140**	Workshop/Symposia	38	27.1
	Bulletin/Leaflet	34	24.3
	Friends	17	12.1
	Lecture halls	17	12.1
	UI Radio	9	6.4
	Peer educators	7	5.0
	Youth Friendly Centre	7	5.0
	Internet	6	4.3
	During HIV screening	2	1.4
	Department/Faculty	2	1.4
	Student affairs Unit	1	0.7

* *Multiple responses were included*

** *'No responses' have been removed*

Note: Percentages were based on the n for each of the categories

Table 4.10: Respondents' awareness of opportunities or fora for disseminating information on the HIV and AIDS Policy of UI

N=64*

Variable	Number (%) AS n=7	Number (%) NS n=10	Number (%) Students n=47
Union meeting	4 (57.1)	6 (60.0)	16 (34.0)
Seminar/Workshop/ Conference	3 (42.9)	7 (70.0)	20 (42.6)
Peer education program	2 (28.6)	6 (60.0)	10 (21.3)
University Health Service (Jaja Clinic)	3 (42.9)	6 (60.0)	16 (4.0)
Special occasions	7 (100.0)	2 (20.0)	2 (4.3)
Newsletter/Handbill	1 (14.3)	3 (30.0)	14 (29.8)
Departmental/Hall meetings	7 (100.0)	1 (10.0)	11 (23.4)
Internet	7 (100.0)	1 (10.0)	2 (4.3)
Others (Specify)**	1 (14.3)	1 (10.0)	12 (25.5)

* *Total number of AS, NS and students who have read the HIV and AIDS policy*

** *Include GES courses (for students). UI radio (Diamond F.M.)*

Many of Key Informants were aware that the University of Ibadan has an HIV and AIDS policy. However, only a few of them however had copies. Many had heard about it but had not seen it while many of those that had copies had not fully read it. Typical responses were:

- *"There is the HIV and AIDS policy and I was part of the development committee. For the HIV and AIDS policy, different people were co-opted from almost every faculty if not all the faculties in the University". (MHPDC)*
- *"I heard about it sometimes ago but did not see it. so I've not read it. I don't have a copy so I don't believe students have. We were just talking one day when some-body said it looks like there is something like that on campus". (SL)*
- *"The University has a HIV and AIDS policy or let me say I knew about the draft HIV and AIDS policy on HIV and AIDS. A copy was sent to us the Muslim community to critique. The final copy was sent but I did not read it". (MRL)*
- *"There should be one but I have not seen it. I have only seen that of Olunyoro hospital. Even those of us working here in Jajn. I don't think any of us has a copy not to talk of the students". (UHSP)*
- *"The University has given the issue of HIV a lot of attention. There was the HIV and AIDS policy which was given to all of us: at least a copy was given to me. It has been a long time now maybe 4-5 years ago. But I have not read it fully". (CRL)*
- *"Yes, I am aware of the HIV and AIDS policy though I haven't read it but I know the University has one. I don't have a copy and it was someone that told me of its existence. I believe it is the best thing UI has done about HIV though I have not even seen it. I just knew about it". (SUL)*
- *"I am aware that U. I. has a written HIV and AIDS policy about HIV and AIDS. I don't have a copy per se but I have something written about the HIV and AIDS policy (a handbill) which states some of the things in the HIV and AIDS policy". (HIV Organisation Coordinator - HOC)*

The Key Informants were unanimous in noting that the University has given a lot of attention to the issue of HIV and AIDS by formulating a policy regarding it. They stated that there is low awareness about it among the members of the UI community. Their responses included:

- *"About the HIV and AIDS policy awareness, a copy was sent to me and to all the people involved in the development including the students among us. What I don't know is whether those students have graduated or not and whether they passed the HIV and AIDS policy to their colleagues. Also I don't know if the HIV and AIDS policy was generally disseminated or distributed to people. I'm not sure if everybody has a copy of the HIV and AIDS policy. (MHPDC)*
- *"I don't think there is any awareness about the HIV and AIDS policy. If the university wants people on campus to know about something especially students, they know how to do so. They could have distributed it hall by hall or faculty by faculty and you can bet, students will read it. But there is nothing like that." (SL)*
- *"The awareness of the HIV and AIDS policy in UI is so low! The problem with HIV and AIDS policy making in Nigeria is that we just put things on paper; our people do not know about it. There is so much secrecy and silence about these things. I do not think students and staff know about it, if they do, I would have come across it in peoples offices. I was sent a copy but I did not read it. The same may have happened with whoever it was sent to. There is no awareness at all relating to this HIV and AIDS policy. If students and staff have a copy, they will know their rights and what they are supposed to do or not supposed to do as regards HIV on campus". (MRL)*
- *"I have not heard students talk about the HIV and AIDS policy and I have not seen any staff with it. Maybe because of the nature of the illness; people don't want to talk about it" (SUL)*
- *"I don't think students or even staff have copies of the HIV and AIDS policy. Well, I don't think it is available. If copies are made available to*

students and staff, they would one way or the other read it. People in UI, do not know about the HIV and AIDS policy, I'm sure". (HOC)

- *"I don't think every staff or student has a copy of the HIV and AIDS policy. The fact that I was given one does not mean everyone has. It's because I was part of the committee that looked into the HIV and AIDS policy development. Students especially do not have copies because it is not part of their orientation. I think it is a mistake from the beginning." (MHPSC)*

The key informants that were not aware and had never seen the HIV and AIDS policy also expressed their views nonetheless. A majority of them were student leaders and their responses included:

- *"I for one have never seen this copy. It was not passed or handed over to me by anyone. If it is true that the University has done this, it should be distributed to every student and every staff. It should be handed over to student undergraduate or post graduate as they are doing registration. It is the low level of awareness that is responsible for students not having copies, even the hall chairman has no copy!" (SL)*
- *"I'm not aware of any HIV and AIDS policy of the University. I don't think the students know. I don't know about its existence myself which is something serious. If the university can formulate the HIV and AIDS policy, they can as well put it on the website for students and staff to see and read. They should make it as popular as possible." (SL)*
- *"I'm not aware at all. I don't think students have copies because I myself as the hall chairman I am not aware of such a HIV and AIDS policy and I believe that if such HIV and AIDS policy is in existence, it should be widely made available on campus". (SL)*
- *"I can't say there is awareness of the HIV and AIDS policy because if I, the chairman in this hall does not know about it, how would they especially the ones in my hall know? Nothing of such was handed over to me by the last hall chairman and the hall warden has never mentioned anything like that. I have never heard of any student talk about it or seen a copy. What you don't*

see you don't have. I haven't even come across it in any lecturers' office so it means the whole school is not really aware of it. I don't know who wrote the HIV and AIDS policy or the people involved in it but I think there has been no communication about it to all in the school community". (SL)

- *"Well, I will not say people are not aware just because I am not aware. But one thing is certain, I did not meet anything like that in office and none of my other officers has ever mentioned it to me". (SL)*
- *"We are not part of the university per se. We are an institution within an institution. That's what we are. There may be a HIV and AIDS policy or, HIV but it was not communicated to us and as such we cannot know". (CRL)*
- *"I wouldn't say most students or staff are aware because I have not heard anyone talk about it. Maybe they don't have copies like me. I have never even seen it though we in SSANU have been organizing HIV programs. Our programmes have never had anything to do with a HIV and AIDS policy. People don't have copies and what you don't have you can't know". (SUL)*

The possible reasons which accounts for the people's low level of awareness of the HIV and AIDS policy of U.I. were advanced by the Informants. These reasons included inaction on the part of the organ of the University that should make people aware of it, non-availability of the policy and lack of funds. Many of the Key Informants' views relating to non-availability of the policy as a factor included:

- *"I think the low awareness of the HIV and AIDS policy is due to the fact the people that should be doing the distribution are not doing it". (SL)*
- *"I really can't say but maybe it's just negligence on the part of the people involved. If such a thing is developed by the university I don't see any reason why it should not be distributed or made known to the people that will benefit from it continually" (SL)*
- *"Well, I don't think the HIV and AIDS policy is readily available. If copies are made available to students and staff, they would one way or the other read it. People in U.I. do not know about the HIV and AIDS policy. I'm sure". (HOC)*

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- *"We are not part of the university per se. We are an institution within an institution. That's what we are. There may be a HIV and AIDS policy on HIV but it was not communicated to us and as such we cannot know". (CRL)*
- *"I wouldn't say most students or staff are aware because I have not heard anyone talk about it. Maybe they don't have copies like me. I have never even seen it though we in SSANU have been organizing HIV programs. Our programmes have never had anything to do with a HIV and AIDS policy. People don't have copies and what you don't have you can't know". (SUL)*

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- *"Well, I don't think the HIV and AIDS policy is readily available. If copies are made available to students and staff, they would one way or the other read it. People in U.I. do not know about the HIV and AIDS policy, I'm sure". (HOC)*

- *"I think fund was not enough. If there was enough funding, there should be enough of the copies. Another thing, maybe the manpower was not enough to do the distribution and dissemination of the HIV and AIDS policy. Everything comes to funds". (MHPSC)*
- *"The people in charge are not making much efforts or they do not have what it takes to sustain their efforts - I mean funds or support from the university". (MRL)*

The other reasons adduced by few Key Informants for the low level of awareness of the people in UI community about the policy included:

- *"...maybe they are assuming that HIV is on the decline but from the reports that we get students and staff are still involved in all sorts of sexual practices which can contribute to the spread of HIV on campus" (CRL)*
- *"I think the low awareness of the HIV and AIDS policy has to do with people getting tired of the whole HIV thing" (SL)*

A minority of the Key Informants were not of the view that the awareness of the HIV and AIDS policy of UI is low in the UC. Such perceptions are inherent in the following statements such as follow:

- *"I would not want to use the word 'HIV and AIDS policy' because the students are aware of the guidelines but of not of the HIV and AIDS policy. They might not know that the guidelines guiding issues of HIV are from the HIV and AIDS policy. They may not know that we are talking about the HIV and AIDS policy. And the staff are aware. Well I said that because when this HIV and AIDS policy was being developed, every stakeholder was involved - every stakeholder on campus". (UHSP)*
- *"Well for staff, I can only speak for NASU members. Some of them are aware but not all. About 20 percent were aware. I remember that when the HIV and AIDS policy was sent to us, we organized some activities to let some of our members know, especially the executive members though it has been a while so I will not say all of the NASU members are aware". (SUL)*

- *People should know - students and staff alike. They should know because it is on the university website on www.ufed.com.ng. It's there for anyone to see. It is in the public domain. You don't have to be a student or staff of UI to go there. I'm not sure about that if every student and staff has a copy but I know that it is on our website. (UPO)*

4.3. Awareness of respondents on HIV and AIDS programmes in the University of Ibadan

Table 4.11 presents data on respondents' awareness of HIV and AIDS programmes on campus. Majority of respondents – AS (69.5%), NS (69.2%) and students (88.4%) were not aware of the training programmes on HIV and AIDS for academic staff, while 74.6% of AS, 61.6% of NS and 89.8% of students were not aware of HIV and AIDS training for non-teaching staff. Slightly above half of the respondents across the three categories were not aware of training programmes on HIV and AIDS for students (AS – 57.6%, NS -53.4% and students – 54.3%). Few AS (37.3%), NS (28.8%) and students (14.0%) were aware of HIV-related activities at the University Health Service (UHS). Awareness of HIV-related activities of the Youth Friendly Centre was observed among AS (33.9%), NS (36.3%) and students (49.9%). Many AS (59.3%), NS (61.6%) and students (60.4%) were not aware of the HIV awareness programmes as part of orientation given to fresh students in UI. Slightly less than half AS (47.5%), NS (49.3%) and many students (55.5%) were aware of HIV peer education programme on campus. Only 27.1% of AS, 16.4% of NS and 41.4% of students were aware that HIV has been integrated into General Education Studies (GES) in the UI.

Out of the 656 respondents that were aware of HIV peer education in UI, a few AS (7.1%), NS (13.9%) and students (19.4%) knew at least one HIV peer educator on campus. (See Figure 4.5 for details). Out of the 454 respondents that were aware of integration of HIV courses into GES courses at UI, a few AS (12.5%), almost half of NS (41.7%) and majority of students (65.9%) could recall the correct course codes of the HIV-related GES. On the other hand, majority of AS (87.5%), NS (79.2%) and students (81.6%) who were aware of the HIV courses in GES could mention the correct level of study when UI students undertake the HIV-related GES courses.

Respondents' awareness of the HIV-related activities at the University Health Service (UHS) was presented in Table 4.12. Most of AS (94.7%) who were aware of HIV-related activities at the UHS knew about HIV screening while only 5.3% were aware of referral services of HIV positive persons to other treatment facilities. Similarly, majority of NS (81.3%) were aware HIV screening while only 6.2% were aware of HIV education being

offered at the UHS. Most of the students (90.0%) were also aware of HIV screening while only 7.0% were aware of HIV education as part of the HIV-related activities of the UHS.

Table 4.11: Respondents' awareness of HIV and AIDS programmes in the University of Ibadan

Variable	AS (%) n=59		NS (%) n=446		Students (%) n=1001	
	Yes	No	Yes	No	Yes	No
Awareness of HIV and AIDS training programmes for academic staff	18 (30.5)	41 (69.5)	45 (30.8)	101 (69.2)	116 (11.6)	885 (88.4)
Awareness of HIV and AIDS training programmes for non-teaching staff	15 (25.4)	44 (74.6)	56 (38.4)	90 (61.6)	102 (10.2)	899 (89.8)
Awareness of HIV and AIDS training programmes for students	25 (42.5)	34 (57.6)	68 (46.6)	78 (53.4)	457 (45.7)	544 (54.3)
Awareness of HIV course as part of GES in UI	16 (27.1)	43 (72.9)	24 (16.4)	122 (83.6)	414 (41.4)	587 (58.6)
Awareness of programmes on HIV as part of fresh students' Orientation	24 (40.7)	35 (59.3)	56 (38.4)	90 (61.6)	396 (39.6)	605 (60.4)
Awareness of HIV peer education programme in UI	28 (47.5)	31 (52.5)	72 (49.3)	4 (50.7)	556 (55.5)	445 (44.5)
Awareness of HIV and AIDS related services in Jaja clinic	22 (37.3)	37 (62.7)	42 (28.8)	104 (71.2)	140 (14.0)	861 (86.0)
Awareness of HIV and AIDS programmes of REACH in UI	14 (23.7)	45 (76.3)	36 (24.7)	110 (75.3)	64 (6.4)	937 (93.6)
Awareness of HIV and AIDS programmes of AGAH in UI	6 (10.2)	53 (89.0)	9 (6.2)	137 (93.8)	150 (15.0)	851 (85.0)
Awareness of HIV and AIDS programmes based at Youth Friendly Centre in UI	20 (33.9)	39 (66.1)	53 (36.3)	93 (63.7)	499 (49.9)	502 (50.1)

Note: Percentages were based on total n of each category of respondents

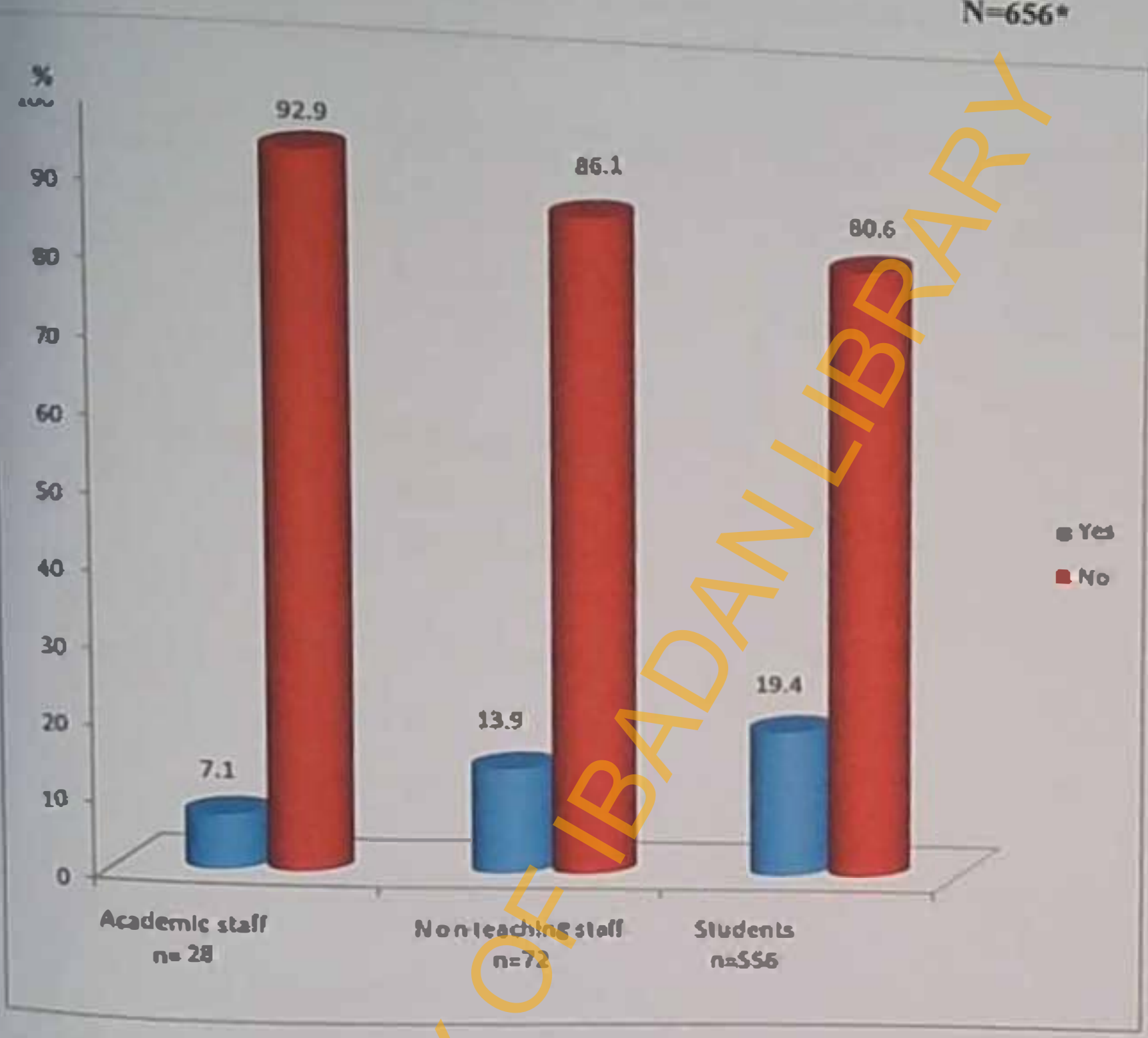

Figure 4.5: Respondents who knew at least one HIV peer educator on campus

** Only applies to respondents who were aware of the existence of peer educators in UI*

Table 4.12: Respondents who were aware of HIV-related activities at the University Health Service (Jaja Clinic)

Category	HIV-related activities	Number	%
AS (n=19)	HIV screening	18	94.7
	Referral to other HIV treatment facilities	1	5.3
NS (n=32)	HIV screening	26	81.3
	HIV Counselling	4	12.5
	HIV Education	2	6.2
Students (n=100)	HIV screening	90	90.0
	HIV Counselling	3	3.0
	HIV education*	7	7.0

* Includes HIV orientation for fresh students

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	HIV Counselling	4	12.5
	HIV Education	2	6.2
Students (n=100)	HIV screening	90	90.0
	HIV Counselling	3	3.0
	HIV education*	7	7.0

* Includes HIV orientation for fresh students

Majority of the key informants had something to say about the University of Ibadanbased HIV programmes. Here are some of their views:

- *"The University has done many things. In fact U.I. is one of the first institutions that took the bulls by the horns when it comes to HIV and AIDS like workshops organised for academic staff on the issue of HIV and AIDS". (MHPDC)*
- *"The University has been supportive in encouraging the students body to be involved in activities for the control of HIV especially in the area of prevention. We are given free hand to conduct campaigns and seminar on HIV especially during our week celebrations. I also remember this book on HIV that we were given during registration as fresh students" (SL)*
- *" The University has also established a Youth Friendly Centre which I'm aware of. And they make it in such a way that it is not just a place solely for screening for HIV status, there are other services so that when people see you coming out of the place, they will not stigmatise you. There they create awareness in HIV, screen people and support them if they are positive" (SL)*
- *"The best thing that the University has done about HIV on campus is the general studies they just started, GES 107. The GES is about HIV and AIDS and other sexually transmitted diseases for undergraduates. It is really a good step by the University management". (SL)*
- *"The University through the University Health Service has taken care of what should be done about HIV". (SUL)*
- *"In the care of anyone that turns out to be positive, the University has been very supportive, keeping their status confidential by not having their status reflect in the students' file but of course we have their records so as to keep track of them for follow after we refer them for treatment in other facilities that we have a link with. Such students are allowed to continued with their studies by the University" (HOC)*

- *I'm aware of HIV orientation given to fresh undergraduates and the HIV peer educators programme where students are trained to talk about HIV and its issues with other students. (SL)*
- *The University of Ibadan is very much involved in research and I can mention the Melinda and Bill Gates' which have been very impressive. A lot of research activities are ongoing. This is part of what the HIV and AIDS policy talks about (UPO)*
- *"If you notice, you will also see some of the billboards bearing messages on HIV prevention especially at the 2 female halls of residence. Queen Elizabeth and Idia, something about Abstinence till Marriage aimed at telling the students to abstain from sex and not to have unprotected sex if they cannot abstain". (SL)*

The opinion of some of the Key Informants was that most of the HIV awareness programmes being implemented on campus focus on undergraduate students and leaving postgraduate students untargeted. The following were their responses:

- *"There is HIV orientation during the orientation programme for fresh undergraduates. It is supposed to be for all students but attention is not really on postgraduate students though some of them had their first degree from UI. It should cut across all students" (UHSP)*
- *"Sincerely, I cannot talk about undergraduates but for us postgraduates, there is nothing like HIV awareness. It is even as if we are left out of such things in the school. There is no forum at all where they gather us together for any orientation unless in the hall and when they do it, it does not have anything to do with HIV". (SL)*

Some of the Key Informants noted that apart from the University administration, HIV and AIDS control and prevention programmes on campus are implemented by several groups. The organisers of the HIV and AIDS related programmes in the University were inherent in the following quotes:

- *"In the University, there are so many groups and associations that are into awareness and education of HIV to make sure that every student has heard of HIV and AIDS" (MHPSC)*
- *"We organize seminars about HIV and AIDS in the church. We also have counseling regarding it apart from speaking from the pulpit" (CRI.)*
- *"I am sure to talk about SSANU, we have a programme now for HIV and we have organised series of programmes before. I am sure of four times when we have brought some organizations to conduct counseling and testing on this campus".(SUL)*
- *"The HIV related programmes we have here are basically our programmes". (HOC)*

A few of the key informants did not seem to be aware of what the University administration is doing relating to HIV and AIDS. They declared:

- *"There have not really been programmes to enlighten people on HIV and AIDS at least that I'm aware of. I know there have been health programmes but not really that much on HIV and AIDS. There should be awareness so that people will know what HIV and AIDS is all about and how they can avoid contacting it from sharp instrument and so on". (SUL)*
- *"HIV programme that I know is the test organized by my department where people came to know their status. The youth friendly centre helped to conduct the test. I know they are taking such things to other departments and the campaigns but I don't know if there are other things related to HIV that are done by the University". (SL)*

4.4 Knowledge of staff and students of University of Ibadan on its HIV and AIDS policy

Results relating to respondents' knowledge of the University's HA policy are presented in tables 4.13, 4.14, 4.15 and 4.16. Overall, Only 64 (5.3%) of the respondents had read the policy. The knowledge of AS, NS and students on the features of the HA policy of the University is presented in Table 4.13. Majority of AS (85.7%), NS (70.0%) and students (70.2%) knew that the policy acknowledge HIV and AIDS as a problem in the University of Ibadan. Majority of AS (85.7%), NS (80.0%) and students (78.7%) were knowlegdeable of the policy's provision that stressed that one does not cease to be a student or staff of the University if confirmed to be HIV positive. Most AS (85.7%), NS (90.0%) and students (80.9%) were aware of the provision of the policy which stated that HIV infected staff or students could share office and other facilities with others who are not infected. Most AS (85.7%), all the NS (100.0%) and majority of students (76.6%) were knowledgeable about the provision of the HA policy that infected staff and students the policy are entitled to the infectered access to the same health care as others who are not infected.

However, majority of AS (85.7%), NS (60.0%) and students (61.6%) claimed that the policy did not say that staff and students seeking employment or admission to the University should be routinely screened for HIV before being considered. Majority of AS (71.4%), NS (80.0%) and many students (59.6%) were able to state correctly that the policy says the University has to provide infected students, staff and their dependants with treatment and care services. The details are presented in the table under review.

Results of knowledge of staff and students on their rights as contained in the University HA policy is presented in Table 4.14. Many AS (42.8%), few NS (20.0%) and students (31.9%) had the knowledge of the provision of the University HA policy which says compulsory testing for HIV for staff and students before employment or admission is a violation of their right. Majority of AS (71.4%), many NS (60.0%) and some students (46.8%) also correctly reported that the policy says that prospective students or staff do not have to disclose their HIV status to the University before admission or employment. Majority of AS (85.7%), half of NS (50.0%) and slightly over half of students (53.1%) correctly said the

policy says staff and students are not required to undergo HIV test by right as a requirement for continuation of study or employment. The proportions of AS (85.7%), NS (70.0%) and students (70.2%) claimed that the policy says all staff and students and not only the HIV affected ones should be provided with information about universal precaution in order to protect themselves. On the other hand, majority of AS (71.4%), few NS (20.0%) and majority of students (65.9%) erroneously stated that the policy says AIDS should not be treated like any other condition which someone can live with for a long time. The details are contained in the table under review.

Results relating to knowledge of staff and students on their responsibilities as contained in the University's HA Policy are presented in Table 4.15. Less than half (42.8%) of AS, all NS (100.0%) and 63.8% students stated correctly that the policy says it is the sole responsibility of staff and students to protect themselves against HIV infection. Majority of AS (71.4%), NS (80.0%) and many students (55.3%) said that according to the HA policy, staff and students are encouraged to seek information about prevention of HIV and AIDS alone. Also, majority of AS (71.4%), NS (70.0%) and many students (59.6%) correctly stated that the policy says each staff/student should make the decision to undergo counseling and testing for HIV or not. Majority of AS (85.7%), many NS (50.0%) and students (55.3%) correctly stated that the policy does not ask any staff or students to disclose the identity of persons who are living with HIV on campus for monitoring as a preventive measure. Majority of AS (85.7%), NS (90.0%) and students (70.2%) stated correctly that the prevention of HIV and AIDS on campus is a joint responsibility of everyone. (See Table 4.15 for details)

Table 4.16 presents results on knowledge of staff and students on interventions for HIV and AIDS as contained in the HA policy of the University. Majority of AS (85.7%) said only sexual abstinence is promoted in the policy for HIV prevention among staff and students. Majority of NS (70.0%) and students (72.3%) however described this as false. Majority of AS (71.4%), most NS (90.0%) and many students (44.6%) said correctly that the HA policy advocated for the integration of HIV counseling and testing into the services provided at the Infa c linic. Majority of AS (71.4%), students (65.9%) and half of NS (50.0%) disagreed

with the fact that the policy is silent on the screening of blood and blood products at Jaja clinic. Support groups for persons living with HIV and AIDS was said to be advocated for in the policy by majority of AS (71.4%), half of NS (50.0%) and 48.9% students. Most AS (85.7%), 90.0% NS and many students (59.6%) were correct in stating that the policy contains the provision that voluntary testing for HIV should be a regular exercise for everyone in the University. The proportions of AS, NS and students who stated that the policy says courses on HIV and AIDS should be integrated into various curricula in the University were 71.4%, 90.0% and 46.8% respectively and that of integration of HIV education into GES courses were AS (42.8%), NS (70.0%) and students (68.1%).

Figure 4.6 shows the respondents' level of knowledge of the University's HA policy. The proportion of AS who had good knowledge was 57.1% and this is highest proportion of good knowledge among the three categories of respondents. The AS also had the smallest proportion of poor knowledge (14.3%) compared with NS and students. The proportions of AS with fair knowledge was 28.6%. The NS had 30.0% good knowledge, 30.0% fair knowledge and 40.0% poor knowledge. The proportions of students rated with good, fair and poor knowledge 23.4%, 44.7% and 31.9% respectively. Mean knowledge score among the AS, NS and students were 29.1 ± 6.7 for AS, 23.2 ± 7.0 for NS and 23.4 ± 7.1 respectively. (See Figure 4.6 for details).

Overall, there was no significant difference in respondents' mean knowledge scores by sex. This is presented in table 4.17. Among the AS for instance, the mean score among the males and females were 30.8 ± 5.5 and 19.0 ± 0. The comparison of staff respondents' mean knowledge scores by years of working experience in the University is highlighted in table 4.18. The mean scores for the AS among those with 1-9, 10-19 and 20-29 years working experience were 29.0 ± 4.6, 28.0 ±12.7 and 36.0± 0.0 respectively. (See the table for details of the mean scores among the NS). For both groups, there was no significant difference in their mean scores. Table 4.19 shows the comparison of the mean knowledge scores of students by year or level of study. Those in 300 level had a mean score of 24.6 ± 6.9, followed closely by those in 200 level with a score of 23.0 ± 8.4. Students in 100 level had a mean score of 27.0 ± 2.6. The difference among them was not however statistically significant. (See Table under reference for details).

The comparison of the mean knowledge scores of the staff on the University's HA policy by faculties is reflected in Table 4.20. The AS in the faculty of social sciences had a mean score of 34.7 ± 0.7 followed by those in the faculty of education with a mean score of 25.05 ± 0.0. For both AS and NS, the differences in respondents' mean scores were not significant. The mean knowledge scores of students in the various faculties are presented in table 4.21. The mean scores that topped the list was 28.8 ± 5.3 obtained by those in the faculty of Arts; those in the faculty of Veterinary Medicine had a mean score of 28.0 ± 8.0. The difference in their mean scores was not however statistically significant.

Table 4.13: Knowledge of respondents on the major provisions of the HIV and AIDS policy of the University of Ibadan

N= 64*

Major provisions of HA Policy	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
HIV and AIDS not recognized as a University problem	0 (0.0)	6** (85.7)	1 (14.3)	0 (0.0)	7** (70.0)	3 (30.0)	5 (10.6)	33** (70.2)	9 (19.1)
There should be no interaction with people living with HIV and AIDS in the University to check its spread	1 (14.3)	6** (85.7)	0 (0.0)	0 (0.0)	9** (90.0)	1 (10.0)	2 (4.3)	36** (76.6)	9 (19.1)
Students/staff seeking for admission/employment should be screened for HIV before being considered	1 (14.3)	6** (85.7)	1 (14.3)	3 (30.0)	6** (60.0)	1 (10.0)	7 (14.9)	29** (61.6)	11 (23.4)
Counseling is not mandatory for staff and students before they undergo HIV test	1 (14.3)	5** (71.4)	1 (14.3)	4 (40.0)	4** (40.0)	2 (20.0)	6 (12.7)	34** (72.3)	7 (14.9)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements*

** *Correct response*

Table 4.13: Knowledge of respondents on the major provisions of the HIV and AIDS policy of the University of Ibadan (contd)

N=64*

Major provisions of HA Policy	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
One ceases to be a student or staff of UI if found to be HIV positive	0 (0.0)	6** (85.7)	1 (14.3)	1 (10.0)	8** (80.0)	1 (10.0)	2 (4.3)	37** (78.7)	8 (17.0)
Infected staff/student should have limited information on his/her status so that they will not commit suicide	0 (0.0)	6** (85.7)	1 (14.3)	1 (10.0)	7** (70.0)	2 (20.0)	3 (6.4)	32** (68.1)	12 (25.5)
Infected staff should not share the same office and other facilities with others who are not infected to avoid spread of infection	0 (0.0)	6** (85.7)	1 (14.3)	0 (0.0)	9** (90.0)	1 (10.0)	1 (2.1)	38** (80.9)	8 (17.0)
Students living with HIV should not have access to the same hostel accommodation as others so as to avoid spread of the infection	0 (0.0)	6** (85.7)	1 (14.3)	0 (0.0)	8** (80.0)	2 (20.0)	4 (8.5)	34** (72.3)	9 (19.1)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements* ** *Correct response*

Table 4.13: Knowledge of respondents on the major provisions of the HIV and AIDS policy of the University of Ibadan (contd)

N= 64*

Major provisions of HA Policy	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
Staff and students living with HIV should not have access to the same health care facility as others to avoid spread of the infection	0 (0.0)	6** (85.7)	1 (14.3)	0 (0.0)	10** 100.0)	0 (0.0)	2 (4.3)	36** (76.6)	9 (19.1)
Staff or students who have HIV should not share toilets with others in the hostels to prevent its spread	0 (0.0)	6** (85.7)	1 (14.3)	0 (0.0)	8** (80.0)	2 (20.0)	3 (6.4)	37** (78.7)	7 (14.9)
The University does not have to provide infected students, staff and their dependants with a link for treatment and care services	0 (0.0)	5** (71.4)	2 (28.6)	1 (10.0)	8** (80.0)	1 (10.0)	5 (10.6)	8** (59.6)	14 (29.8)
Staff/students must inform the University management of their HIV status whether positive or not	0 (0.0)	4** (57.1)	3 (42.9	4** (40.0	3 (30.0)	3 (30.0)	13 (27.7)	19** (40.4)	15 (68.1)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements* ** *Correct response*

Table 4.14: Knowledge of respondents on their rights as contained in HIV and AIDS policy of the University of Ibadan

N=64*

Provision of U. I HA policy relating to rights of staff and students	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
Compulsory HIV testing before admission/employment is not a violation of right but a drastic step toward HIV prevention	3 (42.8)	3** (42.8)	1 (14.3)	7 (70.0)	2** (20.0)	1 (10.0)	15 (31.9)	23** (48.9)	9 (19.1)
Prospective staff or students must disclose their HIV status before employment or admission	1 (14.3)	4** (71.4)	2 (28.6)	3 (30.0)	6** (60.0)	1 (10.0)	10 (21.2)	22** (46.8)	15 (31.9)
Staff and students are required to undergo HIV test if they want to continue their employment or academic programmes in UI.	0 (0.0)	6** (85.7)	1 (10.0)	4 (40.0)	5** (50.0)	1 (10.0)	10 (21.2)	25** (53.1)	12 (25.5)
UI should keep staff and students with HIV or AIDS under close watch or surveillance to ensure they do not infect others	0 (0.0)	6** (85.7)	1 (10.0)	3 (30.0)	5** (50.0)	2 (20.0)	6 (12.7)	31** (65.9)	10 (21.3)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements* ** *Correct response*

Table 4.14: Knowledge of respondents on their rights as contained in the HIV and AIDS policy of the University of Ibadan (contd)

N=61*

Provision of U. I HA policy relating to rights of staff and students	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
UI should keep records of HIV status in staff or students' personal files which are open to anyone in the University to see	0 (0.0)	5** (71.4)	2 (28.6)	3 (30.0)	6** (60.0)	1 (10.0)	2 (4.3)	33** (70.2)	12 (25.5)
AIDS should not be treated like any other health condition which someone can live with for a long time	5 (71.4)	0** (0.0)	2 (28.6)	2 (20.0)	7** (70.0)	1 (10.0)	9 (19.1)	31** (65.9)	10 (21.3)
Only students/staff without HIV or AIDS should be provided with information about universal precaution so they can protect themselves	0 (0.0)	6** (85.7)	1 (14.3)	2 (20.0)	7** (70.0)	1 (10.0)	8 (17.0)	33** (70.2)	9 (19.1)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements*

** *Correct response*

Table 4.14: Knowledge of respondents on their rights as contained in the HIV and AIDS policy of the University of Ibadan (contd)

N=64*

Provision of U. I HA policy relating to rights of staff and students	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
Students/staff should not have information on safe sex practices so that they will not experiment with such practices	0 (0.0)	6** (85.7)	1 (14.3)	0 (0.0)	7** (70.0)	2 (20.0)	3 (6.4)	35** (74.5)	9 (19.1)
The policy is silent on seeking redress in the University of Ibadan by people living with HIV of the in case of discrimination	0 (0.0)	6** (85.7)	1 (14.3)	2 (20.0)	3** (30.0)	5 (50.0)	6 (12.8)	28** (59.6)	13 (27.6)
Any staff or student confirmed to be HIV positive could be dismissed or rusticated from the university as a preventive measure	0 (0.0)	6** (85.7)	1 (14.3)	1 (10.0)	7** (70.0)	1 (10.0)	5 (10.6)	35** (74.5)	7 (14.9)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements*

** *Correct response*

Table 4.19: Knowledge of respondents on their responsibilities as contained in the HIV and AIDS policy of the University of Ibadan

N=64*

Responsibilities of staff and students as contained in the UI HA Policy	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
It is the sole responsibility of staff and students to protect themselves against HIV infection	3** (42.8)	2 (28.6)	2 (28.6)	10** (100.0)	0 (0.0)	0 (0.0)	30** (63.8)	14 (29.8)	3 (6.4)
Staff and students are encouraged to seek information about prevention of HIV and AIDS alone	5** (71.4)	1 (14.3)	1 (14.3)	8** (80.0)	1 (10.0)	1 (10.0)	26** (55.3)	13 (27.6)	8 (17.0)
The decision to undergo counseling and testing for HIV or not rests on individual staff/student	5** (71.4)	0 (0.0)	2 (28.6)	7** (70.0)	1 (10.0)	1 (10.0)	28** (59.6)	10 (21.3)	9 (19.1)
Staff/students should help identify persons who have HIV on campus for monitoring as a preventive measure	0 (0.0)	6** (85.7)	1 (14.3)	4 (40.0)	5** (50.0)	1 (10.0)	10 (21.3)	26** (55.3)	11 (23.4)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements*

** *Correct response*

Table 4.15: Knowledge of respondents on their responsibilities as contained in the HIV and AIDS Policy of the University of Ibadan (contd)

N=64*

Responsibilities of staff and students as contained in the UI HA Policy	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
Staff/students should disclose the identity of fellow staff/students living with HIV so as not to spread the virus to innocent people	0 (0.0)	5** (71.4)	2 (28.6)	3 (30.0)	6** (60.0)	1 (10.0)	13 (27.6)	24** (51.1)	12 (25.5)
Jaja clinic should tell staff, their dependants and students that regular HIV counseling and testing is mandatory	0 (0.0)	4** (57.1)	3 (42.9)	9 (90.0)	1** (10.0)	0 (0.0)	19 (40.2)	15** (31.9)	13 (27.6)
Prevention of HIV and AIDS on campus is a joint responsibility of everyone	6** (85.7)	0 (0.0)	1 (14.3)	9** (90.0)	1 (10.0)	0 (0.0)	33** (70.2)	9 (19.1)	5 (10.6)

* *Total number of respondents that have read the UA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements*

** *Correct response*

Table 4.16: Knowledge of respondents on interventions for HA as contained in the HIV and AIDS policy of the University of Ibadan

N=64*

Intervention as contained in the HI policy of UI	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
Only sexual abstinence is promoted among staff and students for HIV prevention	6 (85.7)	0** (0.0)	1 (14.3)	2 (20.0)	7** (70.0)	1 (10.0)	11 (23.4)	34** (72.3)	2 (4.3)
The integration of HIV counseling and testing services into the services of Jaja clinic is advocated	5** (71.4)	1 (14.3)	1 (14.3)	9** (90.0)	1 (10.0)	0 (0.0)	21** (44.6)	13 (27.6)	13 (27.6)
The policy is silent on the screening of blood and blood products at Jaja clinic	0 (0.0)	5** (71.4)	2 (28.6)	2 (20.0)	5** (50.0)	3 (30.0)	6 (12.7)	31** (65.9)	10 (21.3)
UI is not interested in support groups for persons living with HIV and AIDS because it is not a hospital	0 (0.0)	5** (71.4)	2 (28.6)	2 (20.0)	5** (50.0)	3 (30.0)	11 (23.4)	23** (48.9)	13 (27.6)
The policy states that voluntary testing for HIV should be a regular exercise for everyone in U. I	6** (85.7)	0 (0.0)	1 (14.3)	9** (90.0)	0 (0.0)	1 (10.0)	28** (59.6)	12 (25.5)	10 (21.3)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements* ** *Correct response*

Table 4.16: Knowledge of respondents on interventions for HA as contained in the HIV and AIDS policy at the University of Ibadan (contd)

N=64*

Intervention as contained in the HI policy of UI	AS (%) n=7 True	False	Don't Know	NS (%) n=10 True	False	Don't Know	Students (%) n=47 True	False	Don't Know
No provisions for how staff and students who need drugs for HIV infection could get such in the policy	1 (14.3)	4** (57.1)	2 (28.6)	3 (30.0)	4** (40.0)	3 (30.0)	10 (21.3)	20** (42.5)	17 (36.2)
The policy says courses on HIV and AIDS should be integrated into various curricula in the University	5 ** (71.4)	1 (14.3)	1 (14.3)	9** (90.0)	1 (10.0)	0 (0.0)	21** (46.8)	13 (27.6)	13 (27.6)
The integration of HIV education into the General Education Studies (GES) of UI is not supported	0 (0.0)	3** 42.8	4 (57.1)	1 (10.0)	7** (70.0)	2 (10.0)	1 (2.1)	32** (68.1)	14 (29.8)
The University does not encourage HIV and AIDS related activities on campus	0 (0.0)	5** (71.4)	2 (28.6)	0 (0.0)	8** (80.0)	2 (20.0)	8 (17.0)	28** (59.6)	11 (23.4)

* *Total number of respondents that have read the HA HIV and AIDS policy but which varies depending on the number of persons that responded to each of the knowledge related statements*

** *Correct response*

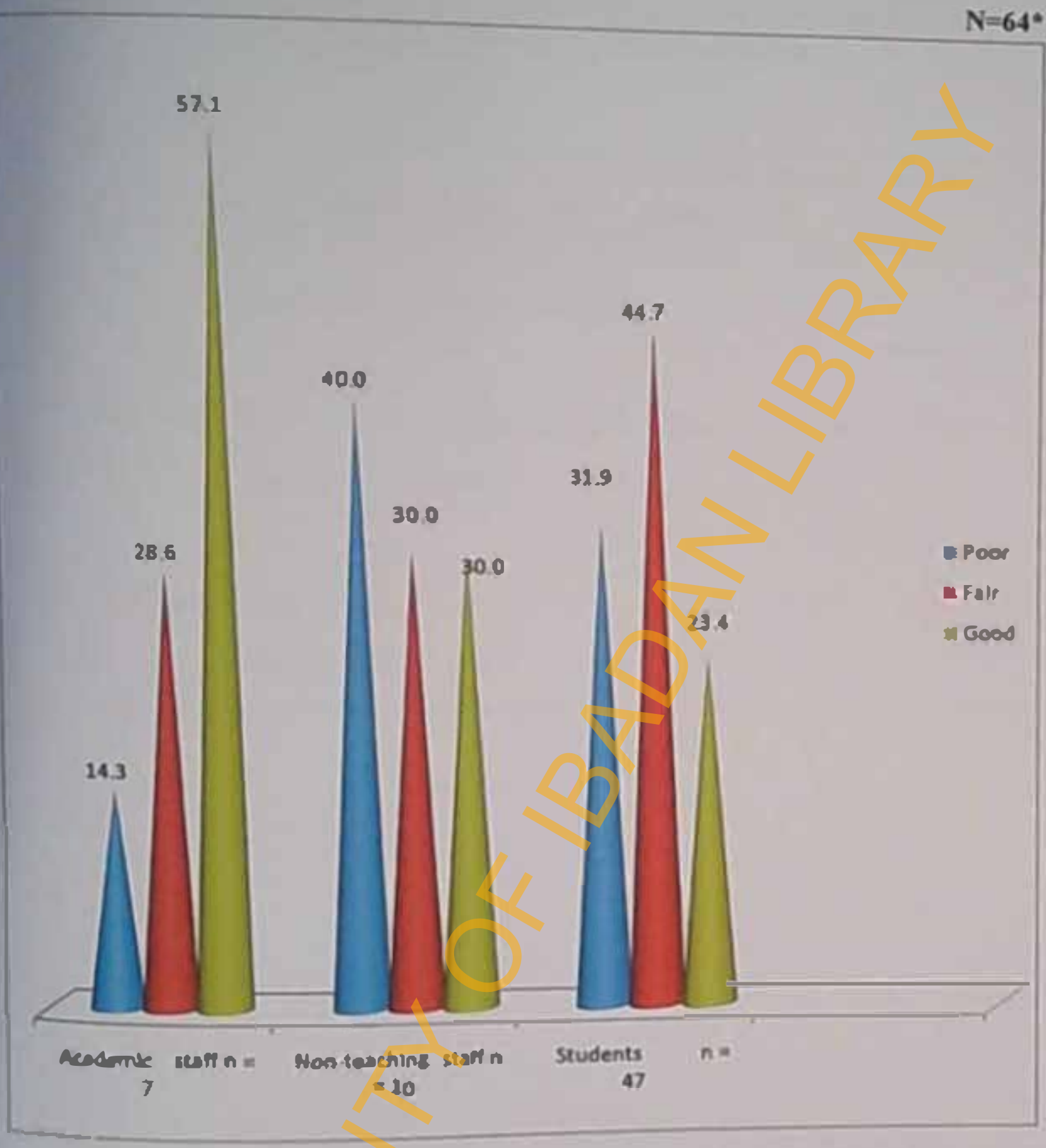

Figure 4.6: Respondents' level of knowledge of UI HIV and AIDS Policy

* Total number of respondents that had ever read the HIV and AIDS policy of UI

Note: Mean knowledge scores were 29.1 ± 6.7 (AS), 23.2 ± 7.0 (NS) and 23.4 ± 7.1 (Students)
p value = 0.39 (p > 0.05)

Categories of knowledge scores: Poor knowledge = ≤ 20, fair knowledge = 21-28 and good knowledge ≥ 29

Table 4.17: Comparison of Mean knowledge scores of staff and students on the University's HIV and AIDS Policy by sex

	Sex	No	Mean	SD	Overall mean	Overall SD	t-value	P Value
AS	Male	6	30.83	5.49	29.14	6.719	1.994	0.1026
	Female	1	19.00	0.00				
NS	Male	3	19.333	3.506	23.20	7.099	-1.147	0.2844
	Female	7	24.857	6.793				
Students	Male	33	23.182	7.10	23.43	7.157	0.246	0.806
	Female	14	22.571	9.188				

Table 4.18: Comparison of mean knowledge scores of staff on the University's HIV and AIDS Policy by working experience (In years)

n=17

	AS				NS			
	No	Mean	SD	F test	No	Mean	SD	F test
1-9	3	29.0	4.58	0.15	5	23.8	6.76	0.11
10-19	2	28.0	12.72	P=0.90	3	24.0	11.14	P=0.95
20-29	2	36.0	0.00	df=3	1	22.0	0.0	df=3
30-39		N/A			1	19.0	0.0	

Table 4.19: Comparison of mean knowledge scores of students on the University's HIV and AIDS Policy by years/level of study

n=47

Years of study	Knowledge			
	Number	Mean	SD	F test
1 (100 level)	3	27.00	2.64	0.99
2 (200 level)	11	23.00	8.43	
3 (300 level)	21	24.61	6.95	P=0.43
4 (400 level)	7	18.28	7.38	
5 (500 level)	2	21.00	7.38	df=5
6 (600 level)	3	20.00	14.00	

Table 4.20: Comparison of mean knowledge scores of staff on the University's HIV and AIDS Policy by Faculties

n=17

	Knowledge							
	AS				NS			
Faculties	No	Mean	SD	P value	No	Mean	SD	P value
Clinical science	2	24.50	7.77	X^2 =4.92	1	27.00	0.00	X^2 = 6.32
Pharmacy	0				2	23.00	9.89	
				P=0.89				P=0.78
Social Sciences	3	34.75	0.70	df=10	0			df=10
Education	1	25.00	0.00		2	31.50	0.00	
Science	0				2	17.00	0.00	
Technology	1	24.00	0.00		2	17.00	0.00	
Non teaching departments*	0				1	18.00	0.00	

Table 4.21: Comparison of knowledge of students on UI HIV and AIDS Policy by Faculties

n=47

		Knowledge		
Faculty	Number	Mean score	SD	F statistic
Arts	7	28.75	5.34	
Social science	9	22.33	6.61	1.84
Science	6	22.21	7.83	P=0.87
Technology	4	22.71	9.05	df=10
Education	7	25.67	4.16	
Pharmacy	1	23.05	5.98	
Basic Medicine	2	20.43	7.81	
Clinical sciences	2	20.50	3.54	
Agriculture and Forestry	3	12.25	10.24	
Dentistry	1	27.00	3.00	
Public Health	2	20.00	0.00	
Veterinary medicine	2	28.00	8.00	
Other academic Departments/Centres	1	24.00	0.00	

Some of the Key Informants that had read the HIV and AIDS policy stated correctly some of its features and specific objectives. The following quotes reflect some of their knowledge of the policy:

- *"One of the objectives of the HIV and AIDS policy is to make the UI community aware of HIV, know the mode of transmission, signs and symptoms, the prevention and all the issues surrounding it like discrimination and stigmatization of people living with HIV. Another objective of the HIV and AIDS policy is getting the HIV education into the curriculum; this is done through the 100 level GES courses. Through GES, all the students are exposed to the education about HIV and AIDS. The HIV and AIDS policy also 'talked' about caring for those who are found to be positive with HIV. There is a commitment to their referral to a facility where they can get adequate care and they are also followed up."* **(UHSP)**
- *"One of the objectives is to take the HIV issues as something that concerns the university as a whole and not an individual. Also to get across to the community with the education about HIV for prevention, treatment and care and tackle the issue of discrimination. Moreover, it is for everyone to know their rights as well as their responsibilities in the HIV prevention". (SUL)*
- *"The objective consists of two dimensions; the whole thing is to, as much as possible eradicate HIV among our students, among staff and the university is looking at it from two 'fronts'. Firstly, education as much as possible in all strata of the university. Secondly, the University also goes into research. I'm sure you are aware that the University is into collaboration with foreign institutions on both clinical and applied research. So I think from these 2 angles, the University is making its own contributions. I think prevention is also one of the things talked about in the HIV and AIDS policy". (UPO)*
- *"...it is a long time that the HIV and AIDS policy was put in place but I think the main objective is to prevent the spread of the infection on campus by giving information, education as they (students) come in. In a nutshell, the HIV and AIDS policy is a preventive approach that is based on the fact that information is a weapon. It has also brought forward the*

development of educational materials on campus. One of the things that have come out of it is GES courses on HIV. (MHPSC)

One of the Key Informant expressed a concern relating to the limitation of the scope of the UI HIV and AIDS policy thus:

- *"Everyone within the community of University of Ibadan (students and staff) is targeted by the HIV and AIDS policy but attention is largely focused on students because their population is more. Some of them (students) even reside outside the campus like Agbowo and other places around U.I. These are the ones that live 'off campus" These off-campus students mingle with other people who are not members of the University community and then come back to the University. But how the HIV and AIDS policy is going to reach all of those people. I don't know".*

  (MHPSC)

4.5. Perception of the University's HIV and AIDS policy by staff and students

Tables 4.22 presents the perception of staff and students on the University's commitment to HIV control as contained in the HIV and AIDS Policy. All AS (100.0%), most NS (90.0%) and many students (59.5%) were of the opinion that UI should implement the HIV and AIDS policy as it is not a waste of time. Majority of AS (85.7%), 60.0% NS and 40.4% students disagreed with the view that not making HIV testing obligatory in the policy shows that the UI is not really serious about controlling HIV on campus.

Majority of AS (85.7%), NS (70.0%) and students (66.0%) disagreed with the view that the University's HIV and AIDS policy should not allow any staff or students living with HIV to continue working or studying in UI. The perception of 14.3% AS, 20.0% NS and 10.6% students was that the University's campaign on HIV campus only exists on paper. Similarly, the perception of 14.3% AS, 20.0% NS and 17.0% students was that the HIV and AIDS policy of UI is designed for only sexually active persons on campus. The view of 14.3% AS, 20.0% NS and 25.5% students was that the HIV and AIDS policy of UI does not involve staff and students well enough on AIDS control activities. The view that the control of HIV on campus should be the sole responsibility of the UI authority cut across a majority of AS (71.4%), 60.0% NS and 34.1% students (For details, please see the Table under reference).

The perceptions of respondents on the provisions of the HIV policy of UI are highlighted in Table 4.23. Few of the AS (14.3%), NS (10.0%) and students (10.7%) were of the view that it is not proper for the policy to promote the use of condom as a way of preventing HIV on campus. Majority of AS (71.4%), 60.0% NS and 53.1% students were of the opinion that the HIV and AIDS policy of UI which favours the employment of HIV positive persons is a good one. A majority of AS (71.4%), NS (80.0%) and some students (59.6%) considered the policy's provision which frowns at the discrimination against of HIV positive persons to be appropriate. The perception that the policy should not insist that HIV positive staff or students the University be dismissed or expelled cut across the majority of AS (85.7%), NS (80.0%) and students (66.0%). The majority of AS (85.7%), 50.0% NS and 44.7% students (44.7%) did not share the view that it is not practicable for people in UI to report to the Jaja Clinic if they are HIV positive as required by the policy.

The results relating to the perception of staff and students on the effect of the HIV and AIDS policy of the University is presented in table 4.24. Majority of AS (85.7%), NS (80.0%) and many students (51.0%) did not share the perception that HIV has come to stay despite all preventive actions and so, the policy is not necessary. Majority of AS (85.7%), NS (80.0%) and students (63.8%) held the belief that HIV education has positive effect on sexual behavior of people in UI. Only a few of respondents among the AS (14.3%), NS (10.0%) and students (12.7%) were of the view that the UI HIV and AIDS policy is a mere academic exercise with no impact on the University community. Majority of AS (71.4%), NS (60.0%) and some students (48.9%) were of the view that the HIV and AIDS policy of the University is not difficult to implement.

Overall, AS had the highest level of favourable perception relating to the HIV and AIDS policy of the University (85.7%) followed by NS (70.0%). The level of perception of students, however, was the least favourable (46.7%). The mean perception scores were 13.0 ± 2.9 (AS), 11.8 ± 3.4 (NS) and 9.2 ± 4.7 (students) ($p<0.05$) which is statistically significant. (See details in Figure 4.7).

Table 4.22: Respondents' perception of the University's commitment to HIV control in the UI HIV and AIDS Policy

Perception	Responses*	Category of respondents		
		ASt (%) n=7	NSt (%) n=10	Studentst (%) n=47
UI should not waste it's time implementing the HA policy as issues relating to HA are personal	A	0(0.0)	1(10.0)	11(23.4)
	UN	0(0.0)	0(0.0)	7(17.0)
	D	7(100.0)	9(90.0)	28(59.5)
Not making HIV testing obligatory in the policy shows that the UI is not really serious about controlling HIV on campus	A	1(14.3)	3(10.0)	16(34.0)
	UN	0(0.0)	3(30.0)	9(19.1)
	D	6(85.7))	6(60.0)	19(40.4)
UI HA policy should not allow any staff/ students living with HA to continue working or studying in U.I. in order not to infect others	A	0(0.0)	0(0.0)	4(8.5)
	UN	1(14.3)	3(30.0)	9(19.1)
	D	6(85.7)	7(70.0)	31(66.0)
The campaign on HIV on campus only exists on paper	A	1(14.3)	2(20.0)	5(10.6)
	UN	2(28.6)	2(20.0)	14(29.8)
	D	3(42.8)	6(60.0)	22(46.8)
The HIV and AIDS policy of U.I. is designed for only sexually active persons on campus	A	1(14.3)	2(20.0)	8(17.0)
	UN	1(14.3)	0(0.0)	20(42.6)
	D	5(71.4)	8(80.0)	15(31.9)

† No responses have been removed from calculation
* A = Agree, UN = Undecided, D = Disagree

Table 4.22: Respondents' perception of the University's commitment to HIV control in the UI HIV and AIDS policy (contd)

Perception	Responses*	Category of respondents		
		AS† (%) n=7	NS† (%) n=10	Students† (%) n=47
The control of HIV on campus should be the sole responsibility of the UI authority	A	1(14.3)	3(30.0)	15(31.9)
	UN	1(14.3)	1(10.0)	13(27.3)
	D	5(71.4)	6(60.0)	16(32.4)
The U.I. HIV and AIDS policy should not encourage the conduct of HIV and AIDS researches	A	0(0.0)	2(20.0)	6(12.8)
	UN	0(0.0)	1(10.0)	11(23.4)
	D	6(85.7)	7(70.0)	27(57.4)
The HIV and AIDS policy of U.I. does not involve staff and students well enough on AIDS control on campus	A	1(14.3)	2(20.0)	12(25.5)
	UN	2(28.6)	4(40.0)	9(21.2)
	D	4(57.1)	4(40.0)	14(44.7)

† *No responses have been removed from calculation*

* *A = Agree, UN = Undecided, D = Disagree*

Table 4.23: Respondents' perception of provisions of the HIV and AIDS policy of UI

Perception	Responses*	Category of respondents		
		AS† (%) n=7	NS† (%) n=10	Students† (%) n=47
It is not practicable for people to report to the Jaja Clinic that they have HIV and AIDS as required by the policy	A	1(14.3)	1(10.0)	10(21.3)
	UN	1(14.3)	4(40.0)	13(27.7)
	D	6(85.7)	5(50.0)	21(44.7)
It is not proper for the UI HIV and AIDS policy to be promoting use of condom as a way of preventing HIV	A	1(14.3)	1(10.0)	5(10.7)
	UN	1(14.3)	2(20.0)	12(25.6)
	D	5(85.7)	6(60.0)	25(53.2)
U.I. HA policy which favours the employment of HIV positive persons is good	A	5(71.4)	6(60.0)	25(53.2)
	UN	2(28.6)	4(40.0)	11(23.4)
	D	0(0.0)	0(0.0)	8(17.1)
U.I. HA policy that frowns at discrimination against HIV positive persons is appropriate	A	6(85.7)	8(80.0)	28(59.6)
	UN	0(0.0)	1(10.0)	8(17.1)
	D	2(28.6)	1(10.0)	8(17.1)
The policy must insist that HIV positive staff/students of U.I. should be dismissed or expelled	A	0(0.00)	0(0.00)	4(8.5)
	UN	0(0.00)	2(20.0)	8(17.1)
	D	6(85.7)	8(80.0)	31(66.0)

† *No responses have been removed from calculation*

* *A = Agree, UN = Undecided, D = Disagree*

Table 4.24: Respondents' perception of the effects of the U. I. HIV and AIDS policy

Perception		Category of respondents		
		AS† (%) n=7	NS† (%) n=10	Students† (%) n=47
HIV has come to stay despite all preventive actions, so U. I. policy on HIV is not necessary	A	0(0.0)	2(20.0)	10(21.3)
	UN	0(0.0)	0(0.0)	10(21.3)
	D	6(85.7)	8(80.0)	24(51.1)
Education on HIV and AIDS does not have any positive effect on sexual behaviour of people in UI as they are adults	A	0 (0.0)	1(10.0)	7(14.9)
	UN	1(14.3)	1(10.0)	6(12.7)
	D	6(85.7)	8(80.0)	33(63.8)
The HIV and AIDS policy of U.I. is a mere academic exercise	A	1(14.3)	3(30.0)	6(12.7)
	UN	0(0.0)	0(0.0)	15(31.9)
	D	5(71.4)	7(70.0)	21(44.7)
The HIV and AIDS policy of U.I. is difficult to implement	A	1(14.3)	1(10.0)	10(21.3)
	UN	1(14.3)	2(20.0)	10(21.3)
	D	5(71.4)	6(60.0)	23(48.9)

† No response has been removed from calculation
* A = Agree, UN = Undecided, D = Disagree

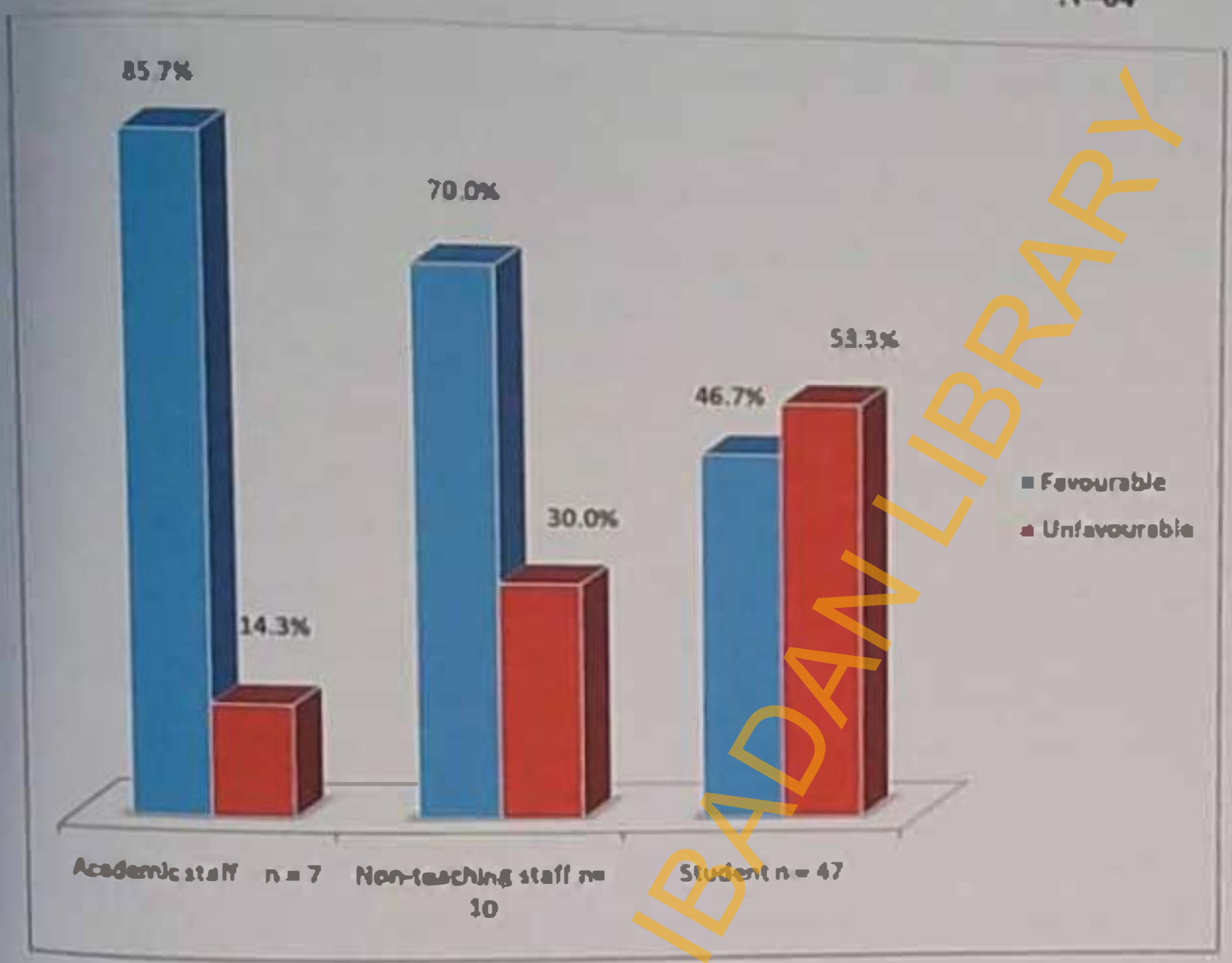

Figure 4.7: Level of perception of respondents

Note: Mean perception scores = 13.0 ± 2.9 (AS), 11.8 ± 3.4 (NS) and 9.2 ± 4.7 (students) (p=0.04). Overall mean perception 10.1 ± 4.5

4.6. Stakeholders perceived challenges to the implementation of HIV and AIDS Policy and programmes at the University of Ibadan

Majority of the Key Informants listed one challenge or the other facing the implementation of the University's HIV and AIDS policy and programmes. Some of the challenges relate to lack of funds and poor dissemination of the policy which have hindered its full implementation. The listed challenges are inherent in the following:

- *"Firstly the low awareness of the HIV and AIDS policy is a problem. If people do not know of the existence of the HIV and AIDS policy, how can they talk about its implementation? Secondly, the stigma attached to HIV status is still there. This can't make it easy to implement if the University does not have an effective mechanism for dealing with it. Thirdly the issue of its sustainability is a challenge. When a set of student leaves the campus, the new ones coming in for whatever programme (undergraduate or post graduate) should have a sustainable system in place for the awareness of the HIV and AIDS policy. The same applies to new members of staff". (MRL)*
- *"There are not enough materials to make people aware of the existence of the HIV and AIDS policy. There is no awareness at all and I also think there are no funds given to propel the activities related to the HIV and AIDS policy. Furthermore, there is no motivation even for the people doing the awareness and screening". (SL)*
- *"First, there seems to be no clear direction of how the HIV and AIDS policy would be implemented. Secondly, the problem of funds for so many things that need to be put in place and lastly I don't think the number of people to facilitate the implementation are adequate". (SUL)*
- *"For some time now, I have not heard anything being said about this HIV and AIDS policy. I do not know if up to 10 percent of the UI population know about it so I will think lack of awareness of the HIV and AIDS policy itself is a challenge. I am privileged to know about it because of my position in the union, same goes for some of our members. Another thing I will think is a problem is that of finance. Nothing can be done without money. If at the time the HIV and AIDS policy was developed, there was some money, the people in charge would need more money, more hands to help with the distribution and of what it contains. In addition, money is*

needed to always make it available to students and staff. You know, the number of students that come in yearly, undergraduate, post graduate, new staff as well" (MHPSC).

Another challenge mentioned by the Informants relate to the prevailing attitude of some people in the UI community concerning HIV and AIDS. Informants' view which relate to the attitudinal barriers include the following:

- *"Attitude to HIV would be a problem if we think the prevalence is going down and we switch to other things, a time will come when there would be a surge of people infected." (SUL)*
- *"People think HIV is not a new thing so they see it as something that has been overdone; that too much attention has been given to it than it deserves". (SL)*
- *" I think everybody is busy somehow coupled with the fact that we don't know who has HIV or not; people may think it is not as bad as it is painted". (UHSP)*
- *"Another challenge is the stigmatizing attitude relating to HIV. It will not make people respond to the programme. People still don't want to be attached to anything called HIV. All hands must be on deck to show that HIV is no respecter of anyone. As an example, the Vice Chancellor may publicly do HIV test to encourage other people. That is leadership. It shows example for people not to hide but to come out and know their HIV status. That will build a lot of confidence". (UPO)*

4.7. Participation of staff and students in HIV and AIDS control programmes in the University of Ibadan

Participation of staff and students in HIV and AIDS control activities on campus are presented in the next set of tables. Table 4.25 indicates participation of staff and students in HIV and AIDS training on campus. Majority of AS (88.9%) and students (68.1%) attended training programmes on HIV and AIDS on campus; only 44.6% NS ever participated. Results related to participation of staff and students in HIV-related programmes of the University Health Service (Joja Clinic) showed that out of the 204 respondents that were aware of HIV-related activities in Joja Clinic (in table 4.11), a total of 62 AS, NS and students ever participated in any HIV-related activity of UHS. 5 out of 22 AS (22.7%) 8 out of 42 NS (19.0%) and 31 out of 140 students (22.2.0%) ever participated in HIV counseling and testing (HCT) while 2 NS (4.8%) and 11 students (7.9%) of those that were aware had only counseling on HIV. Only 3 students (2.1%) ever had HIV education at Joja clinic while two students (1.4%) ever had free condom for HIV prevention at Joja clinic.

Only two NS (5.6) of the 36 that were aware of the HIV related activities of Research Alliance to Combat HIV and AIDS (REACH) and one student (16.)7% of out the 6.1 that ever participated in the HCT through the REACH which is a campus based HIV research programme. 16 students out of 150 that were aware of Action Group on Adolescent Health (AGAH), a campus based youth group's programme, ever participated in any of its HIV related activities. 3.6% of the students had HCT while the remaining 7.9% participated in HIV education organized by AGAH. Similarly, more students than staff participated in HIV-related activities of the Youth Friendly Centre (YFC). Out of the 55 that participated in YFC activities, 5 NS and 15 students only took part in the HIV education programme while 34 students had HCT done at the centre. Out of the 353 student that attended the orientation programme organised for fresh students in UI by the university authority, only 54.0% ever attended the HIV educational programme as part of the orientation.

Table 4.26 shows the places where staff and students had HIV voluntary counseling and testing (VCT). Majority of AS (61.0%), some NS (43.8%) and students (44.3%) had ever participated in HCT anywhere. A small proportion of AS (13.9%), NS (23.4%) and students (30.9%) had ever participated in HCT that was done on campus. The places of participation of HCT on campus were indicated in table 4.32. Out of the five AS respondents who had HCT on campus, some (40.0%) did so at Joja Clinic, few (20.0%)

had it done at Virology Department, while some (40.0%) did at various outreaches within the campus. On the other hand, out of the 15 NS who had done HCT on campus, slightly more than half (53.3%) did so at Jaja clinic, few (20.0%) had it done at YFC, few (13.3%) did at Virology Department while the remaining 13.3% did at various outreaches within the campus. Out of the 137 students who had HCT on campus, few students (27.7%) had HCT at Jaja clinic, (21.9%) had it done at the YFC, a very small proportion (3.0%) did at Virology Department, while 47.4% did at various outreaches in the campus. (See Table 4.27 for details).

The level of participation of HIV-related programme among AS, NS and students of the University is highlighted in table 4.28. Respondents with high level of participation were AS -42.5%, NS - 37.0% and students - 42.9%. Moderate participation was recorded among the AS (55.9%), NS (60.3%) and students (49.3%). Respondents with low level of participation were AS - 4.9%, NS - 2.7% and students - 7.8%. The level of participation among the three categories was however significant ($p<0.05$). See Table 4.28 for details.

Table 4.29 shows the relationship between respondents' participation in HIV programmes and their levels of knowledge. Among the 64 AS, NS and students who had read the University's HIV policy, 12 participated in training programmes on HIV. Among this cohort, respondents who had poor, fair and good knowledge of the policy were 41.7%, 25.0% and 33.3% respectively. Among the 17 respondents who participated in the HIV-related programmes of the University Health Service (Jaja Clinic), 52.9% had poor knowledge of the policy while those with fair and good knowledge were each 23.5%. Only 17 respondents who had read the HIV policy of the University participated in HCT on campus. Out of these, 17.6% had poor knowledge, 35.3% had fair knowledge of the policy while 47.1% had good knowledge of it. There was no significant relationship between participation in HIV programme and level of knowledge of the staff and students on the University's HIV policy. (See Table under reference for details).

Table 4.25: Participation of staff and students in HIV and AIDS training in U. I

Ever attended training on HIV and AIDS	Yes	No
	N=531*	
AS (%) n=18	16 (88.9)	2 (11.1)
NS (%) n=56	25 (44.6)	31 (55.4)
Students (%) n=457	311 (68.1)	146 (31.9)

* *Those that ever attended any training in HIV and AID among all the respondents that were aware of such programmes*

Majority of the Key Informants stated that various HIV and AIDS programmes are implemented on campus but there are programmes mostly on awareness and education programmes. Here are some of their responses:

- *"I know about HIV education and awareness. Many associations are responsible for this. ANUESA that is 'All Nations United Students Association' has also done a lot on this. Our own students' union also, the Youth Friendly Centre, AGAH all participate in creating awareness and educating people about HIV. Those that require counseling, I mean the students, are referred for counseling and testing when the need arises. HIV orientation is given to fresh students (undergraduates) during the orientation programme when they just resume. I am aware of that too". (SL)*
- *" The YFC and Jaja clinic are involved in HIV education. I did not attend the health day of my orientation because there were many things I needed to do at that time but I know, there is HIV talk during orientation". (SL)*
- *"...HIV awareness activities are carried out by students' union, University Health Service and some other organisations including faith-based organisations, within the institution. Also there have been so many researches which I believe are important to HIV control. Even at the College of Medicine, social sciences, department of education, there have been seminars, workshops organised for staff" (SUL)*
- *"There is also the F.M station, the Diamond F.M. It is a radio station in UI and I have heard them talking about HIV AIDS during one of the programmes. It is a very good medium of information". (CRL)*
- *"There were workshops for staff of different categories. Lots of orientation, lots of seminars. Those who cared came, you know, ordinarily some people will say it is another jamboree but those who cared came". (SUL)*
- *" HIV education, awareness campaigns during hall week, outreaches in faculties for HIV counseling and testing were carried out. At these campaigns, the people are given the message of hope that for anyone that tests positive, hope is not lost, such can still have a good life". (HOC)*
- *"I know that there is a lot of campaigns on HIV by different groups. Our union is one of such groups. There are campaigns about HIV to give people information about it. Some do it on departmental basis and in some cases they*

go to halls of residence. The same thing applies to HIV screening. Some groups are organizing HIV screening for their members periodically". (SUL)

- *"There are materials for education on HIV in U.I. There are some that they put in the students package at resumption. that is the fresh students and there are materials from GES courses. The HIV courses in GES constitute another good thing that U.I has done but again it is for only undergraduates. I think the emphasis is on the undergraduate because they are the ones that are supposedly innocently coming from secondary school and their homes not knowing much of what happens in the outside world". (UHSP)*

One Informant was of the opinion that HIV programmes focusing on awareness and education are not doing enough. The Informant declared:

- *"For HIV Education, it is only what the Youth Friendly Centre does that I can say. There is really no awareness as it should be on this campus about HIV. It is expected that you will find billboards everywhere on campus, at the gate, in halls of residence, at the faculties, everywhere but it is not so. Except for when certain halls are doing their week and they talk about HIV which s not all the time (SL)*

A majority of the Key Informants were aware that General Education Studies (GES) programmes of the University for fresh undergraduates include the learning of HIV and AIDS related issues being taken by all fresh students at undergraduate level. Many of them did not participate in the teaching of GES courses on HIV; they nevertheless shared their opinions on the integration of HIV related issues into the GES courses. Their responses included the following:

- *"The general studies named GES 107 just started. It teaches the students about HIV and AIDS". (UPO)*
- *"I know there are HIV and AIDS related issues now integrated into the University curriculum and there are some GES courses on HIV at 100 level and even at 200 level for those who come in through direct entry. This has really gone a long way to get students educated on HIV and AIDS unlike we used to have in the past".*
  (MHPSC)

- *The GES also is another way of educating the students about HIV but you know people just do it to pass examinations". (SL)*
- *"The University has incorporated HIV courses into the GES programme, so every undergraduate has to pass through the course and this is a giant step taken by the university to empower the students with HIV knowledge I deal with students you know. There are GES courses that teach about HIV and AIDS to our undergraduates. One example is GES 107" (SL)*
- *"I know there is a GES that takes care of HIV for students now. I don't know the title or course code". (SUL)*

A few of the Key Informants were not aware of the integration of elements of HIV and AIDS into GES. The following statements reflected their responses:

- *"I don't know about HIV courses but I want to believe that such will be taught in medical school, department of nursing or basic sciences. Well as medical students yes. HIV and AIDS is part of some of our courses. But as a course of GES in U.I., I don't know, I am not aware". (MHPDC)*
- *"No, I do not know of any GES course on HIV in U.I. but in some of our medical courses, there are." (SL)*
- *"I am not aware of any course on HIV. Although I know there are GES courses, I'm not aware of any on HIV. I have not heard about that. I have not seen any book on HIV in the school". (SUL)*

One Key informant was of the opinion that GES courses on HIV should also be extended to postgraduate students. He declared thus:

- *"The integration of HIV courses into the GES programme of the University is another good thing that U.I has done but again it is for only undergraduates. Although the undergraduates are the ones that are supposedly innocently coming from secondary schools do not know much of what happens in the outside world, the post graduate students too should be taken into consideration". (MHPSC)*

Table 4.26: Places where staff and students had HIV voluntary counseling and testing (HCT)

N=1206

Variable	AS (%)		NS (%)		Students (%)	
	Yes	No	Yes	No	Yes	No
Ever participated in HIV VCT anywhere	36 (61.0)	23 (39.0)	64 (43.8)	82 (56.2)	443 (44.3)	558 (55.7)
	n=59		n=146		n= 1001	
Ever participated in HIV VCT on UI campus*	5 (13.9)	31 (86.1)	15 (23.4)	49 (76.6)	137 (30.9)	306 (69.1)
	n=36		n=64		n=443	

** Out of the respondents that have participated in HCT anywhere before*

Table 4.27: Place of participation of staff and students in HIV voluntary counseling and testing (HCT) on UI campus

n=157

Place	AS (%) n=5	NS (%) n=15	Students (%) n= 137
Jaja	2(40.0)	8(53.3)	38(27.7)
YFC	0 (0.0)	3(20.0)	30(21.9)
Virology UCH*	1(20.0)	2(13.3)	4(3.0)
Outreaches**	2(40.0)	2(13.3)	65(47.4)

* *Virology, UCH is one of the departments under Faculty of clinical sciences in College of Medicine but based in UCH, the affiliate Teaching Hospital of the University.*

** *Outreaches listed were - Department of nutrition Students Union Building, Department of Theatre Arts, Love Garden, Former Sports Complex, Trenchard hall, Onasede park under a tent, Obafemi Awolowo hall, Queen Elizabeth hall and Nnamdi Azikiwe hall*

Many of the Key Informants discussed HIV Counseling and Testing (HCT) on campus. Few of them however reported that HCT is done on campus mainly at the Youth Friendly Centre and The University Health Service also called Jaja Clinic. Some of the Informants did not consider the YFC ideal for conducting HCT because of issues relating to confidentiality. The following are some of their responses:

- *"I really can't say much other than the VCT is done in Jaja or Youth Friendly Centre" (SL)*
- *"The Youth Friendly Centre helped my department to carry out HIV test where people came to know their status. They are also helping to do the same in other departments". (SL)*
- *"The YFC does HIV testing at least I know of the time they came to my department. They talked to us and they asked people to come to the centre". (SL)*
- *At the Jaja Clinic they do a lot of test which HIV is part and of what the HIV and AIDS policy addressed. (MRL)*
- *"The University Health Service is actively involved in the translation of the HIV and AIDS policy to action, so also is the Youth Friendly Centre in the area of HIV counseling and testing" (UHSP)*
- *"Students also go to the YFC for counseling and testing. Any student can go there but it's not easy going there, you know, everyone will know what one is going there for". (SL)*
- *"Since people know that HIV test is done at YFC, I for example may not want to go and do it there. I will prefer to have it brought to my hall during the hall week where everybody is encouraged to do it". (SL)*

Contrary to the opinions of some Key Informants who felt the YFC is not ideal for people to take HCT, one student leader believed it is the best option for HCT on campus. He explained as follow:

- *"The University has established a Youth Friendly Centre which I'm aware of. And they make it in such a way that it is not just a place solely for screening for HIV status, there are other services that are provided. When people see you coming out of the place, they will not stigmatise you. You can go there to relax and play games. What they do there on HIV is*

screening and they have counselors that counsel you before and after the test. They make the result of the test confidential and they provide counseling which I think is a very good one. The fact that, the place is not only a place for games, you can read in the library, the risk of being stigmatized is reduced because, people won't know who has gone for the test and who is positive or negative". (SL)

A union leader declared that his union did not have to wait for the University before it organised VCT service for its members. He noted, however, that members' response to the HIV testing was poor.

- *"I don't know what the university is doing now about HIV testing though they have counselors at Jaja clinic But we at SSANU used to do it. Even now when you ask people to come and do test, they won't come because everybody is busy looking for what to eat. So the issue of HIV is like a second thought to them". (SUL)*

One Key Informant was concerned about the ready availability of HCT services in UI. His observation was that there are few opportunities for HIV counseling and testing on campus unlike what obtains in some other institutions outside the country. He noted that:

- *"I don't think we have enough HIV testing centres in U.I. Look, there are some institutions that are so serious about HIV that they have testing centres everywhere on campus. I was at the University of Botswana and they have HIV testing centres around the campus. But here, the individual takes a decision whether to test or not and where to test is the question. When I was outside the country I did the test, when I came back, I did the test again, on campus but I have to ask for it at the UHS (Jaja). It has to be a decision that is personal because of confidentiality and the issue of stigmatization. Some people are afraid of some of these things." (SUL)*

Table 4.28: Level of participation of HIV-related programmes

Participation	AS (%)	NS (%)	Students (%)	Chi-square	Df	P-value
High (5-8)	25	54	430			
	(42.4)	(37.0)	(42.9)			
Moderate	33	88	493	11.6	4	0.02
(3-4)	(55.9)	(60.3)	(49.3)			
Low	1	4	78			
(1-2)	(1.7)	(2.7)	(7.8)			
Total	59	146	1001			
	(4.9)	(12.1)	(83.0)			

Table 4.29: Knowledge of staff and students on UI HIV and AIDS Policy and their participation in HIV related programmes

N=64

Participation	Knowledge: Poor (%) (≤20)	Fair (%) (21-28)	Good (%) (≥ 29)	Total	P value
Training programme on on HIV	5 (41.7)	3 (25.0)	4 (33.3)	12 (18.8)	$X^2 = 7.1$
HIV related programmes in Joja clinic	9 (52.9)	4 (23.5)	4 (23.5)	17 (26.6)	P=0.3
HIV related programmes of AGAH	5 (83.3)	1 (16.6)	0 (0.0)	6 (9.4)	
HIV related programmes of REACH	0 (0.0)	2 (66.7)	1 (33.3)	3 (4.7)	
HIV related programmes of YFC	4 (44.4)	2 (22.2)	3 (33.3)	9 (14.1)	
HIV Voluntary counselling and Testing	3 (17.6)	6 (35.3)	8 (47.1)	17 (26.6)	

* *Only the respondents who ever read the HA HIV and AIDS policy of UI*

Note: The rating of knowledge was expressed in points

A few Key Informants mentioned other HIV programmes on campus which include treatment, care and support for HIV positive persons, universal precautions and research. All the Key Informants that spoke about treatment and care mentioned UCH as the linkage facility. The responses of some of the KIs were as follow:

- *"First the university has a linkage with a facility in the teaching hospital where anyone that is positive here is sent to for confirmation and for subsequent medical management. Such persons can still come here for whatever complaints also. The University also support them by allowing such persons go for treatment during work or school hours. Though the antiretroviral drugs are not given here, such persons have access to them in the affiliate facility". (HOC)*
- *"About care and support. Yes, UI gives the care and support that is necessary. ...one post graduate student that tested positive was referred to UCH". (UHSP)*
- *"The University has provided linkage with some facilities in UCH. This is part of the responsibilities of the health service, to follow it through for whosoever turns out to be positive of HIV be it student or staff". (UPO)*
- *"The University Health Service (Joja clinic) in UI does its own part. They refer anyone that is positive during screening to UCH where there is a centre for such people can have treatment. The University supports them by allowing them time to keep their medical appointments". (UHSP)*

Other programmes which a handful of the Key informants mentioned included:

- *I know there is Red Cross society on campus. I also know that for students, there are peer educators. For example, a handful of my classmates are peer educators. They were trained on how to influence their peers and thus influence the behaviours of their peers through knowledge and attitude change. (SL)*
- *"We educate and train the workers here on universal precautions which includes what to do in emergency situation and whoever should protect themselves. The people in sports are also trained on this". (UHSP)*
- *"I am a member of the Red Cross and we also do some programmes about first aid and HIV on campus". (SL)*

4.8. Level of support of the various stakeholders in the University of Ibadan for the HIV and AIDS policy

Few of the Key informants were able to talk about support of various stakeholders in UI for the policy in terms of translating it to action through the implementation of HIV-related programmes. The activities of the Health personnel at the Jaja clinic, the YFC, faculties and department were mentioned. Typical responses of the KIs were as follow:

- *"The University Health service is actively involved in the translation of the HIV and AIDS policy into action. The Youth Friendly Centre, the General studies programme are also involved. People like us in the UHS are very involved with the HIV and AIDS policy because we are in the lead for the healthcare of the University. We are also responsible for its implementation like HIV education, orientation, HIV counseling and testing, referral to treatment facilities, liasing with other organizations or agencies and so on. We educate and train the workers here on universal precautions which includes what to do in emergency situation, protecting themselves" (UHSP)*
- *The University also has established a Youth Friendly Centre which I'm aware of which I believe should be part of the implementation of the HIV and AIDS policy" (UPO)*
- *"At the YFC, the University has been very supportive of programmes though there can be improvement. I believe what we are doing is what the HIV and AIDS policy talks about so we are actively helping to translate the HIV and AIDS policy into action. We give HIV education and orientation of new students and we counsel, test, link with care and treatment facility when confirmed positive. We work with the University authority to support the positive people, we work against discrimination, name it, we are doing all those" (UOC)*
- *"I really don't know much about the implementation of the HIV and AIDS policy or support for it. But I know that religious leaders in the U.I. community help disseminate information about HIV and AIDS. This is done at the Chapel of the Resurrection from the pulpit and in seminars they organised. The University may give out all the information and education but to change depends on the people themselves. We cannot force them, all we can do is to advice them. We also are mentors to the students, this is*

one of our roles as lecturers especially in our own department. We interact with students through the mentorship programme, find out the problems they have. The faculty has also gone a step further to start a programme called Student Leadership Development Programme. It exposes students to issues like sexuality, life on campus and the society at large, we included HIV and AIDS issues also give them all the information they need to survive not only on this campus but in the larger society. These to me are some support for what the HIV and AIDS policy stands for" (MHPSC)

- *"I know that there is a lot of campaigns on HIV by different groups. Our union is one such groups. There are campaigns about HIV to give people information about it. Some do it on departmental basis and in some cases they go to halls of residence. The same things applies to HIV screening. Some groups organise HIV screening for their members periodically. We do that a lot also. We, one way or the other, support the HIV and AIDS policy" (SUL)*

Some of the KIs were of the opinion that there has not been much of support by stakeholders for the HIV and AIDS policy as evidenced by low awareness of the policy. Nevertheless there are some existing programmes which are expected to be implementing some of the interventions contained in the policy. The following quotations summarized their views:

- *"I would not say there is any involvement of stakeholders in implementing the HIV programmes as stated by the HIV and AIDS policy when people do not even know about the said HIV and AIDS policy. I also have not seen much being done at the University Health Service which I think should be in the forefront of implementing the HIV programmes" (NRL)*
- *"It was not clear how the implementation will be achieved from the beginning, who will be in charge of what and continuity except for the linkage with UCH for the treament and care if any students or staff who gets infected with HIV. That is the responsibility of the University Health Service" (HHPDC)*

A religious leader and one staff union leader has the following to say about their support for the implementation for the programmes of HIV on campus.

- *"Talking about the people responsible for the implementation of the programmes for HIV, I don't know them but they may be medical people and other people from all the groups within the University. But for us here (the parish) we do the little we can about passing current information to our flock about the epidemic and its prevention". (CRL)*
- *"Though I don't know about the HIV and AIDS policy, we have organised seminars for members of our union on the issue of HIV so that people could be careful the way they interact. We try to do orientation for them concerning HIV. We have had HIV related programmes and we have organised series of programmes before. I am aware of four times when we have brought some organisations to conduct counseling and testing on this campus". (SUL)*

Two University administrators stated how the University has supported the institutional HIV and AIDS policy and its implementation thus:

- *"The HIV and AIDS policy actually named the University Health Service as the facility to carry out many of the programmes on HIV since they have medical professional background. But we have a website and we have put the HIV and AIDS HIV and AIDS policy on it for all to see and to know about the programmes put in place to address it" (UPO)*
- *The University Health Service is actively involved in the translation of the HIV and AIDS policy to action . the Youth Friendly Centre. the General studies programme also are involved (MHPSC)*

CHAPTER FIVE

DISCUSSION

Socio-demographic profile of participants

The ages of the three categories of respondents differ. The staff respondents consisting of academic and non-teaching staff, had a variety of young and middle aged adults with majority of them falling within the most productive age. A mean age of 39.5 ± 9.3 for academic staff and for non-teaching staff was 44.0 ± 7.9. Some other studies the academic staff in 23 South African Universities revealed a slightly higher mean of 44 years for academic staff with the youngest mean age of academics at a single university being 32 years while the highest mean age of academics at a university was 53 year (Nieuwenhuizen, 2011). Likewise, an almost similar mean age of 44.5 was found among non-teaching staff of Lagos University (Adigun and Okoiye, 2012) while a lower mean of 42.6 ± 0.9 was found in a Nigerian private University (Nwoziehi and Farotimi, 2014). According to ILO (2011), HIV deals a blow on this subject wherever it is endemic.

On the other hand, majority of the student respondents were within the age range of late teenage years to early adulthood with a mean age of 24.5 ± 6.0, a larger proportion being undergraduates. A study of Asante and Ofi-Boadi (2013) revealed a lower mean age of undergraduates to be 22.9 years. This trend shows that student population in a University consists of many young people as has been observed that higher institutions of learning usually consists of a large proportion of sexually active young persons who are vulnerable to HIV infection as a result of their indulgence in risky social and sexual practices (Chetty, 2003). Current statistics on HIV and AIDS in Nigeria provide evidences that young people within the age bracket of undergraduates are the high risk group (Okonkwo, Ifelusi and Ilika, 2005). The reasons that have been adduced to number of factors which include lack of communication between parents and child about sexually, high level of illicit sexual practices, high incidence of campus prostitution, poverty or hash economic conditions among other factors (Fawole, Ogunkan and Adegoke, 2011). Universities are noted in the literature to be high-risk areas for HIV infections (South Africa National AIDS Council, 2011). Engagement in these high risk sexual behaviours may expose both students and other members of university communities, such as academic and non-academic staff to the risk of being infected with HIV (Sandy and Mavhandu-Mudzusi, 2011).

There were more males than females among the three categories of respondents. This may have been so partly because of male dominance in virtually every aspect of life (Scullen, 2008; Mazur and Booth, 1997) and partly because of socio-cultural challenges which adversely affects the educational attainment of females at various levels until lately (Nwajiuba, 2011; Brock, and Cammish, 1997). In Nigeria, it is also consistent with the findings of male dominance in education in the National Demographic and Health Survey (NDHS) of 2008 according to NPC (2009). Nwajiuba (2011) showed evidence of marked sex inbalance among male academic staff and students than female in several Universities in Nigeria.

Many of the academic staff had worked in the University for about nine years while about a quarter of them had served for about two decades. Few of them had taught students in the university for more than 20 years. This shows that the lecturers have been in the University system long enough to make them familiar with issues within the University community (Hénard & Roseveare, 2012; Darling-Hammond and Brandford, 2007) which include HIV and AIDS and its policy related activities. The students on the other hand had stayed in the University for between one and seven years depending on their programme and course of study. Within this period, they have been exposed to information about the University including HIV and AIDS. According to IIEP, (2007b) a student has the tendency to have a lot of information about happenings on campus within a few years of being on campus. This mean that the period of time academic staff, non-teaching staff and students have stayed in the University community is enough for them to be aware of its HIV and AIDS policy. Soko et al, 2012 corroborated this when they found in their study that the years of stay on campus have an influence on the staff and students' awareness of HIV policy. According to Soko et al (2012), the members of staff who had been with College of Medicine for more than five years and were present when the policy was being launched had a chance of patronizing it earlier on, were aware of the policy.

Awareness and knowledge of staff and students of University of Ibadan on the institutional HIV and AIDS Policy

Most respondents in the University community had heard of AIDS caused by the HIV. This is not a strange phenomenon in a university community and it cuts across the general population as the findings of 2013 NDHS revealed that ninety three percent women and ninety six percent men were aware of HIV and AIDS. This is not fundamentally different from previous studies in universities. For example, Asante and Oti-Boadi (2013) found

that majority of the undergraduates studied in a Ghanian University were aware of HIV and AIDS having received information from television, radio and the internet. In study by Owuamanam, Ogunsanmi and Osakinle (2008) carried out on students drawn from three higher institutions including two universities, it was found that majority of undergraduates demonstrated adequate awareness/knowledge about HIV and AIDS. However, there has been a dearth of information on previous studies about the awareness of academic staff, non-teaching staff and postgraduate students on HIV and AIDS.

On the other hand, the academic staff were more aware of the University's policy on HIV and AIDS. This may not be unconnected with the fact that they are more inclined towards research and community development work which make them tend to pay anention to what goes on around them. The proportions of non-teaching staff and students who have heard of the policy was very low. This could be adduced to the observation of UNESCO (2008a) that institutions are not always aware of policies established by the educational institutions which often causes a gap between policy and practice.

The low proportions of the respondents that had ever seen the policy and a much lower proportions of those that had a copy despite their awareness of the policy is very significant. This is consistent with the findings of Laas (2009) in a study of selected organisations in South Africa where only a small percentage of respondents confirmed their awareness of an HIV and AIDS workplace policy at their respective workplaces. Also in a study of the College of Medicine, University of Malawi (UNIMA), most students and staff were not aware of the existence of the UNIMA HIV and AIDS policy. Among adduced reasons for these were new members of staff have joined, student numbers have doubled or even tripled and new programmes have been introduced which had made them not exposed to the policy (Soko, Umar, Noniwa, Lakudzala, 2012) The UNIMA study concluded that the student's awareness of the policy depended on how active they were in organizations and the students union. This low level of awareness of the HIV and AIDS policy will lead to lack of understanding of the policy and subsequent low uptake of services provided in relation to the policy (Laas, 2009).

Overall, few of the respondents who were aware of the UI policy read it. Generally, print media (bulletin and leaflets) and workshop or symposia were sources of information about the University's HIV and AIDS Policy that cut across the three groups. The United Nations also confirms that workshops and symposia are important to make the staff

become aware of the workplace HIV and AIDS policy in order to encourage their ownership of the policy (United Nations, 2012). Neema and Koster, 2008 also stated that there's a need to keep discussing the policy in routine meetings so as to keep all involved informed and up to date, and increase understanding of the contents. The other sources that were common to the three groups in lower proportions were friends and UI Radio. The internet as a source of information for the University's HIV and AIDS policy was observed to be common to the academic staff and students only while some non-teaching staff and students got their information about the policy during HIV screening. Academic staff and student do a lot of research online and may have come across the policy online as it is not on the University website. In a study on tertiary institution based programme for awareness creation in order to integrate HIV and AIDS issues, it was found that 26.6% of students agreed that they access the internet because it provides enough awareness about HIV and AIDS (Onyeneke, Uzoka, Ikonta and Bakare, 2010).

Some of those that did not read the policy but that were aware of it among academic staff and students attributed it to lack of time to read the policy. This may be attributed to the time consumed by a workload of teaching and research that is expected of them. Some non-teaching staff and students who were aware of the policy but did not read it attributed it to non-possession of personal copies and lack of time to read. Cull (2011) observed that although the University is an environment for indepth reading, the trend, especially from a print material is fast disappearing as younger people tend to be heavy internet and cell phone users. This he particularly observed to be true if the print material is not for academic purpose. Non-availability of a copy of the policy will naturally be a reason for anyone not to read any print material like the UI HIV and AIDS policy. These groups may turn to the internet to get the information about it if such information is available online (Hilleaund, 2010).

It was however revealed from the results that, only half of the key informants were aware of the HIV and AIDS policy as part of the University's response to the scourge of HIV and AIDS in its community and a few of them had copies. The key informants are the stakeholders on the issues that concern the welfare of the University community such as HIV and AIDS on campus. They are supposed to be aware of the document that states the commitment of the University to the prevention and mitigation of HIV and AIDS on campus. The University of Zambia clearly stated the process of implementation to include

making available the policy to all the stakeholders in the institution (University of Zambia, 2006). The stakeholders must also have briefing of the policy and they include Deans of Schools, Heads of Academic and Non-Academic Departments, and other Units, Student Clubs and Associations and other Unions (University of Zambia, 2006). ILO and UNESCO (2006) similarly pointed it out that a copy of HIV and AIDS policy is to be kept on display in the institution and made available to all employees and students for reading and for reproduction. It was furter said that all fonns of communication used in the institution such as, posters, circulars to employees, staff meetings, notice boards, student body meetings, institution assemblies and electronic mail should be used to make the policy known and helpensure its application (ILO and UNESCO, 2006).

The key informants however pointed to the low awareness of the University's HIV and AIDS policy among the members of the community evidenced by its being unpopular on campus. The student leaders among the key informants who had never seen the policy were particularly upset about the low awareness and little publicity given to the policy which they claimed was not good for the fight against HIV and AIDS on campus. This low awareness of the policy would lead to its not being embraced and owned by the community for adoption. According to Bakuwa (2011), an analysis of factors hindering the adoption of HIV and AIDS workplace policies in Malawian private sector companies revealed that no staff participation in the activities of HIV and AIDS in institutions, was one of the top three significant factors. HIV policies adoption can occur when knowledge about such new policies or practices needs to be diffused and made members of staff of that company or institution (Bakuwa, 2011)

Communication of the HIV and AIDS policy to the beneficiaries is important. Makinde (2005) stated that communication is an essential ingredient for effective implementation of public policies through which orders to implement policies are expected to be transmitted to the appropriate personnels in a clear manner. One of the actions of improving the lives of people in the workplace is to inform them about existing HIV related policies and programmes (ILO, 2009a). Torjman, (2009) pointed to a major problem arising from the fact that potential beneficiaries of programs may not be aware of the issues raised in the policy. As a result, there will be no basis for understanding the need for the programmes and this presents a problem for the uptake of activities related to the policy in the mitigation of HIV and AIDS on campus.

The key informants attributed the low awareness of the policy to the inaction of the organ responsible for making the policy available to people and inadequate funds. Inadequate funding of the policy dissemination and communication activities will not allow continuity even if it is initiated at the beginning. This in turn will make the efforts at raising the awareness of the staff and students in the community die down as new students are admitted or new staff are appointed. Stop AIDS Now! Project of Uganda (2009) reported an observation that lack of funds or late funding is one of the factors inhibiting the HIV policy and programmes. The Economist, (2010) concluded that funding is of a huge importance for starting and sustaining policy implementation.

Another reason raised by few of the key informants for the low awareness including a religious leader was the assumption that HIV is on the decline while not taking into consideration the risky sexual practices by staff and students on campus. This is referred to as prevention fatigue. According to Spire, de Zoysa and Himmich (2008), prevention fatigue is said to pose a threat to the acceleration and sustainability of HIV prevention efforts. When there is a perceived decline in the prevalence of HIV, people tend to relax in any activity that is designed to prevent or control it and engage in the risky behaviours that promote the spread of HIV such as sexual practices.

Overall, a very small proportion of the total respondents had ever read the HIV and AIDS policy of the University of Ibadan. The situation was not different in a Kenyan study of teachers where only 6.0% of the study had read the Education Sector Policy on HIV and AIDS. Even when they had access to the policy at Teachers matter meetings afterwards, only 29.0% read it. It is however, worthy of note that across the three groups of respondents in this study, majority of those that have read it believed that the policy makes it clear that HIV and AIDS is a problem of the University. The University as a place where the well-being of each member is sensitively supported according to Elkins and Forrester (2011) therefore one would expect it to rise to the occasion, by "challenging the challenger" as in the case of HIV and AIDS. Necina and Koster (2008) also pointed out that there is the need to keep discussing the policy in routine meetings so as to keep all involved informed and increase understanding of the contents.

The results of this study showed that generally, of the small proportion that ever saw the HIV and AIDS policy, more academic staff than non-teaching staff and students read it.

This could be as a result of their roles as lecturers who read all the time for the purpose of self development, teaching and research (Hanover Research, 2012). On the other hand, majority of the respondents across the three categories were knowledgeable about the policy's position that HIV and AIDS is recognized as a University problem. This is not unconnected with the awareness of HIV and AIDS they have had. Gobind and Ukpere (2014) affirms that a well planned HIV and AIDS policy outlines or describes how a particular organisation, institution or business is going to manage HIV and AIDS within the institution.

It was observed that majority of the respondents had the knowledge of the policy's position that routine HIV screening of staff seeking employment or of students seeking admission to the University is not required before they are offered employment or admission. However, of the three groups, majority of the non-teaching staff of the university did not have the knowledge of the provision of the University's HIV and AIDS policy that compulsory testing for HIV for staff and students before employment or admission is a violation of their right. Molatlhegi and Associates (2005) in a report of review of Laws and Policies relating to HIV and AIDS stated that mandatory pre-employment HIV testing undermine the fundamental rights of workers. The report concluded that health policies and programmes will be more effective when they incorporate human rights perspectives and objectives.

The results showed that majority of the academic staff, non-teaching staff and students had the knowledge of the autonomy of decision by individuals on campus to undergo counseling and testing for HIV according to the policy. This may be related to their previous knowledge on voluntary decision to partake in HCT. Nwozichi and Faroumi (2014) observed in their study of non-teaching staff's knowledge about HCT, more than half of the participants knew that HIV testing goes along side with counseling. Majority of them also were observed to have the knowledge that even when staff or students can identify fellow staff/students living with HIV, it is not their responsibility to disclose such person's identity to others. Adherence to this provision is expected to reduce discrimination and stigmatization of PLWHA. Negative regard from others in the form of stigmatisation and discrimination can lead to negative self-perception, feelings of discomfort, low self-esteem, mental health problems and subsequent suicide (Sandy and Mavhandu-Mudzusi, 2014).

The proportions of academic staff, non-teaching staff and students who stated that the policy says courses on HIV and AIDS should be integrated into various curricula in the University were more than those that knew of HIV education into GES courses This may be due to a confusion of the content of the HAP regarding the integration of HIV-related courses into the educational programmes as part of the curriculum for a course or as a stand-alone course compulsory in the University. The implication of this is that, there is still a need for orientation of the student and staff population on the different education strategies related to integrated HIV or the compulsory course for effectual learning

Some of the key informants who had read the policy were able to state some of its objectives and provisions. One of them expressed a concern relating to the limitation of the scope of the policy in reaching the students who are living off-campus so that the expected outcome of the policy implementation will be fully realised. This is important as students who live 'off campus' are still part of the University and the policy has not provided for them

Overall, the proportion of respondents that had good knowledge of the policy out of those that read it was not adequate. The highest proportion for good knowledge of the policy was found among the AS which was just above half of the few that read the policy while both NS and students had low proportion of good knowledge. This is in line with a study of physicians at an Academic Medical Center which revealed a mean survey score of 51.2% indicating that respondents had relatively limited knowledge regarding institutional policies and procedures on issues of confidentiality specific to patients with HIV or AIDS. (Thomas, Rogers and Maclean, 2003). Also, in a study to explore the knowledge of managers of a freight company in South Africa, the knowledge of a workplace's HIV and AIDS policy was found to be poor as well as the fact that there was lack of ownership of the firm's HIV and AIDS programmes by the employees. (Mabuza, 2010)

Mean knowledge scores were 29.1 ± 6.7 (AS), 23.2± 7.0 (NS) and 23.4 ± 7.1 (Students) on a 38-point scale. A slight raise was observed in the mean knowledge score of the AS. This may be an indicator of the fact that academic staff are more likely to read documents such as the HAP than non-teaching staff and students. Also, no relationship was found between the faculties that students and staff belong and their knowledge of the policy.

This showed that the field of study as evident by the faculties did not have any influence on their knowledge of the policy.

Staff and students' perception relating to the University's HIV and AIDS policy

The view that the control of HIV on campus should be the sole responsibility of the UI authority cut across a majority of staff respondents which corroborated the findings of Mabuza, (2010) that some managers' perception was that the control of HIV and AIDS through programmes is the responsibility of the workplace through some department and the clinic. Majority of the staff respondents across the three groups were of the view that making HIV testing obligatory in the policy would not mean that the University is really serious about controlling HIV on campus. Nevertheless, a majority of the students respondents had a different view that if the University is serious about controlling HIV on campus, it would make HIV testing compulsory for staff and students. This showed a variation in the perceptions among the few respondents' that had knowledge of the University's their company's HIV and AIDS policy (Mabuza, 2010).

Another critical issue that was from the views of key informants was the non promotion of condom use as a way of preventing HIV on campus. Although the policy did not mention the promotion and distribution of condom on campus, very few respondents (staff and students) opposed it. The perception of the respondents may be a pointer to the undeniable fact that condom is being used on the campus and should be included in the policy. The CDC (2010c) described condom distribution as a structural-level intervention which is particularly attractive in HIV prevention efforts because they are designed to address external factors that impact personal risk for HIV. The AAU (2007a) had recorded that there was significant debate at the University of Ibadan on the merits of condom distribution and no agreement had yet been reached on distribution at the students halls of residence or at Jaja clinic but condoms are typically available in shops operating on the campus. Barriers to condom use on campus include sociocultural and religious values (Sarkar, 2008; International Council of AIDS Service Organizations, 2007). Magu, Waweru, Mutugi, Ndahi and Gathara (2013) however stated that to promote condom use, barriers and challenges among the youth need to be tackled in a supportive environment in mobilizing the institution of learning to become a vehicle for a HIV prevention.

A large proportion of the three categories of respondents however were of the opinion that the University's HIV and AIDS policy has done well to allow any staff or students living

with HIV to continue working or studying in UI. Also in the study of South African Rural based Universities, Sandy, and Mavhandu-Mudzusi, (2014) in comparison, found that some participants agreed with the view that the policy of the HIV and AIDS had guided their day-to-day approaches to the provision of HIV support and care. This support include allow HIV infected students and staff in the Universities.

The mean perception scores among the three categories (13.0 ± 2.9 -AS, 11.8 ± 3.4 - NS and 9.2 ± 4.7 – students) showed favourable perception among the academic and non-teaching staff but unfavourable perception among students. This disparity between staff and students's perception revealed a gap in the acceptability of the policy between staff and students

Respondents' participation in HIV and AIDS policy related activities in the University

Generally across the three categories of the respondents, the awareness of HIV-related activities highlighted in the HAP was low. Many of the respondents were not aware of several HIV-related activities which are ongoing on campus. For example majority of the respondents across the group were not aware of training related to HIV and AIDS for academic staff, non-teaching staff or students. Also, only few of the respondents were aware of the HIV related activities of the University Health Service and those of the Youth Friendly Centre which include HIV counseling and testing. Other HIV related activities that respondents were not aware of are HIV awareness programmes as part of orientation given to fresh students and the integration of HIV courses into General Education Studies in UI. These activities were mentioned as part of the intervention regarding the prevention and control of HIV and AIDS for staff and students (University of Ibadan, 2008). This low awareness may be due to lack of wide and continuous publicity or awareness programmes regarding these activities and where the services can be obtained (Soko et al, 2012).

It is evident that only few academic staff, non-teaching staff and students were aware of HIV-related activities at the UIHS (also referred to as Jaja Clinic) and the YFC. Although it is expected that every staff and student has to go to the Jaja clinic at one time or the other especially when such is newly employed or admitted into the institution, respondents were not aware of HIV related activities. New Students are also supposed to have orientation about HIV and AIDS at Jaja clinic and YFC yet they were not aware of such activities.

This may have been due to the poor attention paid to HIV education and HCT at the UHS. More attention is being paid to offering treatment to staff and students. Lack of motivation on issues relating to HIV and AIDS as part of the services of the UHS may be the reason for this. Mbilinyi, Daniel and Lie, (2011) in a study of health workers' motivation in the context of HIV, made an assertion that health worker motivation can potentially affect the provision of health services. Low morale among the workforce can undermine the quality of service provision.

The HIV-related activities of the Youth Friendly Centre, as HIV resource centre, were not popular among the respondents which is partly due to low awareness of the centre. The low awareness may not unconnected to the location of the YFC on campus. The location becomes a factor where people think others will see them and bring about stigmatization. A Case Study of a South African Rural-Based University revealed that both staff and students were worried about utilizing HIV counseling and testing because of stigma attached to the infection (Sandy and Mavhandu-Mudzus, 2014). The case study also reported that many staff and students of the University have HIV but they would not go to the HIV Unit which the HIV policy of the institution has designated for screening, care and supports because of stigmatisation. According to AAU (2010b) in Eastern Africa for instance, VCT services, annual HIV and AIDS enlightenment activities, and special services to PLWHA are efforts geared at reducing stigmatisation. Also, in Southern Africa, VCT for HIV infection is relatively wide spread, while Information, Education and Communication (IEC) activities are a regular feature of campus life.

However, majority of the key informants were aware of mostly education and awareness activities and programmes related to HIV and AIDS on campus which were said to be spearheaded by the university health service, Youth Friendly centre and other faith based organizations. Also, majority of the Key Informants stated that various HIV and AIDS activities and programmmes are implemented on campus but there are programmes mostly on awareness and education programmes. It was noted however that even the activities on HIV awareness and education are not enough. Some KIs were aware of the GES courses on HIV but were concerned about the targets of the courses only being fresh undergraduates and not including postgraduate students. (Ministry of Education, Ethiopia, 2012).

The results of this study revealed that the academic staff participated more in training on HIV and AIDS than their non-teaching staff counterparts and students. Also, out of the very few that were aware of the HIV related activities of the UHS (Jaja Clinic), academic staff were more than non-teaching staff and students. On the other hand, only student participated in HIV counseling and testing service of the YFC. This is contrary to the report of HEAIDS (2010) that in a number of the case studies conducted in higher education institutions, students were more active in HIV and AIDS response initiatives than members of staff.

Regarding attendance of the HIV session at the orientation programme organised for fresh students by the University authorities, only 54.0% of students who are the actual target of the activity ever attended the session. This may be due to the fact the HIV orientation sessions are only attended by fresh students who are considered new to the university system and not post graduate students who may feel they are not new to the University system. A very low proportion of the respondents participated in HIV-related activities of the University Health service (Jaja clinic). Also, HCT on campus was not popular among the respondents and the preferred places of testing for those who ever did.on campus were Jaja clinic, Virology Department and outreaches. Some proportion of students had their HCT at the Youth Friendly Centre. Although generally, the level of participation in HIV-related activities among the three categories was significant ($p<0.05$), there was no relationship ($p>0.05$) when compared with the level of knowledge among those that read the policy

There was no evidence of coordinated efforts at HIV-related activities on the campus of the University. The policy stated that the University of Ibadan shall establish a committee on HIV and AIDS which shall be responsible for coordinating the timely and effective development, implementation, monitoring and revision of the HIV Policy. This committee shall advise appropriately on matters relating to the implementation of the policy. Some union leaders key informants said they had independently organised activities on their own which included HIV awareness and education and HCT at different times in the past. It has been said that coordinated response to HIV and AIDS remains one of the 'grand challenges' facing policy makers today (Spicer, Aleshkina, Biesma et al, 2010). Therefore, Iskoum (2008) concluded that there is the need to commit resources from the University budget and other sources to ensure that there is coordinated and sustained action on the

various campuses against HIV AIDS. According to Saint et al (2004), this is because institutions that establish AIDS coordination units have better organised programmes for addressing HIV and AIDS.

Contributions of stakeholders relating to the implementation of the HIV and AIDS Policy

The responsibilities relating to the implementation of HIV and AIDS policy usually rest on some group of stakeholders. (Badock-Walters, 2005). Not many of the key informants were able to talk about support of various stakeholders in University of Ibadan for the policy in terms of translating it to action through the implementation of HIV-related programmes. From them, it was gathered that there are HIV and AIDS stakeholder on campus such as the University Health Service, the Youth Friendly Centre, the General studies Programme, various unions and religious leaders. These are involved in the implementation of the interventions proposed by the HAP of the University (University of Ibadan, 2008)

The University Health Service is saddled with the responsibility of HIV education on safe sex and prevention of mother-to-child transmission as well as HIV counseling and testing (University of Ibadan, 2008). It conducts HIV orientation sessions for fresh students as part of its HIV education programme. These and some others were confirmed as responsibilities of the UHS in the implementation of the HIV and AIDS.policy by a key informant who is a key personnel of the UHS. A gap is however evident in the policy and its implementation by the UHS as the proportion of students that attended HIV orientation was not adequate. Also, low awareness of the HIV related activities of the UHS was observed and this points to the need for the university to look into the staffing, their training and retraining on HIV and AIDS, as well as the reactivation of activities related to HIV and AIDS in the facility. According to Chokwe, et al (2013), University clinics play significant role in the implementation of HIV programmes. They therefore should mobilise students and staff members for HCT and providing trainings on HIV and AIDS (Gareth, Pandey, and Katodia, 2014).

The Youth Friendly Centre is a resource centre for the youth where they can have access to HIV education and orientation of new students as well as HCT (University of Ibadan, 2008). A key informant revealed that the Centre provides a link with care and treatment facility when someone is confirmed positive. It also works with the University authority to

support the positive people and against discrimination. It was however observed in this study that the awareness of its existence and HIV related activities was low across the three groups of respondents. Although it was only students that accessed HCT at the YFC in this study, the proportion was still low which corroborates with previous studies of Daniel (2014) and Katibi and Adegoke, (2013) establishing low uptake of HCT by Nigerian youths in HEIs despite their possessing of high knowledge of HIV and AIDS. ECDC (2010), identified lack of funding, staff and office space, as well as lack of training of the staff as main barriers to offering on-site HIV testing and counseling. But in the case of YFC of UI, the services are available, supported by the University but its awareness and utilization is low. Akodu et al, (2012) submitted that students are not particularly interested in HIV despite the high awareness of availability of HCT centre located within their institutions. Therefore the issue about location of the YFC and HIV service of the UHS may then be of note as Daniel, (2014) postulates that adults and young people often do not seek HCT because they fear being seen at a testing site or having health care personnel tell others that they have to be tested.

The General Studies Programme of the University had lived up to the responsibility according to the (AAU, 2010b and University of Ibadan, 2008) by integrating reproductive health issues, including HIV education, into the General Education Studies (GES) courses. It was recorded in AAU, 2007a that some courses were taught about HIV between 2003 and 2006 as integrated but as stand- alone GES subsequently. This was facilitated by GSP and NEPIN in the year 2012 (University of Ibadan, 2012). McGinty and Mundy, (2008) had submitted that evaluation of a stand-alone module on HIV and AIDS for all first year students at the University of Namibia suggests that timing, personal relevance, levels of practicality and so on are all vital. Many key informants also praised the efforts of the University of Ibadan in integrating HIV and AIDS into GES courses. The gap however is that not many of the respondents generally were aware of it.

The religious leaders play some roles in education and awareness of HIV and AIDS in spite of not being directly involved in the actual implementation of the policy. CUAHA (2009) stated that religious leaders are in the unique position of being able to alter the course of the HIV pandemic because they can shape social values, promote responsible behaviour that respects the dignity of all persons, increase public knowledge and influence opinion. UNICEF (2003) also said they can support enlightened attitudes, opinions,

policies and laws and promote action within a community. The religious leaders in UI support the policy though not all of them were aware of it.

The union and youth leaders can help promote the HIV policy as well as motivate their members to participate (Szekeres, et al, 2008). The unions among other groups within the University community also showed evidences of their own contribution in organizing various HIV-related activities even though some of them were not aware of the policy. However, only the non-teaching staff unions and student unions showed evidence of involvement in the HIV related activities of the University. The HIV-related activities that were organized by the mentioned unions were HIV education/campaigns and HCT. The academic staff union did not in any way showed any evidence of having organized any HIV related program.

Often organisations develop policies but fail to move to the implementation phase. Possible explanation for this being the inability of organisations to operationalise HIV/AIDS policies into effective programmes, the lack of knowledge, skills and resources and often the policy is not understood or communicated to employees (Laas, 2009). The policy and the ensuing programmes must therefore be communicated by a wide dissemination to the entire community as a policy developed to address HIV and discrimination (UNESCO, 2011) for ownership.

Communication is an essential ingredient for effective implementation of public policies (Makinde, 2005). Few key informants were blunt about the fact there no clear plan of implementation plan from the start of the policy development, there was no mention of specific names of people to be in charge of specific activities which points to the loophole which can impede the implementation and coordination of the activities. Departments and groups were mentioned in the policy but there was no clear directions concerning what, when and where some of the activities would be carried out. The implementation of any HIV and AIDS policy brings about the establishment of programmes on HIV prevention, treatment, care and support; this in turn will boosts the morale of the workplace and bring about a positive impact on the surrounding community (IFC, 2012). Makinde (2005) however stated that an implementation problem could occur when the desired result on the target beneficiaries is not achieved.

Stakeholders' perceived challenges to the implementation of HIV and AIDS Policy and programmes

It was evident from the study that the stakeholders' view reflected that the implementation of the UI HIV and AIDS policy is characterized by major barriers. The challenges as highlighted by some key informants included poor dissemination of the policy and lack of resources (financial and human). KNUST. (2011) emphasised that the effective implementation of HIV policy requires human, financial and material resources. these included trained technical and administrative personnel, professional counselling staff and infrastructure such as a furnished office which is conducive for effective work, an HIV and AIDS fund, as well as facilities for diagnosis, treatment and research

The attitudinal disposition of the UI community to HIV was another factor identified by the key informants as a hindrance to the implementation of the policy. The lukewarm attitude of the community toward the policy and the perception that there is a decline in the prevalence of HIV have great potential for adversely affecting people's interest in HIV and AIDS activities (Mbilinyi, Daniel and Lie. 2011).

The results from the qualitative study revealed that the policy contains no clear role delineation for the major stakeholders in the University in terms of who does what and how. One of the concerns of several key informant was that the policy was silent on condom availability and promotion. This situated lack of condom-related guideline may be a deliberate action arrived at avoiding conflict with the active religious groups within the University who are vehemently opposed to condom promotion. Policies that avoid reference to condom are often formulated based on religious and moral considerations (Population Division. 2003).

Implication of the Findings for Health Promotion and Education

The findings from this study have many implications for health promotion and education. Low awareness and knowledge of the institutional HIV and AIDS policy was evident in the University community. Furthermore it is to be noted that the indicators for facilitating the monitoring and evaluation of HIV and AIDS related programmes are often based on factors which include the proportion of the various categories of targeted proportion of persons whose level of knowledge has been upgraded to the proportion of people who have adopted HIV prevention behaviours (UNAIDS. 2009. ILO. 2004). Therefore the

modalities for making stakeholders to work individually or collaboratively to actualize the intent and spirit of the policy need to be well specified either in the policy or in a policy implementation framework.

Healthy Public Policies are cardinal to the promotion of HIV and AIDS control and prevention efforts (Kumar and Preetha, 2012; WHO, 2009). However, health promotion also as a package has a critical role to play in creating supportive environments, strengthening community action, developing personal skills and reorienting health services (Kessler and Renggli, 2011) aimed at addressing the challenge posed by HIV and AIDS. In the light of these, multiple interventions are needed to address the phenomenon. Health education is about providing health information and knowledge to individuals and communities and providing skills to enable individuals to adopt healthy behaviors voluntarily. Health promotion on the other hand, takes a more comprehensive approach to promoting health by involving various players and focusing on multisectoral approaches (Kumar and Preetha, 2012).

Dissemination is the targeted distribution of information and intervention materials to a specific public health audience. The intent is to spread knowledge and the associated evidence-based interventions. Effective and efficient information dissemination and exchange are important tools in the effort to control the HIV pandemic (Fernández-Peña, Moore, Goldstein, DeCarlo, Grinstead, Hunt, Bao, and Wilson, 2008). The strategies for intervention should focus on the provision of factual information aimed at promoting awareness of the institutional HIV and AIDS policy as well as the knowledge of its provisions including rights and responsibilities of each group of persons in the University community. They include public enlightenment using the print and electronic mass media. The media are in a position to create greater public awareness of HIV and AIDS being able to create an enabling and supportive environment where some underlying driving forces of the pandemic can be addressed (Wanjulu, 2007). The print media include leaflets, bulletin, posters, (Gobind and Ukpere, 2014; Palluy, Arcand, Choinière, Martin, and Roberge, 2012) and billboards.

There should be dissemination of the content of the policy to various groups of people in the University community at the routine meetings, (Neema and Koster, 2008), departmental and hall meetings for Principal Officers, academic staff, non-teaching staff (senior and junior), students (undergraduates and postgraduate students), dependants of

staff, religious leaders and their groups and other types of employees of the University. The creation and dissemination of a workplace policy can, itself, begin to raise awareness about HIV and AIDS and, by enshrining the rights of both HIV-positive and HIV-negative employees, help to combat stigma and discrimination. (UNESCO, 2008a). The electronic media include the University website and radio through jingles and related radio based HIV programmes (Otieno, 2009). Peer education can also be used to facilitate the knowledge of the provisions of the University's HIV and AIDS policy and implementation (Myers, 2011). Peer educators can be trained among academic, non-teaching staff and students of various categories. These will work among their peers to promote the dissemination of the policy (ILO, 2001).

For wide distribution of copies of the policy, community organization strategy can be adopted. This makes use of the leadership roles of some persons who are academic and opinion leaders within the University community (Szekeres, Contes, and Ehrhardt, 2008). The UI community has leaders which are Principal Officers, Deans of Faculties, Dean of Students Affairs, Heads of Departments, Academic staff union leader, Senior Staff, Non academic (junior staff), Technologists union leaders, student union leader, hall chairmen and Warden. Others are Head of the UIHS, Reproductive Health Cnordinator of the UIHS, YFC Coordinator, religious leaders and other HIV groups coordinators.

On the promotion of condom use on campus, advocacy, counseling and partnership are strategies that can be used. Advocacy is self-initiated activities that attempt to contribute to health promoting systemic change by influencing policy processes (Jonhson, 2009). Engaging in public health advocacy acknowledges the explicitly political aspects of public health and in University community can be used to discuss the merits and demerits of condom use and arrive at an evidence-based conclusion. A cardinal strategy in the prevention of HIV is the promotion of the use of condoms during sexual intercourse among those who find abstinence difficult (Asekun-Olarinmoye and Oladele, 2009). Partnership between the unions, YFC and UIHS and religious leaders may go a long way in resolving the reservations about condom use on campus.

Advocacy can also be employed in increasing awareness of the people in the University community about the HIV related activities of designated facilities – UIHS and YFC. According to WHO (2014), it is important to involve, coordinate and mobilize a range of stakeholders in order to confront the epidemic, both because they are affected and because

they can play various roles. The union and youth leaders can help promote the HIV policy as well as motivate their members to participate and utilise the programmes on HIV control on campus (Szekeres, 2008). Such programmes include HCT, HIV education and campaigns, HIV trainings and peer educators' programmme.

Uptake of HCT is low in Nigerian Universities. The results of this study have attested to this. In order to improve the uptake of HCT on campus, health promotion strategies of mass media, public enlightenment (South African AIDS Council, 2010) and peer education can be used USAID (2013). Social marketing in form of mobile HCT will also work. Choosing a strategic mix of service delivery models to achieve universal and equitable access to HIV testing and counseling (WHO, 2012b) works better than a single model. The operators of HCT facilities must go beyond the wait for students and staff to have HCT and take the screening exercises to the students through various innovative campaigns (Abiodun, Sotunsa, Ani, and Jaiyesimi, 2014).

Conclusion

This study has revealed the level of awareness, knowledge, perception and the participation of three categories or respondents – the academic, non-teaching and students of the HIV and AIDS policy-related activities of the University of Ibadan. Furthermore, the study elicited contributions of the key stakeholders in the University relating to the implementation of the HIV and AIDS Policy.

The policy of HIV and AIDS dates to 2008. The people within the University community were generally not aware of the policy as evident by the responses of the three categories of participants. Distribution and dissemination of the policy had been limited. There is no evidence of a strategy for ensuring that all the key stakeholders are adequately briefed on the content and use of the policy and no mechanism to ensure continuity of briefing new stakeholders as they come onboard. The policy is not on the University website whereas other policies are. The student populace on campus did not have access to copies of the policy document and were not sensitised and trained on the interpretation and implementation of the policy.

In addition, knowledge of the policy among the few that were aware of it was not adequate. Majority of the participants did not know their duties and responsibilities in the

interpretation and implementation of the policy. One underlying factor observed to be responsible for the low level of awareness and knowledge of the policy was the limited distribution of the policy. Other factors were dearth of information about the policy due to low level of its dissemination and failure to communicate policy to the beneficiaries and the flippant attitude of the people to HIV and AIDS in general and the non commitment of the stakeholders in terms of resources. Many of the key stakeholders were not aware of the policy which showed lack of continuity as new employees and students come into the University from time to time.

The academic staff and the non-teaching staff that had read the policy had favourable perception of it while most students had unfavourable perception of the policy. In addition, awareness of the policy-related activities was generally more of HIV education among all the respondents and participation in various HIV activities related to the policy was more among the academic staff than among non-teaching staff and students. This is in spite of the fact that everyone is potentially at risk of contracting HIV and the activities are targeted at all employees including middle and management as well as students.

It has been established that there is a gap between policy and practice. When the level of participation of HIV activities was compared with the knowledge of the policy, no relationship was found. It was also found that the programme/activities were vertical in their approach. Individual facility or organization carried out their HIV-related activities separately and not integrate or work together with others who are also involved in such activities. There was no clear evidence of coordination of the implantation of the policy.

Recommendations

The following recommendations are made based on the findings of this study:

1. It is essential to raise the level of awareness and knowledge of existing HIV and AIDS policy among the University administrators, academic, non-teaching staff as well as student relating to the policy through a variety of approaches including public enlightenment and training.
2. The policy should be made readily available through the UI website, wide distribution among staff and students, religious bodies, library and other organizations within the university. A copy of the sunimarised policy should be kept visible in public places like rest rooms, libraries, restaurants and union

buildings. There should be edutainment sessions, drama group, sport festivals organised to conduct regular awareness raising sessions

3. The University should design an HIV and AIDS implementation framework aimed at translating the policy to action. Such a framework should spell the key and general responsibilities of the stakeholders. In addition, in order to ensure accountability and sustainability, an HIV and AIDS focal person is needed to plan, implement and coordinate HIV and AIDS related activities/programmes within the University.
4. Sensitization of various level of stakeholders in the University of Ibadan on the roles and responsibilities relating to HIV and AIDS prevention on campus as spelt by the policy should be put in place.
5. There should be a monitoring and evaluation system for the implementation of the HIV and AIDS policy and periodic review of the policy to effect changes that emanate from the such evaluations as well to accommodate emerging issues such as condom use on campus.
6. The University should reorient and improve the capacity of the healthcare providers in relation to the HIV and AIDS policy and their roles in its implementation.

Recommendations for further studies

1. Evaluation of the University's HIV programmes to determine best practices in the its response to HIV and AIDS as an educational institution
2. Impacts of HIV-related activities on the sexual practice risk groups in the University.
3. Uptake of HIV prevention programmes and activities by the University community.

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APPENDICES

Appendix I: Questionnaire

KNOWLEDGE, PERCEPTIONS AND PARTICIPATION IN HIV AND AIDS POLICY-RELATED ACTIVITIES AMONG STAFF AND STUDENTS OF UNIVERSITY OF IBADAN, NIGERIA

Dear respondents

Good day to you. I am a student in the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan. I am carrying out a survey which focuses on the knowledge, perceptions and participation in activities among staff and students of University of Ibadan relating to the institutional HIV and AIDS policy.

I assure you that your responses to the questions in the questionnaire will be kept confidential. It is to be noted that this is not an examination or test. Your participation is voluntary and you are free to withdraw from the study if you so decide at any time without any penalties. Your names are not required on the questionnaire. This is one way of promoting anonymity of the responses. You are free to ask any question as you progress with the survey.

Thank you.

For Office Use Only	
Serial no_____	Date __/__/____2012
Interviewer's ID _____	
Category of interviewee -	Academic staff ☐ Non teaching staff ☐ Student ☐
Knowledge score _____	
Perception score _____	
Participation score _____	

SECTION A: DEMOGRAPHIC INFORMATION

Please tick ☑ the appropriate response(s) to the questions in this section from the alternatives provided. In some cases simply supply the needed information in the spaces provided

1. Age in years (Your age as at last birthday) _____
2. Sex (1) Male ☐ (2) Female ☐
3. Marital status
   (1) Never married ☐ (2) Married ☐ (3) Divorced ☐ (4) Separated ☐
   (5) Widowed

4. Religion (1) Christianity ☐ (2) Islam ☐ (3) Traditional ☐
(4) Others specify _____

If you are a student, please skip questions 5 - 8 and go to question 9

5. Highest educational qualification *(University staff only)*
(1) Secondary School leaving certificate ☐ (2) Diploma - OND ☐
(3) Diploma - HND ☐ (4) University degree ☐
(5) Post graduate degree/diploma (Specify) _____ (6) Professional qualification (Specify) _____
(7) Any other qualification (Specify) _____

6. In which Department/Unit/Centre/Institute do you work presently in the University? (For staff)

_____

7. What is your Position/Official designation in the department/Unit/Centre/Institute?

_____

8. How long (in years) have you been working for U. I.? _____

If you are a staff, please skip questions 9 – 12 and go to question 13

9. Study programme *(For Students only)*
(1) Diploma student ☐ (2) Undergraduate student ☐
(3) Master degree student ☐ (4) Doctoral student ☐

10. How long (in years) have you been in the University as a for this programme related to in question 9 above? *(Students only)*

_____

11. In which Department/Institute/Centre are you? *(Students only)*

_____

12. What is your course of study? *(Students only)* _____

SECTION B: AWARENESS OF HIV/AIDS POLICY OF THE UNIVERSITY OF IBADAN

Please tick ☑ the appropriate responses to the questions in this section from the alternatives provided. In some cases simply supply the needed information in the spaces provided

13. Have you ever heard of AIDS? (1) Yes ☐ (2) No ☐
14. Have you ever heard of any HIV and AIDS policy? (1) Yes ☐ (2) No ☐
15. Are you aware of the HIV and AIDS policy of this University? (1) Yes ☐ (2) No ☐

If No to question 15, skip 16 – 27 and go to Section B: question 28

16. If you are aware of the HIV and AIDS policy of the University of Ibadan, what are your sources of information about it?

_____

_____

17. If you have heard about the HIV and AIDS policy of U.I, have you ever seen it?

(1) Yes ☐ (2) No ☐ If you say "No" go to section E question 28

If you say "Yes" to question 17, continue with question 18

18. If you have seen the University of Ibadan HIV and AIDS policy, do you have a copy of it? (1) Yes ☐ (2) No ☐

19. If you have seen or have a copy of the HIV and AIDS policy of U.I., have you ever read it? (1) Yes ☐ (2) No ☐ If you say "No" go to question 20

If you say "Yes" go to question 21

20. If you have never read the HIV and AIDS policy, why is it so?

_____

21a. Has there been a forum for making students aware of the U.I. HIV and AIDS policy? (For students)

(1) Yes ☐ (2) No ☐ (3) Don't know ☐

21b. Has there been a forum for making staff aware of the U.I. HIV and AIDS policy? (For staff)

(1) Yes ☐ (2) No ☐ (3) Don't know ☐

22. If yes to question 21a or 21b. complete table (For both students and staff) *Tick only the forum or education session you are aware of (Could be one or more)*

Table 1

22(a) Forum for briefing staff on U.I. HIV' Policy ☑		22(b) Forum for briefing students on U.I. HIV' Policy ☑	
	Tick		Tick
Union meeting		Union meeting	
Seminar/Workshop/Conference		Seminar/Workshop/Conference	
Peer education program		Peer education program	
Jaja Clinic		Jaja Clinic	
Special occasions		Special occasions	
Newsletter/Handbill		Newsletter/Handbill	
Departmental meetings		Hall meetings	
University website		University website	
Others (Specify)		Others (Specify)	

16. If you are aware of the HIV and AIDS policy of the University of Ibadan, what are your sources of information about it?

_____

_____

17. If you have heard about the HIV and AIDS policy of U.I, have you ever seen it?

(1) Yes ☐ (2) No ☐ If you say "No" go to section E question 28

If you say "Yes" to question 17, continue with question 18

18. If you have seen the University of Ibadan HIV and AIDS policy, do you have a copy of it? (1) Yes ☐ (2) No ☐

19. If you have seen or have a copy of the HIV and AIDS policy of U.I., have you ever read it? (1) Yes ☐ (2) No ☐ If you say "No" go to question 20

If you say "Yes" go to question 21

20. If you have never read the HIV and AIDS policy, why is it so?

_____

21a. Has there been a forum for making students aware of the U.I. HIV and AIDS policy? (For students)

(1) Yes ☐ (2) No ☐ (3) Don't know ☐

21b. Has there been a forum for making staff aware of the U.I. HIV and AIDS policy? (For staff)

(1) Yes ☐ (2) No ☐ (3) Don't know ☐

22. If yes to question 21a or 21b, complete table (For both students and staff) Tick only the fora or education session you are aware of (Could be one or more)

Table 1

22(a) Forum for briefing staff on U.I. HIV Policy ☑		22(b) Forum for briefing students on U.I. HIV Policy ☑	
	Tick		Tick
Union meeting		Union meeting	
Seminar/Workshop/Conference		Seminar/Workshop/Conference	
Peer education program		Peer education program	
Jaja Clinic		Jaja Clinic	
Special occasions		Special occasions	
Newsletter/Handbill		Newsletter/Handbill	
Departmental meetings		Hall meetings	
University website		University website	
Others (Specify)		Others (Specify)	

SECTION C: KNOWLEDGE OF STAFF AND STUDENTS ON THE ELEMENTS OF THE HIV AND AIDS POLICY OF THE UNIVERSITY OF IBADAN

Instruction – The questions in table in 2 are for those whose answer to question 19 in Section B is "Yes".

For each of the statements relating to the elements of the U.I. HIV and AIDS policy in table 2, please tick ☑ whether it is True, False or Don't know

If you have never seen and read the policy, please go to question 28 in Section E

Table 2

23	Statements	Tick ☑		
		True	False	Don't know
23.1	The University policy does not recognise HIV and AIDS as a University based problem			
23.2	The policy says there should be no social interaction with people living with HIV and AIDS in the University so as to check its spread			
23.3	Policy says students/staff seeking for admission/employment should be screened for HIV before being considered for admission			
23.4	The policy does not make it mandatory for staff and students to be counseled before they undergo HIV test			
23.5	The policy states that one ceases to be a student of U.I. if found to be HIV positive			
23.6	The policy says that an infected staff or student should have limited access to information on his/her status so that they will not commit suicide			
23.7	Policy says staff infected with HIV should not share the same office and other facilities used by others who are not infected to avoid spread of infection			
23.8	Policy says students living with HIV should not have access to the same hostel accommodation used by others who are not infected to avoid spread of the infection			
23.9	Policy says staff and students living with HIV should not have access to the same health care facilities used by others who are not infected to avoid spread of the infection			
23.10	The policy made it clear that staff or students who have HIV should not share toilets with others in the hostels so as to prevent the spread of the infection			
23.11	Policy says it is not the responsibility of the University to provide infected students, staff and their dependant with a treatment and care services			
23.12	According to the policy, it is compulsory for students to inform the University management of their HIV status whether positive or not			

Instruction: *The questions in tables 3 are for those whose answer to question 19 in Section B is "Yes".*

For each of the statements relating to the rights of staff and students of U.I. in the HIV and AIDS policy in table 3. and statements relating to the responsibilities of staff and students of U.I. concerning HIV and AIDS policy in table 4, please tick ☑ whether it is True, False or Don't know.

If you have never seen and read the policy, please go to question 28 in Section E

Table 3

24	Statements	Tick ☑ True	False	Don't know
24.1	The policy says compulsory testing for HIV before admission/employment is not a violation of staff or students' rights; it is only a drastic step to prevent the deadly disease condition			
24.2	According to the policy, it is compulsory for intending students/prospective staff to disclose their HIV status before admission/employment			
24.3	Policy makes it clear that staff and students are required to undergo HIV test if they want to continue their employment or academic programmes as the case may be			
24.4	The policy says that the University will keep staff and students with HIV or AIDS under close watch or surveillance to ensure they do not infect others			
24.5	According to the policy, the University keeps records of HIV status in staff or students' personal files which are open to anyone in the University to see			
24.6	According to the policy, AIDS should not be treated like any other health condition which someone can live with for a long time			
24.7	The policy says only students/staff without HIV or AIDS should be provided with information about universal precaution against HIV so that they can protect themselves from the infection			
24.8	The policy says students/staff should not have information on safe sex practices so that they will not be experimenting with such practices			
24.9	The policy is silent on how people living with HIV of the University of Ibadan could seek redress in case of discrimination			
24.10	At the University of Ibadan, a staff or student found to be HIV positive runs the risk of being dismissed or rusticated as the case may be from the university as a preventive measure			

Instruction: *The questions in tables 4 are for those whose answer to question 19 in Section B is "Yes".*

For each of the statements relating to the responsibility of staff and students of U.I. in the HIV and AIDS policy in table 3. and statements relating to the responsibilities of staff and students of U.I. concerning HIV and AIDS policy in table 4. please tick ☑ whether it is True, False or Don't know.

If you have never seen and read the policy, please go to question 28 in Section E

Table 4

25	Statements	Tick ☑ True	False	Don't know
25.1	The policy says that it is the sole responsibility of staff and students to protect themselves against HIV infection			
25.2	The HIV policy encourages staff and students to seek information about prevention of HIV and AIDS alone			
25.3	The policy says that individual staff or student should make the decision whether to undergo counseling and testing for HIV or not			
25.4	The policy says that staff and students should help identify persons who have HIV on campus so that such persons can be monitored as a preventive measure			
25.5	Based on the policy, staff and students should disclose the identity of fellow staff/students living with HIV so as not to spread the virus to innocent people			
25.6	The policy says that the University Health Centre (Ajja clinic) should be telling staff, dependants of staff and students that it is mandatory to come for regular HIV counseling and testing			
25.7	The policy makes the prevention of HIV and AIDS on campus the joint responsibility of everyone			

Instruction – *The questions in table in 5 only are for those whose answer to question 19 in Section B is "Yes"*

For each of the statements relating to HIV interventions as contained in U.I. HIV and AIDS policy. In table 5, please tick ☑ whether it is True, Folse or Don't know.

If you have never seen and read the policy, please go to question 28 in Section E

Table 5

26	Statements	True	False	Don't know
26.1	According to the policy, only sexual abstinence is promoted among staff and students for the prevention HIV transmission			
26.2	The policy advocates for the integration HIV counseling and testing services into the health care services provided at Jaja clinic			
26.3	The policy is silent on the screening of blood and blood products at Jaja clinic			
26.4	According to the policy, the University is not interested in the formation of support groups to care for persons living with HIV and AIDS because U I is not a heath care institution or hospital			
26.5	The policy states that voluntary testing for HIV should be a regular exercise for everyone in U. I.			
26.6	The policy on HIV and AIDS in U.I does not make provisions for how staff and students who need drugs for HIV infection could get to places where such drugs are available			
26.7	The policy says courses on HIV and AIDS should be integrated into various curricula in the University			
26.8	The policy does not support the integration of HIV education into the General Education Studies (GES) of University of Ibadan			
26.9	The policy says that the University does not encourage HIV and AIDS related activities conducted by government and non-governmental organizations on campus			

SECTION D: PERCEPTIONS OF THE UNIVERSITY OF IBADAN HIV AND AIDS POLICY

Instruction: *The questions in table in 6 ore for those whose answer to question 19 in Section B is "Yes".*

For each of the statements on the Perceptions of staff and students of University of Ibadan on U.I HIV and AIDS policy in table 6, please tick ☑ to indicate whether you are Agree, Undecided or Disagree with it If you have never seen and read the policy, please go to question 28 in Section E.

Table 6

27	Statements	Tick ☑		
		Agree	Undecid	Disagree
27.1	The University should not waste it's time implementing the HIV and AIDS policy as issues relating to HIV and AIDS are personal			
27.2	Education on HIV and AIDS does not have any positive effect on the sexual behaviour of people in a University community because people in a University setting are adults who are free to indulge in their chosen sexual lifestyle so there is no need for a special policy on HIV			
27.3	It is not proper for the University's HIV and AIDS policy to be promoting use of condom as a way of preventing HIV			
27.4	The University of Ibadan HIV and AIDS policy which favours the employment of HIV positive persons is good			
27.5	The U.I HIV and AIDS policy that frowns at discrimination against of HIV positive persons is appropriate			
27.6	Not making testing for HIV obligatory or compulsory in the policy shows that the University is not really serious about controlling HIV on campus			
27.7	The University policy should not allow any staff or students living with HIV and AIDS to continue working or studying in U.I. in order not to infect others			
27.8	HIV has come to stay despite all prevention interventions, so U.I policy on HIV is not necessary			
27.9	It is not practicable for people to report to the University health centre that they have HIV and AIDS as required by the policy			
27.10	The campaign on HIV in the campus only exists on paper			
27.11	The HIV and AIDS policy of U.I is designed for only sexually active persons on campus			
27.12	The HIV and AIDS policy of U.I is a mere academic exercise			
27.13	The HIV and AIDS policy of U.I is difficult to implement			
27.14	The policy must insist that HIV positive staff or students of U.I should be dismissed or expelled			
27.15	The control of HIV on campus should be the sole responsibility of the University authority			
27.16	The U.I HIV and AIDS policy should not encourage the conduct of HIV and AIDS researches			
27.17	The HIV and AIDS policy of U.I does not involve staff and students well enough on AIDS control on campus			

SECTION E: AWARENESS OF AND PARTICIPATION OF STUDENTS IN THE UNIVERSITY OF IBADAN HIV CONTROL PROGRAMMES

28. For question 28, tick the campus based HIV and AIDS control programmes you are aware of in U.I. in table 7

Table 7

		Awareness	
	Category of HIV and AIDS control programme aware of	Yes	No
a.	HIV and AIDS programmes for students		
b.	HIV and AIDS programmes for academic staff		
c.	HIV and AIDS programmes for non teaching staff		

29. Which of the following HIV and AIDS programmes in table 8 have you ever attended?

Table 8

	Category of HIV and AIDS control programme ever attended	Yes	No
a.	HIV and AIDS programmes for students		
b.	HIV and AIDS programmes for academic staff		
c.	HIV and AIDS programmes for non teaching staff		

Instruction: *For question 30 – 49. tick ☒ the appropriate responses to the questions in this section from the alternatives provided. In some cases simply supply the needed information in the spaces provided*

30. Are you aware that there is a course on HIV as part of the General Studies Programme in U.I.?

Yes ☐ No ☐ If no go to question 33

31. If yes to question 30, what is the title or course code of the course?

_____

32. If yes to question 30, in what year of study do students undertake the HIV and AIDS related GES course? _____

33. Are fresh students in U.I. given orientation on issues related to HIV given to first year students in U.I.? Yes ☐ No ☐ If No go to question 35

Question 34 is for students alone

34. Did you attend the orientation sessions at which HIV and AIDS was discussed when you were admitted to the University?

Yes ☐ No ☐ Not applicable ☐

Question 35 – 49 should be answered by staff and students

35. Have you ever been at the University Health Centre (Jaja Clinic)?

Yes ☐ No ☐ If No go to question 40

36. How often do you go to the Jaja clinic for any medical attention?

Rarely ☐ Occassionally ☐ Always ☐

37. Are HIV related services offered at Jaja clinic?

Yes ☐ No ☐ Don't know ☐ If No go to question 40

38. What are the HIV related activities of the Jaja clinic that you know? (Please don't consult any book or persons but just list them as you know them)

_____

_____

_____

39. Which of the HIV related activities of Jaja clinic have you ever benefited from?

(Please list) _____

_____

_____

40. Are you aware of HIV peer education programme in U. I.?

Yes ☐ No ☐ If No go to 42

41. Do you know anyone that is an HIV peer educator in U.I.?

Yes ☐ No ☐

42. Which of the following HIV and AIDS related programmes are you aware of in U.I. (Tick all the ones you know)

	Yes	No
a. Research Alliance to combat HIV (REACH)	☐	☐
b. Action Group on Adolescent Health (AGAH)	☐	☐
c. Youth Friendly Centre (YFC)	☐	☐

43. Table 8 contains a list of HIV related programmes. For each, state where the programme is located in U. I.

Table 9

HIV related programme on campus	State location
REACH (Research Alliance to combat HIV)	
AGAH (Action Group on Adolescent Health)	
YFC (Youth Friendly Centre)	

44. Table 9 contains a list of HIV related programmes. For each, state its related HIV and AIDS related activities that you have participated in.

Table 10

HIV related programme on campus	Its HIV and AIDS activities participated in by you	If not heard of it tick here
REACH (Research Alliance to combat HIV)		
AGAH (Action Group on Adolescent Health)		
YFC (Youth Friendly Centre)		

45. Have you ever participated in an HIV voluntary counseling and testing?

Yes ☐ No ☐ If "No" go to question 49

46. If yes to question 45, was it done on campus? ☐ Yes No ☐

47. If yes to question 46, where in U.I. was the counseling and testing done?

48. If you decide to do the HIV testing say tomorrow of any moment from now in U.I., where will you like to do it? (Choose from the following alternative locations)

a. The University Health Centre (Jaja Clinic) ☐ b. Youth Friendly Centre ☐

c. Action Group on Adolescent Health (AGAH) ☐ c. Others_____ (Specify)

49. If no to question 45, why is it so?

Thank you for participating in the survey

Appendix 2: Knowledge scale

S/N	Variables - knowledge questions	Appropriate response	Point per variable	Total points
23	Major provisions of the U.I. HIV and AIDS policy			
	The University policy does not recognise HIV and AIDS as a University based problem	False	1	
	The policy says there should be no social interaction with people living with HIV and AIDS in the University so as to check its spread	False	1	12
	Policy says students/staff seeking for admission/employment should be screened for HIV before being considered for admission	False	1	
	The policy does not make it mandatory for staff and students to be counseled before they undergo HIV test	False	1	
	The policy states that one ceases to be a student or U.I. if found to be HIV positive	False	1	
	The policy says that an infected staff or student should have limited access to information on his/her status so that they will not commit suicide	False	1	
	Policy says staff infected with HIV should not share the same office and other facilities used by others who are not infected to avoid spread of infection	False	1	
	Policy says students living with HIV should not have access to the same hostel accommodation used by others who are not infected to avoid spread of the infection	False	1	
	Policy says staff and students living with HIV should not have access to the same health care facilities used by others who are not infected to avoids preads of the infection	False	1	
	The policy made it clear that staff or students who have HIV should not share toilets with others in the hostels so as to prevent the spread of the infection	False	1	
	Policy says it is not the responsibility of the University to provide infected students, staff and their dependant with a treatment and care services	False	1	
	According to the policy, it is compulsory for students to inform the University management of their HIV status whether positive or not	False	1	

Knowledge scale (contd)

S/N	Variables - knowledge questions	Appropriate response	Point per variable	Total points
24	**Rights of staff and students of U.I. in the HIV and AIDS policy**			10
	The policy says compulsory testing for HIV before admission/employment is not a violation of staff or students' rights, it is only a drastic step to prevent the deadly disease condition	False	1	
	According to the policy, it is compulsory for intending students/prospective staff to disclose their HIV status before admission/employment	False	1	
	Policy makes it clear that staff and students are required to undergo HIV test if they want to continue their employment or academic programmes as the case may be	False	1	
	The policy says that the University will keep staff and students with HIV or AIDS under close watch or surveillance to ensure they do not infect others	False	1	
	According to the policy, the University keeps records of HIV status in staff or students' personal files which are open to anyone in the University to see	False	1	
	According to the policy, AIDS should not be treated like any other health condition which someone can live with for a long time	False	1	
	The policy says only students/staff without HIV or AIDS should be provided with information about universal precaution against HIV so that they can protect themselves from the infection	True	1	
	The policy says students/staff should not have information on safe sex practices so that they will not be experimenting with such practices	False	1	
	The policy is silent on how people living with HIV of the University of Ibadan could seek redress in case of discrimination	False	1	
	At the University of Ibadan, a staff or student found to be HIV positive runs the risk of being dismissed or rusticated as the case may be from the university as a preventive measure	False	1	

Knowledge scale (contd)

S/N	Variables - knowledge questions	Appropriate response	Point per variable	Total points
25	Responsibilities of staff and students of U.I. concerning HIV and AIDS policy			
	The policy says that it is the sole responsibility of staff and students to protect themselves against HIV infection	False	1	
	The HIV policy encourages staff and students to seek information about prevention of HIV and AIDS alone	False	1	7
	The policy says that individual staff or student should make the decision whether to undergo counseling and testing for HIV or not	False	1	
	The policy says that staff and students should help identify persons who have HIV on campus so that such persons can be monitored as a preventive measure	False	1	
	Based on the policy, staff and students should disclose the identity of fellow staff/students living with HIV so as not to spread the virus to innocent people	False	1	
	The policy says that the University Health Centre (Jaja clinic) should be telling staff, dependants of staff and students that it is mandatory to come for regular HIV counseling and testing	False	1	
	The policy makes the prevention of HIV and AIDS on campus the joint responsibility of everyone	False	1	

Knowledge scale (contd)

S/N	Vnriables - knowledge questions	Appropriate response	Point per varinble	Total points
26	HIV interventions as contained U.I. HIV and AIDS policy			
	According to the policy, only sexual abstinence is promoted among staff and students for the prevention HIV transmission	False	1	9
	The policy advocates for the integration HIV counseling and testing services into the health care services provided at Jaja clinic	True	1	
	The policy is silent on the screening of blood and blood products at Jaja clinic	False	1	
	According to the policy, the University is not interested in the formation of support groups to care for persons living with HIV and AIDS because U.I is not a heath care institution or hospital	False	1	
	The policy states that voluntary testing for HIV should be a regular exercise for everyone in U. I.	True	1	
	The policy on HIV and AIDS in U.I. does not make provisions for how staff and students who need drugs for HIV infection could get to places where such drugs are available	False	1	
	The policy says courses on HIV and AIDS should be integrated into various curricula in the University	True	1	
	The policy does not support the integration of HIV education into the General Education Studies (GES) of University of Ibadan	False	1	
	The policy says that the University does not encourage HIV and AIDS related activities conducted by government and non-governmental organizations on campus	False	1	

Appendix 3: Ranking of Respondents' Knowledge Scores

	Table 2	Table 3	Table 4	Table 5	Total
Number of items	12	10	7	9	38
Total score	12	10	7	9	38
Knowledge scores ranking			Poor	Fair	Good
			0-19	20-28	29-38

Appendix 4: Perception scale

SN	Variables - perception	Appropriate response	Point per variable	Total points
23	The University should not waste it's time implementing the HIV and AIDS policy as issues relating to HIV and AIDS are personal	Disagree	1	17
	Education on HIV and AIDS does not have any positive effect on the sexual behaviour of people in a University community because people in a University setting are adults who are free to indulge in their chosen sexual lifestyle so there is no need for a special policy on HIV	Disagree	1	
	It is not proper for the University's HIV and AIDS policy to be promoting use of condom as a way of preventing HIV	Disagree	1	
	The University of Ibadan HIV and AIDS policy which favours the employment of HIV positive persons is good	Agree	1	
	The U.I. HIV and AIDS policy that frowns at discrimination against of HIV positive persons is appropriate	Agree	1	
	Not making testing for HIV obligatory or compulsory in the policy shows that the University is not really serious about controlling HIV on campus	Disagree	1	
	The University policy should not allow any staff or students living with HIV and AIDS to continue working or studying in U.I. in order not to infect others	Disagree	1	
	HIV has come to stay despite all prevention interventions, so U.I. policy on HIV is not necessary	Disagree	1	
	It is not practicable for people to report to the University health centre that they have HIV and AIDS as required by the policy	Disagree	1	
	The campaign on HIV in the campus only exists on paper	Disagree	1	
	The HIV and AIDS policy of U.I. is designed for only sexually active persons on campus	Disagree	1	
	The HIV and AIDS policy of U.I. is a mere academic exercise	Disagree	1	
	The HIV and AIDS policy of U.I. is difficult to implement	Disagree	1	
	The policy must insist that HIV positive staff or students of U.I. should be dismissed or expelled	Disagree	1	
	The control of HIV on campus should be the sole responsibility of the University authority	Disagree	1	
	The U.I. HIV and AIDS policy should not encourage the conduct of HIV and AIDS researches	Disagree	1	
	The HIV and AIDS policy of U.I. does not involve staff and students well enough on AIDS control on campus	Disagree	1	

Appendix 5: Ranking of Respondents' Perception Scores

	Table 6	Total
Number of items	17	17
Total score	17	17
Perception score rating	Unfavourable	Favourable
	0 -6	7-17

Appendix 6: Participation scale

S/N	Variables - participation questions	Total points for students	Total points for staff	Total points
29a.	HIV and AIDS programmes for students (for students alone) - Yes = 1			
b.	HIV and AIDS programmes for academic staff (for staff alone) - Yes = 1	1	2	
c.	HIV and AIDS programmes for non teaching staff (for staff alone) - Yes = 1			8
34.	Student's attendance at HIV orientation programme (for students alone) - Yes = 1	1	0	
39	HIV-related activities of Jaja clinic ever benefited from *Any two of HIV education, HIV orientation, HIV counseling, HIV counseling and testing, Referral services = 2*	2	2	
44a.	HIV and AIDS activities participated in at AGAH Yes = 1			
b	HIV and AIDS activities participated in at REACH Yes = 1	3	3	
c.	HIV and AIDS activities participated in at YPC Yes = 1			
46	Ever participated in an HIV voluntary counseling and testing on campus Yes = 1	1	1	
Maximum points for staff or students		=	8	

Appendix 7: Ranking of Respondents' Participation Scores

Participation rating	Participation score
Low	0-2
Moderate	3-4
High	5-7

Appendix 8: Key Informant Interview Guide

KNOWLEDGE, PERCEPTION AND PARTICIPATION IN HIV AND AIDS POLICY-RELATED ACTIVITIES AMONG STAFF AND STUDENTS OF UNIVERSITY OF IBADAN, NIGERIA

QUESTIONS	PRONE(s)
1. What is the situation of HIV in this university?	a. How common is HIV infection on campus? b. What are some of the factors including practices that can promote the spread of HIV on campus?
2. How does the university respond to the control of HIV and AIDS among staff and students in this university?	a. What has the university done or is doing? b. Who are the people responsible for planning, design and implementation of HIV prevention and control programmes for staff and students?
3. I want to ask some questions about the University HIV and AIDS policy. *Does the university have a written HIV and AIDS policy?*	a. What are the objectives of the policy? b. Who are the targets of the HIV and AIDS policy? c. What are the issues covered by the policy ? Possible areas to probe if not mentioned: *What does the policy say about:* i. Prevention of HIV ii. Alleviation of impacts iii. Care and support of student and staff infected with HIV iv. Prevention of discrimination and stigma related to HIV v. Research on HIV and AIDS
4a. What is your opinion about the level of awareness of students concerning the U. I. HIV' policy?	a (i) What kinds of activities/programmes or strategies are in place to make the students aware of the U.I. HIV and AIDS policy? *Probe into specific educational efforts* e.g school based activities such as campaigns, seminars, hall based education programe/outreaches, distribution of the HIV policy as handbills and internet ii. Do most of the students have a copy of the HIV policy? What proportion of students would you say have the policy? iii. What about the academic and non-teaching staff, what proportion of each group would you say have a copy of the HIV policy? iv. How are copies of the policy distributed within the university? iv. Is HIV and AIDS related education taught to students in UI? v. If yes, how is it taught to students

QUESTIONS	PROBE(s)
4b. What will you say about the level of awareness of staff concerning the U. I. HIV policy?	b. What kinds of activities/programmes or strategies are in place to make the staff aware of the U.I. HIV and AIDS policy? *Probe into specific education efforts, e.g* campaigns, seminars/workshop, World AIDS day celebration, media programmes, university bulletin, departmental meetings, internet, distribution of the HIV policy as handbills
5. How related is the U.I. HIV and AIDs policy to National and international HIV policies and guidelines?	a. How does the policy relate to - National HIV and AIDS policy? - National Workplace HIV and AIDS Policy? - Guidelines of the International Labour Organisation on HIV policy development? b. In what way does the policy address the needs and interests of i. students? ii. staff?
6. Let us discuss the roles and responsibilities of members of the U.I. community. What should be the role of the university community regarding HIV and AIDS on campus?	a. What should students be doing in order to prevent HIV and AIDS as dictated by the policy? b. What should the staff be doing to ensure they prevent themselves from contacting HIV infection? c. What should health workers be doing to help prevent HIV and care for those infected or affected by it in the university? d. What should be the role and responsibilities of the underlisted in the control of HIV in the university community? i. Students ii Staff – academic, non-teaching iii. Health workers (Jaja clinic) iv. University authority v. Senior Staff Association vi. NASU vii. ASUU viii. Student union ix. Other campus based organizations x. Religious leaders
7. What has been the level of support of the various stakeholders in U. I. for the policy?	a. What have been done as support for the policy and its implementation by. - University Authority - Students organization - Workers' Union such as ASUU, SAANU, NASU - Main religious groups - Other organizations related to the University

QUESTIONS	PROBE(s)
	bi. Which groups or organizations are actively involved in the translation of the policy to action? ii. Why do you single out these groups/organizations?
8. How has the stakeholders contributed to the dissemination of the provisions of the U. I. HIV and AIDS policy?	a. Who are the persons and groups dedicated exclusively to manage HIV and AIDS in the university? (i.e including the implementation of the policy) b. What is the role of the group or organizaton that you represent in publicising the HIV and AIDS policy ? ci. What should the University do to make students become familiar with the HIV and AIDS policy? ii. What should the University do to make staff become familiar with the HIV and AIDS policy?
9. I will like to ask about implementation of the HIV and AIDS policy and programmes based on the provisions of the policy.	a. Is there an HIV and AIDS committee on campus? i. Who make up the HIV and AIDS committee in the University? ii. How does the committee operate or function? iii. How do they get funds for the activities geared toward the prevention and control of HIV and AIDS on campus? b. What role(s) has your organization or the group you represent played in the implementation of the policy? c. What are the specific methods employed in the prevention of HIV by your organization?
10. Let us discuss specific HIV and AIDS related programmes of the University	i. HIV orientation for fresh students ii. Education and awareness to the staff (e.g. seminar/workshop, university bulletin) iii. HIV counseling and testing (VCT) iv. First aid or emergency care v. Care and support of student and staff living with HIV/linkage with other health facilities for treatment vi. Prevention of mother to child transmission vii. Universal precaution against blood borne infections including HIV viii. Other programmes

QUESTIONS	PROBE(s)
12. What are the means of monitoring and evaluation of the institutional HIV policy	a. How has the policy been implemented so far? bi. Mention some of the groups of students that have received any training on HIV and AIDS policy ii. Mention some of the groups of staff that have received any training on HIV and AIDS policy c. How were the beneficiaries of the training selected? d. Mention any HIV campaign in the university since the publication of the policy e i. Where do students go for HIV counseling and testing on campus? ii. Where do staff go for HIV counseling and testing on campus? f. Has there been a review of the policy since it was formulated? g. What are the current activities relating to the integrating of HIV into GES courses and various curricula of the various departments in the University? h. How are the HIV related programmes monitored? i. Has any of the HIV related programmes been evaluated?
13. What are the challenges you think are facing the implementation of the U. I. policy	a. What are the challenges militating against the implementation of the HIV policy of the University of Ibadan? b. In your opinion, how can these challenges be addressed?
14. What are the areas that you think the policy did not address properly	*Probe into the following* a. Condom promotion b. Specific roles of the University in terms of the care of staff and student living with HIV and AIDS c. Monitoring and evaluation of the implementation of the HIV and AIDS policy? d. Funding of HIV and AIDS programmes

Thank you very much for your time!

Appendix: 9 Notice of Ethical Approval

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)

COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN, IBADAN, NIGERIA

E-mail: imratcomui@yahoo.com

UI/UCH EC Registration Number: NHREC/05/01/2008a

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Appraisal of Knowledge and Perceptions Relating to the Institutional HIV and AIDS Policy among Staff and Students of University of Ibadan, Nigeria.

UI/UCH Ethics Committee assigned number: UI/EC/11/0151

Name of Principal Investigator: Toyin L. G. Aulagu [illegible]

Address of Principal Investigator: Department of Health Promotion & Education, College of Medicine, University of Ibadan, Ibadan

Date of receipt of valid application: 22/08/2011

Date of meeting when final determination on ethical approval was made: 30/10/2011

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the UI/UCH Ethics Committee.

This approval dates from 30/10/2011 to [illegible]. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the UI/UCH EC assigned number and duration of UI/UCH EC approval of the study. It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. No changes are permitted in the research without prior approval by the UI/UCH EC except in circumstances outlined in the Code. The UI/UCH EC reserves the right to conduct compliance visit to your research site without previous notification.

Prof. A. Ogunniyi
Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: [illegible]

Appendix: 10 Letter of Permission to collect data

DEPARTMENT OF HEALTH PROMOTION AND EDUCATION

College of Medicine, University of Ibadan, Nigeria

Adémola J. Ajuwon

Oladimeji Oladepo

Ademola J. Ajuwon

Frederick Olore Oshiname

Oyedunni Sola Arulogun

Oyediran Emmanuel Oyewole

Musibau Ayoade Titiloye

Yetunde Olufisayo John-Akinola

Ref: HPE/A.29

4th May, 2012

TO WHOM IT MAY CONCERN

Re: ANIAGWU,Toyin Ibironke Grace
Matric No: 146248

This is to certify that the bearer is an M.PH (Health Promotion and Education) student in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan.

Kindly accord her all necessary assistance she may require in connection with her research project titled: **"Knowledge, Perceptions and Involvement in Activities Relating to the Institutional HIV and AIDS Policy among Staff and Students of University of Ibadan, Nigeria."**

Thank you

Prof. A.J. Ajuwon

HEAD

Appendix 11: Informed Consent Form

KNOWLEDGE, PERCEPTION AND PARTICIPATION IN HIV AND AIDS POLICY-RELATED ACTIVITIES AMONG STAFF AND STUDENTS OF UNIVERSITY OF IBADAN, NIGERIA

Good day. I am Toyin Ibironke Aniagwu and I am a graduate student (MPH) of the Department of Health Promotion and Education, College of Medicine, University of Ibadan. I am carrying out a research study in on the knowledge and perceptions of staff and students of the University of Ibadan regarding the institutional HIV and AIDS policy. The findings of this study will be useful in assisting relevant stakeholders in the university system to identify factors militating against the implementation of the policy and thus facilitate the design of a strategic framework for the effective implementation of the provisions of the policy.

I invite you to take part in this research project and this is done by answering the questions in the questionnaire. If you do not wish to answer any of the questions you may say so and move on to the next question. All your recorded responses are considered confidential. You are not requested to write your name on the questionnaire given to you to fill. No one except Mrs Aniagwu Toyin and other researcher working with her will have access to the information documented during the research. The filing of the questionnaire will only take about 20 minutes of your time and you will not be requested to do any other thing after it.

There are no risks or harm posed by the questions and there are no direct benefit to you rather than the general benefit of helping the fight against HIV and AIDS move forward.

If you wish to ask any question, you may contact any of the following:
Toyin Aniagwu, Department of Health Promotion and Education, College of Medicine, University of Ibadan. Tel 0803 353 5370, e-mail: taniagwu@yahoo.com or Dr Fred Oshinaike, Department of Health Promotion and Education, College of Medicine, University of Ibadan, Ibadan. Tel 0803 500 1060 e-mail: foshinaike@yahoo.com

I have fully explained this research to _____ and have given sufficient information including risks and benefits, to make an informed decision.

Signature of participant: _____ Date: _____

Signature of researcher: _____ Date: _____

Appendix 12: Key Informant Interview Informed Consent

KNOWLEDGE, PERCEPTION AND PARTICIPATION IN HIV AND AIDS POLICY- RELATED ACTIVITIES AMONG STAFF AND STUDENTS OF UNIVERSITY OF IBADAN, NIGERIA

Greetings. I am Toyin Ibironke ANIAGWU and I am a graduate student (MPH) of the Department of Health Promotion and Education, College of Medicine, University of Ibadan. I am carrying out a research study in on the knowledge, perceptions and practices of staff and students of the University of Ibadan regarding the institutional HIV and AIDS policy. I use this time to invite you to participate in the key informant interview as a key person in the institution.

This key informant interview is voluntary. Do not hesitate to withdraw from the study if you feel distressed. Your participation in this study has no direct benefit. However, your participation in this study will serve as provide in-depth information about the issues surrounding the institutional HIV and AIDS policy and its implementation. I assure you that the information that will be provided during this discussion will be kept strictly confidential and used solely for the purpose of research. Please do not mention your name or any other person's name during this discussion. There is no right or wrong view, so feel free to express yourself. This discussion will last between 30 minutes to 45 minutes.

I have fully explained this research to _____ and have given sufficient information including risks and benefits, to make an informed decision.

Signature of participant: _____ Date: _____

Signature of researcher: _____ Date: _____

Appendix IA: SAFAIDS/ILO summarised steps to facilitate the development of an HIV and AIDS policy

Major Step	Key Activities/Outcomes Responsibility Timeline
1. Do initial Planning	• Obtain labour and management support for developing a policy • Organise an HIV and AIDS planning committee (if none) • Agree on an action plan with assignments and timetable, a scope of effort, and a focus for guidance
2. Gain needed knowledge and understanding	• Learn about HIV and AIDS and its effect on the community • Review this guide • Learn about applicable laws • Review existing policies and contracts • Learn about worker needs • Agree on use of a 'rationale' for each recommended policy Component
3. Draft the HIV and AIDS Policy	• Draft in a consultative process, summary rationale • Policy statements • Workplace guidelines, outline of HIV and AIDS prevention education, care, and support activities
4. Gain approval for the Policy	• Complete and revise the draft policy • Reach committee agreement on the final draft policy • Obtain labour approval and support • Obtain top management approval and support
5. Implement the policy	• Develop a communication plan to inform all employees about it • Carry out sequenced additional communication. implement the policy • Periodically monitor, review, and revise the policy
6. Make key provisions of the policy a part of your labour contract	• Review current contracts along with the new policy • Agree on key provisions to be added to future agreements

Source: SAFAIDS/ILO 2010. Workplace HIV and AIDS Policy and Programme Development Training Manual

Appendix 14: List of Universities that sent representatives for a workshop on developing HIV and AIDS Policy for Nigerian Universities February, 2006

	Institutional address	Ownership of Institution
1.	American University, Yola	Private
2.	Obafemi Awolowo University, Ife	Government
3.	Wesley University of Science and Technology, Ondo	Private
4.	Lead City University, Ibadan	Private
5.	University of Agriculture, Markurdi	Government
6.	Ibrahim Badamosi Babangida Univeristy, Lapai	Private
7.	Kano University of Science & Technology, Kano	Government
8.	Osun State University, Osogbo	Government
9.	Bowen University, Iwo	Private
10.	University of Uyo	Government
11.	Igbinedion University, Okada	Private
12.	Redeemers University	Private
13.	University of Ilorin	Government
14.	University of Jos, Jos	Government
15.	Wits University, South Africa	Overseas
16.	University of Calabar	Government
1.	Niger Delta University Bayelsa	Government
18.	Joseph Ayo Babalola University, Ikeji-Arakeji, Osun State	Private
19.	Federal University of Technology Yola	Government
20.	University of Ado-Ekiti	Government
21.	Usman Danfodio University Sokoto	Government
22.	University of Southampton	Overseas
23.	University of Abuja	Government
24.	Federal University of Technology, Owerri	Government
25.	Bingham University, Karu	Private
26.	Bayero University, Kano	Government
2.	Federal University of Technology, Akure	Government
28.	Tai Solarin University of Education	Government
29.	Federal University of Agriculture, Abeokuta	Government
30.	Adekunle Ajasin University, Akungba Akoko	Government
31.	National Open University	Private
32.	Babcock University, Illishan	Private
33.	Fountain University	Government
34.	Imo State University Owerri	

Source: Attendance list of the workshop on developing HIV/AIDS policy for Nigerian Universities held at the Conference Centre, Obafemi Awolowo University, Ile-Ife, Nigeria on February 23 to 26, 2009.

Appendix 15: Nigerian Universities that have their HIV and AIDS Policy on AAU Website

- University of Ilorin

  www2.aau.org/aur-hiv-aids/...HIVAIDS.../Ilorin%20-%20policy.pdf

- University of Port Harcourt

  www2.aau.org/aur-hiv-aids/...HIVAIDS.../portharcourt_policy.pdf

- University of Agriculture, Abeokuta

  www2.aau.org/aur-hiv-aids...HIVAIDS.../Abeokuta/Abeokuta%20-%20policy.pdf

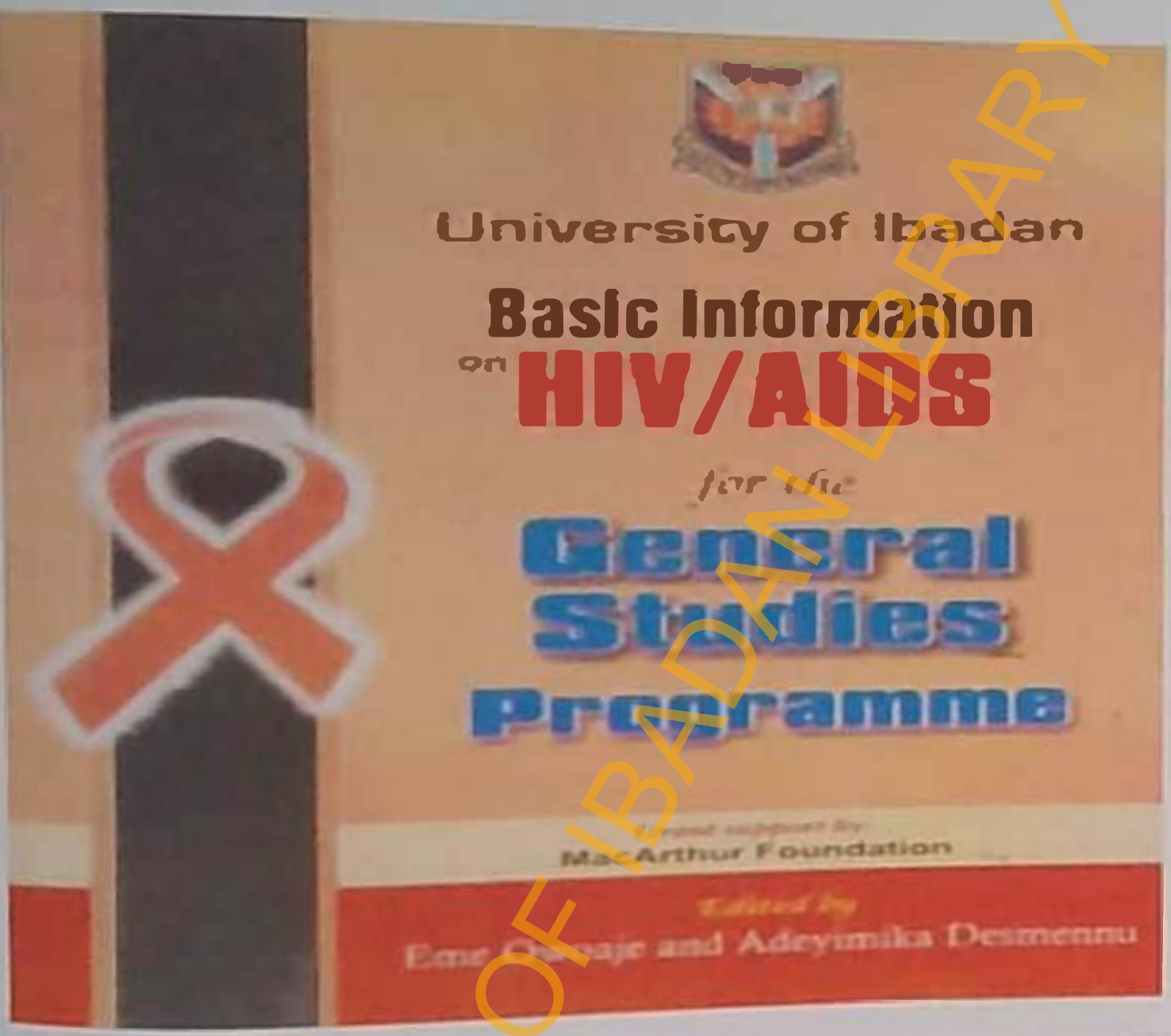
- University of Ibadan

  www2.aau.org/aur-hiv-aids/docs/...HIVAIDS.../Ibadan_policy.pdf

- Covenant University

  www.covenantuniversity.edu.ng/.../HIV%20AIDS%20Policy.pdf

Appendix 16: An example of the HIV Education material of the University of Ibadan



Source: HIV and AIDS and Higher Education in Africa: A review of best practices models and trends, AAU 2007

Appendix 17: General Studies (GES) course material of the University of Ibadan