The Formation Of A Critical, Compassionate Citizenry: The Inculcation Of HIV/AIDS Curricula Into South African Higher Education.

A Literature Review, Guiding Principles and Recommendations. Prepared for Higher education addressing HIV/AIDS.

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Introduction

There have been numerous programmes internationally and continentally that involve the careful and sometimes not too careful inculcation of HIV/AIDS awareness into curricula. The majority of these have centred on adolescent programmes because, naturally, it is generally perceived that this age group is both sexually active and adventurous in so far as they are exploring boundaries that are simultaneously sexual, political and social. As the Love Life campaigns have proved, the adolescent and especially the early adolescent is a notoriously difficult age group to address effectively. The unique cultural sensitivities that can be particular to a small group make reaching this group very much a hit and (more often) miss affair.

The period of late adolescence/early adulthood brings with it a growing responsibility and a greater opportunity. It is thus a period of social acculturation that settles the student into more steadfast sub-cultural groupings that may not meet with the unconditional approval of mainstream society but, at least, are becoming more consolidated and recognisable. As far as the student is concerned, this makes the introduction of AIDS awareness into the courses he or she studies intellectually easier provided that this kind of learning does not clash with the specific inclination of the sub cultural belonging.

Higher education differs from schooling in one major respect – the comfort zone of the school, the many years of habitualised learning and the pace of learning is replaced by a foreign, larger environment where the demands made upon the student are such that learning occurs at a greater speed and in a less secure environment. This means that the curriculum that they are confronted with must not only appear relevant to the present circumstances but also useable in later life. Moreover, it must also contribute to the formation of a critical, compassionate citizenry: a graduate that is able to think conceptually and critically about the world around him or her, that has the capacity to act compassionately towards those less fortunate and equipped to take his or her place in the betterment of the nation.

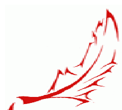
Literature Review

This literature review will concern itself with the seminal articles that have come out of an extensive search through available material. Unless the articles have appeared directly relevant to our investigation, I have limited my research to articles from 1995 onwards.

In "HIV Prevention Strategies for Community Colleges: Lessons Learned from Bridges to Healthy Communities" (2001) the authors conducted an array of HIV prevention activities to promote systematic and individual change. Building strong connections between service learning and HIV prevention was the focal strategy for these changes.

The American Association of Community Colleges (AACC) instituted the Bridges to Healthy Communities project (1995-2000) to help develop campus-based programs for preventing HIV infection and related problems among college students.

The Bridges project showed how community colleges can help to improve the health of community members, staff, and students by taking part in the strategic planning and



decision making of campuses and communities. Community colleges provide a network for disseminating information about healthy behaviours. In addition to this, they can also assess and implement change in the eight indicators of success, which were identified by Hoban et al:

- Collaboration;
- Health services;
- Careful attention to priority populations;
- Prevention programs;
- Student leadership;
- Professional development;
- Health messages;
- Campus environment and policy.

There are several systematic changes that help to promote health. These are:

- Employ evidence-based strategies for change.
  - Be open to altering the course or direction when something is not working as intended.
  - Make use of cultural differences, such as using the language of the intended audience, in order to amplify the impact of health promotion efforts.
  - Make regular use of health messages in staff and student orientations and in leadership and development opportunities.
  - Align campus strategies with prevention efforts that are known to work.

- Support faculty members.
  - Involve adjunct faculty members in college-wide goals for preventing disease and promoting health.
  - Help enable faculty members to develop the skills required to move students from information acquisition to behaviour change.
  - Share models of health-related teaching materials with faculty members in both occupational programs and traditional academic disciplines.
  - Provide incentives for faculty, such as recognizing the value of health courses, service activities in promotion and tenure reviews, and community alliance.

- Engage leaders in creating change.
  - It is important to initiate action in environment, health messages, policy, student leadership, professional development, prevention programs, collaboration, health services, and attention to priority populations.
  - Support healthy, credible initiatives that come from the campus 'grassroots' environment, such as a maintenance person requesting safer disposal of lab materials.

- Place health messages strategically.
  - To prevent the judgment that health is an add-on responsibility or curriculum extra, integrate health information into already existing courses and structures; for example, by using health-related topics in speech or

English composition courses, or by analysing health-related Web sites in a Web design course.
    - Integrate health information, skill-development activities, and health-promotion messages into higher education, in highly visible forms.

- Create financial models that support health.
    - Identify and secure seed money for health initiatives to support collaboration with community-based organizations and to pay personnel.
    - Form partnerships with local governments to provide recreation and health facilities for the community.
    - Leverage college funds obtained through student activity fees and other sources to support healthy campus initiatives, such as smoke-free policies and peer education clubs.

- Offer health-related prevention and treatment services.
    - Promote collaborative relationships with private and nonprofit organisations.
    - Secure funds for testing from local and state health departments, insurance, private foundations, the college, or from client reimbursements.
    - Ensure that conversations with students are kept confidential.
    - Provide voluntary counselling and testing for HIV/AIDS to reduce the number of new infections and to encourage early diagnosis and treatment.

There are certain events and activities that can be used for the promotion of health, and although they are mainly used overseas, implementation here may serve as a great advantage.

Events

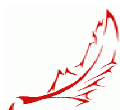
- National Collegiate Alcohol Awareness Week.
- Great American/South African Smoke-Out.
- World AIDS Day.
- Spring Holidays, and Valentine's Day.

Activities

- Clothesline Project.
- Peer presentation to classes when instructors are absent.
- Annual speech contest on "Myths Surrounding HIV/AIDS."
- Distribution of safer sex kits.

Along with the acknowledgement that HIV prevention and health-promotion activities are of extreme importance, the importance of creating a healthy campus environment where health is taught, learnt, and practiced in many different ways throughout the institution was also emphasised. To create healthy campus environments, college leaders should consider community as well as student and institutional contexts.

According to the AACC policy statement on health and wellness, community colleges recognise the importance of health in the learning, retention, productivity, and well-being of students, faculty, and staff alike. Health is not merely the absence of disease, but is the promotion of the mental, physical, social, environmental, and spiritual well-being of



individuals and communities. Being largely social, environmental, and behavioural, means that many modern-day illnesses are preventable, but only through a combination of individual and broad community measures. In an effort to encourage citizens to embrace their personal and social responsibility, and higher education institutions to embrace their organisational responsibilities in matters of health, the American Association of Community Colleges encourages the integration of health into all facets of community college life and offers the following recommendations:

Community colleges/universities should create an environment that supports health in which institutional mechanisms such as policy, programs, curricula, services, and collaborative work with the community promote and support health and wellness. Among the issues to be considered in health and vitality policy development are: tobacco use, HIV infection, and the use of alcohol and other drugs.

Community colleges should remain on the cutting edge of health care transformation by preparing clinically and culturally competent allied health professionals. These professionals range from degree nurses to substance abuse counsellors, medical assistants, radiological technologists, medical technologists, and a wide range of therapy assistants in occupational, recreation, rehabilitation, and related therapies. These and other allied health occupations fill a critical niche for practice in the 21st century.

Because of their easy accessibility and capacity for providing customised training, community colleges also should continue to offer progressing education for faculty and other health care professionals.

Universities should view health as a powerful and appealing vehicle for interdisciplinary learning, skills building, and career development.

Along these same lines, the ACU offered several ways in which the topic of health could be integrated successfully into curricula. The Association of Commonwealth Universities (ACU) consists of approximately 500 universities in 36 countries. The ACU states that universities are in a unique position to shape action, policy, debate and practice in the battle against an epidemic, which will have dire consequences not only for the societies in which we live, but for our institutions as well.

A primary aim of ACU is to support and encourage every member institution to develop and implement a university specific policy on HIV/AIDS. The question may arise whether other organisations in the international community are not better placed to confront and tackle the epidemic. ACU's belief is that it has unique strategic advantages, which must be exploited in the interests of the higher education community.

- ACU has global reach and is particularly concerned with issues involved in higher education.
- ACU has access to many knowledge resources across a range of institutions in the developed and the developing world and is able to monitor them collectively.
- ACU has direct access to the executive heads of member universities allowing it to have a direct impact on the decision-making processes and opinion makers.

In this context, all signs point to a few critical factors, which will determine our success in responding to the epidemic. In order to be successful, the following elements should be embraced:

- ***Community engagement:*** Each institution is a unique part of its own national and regional community, but all have in common that society expects a great deal from them. In the context of HIV/AIDS, this expectation is extended in that universities cannot ignore the needs of their staff, students and the communities in which they function.

- ***Leadership:*** The University plays a proactive and progressive role in society and gives leadership through research and role modelling in solving social problems. In our time, HIV/AIDS is undoubtedly one of the largest and most immediate of these social problems.

- ***Knowledge generation:*** Every discipline requires an emphasis on HIV/AIDS related research – not only those which contribute to institutional responses and controlling the disease but also those which add, for example, to the body of knowledge about the demographic, legal and developmental aspects of HIV/AIDS.

- ***Role-modelling:*** The University is an example of society which works against the denial, stigma and discrimination that affect individuals with HIV/AIDS, their friends and families.

- ***Awareness:*** It is fundamental that HIV/AIDS literacy be an essential capability for every university graduate and professional. Therefore, curricula alterations must ensure that all undergraduates comprehend the basics of HIV/AIDS and are aware of its implications for their fields of study and in the world of work.

- ***Capacity:*** The University must have the capacity to manage and mitigate the impact of HIV/AIDS as a work place issue.

- ***Planning:*** Universities must be able to plan for and respond to the impact on which HIV/AIDS related illnesses and deaths may have on the management, financing, and operations of institutions.

Across the Commonwealth, the space which universities create and maintain for critical open thinking must be used towards advocacy, towards creating a public platform for people with HIV/AIDS, towards making the social and sexual behaviours of young adults more thoroughly understood and making behaviour more responsible. Although part of this battle has been won in Africa, denial has played a restricting role in the public discussion of these critical issues.

Research on higher education responses to the epidemic has highlighted the extent to which universities are relying on prevention and awareness raising strategies. These assumptions rely on the assumption that in the absence of a cure, education is the best 'social vaccine' against the epidemic. "Strategies focused on prevention are important and need constant re-enforcement because of the vagaries of communication and the

knowledge that the availability of information by itself is not sufficient to cause behavioural changes. Sustaining and building on positive behaviour changes is an even greater challenge." (Association of Commonwealth Universities, April 2002).

However, while prevention strategies must continue to be built upon, ACU argues that it is important to think beyond prevention in a context where universities in many areas of the world have students and staff who have died, are ill, or whose families are seriously affected by the epidemic. Prevention alone will not address the gravity of their needs – it is insufficient. In this context, powerful arguments are emerging in wider society and within universities that any response to HIV/AIDS has to work across a continuum that includes treatment, care, prevention, and support and that extends to proactive management of the impacts of the epidemic.

It is important to sensitise, to inform, and to persuade leaders in the university community to engage in a process of self-reflection about whether they have recognized the threat that the epidemic poses to their mission and operations, responded to its demands and identified how they may choose to respond in the near future.

The HIV/AIDS epidemic needs to be addressed through a process of inquiry. There are several things that universities can do in response to the epidemic.

Step 1: Leadership
The leader has a critical role to play in this process and should commit the organization to a process of self-reflection by rallying the key stakeholders in the university community.

Step 2: Situation analysis (institutional impact)
The extent to which the epidemic has already affected the work of the university and the community it supports should be identified.

Step 3: Situation analysis (institutional response)
It must be determined whether the university has responded in any way to the reality of the epidemic as an organization or through the work of individuals. Once this has been determined research should be done to decide whether the responses are adequate and appropriate.

Step 4: Potential impacts
It must be determined what the epidemic means for the core business of the university. It is important to clarify this with regards to:

- Community engagement,
- Research,
- Teaching,
- Management.

Step 5: Proactive responses
Within each of these four areas of activity the following questions may be asked: What role in the struggle against HIV/AIDS does the university see for itself

- In keeping with its mission
- In the world in which it operates

- And, its responsibility to students, staff and the community it supports?

Step 6: Response mode

The form of the response to the epidemic that should be taken must be determined.

Step 7: Process leadership

It must be decided who will lead the process of defining the response.

Step 8: Structure, representation and accountability

What structure will be put in place to drive the process of developing and implementing the response? To whom will it be accountable?

Step 9: Resources

Resources that can be mobilised within and outside the university to support the response must be determined.

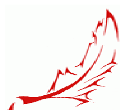
Step 10: Monitoring and evaluation

How the success of the response will be measured, must be determined.

Several steps have been identified to clearly show that a host of co-factors come into play once the process is underway – all of which have a critical bearing on the integrity of the response. These include:

- Resources
- The will to act
- Sustainability
- Leadership
- Capacity to implement
- Setting priorities
- Decision making processes
- Management structures
- Institutional culture.

The evidence is abundant that universities are able to – should they choose – play a vital role in the battle against HIV/AIDS. It is obvious that no institution will be able to cope with such an epidemic by itself, but one factor stands out in almost every example of a strong and well conceived response to HIV/AIDS in the university sector: leadership. Without leadership there is no commitment to change, little chance of shifting institutional culture, creating a sense of urgency or mobilizing key stakeholders. Leaders are able to and do change attitudes: leadership is the key to driving management structures, overcoming barriers, making resources available, and mobilising resources. That is the challenge to senior executives in a world severely affected by the HIV/AIDS epidemic. Every good leader needs a place to start. Several seminal guidelines have been put forward in order to pilot HIV/AIDS successfully into the programme of study.



Theories, Innovations and Further Studies

Questions have arisen as to whether university students are already too old for conventional sexuality education if they are already sexually active – they may be affected to some degree by 'AIDS fatigue.' The value of the skills that they achieve through extra curricular education is also undermined because it receives no recognition and is not often linked to a career path or qualification. Its voluntary nature places the burden on students and the consistency of the programme cannot be guaranteed.

Various other options are at present being tested in a number of institutions and it is still too early in the process to determine which are the most appropriate or successful. As so far, four working models using different approaches are worth noting.

An Integrated Model

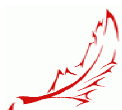
This model places the onus on every faculty to ensure that students as well as teachers are AIDS literate and that HIV/AIDS is incorporated into the structure of their degrees. It is based on the proposition that HIV/AIDS must be made relevant to the life and career prospects of every student and that every university educator must take note of the ways that HIV/AIDS can and does affect their specific discipline. Skills related to managing and preventing HIV/AIDS are developed in relation to career paths and marketability (Crewe, 2001).

Compulsory Model

The Sex and Risk Programme at the University of Durban-Westville involves a foundation level course for all incoming students in which HIV/AIDS is part of a credit bearing and risk education programme (UDW, 2001). This specific approach challenges both students and educators to work with a variety of issues, which are much wider than the biomedical aspects of the epidemic, and is targeted at providing students with sufficient knowledge about HIV/AIDS, increased awareness of risk and skills to make better, more educated choices in their social and sexual relationships. The requirements that students treat the subject as a conventional academic topic involving assignments, tests, and research, has yielded extremely imperative feedback to the university on their levels of knowledge, their attitudes and skills to deal with HIV/AIDS. Aside from this, it also provides a conduit through which students can approach the network of services, such as testing and counselling, that are otherwise treated with some scepticism.

Non-Formal Model

This particular model involves the recruitment and training of a yearly cohort of students in various roles to work with their peers. Recruitment is done through special interest activist groups; groups with a community outreach orientation or HIV/AIDS support groups. These programmes are typically voluntary, unpaid and target the more senior student to work with new incoming students. Peer counselling and peer education approaches to HIV/AIDS have been particularly successful in these initiatives and exemplify the strength of non-formal interventions. Peer education has numerous advantages. It has been used in institutional settings for many years to tackle substance abuse and much other risky and dangerous behaviour and can therefore be easily adapted to focus on HIV/AIDS.



Experience has proven that students learn more readily from their peers. Added advantages of peer education strategies include low cost, flexibility, and it is able to reach substantial numbers with little infrastructure.

Specialised Courses

With specialised courses there are two possible options from which to choose:
The first is that programmes can be offered within any faculty or discipline as a qualification-bearing programme with a specific focus on HIV/AIDS. The programme may include content from a wide range of disciplines.
The second option is that compulsory or elective modules are built into degree structures as a discrete requirement with a specific focus on HIV/AIDS.

No successful model can be chosen for a particular programme without clear and precise knowledge of its possible outcomes. The only way this can be appropriately done is through research. Several research strategies have been suggested.

Research Strategies: Research has been defined as the generation of new knowledge and understandings. It is at the centre of the concept of a university. Research strategies can have both have an external orientation, such as commissioned projects and publications, and an internal focus on the needs of the institution itself.

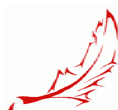
The answer to 'why the focus should be on HIV/AIDS' is multifaceted.

- New opportunities for funding are always coming to the fore.
- It cannot be doubted that HIV/AIDS constitutes a large problem for societies as a global emergency, which threatens gains in economic development and human dignity.
- Many of the problems created by the disease and the epidemic are interdisciplinary. Therefore they provide opportunities for working across disciplines, geographical institutions and types of institutions.
- New knowledge is crucial to our efforts at combating and managing the epidemic.
- New knowledge promotes human development, strengthens the university's engagement with the society which it serves, strengthens teaching, and can support the development of more informed and hence better policies.

Universities have a major stake in the global search for improved social, economic, and bio-medical understandings of HIV/AIDS. As institutions founded with a mandate to find and generate new knowledge, the ultimate aim must be that research efforts should contribute to a better and fuller understanding of the epidemic and improvements in the technologies needed for treatment, care, support and prevention.

Aside from the need for constant biomedical research within universities, there is also a need for well-conceived and up to date research on a host of legal, social, economic, ethical and other aspects of HIV/AIDS. Where the research does exist, it is of high quality. However, there are minimum existing means for sharing the information and its practical applications.

Should HIV/AIDS research programmes be expected to take off and be sustained, universities will need vigorous academic leadership and an intellectual culture that values research and its connections to what is taught. Attempting to create an ethos of curiosity



about HIV/AIDS is not something that can be enforced – it needs to grow from a process of intellectual engagement with the meaning and manifestations of the epidemic.

Internal Intelligence: The dimensions of the epidemic as an internal phenomenon are just as important research areas. A look at research issues, which have immediate relevance within individual institutions, may include the following:

- Do the staff and/or students hold religious, social or cultural beliefs that could possibly impede or facilitate efforts at prevention?
- What are the specific kinds of life skills training or sexuality education that work best for young adults between the ages of 18-25 as well as for older staff and students?
- What are the factors that affect women – specifically in societies where women are economically and socially subordinate and cannot negotiate sexual behaviour?
- Upon their arrival at university, what do the young adults know about HIV/AIDS?
- To what extent have the young individuals already been involved in unsafe sexual behaviour?
- What forms of awareness and education against HIV/AIDS have the individuals already been exposed to?
- Ways must be found to engage young adults about sexuality in social as well as cultural contexts where sexuality and sex are taboo and poorly understood.
- What is the impact that HIV/AIDS has had on the way in which the university conducts its business?
- It must be determined whether the epidemic has yet had an impact on the finances of the university.
- What are the effects that the epidemic has had on morale and workloads amongst the teaching staff?
- How receptive are local communities to the idea of universities advocating non-discrimination and public discussion of sexuality?

This internal intelligence allows for the possibility for the epidemic to be better understood. Apart from this, it also offers the possibility of anticipating what can be expected from students and staff when they are confronted with the actual reality of the epidemic.

Collaboration: Collaborative research is an extremely powerful tool that helps to overcome some of the constraints of funding and geography. With a network of approximately 500 institutions, the Commonwealth is in a unique position to foster and facilitate such collaborations. Partnerships around information sharing and fully collaborative teams are already well established in some areas but there is still ample room for growth opportunities. Within the context of the Commonwealth, those partnerships that bridge the north-south divide are extremely valuable. The challenge of disseminating research on HIV/AIDS in the education sector has been boosted by collaborative ventures such as the International Institute of Education Planning's (IIEP) information clearing-house on HIV/AIDS. Inter-university bodies and the Commonwealth Knowledge Network should be exploited as a means of strengthening institutional research capacity, attracting additional resources and disseminating information.

Opportunities: Universities are especially well equipped to have a primary impact on the most pressing health, social and economic issue in recent history. Researchers have the

advantages of institutional backing, access to infrastructure and knowledge networks that are unique to universities. The diversity and concentration of expertise within universities is also not found in many other institutions coupled with a spirit of intellectual openness and academic freedom. These factors make it easier to address HIV/AIDS, especially where ignorance and stigma come in abundance and where new approaches to prevention, care or treatment and support can provide a platform for advocacy and setting new standards. The availability of concentrated high-level skills within universities also makes them very important partners in programmes driven by government or other multi-lateral agencies. Their role in the shaping of the policy as the result of these partnerships is highly strategic.

Trends: Since the late 1990's the degree of change in new research on HIV/AIDS and education has picked up remarkably. Much of the available information has been generated by and for international agencies such as UNAIDS, the World Bank and development cooperation agencies. A cursory overview (2002) indicates that much of the focus continues to be on the African scenario which remains the most pressing in terms of the impact of HIV/AIDS, with a predominant focus on school level education rather than higher education. It is also important that, with a few exceptions, external agencies and not the universities themselves have commissioned the studies.

Writing from an African perspective on higher education, Kelly (2000) has argued the case for the need for universities to react. His analysis points to key shortcomings in their reactions to date. Institutional responses, even in countries that have been most visibly affected by the epidemic, are characterised by:

- A focus on deterrence rather than pro-active control.
- Less than perfect knowledge of the disease.
- Few, if any, attempts at integrating responses to HIV/AIDS into the centre functions of universities.
- A reluctance to treat HIV/AIDS as more than a health problem.
- Shame, silence, discrimination and denial.

Early in 2001, the South African Universities Vice Chancellors Association (SAUVCA) published its own analysis of institutional responses to HIV/AIDS in the South African university system, which encompasses 21 universities providing for approximately 330 000 students. Many of the arguments made by Kelly were confirmed but the report also reflected a range of significant, often small, and innovative approaches to the epidemic which have been made since the early 1990s (Chetty, 2000). The report argued strongly for the development of institutionally defined responses predicated on set minimum standards for prevention treatment, and care, towards which every institution should work and strive to maintain.

Community Engagement

In the face of HIV/AIDS, universities bear the responsibility to act with courage, imagination, authority and respect in the vision that they promote of scholarship, democratic citizenship, learning, economic and human development. In all of these dimensions, engagement is a central principle.

- Engagement strategy: There are several ways in which a university can bring their engagement strategy benefits – focused primarily on HIV/AIDS – to the institution

and the communities, whether they are political, educational or commercial, that they serve.

- Engagement need not necessarily be on a voluntary basis – universities can provide knowledge and training to youth and adults who may be willing and able to pay for such access.
- Universities cannot manage without being positioned in communities and engaging them in the life of the institution.
- The research community benefits especially from community engagement activities when opportunities arise from working with clinics, schools, etc.
- Community engagement initiatives provide excellent opportunities for students and staff to provide much needed services to communities, to engage their expertise in a realistic setting and to build a stronger basis for the mission of the university.
- Engagement with communities not only facilitates the identification of problems facing communities but also creates opportunities for working together toward solving them.

Experimental learning: Students who have little, if any, experience of the workplace or of being an adult responsible for the lives of others, are a major source of goodwill that can be made available to people who are living with HIV/AIDS. In the same way, engagement within the community can provide opportunities for people living with HIV/AIDS to take advantage of the resources and support which universities may be able to offer. Home-based care projects are able to provide an ideal source for this type of engagement.

Community engagement as advocacy: A commitment from universities to work with students, their families, communities and vulnerable populations will send a influential message to decision makers and ordinary people that universities do care; that they are prepared to lead in the battle against HIV/AIDS and that they will use their intellectual resources and authority in order to prevent the spread of the epidemic. Advocacy around HIV/AIDS has in some instances pitted academics and intellectuals against government policies, business practices in the health care industry and against one another in scientific and philosophical debates about the epidemic. These instances exemplify the university's role in promoting academic freedom, critique and the generation of new and alternative understandings. Engagement has the potential to expand academic freedom beyond the confines of the university and serve a wider mission.

GIPA – Greater Involvement of People Living with HIV/AIDS: Universities can and do set precedents that influence opinion makers and decision makers. Popular opinion and prejudice – as in the stigma attached to people with HIV/AIDS – often militates against intellectual argument but universities have the capacity to show that preventing the spread of HIV/AIDS is essential; that living with HIV/AIDS with dignity and without fear is possible and that universities are places of compassion and care. People living with HIV/AIDS who are supported by universities in their public disclosure are powerful beacons and need to be brought into the thinking and decision making process of institutional responses to HIV/AIDS.

When management begins to approach the issue of HIV/AIDS they often find themselves deep in controversy. Because it has to do with community values, religious beliefs, and customs, HIV education is a complex and sensitive subject. It involves talking about sex and also about death and dying. These topics may make many individuals feel uneasy. In

addition, although a continually growing body of research confirms how HIV is and is not transmitted, there continues to be a great deal of fear based in misinformation and mistrust.

Adolescents are considered a high-risk group for HIV/AIDS for three main reasons:

1. They are exploring their sexual identities and are often experimenting not only with sex but also with drugs;
2. Their behaviour tends to be impulsive and is to a large degree influenced by peer pressure; and
3. They often feel invulnerable and have trouble seeing the long-term consequences of their actions.

The goal of HIV education, according to Centres for Disease Control (CDC) guidelines (Dennis Tolsma et al.: 1988), is to prevent infection through behaviour changes. A successful method in which this can be done is through the moulding of the characteristics and perceptions of individuals who are or will be working directly with HIV/AIDS positive persons.

"The calls for new and sustained education efforts have generally been advanced for health professionals, mental health providers, nurses, medical students, social workers, psychologists, educators, and counsellors. Community leaders and public health education leaders have also been targeted." (Panter, A.T. et al.: 2000)

The study findings show that, across a varied set of HIV/AIDS training projects, trainee attributes are combined systematically with higher average ratings in training quality. Recognising the boundaries of self-reported documentation of trainee characteristics and apparent quality, the characteristics showing effects were ethnicity, age, professional credentials, primary involvement with HIV-positive individuals, comfort levels in treating HIV-positive individuals, and reason for taking the training. Factors that did not relate to training quality included gender and amount or extent of experience in the HIV/AIDS field. Although the effect sizes for these results were generally comparatively small, this study indicates that evaluations about how well a training experience served its purpose were incoherent across particular groups of trainees. It is valuable, when designing HIV/AIDS educational programmes, to pay special attention to the fact that some professional groups, such as doctors, will, on average, not perceive the training to be as practical and efficient as others, such as nurses, from the start. Thus, in these cases, the bar for these educational programs needs to be raised even further, so that excellence in providing HIV/AIDS training is achieved and so that opportunities for all trainees to benefit from the educational experiences are maximised.

According to the National Commission on AIDS (1994), a HIV education programme includes four components:

(a) Information,
(b) Exploration of personal values and attitudes,
(c) Access to services, and
(d) Skill building.

Therefore, programmes should focus instruction on high-risk behaviours and provide students with accurate, complete, relevant, and age-appropriate information regarding the

transmission of HIV infection, such as unprotected sex and intravenous drug use and preventing exposure to HIV infection. Programmes should also enable students to explore values and attitudes as a basis for developing responsibility for their own behaviours and health as well as those of others. HIV education programmes must also provide opportunities for students to develop positive behaviours and to practice interpersonal and social skills, such as decision making, communication, etc., that enable them to identify, avoid, escape, and/or manage high-risk situations.

A comprehensive schooling health education programme ideally would be integrated across the curriculum; that is, it should be an interdisciplinary programme ensuring that all students learn of all the ramifications of the disease.

It is important to remember that "comprehensive HIV education programmes need to be presented within the broader context of health education and family life curricula that address human relationships and that help to develop negotiation skills." (Prater, M.A. HIV Disease, 1995).

Case Studies – Distinct Disciplines

What follows is a brief review of the ways in which HIV/AIDS curricula has been integrated into a variety of courses. Naturally this list is not comprehensive, but is intended to offer ideas as to ways in which the subject can be creatively treated.

Many counsellors are not yet well informed regarding the intricacies of AIDS, as it is a 'relatively new' problem. According to Hoffman, AIDS education and training methods aren't being methodically incorporated in counselling curricula. It has also been suggested that preparation concerning AIDS should be offered as an ongoing and integral part of any graduate program in counselling (Campos et al., 1989; Gray, Cummins, Johnson, & Mason, 1989; Hoffman 1991).

Psychology

Ann R. Bristow (2000) stated that there are three related ways in which instructors can integrate HIV into the psychology curriculum:

1. "By using research findings as examples for course content already being covered,
2. By exploring diversity issues raised by HIV's presence in the world, and
3. By exercising students' critical thinking skills." (Bristow, Ann R. 2000)

Bristow indicated that there are many ways in which to integrate HIV issues into the psychology curriculum. At the very least, instructors can utilize HIV topics as well-placed examples of psychological issues, constructs, and theories. Education about HIV could naturally occur in every psychology course, although the most obvious psychological content areas for curricular infusion are substance use and abuse and sexual behaviour.

Practical suggestions given by Bristow deduced that "instructors should base discussions of HIV disease on available information about this epidemic and psychological science." (Bristow, Ann R. 2000). Should instructors not feel sufficiently prepared to teach about the

HIV disease, it is recommended that a good alternative would be to bring in outside speakers.

Faculty, unless they have support, tend not to change curriculum. Bristow stated several possible ways in which this support can be arranged:

1. "Conducting a departmental survey to find out how, when, and where colleagues are addressing HIV and AIDS in their courses,
2. Supervising independent studies integration projects for students who have completed a course, and
3. Including a service learning component in the course and developing an assignment in which students integrate the service learning activity with course content." (Bristow, Ann R. 2000)

Mental Health Professionals

To establish the attitudes and knowledge about AIDS of helping professionals (including nurses, social workers, psychologists and counsellors), numerous surveys have been carried out. "Every study of the attitudes and knowledge of nurses and nursing students towards AIDS pointed to the need for more education, both on an entry level and in continuing education." (House, Reese M, et al, Sep/Oct 1995) Most of the researchers acknowledged that successful education about AIDS issues requires an approach by which the input on attitudes with knowledge of facts is combined. Educational programs for the social work profession must be structured toward boosting social workers feelings of competence about working with people living with AIDS (PLWAs) as was concluded by various studies.

Social work schools need to take well-defined steps to enlighten social workers about AIDS as reported by the AIDS Task Force on Social Work Education (1988). This report and the article by Wexler (1989) called for AIDS content throughout undergraduate and graduate social work programs. St Lawrence et al. (1990) suggested that "professional psychology programs should be encouraged to examine their curricula and to provide training in areas specifically related to AIDS"

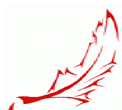
Turner evaluated the AIDS knowledge of mental health counsellors (1992). She found that their AIDS knowledge was generally high, but also found definite information gaps. She recommended that AIDS training be a prerequisite for obtaining licensure as a mental heath counsellor.

Training Models for Helping Professionals

Hoffman presented four training modules for future mental health counsellors that highlight methods to successfully assist specific populations, address ethical issues, examine the impact of AIDS issues on the counsellor, and focus on the psychosocial issues that interfere with HIV.

Dworkin and Pincu (1993), Allers and Katrin, Gray and House suggested a five-part model in order to prepare mental health counsellors to work with sexually active clients in the 1990's.

A 1989 survey of social work master's programs indicated that close to half (45%) offered no training in AIDS primary prevention and only 14% offered a full course on AIDS, and just



over one third incorporated AIDS topics into their established programs. Diaz and Kelly recommended a comprehensive AIDS curriculum for all social work students.

The aim of this study was to assess how counsellor programs in the United States train students in areas related to AIDS. Three key areas were addressed in the survey.

1. The first assessed the degree to which graduate counsellor education programs currently offer training in sexuality topics.
2. Second, the survey explored the extent to which programs integrate specific AIDS-training topics.
3. Third, the survey required information on the number of faculty and students currently carrying out research in topics relevant to AIDS, including dissertations, theses, and grant-funded projects.

42% of the responding programs reported that they offer separate courses in sexuality and respondents reported that the topic of AIDS was covered by 76% of these courses. When asked whether certain topics concerning sexuality should be included, AIDS was noted to have the highest rating with 95%. 30% of respondents reported that their programs provide graduate students with training concerning AIDS through discussion in course work or through issues that develop in internship or class settings, while several respondents commented that lack of time or space in their curricula restricted the development of an entire course on any topic. 86% of responding programs indicated that graduate students were encouraged to partake in workshops and classes related to AIDS outside their program. 50% of responding programs required their Masters students to compile a thesis, a total of 2,476, of which 61% focused on the topic of AIDS.

More than one third of counsellor education programs did not offer education in even the basic facts about AIDS. This lack of training suggests that many students entering the counselling profession may not be prepared to assist clients with AIDS-related issues. As the prevalence of AIDS increases, neither counsellor education nor counsellors can ignore its effect on society. By increasing the opportunities for the continuation of AIDS education for counselling faculties, counsellor educator skill and comfort levels will be greatly enhanced.

Changes in certification standards, joined with increasing demands from local and state agencies to include specific topics in counsellor education programs, cause programs to continually revise and expand their curricula. For those counsellor education programs able to offer a specific course pertaining to AIDS, counselling techniques such as problem solving, crisis intervention, encouragement, group and family therapy, and assessed skills specific to the HIV-positive population need to be included. "AIDS topics could easily be included for discussion in courses that address research, helping relationships, substance abuse, group work, appraisal, social and cultural foundations, family counselling, or ethical issues." (House, Reese M, et al, Sep/Oct 1995)

Guidelines

These guidelines arise out of the literature and are collated here in order to provide a summary of existing implementational research.

Living in a world affected by HIV/AIDS means that the needs of students and graduates and societies' requirements of them are being fundamentally changed. "It is only when this question of 'why teach HIV/AIDS' has been resolved that we can move onto a more sustained discussion about 'how we teach HIV/AIDS.'" (Association of Commonwealth Universities, April 2002). Guidelines that will be most successful in a particular course need to be extracted by the leader in order for the course to obtain its full potential.

Curriculum change: In the context of the curriculum policy and classroom, two dimensions of this issue are critically important. Providing skills, values and knowledge about HIV/AIDS through the curriculum has benefits that are both professional and personal.

The personal benefit comes from being informed (through whatever means are available) about how to understand HIV/AIDS, to reduce risk, how to avoid infection, manage living with HIV and how to act as a responsible citizen in a world affected by HIV/AIDS. Though there is some agreement on the need for this level of intervention, it is fair to say that the results are less than satisfactory.

The professional benefits to students and staff derive from being able to work effectively in an HIV/AIDS infected society. To do this the necessity of being aware of how HIV/AIDS affects their discipline, profession and world of work must be realised in order to be able, in turn, to deploy their professional expertise to the betterment of that society.

Formal or non-formal HIV/AIDS education programmes: Although there is widespread agreement that university curricula should in some way or form reflect the impact of HIV/AIDS on our comprehension of, and approach to, all disciplines, the mechanics of changing what is taught and how it is done so are less than straightforward. The range of options include the following:

- Provide education on HIV/AIDS through non-formal means as part of a prevention strategy, through means such as workshops, peer education programmes, etc. The skills gained in these activities could possibly lead to a career path, if formalised.
- Compulsory courses, which include HIV/AIDS issues within a life skills curriculum, should be implemented.
- Infuse issues of HIV/AIDS across the curriculum as both an academic requirement and as a prevention strategy.
- Core compulsory courses across all disciplines should be devised (academic and prevention requirement).

A choice between non-formal and formal approaches involves different considerations about resources, scale and time. Developing and accrediting a formal curriculum can take up to 18 months and inevitably involves some costs, depending on institutional processes.

If one should choose to follow the formal route, and depending on whether the defined purpose is to highlight the interaction between HIV/AIDS and each discipline area or to teach sexuality education (or a combination of the two) several questions may arise for the educator and curriculum planner:

- In terms of scale, should the approach being used reach across the institution from a central point or be driven by individual faculties?
- Is it the university who is responsible for the enforcement of compulsory education on HIV/AIDS?
- In what ways can one support the lecturers who are doing the work? What, if any, additional resources are available for them to develop new curricula?
- It must be remembered that university education is not compulsory and that students have choices – with this in mind, how would one reconcile this with a compulsory curriculum approach?
- How will the possibility that students simply learn the content by rote be avoided?
- What should be given up or done away with in order to make space for the learning of HIV/AIDS?
- As this may be seen as a course that is treated as an extra burden by educators, how is it possible to assure the quality teaching of the course?

Options of a non-formal kind are typically simpler to implement, cheaper, more flexible and offer the possibility of mobilising students, staff and communities in other ways. Despite these advantages, there are significant conceptual weaknesses and difficulties in pursing non-formal alternatives.

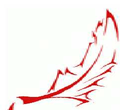
Distance Education: New distance education technologies and pedagogies now allow universities to reach a hugely expanded number and range of students. Existing distance education infrastructure using print materials or electronic media can be adapted so that the same technology and the pedagogical power of distance education can also be harnessed to address HIV/AIDS: to provide education and information on HIV/AIDS, to link distance learners to networks, to provide support services, and to reach new communities where learners are situated. However, there are substantial difficulties that distance also creates. Providing support and services to students at a distance continues to remain a challenge.

Teacher Education: Universities play an extremely important role in training teachers in many countries. However, the extent to which teacher education programmes reflect a world in which parents and children with HIV/AIDS are a reality, remains a matter of concern. It is obvious that teachers play a crucial role in reaching hundreds of young children on a daily basis and have the power and influence to shape positive attitudes with regards to HIV/AIDS.

The growing number of orphans, increasing social instability in poverty-affected communities and the loss of teachers has placed new burdens on schools that are already fragile structures. Within this context, debate has come to the fore about the role of the teacher and the role of the school.

- How feasible is it to expect teachers to take on the role of care-givers for orphans?
- Is it possible for teachers to realistically implement a life skills curriculum with minimal preparation and insufficient support?
- Can universities be expected to prepare teachers for these realities when they themselves are lacking the skills to analyse and respond to the epidemic?

Though the efficacy of teachers as a conduit of AIDS education is alleviated by a range of contextual factors, there is a case to be made for university based teacher education



faculties to recognize the urgency of including orphan response, life skills, counselling skills and other cross cutting HIV/AIDS issues in their programme structures and curriculum policies. The same faculties must make better use of the opportunities for research that their access to in service teachers and schools allows. The government, which is the primary provider of education services, is often constrained in developing countries in its ability to collect and analyse local level data and community level responses to HIV/AIDS. It is within this area that universities will fill a crucial need for improved information in support of policy and provide staff and students with first hand experience of the dynamics of the epidemic.

Teaching as advocacy: Academic freedom is an extremely powerful and influential tool for advocacy purposes when joined with the need to provide public information and to counter public denial, the need to promote the rights of individuals living with HIV/AIDS and to overcome public reluctance to testing. Students are able and willing to communicate these messages to a range of different audiences outside the institution through their research, work, and community outreach. In many ways, the classroom is the ideal place to encourage innovation, debate and action around HIV/AIDS.

Several additional generalised guidelines concerning AIDS education will aid in the successful implementation of the exercises and learning experiences. College educators have suggested that faculty should not use scare tactics and messages should be simple and concentrate on the positive. College instructors must be equipped to deal with the consequences of opening discussions about AIDS and sexuality. Faculty members need to supply information in a non-judgemental manner and allow students to ask questions. Many students are uncomfortable when talking explicitly about sex and may feel uneasy admitting that they do not know certain information, which they believe they should know. When asking for help or information, students may go through all the emotional strains that go along with asking for help, just as a client might.

Similarly, social work educators must be responsible and prepared to deal with the influence of this information on students. Sometimes students use such discussions as an opening to tell a faculty member that they are gay or lesbian, had a sexual relationship with an actual or suspected drug user, have a history with drugs, have a friend or relative who is HIV positive, or are HIV-infected themselves. All of these revelations may be threatening and overwhelming to the student, who must later face the faculty member in the classroom.

The faculty also need to be responsive to cultural diversity and the differential impact of AIDS on racial and ethnic groups (Lester and Saxon, 1988; Navarro, 1989). In certain college settings large numbers of inner-city Blacks or Hispanics have had extensive experience with AIDS. In such settings it is very likely that students will have personal experiences, which they may or may not wish to communicate in class. Such students may have concerns about their own health and have experienced loss among friends and family. Once on a college campus, these students are socially active and need truthful information about safer sex. All students need to understand the effects of AIDS in minority communities, cultural helping patterns and factors that may hamper prevention measures.

An added concern about respecting diversity occurs at colleges with religious affiliations. The public standpoint of certain religious organizations (Horrigan, 1988) may make

discussion of sex and sexual activities of students difficult. In settings such as these, campus-sponsored programmes may not be accessible or possible. The social work faculty, through their professional directive, has the opportunity to satisfy the need for AIDS education that might otherwise be ignored or avoided.

It is important that the provision of information about AIDS and minority groups, particularly among stigmatised groups such as gays or lesbians, prostitutes and drug abusers, does not reinforce the stereotyping of such groups. Society at large has used the AIDS epidemic as a means of mitigating oppression of certain individuals

As social work educators, the same skills and knowledge used with clients may be used with students. Confidentiality and a non-judgemental attitude are exceptionally valuable. Because the nature of the student-faculty relationship is not the same as the worker-client relationship, when the needs of the student surpass the bounds of this relationship, a faculty may have to assist the student to find desirable resources and services.

In order to establish which guidelines work best for specific programmes, research should be conducted on past, present, and possibly future theories and studies.

Guiding Principles

1. ***Make it matter***. Any integration of HIV/AIDS curriculum needs to be seamlessly incorporated into
    - Existing life experience and knowledge
    - The appropriate scope of the specific discipline – in line with the applicable year of study.

2. ***HIV burnout.*** It must be realised that by the time in which young adults enter into higher education, they have already been exposed to HIV/AIDS theories and prevention strategies from an early age. This often instils HIV/AIDS fatigue. This means that they are susceptible to the disease but immune to the remedy.

3. ***An early beginning.*** Research has shown that many students discontinue their studies after the successful or unsuccessful completion of their first year. If HIV/AIDS is added to the curriculum within the first year, or preferably the first semester, individuals are 'encouraged' to learn about the epidemic and thus the message is sure to be spread more evenly throughout the faculties. Moreover, inculcation requires a sustained and increasingly sophisticated implementation throughout the course.

4. ***Hire expertise.*** Existing staff have to be trained up to incorporate HIV/AIDS in a way that is non-threatening both to the student and to the staff member. This may mean additional resources being employed to train the trainer.

5. ***Network.*** For HIV/AIDS inculcation to be effective requires the breakdown of departmental insularity. Philosophy, for example, needs to communicate/integrate with medicine (who in turn…) in order to produce a vibrant HIV/AIDS network.

6. ***HIV potentialities.*** It is no longer sufficient to understand and transfer existing knowledge regarding HIV/AIDS. For powerful dissemination to occur requires that the existing curriculum is opened up to innovative branches within the given discipline. For the combating of HIV/AIDS to take place will need the student to push the boundaries of knowledge back.

7. ***Systemic implementation.*** A one-dimensional integration of HIV/AIDS will inevitably ignore cultural, racial and ethnic sub cultural needs. A multi-dimensional approach necessitates a holistic understanding of the discipline.

8. ***Make it real.*** The formation of a critical citizenry needs a practical component that sensitises management, staff and students to the plight and the daily complexity of the sufferer. It is imperative that the student is not alienated from the reality of the condition.

9. ***Update.*** Lecturers must be given the freedom to negotiate with students a course that is pertinent and contemporary. The radical transmutations of the pandemic together with an ever changing cultural influences make it necessary to have a course that addresses the HIV/AIDS constants as well as the break-throughs in research and cultural reconfigurations of the disease.

10. ***Analyse the ideology.*** Irrespective of discipline, it is necessary to interrogate the theoretical assumptions underpinning HIV/AIDS. Only via this analysis will it be possible for students and staff to examine critically the assumptions under which they are working.

11. ***Cascade knowledge.*** Empowering the students to empower themselves and others is in a sense a reward of its own. Such as in the case of a affirmative pyramid scheme, one student, in the future, will, after being guided by his/her lecturer, in turn guide numerous other individuals in such a way that a cascading revolution of knowledge can occur. Students also need to be made to realize that their actions in the present could have long-lasting effects for the future, such as experimenting with drugs.

12. ***Cutting edge.*** Keeping up-to-date with current and advancing research allows new ideas for both the lecturer and the student. This could help to eliminate the repetitiveness of the epidemic that so many individuals feels exists. Knowledge is power and teaching or being taught the same thing year after year can limit the wisdom needed for the successful implementation of the epidemic.

13. ***Supervision.*** Universities need to monitor the students' levels of interest in the course in order to determine whether the interest in the epidemic is at an incline or decline and this may indicate specific parts of the course that need re-evaluation and perhaps change.

14. ***Keeping an open mind.*** Although the disease triggers many deeply rooted feelings within the individual, it must be realised, especially for the lecturer, that open-mindedness is important. Allowing for different opinions, even if they differ with one's

own, can help to break down the limitations, which are often caused by the individuals themselves.

15. ***Encourage growth.*** It must be kept in mind that within the Higher Education environment, many of the students, for the first time are being allowed to freely make their own decisions. This individuality and growth should be encouraged. However, students should know that they are now young adults, and have heightened responsibilities towards themselves as well as others.

16. ***Educational tactics.*** Research has shown that the use of scare tactics within the teaching of HIV/AIDS has a negative impact on students. Providing students with realistic information about the epidemic coupled with pertinent facts requires and encourages students to formulate their own ideas and opinions.

Practical Recommendations & Ways Forward

While there is cognitive support for the importance of HIV/AIDS in Southern Africa among higher education institutions it does not follow that implementation of HIV/AIDS into the curricula will be effortless. The demographic of South Africa's professoriate is skewed towards middle-aged (and aging) white male academics. There is no question that this majority are intellectually sensitive to the pandemic. What is less evident is whether this grouping has the grass roots understanding to make implementation an urgent and practical reality. The Ministry's National Plan for Higher Education (NPHE), together with existing Labour Law are presently attempting to redress this demographic profile but it is foreseeable that racial and sexual equity will not be achieved in the short term. With this in mind, the following recommendations will seek to negotiate a practical way forward.

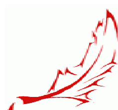
Nevertheless higher education has to signal its commitment not only to wealth creation but to the preservation of society's future well being. Even if the implementation of HIV/AIDS curricula is incremental and gradual, the institution must show its commitment to becoming a flagship for HIV/AIDS education and research within society.

The proposed approaches must be conducted systemically, addressing, simultaneously, institutional management, the staff-student interface and peer education interventions.

1. ***Conduct a comprehensive audit of existing HIV/AIDS courses present in the curriculum.*** The HEAAIDS office would need to conduct a rigorous assessment, across institutions, of:
    - Related research
    - Appropriate courses and at what level
    - Peer education

   This information needs to be collated into a working database of resources and updated on a regular basis.

2. ***Start at the top.*** Senior management needs to internalise both emotionally and cognitively the extent of the pandemic. This would necessitate a hard-hitting programme aimed at senior management and which attempts to bring home the



epidemic in a way that connects in a series of psychological, intellectual and emotive ways. The project objective is to achieve emphatic buy-in that can be passed down and through the institution.

3. ***A negotiated curriculum.*** As a central organisation, HEAAIDS can play a formative role in coordinating, disseminating and assisting in the implementation of a generic framework with guideline that can be used by departments in order to flesh out curriculum opportunities. These guidelines would allow the department concerned to begin to think constructively about aspects of the epidemic that can be inculcated in a relevant manner. It is hoped that the 'personalising' of these guidelines would integrate with staff research interests as well as student relevance.

4. ***HEAAIDS as network.*** While this task is daunting, HEAAIDS is perfectly placed to act as a Network Hub that coordinates institutional interests and missions in order to establish vibrant networks of connectivity across department, faculties and institutions. Using as its resource material the audited database, HEAAIDS would dedicate resources to linking staff across the spectrum of the sector in order to assist in shaping research projects, offering available support and coordinating curricula development. This hub could also extend its reach across the divide that presently separates the university from the technikon and further towards bridging South African institutions with SADC counterparts as well as tapping into the rich resources of international partner organisations.

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