HIV and AIDS in Teacher Education

Evaluation Report of a Pilot Project in South African Higher Education Institutions

HEAIDS

HIGHER EDUCATION HIV/AIDS PROGRAMME

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Contents

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ACE	Advanced Certificate in Education
ACU	Association of Commonwealth Universities
CHE	Council of Higher Education
CPTD	Continuing Professional Teacher Development
CTP	Committee of Technikon Principals
DoE	Department of Education
EC	European Community
EU	European Union
EDF	Education Deans' Forum
HEI	Higher Education Institution
HEAIDS	Higher Education HIV and AIDS Programme
HESA	Higher Education of South Africa
HIV	Human Immunodeficiency Virus
NQF	National Qualifications Framework
NPDE	National Professional Diploma in Education
OCF	Online Collaborative Forum
OVC	rphans and Vulnerable Children
PCU	Programme Coordinating Unit (HEAIDS)
PGCE	Postgraduate Certificate in Education
PLWHA	People living with HIV and AIDS
PWG	Programme Working Group (HEAIDS)
SAIDE	South African Institute for Distance Education
SASA	South African Schools Act
SAQA	South African Qualifications Authority
SAUVCA	South African Vice-Chancellors' Association
STI	Sexually Transmitted Infection
UN	United Nations
UNGEI	United Nations Girls' Education Initiative
USAID	United States Agency of International Development
VCT	Voluntary Counselling and Testing
USAID	United States Agency of International Development

Executive Summary

INTRODUCTION

The HIV and Teacher Education Pilot Project was initiated under HEAIDS Phase 2 and was premised on the critical importance of the capacity of the education and training system to deal with the challenges posed by teaching and learning in an HIV/AIDS affected and infected society. The objective of this project was to ensure sector-wide engagement with these challenges, and to provide the necessary support and resources for the development of educators who are equipped to deal effectively with the HIV/AIDS epidemic and its impact as it manifests in their work environment, and on their personal and community lives. More specifically, the purpose was to enhance the personal and professional competencies of teacher education graduates through:

- the provision of support for the piloting of an HIV/AIDS teacher education module in teacher education faculties, and
- the identification, evaluation and dissemination of effective strategies for incorporation of HIV/AIDS related education into teacher education and other curricula.

The story of the HIV and Teacher Education Pilot Project and its evaluation pivots around the development of a Learning Guide – *Being a teacher in the context of HIV/AIDS* – and the Reader that accompanies it. These materials represent updated versions of earlier materials originally developed under HEAIDS Phase 1 to support the core module on HIV/AIDS in pre- and in-service professional teacher education qualifications up to National Qualifications Framework (NQF) Level 6. The materials cover the minimum competences to be achieved by all qualifying educators across all phases of schooling and all learning areas.

Guided by the HEAIDS Programme Co-ordinating Unit (PCU) and the Programme Working Group (PWG), and endorsed and supported by the Education Deans' Forum (EDF), the project commenced on 9 October 2007. Against the background of strong institutional autonomy, the HIV Pilot Project could justifiably be seen as a unique intervention in teacher education (if not in the broader HE sector). A flexible methodology for implementation was accordingly developed to provide a framework and support mechanism which would promote the necessary institutional 'buy in' whilst not being overly prescriptive. This methodology was further informed by a literature review and a situational analysis carried out between mid-December 2007 and early March 2008.

As a result, institutions were offered four curriculum options as a basis for participation in the project:

- **Option 1:** Evaluation support for existing activity;
- **Option 2:** Piloting the HEAIDS module;
- **Option 3:** Curricular adaptation (the 'bolting-on' of the module or component parts of the module onto a single existing module); and
- **Option 4:** Cross curricular integration into more than one existing module.

The pilot module was ultimately implemented in 27 pre-service and in-service teacher education programmes on 25 sites in 21[1] Higher Education Institutions (HEIs) A total of 6 485 pre-service and in-service teachers benefited from the module offered in 23 programmes in 2008, and in a further four which commenced in 2009. Nationally, implementation was supported by:

- The provision of a learning guide and reader to the pre-service and in-service teachers;
- Provision of a laptop, lcd projector and screen at 23 sites;
- The appointment of student interns at 23 sites;
- An electronic information resource called the On-line Collaborative Forum (OCF), in which training was offered to 68 academics; and
- Regional Support Experts from the implementing team responsible for liaison and support at each HEI, and Key Experts in the fields of teacher education, curriculum, evaluation, and teacher support and development.

The support of the implementing team was crucial, but the learning guide and reader were fundamental to implementation.

In terms of sheer numbers and representivity the project thus provides a powerful base for evaluation. A good range of pre-service and in-service teacher programmes was also represented in HEIs' offerings, with the in-service National Professional Diploma in Education (NPDE) programmes bringing adequate representation of the rural voice. In addition, HEIs' curriculum choices reflect a balance of the most useful choices from an evaluation perspective: in 12 programmes, the full module was offered in stand-alone form, and in 14 it was integrated into existing modules. This provides the basis for meaningful comparison between the relative effectiveness of the two major curriculum strategies for offering HIV/AIDS education.

LITERATURE STUDY

An extensive literature review situates the Pilot Module on HIV/AIDS and its evaluation within an analysis of how HIV/AIDS is being addressed in teacher education at the local level, and within the context of regional and international literature on addressing HIV/AIDS in Teacher Education. It also contextualises the work on curriculum integration within the broader area of Higher Education.

Much of the literature is recent. Interventions in higher education are seen to be infrequent and uncoordinated, with few institutions having policies and frameworks concerning HIV/AIDS. Many of the case studies conducted in higher education institutions show that pre-service and in-service teachers are more active in HIV/AIDS response initiatives than members of staff. This would suggest that the bulk of initiatives are extra-curricular rather than curricular in nature. At the heart of 'across the curriculum' integration is the fact that there is a paucity of literature on the 'how to' of curriculum integration. The literature also points to a paucity of evaluation studies.

Several key areas informed the Pilot Module and teacher development in the area of HIV/AIDS:

- The significance of instructors' own self-knowledge and how they engage with HIV/AIDS (through reflexivity and self-study), and the need for ongoing professional support;
- Participatory methodologies and pre-service and in-service teacher engagement;
- Flexibility, multiple modes of delivery and differentiated curricula;
- Collaborations (for example, team teaching) and partnerships;
- Greater support for curriculum integration; and
- Interrelatedness of curriculum (design, planning, evaluation) and up-to-date knowledge in the area of HIV/AIDS.

METHODOLOGY

The project plan envisaged a dual focus on methodology:

- The participating HEIs would be encouraged to provide an account of the module from their own perspective; and

- The implementing team would monitor and evaluate each module as rigorously as possible, using standardised instruments to allow for the integration of individual experiences into a coherent overall evaluative account of the pilot in a way that could inform future practice.

The Education Deans Forum (EDF) meeting on 7 November 2007 expressed the view that implementation would not be possible before 2009. An unintended consequence of good project 'take up' by HEIs – as seen above – was that it led to a disjunction between the planned and actual implementation schedule. This had major implications for the scope of institutional preparedness and evaluation activity. By the time the necessary ethical approvals for evaluation had been obtained and the Evaluation Model had been formally presented to the sector (at the second National Colloquium on 22–23 September 2008), implementation had not only commenced in the majority of HEIs, in some it had already been completed. With different curriculum options being implemented earlier than anticipated, standardised, formulaic evaluation practices were difficult and sometimes inappropriate in individual HEIs. The baseline questionnaire was particularly compromised by excellent project 'take up'. Significant HEI differences affecting evaluation included:

- outcomes addressed;
- selection of content;
- the nature of the programme (pre-service or in-service);
- teaching time and notional study hours allocated to the module; and
- the qualifications and experience of module presenters.

Activities associated with Inputs, Outputs and Outcomes provided the theoretical underpinning for evaluation. A 'mixed methods' design was drawn from the literature as a "procedure for collecting, analysing and 'mixing' both quantitative and qualitative at some stage of the research process within a single study to understand a research problem more completely". (Creswell and Clark 2007, p.5) Pragmatism, necessary under the circumstances, is the overarching paradigm in mixed methods studies to serve purposes beyond triangulation so as to include the convergence of results across qualitative and quantitative methods.

Correct procedures were observed with respect to protocols for ethical approval and confidentiality in matters of evaluation. Extensive evaluation activity was then carried out.

Where possible, evaluation at each HEI included an analysis of pre-service and in-service teachers' assessments and the routine internal module evaluations conducted by some HEIs as part of their own quality assurance processes.

In analysing data, SPSS software was used with the quantitative questionnaire data to generate descriptive statistics presented in graphs, and complemented by an interpretation of the results.

All interviews were audio recorded and then transcribed. Analyses of the three forms of interviews were conducted by members of the implementing team in relation to the specific HEIs for which they were responsible. Tesch's open-coding method (Creswell 1994) was applied to identify emerging themes and categories. Both sensitising concepts (theoretical concepts that framed the interpretation) and indigenous concepts (those that arose directly from the qualitative data) were used to identify themes relating to competence and curriculum issues. Themes relating to curriculum were informed by three perspectives: a socio-ecological perspective, an inclusive education perspective and 'health-promotion in schools' perspective. Themes relating to competence were informed by a model of professional competence in the age of HIV/AIDS. Analysis was both deductive and inductive. (Merriam 2008) A further layer of meaning in working with the qualitative data was added through the use of anecdote (and conecdote or connected pieces); as well as polyvocal fictional narratives, and composite stories and letters. (Table 4)

FRAMING THE FINDINGS: THEORETICAL PERSPECTIVES ON CURRICULUM DESIGN, IMPLEMENTATON AND IMPACT

This chapter maps out the theoretical underpinning of the work in order to frame the presentation of findings offered in Chapter 5.

Curriculum-in-use

Curriculum-in-use (actual day-to-day interactions among lecturers, pre-service and in-service teachers, content) frames the findings related to curriculum design and implementation. It is premised on three perspectives:

- The *socio-ecological*
- The *health promotional*
- The *inclusive education*

Curriculum impact

Curriculum impact frames a model of professional competence in the age of AIDS by foregrounding three broad areas:

- Teacher roles (prevention agent; caregiver, leader/ role model);
- teacher sensitivities (awareness of vulnerable learners and colleagues; gender issues; cultural heritage, contextual assets and constraints); and
- teacher agency (willingness to reflect and act).

EVALUATION FINDINGS

This chapter presents an overview of the collated reports on nineteen individual accounts of the pilot in each of the HEIs. These reports were based on interview data gathered from staff and pre-service and in-service teachers as well as data from the pre-test and post-test questionnaires administered to them. The chapter also integrates:

- The experience and perceptions of implementing staff prior to implementation;
- HEIs' judgments on the implementation of the module; and
- Evaluations of three national colloquia held in April 2008, September 2008, and May 2009.

These integrated findings are presented in two sections:

- *Curriculum;* and
- *Competence*.

Findings, as reported here, are necessarily summarised accounts.

Evaluation of Pilot Experiences: Curriculum

Broadly, the same pilot module outcomes were applied across these institutions, but the content and skills emphasised differed in response to the widely differing target audiences and the constraints/opportunities of the programmes into which the module was integrated. Emergent themes are discussed under eight curriculum categories.

Content and outcomes

The module had given pre-service and in-service teachers new insights into HIV/AIDS and a sense of empowerment through knowledge. It is clear that attitudinal and behavioural changes will need to be nurtured over time if they are to result in permanent change. The module needs to be supplemented with phase-specific practical teaching approaches.

Materials

Pre-service and in-service teachers generally felt that the materials were accessible and relevant to their needs, especially in terms of providing a lived experience of HIV/AIDS. Lecturers felt they had learned more about HIV/AIDS through engaging with the materials and, further, that the particular *pedagogical approach* used in them enhanced active learning in their pre-service and in-service teachers and their engagement through participative processes. While the materials were generally seen as comprehensive, some specific gaps were identified which should be addressed either in adaptation as part of course design, or in a revision of the core materials.

Table 1 Summary of evaluation instruments and activity

Instrument	Population	Purpose	No. of Respondents
'Situating ourselves' questionnaire	Academic staff	Elicit an account of teacher educators' perceptions and experiences of their work in HIV/AIDS education prior to implementation of the pilot module	75 (45 academics; 30 tutors)
HEIs' questionnaire	Unit offering the module	Capture detail and reflections on their own experience of implementing and completing the HIV module	19
Baseline and Post-test Questionnaire	Pre-service and in-service teachers doing the module	Provide a comparative pre- and post-test view of pre-service and in-service teachers' knowledge on: HIV/AIDS-related biomedical knowledge; the degree of their HIV/AIDS-related activity/activism; the nature of their gender-related and other relevant discriminatory attitudes in relation to HIV/AIDS	2746 (Baseline responses) 2075 (Post-test responses)
Focus group interviews	Pre-service and in-service teachers who had completed the module	Elicit responses from pre-service and in-service teachers to HIV/AIDS scenarios in classrooms; reflection on the module; views of the way forward	192 in 21 focus groups
Individual interviews with pre-service and in-service teachers	Pre-service and in-service teachers who had completed the module	Reflections on pre-service and in-service teachers' knowledge, perceptions and attitudes before, during and after the module	99
Interviews with implementing staff	Academic staff/ tutors	Reflections on the module (the materials and support; pre-service and in-service teachers' learning; problems and successes; what should be done differently, and the way forward)	48
Evaluation questionnaires on Colloquia	Participating staff and interns after each of three colloquia	Monitor and evaluate the effectiveness of the three colloquia in introducing, supporting and evaluating the pilot	*Colloquium I* 22 responses (all academics) *Colloquium II* 36 responses (25 academics and 11 interns) *Colloquium III* 19 responses (17 academics and 2 interns)

Course Structure

Key themes related to the option selected, *programmes and learning areas* into which the module was integrated, and how much time could be devoted to the module within different pilot options and when in the year it could best be taught. Further research is required on this issue. There were more compelling suggestions that the materials were not entirely commensurate with the academic level required for more senior groups, such as the Post Graduate Certificate in Education (PGCE).

Target audience

The target audience for the module was very broad, consisting of pre- and in-service teachers. This included those training to teach at different phases, younger and older people – some rural and some urban – but most significantly, of pre-service and in-service teachers with considerable lived experience of HIV/AIDS.

Pedagogy

It is clear that a number of institutions engaged in a variety of participatory, experiential and active learning methods which had beneficial effects on their pre-service and/or in-service teachers not only in terms of the development of *understanding* of HIV/AIDS issues but also, and perhaps most importantly, in terms of relationship sensitivities, *mutual support and ownership of the issues involved*. Classes with large numbers of pre-service and/or in-service teachers constituted the main *difficulty* in using these methods. However, a number of creative ways of *resolving* it were identified.

Key findings are:

- Effective teaching of HIV/AIDS must be participative and relationship-based. *Experiential learning* is critical, particularly for pre-service and in-service teachers with little lived experience of HIV/AIDS.
- *A combination of active learning methods* is most effective in HIV/AIDS teaching.

Assessment

While the extent of assessment differed widely across institutions, four distinct *forms* of assessment emerged, all of which were both creative and *effective*.

- Assignments that get pre-service and in-service teachers to engage with the materials.
- Assignments that require school-based research.
- Assignments that require lesson planning or a critique of HIV/AIDS related lessons.
- Assignments that require reflection on experiential learning such as, for example, a visit to an AIDS centre.

Used singly or in combination, these forms of assessment represent effective ways of assessing pre-service and in-service teacher achievement in the module. *Difficulties* were no different to those experienced in the assessment of any other content area.

Personnel/implementing staff

Most of the staff members involved, both tutors and lecturers, were not qualified in a formal way to offer the module, but their enthusiasm and commitment led them to seek out professional development opportunities, including involvement in the pilot. The people who are attracted to work in this area need, value and benefit from support and professional development. These came not only from the implementing team, the materials, and the OCF, but from being part of the community of practice that was established through the Colloquia.

In cases where suitably qualified interns were appointed in good time and fully integrated in the offering of the module, they were an extremely valuable resource.

Use of technology

Despite generally positive support for the OCF from the HEIs, the potential of the OCF to support pedagogy was not realised during this pilot predominately because of *lack of time and access.*

Evaluation of Pilot Experiences: Competence

As was the case in the 19 individual institutional evaluations from which it was condensed, principal evaluative findings in relation to the growth or enhancement of pre-service and/or in-service teachers' professional competence and practice do not present an absolute conclusion about *actual* growth of competence. The summative evaluation documents pre-service and in-service teacher and lecturer views of *perceived* competence and draws out lessons of experience in *terms of these perceptions.*

Qualitative findings

Awareness of Context

Both *in-service* and *pre-service* teachers showed a heightened awareness that HIV/AIDS affects everyone indiscriminately. While in-service teachers tended to have extensive lived experience of the effects of the pandemic, this contrasted with many of the pre-service teachers who had not yet been directly affected by it. The personal background of most of the *pre-service* and in-service teachers had an impact on their understanding of the reality of HIV/AIDS and how it could be addressed from an educational perspective.

Preventative agent

Teachers are obligated by policy to provide prevention education and to prevent any learner from being stigmatised or discriminated against. Both in-service and *pre-service* teacher narratives in this pilot show that they have unanimously accepted this role and are aware of the challenges and opportunities of being agents of social change. All pre-service and in-service teachers showed:

- Awareness of the importance of prevention education;

- Awareness of the challenges prevention education poses; and
- A belief that prevention education is not just limited to the classroom.

The sense of agency and commitment developed in the pre-service and in-service teachers in relation to promoting and teaching preventative practices, whether in the classroom or the community, was strong. Most of the pre-service and in-service teachers thought they were well informed about the facts of HIV transmission and the socio-cultural contexts and so would be able to teach relevant issues. This perception was not always supported by the quantitative results which highlighted many instances of pre-service and in-service teachers not knowing the facts.

In terms of the challenges facing them as preventative agents, *pre-service* teachers were skeptical about their potential impact because of perceived learner apathy as well as having reservations about the legitimacy they would be perceived to have in the community. They were realistic about the task of achieving behaviour change, realising that it would not be easy and would take commitment from them. Generally, they felt uncomfortable addressing sexuality related issues, thus emphasising the need for teachers to consider their identity in relation to their sexuality as well as their position on teaching sexuality related issues.

In comparison, in-service teachers did not display the reservations voiced by the pre-service teachers. They felt empowered by the pilot module, which served to remove any fears they had had previously about conducting HIV prevention education.

Caregiver role

Both *in-service* and *pre-service* teachers indicated a strong commitment to provide a caring environment for learners. They were of the opinion that caregiving is vital to protecting the quality of teaching and learning and they indicated that, should they be unable to support the learner adequately, the help of other professionals (psychologists, counsellors, social workers) or the school principal would be enlisted.

The main difference between the pre-service and in-service teachers was that many in-service teachers had had real experience of acting out the role of caregiver, and they gave many examples of the care and support they had provided. Generally, *pre-service* teachers expressed a greater degree of inadequacy. However they did also think that they could provide practical support, create a warm and caring environment and refer to specialists. They talked about involving parents as well, but showed little awareness that many of the children may not have parents, or be living with caregivers who were not that concerned about their emotional needs.

There were also several references amongst *pre-service* and *in-service* teachers to the added burden that the caregiving role places on teachers, and while willing to take it on, there was concern that they would not be able to cope because of the extra time needed as well as the added responsibility. Amongst pre-service teachers, it appeared that the anticipated counselling role was a challenge for them and they felt that they had not been prepared for it, although they did feel able to offer informal support.

Collegial sensitivity

In the light of their little or no experience in actual teaching and interacting with colleagues, *pre-service* teachers did not touch on this aspect of competence. Amongst the *in-service* teachers, there was little mention of colleagues who might be infected/affected, but there were several references to the ignorance of colleagues and their resistance to teach about HIV/AIDS.

Reflexivity

On a personal level, there were various instances of *pre-service* teachers stating that the pilot had made them more aware of their own attitudes, beliefs and behaviour in relation to HIV/AIDS. Casual sex without consideration of HIV infection had become unacceptable to many, and they were willing to confront their friends about this, which implies reflection about their own sexual behaviour. Some of these pre-service teachers, both male and female, indicated that it was difficult to limit themselves to one partner, but they

had begun to think more deeply about their sexual behaviour as well as their values and attitudes.

The *in-service* teachers also indicated that they had thought more deeply about their behaviour since doing the module and many of them mentioned that they now intended to get tested.

Leadership

The responses of the *pre-service* teachers indicated that they had begun to think about this role and the responsibilities it brought. This included knowing their status and behaving in a responsible way. They felt that communities looked to them for leadership. In-service teachers were also aware that they had to be role-models, but in a more concrete way.

Both *pre-service* and *in-service* teachers expressed concern that they were not sure how to overcome resistance on the part of colleagues and principals, as well as parents and SGB members.

Quantitative findings

Biomedical HIV/AIDS knowledge

By the end of the pilot, there was an increase in the biomedical HIV/AIDS knowledge of the pre-service and in-service teachers. The average increase across the whole matched sample, and across phases, was from 7.94 to 9.16 correct answers out of 15. Even those institutions in which pre-service and in-service teachers scored highly in the pre-test, showed some improvement in the number of questions answered correctly in the post test. (For example, in one institution there was an average increase from 9.11 to 9.59 correct answers.) Substantial improvement occurred in items which required more technical knowledge which the pre-service and in-service teachers had not had to begin with.

HIV/AIDS related activities

There was also an increase in the numbers of HIV/AIDS related activities performed by pre-service and in-service teachers – an increase of 3.12 to 5.3 activities out of 10 performed on average across the sample. In particular, the pilot stimulated HIV/AIDS-related discussion not only within the institutions, but in their family and friendship circles.

Discrimination against people living with HIV/AIDS

Overall, there was little or no change in pre-service and in-service teachers' *gender attitudes* between the beginning and the end of the pilot, nor in the extent to which they were likely to *discriminate against people living with HIV/AIDS*. Their attitudes were generally aligned with those in the module from the outset. When female and male responses are compared, female responses are more aligned than those of males. In the responses to some of the gender related statements, there is an indication that, even at the end of the pilot, male dominance in the home and in sexual relationships is endorsed

Confidence in relation to professional practice

By the end of the pilot, pre-service and in-service teachers' confidence in relation to professional practice had increased, but trends are variable across institutions, and for different phases. For the sample as a whole, the greatest increase in confidence was in relation to integrating HIV/AIDS into the curriculum as well as providing learners with HIV/AIDS information.

CONCLUSIONS AND LESSONS OF EXPERIENCE

This chapter synthesises conclusions drawn from the findings regarding the successes, failures and/or limitations of the pilot module. Conclusions are used to identify *lessons of experience* which can inform on-going development and refinement of the module. Since an Executive Summary does not provide scope for developing and elaborating on the line of argument between findings, conclusions and lessons of experience, the focus here privileges the latter. Lessons of

experience are particularly mindful of distinctions between:

- Pre-service and in-service teachers; and
- Those with lived experience of HIV/AIDS, and those with little or no lived experience.

Where a point relates primarily to lecturing staff rather than to pre-service and in-service teachers, this is indicated.

Curriculum design and implementation – strategies for incorporation of HIV/AIDS related education into teacher education

A distinctive feature of this project has been the wide variety of ways in which institutions incorporated the module and materials into the curriculum of existing teacher education programmes. Institutions made choices about:

- Whether to offer the module as a stand-alone, as part of an existing module, or whether to integrate it across a number of modules (cross-curricular integration);
- The disciplinary area into which the module would be incorporated;
- The intended outcomes;
- Methods of assessing achievement of the outcomes;
- In the light of a particular target audience, how to use and adapt the materials, and when and how to teach the module;
- Who would teach the module; and
- How they would engage with the broader project through the OCF and the Colloquia.

This sub-section summarises the lessons of experience in relation to the adaptation of the module and materials as a necessary part of effective curriculum design and implementation.

Content and outcomes in the module and the materials

- Even if there is a particular focus on one or two of the outcomes, or on one or two of the units of the materials, adaptations must take cognisance of the fact that a curriculum for HIV/AIDS has three perspectives – socio-ecological, health promotion and inclusive education, and that each of these needs to be acknowledged and integrated.
- School-based work on HIV/AIDS is critical if pre-service and in-service teachers are going to be able to practise what they have learned in professional settings.
- Attitude and behaviour change need a longer process than simply exposure to a single module that varies in length from a six hour workshop to a semester-long course.
- The way that the personal and professional have to come together in teaching HIV/AIDS means that it is critical to use approaches which allow for pre-service and in-service teachers and their learners to contribute from their personal experience. At the same time, however, this is threatening, and often the use of other people's experience (case studies) or other media, such as the visual, assist.
- More opportunity needs to be given to discussion about how to treat HIV/AIDS in ways that are sensitive to the needs of learners in different phases – either in the materials themselves, or in the mediation of the materials in teacher education programmes.
- The almost universal cry for more help with counselling needs to be addressed either in the materials or in the mediation of these materials through the courses.
- HIV/AIDS is not simply an 'issue' to be taught. The content and pedagogy required for treating HIV/AIDS in appropriate ways assists with understanding of education and teaching more broadly.
- The materials need to be enhanced with case studies and/or visual material that position the variety of in-service and pre-service teacher target audiences as affected by HIV/AIDS.

Course structure

- The content of HIV/AIDS requires a 'home' – either in an existing module, or in a stand- alone module. This provides a base from which cross-curricular integration can be done successfully. The stand-alone option is preferable in that it provides more time for

adequate addressing of all the outcomes, but it may not be possible in certain programmes (such as the PGCE). With good planning, however, the time problems can be addressed to some extent, even when the module is 'bolted on' to existing modules.

- Since the choice of a learning area will result in different emphases in the curriculum of the HIV/AIDS module, more careful thought needs to be given to this. Delivery seems to have been most successful where institutions made context-specific adaptations to the HEAIDS module. Many of the modules demonstrate the effectiveness of the HEAIDS materials to support development of HIV education skills, knowledge and agency when used in conjunction with a pedagogic framework developed by university lecturers to suit the needs of their particular pre-service and in-service teacher contexts.

Pedagogy

- Successful pilots were characterised by the use of a combination of methods, tailored to the specific target audience, and by enabling open discussion from varied life experiences.
- The integration of student- led campus-wide peer educator or research projects into the delivery of the HIV/AIDS module facilitates uptake not only of prevention messages, but also of innovative teaching approaches.

Assessment

- Pre-service and in-service teachers with life experience of HIV/AIDS as well as those with little or none need to be assigned tasks involving authentic experiences in the communities mostly affected by the epidemic so that they can learn from these and 'make a difference' in the lives of those affected and/or infected.

Staffing and support

- There is a need for professional development programmes to support implementing staff to address such issues as socio-cultural beliefs about HIV-related issues (sex, condoms, sexual orientation and so on) or provide more in-depth understanding of the social and educational issues around HIV/AIDS.
- The emotionally taxing character of HIV/AIDS related education suggests the need for the provision of counselling services within the institutions and training in counselling skills for lecturers as well as pre-service and in-service teachers in preparation for their own classrooms.
- The employment of tutors can enable effective delivery of the module to large numbers of pre-service and in-service teachers, but these tutors need initial training and ongoing support.
- Because lecturers/tutors teaching in this area are often unsupported within their institutions and do not have HIV/AIDS specific training, it is important to establish and nurture communities of practice for support and professional development.

Use of technology

- In order to ensure that OCF is both a lecturer resource and a teaching tool in HEI classrooms, design, training and support need to maximise access for both staff and pre-service and in-service teachers.

Curriculum impact - improvement in personal and professional competence

This sub-section draws on themes of emerging competencies to develop lessons of experience so as to provide direction for how module impact can be increased, and personal and professional competence enhanced.

Awareness of Context

There were multiple themes that reflect growing awareness of an HIV-altered context, following pre-service and in-service teacher participation in the pilot.

HIV/AIDS affects everyone:

- Awareness of context is related to personal trajectories and pre-service and in-service teacher ecologies, and these must be considered in the adaptation of the module and materials.
- Middle class pre-service and in-service teachers need to be assisted to acknowledge their personal

vulnerability to HIV/AIDS but also that, in order to be able to teach across different contexts in South Africa, an understanding of the gendered character and economic antecedents of HIV/AIDS is crucial.

Children are innocent victims:

- Future teachers' attitudes to people living with HIV/AIDS are effectively challenged through focus on the children who are victims of the epidemic.

Giving practical expression to awareness:

- Much more time and focused attention needs to be directed towards supporting pre-service and in-service teachers to translate their increased awareness into practical ways of intervening positively in the lives of learners, their parents, and communities affected by HIV/AIDS.
- Teaching of health-promoting behaviours in an age of HIV/AIDS perhaps needs to emphasise a solution-focused approach, rather than concentrate on the possible risks.

Preventative Agent

Acceptance of role of key preventative agents:

- HIV/AIDS pre-service and in-service teacher education courses need to assert that all teachers (not just Life Orientation teachers) need to be preventative agents, and knowledge is critical in preparation to play this role – knowledge not only of the facts to support choice, but an understanding of the contexts of disempowerment that impede choice.
- HIV-related training of pre-service and in-service teachers needs to include overt introduction to pedagogical strategies that facilitate the integration of HIV into the curriculum; overt strategies for involving parents; encouragement to consider their identity in terms of their sexuality as well as their position on teaching sexuality-related issues; clear teaching of the importance of being (modelling), not just doing (teaching).

Being a preventative agent in the community:

- There is a need for more thought about how pre-service and in-service teachers might be empowered to feel comfortable and capable enough to address HIV issues in conservative and cynical communities. Possibly there are also cultural barriers that need to be overcome before preventative community action is possible.

Caregiver

Strong commitment to, and understanding of, the caregiver role:

- Both in-service and pre-service teachers expressed a strong commitment to the role of caregiver. All in all, the findings suggested endorsement of, and enablement towards, teachers-as-caregivers, which pointed to the pilot having played a positive role in encouraging emerging competence.

Lack of understanding of the context of care:

- More needs to be done to prepare pre-service and in-service teachers for the complex and different contexts from which South African learners may come, as well as the extent of support available in schools.

Perceived ability to perform caregiver role:

- Attention needs to be paid to the request for counselling skills.

Collegial Sensitivity

- A possible lesson of experience is that collegial sensitivity cannot be directly taught as part of a HEI-based teacher education programme. For pre-service teachers, it might be possible to use teacher preparation to sensitise them to infected and affected fellow pre-service teachers who might well be their future colleagues. In-service teachers could be supported to understand and engage with policy-aligned support structures in their schools, such as School-based Support Teams.

Reflexivity

Reflection on a personal level:

- Gender inequality runs very deep in society, and internalisation of understanding that runs counter

to convention requires concerted effort beyond what the pilot module and materials were able to afford.

Reflection on a professional level:

- Reflexivity in the age of AIDS requires relating the personal and professional, and needs time and support to result in attitudinal and behaviour change.

Leadership Role

- It might be worthwhile researching what the ecological and personal assets and processes are that facilitate enactment of leadership roles, not just in the classroom, but also at home.

RECOMMENDATIONS

Recommendations are directed at answering questions related to how the impact of the module can be increased and also how it can be implemented in a sustainable way.

While informed by discussions held with the participating institutions at the final Colloquium on 4 May 2009, the recommendations draw directly on and they elaborate on the lessons of experience in the previous chapter to which they are cross referenced in the Main Report.

Programme level recommendations for implementing staff

Professional competence in the age of AIDS requires very particular sensitivities and awareness. One iterative lesson of experience noted in this pilot was that sensitive awareness of the nuanced HIV contexts was often related to personal trajectories, the ecologies and intrapersonal factors relevant to pre-service and in-service teachers. Therefore, future HIV/AIDS education needs to recognise that learning is mediated by such multiple factors and in so doing, build on existing pre-service and in-service teacher assets and the ecological assets that can be used to promote educator competence. Lecturing staff need to be familiar with their targeted pre-service and in-service teacher audience, but also purposefully structure contact sessions, inputs and pedagogical approaches in ways that maximise awareness of multiple contexts and sensitivity towards the complex realities of disempowerment.

The recommendations for implementing staff in this section flow from these insights.

Adapt the module/materials to meet the needs of the target audience

Recommendation 1: *Based on knowledge of the target audience, make phase-specific adaptation to the module and materials.*

The module is meant to provide an overview – framing theory, policy, context, and information in relation to HIV/AIDS. It is not intended as a handbook of methods or a collection of phase-specific lesson plans. The following phase-specific adaptations are suggested:

- Phase-specific case studies and examples;
- Phase-specific assessment; and
- Phase-specific methodologies – for example, discussion of age appropriate information.

It is important to recognise, however, that censoring HIV/AIDS information in order to be age appropriate is not an adequate response. Rather, creative strategies that confront the real issues around HIV infection (sex, rape, abuse, etc) must be handled head-on.

Recommendation 2: *Enhance the relevance of the module/ materials for the diverse target audience.*

HIV/AIDS content must be contextual (in the content, examples, images and materials used) and localised. While black participants applauded the focus of the module and materials on what they considered real-life issues, those from other racial groups, whose lives were not presented in the material and module, found them alienating.

The Materials and the module could be localised and contextualised by:

- Selecting or developing content and materials that depict people and situations from diverse backgrounds (race, gender, sexual orientation, social class, religion and others);
- Using experiential learning for all pre-service and in-service teachers, but particularly for those with little or no lived experience of HIV/AIDS, through:
  - Self-study: engaging pre-service and in-service teachers in assignments that explore their own lives vis-à-vis HIV/AIDS and their own vulnerabilities to HIV infection;
  - Exploring HIV/AIDS in their own communities;
  - Ethically appropriate site visits to organisations and communities inhabited by those mostly infected and affected by the epidemic;
  - Real-life or realistic fictional case studies; and
  - Visual methods such as video-documentaries and films on HIV/AIDS and its social and/or educational impacts.

Enhance the module/material to meet the need for counselling skills and school-based support

Recommendation 3: *Include counselling skills development more substantially in order to equip teachers to handle complex and sensitive HIV/AIDS issues.*

The existing materials could be enhanced by including a unit on basic counselling skills to address HIV/AIDS-specific issues such as grief counselling.

Recommendation 4: *Encourage asset-mapping activities.*

Pre-service and in-service teachers need clearer guidance on where they are able to help and where not. This can be done through asset mapping. (Ebersohn 2008) In addition, it would be helpful to develop participatory skills that would encourage community collaboration.

Recommendation 5: *Support pre-service teachers on teaching practice and in-service teachers in schools and communities where they might experience resistance to the implementation of HIV/AIDS teaching, and to positioning themselves as preventative agents.*

HEIs might need to go beyond merely encouraging pre-service and in-service teachers to function preventatively in their communities (as required by education policy) and also encourage community structures and departments of education to endorse them as preventative agents in their communities.

Use participatory approaches to teaching and assessment so that learning is personally invested

Recommendation 6: *Use strategies to facilitate confidential sharing of personal experience.*

Participatory approaches are key to the development of the personal and professional competence of teachers in an age of AIDS.

Recommendation 7: *Integrate the offering of the module with student-led campus-wide initiatives wherever possible.*

Particularly for pre-service teachers, co-curricular projects often provide a better forum for in-depth discussion than the constrained time available in courses that are part of the curriculum.

Recommendation 8: *Provide pre-service and in-service teachers with opportunities for experiential learning in communities affected by HIV/AIDS.*

This recommendation is an extension of the asset-mapping above. Pre-service and in-service teachers need not only knowledge but also experience of accessible health-promoting and health-affirming resources (such as community-based counsellors, or faith-based organisations and NGOs committed to AIDS-related activism).

Recommendation 9: *Implement strategies to increase pre-service and in-service teachers' ability to reflect personally as well as professionally so that they can model attitudes and behaviour rather than simply teaching.*

Future HIV education needs to be unequivocal that prevention is not just about doing (teaching) but also about being (modelling tolerance and embodying healthy sexuality). This will require that lecturing staff model passionate ownership of HIV education and health promoting behaviour that is reflected in their very being.

Active encouragement could include formal opportunities for critical reflection (such as class-or assignment-based activities) and informal opportunities (such as visual or electronic messages posing reflective questions).

In the highly gendered context of HIV/AIDS in South Africa, unless those involved with HIV/AIDS education are personally aware of their own lived gender attitudes, they will unconsciously support attitudes that increase the vulnerability of girls and women, and thus feed the epidemic. This awareness needs to be tackled across all of teacher education.

Recommendation 10: *Use assessment and feedback on assessment activities, to deepen understanding and reflexivity.*

The pilot identified four types of assessment activities that can facilitate reflexivity (as discussed earlier). But reflexivity is also deepened if lecturers take the time to provide sensitive and supportive feedback on assignments.

Recommendation 11: *Collegial sensitivity needs to be cultivated in different ways for pre- and in-service teachers.*

For pre-service teachers, it might be possible to use teacher preparation to sensitise them to infected and affected fellow pre-service and in-service teachers who might well be their future colleagues perhaps through peer education programmes in their own institutions. In-service teachers could be supported to understand and engage with policy aligned support structures in their schools, such as School-based Support Teams.

Institution level recommendations for management/heads of school

Programme design considerations

The fundamental lesson of experience from the pilot for programme design is the following:

> *Lesson of experience:* HIV/AIDS is not simply an 'issue' to be taught. The content and pedagogy required for treating HIV/AIDS in appropriate ways assists with understanding of education and teaching more broadly.

The recommendations for programme design flow from this insight. HIV/AIDS touches intimately core issues for education - teacher identity, considerations of social justice, the implications for inclusivity in an education system that is still divided along race and class lines. Because of this, a teacher education programme that does not provide pre-service and in-service teachers with an understanding of the 'landscape of suffering' (Kistner 2007) into which HIV/AIDS is inextricably woven is failing not only the pre-service and in-service teachers, but the education system as a whole. The content and pedagogical approaches necessary for effective integration of HIV/AIDS are instructive across disciplines in teacher education programmes.

Recommendation 1: *The module should have dedicated space in teacher education curricula*

Without dedicated space to provide pre-service and in-service teachers with an overview of the interrelated challenges of HIV/AIDS for teaching and schools, cross-curricular integration is unlikely to work. Pre-service teachers also need an opportunity to consider the challenge of HIV/AIDS in a coherent way – with all three curriculum perspectives developed and understood.

Recommendation 2: *HIV/AIDS needs a champion within the faculty/school to facilitate cross-curricular integration.*

The staff member responsible for HIV/AIDS should also be given the space to work with programme staff to encourage broader curriculum integration.

Recommendation 3: *Avoid linking the HIV/AIDS module to a disciplinary/learning area which will result in its being seen as the responsibility of Life Orientation/ Guidance teachers only.*

If the module is linked to Life Orientation/Life Skills, it may give the message that teaching about HIV/AIDS is the job of the 'guidance lecturer' only rather than being everyone's responsibility. In addition, it may result in over-emphasising the caregiver role.

It may be preferable, therefore, to link the module to Education/Professional Studies. For example, as participants in the third Colloquium noted, in the PGCE, HIV/AIDS teaching may be incorporated into areas of education studies that deal with social justice or inclusion. This will then provide a framework within which HIV/AIDS can be integrated.

Recommendation 4: *The time devoted to the module as well as the timing of the module in the programme and in the year need to be carefully considered so that the potential impact is not lost.*

A clear finding is that the module is best implemented at a time that enables pre-service teachers to deepen their understanding of HIV/AIDS-related issues in the schools in which they are placed on teaching practice. There is no clear evidence to provide a recommendation on whether the HIV/AIDS module should be taught in the first, second, third or fourth year of the B.Ed. The only recommendation about this is that the module will need to be adapted for the level and particular focus of year of study in which it is implemented.

Recommendation 5: *In implementing the module, space needs to be created for research into school-based practice so that insights from the realities in the schools can be used to inform how the module is offered.*

The ethos and attitudes prevailing in the school environment are powerful enabling or constraining factors for pre-service and in-service teachers implementing what they have learned in HEI-based teacher education programmes. These realities have to be understood by implementing staff as well as by pre-service and in-service teachers to inform curriculum revision.

Staffing

Recommendation 6: *Encourage staff involved in co-ordinating HIV/AIDS teaching within the school/faculty to make use of both formal and informal professional development opportunities, but do not make qualification a pre-requisite for involvement.*

A key finding from the pilot in regard to staffing was that teacher educators with very little formal or informal training carried out the pilot, and, with support, felt that they could teach in a way that they achieved the outcomes. However, the provision of professional development combined with support is important.

Recommendation 7: *Recognise the emotionally taxing character of HIV/AIDS related education, and provide access to counselling services as well as counselling training for staff involved.*

The findings from the pilot point strongly to the need for care for the caregivers. Both pre-service and in-service teachers need to be afforded accessible and regular opportunities for disclosure and debriefing. Specifically, skills that teach them self-care competence need to be developed and resources (services) that provide opportunities/spaces for such self-care and the skills to identify and access them are needed in HEIs as well as in schools. These could include counselling services for the school community (either in the school or in the community) which all stakeholders, including teachers, can access.

Recommendation 8: *Support the continued involvement of implementing staff in the community of practice*

established through this project, and use it also for the professional development of interns.

Although it is clear from the evidence that the community of practice established in this pilot through the Colloquia and the OCF was valued, it is not yet clear how it will be sustained. It is important that it is continued, both because of the support provided for implementing staff and the professional development opportunities it provides for interns.

Recommendation 9: *In large scale programmes, select and use tutors to facilitate contact sessions, but ensure that they are adequately trained and supported not only to contribute to the HEI-led programme but also in the communities from which they come.*

In one of the pilots, this was done particularly well, and tutors (qualified school teachers) reported the added benefit that they were equipped through the module and the training they received to engage with learners and colleagues at their own schools in more sensitive and positive ways.

Service learning

Service learning did not feature strongly in the individual pilot reports, but a robust discussion at the final Colloquium on 4 May 2009 generated important insights.

Recommendation 10: *Service learning is recommended as a way of providing space for gaining better more nuanced understanding of HIV/AIDS education issues.*

Experiences should be provided for pre-service and in-service teachers to contribute through community/school-based projects. But care needs to be taken to ensure that the institution/people who are visited also benefit. The reciprocity of service learning advocates this. Partnering in service learning is also critical, and ethics around service learning must be taught. There must be a shift from community service to community engagement.

Research to invigorate practice

The recommendation was made in the Colloquium on 4 May 2009 that this report should indicate areas for further research arising from the findings of this pilot.

Recommendation 11: *Further research arising from the pilot should be undertaken either within institutions, or preferably, collaboratively across institutions.*

The following are recommendations for further research arising from the pilot:

1. Expand the professional practice model (see Chapter Four) into one that can guide the institution, and which each HEI can adapt.
2. Research the ecological and personal assets and processes that facilitate enactment of leadership roles, not just in the classroom, but also at home.
3. Research and develop models of cross-curricular integration.
4. Conduct tracer or impact studies on the current cohorts of teachers that are involved in the module (i.e. follow up on teachers who participated to see if they practised what they learned).
5. Conduct research on how frequently teachers use disclosure as a means of providing care and whether/when such disclosures have a positive impact on learners.

Sector level recommendations/suggestions

In this section, key questions are asked about what could be done at a sector level to continue the work started in the pilot and ensure sustainable HIV/AIDS related education in teacher education. The questions are not comprehensively answered, but answers provide pointers for future planning for sector-wide attention to HIV/AIDS.

Question 1: How can institutions be encouraged to continue offering the module for both the initial professional education of teachers (IPET), and the continuing professional development of teachers (CPTD)?

The National Policy Framework for Teacher Education and Development (NPFTED) has asserted two main routes to initial teacher qualification – the B.Ed. and the degree plus PGCE. These qualifications will have to be aligned to the qualifications descriptions in the Higher Education Qualifications Framework. (Department of Education, 2007) This will require not only a name change for the PGCE (to the Advanced Diploma Postgraduate), but also particular focus on the practical component in both qualifications (teaching practice). It may also, in the case of the B.Ed., involve adaptation to accommodate serving under-qualified teachers, rather than simply pre-service teachers, as well as different modes of delivery. This would mean that the target audience for the B.Ed. would be more diverse than it is at present.

The NPFTED makes it clear that the life of the NPDE and ACE as upgrading qualifications reaching large numbers of remotely situated serving teachers is limited. In the future, the emphasis will fall much more on needs-driven shorter programmes offered as part of Continuing Professional Teacher Development.

Offering the module in IPET programmes

In an environment in which there is a push to 're-curriculate' (particularly the B.Ed.) in the light of the findings of the national teacher education review and alignment with the HEQF, there is a danger that HIV/AIDS could be back-grounded/sidelined. The crisis in schooling is perceived to be dominantly a matter of learner achievement in literacy and numeracy, and the response of teacher educators could be 'back to basics', to the exclusion of what are perceived to be one among many issues such as HIV/AIDS. HEAIDS needs to encourage a different perception – that an understanding of the impact of HIV/AIDS is critical to addressing the problems in education that are being demonstrated in poor learner achievement.

Recommendation 1: *Particularly in the environment of re-curriculation following the national teacher education review, encourage institutions to see HIV/AIDS not as an issue for which they may or may not have space in their curricula, but as an essential part of the context of education for which they are preparing future teachers.*

A further pointer for future curriculum planning particularly for the initial professional education of teachers is the finding from the module pilot of both the critical importance of awareness of the highly gendered character of HIV/AIDS in South Africa and of the difficulty of internalising health promoting gender attitudes.

Recommendation 2: *Gender awareness is not something that can be addressed in just one module or set of materials. It needs a broader curriculum strategy within teacher education.*

Offering the module in CPTD programmes/short courses

The lessons of experience from the implementation of the module in the NPDE and the ACE could be used to develop CPTD programmes/short courses for serving teachers. The ealier extract from the NPFTED indicates that not only HIV and AIDS support, but also diversity management and inclusive education should be key focuses for CPTD. The module is ideally suited for in-service teachers for the following reasons:

- The best response to the content was from in-service teachers ('It spoke of our life');
- Teachers in schools who acted as tutors for one of the NPDE programmes spoke eloquently of how involvement as tutors helped them in their schools to support their learners and colleagues living with HIV/AIDS;
- The module is supported by self-instructional materials, and this facilitates coherent course development and part-time study; and
- The materials incorporate a range of school-based activities and assignments.

Furthermore, there are good examples of successful delivery of the module to large numbers of teachers remotely situated. (See the individual pilot evaluation reports on NPDE/ACE pilots.)

Provincial departments of education may well be encouraged to work with the module if, at the same time, it could be used for professional development of their own officials.

Recommendation 3: *Support the sector to plan with provincial departments of education for the use of the module as a CPTD short course.*

Question 2: How can the reach of the module be extended effectively into schools and provincial departments of education?

A striking finding from the pilot evaluation was that a major constraining factor for pre-service teachers as well as for in-service teachers in putting into practice what was learned in the module was the environment in the schools. In addition, a major aspect of personal and professional competence in the age of AIDS – collegial sensitivity – did not feature much in responses of pre-service and in-service teachers in interviews.

These kinds of environments cannot be dealt with simply by pre-service courses, or even by CPTD courses. There have to be whole school interventions and engagement of school management structures. This is meant to happen in the roll out of the inclusive education policy through structures such as School-based Support Teams, and District-based Support Teams. There are also numerous donor-funded projects supporting whole school initiatives. But what appears to be missing is coordination between HEIs involved in the initial professional education of teachers and these whole school initiatives.

Recommendation 4: *There is a need for sector-wide coordination of the work of HEIs, NGOs and provincial departments to support schools to deal with the impact of HIV/AIDS. If this does not happen, much of the benefit of successful HIV/AIDS work in pre-service and in-service teacher education will be lost.*

Question 3: How should the professional development of teacher educators/implementing staff in relation to HIV/AIDS be handled in the future?

It is clear from the findings and conclusions of this evaluation that there is no standard qualification for involvement in HIV/AIDS education, and that the implementing staff were for the most part relatively new to the area.

The challenge for teacher educators is a challenge of leadership. Competent teachers in the age of HIV and AIDS will have acknowledged that they are uniquely positioned as agents of change and leaders. The evaluation showed that although many pre-service and in-service teachers had accepted this, they were not always sure how to translate theory into meaningful practice. In this regard it is necessary to encourage the development of skills and knowledge that will facilitate practical commitment to, and meaningful enactment of, the role and responsibility of teacher-leaders. As noted previously, this again implies that implementing staff need to accept that they too are uniquely positioned as leaders in the age of HIV and AIDS and they need to model (rather than just teach) such leadership.

There is also the possibility of developing a module on HIV/AIDS for the SAQA registered Postgraduate Certificate in Higher Education offered for lecturing staff in many HEIs.

Recommendation 5: *It is important to encourage particularly those staff who implemented the pilot to become leaders in the field, and engage in further qualification. This could be supported by the development of an HIV/AIDS module as part of the Postgraduate Certificate in Higher Education and a national effort to enroll those teacher educators involved in HIV/AIDS related teaching.*

Question 4: How can the use of the materials – the learning guide and the reader, as well as Curriculum-in-the-Making – be continued and expanded?

Recommendations have been made in the previous sections for enhancement and adaptation of the module and materials to meet the needs of a variety of audiences and to strengthen particularly the guidance provided on counselling.

It is important, however, to distinguish between the kinds of additions that should be made to centrally available materials, and the kinds of revisions that individual institutions do in order to tailor them for their particular target audience. There will be no perfect set of materials for every audience and context. The issue is whether or not the materials are 'good enough'. (Welch and Sapire 2009) The results of the evaluation of the materials supporting the pilot suggest that the materials were indeed good enough.

The recommendation is therefore that there is little point in extensive revisions/additions to the centrally available materials. An additional section on counselling might be useful, as would case studies that reflect a more diverse experience of HIV/AIDS. More important is to make the materials available in an accessible format so that institutions can adapt and use them easily.

Finally, it is critical that institutions are aware that all the materials – learning guide, reader and Curriculum-in-the-Making – are available. The experience of other similar projects indicates (Welch and Sapire 2009) that it is important not only that the materials are digitally available, but that there is an advocacy strategy (such as workshops at HEIs) to make people aware of their potential and the terms of their use.

Recommendation 6: *Revise the learning guide through the addition of a section on counselling as well as case studies that reflect a more diverse experience of HIV/AIDS.*

Recommendation 7: *Make the materials available to institutions in digital format, so that they can easily adapt, enhance and update them.*

Recommendation 8: *Ensure that HEIs are aware of the existence, potential and terms of use of all the materials produced by the project.*

Question 5: How can the community of practice that has been established through this project be sustained?

As was pointed out in the findings and conclusions, participating institutions valued the community of practice established.

Recommendation 9: *While continued engagement would be valuable via the online forum, participation in other interactive colloquia would also encourage institutions to continue to engage with the initiative.*

The sustainability of the OCF needs to be directly addressed, however.

Recommendation 10: *Move towards open access to the Online Collaborative Forum allowing learners access.*

Allowing open access to the OCF has the potential to enable all Web users, with a particular emphasis on learners, to access the material and engage with the community of practice. This can be done in the following ways:

- Permit open access to the restricted site through automatic self-registration;
- Module materials and Curriculum-in-the-making (CITM) to be made available under a Creative Commons licence;
- Embrace Web 2.0 technologies more (e.g. folksonomy to replace taxonomy); and
- Encourage users' own voice whilst ensuring balance with directed/mediated core material through different sections of the OCF.

CHAPTER ONE

Introduction

SETTING THE STAGE

The HIV and Teacher Education Pilot Project had its antecedents in former Minister Kader Asmal's 1999 call for concerted intervention along with well-informed leadership from the sub-sector in the *Tertiary institutions against AIDS Conference*. This conference clearly marked the beginnings of the sub-sector's response to HIV/AIDS.

Debate around whether the education system had a role to play gained momentum when both the South African Vice Chancellors' Association (SAUVCA) and the Committee of Technikon Principals (CTP) began to dialogue around the issue and the comprehensiveness of its response. The sub-sector, under the leadership of SAUVCA and CTP, initiated its collective response in 2001 under the banner of the 'Higher Education HIV/AIDS Programme (HEAIDS) Phase 1'. This mobilised institutions to respond sensitively, appropriately and effectively to the epidemic[2] through their core functions of learning, research, management and community service.[3] Phase 1 provided direct support to institutions, made key recommendations and produced tools to assist educator communities in the effectiveness of their response.

The second phase of the HEAIDS Programme was constituted under the bi-lateral partnership between the European Community (EC) and the Republic of South Africa, with the Department of Education (DoE) as the beneficiary, and is based on the objectives of the *South African – European Community Country Strategy Paper and the Multi-year Indicative Programme for the period 2003 – 2006* in assisting South Africa in addressing the prevention, management and mitigation of HIV/AIDS in the Education sector. The purpose of the HEAIDS Programme Phase 2 was to reduce the spread of HIV/AIDS in the Higher Education sub-sector, to mitigate its impacts through planning and capacity development and to manage the impact of the epidemic in a way that reflects the ethical, social, knowledge transmission and production responsibilities that are the mission of the Higher Education Institutions HEIs) in South Africa. Phase 2 was comprised of a grant scheme and several sector research projects, including The HIV and Teacher Education Pilot Project.

The HIV and Teacher Education Pilot Project was premised on the critical importance of the capacity of the education and training system to attract and retain well educated, highly skilled, competent educators who are equipped to deal with the challenges posed by teaching and learning in an HIV/AIDS affected and infected society. The objective of this project was to ensure sub-sector-wide engagement with these challenges, and to provide the necessary support and resources for the development of educators who are equipped to deal effectively with the HIV/AIDS epidemic and its impact as it manifests in their work environment, and on their personal and community lives. More specifically, the purpose of this project was

to enhance the personal and professional competencies of teacher education graduates through:

- The provision of support for the piloting of an HIV/AIDS teacher education module in teacher education faculties, and
- The identification, evaluation and dissemination of effective strategies for incorporation of HIV/AIDS related education into teacher education and other curricula.

HIV/AIDS AND TEACHER EDUCATION

The HIV and Teacher Education Pilot Project and its unfolding needs to be understood firstly in relation to the context of Teacher Education in South Africa more broadly. Teacher Education has been radically reshaped by post-apartheid changes, ranging from the development of a new NPDE for the upgrading of under- and unqualified teachers. along with a certificate program, the Advanced Certificate in Education (ACE), to the development and implementation of the Norms and Standards for Teacher Education, through to its role in preparing teachers for a challenging new school curriculum which draws on outcomes-based education, integrated knowledge, learner-centre pedagogy and continuous assessment. It also plays a critical role in preparing teachers and school managers for the democratic governance structures of schools as a result of the South African Schools Act (SASA). Alongside the new NPDE and ACE programs were more traditional (but radically changed) preparation programs for pre-service teachers, the four year B.Ed and the Post-graduate Certificate in Education (PGCE) for students who already have an undergraduate degree. In addition to curricular and governance changes in schools, there have been key structural changes within higher education with the closure of colleges of education and only a selected few being incorporated into universities. Then, a number of universities have themselves experienced major structural change in the form of mergers.

At the same time, there are two critical, interlinked contextual issues inherent in the sector which also provide a context. First, in the age of AIDS, teachers are expected to function as *agents of prevention*: they are professionally obliged to teach their learners about safer sex, healthy sexuality and HIV prevention. (Carr-Hill 2003) Teachers are further obligated to prevent discriminatory practices and the stigmatisation of learners and colleagues who might be infected or affected by HIV/AIDS. (Hoadley 2007) These obligations are entrenched in the National Policy on HIV/AIDS for Learners and Educators (DoE 1999) and the Norms and Standards for Educators. (DoE 2000) Furthermore, one of the minimum standards in the criteria for National Review of Teacher Education carried out by the Higher Education Quality Committee in 2006/ 2007 was: "Appropriate curriculum initiatives include a focus on HIV-AIDS, in order to develop an informed understanding of the pandemic and its impact on schooling, and to develop the competences to cope responsibly with the effects of the pandemic in learning sites". (CHE 2006)

Secondly, there is a strong tradition of institutional autonomy within the higher education sector in South Africa, and its importance is emphasised in the Higher Education Strategic Plan.

In combination, these two issues have resulted in a situation in which the strong obligation on teacher education to respond to the HIV/AIDS epidemic has not been characterised by the development, in practice, of unified approaches accompanied by appropriate forms of support.[4]

Against that background, The HIV and Teacher Education Pilot Project can be seen, justifiably, as a unique intervention in teacher education (if not in the broader HE sector).

Conceptualisation of the project and its implementation took account of this background. It was recognised that it would not be appropriate or practical to expect 23 disparate institutions to follow exactly the same plan in exactly the same way and to achieve exactly the same outputs. A flexible methodology was accordingly developed to provide a framework and support mechanism which would promote the necessary institutional 'buy in' whilst not being overly prescriptive.

This methodology was further informed by a literature review and a situational analysis. (See Chapter 2.)

BACKGROUND ON THE HIV AND TEACHER EDUCATION PILOT PROJECT

The story of the HIV and Teacher Education Pilot Project and its evaluation pivots around the development of *Being a teacher in the context of HIV/AIDS* Learning Guide and the Reader that accompanies it. These materials represent updated versions of earlier materials originally developed by HEAIDS to support the core module on HIV/AIDS in pre- and in-service professional teacher education qualifications up to NQF Level 6.[5] The materials cover the minimum competences to be achieved by all qualifying educators across all phases of schooling and all learning areas.

The development of the pilot project dates back to 2003/2004 when SAUVCA undertook to commission draft proposals for learning materials that could be used in pre-service and in-service teacher education programming to address HIV/AIDS. In these proposals, the difficulties of the multiple target audience (in-service and pre-service, as well as year of study), as well as the fact that it is not possible in materials of this kind (not phase or learning area specific) to give pre-service teachers sufficient guidance about how to teach HIV AIDS in phase/learning area specific ways, was made clear. During the development phase consultations between the South African Institute for Distance Education (SAIDE) and the South African University Vice Chancellors Association (SAUVCA) and various stakeholders took place with the result that by January, 2006 a full version of the materials – *Being a teacher in the context of the HIV/AIDS pandemic* – was completed. Four outcomes which reflect critical areas of teacher development and key areas related to HIV/ADS are identified in the materials. These are:

- To implement participative pedagogical approaches to teaching biomedical facts about HIV/AIDS;
- To understand how issues of poverty, gender, stigma and discrimination relate to HIV/AIDS in the South African and wider African context and to engage learners around these issues in a participative manner;
- To understand the physical, economic, social and emotional impact of the HIV/AIDS epidemic on teachers, learners and their communities; and
- To respond in sensitive, positive and holistic ways to the practical as well as psychosocial needs of learners and colleagues.

As part of the Inception phase, the Implementing Team undertook to get feedback from the Programme Working Group (PWG) on the learning materials with the idea of updating and revising the materials as necessary. The revisions include the addition of an introduction providing a conceptual framework for the integration of the ideas, activities and readings. At the time of the Inception Phase, it was also envisioned that a *Facilitator's Guide* would be developed to go along with the learning materials. In recognition of the diverse ways in which institutions might use the materials, a decision was made to develop a more general guide called *Curriculum-in-the making* and to see this document along with an online collaborative forum (OCF) as replacing the *Facilitator's Guide*.

The actual HIV and Teacher Education Pilot Project commenced on 9 October 2007. From the outset it was guided by the HEAIDS Programme Coordinating Unit (PCU) and the Programme Working Group (PWG), and endorsed and supported by the Education Deans' Forum (EDF). The EDF which meets four times a year is a national body under the auspices of HESA, and made up of the Deans of Education of all public higher education institutions in South Africa. The Forum promotes the interests of education in South Africa by providing the opportunity for Deans to discuss matters of concern to them and their Faculties both in relation to carrying out their responsibilities for teacher education as well as in relation to the actual disciplined study of education and related research. In its focus on the preparation of teachers, it addresses concerns related to both initial and continuing professional education. As the most crucial gatekeeper to project implementation, the EDF had resolved as far back as 18 September 2003 that a module on HIV/AIDS education could not be a compulsory component in teacher education

programmes, but that adequate coverage (at least 6 NQF credits) should be required in all professional teacher education programmes. In the very early stages of the present HIV and Teacher Education Pilot Project[6] its objectives and methodology were presented to the EDF which expressed its support for the project. However, it also expressed certain provisos regarding the capacities of HEIs to initiate a new activity, given that some were already implementing HIV/AIDS modules. At the same time, the EDF expressed willingness to accept support in examining existing initiatives more closely.

A SITUATIONAL ANALYSIS OF TEACHER EDUCATION IN HEIS IN SOUTH AFRICA

One of the first activities of the Implementing Team of the HIV and Teacher Education Pilot Project was to carry out a situational analysis of teacher education institutions in the country. The situational analysis which involved all teacher education faculties being visited by the implementing team between mid-December 2007 and early March 2008 was a direct result of the November 2007 presentation to the EDF. The institutional visits to all teacher education faculties/schools were meant to serve several objectives, and were particularly useful in offering the opportunity to the implementing team to find out what was happening at the various institutions across programmes ranging from B.Ed, ACE and NPDE, the Postgraduate Certificate in Education (PGCE) and, in some institutions, Honours programmes. The meetings also afforded the beginnings of a dialogue between the Team and Institutions about the ways in which faculties could participate in the HEAIDS pilot in relation to the various options described in the previous section.

Overall, there was a wide range of initiatives in teacher education institutions, ranging from a stand-alone module for all 400 first year B.Ed students at the University of Zululand, to a web-based initiative being piloted with PGCE students at University of the Western Cape (UWC), to a 12 hour component of a diversity module at the University of Cape Town (UCT) - and many interventions in between. Some institutions are very creative in how they integrate HIV/AIDS, including, for example, an online module at the University of the Western Cape (UWC). There was no institution that was not doing something, but the scale was often very small. In one institution, for example, HIV/AIDS was addressed in a guidance and counselling module involving fewer than 20 students. In another, the delivery was entirely under the auspices of the HIV programme within Student Health (but tailored so that the students had an assignment that they carried out in their Practicum). Some of the initiatives were quite new and were still in a pilot stage while others, such as the compulsory module for all B.Ed students at the University of Zululand, had been in existence since 2005.

The actual modes of delivery at the different institutions fell into three categories: stand-alone modules, integration, and addressing HIV/AIDS in the Practicum.

Stand-alone modules: A few institutions had embarked upon developing their own stand-alone module on HIV/AIDS or a Life Orientation Module in which the focus was on HIV/AIDS. Credit weightings varied as did the actual topics covered and the number of hours of contact time. North-West University, for example, in an 8 credit ACE module that they offered for the first time in the second semester of 2008, had identified four key areas: Legislation, Counselling, Health Promoting Schools, Learner Support. In their eight credit B.Ed module they identified three key areas: The Educator, Policy, and Caring. Several institutions, notably UWC and Durban University of Technology (DUT), spoke of the use of innovation through on-line delivery, although they also acknowledged that face to face contact is critical.

Integration: It was often not clear from the descriptions that instructors were offering of their courses exactly how they were distinguishing the various options related to integration and infusion. Significantly, while there are relatively few examples of integration across several curricular areas in any one institution, many faculties were integrating HIV/AIDS into their Life Orientation or Life Skills Programme. Indeed, this was probably the most common type of integration. At the same time, some institutions spoke of very innovative approaches to integration. The music instructor at Walter Sisulu

University (WSU) for example, integrated HIV into Arts and Culture within the B.Ed program. Students use the internet to locate sources for addressing HIV and culture (in relation to, for example, abstinence, virginity testing and such like). At the University of KwaZulu-Natal (UKZN) in a pilot research study in Primary Mathematics Education, again in the B.Ed programme the instructor was using the topic of Probability and Data Handling as an entry point to addressing a component of HIV/AIDS. At the Central University of Technology (CUT), instructors spoke of the integration of HIV and AIDS into graphics, natural and life sciences, computer studies, accounting, mathematics and a research module all at the B.Ed level. At the Cape Peninsula University of Technology (CPUT), the instructor spoke of integrating HIV and AIDS into a module within Professional Studies on Research. Students conducted projects involving interviews with a wide range of people on the topic of HIV and AIDS – medical doctors and sex workers, for example – and presented their findings to the whole class. Mangosuthu University of Technology (MUT), although it does not offer teacher education programmes nonetheless offered some additional perspectives on curriculum integration. The Vice Chancellor had instructors across all areas addressing some aspect of HIV and AIDS in their curricula. At issue, as many participants pointed out, was the haphazardness of this approach and the challenges associated with seizing on appropriate opportunities. Such an approach also relies heavily on the interests and knowledge of the instructor. Several instructors worried that students might pose questions to which they did not know the answers. They were also concerned lest this inability to answer was taken to be evidence of their trivialising of the issues. They also said that as instructors they just do not know enough. As one lecture observed, *"A student comes to you who discloses her positive status and the sickness in her family and you don't really know what to do."*

Field experience/Practicum: A relatively under-studied (or under-documented) area within the general literature on HIV/AIDS in teacher education, but a critical one as we discovered in a number of the visits to institutions, relates to the ways in which HIV/AIDS is being addressed through the Practicum. All B.Ed and PGCE students spend a substantial amount of time (at least 4 weeks per year) in school or community settings. In many programmes the Practicum is attached to Professional Studies, with relevant assignments that must be conducted during the student teaching placement. In several institutions students were given assignments related to policy issues in relation to working with learners (especially orphans and vulnerable children). The University of Stellenbosch (SU), for example, offers a four hour diversity unit which culminates in an assignment carried out during the Practicum. Service learning is another way in which institutions are delivering some of their work on HIV/AIDS. Students, as part of a course, will do service work in an AIDS based-NGO or school where there are many children who are orphaned or vulnerable in some way as a result of HIV and AIDS. This is a regular part of the work of students at Nelson Mandela Metropolitan University (NMMU) and also part of a new project at UCT for PGCE students.

In the course of the institutional visits, the respondents identified a number of critical issues that they considered important, as well as barriers and challenges. These included the following:

1. **The overloaded timetable:** Many instructors pointed out that the B.Ed and PGCE timetables remain overloaded and that it is very difficult to find time within current timetables to deal adequately with HIV/AIDS, an area which must compete with other topics and issues. As several members of various institutions pointed out, it is often all about power and politics and about who can make a more convincing case. A number of respondents reported a very *ad hoc* process which depends largely on the interests of the instructors themselves rather than on institutional planning.

2. **Monitoring and evaluation:** Few institutions monitor what students are learning each year across a programme to see what the gaps might be and, in addition, the issue of evaluation more broadly was of concern. As one of the instructors at WSU explained, "We don't know what difference our teaching makes." No institutions seem to have any

base-line data on what it is that they are teaching teachers, such as knowledge of AIDS, knowledge of pedagogy and so on. This is clearly a critical area for further development.

3. **Staffing, teacher educators and professional development:** What must be noted is the fact that there is a great deal of passion and obvious commitment amongst people who are teaching in the area of HIV/AIDS education, and many of those currently involved in this work in the country are clearly champions of addressing HIV/AIDS in teacher education. However, ensuring that there is a sustainable approach to staffing is a critical issue. In one institution the work was being done entirely by a contract staff member and in another the training was provided through the HIV programme of the university as a whole rather than within the Faculty of Education. The need for training for teacher educators came up at several institutions. Instructors who do not teach Life Orientation worried that they might not know enough about the issues in order to be able to integrate HIV/AIDS into their teaching.

   In several institutions there was a very close link between what happens in Education and other disciplinary areas. At UCT, for example, the students in Education and the students in Sociology take a module in common that addresses HIV and AIDS. In many institutions there is an HIV office which co-ordinates many activities – from orientation sessions to peer counselling. Several of the institutions were currently revising their programmes, and in some cases 'reviving' initiatives at the time of these interviews.

4. **Post merger climate:** It is fair to say that Faculties of Education in the country, many of which are very new as a result of the mergers, still have a great number of challenges in relation to addressing such issues as distance (sites more than 3 hours apart), diversity of resources (one site may be well resourced and another not), diversity of student populations (there remain sites that are primarily white and others that are primarily African), and the location of decision-making bodies that have an impact on the implementation of HIV/ AIDS education. AIDS fatigue was an issue. As staff pointed out, their students are tired of hearing about AIDS.

5. **Theoretical frameworks and curriculum:** The need for strong theoretical frameworks was identified during some of the interviews. At UWC the issue had to do with the idea of the reflective practitioner and the caring practitioner. At UCT the critical theoretical issue concerned social identity and the impact this has on what teachers need to know. There were also some very interesting metaphors expressing what HIV and AIDS allows for. For example, AIDS was described as an entry point to a whole range of areas such as reproductive health and gender-based violence. In another institution the metaphor of AIDS as a lightning rod was used. Several institutions pointed to the challenges (and the necessity) of addressing the 'self' in teacher education in relation to this area of HIV/AIDS education. This could be the caring self, the social self, the self in relation to sexual and reproductive health, the teacher's sexual self or the teacher's self in relation to issues of gender and power.

DEVELOPING THE CURRICULUM OPTIONS

Arriving at the various curriculum options available to institutions during the Pilot Implementation reflected an iterative process. The implementing team in its institutional visits had to make full use of the time and in so doing spoke about the *Being a teacher in the context of HIV/AIDS* materials and some of the ways that it might be used in a teacher education program. Concomitantly, the institutions themselves in describing their current offerings, resources and goals informed the Implementing Team of some of the models and approaches that they thought might work for them and in this way contributed to shaping the range of options that would be feasible during the pilot period. Thus, coming out of the institutional visits and situational analysis study, and in line with appropriate curriculum models, the institutions were offered four curriculum options as a basis for participation in the project.

Option 1: Evaluation support for existing activity
Option 2: Piloting the HEAIDS module in 'stand-alone' form
Option 3: Curricular adaptation or 'bolt-on' of the module or component parts of the module onto a single existing module
Option 4: Cross-curricular integration of the module into more than one existing module.[7]

The four curriculum options were presented at the first National Colloquium held on 7 - 8 April 2008 and attended by representatives of 22 HEIs. Largely as result of this colloquium, in conjunction with the promotional work of the implementing team assigned with responsibility for liaising with individual HEIs, the pilot implementation took place in 23 pre-service and in-service teacher education programmes on 25 sites in 20 HEIs. A total of 6485 students benefited from the pilot implementation in 23 programmes in 2008, and a further four which commenced in 2009.

Supporting the Pilot Implementation

Nationally, implementation was supported by:

- The provision of a learning guide and reader to 6273 students;
- Provision of a laptop, lcd projector and screen at 23 sites;
- The appointment of interns at 23 sites;
- An electronic information resource called the Online Collaborative Forum (OCF). The OCF is a fully functional, secure web-based arena for participating HEI members to communicate with one another and to upload and download shared resources, collaborate on these resources, and to publish selected resources to a wider audience.
- Regional Support Experts from the implementing team responsible for liaison and support at each HEI. HEIs also had access to expert support in relevant fields such as teacher education, curriculum, evaluation, and teacher support and development.

While the support of the implementing team was the most critical form of support, the learning guide and reader were fundamental to implementation. Provision of learning materials was, in fact, a powerful inducement to HEIs to participate in the first instance.

TELLING THE STORY: OVERVIEW OF THE REPORT

As noted above, a total of 6485 pre-service and in-service teachers benefited from the pilot implementation in 23 programmes in 2008, and a further four which commenced in 2009. What difference did this project make and what can we learn from the project as a whole? The goal of this report is to offer an analysis of the overall evaluation of the HIV and Teacher Education Pilot Project. This introductory chapter has provided a context for addressing HIV/AIDS in teacher education in South Africa and has provided background on the HIV and Teacher Education Pilot Project. A situational analysis of HIV/AIDS in teacher education in HEIs took place in the early stages of the HIV and Teacher Education Pilot Project, with the findings from that study reported here. The second chapter offers a review of the literature on HIV/AIDS in teacher education and in so doing situates the Pilot Project within the broader range of initiatives regionally and internationally, and within a consideration of various models and approaches of curriculum integration. Chapter Three maps out the Methodologies of the project, and in so doing includes both the methodologies of implementing the HIV and Teacher Education Pilot Project and the model for evaluating the project. Chapter Four provides an overview of the curriculum models in use. Chapter Five offers an analysis of the findings. These findings are divided into two main sections; one section focuses more on the evaluation of the curriculum itself. The second section focuses on an evaluation of the project in relation to professional competencies. The focus of Chapter Six is on the conclusions and lessons of experience. One section of this chapter is on the conclusions about curriculum design and implementation. The second section of the conclusion is on curriculum impact. Finally Chapter Seven offers a series of recommendations: at the programme level, at the institutional level and at the sector level.

CHAPTER TWO

The Situation of HIV/AIDS Education in Teacher Education and in Higher Education more broadly

INTRODUCTION

> HIV/AIDS presents the greatest learning challenge to education systems. In the past, the consequences of failure to learn involved simply a delay in progress from one academic level to another or confinement (sometimes temporary) to a lower socio-economic order. With HIV/AIDS the consequence of pedagogic failure is terminal....' (Hubert Charles 1999, np.)

> How can you train teachers on this critical new issue [HIV/AIDS] when large numbers of teachers are not receiving any training at all – and when others are trying to cover traditional, already overloaded training courses in accelerated timeframes? (Boler and Archer 2008, p. 39)

The two quotes above might be read as 'bookends' to the crisis in teacher education around HIV/AIDS in addressing, on the one hand, the critical need to make sure that learners in schools are receiving the education they need to survive the epidemic, and, on the other, the constant under-valuing of teacher education and the teaching profession itself. Indeed as Boler and Archer (2008) point out in *The Politics of Prevention: A Global Crisis in AIDS and Education*, the very global institutions such as the World Bank that could be making a difference in teacher education (and especially in pre-service teacher education) often are contributing to eroding teacher education programmes especially in areas of Africa that are hardest hit by the pandemic. They cite the fact, for example, that in Mozambique students who have completed grade ten can now qualify as teachers by completing a one-year training course. In other cases, governments are being encouraged to consider in-service education over pre-service teacher education, something that could make sense at a time when there may be teacher shortages, but in actual fact is an approach that is rarely implemented effectively because it requires planning and sustainability – issues that are already challenges in most systems. Boler and Jellema (2005) in their earlier Deadly Inertia study of 18 countries noted that only three had initiated any type of sustained teacher education programming to address HIV/AIDS.

HISTORICAL CONTEXT

The response of HEIs to the pandemic

To date more work has been done in the area of Higher Education more broadly than in the very specific area of teacher education as one faculty or school within a Higher Education Institution. In spite of this, there are stock comments in reports and studies related to addressing HIV/AIDS in the schools in Southern Africa that "more work for teacher trainees is required" and "without preparing teachers to work in this area, there is a limit to what can be achieved". Interestingly, much of the available literature on HIV/AIDS and

education in sub-Saharan Africa, up to 2005 at least, focuses more on the impact of HIV and AIDS on the education sector more broadly in terms of reduction in demand; reduction in supply; reduction in availability of resources; adjustments in response to the special needs of a rapidly increasing number of orphans; adaptation to new interactions both in schools and between schools and communities; curriculum modification; altered roles that have to be adopted by teachers and the education system; the ways in which schools and the education system are organised; the planning and management of the system; and donor support for education. (Kelly 2000a; 2000b; 2001; 2002; Chetty 2000; Abebe 2004; Coombe 2002; Shisana et al. 2005; Vass et al. 2008)

Most of the studies on the response of higher education institutions to HIV/AIDS in sub-Saharan Africa date back to the work of Kelly and Chetty, and it is worth noting that there is relatively little work published in the region prior to 2000. The 12th International AIDS conference held in Durban in 2000 with its 'breaking the silence' theme stands as a critical landmark or reference point in relation to the Education sector. As early as 2000 Kelly pointed to several challenges in the institutional responses which fall short of integrating responses to HIV/AIDS into the centre function of universities. Around the same time, the Chetty report (2001) on the situation in South African universities documented responses in four areas: management, planning, programmes, and policy. It analysed key strategy issues including leadership, capacity, resources and the system-level impacts that HIV/AIDS will have on higher education. Chetty's report also indicated that much of the focus of research on HIV/AIDS and education continues to be on school level education rather than in higher education. Kelly (2000; 2001; 2003) and Chetty (2002) found that interventions by higher education were infrequent and disorganised, with few institutions having policies and frameworks concerning AIDS. Kelly's and Chetty's reports argued for the development of institutionally defined responses which focus on prevention, treatment and care. HIV education programmes must provide opportunities for students to develop positive behaviors and to practice interpersonal and social skills such as decision making, and communication skills to enable them to identify, avoid, escape, and manage high-risk situations. The more comprehensive documents on HIV/AIDS and higher education in Africa have been the result of case studies commissioned by the Association for the Development of Education in Africa (ADEA), the Working Group on Higher Education (WGHE) and the South African Universities Vice Chancellors' Association (SAUVCA). However, Kelly (2001) noted that much of the research done by institutions of higher education is commissioned and carried out by individuals, and, significantly, that the findings are disseminated mostly in international AIDS conferences and journals rather than at the national level. Meyer (2003) a year or so later drew attention to the ways in which many institutions were establishing campus health services, launching increased and continual intervention programmes in place of only isolated programmes, events, and guest speakers.

A number of meetings, conferences and workshops (with follow-up reports) have been held which focus on the theme of HIV/AIDS in higher education institutions in Africa. The Association of Commonwealth Universities organised meetings in collaboration with its partner institutions in Africa to discuss the problem of HIV/AIDS. A workshop was held in 2001 which was attended by senior representatives from ten universities in Africa. The proceedings of this workshop were compiled into a report "*HIV/AIDS: Towards a strategy for Commonwealth Universities, Report of the Lusaka Workshop hosted by the University of Zambia*." The Association of Commonwealth Universities (ACU) also produced guidelines for institutional response. (ACU 2002) A Regional Workshop organised by African Women in Science and Engineering was attended by several East African institutions. The workshop explored the impact and responses of higher education institutions in Eastern Africa to HIV/AIDS. The workshop proceedings were compiled in a report titled "*Women in higher education and science: African universities responding to HIV/AIDS*". (Katahoire 2004) In South Africa, the '*Imagined Futures: Universities as Incubators of Change*' conferences in 2006 and 2007 held at the University of Pretoria highlighted, amongst the many critical issues of interest to universities, the significance of challenging

HIV/AIDS stigma and discrimination amongst students by incorporating HIV/AIDS into the curriculum. (See for example Mohammed 2007; Mathebul, Wood and Mohammed 2007.)

Abebe (2004) produced a synthesis of case studies carried out in several African countries that assessed African universities' capacity to contribute to solutions to the HIV/AIDS pandemic. The case studies collected information about how universities are responding to the HIV/AIDS pandemic through their administrative policies, academic programmes, and involvement with national policy and with AIDS issues at community level in relation to NGOs and faith-based organisations among others. The study included universities in Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania and Zambia. Abebe noted that African universities are at different stages in terms of their response to the HIV pandemic. The dominant situation is, however, characterised by inadequate or inappropriate institutional behaviour and action. This is demonstrated by the lack of appropriate policies to guide actions, the lack of formal units within institutional structures, plans and budgets, and low levels of involvement by the university community. A report by Saint et al. (2004) published by the World Bank, "*Crafting institutional responses to HIV/AIDS: Guidelines and resources for tertiary institutions in sub-Saharan Africa*" comes to similar conclusions. Katahoire (2004), however, highlights the fact that institutions such as the University of Botswana, the University of Cape Town, the University of KwaZulu-Natal, Kenyatta University and the University of Namibia had established HIV/AIDS units to co-ordinate activities across the institutions and to prevent ad hoc approaches to programmes as well as to ensure institutional involvement in HIV/AIDS prevention. The University of Pretoria, amongst other universities in South Africa, established a Centre for the study of AIDS in Africa whose primary purpose is to mainstream HIV/AIDS through all activities of the university to ensure that it is able to plan for, and cope with, the impact of HIV/AIDS on the whole tertiary education sector. According to Saint et al. (2004), institutions that establish AIDS co-ordination units have better organised programmes.

Central to deepening an understanding of the role of pedagogy and curriculum in addressing HIV/AIDS, many of the case studies conducted in HEIs show that students are more active in HIV/AIDS response initiatives than are members of staff. This would suggest that most of the initiatives are *extra-curricular* rather than *curricular* in nature. Abebe (2004) observed that staff involvement, particularly among the academic staff in HIV/AIDS response initiatives, is almost invisible. Student-based activities are more dominant and staff involvement is the exception rather than the rule. This, of course, undermines the effectiveness and sustainability of intervention programmes. Students in HEIs have generated in creative ways an array of activities in response to the HIV crisis. Katjavivi and Otaala (2003) highlight examples of good practice by universities that feature community engagement. For example, they discuss the use of a Youth Radio Station by the University of Namibia to entertain and educate the youth on issues of HIV/AIDS. Some institutions report a persistent difficulty in mobilising students beyond once-off activities, and a low level of interest from student organisations, while others have been able to engage students through their professional interests and volunteer projects. (Chetty 2000; AWSE 2001; Ennals and Rauan 2002) Saint et al. (2004) argue that AIDS activities planned and executed with student involvement are more effective because students generally have a better understanding of their social milieu and that older adults often lack this. Peer counsellors are also likely to be present where they are needed most, and to be available nearly 24 hours a day. In addition, the action of peer counselling serves as an important role model and also has a positive impact on those who do the counselling as well as on those who are counselled. Crucially, these student-initiated extra-curricular activities read through the lens of 'creative engagement as pedagogy' suggest the need for curricular models that capture the idea of learner-centeredness.

The response of teacher education with HEIs to the pandemic

There are several phases of work in the area of teacher education. The snapshot of North America, for example, offers an early (1990s - 2002) analysis and

a set of programmes in teacher education to address HIV/AIDS, reflecting the point at which education systems began to realise the need for this work. This work in the 1990s was followed by a relative silence in the period between 2000 or so and 2006, reflecting both a changing political agenda and a change in the priorities around sexual health in North America as a result of greater access to treatment.

As recently as 2003, various authors were beginning to call for a review of programmes in an African context. Coombe (2003), for example, highlights that INWent, an initiative of Capacity Building International, convened a regional meeting of 60 senior officials and representatives of governments, universities and other tertiary institutions, non-governmental organisations, and unions. Professionals from Kenya, Malawi, Mozambique, Rwanda, Tanzania, South Africa and Uganda met to determine what support teachers and teacher educators require in responding to the complex needs of learners and educators affected by HIV/AIDS. The consultation focused initially on teacher education (pre-service and in-service) and how best to upgrade the capacities not only of school teachers, but of teacher educators in colleges and universities, to deliver life skills curricula. In general, life skills education for educator and learner populations has been inadequate, many educators have been reluctant to teach the sexuality curriculum, and there are too few teaching and learning materials *in the system*. In-service programmes are rarely comprehensive or systematic enough to deliver adequate skills and materials to serving teachers. Not all pre-service teachers are getting HIV awareness training in their programmes. Ultimately in Coombe's work, two routes were identified for further strategic planning:

- A slower, long-term *development approach* to prevention, care and counselling in which the aim is to change the behaviour of learners – as well as educators, parents, elders and others – so as to save lives and mitigate the consequences of HIV and AIDS; and
- A quicker, short-term direct intervention *humanitarian approach* to prevention, care and counselling in which the aim is to save lives now, keep learners safe and in school and, at the same time, support the build-up of capacity to deliver on behaviour change.

Coombe also notes that it is important to make HIV-related subjects a stand-alone (examinable) subject so that all learners get all the information they require. This is the minimum. This work pointed to some critical questions that ultimately have an impact on teacher education itself. Is the school curriculum the best tool for responding to HIV *as an emergency*? Can educators do what needs to be done? Is it possible to create the 'new teacher' with a realistically adjusted curriculum, and if not, then what are the alternatives for saving lives?

SPECIFIC PROGRAMMES AND INTERVENTIONS IN TEACHER EDUCATION

This section is divided into several sub-sections. It starts with a section on the international context, particularly in relation to countries that have been particularly hard hit by HIV/AIDS. It then goes on to look at country-specific studies in sub-Saharan Africa, and then finally, at studies in South Africa.

International context

Asia: A number of countries within Asia have been studied as part of multi-country studies. The report on the 'Expanding the use of innovative HIV prevention approaches using traditional forms of performing arts in Asia' project (2008) discusses how the project used the unique artistic expression, cultural practices, ways of life, value systems, traditions and beliefs of the communities participating in the project, as well as focusing on their fundamental human rights. The project ran for two years (2006 - 2007) and included a sub-regional training workshop organised by the Philippine Educational Theatre Association (PETA) as well as national performances and training activities in China, Cambodia, Indonesia and Vietnam. It is argued that the performing arts have been proven to be a powerful and successful medium for transmitting

messages on gender issues and sexual health. Despite the wide differences among the countries participating in the project, it was found that cultural contexts provide recognisable reference points that can effectively both guide script writers and engage the audience. These performances must involve dialogue among all participants. The report argues that by having an active role in the performance, the audience is more likely to approach the performance as educational entertainment rather than as propaganda, and less likely to see it as irrelevant to their own lives. The overall argument in relation to this project is that performing arts should be the medium of choice for communicating life-saving messages related to sexual health to young adults, since they have proven to be more effective than textbooks and lectures – an insight that could reform current health education strategies for young people. In order to strengthen this innovative approach, a system should be devised to measure the penetration and impact of messages delivered through different media platforms. This system would have to study not only the passive response to factual knowledge, but also resultant behavioral changes.

A UNESCO (2008b) report on how UNESCO and the Organization of Petroleum-Exporting Countries (OPEC) Fund supported the implementation of a programme in nine Asian countries and three Arab States that highlights the significance of teacher education. The aim of the programme which ran from May 2005 to February 2008 was to raise awareness about HIV/AIDS through the education system by engaging Ministry of Education officials, integrating HIV/AIDS into education curricula and training teachers and young people to relay information to pupils in schools across the region. The programme built on UNESCO's experience and leadership in education, and adapted many existing teacher training manuals and advocacy toolkits that had already been developed. The countries involved were Cambodia, China, Vietnam, Thailand, Bangladesh, Afghanistan, Uzbekistan, Kazakhstan, Syria, Jordan and Lebanon. This report argues that by reaching out to education officials, teachers and schools, there is the possibility of reaching millions of young people with potentially life-changing social consequences.

China is home to nearly 20 percent of the 10- to 20-year-olds in the world and this country follows the patterns of HIV infection among young people in the global context. In December 2004, the report from China's Ministry of Health indicated the probable development of the HIV/AIDS epidemic in China. By then it was being spread largely through heterosexual transmission among young people from high-risk groups to the general population; young women were increasingly emerging as the most vulnerable group in the context of gender inequality. (*Sohu news* December 2004) Thompson (2004) also reveals that the sexually spreading epidemic is on the rise as can be seen from the new infections among young Chinese women when these are compared with the increase among their male counterparts. As remarked by Zhang Weiqing, Minister of the State Population and Family Planning Commission, about 60 percent of HIV infections in China are estimated to occur in young people aged 15-29 with young women emerging as the most vulnerable, and sex the dominant mode of transmission. (*Xinhua News 2006*)

Latin America: UNESCO has played a critical role in the Caribbean region in terms of bringing together a critical mass of teacher educators and stakeholders to consider the ways in which teacher education can make a difference in addressing HIV/AIDS. In September, 2004 UNESCO convened a large scale consultation where, amongst other initiatives, they did the following:

- Opened up their Teacher Education and HIV/AIDS network to include many different organisations with a stake in teacher education;
- Set up a number of thematic areas including initial teacher education, in-service training, attention to special needs and so on;
- Embarked upon setting up a co-ordinating mechanism for looking at programming across the region;
- Designed and established individual webpages which would provide for closed and open forums for discussion around critical issues in addressing HIV/AIDS in teacher education.

Martel (2003) conducted a study that examined the predictive power of HIV/AIDS-related knowledge

acquisition; attitudes towards teaching about HIV/AIDS; support for AIDS education; AIDS teaching comfort; HIV/AIDS teaching behavioural control; religious and cultural beliefs about HIV/AIDS; subjective norms about teaching HIV/AIDS, and demographic factors on Haitian educators' reported HIV/AIDS teaching behaviour. It also assessed the short-term effects of an HIV/AIDS teacher training course offered to 214 teachers in Haiti. Results showed that the odds of teaching about HIV/AIDS were greater for those participants with higher perceived subjective norms and behavioural control and lower cultural and religious beliefs about HIV. The odds of teaching about HIV/AIDS were also higher for males and secondary teachers – a finding that contrasts with the work of, for example, Van Laren (2008) in South Africa who found that female teachers were more likely to see the value of this kind of work. Also, according to Martel (2003) there was a significant increase in teachers' knowledge, teaching comfort, and perceived behavioral control about teaching HIV/AIDS after the intervention.

Munoz (2001) reports that a few decades ago it was considered normal and even desirable in Latin America for young girls to become pregnant before they were 20 – provided they were married – while young men were expected to become sexually active as soon as they entered adolescence, without much concern about both the potential risk of such activity and the person with whom they did so as long as it was a woman. This view is now changing. There seems to be a general consensus that education is necessary to prevent adolescent pregnancy, abortion, STI/HIV transmission and sexual abuse. Attempts to reach agreement as to what kind of education and where, and how and when to provide it often fail, however, because of the conflicting views of sexuality upon which they are based. Munoz (2001) discusses conflicting concepts of sexuality and describes the theory of critical pedagogy followed by Asociación Venezolana por una Educación Sexual Alternative (AVESA), a Venezuelan NGO whose work focuses on sexuality, problems of sexuality and alternative sex education. He describes AVESA's practical experience in training youth promoters and running an ongoing youth education programme in sexual and reproductive health. AVESA advocates an educational alternative that builds self-awareness and a critical understanding of social reality and it encourages individuals to engage with their own history and circumstances in order to experience their sexuality in a full, responsible, pleasurable and just manner.

Gilliam et al. (2001) writing in Antigua argue that lessons learned in designing HIV prevention programmes from around the world can be shared to save valuable programmatic resources. However, they point out that programmes must be adapted to meet the needs of the target population, and this can be done only through shared responsibility and participation of key individuals from the target community. In order to design culturally sensitive theory-based interventions, formative research that draws on theories and epidemiological data must be complemented by ethnographic methods. The Antigua school project they designed used ethnographic methods to assess needs and to guide the development of the intervention. The authors discuss the process of designing a theory-based, culturally sensitive intervention to decrease behaviours that result in the transmission of HIV and STDs. The intervention includes a classroom component, a parent involvement component, and a community component.

The regional context

Within sub-Saharan Africa, studies on teacher education include broad multi-country studies which offer an important comparative advantage along with single-country studies which tend to be more in-depth. A four country study by Nzioka and Ramos (2008) of Kenya, Ethiopia, Zambia and Uganda is one of the most comprehensive and up-to-date, in its focus on a sampling of teacher education institutions across the four countries in order to study the delivery of HIV/AIDS programming within pre-service teacher education. In their study they arrive at a number of observations.

- **Institutional Policies**: Only one of the colleges had an institutional policy. Most, however, had some version of an AIDS control unit.

- **Budgets:** Most institutions had relatively small budgets for their HIV/AIDS activities, and most budgets are donor driven. (Funding mostly targeted anti-AIDS clubs and peer education.)
- **Trainers:** There was a shortage of adequately trained personnel to deal with HIV/AIDS in the Education sector in all 4 countries, relatively little support for training of teacher educators, and what did exist was donor driven.
- **Leadership:** There was a lack of strong leadership to address HIV/AIDS effectively.
- **Testing:** Most institutions had no systems although in the case of Ethiopia where testing was done on the prevalence rates amongst university students more generally, higher rates were found amongst university students than amongst young people of the same age in the general population.
- **Evaluation:** Relatively little sustained research on what works and with whom was done, but most studies support the need for triangulation of data (focus groups, in depth interviews, base line data and so on) and draw attention to the need to include visually verifiable observations such as the existence of condom dispensers, awareness posters, graffiti in toilets and so on.

Carr-Hill et al. (2002) examine the impact of HIV/AIDS on sub-Saharan African countries. Their work looks at both the macro and micro levels and it emphasises the need to react quickly as well as to institutionalise the response of education systems to the negative consequences of the pandemic. Drawing on studies of a few countries in sub-Saharan Africa, the first part of their book discusses the practicability of implementing a range of indicators for monitoring the impact of HIV/AIDS, specifically on the demand for supply, management, and quality of education at all levels. It underlines the difficulties of assessing and monitoring the impact on demand, supply, and quality in many of the worst affected countries in Africa. The second part focuses on the essential role that the education system has to play in preventing the expansion and mitigating the impact of the pandemic. A range of responses is described, drawing on the experience of various national and international programmes to impart life skills to children and young people. It considers the problems of evaluating such programmes in the light of cost effectiveness.

Beyond these multi-country studies within the region, however, there are also single-country studies of teacher education interventions.

Ethiopia: Desalegn, Tadele and Cherinet (2008) conducted a study of how 4 teacher training institutions are addressing HIV/AIDS. At the time of the study, none of the teacher training institutions were found to have policies, structures and formal programmes in place although the authors acknowledge that within the new national curriculum of teacher preparation in the country, HIV/AIDS and life schools are integral. In 2008 no documentation on the success of the new curriculum was available. A critical area that they noted across the institutions was the lack of training for teacher educators themselves and an absence of any attempt to find out what teacher educators might need. They observe, overall, that teachers do not have enough knowledge about HIV/AIDS, and this, coupled with the culture of secrecy (not talking about sex openly) and time constraints on account of heavy workloads, prevents teachers from being effective. In one of the four institutions they noted that each of the teacher educators is supposed to integrate HIV and AIDS issues into subject-specific teaching activities and address gender and other related issues, but capacity is often a limiting factor. In that institution there has been a requirement that every lecturer use the first 5 to 10 minutes of lectures to discuss HIV and AIDS issues, but this practice was found to be ineffective. HIV/AIDS slogans and other messages are included at the bottom of exam papers, and campus posters and billboards are used to convey key messages concerning HIV/AIDS.

Ghana: Stackpool-Moore and Boler (2006) report on participatory theatre-based approaches to working with pre-service teachers in Ghana as a way to engage new teachers in a reflective process, particularly in relation to deepening an understanding of gender, power and HIV/AIDS transmission. In their description of 'Theatre for Change', a programme involving pre-service teachers, they outline some of the key reasons

why this kind of participatory work is so critical to encouraging participants to experience first-hand the significance of learner-centred approaches, and why such approaches are central to opening up spaces for teachers to engage learners in open discussion around issues of sexuality and HIV/AIDS. An evaluation of 'Theatre for Change' (Easby 2005) raises some challenges to this kind of work, noting, for example that it requires excellent facilitation skills to carry out the training and that facilitators find it difficult to remain neutral while discussing sensitive issues relating to HIV/AIDS. The evaluation also points to the possibility that pre-service teachers will not take drama seriously because it is perceived to be fun. Another key challenge is that sometimes dramatic forms end up reproducing the very stereotypes that are meant to be interrogated and in some cases could even exacerbate gender tensions. Notwithstanding these concerns, however, Stackpool-Moore and Boler (2006) offer several key recommendations:

- For teacher education to be transformative, the process needs to be experiential and sustained over time.
- More effort needs to be made to shift to a participatory approach in what is currently a non-participatory system. Teacher education initiatives and expectations need to take into account the realities of formal education systems that may conflict with certain prerequisites for participatory methodologies.
- Local contexts need to be taken into account. Initiatives should always be multifaceted and fine-tuned to the context, and be cognisant of power structures within communities. (Adapted from Stackpool-Moore and Boler 2006, p.188.)

Kenya: Nzioka et al. (2007) point out that in Kenyan teacher colleges, pre-service training in HIV and AIDS is offered as part of the training programmes in both private and public Teacher Training Colleges in the country, while in-service HIV/AIDS training is mounted during school holidays so as not to interfere with the normal school teaching programme. Much of the in-service training for primary school teachers in Kenya is organised by the Ministry of Education (MoE) with the assistance of the Primary School Action for Better Health (PSABH) programme. The PSABH is a school-based intervention that trains teachers, community leaders and peer educators in delivering HIV/AIDS education in schools in Kenya. The Kenya Institute of Education (KIE) has also developed a national AIDS education syllabus for schools and colleges. Studies with pre-service teachers in Kenya at Kenyatta University explore the significance of gender relations in addressing HIV. Chege (2006), for example, conducted a memory work study with pre-service teachers in which she asked them to recall experiences of sexual violence and gender abuse. Her work is part of a larger study of the gendered aspects of HIV/AIDS.

Malawi: A study by Lee (2007) seeks to understand the effects of HIV/AIDS on the education sector and to assess its capacity to be an effective safeguard against the spread of HIV/AIDS. The study fills in gaps in the literature by analysing the perspectives of educators at six levels of the hierarchy – from schools to the Ministry of Education – and assessing their professional, as opposed to personal, HIV/AIDS-related knowledge, attitudes, and practices (KAP). This study benefits international education and health specialists in the preparation and implementation of HIV/AIDS strategies. The data was collected from representatives of the six levels of the hierarchy: teachers, head teachers, zonal advisors, district managers, division officers, and Ministry personnel. Education personnel – especially those at the school level – are knowledgeable, have positive attitudes about their capabilities, and demonstrate a strong desire to provide teaching and counselling services to their students. Although HIV/AIDS has severely weakened the education sector, the self-reported high levels of confidence amongst Malawi's educators could enable them to take positive steps to change their own behaviour and to influence behaviour change in others, thus allowing them to play the role of 'doctor' to help cure the rest of society of the ills of HIV/AIDS.

Zambia: Ramos (2007) conducted an in-depth study of teacher training institutions, looking closely at pedagogy, policy, the impact of the HIV/AIDS on staff and students, partnerships in the community,

and particular barriers to successfully preparing new teachers to address HIV/AIDS in their teaching. The design of the study itself is remarkable for its comprehensiveness, and for its attention to pedagogy, emotional support, and barriers to implementation. She concludes that critical areas include lack of financial resources and materials, a lack of leadership, the effects of stigma on even teaching about the issues, and finally the fact that sexual harassment continues to dominate the social fabric of teacher education institutions. Putting gender on the agenda in this way makes the point that without attention to gender relations, it is difficult to bring about change in teacher education.

Ramos (2008) also conducted a case study of one teacher training institution as a way to get an up-close look at the issues and challenges. Her view is that there is not enough known about what actually happens in the courses and programmes in relation to HIV/AIDS. Her case study then offers in-depth interviews with instructors and pre-service teachers and it includes work with the pre-service teachers in their Practicum experience. Overall she identifies a number of key challenges to addressing teacher education at the pre-service level in Zambia. First, HIV/AIDS prevention is not consistently examinable and she found that there was an over emphasis on biomedical facts (relatively easy to examine) to the neglect of such issues as gender, poverty, and care. She also notes a kind of selective teaching in that pre-service teachers often failed to bring up issues around sexuality that they might be shy to discuss with learners. Noting in a previous study the lack of appropriate resources and teaching materials, in this study she goes on to talk about the fact that although videos are found to be a very effective medium for teaching, colleges often lack IT facilities to screen these videos. And, although pre-service teachers often seem keen to use computers to access information about HIV and AIDS, they have relatively little access to technology. She notes the challenges around integrating rights-based messages and gender-responsive scientifically accurate, culturally appropriate information into the curriculum. She also refers to the value of participatory and interactive teaching methodologies that place a greater emphasis on learners playing an active role in the learning process. In the college that she studied, pre-service teachers participated in a one day session on these methods but this is far from being adequate. Ramos recommends that college lecturers themselves be given greater support in developing creative and participatory methodologies in their classrooms. She also notes the importance of giving recognition to the champion lecturers working to integrate HIV and AIDS into their teaching as a motivational factor.

Zimbabwe: O'Donoghue (2002) documents the development of the primary and secondary school AIDS Action Programme from 1991 to 1998. He evaluated six programme aspects: programme start-up; planning and management; development of syllabi and materials; teacher training; research; monitoring and evaluation; and co-ordination. O'Donoghue argues that the programme drew on resources from within the existing educational system, and because of broad-based consultation and participation, it was supported by Government and partners. Flexible management ensured implementation of mid-course corrections. According to O'Donoghue, school AIDS programmes should stress participatory teaching and learning methods and life-skills training. He highlights the point that curriculum writers and teachers need training and supervision in participatory techniques. Cluster workshops between district and school levels are needed to strengthen the cascade model of teacher training that has been adopted.

Teacher education programmes and interventions in South Africa

Baxen and Breidlid (2004, 2009) highlight several trends in HIV/AIDS research in education in South Africa. The first focuses on research aimed at examining the knowledge base or attitudes of different groups within school communities (for example teachers and students) of those within the education sector. (See Harrison, Xaba, Kunene and Ntuli 2001; Levine and Ross 2002; Peltzer 2000; Peltzer and Promtussananon 2005; Wood, Maepa and Jewkes 1997.) This research often includes investigations into whether learners and/or teachers have adequate knowledge about HIV/AIDS

transmission and prevention as well as their attitudes towards those infected with the virus. The dominant research strategies include the use of questionnaires and large scale surveys.

Another trend includes research that projects the impact of the epidemic at the systemic level and the catastrophic consequences this might have on education systems. Through applying modelling and projective techniques, some of this research maps out the potential loss in capacity and delivery of quality education as a result. (See Barnett and Whiteside 2002; Human Science Research Council 2005; Johnson 2002; Shisana 2002; World Bank 2000.) Other researchers in this field of work project the consequences of the epidemic through illness and morbidity of teachers and learners and how this would potentially affect planning for quality education. These researchers describe, often without accurate data, the devastating effects of the epidemic and the consequences these hold for human resource development, financing education, and the demand and supply of teachers at national, district and school levels. (See Kelly 2000; Kelly 2002; Coombe 2000.)

The third pattern is one that includes studies measuring the impact of training, with a particular emphasis on the impact of training youth and teachers. (See Bloomberg 1993; Hopson and Scally 1981; Kelly 2000; Sliedrecht 1996.) The term 'impact' here is often interpreted as a change in attitude towards those infected or an increase in knowledge about forms of transmission and prevention. Survey data and questionnaires are often the primary forms of data collection. The results consistently suggest that these groups have adequate knowledge about transmission and prevention and hold empathetic and supportive views towards the infected. However, reviews like the one by Kaaya et al. (2002) analyse these studies and question interpretations of 'impact'. They point to the methodological and interpretive limitations of such studies.

Variations in the patterns of research have included some work that focuses on youth with a view to examining the nexus between education and sexual behaviour. This body of research asks why, in the face of the many prevention programmes geared towards education against prevention, youth are still reported as the population group whose rates of infection show the greatest escalation. (See LeClerc-Madlala 2002; Scorgie 2002; Wood and Jewkes 1998.) Emerging research has gone some way in its attempt to insert a different discourse to that described. This research, also with a focus on youth, begins to acknowledge the social embeddedness of the epidemic and as such, begins to examine some of the social and cultural practices that add complexity to issues associated with infection and prevention. (See Campbell, Foulis, Maimane and Sibiya 2005; LeClerc-Madlala 2002.)

In addressing the paucity of research that goes beyond knowledge about HIV/AIDS among youth, LeClerc-Madlala (2002) expresses the need for new research trends that "shift from an emphasis on *more knowledge* to enabling youth to understand constructions of self and sexual identity in contexts in which issues of gender, power, sexuality are deeply connected to constructions of safe-sex and negotiation within relationships and HIV/AIDS knowledge". (cited in Baxen 2005, p. 59) The limitation in this emerging work, though, lies in it not necessarily questioning the underlying dominant epistemological and methodological discourses. Thus the recommendations produced are similar to outcomes that sometimes make simplistic associations among knowledge, behaviour, and training. (See Campbell, Foulis, Maimane and Sibiya 2005; Hartell 2005.) This notwithstanding, these studies have gone some way to illuminate the complex sets of issues at hand by beginning to ask different kinds of questions that require a shift away from positivist constructions of the epidemic. (See Baxen and Breidlid 2004; Baxen 2005.)

In relation to actual programming in the area of teacher education in South Africa, the terrain can be divided into work with in-service teachers that is for the most part outside of formal degree-granting programmes (though there is an emerging body of work with teachers in ACE programs), and those which are contained in formal pre-service programmes.

In-service Teacher Education in South Africa: Visser's (2001) research monitored the teacher training and programme implementation for two years in two educational districts in South Africa by means of action research including both qualitative and quantitative research methods. From an ecosystemic framework, interaction processes in the school system, related to programme implementation, were identified (process evaluation) and high-risk behaviour patterns of learners were monitored as outcome evaluation. The results indicated that during the monitoring period of two years, limited programme implementation took place. It was shown that higher order processes in the organisation and structure of the school as a system, the Department of Education and the community contributed to limited programme implementation. After the two-year period learners demonstrated more knowledge of HIV/AIDS, but there was not a statistically significant change in the learners' reported behaviour patterns. Recommendations are made for improving programme implementation, in terms of: (1) change in the school and educational system, as higher order processes to support programme implementation; (2) the implementation strategy and community participation; and (3) raising the level of intervention by including higher order learning processes.

More recently, Visser (2005) reports that a life skills and HIV/AIDS education programme was implemented in secondary schools as a strategy to combat the spread of HIV/AIDS among school-going young people in South Africa. As part of a joint effort of the Department of Health (DoH) and the DoE, two teachers per school were trained to implement life skills training and HIV/AIDS education in schools as part of the school curriculum. The implementation of the intervention was evaluated in 24 schools in two educational districts in Gauteng province using an action research approach. Data about the implementation was gathered through interviews and focus group discussions with school principals, teachers, and learners. A repeated measurement research design was used to assess the impact of the intervention in terms of knowledge, attitudes and reported risk behaviour in a sample of 667 learners representing learners from grades 8 to 12 from different population groups. Results showed that the programme was not implemented as planned in schools because of organisational problems in the schools, lack of commitment of the teachers and the principal, non-trusting relationship between teachers and learners, lack of resources and conflicting goals in the educational system. In an outcome evaluation over a period of a year it was found that learners' knowledge of HIV/AIDS increased and their attitudes were more positive although the changes could not be attributed to the programme alone. In the post-test more learners were sexually active, although preventative behaviour did not increase. The programme as implemented in the area did not succeed in changing high-risk behaviour patterns among school-going young people. From the evaluation of the intervention a few valuable lessons were learned about the content and implementation of HIV/AIDS preventative interventions which could be useful in the implementation of various other such HIV/AIDS interventions in the community.

A series of participatory interventions, led by teacher education institutions such as Nelson Mandela Metropolitan University and the University of KwaZulu-Natal, speak to the significance of the visual (photography and video) in working with in-service teachers. Olivier, De Lange and Wood (2008), for example, embarked upon the use of photovoice as a tool in terms of which teachers were given cameras to explore and represent issues of poverty and HIV/AIDS in a township community. In their work with these teachers, they focus on the idea of reflective practice and self-study. In other interventions, this time with video documentary and in rural KwaZulu-Natal and the Eastern Cape, teachers represented issues around poverty and community partnerships as approaches to addressing HIV/AIDS (see for example, Mitchell, De Lange, Nguyen 2008; De Lange, Olivier and Wood, 2008) and also as approaches to engaging community members outside of education such as community health care workers. (Mitchell et al. 2005; Mitchell and De Lange, in press) Again, the focus of the interventions as they relate to teacher education speaks to the importance of participatory methods and of teachers having personal and professional input

in both seeing what the issues are and also working towards community-based solutions.

Pre-service Teacher Education in South Africa: Stuart (2004; 2006; 2007) conducted a qualitative study on the uses of a visual arts-based approach for addressing HIV/AIDS through teacher development with pre-service teachers. It was undertaken at the University of KwaZulu-Natal in the face of the HIV and AIDS epidemic. It responds to the suggestion that teachers need to explore their own understanding, attitudes and perceptions of the disease if they are to deal confidently with the demands it places on them as educators in schools. Building on her own background in Media Studies, Stuart engaged 13 pre-service teachers, who had enrolled in a Guidance and Counselling module, in using photographs and drawings to capture their views of HIV/AIDS and to construct messages for their peers. The photo texts were then analysed by the researcher who saw them as socially and culturally embedded constructions. She was interested in how they were affected by, and could have an impact on, cultural and social discourses. Reflections on the photo texts and their associated processes by both the researcher and pre-service teachers lead to suggestions as to the pedagogic possibilities of using a visual arts-based approach in education to address HIV and AIDS. The thesis concludes with discussion of what a visual arts-based approach can contribute to teacher education, particularly in relation to self-study and reflexivity, and the value of this work in relation to the instructor's self study as well as the students' work on self-study. Stuart also considers the limitations of such an approach, noting that it is critical to embed sufficient information about HIV/AIDS within the pedagogical tools of participation.

The recommendations of Stuart's study are consistent with the recommendations of other studies such as YouthNet, a USAID programme on improving the reproductive health of young people. The direction of this work is towards focusing on teacher attitudes and teacher experiences – the teacher at the centre:

> … effective training first has to have an impact on the teachers themselves, helping them examine their own attitudes towards sexuality and behaviours regarding HIV prevention, understand the content that they are teaching, learn participatory teaching skills, and gain confidence to discuss sensitive and controversial topics. (James-Traore et al. 2004, p. 4.)

In another study, De Lange and Stuart (2008) report on a "youth as knowledge producers" arts-based intervention with pre-service teachers working in rural KwaZulu-Natal. In this work a cohort of peer educators who are pre-service teachers in the Faculty of Education volunteered to embark on training in addressing HIV/AIDS through such arts-based approaches as collage-making, hip-hop, video documentary, image theatre and photovoice. During a four-week Practicum, the student teachers conducted workshops with learners on issues related to HIV/AIDS using the various arts-based tools. Along with creating their own "arts-based toolkit" for use in schools, the students have also adapted their lessons for use in a Life-Orientation module. (See also Rahte, Smith and MacEntee 2009.)

Van Laren (2007; 2009) also at the University of KwaZulu-Natal, conducted a study within pre-service teacher education that specifically focuses on integration. Working in the area of primary mathematics education, she carried out a study of how a teacher educator working in this area might integrate HIV/AIDS education into such teaching areas as probability and data handling. In her study she looked at the attitudes of students generally to the idea of integrating HIV/AIDS into mathematics, noting that female students were more predisposed to this work than were males, and that black students saw the value in the work more than did white students. Using what she terms a "starting with ourselves" approach, she worked closely with a smaller group of pre-service teachers to look at how they actually carried out integration during their Practicum. She concludes that it is critical to try to get at the teaching metaphors of the students. She further concludes that this kind of work is vital, noting that in an area such as mathematics which is generally regarded as a 'high status' learning area, there may also be the possibility of a higher status for the actual work around HIV/AIDS. Significantly, in her work, Van Laren draws attention to the links between

the self-study of the educator (in this case herself) and the potential for the self-study of the pre-service teachers with whom she works.

The preparation of pre-service teachers for differing social/geographic contexts – particularly rural contexts – is addressed by Balfour, Moletsane and Mitchell (2008). In their work which draws on the Rural Teacher Education Program (RTEP), they highlight the significance of a place-sensitive approach and offer the point that rurality should not be regarded as a deficit. Drawing on what might be described as a service-learning model, they describe the program in which approximately 20 pre-service teachers per year spend their third or fourth year residential Practicum in several rural schools in one district of KwaZulu-Natal. While the schools where they teach tend to be under-resourced in relation to materials and services more generally, everyone in the community, they learn, has a role to play, and schools more than any other institution can play a pivotal role in promoting the very community participation and partnerships that can bring about social change. Ironically, the least resourced areas in terms of teacher support, are the places where teachers (and the school itself) are in the best position to make a difference in the community.

HIV/AIDS AND CURRICULUM INTEGRATION

The work on addressing HIV/AIDS in teacher education described in the previous sections, is of course located within the broader area of curriculum integration, both in relation to the response of HEIs to HIV/AIDS and to the response of schools to the needs of learners. As Kollapen et al (2006) highlight in the *Report of the public hearing on the right to basic education* (Kollapen et al, 2006) in which they focus on the provision of education for learners aged between 7 and 15 years, one of the critical issues is HIV/AIDS education and the other is the fact that teachers are identified as the most important role-players within the education system to address the issues. While it would seem appropriate that the teaching and learning of HIV/AIDS should be occurring in the Learning Area named 'Life Orientation', the Public Hearing report notes that:

> …experience shows that schools do not adhere to the life orientation curriculum, that specialist life orientation teachers are not used, that teaching is fragmented and often misunderstood, or that the time allocated to it is often regarded as a free period. Furthermore, many teachers are not comfortable with the curriculum due to their own personal values and beliefs. Research indicates that life orientation is not achieving its objectives. In sum, it fails to be recognised as an important subject (Kollapen et al, 2006, p. 15).

This lack of status in relation to Life Orientation offers a key challenge for HIV/AIDS education in the South African school curriculum as well as for teacher education in Higher Education institutions. Faculties of education are required to address these concerns in order to take up the various barriers to learning caused by the HIV/AIDS pandemic. Learners who may be 'unwell, burdened by family responsibilities (or have no family) and/or are emotionally fragile' (Campbell & Lubben, 2004, p. 1), are certain to need the support of all teachers, particularly multiskilled teachers whose work could complement the work of specialist teachers in the care and counselling of learners.

A clear distinction needs to be made between what works in school classrooms and what the most appropriate model is for HIV/AIDS education integration in teacher education. In the literature there is a variety of suggested models for integration given for schools or institutions to respond to HIV/AIDS education. These models range from the integrated (HIV/AIDS education across the curriculum) model to one of a single subject area (Life Orientation and counselling). The recent policy framework document, the *National policy framework for teacher education and development in South Africa* (DoE, 2007), does not directly make provision for a stand-alone compulsory module for teacher education programmes so it is prudent to consider some

alternative methods of including HIV/AIDS education into the functioning of an educational organisation. HIV/AIDS mainstreaming is considered to be such an alternative option.

According to the Inter-Agency Task Team (IATT) on Education (2008), one of the biggest barriers to HIV/AIDS mainstreaming is the many different understandings of the term. Definitions of 'mainstreaming' do, however, appear to point to a need for a comprehensive, in-depth examination of the organisation or sector(s) as a whole. Mainstreaming is not defined as a goal in itself but an active, ongoing process. HIV/AIDS mainstreaming is considered to be a process of integrating HIV/AIDS throughout the functioning of, for example, an educational organisation. HIV/AIDS mainstreaming relates to organisational attempts at including HIV/AIDS issues in all aspects of managing an organisation. Included in these organisational efforts would be the integration of HIV/AIDS education in the curriculum of a higher education institution. The integration of HIV/AIDS education within curricula of disciplines would be required for successful mainstreaming of HIV/AIDS education in a higher educational institution. The notion of including one discipline, such as HIV/AIDS education within another discipline is, however, not a novel concept (Chettiparamb, 2007; DeZure, 1999; Klein, 2006; Mathison & Freeman, 1997).

Many advocates of interdisciplinarity stress the fact that using inputs from more than one discipline provides a deeper understanding of a problem (Chettiparamb, 2007; Klein, 2004; Nowacek, 2005). Klein (2004) points out that the complexity of health care issues necessitates the use of interdisciplinary collaboration. The issues related to HIV/AIDS education are complex and solutions of associated problems require more than the subject-knowledge of a single discipline. An interdisciplinary approach that explores HIV/AIDS education as a discipline provides possibilities of other viewpoints related to the challenges presented by HIV/AIDS. The notion of 'a discipline' has been explained by various authors in terms of scientific-epistemological, social and/or organisational considerations (Chettiparamb, 2007) but there are many understandings of the term 'interdisciplinary'. Nissani (1995), for example, uses four criteria to rank 'interdisciplinary richness', namely, the number of different disciplines that are combined, the distance between the disciplines, the novelty of the combination of disciplines, and the degree of integration of the disciplines. Nissani (1995) considers interdisciplinary richness to lie along a fluid continuum that is separated by the two imaginary poles of pure disciplinary work and he uses these four criteria to arrive at a working definition of interdisciplinarity.

Evaluations of integration of HIV/AIDS education into school curricula have also been classified into a variety of approaches for inclusion. The three main curricular approaches presented by UNESCO (2006) are the following: (1) integration in one already existing main carrier subject, (2) as a cross-curricular issue, and (3) infusion throughout the curriculum. Although there is a variety of approaches to select for integration of HIV/AIDS into school curricula, the UNESCO (2006) manual highlights a number of common shortcomings when HIV/AIDS education is integrated into an official curriculum. Kelly (2007) separates the challenges encountered by teachers when integrating HIV/AIDS issues into a school curriculum into two aspects: professional and personal. He notes that often teachers consider their lack of professional competence to be a result of a lack of preparation. Furthermore, Kelly (2007, p. 70) suggests that the absence of a universally agreed curriculum framework for use in schools hampers professional development of teachers in the area of HIV/AIDS education. The overcrowded school curriculum causes marginalisation of the HIV/AIDS education and the lack of appropriate teaching and learning materials are further professional hindrances. Teachers also point out that they are uneasy about taking on the sole responsibility for HIV/AIDS education and discussions with young people. Teachers often experience a lack of support from school management and other educational authorities and attitudes of parents towards discussions of sexuality and other necessary sexual matters complicate addressing HIV/AIDS issues.

Together with these professional challenges there are personal considerations that make teachers reluctant to consider HIV/AIDS issues in classrooms. Kelly (2007) lists cultural factors, fears and personal sensitivities as further complicating factors. It is, however, important to note that these professional and personal challenges are leveled after evaluating HIV/AIDS education programmes in school curricula; there do not appear to be many studies that report systematic evaluation of integration of HIV/AIDS education in teacher preparation curricula.

Taking into account the various arguments for (and against) integration as noted above, systematic reporting of integration research in teacher education, where professional and personal challenges are considered, needs to be developed and documented. If there is no provision made for a compulsory, stand-alone HIV/AIDS education module in teacher education then the 'already crowded' (UNESCO, 2006, p. 2) teacher education curriculum content of existing curricula requires adaptation through selection of appropriate or acceptable models of integration. By interdisciplinary collaboration between or among disciplines the possibilities for increasing the relevance of particular disciplines would further the preparation of teachers and teacher educators in the area of HIV/AIDS education so that the process of HIV/AIDS mainstreaming can be facilitated.

Some definitions and models

As noted above, curriculum integration can be defined in a variety of ways and can include the development and provision of credit-bearing stand-alone online or direct delivery modules or the development (or adaptation) of courses or modules to include some components of HIV/AIDS. Integrated courses or modules can include various models of integration and infusion in which HIV/AIDS is 'mainstreamed' and infused throughout the module, as well as those which reflect a 'bolted on' approach. In this model the course may include one or two 'units' which are bolted on to an already existing curriculum and which, in some instances, may replace a unit or theme. Curriculum integration may simply include one major project or several assignments.

Stand-alone modules that address HIV and AIDS

Stand-alone modules refer to those modules that focus primarily on HIV/AIDS. They may be part of the curriculum of a particular disciplinary area and hence target that group (see for example *Being a teacher in the context of HIV and AIDS* targeting pre-service and in-service teachers) or they may be a 'one size fits all' module but still part of the overall programme of becoming an engineer, a social worker, an agricultural specialist and so on. While a number of studies in the previous section refer to the need for a stand-alone module for all university students, it must be noted that there are a number of challenges. Mathebula, Wood, and Mohammed (2007), for example, have drawn attention to the fact that universities seem to be very protective of their credits so it is a challenge to get HIV/AIDS integrated into the curriculum across all disciplines. There are also few examples of stand-alone modules that have been evaluated for their overall effectiveness. Such evaluations must take into consideration that fact that not all students (or disciplinary areas) will necessarily respond in the same way in that the student groups themselves may have different interests.

An evaluation of a stand-alone module for all first year students at the University of Namibia suggests that timing, personal relevance, levels of practicality are all vital. As McGinty and Mundy (2008) point out, all students attending the University of Namibia are required to take a course that is part of the core curriculum of the university called 'Contemporary Social Issues' in their first year. It is a course that deals primarily with HIV/AIDS. All first year students get the course material and the same lectures delivered by the same lecturers. As McGinty and Mundy describe it, the course consists of 10 lecture hours over 5 weeks, with two lectures per week. Each of the 10 classes is presented in a large lecture format supplemented by a course reader. The course has a dual focus: one part is a bio medical orientation

to HIV/AIDS and STIs and the other deals with the psycho-social factors that contribute to HIV/AIDS. Interestingly and in keeping with its dual focus, it is coordinated by two departments, the Faculty of Medical and Health science and the Department of Social Work and Community Development. (Haoses-Gorases and Grobler 2006; Katjavfivi and Otaala 2003.) The purpose of the course is to integrate HIV/AIDS into the undergraduate programme in order to provide information on the historical, epidemiological, health, legal and prevention/home-based care aspects of HIV/AIDS. While McGinty and Mundy (2009) do not offer an evaluation of the module as seen through the eyes of all faculties, their analysis of how it was viewed by fourth year B.Ed students offers an interesting perspective on this approach. The students in their study were interviewed about their knowledge of HIV/ AIDS in their final (fourth) year of their program. The interviewers found that 20 per cent of students, when asked if they had ever taken a course on HIV/AIDS, had failed even to remember the course. The majority felt that the component on biomedical knowledge provided in the course had had no bearing on their own knowledge of the disease. What they said they really wanted was a course that would help them to teach about HIV/ AIDS and they felt ill-prepared to do that. Their concerns, of course, are very practical and perhaps not that different from how they would feel about many of their courses, both pedagogical and academic. At the same time, it does speak to content, pedagogy and perhaps even timing. The students had taken the course several years before the interviews. No mention is made of a course evaluation at the time the course was delivered so we are not sure whether the content itself was irrelevant or simply not presented in an engaging matter, or whether the timing was simply too early in their programme to now make a difference in relation to their teaching. What the results do suggest is that a once-off module is probably not enough, certainly for pre-service teachers, and perhaps for in-service teachers as well, or that programme integration requires a more tailored approach or, in other words, the recognition that one size does not fit all.

Integration through Infusion

A few studies in South Africa point to some positive changes in relation to curriculum integration and the ways that staff members are seeing ways to incorporate HIV/AIDS work directly into their teaching. Meyer (2003), for example, reports on how studying HIV/AIDS allows room for improving science education. She argues that incorporating this work into one of her existing courses on Virology for undergraduates at what was then the Rand Afrikaans University (RAU) and is now the University of Johannesburg (UJ), was easy and effective. Lecturers from the Sociology department team taught with lecturers from the Biochemistry department. The Sociology department provided lectures on social issues and HIV/AIDS while the Biochemistry department provided introductory lectures on the biology of HIV/AIDS for a course on the social aspects of HIV/AIDS. Meyer argues that *team teaching has a special appeal because it means more information is provided to students without meaning more work for lecturers.* In line with Meyer, Mohammed (2007) argues that successful incorporation of HIV/AIDS in a non-science course is possible and that it can enrich such a course by overcoming students' HIV/AIDS prejudices and concurrently promoting voluntary counselling and testing. He incorporated issues related to HIV/ AIDS and STIs into a Tourism curriculum at the Cape Peninsula University of Technology, with the aim of mitigating the impact of HIV/AIDS stigma and discrimination among students. Several other studies, as noted in the previous section on teacher education, look at the integration of HIV/AIDS into a primary mathematics module (Van Laren 2007; 2009) and the integration of Media Studies, HIV/ AIDS and Guidance and Counselling. (Stuart 2007)

Some universities in South Africa have conducted their own audits on curriculum integration across the university (and, of course, including Education). UCT, for example, has engaged in a self-study of its own curriculum responsiveness to HIV/AIDS. In 2008 there were two compulsory HIV/AIDS-related courses for all first year students in Commerce and

Health Sciences. Commerce offers a course called 'Evidence-Based Management' which aims to educate students in a general way on issues related to HIV/AIDS and then to explore the relevance of this to the business environment. Health Sciences offer a unit called 'Me and HIV/AIDS' within an umbrella course called 'Becoming a Professional'. This course aims to contribute to developing personal and inter-personal skills, with students undertaking work around stigma, relationships, values, social psychological issues and biomedical issues. Although there are no compulsory HIV/AIDS-related courses in Law, Sciences, Humanities or Engineering and the Built Environment, there are courses that incorporate related components such as gender (in a course called 'Understanding Gender in Humanities' and in work done in the African Gender Institute). The report also notes that many other departments and schools in the Humanities integrate related components, and the Science Faculty explores biological, molecular, cellular and environmental aspects of HIV in some of its courses. A course in the Law Faculty examines human rights issues, and the provision of ARVs to HIV positive women. In Humanities, some courses incorporate work on HIV/AIDS into case studies (for example, in Public Health and Religious Studies, in sociological aspects of HIV/AIDS in Education and so on). (HAICU 2008)

Some critical issues related to curriculum integration in higher education

There are a number of issues related to integration across the curriculum. At the heart of this is the fact that there is a paucity of literature on 'how to' in integration even though there is a fairly well developed literature on mainstreaming gender into the curriculum within Higher Education (see, for example, UNGEI, 2008; Morley, 2007) that could be applied to integration and the mainstreaming of HIV/AIDS into the curriculum. There is even confusion about what counts as integration. Indeed, Van Laren (2009) makes it clear that the terms related to integration themselves may not be well understood by instructors in HEIs. She highlights such terms as 'fusion', 'integration', 'mainstreaming' and so on and suggests that it is critical that instructors understand the nuances of these terms.

Outside of Africa, a good example of some of the challenges of taking on integration across the curriculum can be seen at the University of the West Indies in Trinidad and Tobago. There an initiative to integrate HIV/AIDS into the Higher Education Curriculum was undertaken in 2005. Staff in Academic Planning took the lead in terms of co-ordinating this initiative and organised 3-day training sessions for staff members from all academic units. However, as one instructor who is herself a champion of addressing HIV/AIDS and who had been one of the ones trained, commented, "In Education, we probably were already ahead of things because we had been doing integration and we were already focusing on pedagogy. For other units of the university it was not so easy." (Jocelyn Rampersad, personal communication, Feb. 22, 2009.) She goes on to comment that now almost four years later it is not obvious what the impact of intervention has been or even how it is being sustained. In the case of new staff members, for example, there has been no follow-up with new training sessions.

As noted above in the work concerning curriculum integration in teacher education, attention to the actual AIDS *content* remains a challenge. If the work on HIV/AIDS is to be examinable (arguably a significant feature in and of itself), there is evidence to suggest that it is much easier to assess bio-medical knowledge than other forms of knowledge that might be covered in such a module. If there is integration across a number of modules within one program, what kind of co-ordination is required to ensure that instructors are covering a variety of content issues and not just the area of bio-medical knowledge? Ramos (2008) in her work in Zambia specifically in Teacher Education notes the challenges related to integrating (and examining) more complicated issues such as rights-based messages, along with the need to integrate (and examine) gender-responsive scientifically accurate, culturally appropriate information into the curriculum. At the same time, Stuart (2007) in her work on integrating HIV/AIDS into a Guidance and Counselling module

in a Faculty of Education draws attention to the fact that it is essential to make sure that accurate and up-to-date knowledge is being communicated. How do lecturers who themselves and by their own admission feel somewhat inadequate address this situation? What kind of on-going professional development needs to take place?

Clarke's (2009) comprehensive global study of HIV/AIDS and teaching and teacher education, *Heroes and Villains*, offers a summary of the pros and cons of various models of curriculum integration, ranging from the use of stand-alone modules, to the use of several 'carrier subjects', through to an all encompassing 'HIV/AIDS across-the-curriculum' approach. While Clarke concludes that the more effective approach is likely to be either a stand-alone approach or the use of carrier subjects, the study does not offer very much by way of evidence for or against, and the conclusions seem to be based more on school contexts than on work in Higher Education.

Appropriate pedagogy itself is also a concern. Currently there is relatively little literature on the background of instructors, the most effective approaches, the nature of the engagement of students and so on. Many of the articles and other published works may describe the curriculum in terms of topics covered, readings, number of credits and the assignment, but give relatively little attention to pedagogy itself. However as noted in 2.2 above, in the work in teacher education, most studies highlight the importance of interactive and participatory approaches to teaching, suggesting that curriculum integration models similarly need to draw on such pedagogies. Beyond Faculties of Education where pedagogy is most likely to be the point, how do universities take up these pedagogies? We know that there are many mass lecture strategies. How do these work in relation to HIV/AIDS? How does an instructor build in discussion time? What kinds of assignments work best? The use of new technologies is a relatively untapped area for (a) course delivery in integrating HIV/AIDS (except in isolated cases as noted above) and (b) in relation to instructor support although the studies that do exist suggest that this is a promising area for further development.

While there is widespread endorsement of the idea of curricular integration, clearly there is a need for more documented case studies. As Van Laren and Ismail (2009) point out, typically integration is seen as all-or-nothing, and, as they highlight, it is likely to be more effective for an instructor to start small and in a contained way with perhaps just one unit or one topic within a module rather than with the whole module in the beginning stages of integration. They also note that instructors may see the issues as being synonymous with sex education and for that reason may shy away from them, rather than acknowledging the vast range of social issues that might be included such as poverty alleviation, human rights, gender-based violence and so on. In the literature there are references to specific courses such as 'Contemporary Social Issues' (University of Namibia), 'Evidence-Based Management' (UCT), 'Me and HIV/AIDS' (UCT). How might one compare these courses? How specific are the professional components in relation to Commerce, Public Health and so on? There are other critical issues, however, that speak more to the impact of cross-curricular interventions overall. For example, if an entire programme or department or faculty were to decide to integrate HIV/AIDS, are there certain pitfalls in terms of overlap, redundancy, AIDS fatigue and so on? (Wood 2007) What types of co-ordinating mechanisms are needed? What role can an academic planning unit play in this regard? Are students getting a repetition of some aspects of HIV/AIDS to the point of boredom and then no exposure to other issues? And while we have useful case studies of co-ordinating and managing, say, a unit that offers academic literacy (as a once-off course) we have few examples of what the challenges might be of most students coming into contact with many different approaches and potentially all at the same time. UCT, as noted above, and UWC as well as several other universities conduct audits of all courses that address HIV/AIDS in some way either as a stand-alone module or one that does more direct fusion. However, it is possible that some students take no courses. How can a university audit its courses as well as its beneficiaries?

THE SITUATION OF ADDRESSING HIV/AIDS IN TEACHER EDUCATION: WHAT HAVE WE LEARNED?

Drawing from the various literatures, what have we learned? What are the key issues and how does this work inform future work in the area of Teacher Education in South Africa? Clearly this is all relatively recent literature and as noted above in the section under historical perspectives, in the area of teacher education itself the majority of studies have been carried out in the last 5 years or so. At the very least, this also suggests that any expertise in this area (for researchers or teacher educators) is also relatively recent and concomitantly, there is no agreed upon idea of what a teacher educator qualification in the area of HIV/AIDS instruction should include. Notwithstanding the recency of this work (and drawing from the review above along with findings from the Situational Analysis described in Chapter One), the following are areas that seem particularly promising in relation to curriculum design and implementation and that address the professional competence of teachers.

Curriculum design and implementation

Participatory methodologies: Throughout the literature there is a strong emphasis on appropriate methodologies needed to engage pre-service and in-service teachers. The Situational Analysis in Chapter One offers examples of pre-service teachers engaged in community outreach programmes, arts-based 'knowledge producer' activities and other participatory approaches. Similarly, the review of literature on the response of higher education institutions more broadly highlights the central role that students' own participation plays in engaging with the issues. Thus, participation itself is a key issue with an emerging body of work that focuses on the significance of creative participatory and visual methodologies. (De Lange et al. 2006; Mitchell et al. 2005; Mitchell, De Lange and Thuy 2008; De Lange and Stuart 2008; Stuart 2007, Pithouse, Mitchell and Weber, 2009; Olivier, Wood and De Lange, 2008) While, just as Raht, Smith and McEntee (2009) draw attention to ways of evaluating participatory initiatives in the context of HIV/AIDS, there remains a gap in the literature in relation to studying the overall effectiveness of these approaches in the various institutions. What is clear, though, from the work of Ramos (2008) and others is the need to model learner-centred activities in teacher education classrooms if they are to be applied to classrooms in schools.

Differentiated curriculum: Issues of flexibility and multiple modes of delivery are also important. In the Situational Analysis noted in Chapter One, there are a number of examples of online courses, and accounts of teachers engaged in co-curricular activities that are complementary to other approaches. In the reviews of the literature, mention is made of the need for differentiated curricula according to age and generation, rural or urban setting, class and gender, and, of course, experiences with HIV/AIDS. What difference does it make, for example, if the students are twenty-year-olds in a pre-service education programme and have come through Life Skills curricula in their own learning, or if they are students who are in-service teachers, possibly in their forties and fifties who may have a quite different relationship to the information from that typical of younger people? In other cases, the students report being "sick of AIDS" either because they do not see the issues as affecting them or they have AIDS fatigue. Differentiation and innovation can be critical. What is also key in the review is that programmes need to be systematic and of sufficient length to offer comprehensive coverage.

Partnerships and collaborations: The various studies noted above also speak to the significance of partnerships and collaborations. These can be collaborations within the university as is evident in the work around curriculum integration where it is key that several units work together: Health Sciences and Social Work (the Namibia experience), Biochemistry and Sociology (UJ), Education and Sociology (UCT), or even in one faculty as we saw with Media Studies and Guidance and Counselling at UKZN. (Stuart 2007) The need for greater support for creative and participatory approaches as pedagogy also suggests the

importance of greater collaboration between those who have expertise in working with these methodologies and instructors in the various subject-specialisation areas. This work addresses both co-ordination and the value of team teaching. Collaborations and partnerships can also exist beyond the university and involve the broader community. In the review there are examples of projects and interventions that look at the ways in which communities, ministries and faculties of education might work together. Some of the interventions mentioned in the Situational Analysis likewise describe partnerships (sometimes donor driven) and sometimes initiated by just one faculty member working in a community. And while there are clearly challenges to setting up and maintaining these partnerships, not the least of which relates to what happens when the money runs out – we saw, for example, numerous examples of projects that had simply ended in an institution and no one knew where the materials went – the Literature Reviews highlight the importance of going to scale, and the need for partnerships to do that.

Interrelatedness of knowledge about curriculum design and knowledge about HIV/AIDS: The literature points to the significance of the inter-relatedness of two key areas in the successful planning, implementation and evaluation of curricular interventions in the area of HIV/AIDS in Higher Education Institutions – an understanding of curriculum and the field of curriculum studies more broadly, and an understanding of the social and biomedical dimensions of HIV/AIDS. Following from the idea of the importance of partnerships and collaborations, what role can those working in these two areas play, and how can units on Academic Planning or Teaching and Learning best draw on work in these areas?

Professional competence of teachers

Teachers' sexuality: There is an emerging body of work in South Africa and Lesotho that looks at the sexuality of teachers themselves as a critical component of teacher education programmes aimed at addressing HIV/AIDS. Motalingoane-Khau (2006), Khau, (2009) and Khau, Masinga and Pithouse (2008) use memory work and other autobiographical approaches as entry points for teachers to unpack their own beliefs and experiences about sexuality as starting points for working with learners.

Self-study and reflexivity: Work on the significance of self-study and reflexivity, including the self-study of teacher educators and scholar-teachers (Van Laren, 2007; 2009; Stuart 2007; Khau and Pithouse 2008; Pithouse, Mitchell and Weber 2009) draws on teachers' narratives and autobiography. As Kirk (2005) observes of reflexivity in teaching:

> ": …the praxis of reflexivity' in the field' includes a sustained attention to the positions in which I place myself and am placed by others, a listening to and acknowledging of inner voices, doubts and concerns as well as pleasures and pride, and a sensing of what my body is feeling. It implies a constant questioning of what I am doing and why. I start to probe each of these experiences and sensations, to ask: "Why?" "From where?" "Founded on what?" I start to theorise based on my own experiences. (Field notes and journals serve as the critical, practical tool of reflexivity" (224).

Care and compassion: Work has been done in relation to care and compassion as can be seen in the emerging body of work on caring schools. This includes work on developing counselling skills, addressing resiliency, and working specifically with orphans and vulnerable children. (See, for example, Wood 2008; Jairam 2009; Khanare, 2009; Ebersohn and Eloff 2006; Stuart 2004; Theron et al. 2008.)

The social context of HIV/AIDS particularly in the context of race, class and gender: Not surprisingly given the epidemiology of HIV/AIDS, the demographics of the country and history of South Africa, issues of race, class and gender in the context of HIV/AIDS are also part of the emerging landscape of teacher education in South Africa. This work includes De Kock and Willis' (2007) work on white women teachers' representations of HIV/AIDS, and Van Laren's (2009) study of a multi-racial and mixed sex cohort of beginning teachers in which she notes that it is the white male students who

are least engaged in considering issues of HIV/AIDS a being of significance to them.

Gaps in the literature

The case of passion: In the Situational Analysis data collected in teacher education institutions in South Africa late in 2007 and early in 2008 as noted in Chapter One, it was obvious that many champions of work in this area were working with relatively little support and were involved in developing their own materials if necessary. And although some people worried that they might not know enough, they saw the attention to HIV/AIDS in their teaching as something that needed to be done. While it is clear in the literature that it is important to attend to teachers' lives (pre-service, in-service and teacher educators), the idea of what it takes to become a champion of HIV/AIDS is one that remains relatively understudied? Is passion enough? And what is needed in teacher education programs to motivate teachers to act?

Curriculum integration and the case of 'how to': While there is widespread endorsement of the idea of curricular integration and the recommendation that all educators (or programmes, at least in HEIs) should be addressing HIV/AIDS, clearly there is a need for more documented case studies, and more attention needs to be paid to "how to" and then to the questions, "What difference does this make anyway" and "How do we know?"

What does gender have to do with it? Attention to the significance of mainstreaming gender into HIV/AIDS and teacher education programs is often absent in the literature. Although some of the work on gender violence addresses HIV/AIDS (see for example Chege 2006), overall there remain many issues to be addressed and questions to be posed, such as, "How do male and female teachers respond differently to the epidemic in their teaching?", "How do we get professionals to take seriously the statistics around the high rates of HIV infection amongst 15-25 year old young women?", " How do we prepare teachers to take up gender in their teaching more generally?" (See for example Smith, 2009.)

What difference does this make? The challenge raised throughout is a question of evaluation. In the literature, there are few examples of actually evaluating the programmes although Raht, Smith and MacEntee (2009) highlight some ways of evaluating participatory arts-based approaches. Similarly, the institutions themselves spoke of the absence of evaluation outside of the kinds of evaluations that are carried out at the end of any module. The attempts, however, to monitor who is being taught and in what faculty, as the UCT review advocates, is a good example of one type of monitoring that could contribute to overall evaluation.

Understanding engagement and its role in addressing HIV/AIDS: Although much is made in the literature on the significance of participation and its role in teacher education programs (and, by extension, work with learners in school) in addressing HIV/AIDS, to date relatively little has been written about why and, hence, how best to enhance work in this area. And while issues of evaluation as noted above are critical, so, too, is a better understanding of pedagogy itself.

Constructions of professional practice in the age of AIDS: Perhaps the most glaring gap in the literature relates to some sort of coherent 'map' (or sets of maps) of what constitutes professional competence in the age of AIDS either amongst teachers or teacher educators. Clearly it is a complex body of literature and one which would be enhanced by the development of models which can help to frame the whole area of professional development.

CONCLUSION

This chapter has served to situate the Pilot Module on HIV/AIDS and its evaluation within an analysis of how HIV/AIDS is being addressed in teacher education at the local level, and within the context of regional and international literature on addressing HIV/AIDS in Teacher Education. It also, however, has contextualised the work on curriculum integration as a feature within the broader area of Higher Education. While there are many lessons to be learned from this literature, there

are several key areas that inform the Pilot Module and teacher development in the area of HIV/AIDS:

- The significance of the instructors' own self-knowledge and how they engage with HIV/AIDS (through reflexivity and self-study) and the need for ongoing professional support
- Participatory methodologies and student engagement
- Flexibility, multiple modes of delivery and differentiated curricula
- Collaborations (for example, team teaching) and partnerships
- Greater support for curriculum integration
- Interrelatedness of curriculum (design, planning, evaluation) and up-to-date knowledge in the area of HIV/AIDS.

CHAPTER THREE

Methodology

INTRODUCTION

The purpose of the HIV and Teacher Education Pilot Project is the identification, evaluation and dissemination of effective strategies for the incorporation of HIV/AIDS related education into teacher education and other curricula, and therefore to enhance the personal and professional competencies of teacher education graduates through the provision of support for the piloting of the HIV/AIDS teacher education module in teacher education faculties. In this context, there were actually two sets of methodologies in operation, the overall methodology for implementing the pilot study and then within that, the methodology for evaluating the pilot study.

METHODOLOGY IN IMPLEMENTING THE HIV AND TEACHER EDUCATION PILOT PROJECT

The overall approach to the implementation process was one which was collaborative and participatory in nature in the sense that each expert worked closely with the staff (and interns) at several of the teacher education institutions but in the context of a larger collaborative framework supported by three national colloquia (April, 2008, September 2008, May 2009) and the setting up and training related to the Online Collaborative Forum. Thus, there were a number of opportunities for institutions to offer feed back into the larger project. At the same time, the frequent meetings of the Implementing Team (both face to face and through email and telephone) meant that there was an ongoing engagement with the emerging issues at the various institutions, so that informed decisions were made as we went along about how best to work with the institutions around such issues as ethical clearance, carrying out the evaluation and so on. Thus the work with the institutions as whole could be aligned to the participatory action models of Fals-Borda (2001), Hall (1988) and Kemmis and McTaggart (2005). In this context, the implementation process would be best looked at in three phases.

Phase One: Getting started

As noted in Chapter One, in the first phase of the project, a situational analysis was carried out which involved all teacher education faculties being visited by members of the implementing team between mid-December 2007 and early March 2008. In all cases at least two team members from the Implementing Team carried out the visits. There were several purposes to these visits, ranging from making face-to-face contact as a key entry point for the work we would be doing together, to finding out what institutions were doing already, to explaining to the institutions the main components of the pilot project and the various curriculum options. This iterative process spoke to the need for a collaborative approach, and not one that came with a set of 'top down' assumptions.

As part of this collaborative approach, members of the Implementing Team often made summary notes which could be 'fed back' to the institutions themselves as a type of 'member check' but also serve as notes for the whole team. Out of these institutional visits came a Situational Analysis report (see Chapter One), which helped to lay the ground for finalising the range of curriculum options that could be offered to the institutions, and also to contextualise some of the challenges that could be expected during later phases of the implementation process. For example, the issue of the recent mergers highlighted in the Situational Analysis became an important point in influencing how multi-site institutions would distribute the HEAIDS resources.

Arriving at the various curriculum options available to institutions during the Pilot Implementation reflected an iterative process. The implementing team in its institutional visits had to make full use of the time and in so doing spoke about the *Being a teacher in the context of HIV/AIDS* materials and some of the ways that it might be used in a teacher education program. Concomitantly, the institutions themselves in describing their current offerings, resources and goals informed the Implementing Team of some of the models and approaches that they thought might work for them and in this way contributed to shaping the range of options that would be feasible during the pilot period. Thus, coming out of the institutional visits and situational analysis, and in line with appropriate curriculum models, the institutions were offered four curriculum options as a basis for participation in the project.

Option 1: Evaluation support for existing activity
Option 2: Piloting the HEAIDS module in 'stand alone' form
Option 3: Curricular adaptation or 'bolt-on' of the module or component parts of the module onto a single existing module
Option 4: Cross-curricular integration of the module into more than one existing module.[9]

As noted in Chapter One, implementation was also supported by material resources:

- The provision of copies of *Being a teacher in the context of HIV/AIDS* to 6 273 students;
- Provision of a laptop, lcd projector and screen at 23 sites;
- The appointment of interns at 23 sites;
- An electronic information resource called the Online Collaborative Forum (OCF). The OCF is a fully functional, secure web-based arena for participating HEI members to communicate with one another and to upload and download shared resources, collaborate on these resources, and to publish selected resources to a wider audience.
- Regional Support Experts from the implementing team responsible for liaison and support at each HEI. Through the project, HEIs also had access to expert support in relevant fields such as teacher education, curriculum, evaluation, and teacher support and development.

It should also be noted that each institution also contributed to and received a final report on the findings of the HIV and Teacher Education Pilot Project in relation to their own institution. These reports as appended in this document provide valuable locally-generated data that could be used for further programme development.

Institutional Curriculum Choices and Participation

The four curriculum options were presented at the first National Colloquium held on 7 - 8 April 2008 and attended by representatives of 22 HEIs. Largely as result of this colloquium, in conjunction with the promotional work of the implementing team assigned with responsibility for liaising with individual HEIs, the pilot implementation took place in 23 pre-service and in-service teacher education programmes on 25 sites in 20 HEIs. A total of 6485 students benefited from the pilot implementation in 23 programmes in 2008, and a further four which commenced in 2009.

A summarised position of HEI participation is captured in Table 2.

Although these statistics largely speak for themselves, the most notable feature of the table is the very

Table 2 HEI participation in the HIV Pilot Module

Number of HEIs participating in the project	20
Number of sites of participation (including multi campus operations)	25
Number of programmes in which one of the four options was implemented	27
Curriculum options selected for participation by programme ■ "Fast track" participation for existing modules ■ Stand alone module ■ Single module adaptation ■ Cross-curricular integration (Offering a combination of 3 and 4)	 0 12 14 1
Type of teacher education programmes in which the module/ an option was being infused: ■ ACE (in-servive) ■ B. Ed. (pre-service) ■ NPDE (in-serivce)W ■ PGCE (in-service)	 3 17 3 4
Year of implementation: ■ 2008 (no. of programmes) ■ 2009	 23 4
Projected number of participating students	6485
Number of Learning Guides and Readers distributed	6273
Sets of laptops, lcd screen and projector distributed	23 (2 returned)
Number of interns appointed	23
Number of academics trained on site in using OCF	68 (25 sites of delivery)

considerable extent of HEI participation. Of the 23 HEI institutions in South Africa, one was unable to participate since it does not offer programmes in teacher education; one HEI declined participation; and one withdrew from the project after its students had completed the module.

Phase Two: Module Implementation Phase

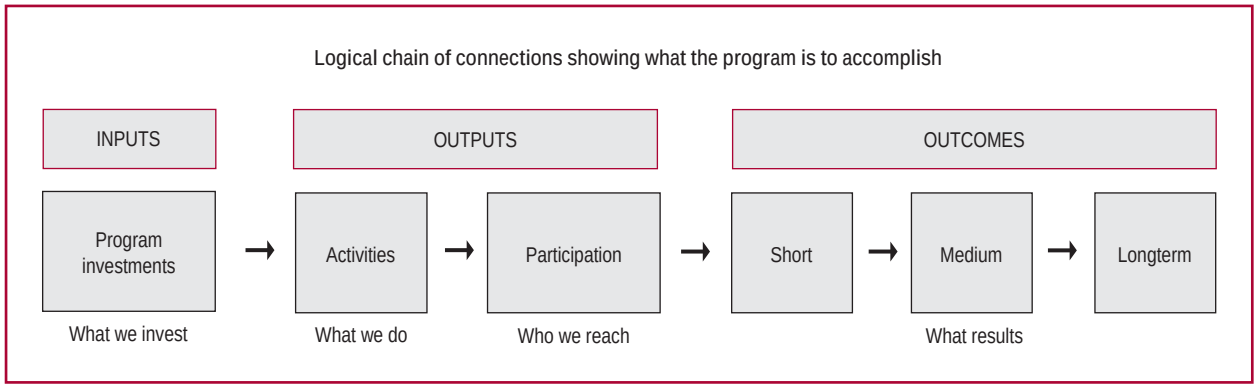
The module implementation phase of the HIV and Teacher Education Pilot Project in the various institutions began in April, 2008. Starting with a pilot intervention with pre-service teachers at one institution and with the very close involvement of one of Key Experts of the Implementing Team offered valuable feedback to the whole team on what was doable over a semester, and some of the constraints in relation to practical work when the pre-service teachers have not engaged in their field experience. By the beginning of July, 2008 several of the pilot interventions were underway and several others completed. The bulk of the pilot interventions, however, took place in the August-November, 2008 semester, although four did not take place until the first semester of 2009.

Phase Three: Evaluation Phase

The evaluation phase included several components: (1) developing an evaluation model for the pilot, (2) applying to the Ethical Review Boards of all of the participating HEIs for approval to conduct the evaluation; and (3) carrying out a workshop approach to fine-tuning the evaluation model with HEI participants and interns at a second national colloquium "On evaluating HIV/AIDS interventions in teacher education" held on 22–23 September 2008. Central to finalizing the evaluation model was the idea that it was critical that the instructors from the various institutions understood the approaches being used, and that where possible that they had some voice in how this work would be carried out and interpreted. For example, at one of the sessions at the September 22–23 colloquium during a workshop on conducting focus groups, it became clear to the Implementing Team that it was necessary to revisit certain types of questions and approaches to interpreting the data as a result of the input from the participants.

In terms of sheer numbers, the project provides a powerful base for evaluation. A good range of pre-service and in-service programmes were represented in HEIs' offerings, with the in-service NPDE programmes bringing adequate representation of the rural student voice. In addition, HEIs' curriculum choices reflect a balance of the most useful choices from an evaluation perspective: in 12 programmes, the full module was offered in stand-alone form, and in 14 it was integrated into existing modules. This would provide the basis for meaningful comparison between the relative effectiveness of the two major curriculum strategies for offering HIV/AIDS education.

Figure 1 Evaluation model



Source: University of Wisconsin-Extension, Program Development and Evaluation

THE EVALUATION MODEL

This section draws on the document, *Evaluation model for the monitoring and evaluation of project procedures and outcomes* produced in June, 2008 as a precursor to applying for ethical review in each of the institutions, and as a way to consult with HEAIDS and the PWG on the proposed model.

The actual evaluation model is based on a partnership that draws on, and respects the requirements of, both the project and each participating institution. The theoretical underpinning for the adoption of the framework is illustrated in the model shown in Figure 1 (University of Wisconsin Extension, Cooperative Extension 2008):

This evaluation model provided the framework for programme development and evaluation of the HIV and Teacher Education Pilot Project in relation to the three phases as noted earlier.

The first phase involved:

- Developing and confirming the *purpose and outcomes* of the module - or unit(s) of the module – to be offered in piloting the teaching of HIV/AIDS with relevant stakeholders (staff and students).
- Identifying which of the four pilot module outcomes would be addressed.
- Establishing *outputs* for the project and *performance* indicators for students participating in the module.
- Establishing *baseline* data in relation to student teachers' knowledge and attitudes towards HIV/AIDS and the teaching thereof. (This same instrument was used as a post-test to assess changes at the conclusion of the module.)

The second phase involved each institution in the following:

- Choosing to implement the HEAIDS pilot module in full or in part (the four Options).
- Implementing particular activities to enable students to achieve the identified outcomes.
- Monitoring the implementation of the activities, the progress and the emerging data (such as issues, milestones and problems).
- Making adjustments where necessary in relation to the above.

The third phase involved conducting a summative evaluation of the piloting of the module. This evaluation facilitated answering the following key questions:

- To what extent, and in what ways, were the intended outcomes achieved?
  - **Outcome 1:** The development of personal and professional competencies of the teachers in training in relation to HIV and AIDS?
  - **Outcome 2:** The identification, evaluation and dissemination of effective course design/ pedagogic strategies for integrating HIV and AIDS into teacher education courses?

- What lessons were learned from the piloting of the module in relation to taking it forward?
- How did the institutions engage in self-evaluation?

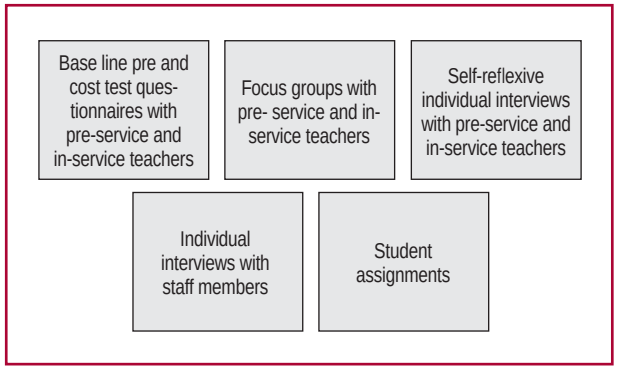
CARRYING OUT THE SUMMATIVE EVALUATION

In the third phase, a mixed methods design (Creswell 1994) was used to achieve the above aims. Mixed methods research is defined as "a procedure for collecting, analysing and 'mixing' both quantitative and qualitative at some stage of the research process within a single study to understand a research problem more completely". (Creswell and Plano Clark 2007, p. 5) We recognise that all methods have limitations and that convergence of data sources across quantitative and qualitative methods is a means of trying to minimise the biases inherent in any single method (Flick 2006; Creswell 2003) so as to arrive at well-validated conclusions.

Data collection

Figure 2 serves to map out the range of data collecting tools used to conduct the summative evaluation. With the exception of administering the base line pre and post test questionnaires, all other aspects of the data collection were carried out by members of the Implementing Team.

Figure 2 Data Collection



Structured questionnaire

Within a mixed methods design, a structured questionnaire was used as a pre-test (providing baseline information) and as a post-test, after the completion of the pilot module. The instrument used to gather the quantitative data was a 71-item *questionnaire*[10] specifically designed to measure the following:

- The accuracy of students' HIV/AIDS-related biomedical knowledge
- The degree of students' HIV/AIDS-related activity/ activism
- The nature of students' gender-related and other relevant discriminatory attitudes in relation to HIV/AIDS

The questions were structured in such a way that the respondents had to make a cross (x) only to indicate the selected response, for example, "I know it is definitely true", "I think it is true", "I don't know", "I think it is false", "I know it is definitely false"; "yes" or "no"; on a 5 point Likert scale ranging from "strongly disagree" to "strongly agree"; on a 5 point Likert scale ranging from "not at all confident" to "very confident" and on a 5 point Likert scale ranging from "very uncomfortable" to "very comfortable".

The questionnaire was administered during the teaching contact time by the instructor and took 45 to 50 minutes to complete. The pre-test questionnaire was administered at the very beginning of the module implementation in each institution, and the post-test questionnaire was administered during the last class.

This questionnaire was a slightly modified version of one used by Vergnani and Lees in their work with ACE teachers at the University of the Western Cape. Because it had been used to evaluate the same concepts and with similar groups of teachers (at least at the in-service level), it was deemed to be acceptable for the purposes of this project. The *validity* of the questionnaire (measuring what it intends to measure) is increased by an evaluation of the representativeness or sampling adequacy of the content and would be considered valid if it provides "an adequate or representative sample of all content, or elements or instances of the phenomenon being measured". (Delport 2005, pp. 160-161) According to Rubin and Babbie (2001) content validity can also be determined on the basis of the judgement of the researchers or other experts, as to whether the instrument

covers all the aspects of the content being measured. In this instance the items in the various sections of the questionnaire were interrogated by two members of the Implementing Team and were adapted where necessary to better reflect what the questionnaire intended to measure.

Reliability refers to the consistency and dependability of the measurement instrument, that is, the extent to which if repeated under similar conditions it would yield the same results. (Terre Blanche and Durrheim 1999) There is no information available about the reliability of this questionnaire, but it had been used with various samples of students, especially teacher educators from across Africa). The reliability of the questionnaire could possibly have been influenced by some participants' being second language speakers and not interpreting the questions correctly and by some questions being deemed problematic. Some of these concerns were addressed when the implementing team analysed the questionnaire data, and questions that seemed problematic were excluded.

The qualitative questionnaire, "Situating Ourselves" was administered to instructors and tutors in order to elicit a report of teacher educators' perceptions and experiences of their work in HIV/AIDS education prior to implementation of the pilot module. The structured questionnaire, with 7 open-ended questions, took the participating teacher educators and tutors approximately 15 to 20 minutes to complete.

Interviews (Focus group and individual)

In this evaluation model, structured individual and focus group interviews were used. All the questions were pre-determined by the implementing team, although in each case the interviewer (always a member of the implementing team) could probe for further clarification.

- *Focus group interviews* with students (requiring the students to respond to two classroom scenarios about infected and affected learners and also to reflect on the module) were held. The interviews were held outside class contact time and lasted about 45 minutes to an hour.
- *Individual self-reflexive interviews* with students (requiring the students to reflect on their experiences before, during and after the pilot, referring to issues around feelings, participation, changes in understanding self, risk, HIV/AIDS, community, a sense of agency, community involvement and life as a teacher) were held. The interviews were held outside class contact time and lasted about 45 minutes to an hour.
- *Individual interviews* with teacher-educators and tutors and, in some instances, the interns (requiring the staff to reflect on the material, pedagogy, student engagement, successes and challenges, support provided by the research team, and the way forward in their institution) were held, to explore to what extent the outcomes had been achieved. The interviews were held outside class contact time and lasted about 45 minutes to an hour.

The participation in the interviews was voluntary, and hence it is necessary to raise the issue of potential sampling bias since only the voices of students who volunteered to participate are represented.

This data was supplemented where possible, by other tools, such as *student assessment tasks*. The instructors also filled in an anonymous "Situating Ourselves" questionnaire which provided useful input on the type of training and support that they saw as important in addressing HIV/AIDS in teacher education.

Table 3 provides an indication of the sample and the data generation instruments.

Table 3 Participants and data generation instruments

Students	Teacher Educators
Pre-test questionnaire N=2448	
Student assessment tasks	'Situating ourselves' questionnaire N= 45 teacher-educators N=30 tutors
Focus group interviews N=192	
Individual interviews N= 99	
Post-test questionnaire N=2075	Individual interviews N= 48

Data Analysis

Pre and post test Questionnaires

For the analysis of the *quantitative questionnaire* data, SPSS software was used to generate descriptive statistics which have been presented in graphs, complemented by an interpretation of the results. As a reliability check, the quantitative data was also analysed by an independent party.

A total number of 607 students could be matched from the pre-test to the post-test, using the institution, gender and secret code to match the data sets. A comparison of a matched sample of pre- and post-test results was intended to demonstrate the degree of change in students' development and learning in the course of the pilot. In cases of institutions at which the matched sample was smaller than 10, only the post-test results were used to indicate student learning and development at the end of the pilot. In analysing the data some limitations were revealed and were addressed as well as possible to maintain the utility of the analysis.

The analysis of the qualitative "*Situating Ourselves*" questionnaire was done by coding for themes and categories.

Interviews

The analyses of the *three forms* of interviews were conducted by members of the implementing team in relation to the specific HEIs for which they were responsible. Tesch's open-coding method (Creswell 1994) was applied in order to identify emerging themes and categories. All interviews were audio recorded and then transcribed by the relevant interns. Both sensitising concepts (theoretical concepts that framed the interpretation) and indigenous concepts (i.e. those that arose directly from the qualitative data) were used to identify themes relating to competence and curriculum issues. In this sense, the analysis was both deductive and inductive. (Merriam 2008).

Two theoretical frameworks, one for the curriculum and one for competence, facilitated making sense of the data and representing it. (See Chapter Four for a full description of these.) In the case of curriculum, a model of curriculum-in-use, or the actual day-to-day interactions among lecturers (teachers), students, content and the social and academic environment having an impact on learning in an HIV/AIDS module, helped in the understanding of the various curriculum aspects and their intersections, within the context of HIV/AIDS that would really make a difference to student learning. Here, too, various data sources were engaged with to draw out important themes.

The theoretical framework for teacher competence, i.e. the "model of professional practice in the Age of AIDS" which emerged from the data and from the literature, has not yet been subjected to peer review outside of the team. Future peer review could enhance the framework to more richly represent the competence issues involved in HIV/AIDS education and prevention. In the analysis of the 'competence', the various data sources were engaged with in order to draw out descriptions of what is understood as competence or approaching competence and was not intended to arrive at a conclusion about whether the participants were competent or not. It was simply meant to document student and lecturer views or perceptions of competence.

In order to add a further layer of meaning to working with the qualitative data, the implementing team also worked with "various structures and devices of narration" as Ely, Vince, Anzul and Downing 1997) describe the use of anecdote (and conecdote or connected pieces), polyvocal fictional narratives, factional stories, composite stories and letters in writing up qualitative research. Cresswell (1994) locates this type of writing within the bigger data analysis process as involving taking apart the data into small chunks (which removes the context), and then constructing a larger consolidated picture which is then recontextualised. The intention is to allow many voices to tell the stories of their experiences and one of the products of the data analysis and careful examination of the "chunks" is a series of polyvocal narratives. Max van Manen (1990, p. 116) writes that anecdote, as a broad category for this work "can be

understood as a methodological device in human science that makes comprehensible some notion that easily eludes us." In developing this approach the team followed a two step process: first, following from the work of Holland et al. (1999) on group approaches to interpreting data, team members put forward orally (and spontaneously) one or two illuminating stories that emerged from their own data set. As a second step, team members undertook to construct/compose an anecdotal narrative piece on several key issues related to professional competence. In some cases the products were sections of transcript which, even when 'found' within the larger transcript, managed to tell a story. In other cases, the team member reconstructed the story.

The trustworthiness of the qualitative research was accomplished through addressing the criteria for credibility (truth-value), transferability (applicability), dependability (consistency), and confirmability (neutrality). (See Guba's model in Krefting 1991; Leedy 1993.) It was attained by means of triangulation, for example, field notes, prolonged engagement, peer review, detailed, dense descriptions, scientific distance, consensus on the final themes and categories that emerged, preservation of raw material as an audit trail, mastery of the enquiry method and reference adequacy. (Leedy 1993) It was also amplified by having multiple data sources (students and staff members) and by using multiple data generation instruments (focus group interviews, individual interviews, module evaluations, and student assignments). In some instances the findings were shared with lecturers and interns and critical comment invited as a form of member checking. As far as constraints in the analysis of the qualitative interview data were concerned, care was taken to ensure trustworthiness as indicated above, but time did not allow for re-coding the raw data. Therefore the only person who interpreted the raw data was the team member working with specific HEIs. Moreover, it needs to be noted that the data overall relies on self-reporting (through questionnaire data, interviews, focus groups) and as such are subject to particular limitations of their own. (Mouton 2008)

ETHICAL CLEARANCE

Ethical concerns relate to three issues – informed consent (i.e. receiving the participants' consent after carefully and truthfully informing them about the purpose of the research), right to privacy (i.e. protecting the identity of the participants), and protection from harm (i.e. emotional, physical or any other type of harm). (Denzin and Lincoln 2003) Punch (in Denzin and Lincoln 2003) places the onus on researchers doing fieldwork to exercise common sense and a responsibility firstly to their participants, secondly to the text, and thirdly to themselves. The implementing team was guided by these principles, which are particularly important when working with a sensitive issue such as HIV/AIDS.

Each university has its own process of applying for ethical clearance, although most institutions have developed templates to apply for ethical clearance that are similar. To that end the implementing team member for each HEI worked with the Dean and teaching staff member to file the ethical clearance application, drawing closely on the details contained in the document, *Evaluation model for the monitoring and evaluation of project procedures and outcomes.* Although every effort was made to obtain ethical clearance prior to implementation of data generation, it was not possible in every instance. One institution in particular had not completed setting up its procedures and for this reason the data from this institution could not be included in the analysis.

CHAPTER FOUR

Framing the Findings

Theoretical Perspectives on Curriculum Design, Implementation and Impact

INTRODUCTION

This chapter maps out the theoretical underpinning of the work and, in so doing, serves to frame the presentation of findings offered in Chapter Five. As noted in the previous chapter, the pilot had a dual focus with attention being paid not only to curriculum but also to deepening an understanding of the professional competence of teachers in the age of AIDS. The findings are thus located within two separate yet interrelated theoretical frameworks – one that addresses curriculum design and implementation and one that addresses curriculum impact (i.e. the professional competence of teachers).

In developing appropriate ways to frame the vast body of data that reflected work with both pre-service and in-service teachers and across the various HEIs and their differing contexts for teaching and learning, we drew on a wide range of literature. The literature on teacher education in relation to addressing HIV/AIDS highlighted in Chapter Two informed these frameworks in an iterative way, drawing on Malinowski's idea of foreshadowings (as opposed to preconceived notions) in the interpretative process. (Malinowksi, 1948).

To illustrate: in the iterative process the materials developed in the first place and prior to the pilot study reflect a number of critical curricular components identified in the literature, including the importance of participatory methods, the interrelatedness of pedagogy and biomedical knowledge about HIV/AIDS, and the need for partnerships and the support of a broader community. Ultimately, the design of the Learning Guide, Being a teacher in the context of the HIV/AIDS pandemic piloted in HEIs led to incorporating four key outcomes. These are:

- To implement participative pedagogical approaches to teaching biomedical facts about HIV/AIDS;
- To understand how issues of poverty, gender, stigma and discrimination relate to HIV/AIDS in the South African and wider African context and to engage learners around these issues in a participative manner;
- To understand the physical, economic, social and emotional impact of the HIV/AIDS epidemic on teachers, learners and their communities; and
- To respond in sensitive, positive and holistic ways to the practical as well as psychosocial needs of learners and colleagues.

Thus, as we embarked upon a framework for the analysis and interpretation of the data on curriculum design and implementation, we returned to these broad outcomes and to the critical components which are contained in the model of curriculum-in-use as described below. Similarly, in looking at curriculum impact in relation to professional competence, the literature both informed the content of materials, and, as we began to work with the data, helped us to identify key thematic areas which could then contribute to shaping a model

of teacher professional competence in the age of AIDS organised around such critical areas as awareness of social context, an awareness of taking on a variety of educator roles, and, finally, a sense of reflexivity, the need for self study and the need to take action.

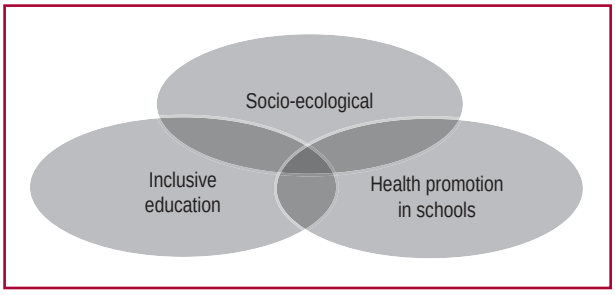
In the sections below we map out a theoretical positioning first, on curriculum-in-use to frame findings related to curriculum design and implementation, and second, on curriculum impact to frame a model of professional competence.

CURRICULUM DESIGN AND IMPLEMENTATION: A MODEL OF CURRICULUM-IN-USE

The curriculum model that is proposed is informed by Hollins' (1996) notion of curriculum-in-use. Curriculum-in-use refers to the actual day-to-day interactions among lecturers (teachers), students, content and the social and academic environment. What is the impact on learning in an HIV/AIDS module? How do lecturers and students receive, understand, interpret and implement the curriculum as product (the written curriculum, in this case, being the HEAIDS manual)? "What is it about [the] curriculum and [the] pedagogy [that lecturers adopt] that really makes the difference to [student] learning?" (Reeves and Muller, 2005, p.103)

The model that is proposed here to address these questions is informed by William Pinar's (2004 p.186) metaphor of curriculum as "an extraordinarily complicated conversation". In order to address this complexity, the model is premised on three perspectives: a *socio-ecological* perspective, an *inclusive education* perspective and a '*health-promotion in schools*' perspective.

Figure 3 Curriculum-in-use multi-perspective model



First, a socio-ecological perspective of curriculum is informed by the notion that, "People can take part in the health promotion process [for example, HIV prevention interventions] effectively only when they have a clear view of the [interrelatedness of] social and environmental factors that affect health and well-being." (Ministry of Education, 1999 p.33) In this regard, the evaluation examines the extent and ways in which the data reveal participant student teachers' and lecturers' understandings of the impacts of the educational and social contexts in which schooling in various localities in South Africa takes place on the general well-being of individuals (learners and teachers) and communities, and on their risk of HIV infection, as well as on the participants' own HIV and AIDS interventions. In effect, the evaluation asks:

- To what extent, and in what ways, do the participants recognise that HIV/AIDS has a negative impact on both individuals and groups in communities and institutions such as schools, and as such, whether HIV prevention behaviours are recognised as involving both social (group) and individual decision-making and choices about well-being?
- How has the curriculum-in-use in the various higher education institutional contexts developed an understanding amongst participant student teachers and their lecturers of their roles, not only as teachers, but also as agents of change in the age of AIDS?
- In what ways has the pilot developed an understanding amongst participants that curricula interventions aimed at reducing infections and minimising the negative impacts of the epidemic must take into account the following realities and imperatives?
  - Schooling is highly contextual and, in the context of HIV/AIDS, it is highly complex.
  - Those charged with implementing educational interventions (for example, teachers) must first make meaning of both the interventions and of the context (social and educational) in which it is implemented.

- Only then can pre-service teachers make use of the intervention in ways that make a difference to the lives of those intended to benefit (their learners and the communities in which they teach or will be teaching as well as themselves).

Second, and related to the above, the health promotion perspective sees the role of schools as creating "supportive physical and emotional environments in classrooms, whole schools, communities, and society, [and encouraging] students to make a positive contribution to their own well-being and that of their communities and environments". (Ministry of Education 1999, p. 32) In this regard health promoting schools are constantly striving to strengthen their capacity as healthy settings for learning and working. (Health Promoting Schools 2009) So, to what extent, and in what ways, has the curriculum-in-use assisted participants to develop an understanding of their own roles and the roles of schools in the context of HIV/AIDS and its impact?

Third, in South Africa, the inclusive education perspective – informed by the Education White Paper 6 - Special Needs Education: Building an Inclusive Education and Training system (Department of Education, 2001) – is premised on the notion that optimal learning can be achieved for all learners, if the barriers to learning which individuals or groups of learners experience can be removed or ameliorated. In the context of an HIV/AIDS module, what kinds of knowledge, skills and attitudes would the curriculum-in-use need to provide for such optimal learning to occur? Specifically, how would the curriculum-in-use enable teacher educators to assist pre-service and in-service teachers to:

- Recognise and minimise the impact of barriers to learning that confront their learners;
- Change their attitudes and behaviour towards difference and learners with different educational needs;
- Differentiate and adapt the curriculum and teaching techniques in line with the varied needs and capabilities of individual learners and groups in their classrooms (Ntombela 2006); and
- Adopt teaching methodologies that support learning for all?

In essence, to what extent and in what ways has the curriculum-in-use, as applied in the various higher education institutions, developed these skills, knowledge and attitudes amongst participant teachers and their lecturers in the pilot module? In what ways are they able to use, or think about ways of using, "... approaches based on critical thinking and critical action when applying the socio-ecological perspective and practising health promotion in their teaching and learning" (Ministry of Education, 1999 p.33).

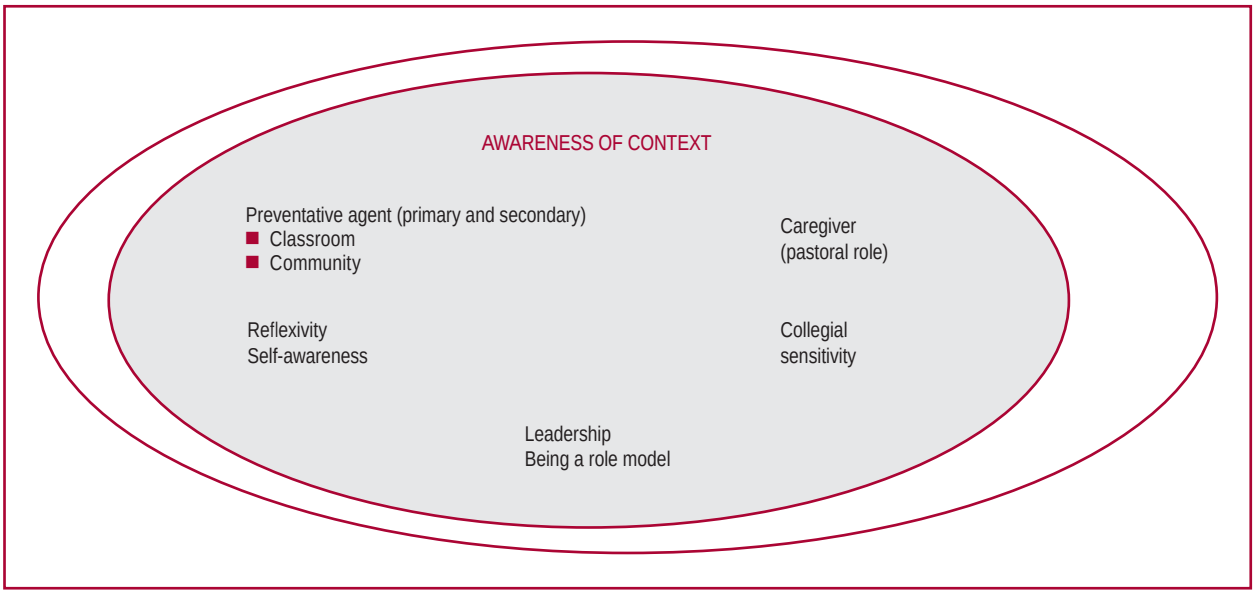
PROFESSIONAL PRACTICE IN THE AGE OF AIDS

Teacher identities and responsibilities, sensitive to the contexts in which teaching occurs, are shaped by eco-systemic factors inherent in their micro- and macro-contexts. (Hall 2004; Hoadley 2002) Following from the review of literature in Chapter Two, and turning to teacher responsibilities, or professional practice as such, it is clear that teaching cannot be thought of as business-as- usual in the age of AIDS. Given the multiple and relentless challenges of the HIV crisis for teachers, teacher roles and responsibilities have mutated to include a range of skills, roles and sensitivities. In brief, this includes raising HIV and AIDS awareness, teaching prevention, supporting infected and affected learners (and colleagues), shouldering increased teaching loads as infected colleagues are absent, and coping with HIV-related sickness and death in significant others. (Bhana et al. 2006:7-18; Car-Hill 2003; Coombe 2003) For this reason we suggest a model of professional practice in the age of AIDS (Figure 4) that foregrounds three broad areas that are critical areas of professional practice:

- teacher roles (prevention agent; caregiver, leader/role model),
- teacher sensitivities (awareness of vulnerable learners and colleagues; gender issues; cultural heritage, contextual assets and constraints);
- teacher agency (willingness to reflect and act)

In the age of AIDS, teachers are expected to function as agents of prevention: they are professionally obliged

Figure 4 Professional Practice in the Age of AIDS



to teach their learners about safer sex, healthy sexuality and HIV prevention. (Car-Hill 2003) Teachers are further obligated to prevent discriminatory practices and the stigmatisation of learners and colleagues who might be infected or affected by HIV and AIDS. (Hoadley 2007) These obligations are entrenched in the National Policy on HIV/AIDS for Learners and Educators (DoE 1999) and the Norms and Standards for Educators. (DoE 2000) This role of the teacher in school often also spills over into the community.

Many teachers are confronted with large numbers of learners made vulnerable by HIV and AIDS (Bhana et al. 2006; Boler 2003) and, hence, care-giving becomes an important issue. Often, these vulnerable learners need more than pedagogical interventions – most require additional support in terms of grief counselling, nutrition, accommodation and school fees, coping with discrimination, abuse, rejection, lost childhood, and so forth. (Bhana et al. 2006; Coombe 2003; Ebersöhn and Eloff 2002) Too often teachers represent the solitary source of hope, information and/or comfort for these learners. (Bhana et al. 2006; Coombe 2003; Hoadley 2007; Theron, Geyer, Strydom and Delport 2008) Provincial departments of education often lack the human resources to provide counselling or they underspend funds earmarked for support and care of HIV affected learners (Govender 2008), so teachers fill the gap.

In rural schools where the HIV epidemic magnifies the contextual barriers that learners face, the burden of care that teachers shoulder is more acutely felt (Bhana et al. 2006), and often plays itself out as the teacher taking up a leading role in making things happen. In rural and other under-resourced schools, the teacher is often 'all things to all people' (for example, social worker, counsellor, caregiver, advisor, and educator). (Bhana et al. 2006; Hoadley 2007; Theron et al. 2008)

All of the above are shaped by the context and culture in which the teacher functions, and by the contexts and cultural heritage that shaped the teacher as a person and as a professional. (Baxen and Breidlid 2004) It can be argued that teachers would probably not respond to the vulnerabilities of their learners or the obligations of policy if they were not aware of, and sensitive to, the challenges inherent to the HIV crisis for their learners (especially female learners), colleagues and communities and if they were not prepared to reflect on their responsibilities and potential influence as a professional in the age of AIDS. Furthermore, teachers' awareness of assets, which they can draw on in the community and from their cultural heritage, can contribute to the mobilisation of these assets towards the empowerment of learners and their communities, and in this way minimise or at least ease the impact of the HIV epidemic on their learners, colleagues and community.

Finally, teacher awareness of the complex reality of HIV would be incomplete without a critical understanding of their own positions and vulnerabilities in relation to the epidemic. This suggests that teacher competence in the age of HIV and AIDS requires teachers to reflect on particular lived experiences (or the lack thereof), assumptions, beliefs, values, fears, sexuality, actions and interactions. Such deep introspection would ideally translate into modified practice, both on a personal and on a professional level.

CONCLUSION

Situated within the broader literature on teacher education in the age of HIV/AIDS and within curriculum studies more broadly, this chapter has provided a theoretical context for interpreting the evaluation data presented in Chapter Five. Central to this work is the idea of curriculum-in-use as a way to frame the work on curriculum design and implementation, and the idea of curriculum impact as a way to frame the data on professional competence.

CHAPTER FIVE

Evaluation Findings

This chapter presents an overview of the collated reports on individual accounts of the pilot in each of the HEIs after each HEI had approved its report. These reports were based on interview data gathered from staff and students as well as student data from the pre-test and post-test questionnaires. The chapter also integrates the experience and perceptions of implementing staff prior to implementation, and HEIs' judgments on the implementation of the module as well as the evaluations of three colloquia held in April 2008, September 2008, and May 2009.

The findings, drawn from these sources, respond to requirements of the Terms of Reference (ToR) for the pilot evaluation, which are to evaluate:

- The enhancement of 'the personal and professional competencies of teacher education graduates' in respect of HIV/AIDS related education, and
- Strategies for incorporation of HIV/AIDS related education into teacher education.

The integrated findings are presented in two sections of Chapter Five – *Curriculum* (i.e. strategies for the incorporation of HIV/AIDS related education into teacher education) and *Competence* (personal and professional competencies of teacher education graduates in respect of HIV/AIDS related education). The theoretical framework for the analysis of the data has been described in Chapter Four.

EVALUATION OF PILOT EXPERIENCES: CURRICULUM

Purpose

The purpose of this section is to summarise the principle evaluative findings in relation to key curriculum elements as built into the pilot module. This summative evaluation has been drawn (and condensed) from the detailed findings and conclusions of nineteen individual institutional pilot evaluations[11] and the methodology and evaluation tools as used in those evaluations.[12] It also integrates selected findings of HEI perspectives on the implementation of the Pilot as well as the evaluation of the three Colloquia.

Broadly, the same pilot module outcomes were applied across these institutions, but the content and skills emphasised differed in response to the widely differing target audiences and the constraints/opportunities of the programmes into which the module was integrated. Given the space constraints of a summative evaluation such as this, all the details of these differences cannot be reflected here. Nevertheless, where they are most relevant to this summative rendering, these differences are incorporated into the findings as reported here so that, as a whole, the findings provide a broad view from which the lesson of experience across all institutions could be distilled in the conclusions and recommendations as presented in Chapter Six.

The theoretical framework for the analysis is described in Chapter Four. As a summative evaluation, the primary methodological focus was on selecting and pointing to themes that emerged commonly across institutions in relation to the curriculum categories listed below. Within this, however, examples are also given that were less common but which pointed to insights or issues having particular significance in terms of lessons of experience. Selected quotations drawn from the individual pilot reports are presented to illustrate the lived experience of the students and staff involved.[13]

Emergent themes are discussed in terms of the following curriculum categories:[14]

- Content and outcomes
- Materials
- Course structure
- Target audience
- Pedagogy
- Assessment
- Personnel/implementing staff
- Use of technology

Findings

Content and outcomes

Central questions in evaluating this curriculum category related first of all to which of the four main outcomes of the module were achieved. The four outcomes of the module, as noted earlier, were (1) to implement participative pedagogical approaches to teaching biomedical facts about HIV/AIDS. (2) to understand how issues of poverty, gender, stigma and discrimination relate to HIV/AIDS in the South African and wider context, and to engage learners around these issues in a participative manner, (3) to understand the physical, economic, social and emotional impact of the HIV/AIDS pandemic on teachers, learners and their communities, and (4) to respond in sensitive, positive and holistic ways to the practical as well as psychosocial needs of learners and colleagues. Other questions related to whether the content of the module was experienced as relevant, how well it was understood by students, and the degree to which the content resonated with the needs of the target group. Some institutions set out to cover all four of the outcomes; some adapted the outcomes in order to integrate them into existing modules, and some foregrounded one or two of the outcomes, but more than half reported covering all of the outcomes.[15] Institutions reported not only on coverage, but also on achievement of the four outcomes. The first three outcomes were adjudged to have been achieved or mostly achieved by 87.5%, 100%, and 89% of respondents respectively. It is not surprising that least certainty of success is expressed with respect to the fourth outcome since judgment in this instance is based on assumptions about students' future actions in circumstances and contexts that could not be known at the time of the evaluation. In the case of work with pre-service teachers in particular, the implementation of the module and the evaluation took place before the regular teaching practice session. In other universities it took place after the implementation of the module but because of how the practicum was organised was not directly linked to the module.

In terms of statements from the interviews about achievement of the outcomes, references to *empowerment through knowledge* were the most common and striking. Thus:

> We didn't have enough information; we just had some perceptions, whereby people tell you that after sex you just take a shower and you will be okay. We just realised that it's not true, we also have the perception that when having sex with a child under age you will be able to cure the virus, we just discovered it's not true. Before we could not challenge this because we were not sure but now we know.[16]

Comments on the importance of understanding the *framing theory* as well as the broader *context* were also significant. As one lecturer commented:

> What is important is the ecological perspective – we must magnify it. They still see if I make this example, they still look at the person who is HIV positive as having a problem and having to deal with that problem alone. And, they don't realise therefore that the fact the person is HIV positive affects those close to that person, so the system will be affected.

There were numerous references in the interviews to the importance of understanding the *economic antecedents*, the impact of *stigma*, and particularly the *gendered* character of HIV/AIDS. The short story in the readings, *Baba's Gift*, clearly made an impact.

> …MaNdlovu was economically dependent on her husband. If she was not economically dependent on her husband, she will … he will let her … he will let him go. You must go back to where you belong, and she must carry on with her life. And … what else. It's … it's … it gives me strength to withstand that, I as a woman, I have the right to say no, to sex, if I don't want to have sex.

For a female student at another institution, the insights from the module particularly as gained through the materials (eg Baba's Gift) empowered her to change her thinking about her relationships with men:

> Baba's Gift changed my thinking; I will not be like MaNdlovu. She was afraid of her husband and nobody will mess me up like that.

While not all students were as bold as her, it was clear that for many, even for pre-service teachers, the module had been revelatory for them in relation to gender:

> It really taught me that we as young girls, we always think that – you know – we are the same as guys. … So you must always bear in mind that you are not the same as guys, you know. We are more valuable and more vulnerable.

Examples like the above point to powerful *personal learning.* However, students in a number of institutions commented that the content of the module had not added significantly to what they already knew about HIV/AIDS while others felt that real *behaviour change* could only occur once they were confronted with real life (physical/'fisies') situations.

> Ek kan nou se, ja, ek gaan heel 'chill' wees daaroor en ek gaan heel normaal optree, maar as jy daar self fisies is, gaan jou nie dalk dan miskien nie.
>
> (I can now say that I will be really chilled about it and that I will act normally, but when you are there physically, that may not be the case.)

In terms of *attitude change*, some students indicated that they had become less prejudiced in relation to HIV/AIDS. Nevertheless, others betrayed, in the nature of their discourse, that actual attitude change could be more problematic. For example:

> I used to think that if you were a bad person, that is why you got it. Actually, at first I was like, I was never exposed to a community with those kind of people.

Finally, with respect to *practical teaching skills*, there was one institution in which the lecturer had clearly amplified the content of the module to meet the needs of Foundation Phase pre-service teachers:

> Persona dolls – I think it is a new concept where you get/buy a fairly big doll of all colours, races or religions. And use this doll as a tool to explain scenarios to the children. Perhaps you can have the doll sit on your lap and say that he/she is your friend who was sexually abused, and maybe tell a story through the doll. The doll relates more to children, with it you can explain the scenario of HIV/AIDS, how you can get it, prevention etc.

In another institution, the lecturer had focused with FET PGCE students on integration of HIV into specific learning areas and this was very helpful to them:

> So I got them to interrogate their curriculum statements and then I got them to go and find resources that actually deal with it and this year I used text books. I said find a textbook in your subject area or learning area and then develop criteria based on the principles of the curriculum and we discussed them in class and then actually had to evaluate whether that textbook was achieving the goals of the curriculum.

Quite commonly, however, students felt that the module should have included more on counselling skills in order to meet the needs of their learners:

> If the designer can add on how to do counselling in our schools because you can talk to the learner about HIV and AIDS and … but we have to understand the emotions that we can overcome to the learner.

Summary: Content and outcomes

There is evidence that the module had given students new insights into HIV/AIDS and a sense of empowerment through knowledge. This appeared to be largely because the module was theoretically framed in terms of both the immediate as well as the broader social context. However, while many seeds have been sown, it is also clear that attitudinal and behavioural changes will need to be nurtured over time if they are to result in permanent change. Finally, the module needs to be supplemented with phase-specific practical teaching approaches. Two institutions, in particular, indicated specific ways through which this could be achieved.

Materials

Central questions in relation to the module materials had to do with whether students experienced them as *relevant* to their needs; how *accessible* students found them to be; how well the *pedagogical approach* enhanced student learning; and whether there were significant *gaps* in the content of the materials**.**

An overall response to the quality of the materials was provided in *HEIs' own stories.* 42% of the 19 institutions rated the materials as 'excellent' and a further 42% rated them as 'good'. Open-ended comments suggest that the materials were well received by students. However, respondents also felt that adaptations of various kinds are necessary, such as selecting and adapting readings and activities to fit a particular module or integrating more theoretical knowledge for PGCE students. These examples suggest that adaptation is regarded as the responsibility of the academic offering the module, rather than that the core materials should be reworked.

Both the general acceptability of the materials and the need for adaptation are confirmed and elaborated on in the interview data.

In terms of *relevance*, the responses to the materials were generally positive, particularly from in-service students. For example, NPDE students at one institution liked the fact that 'it spoke of our life' though it is important to note that this point was in relation to the course as a whole and not just in relation to the materials. This was echoed by NPDE students at another institution:

> Stories that are used are real stories happening in our society, things we are familiar with, like the story of Mr Ndlovu who went to work in the mines, that's what is happening because we always believe men are the superiors, they are the ones who need to tell us. The facts in the material are things we know about and when you read you want to read more.

As noted in the previous section, frequent references were made to the relevance of such stories as Baba's Gift, and so doing offering evidence of the relevance of the materials directly.

Equally, for the lecturers, there were many comments in the individual pilot evaluation reports and staff interviews that lecturers had benefited from the module and its materials in terms of their own professional development in the area.

> I am not a HIV/AIDS expert, but I'm really interested in HIV/AIDS, so for me it (working with the manual) has enriched my own knowledge.

In terms of *accessibility*, the materials were generally viewed as user friendly, accessible and suitable for self-study, even though some NPDE students felt that there were too many readings. The level was regarded as appropriate for first years, but easily adaptable for students at higher levels. An NPDE tutor at one institution said:

> I think they engaged well and enjoyed reading it, judging from their responses in the assignments and it was explained so clearly that many of them didn't have a language barrier, those with English as a second language didn't have a problem, and they coped so well with it.

However, students at three institutions commented that it should be translated into Afrikaans. One of the lecturers stated:

> I have now asked for funds to have this whole module translated into Afrikaans.

In terms of enhancing learning through the particular *pedagogical approach* used in the materials, there was positive comment on the use of questions in the materials that urged students to think deeply and admit that they did not, perhaps, know as much about HIV as they thought they did. The case study approach in the materials was regarded as particularly useful both as a support to lecturers in running the course, and as a classroom resource for later use by students:

> It was easier for me to handle the materials since it encourages participation which I favour. Also, the case studies made it easier for me to discuss those issues that would be difficult to discuss. I remember at the beginning of the module there is a story of the little boy and his community. So for boys of the same age or for some of the children I will be teaching, I can read stories and ask their opinions.

Although many participants said that the materials were comprehensive, others pointed out *gaps* that could be addressed. Specifically, they felt that more was needed on counselling skills; that the theoretical framework be more comprehensively integrated; that there be more in-depth coverage of biological aspects; that there be more about child-headed households and parent-guidance, as well as more about district and school-based support teams; and that the material on treatment literacy be increased. A further important gap was described in the open-ended responses in *HEIs' own stories*:

> We should develop a peer educator model … The power of peer support and education cannot be overly emphasised.

Summary: Materials

Students generally felt that the materials were not only accessible, but that they were also relevant to their needs, especially in terms of providing a 'lived experience', as it were, of HIV/AIDS. Lecturers also felt they had learned more about HIV/AIDS through engaging with the materials and, further, that the particular pedagogical approach used in these materials enhanced active learning in their students and increased their engagement through participative processes. While the materials were generally seen to be comprehensive, some specific gaps, as listed above, were identified and these should be addressed either in adaptation as part of course design, or in a revision of the core materials.

Course structure

Key themes that emerged in relation to course structure related to the option selected, programmes and learning areas into which the module was integrated, and how much time could be devoted to the module in different pilot options and when in the year it could best be taught.

The following information was gathered from HEI's own stories in relation to the 2008 implementing sites.

Types of programme:

- In-service:
  - ACE 1, NPDE 2
- Pre-service:
  - B.Ed. 14 (2 combined with PGCE)
  - PGCE 4 (2 combined with B.Ed.)

Although pre-service programmes are more strongly represented (there were 14) in terms of programme numbers, the three in-service programmes involved hundreds of teachers in each cohort, the vast majority of whom were older people working in predominantly rural areas.

Learning areas into which the module was integrated:

- Life Skills, Life Orientation genre: 11
- Educational Studies, Professional Studies genre: 8

Modules of the Life Skills/ Life Orientation genre will normally include a strong focus on the fourth of the seven roles of the educator,[17] namely the "Community,

citizenship and pastoral role" in which, "The educator will practise and promote a critical, committed and ethical attitude towards developing a sense of respect and responsibility towards others." However, it might be expected that the module would assume a somewhat different character when embedded in programmes of the Educational Studies and Professional Studies genre within the current structures of most Faculties (or Schools) of Education in.South African universities. Such modules would normally be more strongly rooted in the educator roles of learning mediator and scholar, researcher and lifelong learner. The integration of the HIV module into different types of modules thus raises the important question of the type of module/ learning area into which an HIV education module might best be integrated.

In terms of options selected, 8 institutions used the module as a stand-alone (Option 2), and 9 integrated the module into an existing module/course (Option 3).[18] There was only one institution which attempted cross-curricular integration (requiring students to integrate HIV/AIDS into their subject method courses), but the HIV/AIDS content from the module was simultaneously included in a pre-existing module on curriculum.

The amount of *time* devoted to the module varied less than it might appear to have done mainly in terms of how it was staggered. Thus, in some institutions the implementation of the module was staggered over sixteen fortnightly sessions with notional hours of contact time approximating eight while a single intensive workshop held over one day also involved eight hours of contact time. However, those institutions in which the module was 'bolted on' to existing courses (Option 3) generally experienced some time constraints which were often related to the already tight requirements of those courses.[19] For example, this lecturer comment came from a pilot in which the module was bolted onto an existing eight-credit, compulsory course:

> Ek was baie huiwerig aanvanklik, uhm, omdat ek nie geweet het wat dit behels nie en ek het geweet hoe druk die program is waarmee ons werk en hoe did moes inpas.
>
> (I was very uncertain initially, um, because I didn't know what it entailed and I knew how critically important the programme that we were working on was and how it had to fit in.)

In another institution where Option 3 was chosen, the lecturer commented:

> When looking at the course I strongly feel that HIV/AIDS should stand on its own.

In a similar situation, and reflecting the need of the institution to have more time to restructure its curriculum, another lecturer commented that:

> (The project) came (too) quickly: the time was too short to restructure (the existing curriculum).

But the time required is also dependant on the methodology used. In one pilot, in addition to the requirement to integrate into an existing module, the evaluator commented that "the lecturer's strongly participative methodology, although highly constructive, inevitably absorbed a lot of the time available." The evaluator, a lecturer went on to say:

> I thought it (the time) was a bit short. I don't think we went through the whole booklet. Our class went straight to discussion as soon as we got into the stories and the little exercises. We talked about our experiences and I think we did not have enough time.

Another lecturer commented on the importance of having time because a course like this demands an extended period of awareness-raising. Yet another talked about the importance of having time because the course deals not only with intellectual issues, but also with emotions.

In addition to comments about time, there were a number of comments about timing – especially about when in the year the content of the module could be best applied:

> What we have learnt is that the timing of contentious issues in the PGCE programme is not good. That it

> shouldn't be after they come back from school experience. It should be earlier on in the year.

Timing also relates to which year in a programme, such as the B.Ed., the HIV/AIDS component should be dealt with. For example, in some institutions, the module was offered to first or second year students, the rationale being that university students tend to engage in risky sexual practices, and it is best to 'catch' them early. One evaluator commented that the enthusiasm of the first years

> … suggests that there may be a need for continued structured opportunities to talk freely about the HIV crisis, either as part of their academic curriculum or as part of student support services.

In other institutions, final year students were the target with the idea that since they were about to complete their programme, it was important that they should go out into their teaching with sufficient knowledge of how to be able to integrate HIV/AIDS. While most students were positive about this aspect, one participant noted:

> I just feel that it's not … I want to say – in-depth enough. Especially for a 4th year level.

Summary: Course structure

In relation to the issue of having sufficient time to teach the module, it was clear that many institutions that had chosen Option 3 (a 'bolt on' to an existing module) experienced difficulties both in terms of fitting it in as well as having enough time for optimising the participative approach and for students to work through the more sensitive and/or contentious issues. The factors of timing in the year, as well as in B. Ed. year-groups, were also raised with some suggestions offered in relation to these choices.

Target Audience

Of necessity, the materials had to be targeted mainly at a particular audience, but the target audience for the module was still very broad. It consisted of both pre- and in-service teachers, students training to teach at different phases, younger and older students, rural and urban ones, but, most significantly, it consisted of students with considerable lived experience of HIV/AIDS, as well as of students who have spent most of their lives protected from the worst ravages of the disease. A lecturer's comments in this regard relate to the need to explicitly teach pre-service teachers about the impact of gender on HIV infections, particularly those whose lived experiences do not involve traditional gender roles:

> For those students who are women, in particular, they are empowered because they come from homes where gender roles are not traditional – and they were shocked to learn that girls in many homes in South Africa have no choice. You know you keep on saying live responsibly, but if you are not able to make that choice, if it is made for you … that is something they had not confronted before.

Some pilot courses consisted of only a handful of students, whereas others reached hundreds. Both students and lecturers commented on the reluctance of male teachers in schools to get involved in HIV/AIDS teaching. To illustrate: in one institution, in-service teachers complained that male colleagues did not want to get involved with HIV and/or sexuality education. Some accepted this without challenge:

> When we came back from the course, he said he cannot do this, you do it. So now I try to do it [sexuality education course with DoE].

Challenging the reluctance of male colleagues to teach HIV and sexuality in school, one female participant charged, *"He can do sex, why can't he talk about it?"*

The reluctance of male students to participate in HIV teaching was also reflected upon by some of the lecturers. For example, talking about the lack of male students in her class, one NPDE lecturer noted:

> No males, not at all, that is one of our concerns that it is always women, always women but we took it on a positive note that it means we have to stand up and be pro-active.

While this comment, on the one hand, reflects the fact that there are more women in the teaching profession in South Africa, particularly in the Foundation and Intermediate phases, it can also be read, on the other, as reflecting a gendered landscape in relation to who takes up which issues in a school.

Finally, the academic literacy levels of the students were very variable: some programmes were at NQF level 7 for students who have recently graduated, and others were only at NQF level 5 for serving teachers who have outdated professional teaching qualifications.

Some reflection about this complexity and the difficulty of accommodating the materials to the needs of different target audiences – in this case the needs of the phase for which pre-service teachers were training – is apparent in what this lecturer had to say:

> The materials were not sufficiently geared towards my FET students - in particular, some of the scenarios presented in the manual.

A different phase-related problem – in this case pertaining to students training to teach Foundation Phase learners – was expressed by this lecturer:

> My class was full of foundation phase educators mostly from Grade one to three so I discovered that it's not easy for them to talk about HIV/AIDS to younger learners because they are not very much exposed and if you talk about private parts it's very sensitive to them, they are not like other learners who are at intermediate and senior phases.

The level of difficulty of the materials for some students, particularly those whose first language is not English, also posed another challenge as was evident in this evaluator's observation:

> The NPDE students generally have a poor command of English and find it difficult to meet the academic requirements of the university. Practically all students complained that there was too much reading and that the assessments needed a lot of time and effort.

In terms of how the module related to students with different background of experience in relation to HIV/AIDS, this lecturer's comment is pertinent:

> I piloted the module with our PGCE class and that class is 80% white. It's middle class. There is one or two rural students but they are minority. So for 80% of the class who are from white middle class homes, I think they still perceive AIDS as something that affects poor people and 'the other'.

Summary: Target audience

The different nature of target audiences to whom the module needs to be directed is clearly a complicating factor, and a challenge in terms of how the module and its materials should be structured.

Pedagogy

Important questions concerning the pedagogical approach built into the module relate to how different institutions chose to *engage* with the methods, what *effects* these had on their students, what difficulties arose, and how these were *resolved*.

Participatory methodologies struck a responsive chord in those teaching the module. 90% rated participatory methodology and its efficiency in teaching the module as 'excellent' or 'good.'

The interview data shows not only how the students and staff responded to participatory methodologies, but also how they understood this approach.

Critical to *participatory* approaches in HIV/AIDS related teaching is the relationship between tutor/lecturer and students, and among the students themselves. For example, in one pilot particularly, a student commented on the levels of *confidentiality*, *openness*, *trust* and *sharing* that had been achieved:

> With the course, our lecturer is happy to answer anything about it (HIV/AIDS) and we are all sharing in class. It's no longer my knowledge, or my friends, or my lecturer's but everybody's knowledge coming together which is great.

Box 1 Polyvocal

Hi Shirley

Like you, I have just finished tutoring in the Pilot module for HIV/AIDS education. What did you think about the participatory approach and group discussions? Did it introduce new thinking? In the tutorials I was involved in, the University had devised certain activities where I had to do the discussion first and they had to answer questions. I put learners into groups of mixed males and females, they had to work on the activities following guidelines given by the University though at times we diverted as learners brought interesting issues. Mostly it was individual work and group activity. The disadvantage was that it was largely black learners if it was mixed the ideas would have been different.

Hello Sandi

I didn't have any problem with regards to the group work. I'd rather say they were eye openers because in my class for example there was a mixture of cultures with students who are Muslims and those who are Christians so they came out with something according to their religion. For instance, when we talked about HIV/AIDS I thought it was going to be a problem for them to open up because their religion doesn't allow sex before marriage and also when you are married you don't expose your body to the public, so they were very open to talk about those things of which I thought there was going to be a problem. Quite frankly I would say I didn't have any problems.

Found this student evaluation comment about what he thought was the best thing about participating in the module:

The best thing, you know you find the different opinions of the other teachers/students. So, we find, their opinions as we are attending … we are different races - there's whites, and coloureds as well as blacks and everyone comes with his or her opinion …… according to his or her race. So that creates a big understanding that …oh other people look like this and other people they look like that about HIV and Aids. In fact, we used to be in groups …and maybe we read a certain scenario …and then we come with our opinion - how we look. And then the tutor comes with his or her suggestion that it is like this, and then we write on these charts, and we put it differently, or we hear what the one group has been saying, and the other one. And then we put these together … and it gives us complete things to what our discussion was concerning the HIV and Aids… it was a quite interesting module. My life has changed, because I changed from an autocratic teacher, now I'm democratic, partly democratic, because now we discuss.

Makes you think about aiming for diverse groups where possible!

With this, there is not only enhancement of knowledge, but also empowerment, ownership, and an opportunity for emotional healing:

> The module helped some of us to talk about our experiences. I think we grew up (through hearing incidences of other people's life which we had not experienced. As people we have grown a lot because maybe we have healed from that and sharing in the class really healed some of us.

On this topic, the polyvocal in Box 1 brings together voices of NPDE students who are in-service teachers in rural schools and their NPDE tutors.[20]

In one institution, this open discussion was facilitated by using peer education strategies:

> " .. I found that students would engage well with peers on issues of sexuality or HIV and AIDS. They related well with their peers…it created an opportunity to engage with each other, there was a lot of excitement and they could talk at different levels. "

In another, there was significant use in the pilot module of a campus-based peer educator group, Youth as Knowledge Producers (YAKP), made up of a group of pre-service teachers who explore and promote the usefulness of arts-based approaches such as Hip-hop, Forum and Image theatre, poetry, video making, and collage and photovoice in addressing HIV/AIDS.

Participative and active learning methods are, of course, more difficult when there are large numbers of students as was the case in a number of institutions. In one case where there were about 200 students in each of three classes, the lecturer commented:

> *… jy kon nie altyd monitor wat is die mense se betrokkenheid [nie] en ja, dis moeliker.*

(You couldn't always monitor the peoples' involvement, and yes, it's difficult.)

However, in the same institution, a method was found that alleviated the problem to some extent – the use of DVDs that they had located for themselves, which were repeatedly acknowledged as being effective by the student participants. Thus, the lecturer commented:

Maar van die DVDs wat ek gebruik, make hulle – probeer [hulle] bewus maak – daarvan dis almal se uitdaging … dat dit ook studente is en dit kan hulle ook raak, het n redelike verandering teweeg gebring.

(But the DVDs that I use, makes them – tries to make them aware – that it is everyone's challenge … that it is also students' and that it can affect them, brought about quite a change.)

Another solution employed in a distance education programme for practising teachers in large numbers, was to employ a cadre of tutors who were trained to run the contact sessions for relatively small groups of teachers using participatory methods such as group discussion and role play, and encouraging teachers to bring forward issues from their own school reality:

The University devised certain activities where I had to do the discussion first and they had to answer questions and put learner into groups mixed males and females, they had to work on the activities following guidelines given by the University but at times we diverted as learner brought interesting issues.

The self-instructional character of the materials was used in one institution to enable students themselves to read and make presentations to each other on the content of various units:

They were all involved and when they presented, also it was not like one person presented, you could see the whole group was involved in contributing to the discussion.

For students with little lived experience of HIV/AIDS, having guest lecturers – particularly in relation to the biomedical section of the module – was, in a number of institutions, highly successful:

It makes it more believable and understandable. You have to accept it because it is real and actually works that way.

However, the most important strategy for these kinds of students, also used in some institutions, was to use a variety of experiential learning activities – from simulation games to projects which involved visiting and researching the contexts of people living with HIV/AIDS.

Overall, the pilots that were reported as being the most successful were characterised by the use of a combination of methods tailored to the needs of the main target audience. These included *debates, panel discussions, role plays, and practical demonstrations.* In some instances it was clear that the pedagogical approach in the module challenged more established didactic methods:

The methods used aren't the ordinary questions and answers and memorising techniques and stuff like that.

This suggests that, beyond its immediate purpose, the pilot module might have had a wider methodological impact on teacher education in general.

Summary: Pedagogy

It is clear that a number of institutions involved in the pilot engaged in a variety of participatory, experiential and active learning methods which had beneficial effects on their students not only in terms of the development of understanding of HIV/AIDS issues but also, and perhaps most importantly, in terms of *relationship sensitivities, mutual support* and *ownership of the issues involved.* Classes with large numbers of students constituted the main difficulty that had to be faced in using these methods. However, this difficulty was not experienced as insuperable, as is evidenced in the variety of creative ways of resolving it mentioned by different institutions.

In essence, what the evaluation of this critical category of the module curriculum has shown is, first, that effective teaching of HIV/AIDS must be *participative* and *relationship-based*, and that a key competence for lecturers and tutors is the ability to create an environment of trust, openness and confidentiality in which personal sharing can take place, and that this is possible, even with large numbers of students. Second, it has shown that *experiential learning* is critical, particularly for students with little lived experience of HIV/AIDS, and that this experiential learning can be achieved in a variety of ways. And third, it has shown that a *combination of active learning methods* is most effective in HIV/AIDS teaching, as it is in any teaching.

Assessment

Key questions to be asked under this category are, "What *forms* of assessment were used in the pilot?", "Which were *effective* and why was this so?", and "What were the *difficulties* encountered with assessment in relation to the module"?

The types of assessment in relation to the module, and their extent, varied widely from institution to institution. In one there was no assessment, in others there was one assignment per unit followed by an examination, in others there was only an examination, and in yet others there were simply oral presentations.

However, across all institutions, four distinct *forms* of assessment emerged, all of which were *effective*:

1. **Assignments that get students to engage with the materials.** For example, a peer presentation on an aspect related to Units 1-4, and a take-home examination based on the case study used in the introduction to the materials. This was regarded as useful, because it enabled the students to get the most out of the materials.

2. **Assignments that require school-based research.** For example, interviewing school personnel on their approach to HIV/AIDS teaching:

> I always knew about those things, but we got an assignment we had to do during practical teaching, that we had to observe HIV/AIDS [issues] at school, whatever, and that was actually the best thing that I have learnt because I always knew that there was HIV/AIDS but I didn't have the view of it in the school.

or creating an HIV/AIDS policy for the school:

> In our assignment, I focused on a whole school policy and my aim was to make them aware that it is a school problem and not a problem or the challenge for an individual teacher … they realised that may be for the first time that it should be addressed in a systemic way.

3. **Assignments that require lesson planning or a critique of HIV/AIDS related lessons.** For example, at one institution students were expected to source an HIV lesson in a subject-specific text book and critically analyse it according to set criteria. They then had to develop a set of lessons for themselves, integrating HIV into their learning areas. The lecturer concerned was pleased with the results, saying:

> The students were able to critically comment on HIV integration.

4. **Assignments that require reflection on experiential learning.** For example, students had visit some sort of community based centre dealing with HIV/AIDS (eg a clinic or local NGO working with orphans).

Various difficulties were experienced with assessment in the pilot module. None, however, were unique to HIV/AIDS-related teaching.

- It is difficult to monitor the practical work of in-service teachers:

> So the practical side of it, there was no way of knowing if it had been done, you had to take what they are saying to you.

- Providing timely formative feedback on assessment for distance education students is challenging.
- Reflection on learning is difficult for some students.

> Reflection is a technique that most students have not been taught, specifically in the more scientific and commerce-based undergraduate programmes, and the module did not explicitly guide them to do this.

Summary: Assessment

While the extent of assessment differed widely across institutions, four distinct forms of assessment emerged through the analysis, all of which were creative and seemed to be effective from the perspective of the lecturer although this of course is not easy to evaluate Used singly or in combination, these forms of assessment represent desirable ways of assessing student achievement in the module. Difficulties that were mentioned in relation to assessment of the HIV/AIDS module were no different to those common to the assessment of any other content area.

Personnel/implementing staff

Particularly with a sensitive area such as HIV/AIDS, it is important to consider who teaches on the modules and what *qualifications* staff have for being involved, what the *challenges* for personnel are, what kinds of *support* they need, as well as the *benefits* of participation in the module for the implementing staff.

Of the total number of lecturers involved in the piloting of the HEAIDS module 19 were female while 9 were male. While the figures suggest an interest in the subject from both male and female lecturers, there still exists a danger that even at this level, HIV/AIDS is regarded as a 'female subject' and therefore, only women lecturers can/should teach it. Obviously, this would defeat the intention to address gender inequality and to view men as significant partners in the fight against HIV infection. As noted earlier, in the context of schools where there may be more female teachers than male teachers at the Foundation and Intermediate phases it might be expected that there would be more females involved in the teaching. At the level of universities, however, this is not the case,

There were two types of personnel involved in the module pilot – permanent faculty and staff on long-term contracts (academics), and off-campus, part-time contract staff (tutors) employed particularly in large scale in-service programmes to support the offering of the module. Teaching, monitoring and assessment were also supported by student interns. As a separate category of staff, the role of student interns is addressed at the end of this sub-section.

A clear finding is that the field appears to be managed by enthusiasts (both academics and tutors) – committed individuals who have found a variety of ways, both formal and informal, to expand their knowledge in this area. The overall impression is of staff members who are relative newcomers to a relatively new field of endeavour. There is no standard or core type of qualification for practitioners in the field of HIV/AIDS.

Support is therefore critical, and most of the lecturing staff would have liked more support from their own institutions – particularly from management. The greatest challenge for tutors was expressed as the sensitivity issue with affected and infected educators. The support provided by the project was therefore very important to the implementing staff, as this comment reflects:

> The learning materials, participatory methodology and the OCF are really very good and of excellent support.

At the beginning of the pilot study lecturing staff and tutors were asked (at the first Colloquium) to indicate what forms of support they needed. A range of responses was given, but in the case of academics, *networking, training and workshops* were most frequently mentioned, and, in the case of the tutors, *support groups/networking* came second only to learning materials/readings. After the second Colloquium, participants were asked to respond to, and evaluate, the colloquium in terms of logistical arrangements, the programme, the opportunity to improve HIV/AIDS knowledge, understanding of assessment and

evaluation, and the event as an opportunity for networking and becoming part of a broader community of practice. Aside from the logistical arrangements, by far the highest positive rating was for networking and becoming part of a community of practice. Many of the comments showed how relieved academics and tutors were to be connected to other people working in the area, and to feel that they could both learn from, and call on, colleagues in the field:

> I felt so blessed to be part of that conference because I met people from different universities for the first time in my life and I now know whom to consult to broaden my knowledge.

> What a wonderful opportunity to get to know so many people who indicated their willingness to assist one if you were to call on them. Hopefully this will lead to an opportunity to influence policy regarding the teaching of HIV and AIDS.

One person commented on the following as a highlight:

> That I was part of a team that discussed sensitive issues as this faces me on a daily [basis] and I often don't know how to handle it. Thanks to this session I received input from my group and it is going better. I realised that sending students to the counsellor is only part of assisting and that it is okay for me to give input.

References in the individual pilot reports on personnel pointed to the fact that staff responsible for the module still feel anxious about teaching HIV/AIDS content – dealing with socio-cultural beliefs about HIV-related issues (sex, condoms, sexual orientation etc), and understanding the content and sociological and educational issues relating to HIV/AIDS (for example, counselling skills and appropriate teaching strategies). Hence, the support of the implementing team and the resources of the project were critical. A particularly interesting comment from one of the individual pilot reports was the following:

> Participating in the pilot was a positive experience for the lecturer, because it allowed him to experience first-hand how much experiential knowledge ACE students have of HIV and its challenges. Because the lecturer is relatively new to tertiary education, this experience has encouraged him to include students' experiential learning to a greater extent in other classes. In other words, an additional benefit of the pilot was lecturer development.

The benefits were not only in knowledge and professional practice, but also personal:

> I just want to say that personally it helped me a lot. [There are] some family members who are also HIV positive, so at some point it was hard to take care of them but as soon as I got [these materials] I got a lot of material I could use.

This suggests that the personal circumstances of teachers in an HIV/AIDS context have to be attended to.

Finally, the importance of training was identified as key to the successful performance of tutors:

> We had to come for a tutor training course and we had to go through all the activities and the Co-ordinator took us through the activities and explained to us what needs to be done. The material sent by the University was well planned and we knew what needed to be done in each contact session.

Turning to the role of student interns, it is important to note that while the aim had been to appoint postgraduate students with some experience in education, this was not possible in practice. Some institutions did not have postgraduate students in education and some of those that did, did not have postgraduate students with relevant experience. The role of student interns thus varied enormously from institution to institution. In the case of appointees with little or no experience of HIV/AIDS education and with very limited background in respect of the study of education, the role of the intern was very small. In such cases, the intern functioned as an administrative assistant. In the case of well qualified appointees, it is clear that interns were an extremely valuable resource to teaching staff and students as well as to the implementing team in matters of monitoring and evaluation.

Diversity in the roles played by student interns was intensified by the timing and widely differing periods of their employment. The first of 23 intern appointments was made on 29 May 2008. Others followed at regular intervals, with the final appointment being made on 7 November 2008. While some were thus already placed when the module commenced, others were appointed when it was well under way. Generalisations about the role and contribution of interns are accordingly not possible. However, in cases where suitably qualified interns were appointed in good time and fully integrated in the offering of the module, there is strong evidence indicating that student interns can be an extremely valuable resource in the offering of a module on HIV/AIDS education. In addition to working closely with lecturing staff, as students they were able partially to fill the peer education 'gap' identified under Materials.

The following comment, made by a female part-time teacher appointed as an intern, captures well the personal and professional growth reported by other interns of suitable experience and who were appointed in good time and integrated into the offering of the module:

> I am grateful for this opportunity as it has given me a chance to meet and interact with people who are experts in the area of HIV/AIDS. I have been able to acquire new knowledge, skills and understanding of the effect HIV/Aids has on the education sector. As a teacher, I know the information gained from this project will help me in my teaching career and I will be able to equip others with the required knowledge to combat this disease. Through this project, I had the opportunity to sit in on the interviews, transcribe, mark assignments, analyse the assignments, attend colloquia and evaluate response forms. I hope to use the skills and knowledge gained for a better cause.

Internship has the potential to nurture the development of a new pool of expert HIV/AIDS educators.

Summary: Personnel

Most of the staff members involved, both tutors and lecturers, were not qualified in a formal way to offer the module, although, as noted in Chapter Two, there is no existing agreed-upon set of criteria for determining what constitutes such a formal qualification. Clearly, however, their enthusiasm and commitment led them to seek out professional development opportunities, including involvement in implementing the pilot module. The types of people who are attracted to work in this area need, value and benefit from support and professional development. This support and development came not only from the implementing team, the materials, and the OCF, but from being part of the community of practice that was established through the Colloquia.

In cases where suitably qualified interns were appointed in good time and fully integrated in the offering of the module, Student interns, if suitably qualified and integrated into the process of offering the module, were an extremely valuable resource. Internship could serve as a priceless kindergarten for a new breed of better qualified HIV/AIDS educators.

Use of technology

The principal innovative use of technology in the pilot study was the Online Collaborative Forum (OCF). This evaluation asked: *How widespread was the use of the online collaborative forum? What were the reasons for not using it? What was the response from those who did use it?*

Some background is necessary to contextualise the findings that follow. It should be noted that the design of the OCF took place during the inception phase of the project in early 2008, with development of the software commencing in April 2008. Through a series of workshops, a total of 69 academic staff and interns from 26 sites were introduced to the OCF and trained to use the software. During this pre-launch phase, further development of the software continued. It was not, therefore, until 24 September 2008, the day after the second Colloquium, that the OCF was officially launched. It is from this date that the baseline of the use of the OCF is taken.

Owing to the unanticipated high level of participation of HEIs during the second semester of 2008 rather than during the first semester of 2009, most HEIs were well under way with teaching the module by the time

the OCF was launched. Consequently, the OCF was not available to HEIs during the initial period during which most of them began using the module material.

Against this background, the results of a brief investigation of the use of the OCF follow. Data pertaining to the use of the OCF was generated automatically using Google Analytics. The reliability of such automatically generated data is limited.[21] There were 297 visitors to the OCF who made a total of 806 visits. Of these visits there was a high bounce rate[22] of 57% suggesting that more than every second visit made to the OCF resulted in the visitor not looking at another page. The inference is that the visitor did not want to visit the OCF in the first place, possibly having arrived there by mistake. One reason for this might be because there are very few pages on the Public OCF that are not accessible to an unregistered visitor.

With the exception of the homepage (which it is necessary to visit to enter the Restricted OCF), the most popular page visited in terms of the number of overall page views was '/Members/Blog.aspx', which is the landing page for all individuals' blogs, and which also serves as a dashboard for displaying new blog posts and new comments to existing blog posts. The Blogs section was also popular in terms of the number of unique page views, ranking as the fifth highest unique page of the OCF. This suggests that the Blogs section was frequently visited by a high number of different users. Furthermore, the bounce rate of the main Blog page is high at 83%, indicating that visitors were frequently leaving the OCF upon viewing the Blog section without viewing other pages. This suggests that users were logging into the OCF specifically to check the status of the Blog section in terms of new posts/comments, but then leaving, perhaps because no new activity had taken place.

In most of the institutions the OCF was *accessed* and the response to its *usefulness* was in many cases enthusiastic and, in some cases, even emphatic:

> A wonderful, wonderful idea – one of the big positive things for me from this whole thing. I would love it to go on. I really think it is necessary. I love it (the OCF). What I love is that you can decide to converse with the whole group or one person. I have learned so much through going online.

The potential for communication with colleagues across the country through the OCF was specifically recognised by more than one institution:

> It give us the opportunity to communicate with other people from different institutions and share our views and ask question or help if there is something you do not understand.

In only two institutions was the OCF not used at all, and this was because of the lack of online access.

In terms of limitations, a number of institutions' lecturers muted their enthusiasm with comments on the time-consuming nature of an OCF but, in several cases, pointed out the usefulness of the OCF for their interns. For example:

> I think it is absolutely brilliant but I think given my kind of work load at the moment … It's been nice to have as an optional extra, that is how I view it. I would love to spend more time doing it but it just hasn't been possible. But it has been very valuable for the intern and I think it has opened up a new world for her.

Another limitation that was quite commonly mentioned was that students did not have access and that this was unfortunate since they would have found it useful.

Summary: Use of technology

Despite generally positive support for the OCF from the HEIs, the potential of the OCF to support pedagogy was not realised during this pilot predominately because of *lack of time* and *access.* Lack of time was not limited to *users' lack of time* to engage with the OCF as mentioned above, but also to the *overall time* available for the pilot: most HEIs had either completed or were nearing completion of teaching the module before the OCF was ready to be launched. (The number

of participating HEIs during the second semester of 2008 rather than the first semester of 2009 was much higher than anticipated.) *Lack of access* was an issue particularly in terms of the lack of hardware and connectivity in a number of institutions.

Enabling or constraining factors in implementing the curriculum

Undoubtedly, the most important factors that enabled the implementation of the pilot in the various HEIs included the nature of the *materials*, the resources offered by the OCF, the input provided through the *Colloquia*, and the support given to institutions by the *implementing team*.[23]

As elaborated under Category 3 (Course structure), having sufficient time to implement the module constituted a major constraining factor for some institutions, while for others it was less so. Although other factors came into play, such as large classes mentioned under Category 4 (Pedagogy), the difference was largely attributable to choice of option: those institutions having selected the 'bolt-on' or single module adaptation (Option 3) finding it most difficult to integrate the module into pre-existing, and already time-constrained, courses. With the module and its revised materials becoming available only well into the academic year, some institutions also felt that the optimal *timing* for teaching it – for example during orientation or at least before students went on teaching practice – had been missed.

Most commonly, over a range of factors that were potentially constraining, lecturers managed to find solutions which transformed constraining into enabling factors. Just some examples of these transformations were:

- Changing negative attitudes to the module and its HIV/AIDS content, into positive ones:

> One guy in my class said he just fears HIV/AIDS and he doesn't want to talk about it but by the end he had learnt so much because he got rid of that fear and learnt to speak about it.

- Dealing with 'HIV/AIDS fatigue' by bringing in outside experts to amplify and explain the biomedical facts in the module, or providing students with new forms of experiential learning.
- Overcoming cultural, religious, gender or race preconceptions and prejudices through setting up mixed group discussions.

The most difficult constraining factor that lecturers had to deal with was resistance in some schools and/or communities with regard to even talking about HIV/AIDS and sexual issues. For example:

> I can say that it (HIV education) is a taboo in that school, because when we asked for permission to do a workshop the principal was very cold....We realise we can mention things like condoms but we could not actually bring condoms to demonstrate … to them it is like you are teaching them to go and experience (sex).

Perhaps the most critical enabling factor – which had to be actively created by lecturers – was their quality of engagement with students. Two points emerged from the evidence about creating an atmosphere of confidentiality, trust and openness:

- The desire to make a difference – wanting to be able to say:

> *Ek het n verskil aan hierdie een gemaak.*
>
> (I made a difference for this person.)

- But also realising that in order to make a difference to someone else, you have to deal with yourself, your own personal attitudes and life situation:

> A need for self-reflection, before they can be able to help someone else, I don't think we quite did that one.

Concluding comment

Particularly in those institutions which had opted for the 'bolt-on' option, time constraints experienced by

lecturers/tutors related mostly to the structure of already existing tightly packed courses into which the module had to be integrated. It is clear that, for optimally effective implementation of the module in the future,[24] institutions would need more time to plan their course structures and/or programmes to accommodate the module. This is to be expected with any new initiative and does not reflect the unwillingness of the institutions to accommodate the pilot.

Despite the lack of sufficient time to implement and integrate the module and its reflective and participative components optimally into already crowded curricula, the relevance and participative nature of the materials, the use of the OCF as a valued resource, the input of the colloquia, and the support of the implementing team were clearly seen to be enabling factors in achieving the principal goals of the module.

EVALUATION OF PILOT EXPERIENCES: COMPETENCE

Purpose

The purpose of this section is to summarise the principal evaluative findings in relation to the growth or enhancement of students' professional competence and practice in the age AIDS as a result of their experience of the pilot module. As was the case in the 19 individual institutional evaluations from which it was condensed, this summative evaluation does not aim to present an absolute conclusion about *actual* growth of competence, but rather to document students' and lecturers' views of *perceived* competence or lack of competence and to draw out lessons of experience *in terms of these perceptions.*

Broadly, the same pilot module outcomes were applied across these institutions, but the applications and insights emphasised in relation to the growth of professional competence differed in response to the widely differing target audiences and the constraints/opportunities of the programmes into which the module was integrated. Where they are most relevant to this summative rendering (especially, in this case, the differences between pre-service and in-service students) these differences are incorporated into the findings as reported here so that, as a whole, the findings provide a broad view from which the lesson of experience across all institutions could be distilled in the conclusions and recommendations as presented in Chapter Six.

The focus in descriptions of competence is on professional practice - understood as requiring both personal and professional competence appropriate to the context - as described in the theoretical framework represented in Figure 3 in Chapter Four.

The selection of data used in this summative evaluation was based on the preliminary 'Synthesis of Individual Pilot Evaluation Reports: Competence Section' (Appendix 7) which, in turn, was based on the original data analyses, interpretations and conclusions contained in the individual HEI pilot self - evaluation reports.

Qualitative

Owing to the nature of the primary data, a narrative approach has been used in analysing and reporting on the findings. The criteria of students' growth in professional competence (Awareness of context; Preventative agent; Reflexivity; Caregiver; Collegial sensitivity; and Leadership) form the underlying structure of the section below.[25]

Quantitative

The pre- and post- test questionnaires were analysed according to the focus areas of the questions which broadly covered four areas: biomedical knowledge, level of HIV/AIDS activity/activism, gender related and discriminatory attitudes and confidence levels.

Qualitative findings

Awareness of context

As discussed in the theoretical framework, teacher engagement is shaped by the context and culture in which the teacher functions. There are many ways in which we can describe the differences among these contexts and cultures, but for the purpose of analysis

in this chapter, we are taking pre-and in-service as the primary contextual difference.[26] This aspect of professional practice is described in the framework as an awareness of, and sensitivity to, the experiences of vulnerable learners and colleagues, gender issues, cultural heritage, contextual assets and constraints. A discussion of the main themes emerging under this heading, and illustrated with direct quotations from the students follows.

HIV/AIDS affects everyone. Both *in-service* and *pre-service* students showed a heightened awareness that HIV/AIDS affects everyone indiscriminately. The main difference between the two sets of students was that the in-service teachers tended to have extensive lived experience of the effects of the epidemic on a personal as well as on a professional level, whereas many of the *pre-service* teachers had not yet been directly affected by it. This was the first time some of them had really thought about it in terms of something that would affect them directly when they started teaching.

- This (the module) talks about our real lives" (in-service)
- It taught me that this HIV/AIDS crisis does not just infect poor or rich, black or white. It infect (sic) all of us. (pre-service)
- HIV and AIDS is part of the parcel of our lives now.

Some of the *pre-service* students had had more direct experience of HIV/AIDS within their circle of family and friends, and their sharing of these experiences helped the other students to realise the extent of the impact of HIV on the lives of people.

The following conecdote[27] was derived from a focus group interview[28] with undergraduate students (male and female) from a university in an urban area. It deals with the topic of 'talking about your positive status'. One male participant, who 'lived with infected people' wanted it out in the open, while another female participant feared that she would be discriminated against. This debate continued even after the focus group meeting had been concluded. (Box 2).

The reality of being in a class with students from different backgrounds helped them gain a broader understanding of HIV and society's response to it.

> …from a private education school …to coming to a university where there are different cultures, different religions, people that come from backgrounds where there is not much education. I must say it has made me think twice about HIV/AIDS.

There was evidence from both *pre-service* and *in-service* students of an increased awareness that HIV/AIDS has changed the lives of many learners and that students need to be aware of, and responsive, to this.

> … om te sê dis 'n werklikheid en ek wil baie graag eendag in my klas 'n verskil maak.
> (It is a reality and I want to make a difference in my class one day.)

Both *in-service* and *pre-service* students spoke about the socio-economic and emotional impacts of the epidemic on learners and that this negatively influenced their learning experience. Both groups showed awareness of the denial prevailing in the community, the moral criticism of people living with HIV and AIDS, the increased incidence of early sexual activity among learners, the vulnerability of girls and women, and the fact that all of these factors have an impact on schooling.

Increased understanding of the experiences of others was acquired. The knowledge gained from the module was especially helpful in highlighting the differences in how various cultures/contexts experience the epidemic.

Some of the *pre-service* students in particular had not realised how seriously education had been affected by HIV/AIDS, nor how many lives had been changed by it.

> Something that I wasn't aware of, did not think about, was the fact that some students have to go home and then have to deal with parents who are sickly and they are responsible for their parents and they need to go and make sure that those parents get the proper help

Box 2 Breaking the Silence

Mpho:	**...** if we are encouraged to test in other clinics to know our status - ... what's the use of being confidential? I think it's not wise to keep that result confidential because... you might be 'killing' others. We need to know your status so that we can support you, so that we can learn from you and so that we can learn that this thing is real.
Sonia:	Sometimes you discriminate against others, so if you know my status...
Mpho::	No ... if you keep it confidential, that's when you are going to ... feel alone ...because you are keeping it inside you. Therefore you have to let others know that you are positive.
Sonia:	No! You are going to discriminate against me!
Mpho:	Just like ... when you are suffering from headache you can tell me that you are suffering from headache, therefore I give you headache tablets and you feel better. The same thing can apply to an HIV positive person. If I know that you are HIV positive, let's take for example some times you have to attend a class and I know that you are sick, maybe the lecturer knows that you are sick, too, and he will understand that ... maybe she has gone to the clinic or she has gone to see a doctor and so ... we all support you. But if you have kept it in your self... I don't think it's wise to keep it to yourself.
Interviewer:	I think the point you are trying to make is that we are never going to start talking about this if it is kept confidential ...
Mpho:	Yes, we have to talk about it ... to identity and notice that this thing is real and within us, we are living with it. Yes! Yes!
Duke:	I was saying ... HIV and AIDS ... when I look at the people who have high blood pressure and the people who have diabetes, when I compare them with HIV and AIDS, I see the diabetes and high blood being worse than AIDS, but this HIV and AIDS has been cursed ... but if the doctor knows earlier that I'm infected I could be treated, and the treatment is simpler than for the ones who have diabetes and high blood pressure.
Mpho:	You find that the diseases that have been mentioned are incurable, but you find that people are living with it and they know people who are suffering from it.
Sonia:	The thing is that that disease is being ... is being what?
Interviewer:	Stigmatised?
Sonia:	Yes! I try to say that, that's why people are not talking, but because we know that AIDS ... if I have AIDS ... people think that I was behaving, I was behaving badly, so thinking that I was sleeping all over with so many men. So that's why people sort of ...
Mpho:	Yes, that's what I want to get rid of. Being 'big' enough to tell people that I am HIV positive ... that I did not sleep with so many men and women... I think to get that thing from our minds ... Sonia: That's why people are afraid to tell.
Mpho:	You should also remember that whenever you are doing the right thing, people are going to talk. When you are doing nothing, they are going to talk too ... there ... you don't have to worry.
Duke:	I was also saying that this HIV and AIDS, we have the chance to talk about it at grass roots level so that, when we talk with them, I mean those who are infected, we need to encourage them to talk about it freely, not stigmatising it. This will make the learners whom we are teaching make it easier for them to know that AIDS is just a disease like any other disease. If we start it from there...

they deserve. Then the person does not do their homework and now you are upset with them ...you unfortunately have no idea what that person is going through. So to me that is very important - the understanding of the situation. I like that, I like knowing that.

The *in-service* students, however, seemed to have a greater understanding of the socio-economic and familial contexts in which their learners operated, but the module did help them to become aware of the larger context in which the epidemic plays itself out, in terms of heightened awareness of the social inequalities and conditions that fuel transmission, such as poverty, gendered perceptions and stigma.

In HIV people, we as the society, we also stigmatise those people, we make them not to be open about the sickness that was the important part for me because I know now how I can behave when I am with HIV infected people.

The problem of my community is denial, they don't accept that HIV is real – they associate it with the curse of having done something wrong from God or from the ancestors.

Varied perceptions of constraining contextual factors exist. The personal background of the majority of students interviewed did have an impact on their

understanding of the reality of HIV/AIDS and how it could be addressed from an educational perspective.

Pre-service students from more privileged backgrounds gave responses that seemed to indicate that they thought that all the problems could be solved by teaching facts, telling young people to wear condoms and getting them involved in other activities. For example, they did not seem to be aware of the constraining factors around condom use in certain populations.

> I mean if you are in a private Catholic school in the suburbs you are probably going to teach abstinence and that would be practised but if you are in a school in the middle of a poverty cycle [sic], where young girls are married off at 14, you are obviously not going to teach abstinence, you are going to teach about condoms and how you can reduce the rate of infection. So it definitely depends on your class and where you are.

However, there were many instances in which they indicated that they had developed an empathic awareness of the emotional and scholastic impacts that a child affected by HIV probably endures, and a desire to respond in a caring manner.

> Well, uhm, let me give a example of what happened during my practical teaching. There was a child whose parents were HIV positive and the brothers and sisters were also HIV positive, but I don't know about the status of the child, so you can understand that when you come from a HIV family it is like everybody is sick, you are the bread winner. And, the child is in Grade 5. So you can imagine if you were in Grade 5 and something like that would happen to you and things like that? The child struggles basically in whole, not just back at home but at school as well. See, it's very hard to concentrate because you always think what if my mommy dies or my brother or whatever. And she is the youngest in the house, you know. Things like that, you know, touch a person as teacher, because you see that life is not actually about you only … you must also be involved in other people's lives.

This particular student comes from a background of personal experience of HIV-related loss, and this emphasises the fact that personal trajectories may influence the degree of empathy displayed.

Summary comment: Awareness of context

Both *in-service* and *pre-service* students showed a heightened awareness that HIV/AIDS affects everyone indiscriminately. While *in-service* students tended to have extensive lived experience of the effects of the epidemic, this contrasted with many of the *pre-service* students who had not yet been directly affected by it. However, both groups spoke about the socio-economic and emotional impacts of the epidemic on learners and indicated that this negatively influenced their learning experience. The knowledge gained from the module was seen as having been especially helpful in highlighting the different ways in which various cultural groups in different contexts experience the epidemic.

The personal background of most of the members of both groups of students had an impact on their understanding of the reality of HIV/AIDS and how it could be addressed from an educational perspective. *Pre-service* teachers, particularly, tended to think in terms of relatively simplistic solutions, but there were many instances of their indicating that they had developed an empathetic awareness of the emotional and scholastic impacts that a child affected by HIV probably endures, and a desire to respond in a caring manner.

Preventative agent

Teachers are obligated by national policy to provide prevention education and to prevent any learner from being stigmatised or discriminated against. The narratives of the students in this pilot module show that they have unanimously accepted this role and that they are aware of the challenges and opportunities of being agents of social change.

The following sequence from a student focus group interview conducted with female B.Ed. (Foundation Phase) pre-service teachers illustrates a dilemma

Box 3 Teachers' roles

Interviewer: "In your class there is a child who is depressed and can't cope academically. You notice that every drawing that she makes is of boxes with people lying in them. What do you do as a teacher?"

S: "I would consult the parents and if they can't do anything about it I would consult the social worker or the principal."

S: "I would first attempt to speak to the child about the drawings."

S: "In this case of pictures of people lying in boxes I would imagine the boxes are coffin. So probably the child is struggling to come into terms/ with (to accept) death in the family. It would make sense to call the parents first, find out whether somebody has died in the family."

S: "If it is something to do with death, you can have an open discussion in class by probably using a 'persona doll' to see how the child reacts; perhaps it is not about death."

S: "I would also speak first to the child and if the issue is of great concern, I would ask advice from another teacher. If I don't get help, I would consult the parents."

S: "... the counsellor as well."

S: "But definitely not leave the child unattended."

S: "I would keep the drawing to have evidence of what is happening."

S: "It is therefore important for us as future teachers to be very observant, pick up things so that our children will not suffer."

S: "I wouldn't stop the child from drawing; it is an outlet for the child. It is not a good thing to see the child drawing such things but he is expressing himself."

S: "I would probably get the children to draw different pictures and see whether this picture would appear anywhere else."

S: "...or ask them to discuss their drawing."

Several voices: "Yes"

S: "How much attachment should we have as teachers? Because I know as a nurse you have to be completely detached with your patient. As teachers do you think it is about monitoring the situation or what?"

S: "I don't know, it is quite difficult..."

S: "That's an important point - we don't know."

Several voices: "...someone else's responsibility...maybe the parents?"

S: "You can't speak to anyone else without the consent of the parent - but then what else?"

S: "Everybody is saying we should receive counselling training...but then how should we balance counselling with the teaching load."

S: "By the end of the day you should remember your work must be finished by 5th of December, before schools close down. The class as other 40 children to be attended to, you can't focus on one child."

Several voices: "Yes!

faced by many education students, particularly, but not only, in relation to individual learners infected or affected by HIV/AIDS. The fundamental issue at stake for teacher educators is how to help clarify the teacher's *degree of responsibility* in relation to different kinds of problems, as well as an appropriate balance between a teacher's *pastoral* role and his/her *educator* role. (Box 3).

Both in-service and pre-service groups gave similar responses with regard to this role. Some of the main themes which could be identified were as follows:

Students are aware of the importance of prevention education. The sense of agency and commitment developed in the students in relation to promoting/teaching preventative practices, whether in the classroom or the community, was strong. The majority of the students thought they were well informed about the facts of HIV transmission and the socio-cultural contexts and so would be able to teach around them. This perception was not always supported by the quantitative results which highlighted many instances where students had not mastered the facts. Although there were exceptions, the quotations below illustrate the

main tenor of the views expressed in the focus group and individual interviews with regard to this dimension of professional practice in the age of AIDS.

> As a teacher you can lay a foundation for prevention or spreading of the disease…Teaching is not about ABC any more like I thought (before).

> In school…I would like to teach them basic things about HIV/AIDS and make them aware. I (now) have sufficient knowledge, understanding and awareness.

> In certain areas where there is no education these things are happening, HIV/AIDS is happening because there is no education. So if I can learn from it (the module), which I have been, I can educate people.

Pre-service students in particular thought that it was important to be (and remain) well informed in order to function as preventative agents:

> I told myself that I would visit the library regularly to read books regarding HIV and AIDS. Now I am busy reading a book about HIV and AIDS, care and support.

There was also some understanding that HIV education need not be restricted to Life Orientation lessons and that it should ideally be across the curriculum:

> I will also use the AIDS context to teach Maths…

It was interesting that the pilot module awakened a strong sense of agency in some pre-service teachers and that they viewed the module as being more than just another academic requirement:

> …it is actually more like, like I said, that you don't do this because you want to pass the module. You really do this because you want to be a person who fights HIV and AIDS, and for me that's an honour.

Students are aware of the challenges prevention education poses. Some pre-service teachers were skeptical about the potential impact of functioning as preventative agents, because of perceived learner apathy:

> When we get pamphlets they just seem to throw it away because they think that it doesn't touch them or it's got nothing to do with them; people who has HIV/AIDS should read those pamphlets … they just don't want to know anything about it. They just believe that we all gonna die anyway, so it is pointless educating someone that you can't even change their mind perception, you know. I mean, you can try to explain to them that this and this is gonna happen, but if their mind set is set, it stays like that, they don't care about it and they believe so firmly in whatever they believe and that is not going to change anytime soon.

A further reservation regarding the students as preventative agents in the community related to the perceived limited impact one person might have:

> Ek is een persoon en ek kan iets verander, maar ek kan nie baie verander nie, want ek is net een persoon. (I am one person and I can change something but I cannot change all that much because I am only one person.)

They also had reservations about the legitimacy they would be perceived to have in the community as prevention agents:

> I think as, as, pre-service teachers now, if the government can just try to use us sometimes, maybe in preparing us in our holidays to, to talk to the community about HIV and AIDS and what - what, it will work for them…if you come from the government, they can recognise you, but if I can just try to say, ok I just want to organise people and tell them about HIV, they don't know, they won't come.

The students were realistic about the task of behavior change, realising that it would not be easy and would take commitment on their behalf:

> …even though you teach people about things, there are certain people that will never change.

Some of the students still had reservations about their capacity for fulfilling their role as preventative agents,

mostly because of a perceived lack of knowledge and uncertainty about being able to integrate HIV into their learning areas, especially those who taught subjects other than Life Orientation:

> Because I don't think I would be confident enough to teach the biological and medical side of it. Because I don't fully understand it – I mean we only had one lecture which was informative but I don't think I would be able to teach it right now.

However, even those students who were not fully confident of their level of knowledge were committed to learning more to help them to teach effectively:

> I wouldn't say that I know enough, it will probably be an ongoing process … I can relate to it and I will become aware of things that happen in the classroom environment, I will be prepared for what is coming. I don't think you can learn enough about it, because there is probably more that can be discovered, more aid and so on, but if I can make a difference in a learner's life, that would be wonderful.

Students did realise the importance of involving parents in HIV/AIDS education, but did not know, practically, how to set about doing this:

> It is important for us as teachers to make sure that parents form part of the whole process of educating learners about HIV/AIDS, it is a challenge that needs us to do something about it, I am not sure what.

Similarly, these students also felt uncomfortable addressing sexuality related issues, or at least had no idea how they would feel since they did not have opportunity during the module or otherwise to do this, emphasising the need for students to consider their identity in terms of their sexuality as well as their position on teaching sexuality related issues:

> I won't know until I get there because I have not been asked before, so I won't know. I figure I might be uncomfortable if an 18 year old boy comes to ask me a question and I won't say that I won't blush.

In comparison, *in-service* teachers did not display the reservations voiced by the *pre-service* teachers. They felt empowered by the pilot module, which served to remove any fears they had had previously about conducting HIV prevention education:

> I got tools on how to approach my learners about HIV without fear or doubt.

> I feel empowered to help others, and not scared like before.

Students believe that prevention education is not just limited to the classroom. There was a strong feeling that prevention education should not only be limited to the classroom and school, but that teachers should educate the wider community. This belief was reiterated mainly among in-service teachers, who have more daily experience of dealing with HIV and its related stigma and are bearing the brunt of its impact:

> And not only the learners, even our communities, we can teach them, we can talk about HIV/AIDS in our communities. We can even do so in our neighbourhoods, we can just teach them and help if there is a need. And teach those who are affected, because they are in the most pain, they are suffering.

However, some *pre-service* teachers also expressed a desire to educate the community and felt that they could do so due to having completed the module:

> This module empowered us to go out and teach the community about HIV and AIDS because the Department of Education entrusted us to do the job of educating. We must also learn to involve people living with HIV and AIDS.

There was also a sense that if teaching could encourage learners to take ownership of HIV related knowledge, then there was a chance that HIV education would be extended to families and communities:

Many of the students indicated that they would involve helping services in their approach to HIV prevention:

> I will organise nurses for health talks regarding transmissions and stigma around HIV and AIDS.

Other students mentioned local clinics and the Department of Arts and Culture.

The understanding that the problem has to be addressed in various layers of the ecosystem is reflected in their request for systemic intervention, and this was particularly noted in the in-service teacher group:

> …I think is important to involve parents, there is no need for educators to educate learners at schools and when they get home they get that attitude of discriminating others from their parents
> … support from other teachers and the school principal …
> … support from HIV organisations …

Summary comment: Preventative agent

Teachers are obligated by policy to provide prevention education and to prevent any learner from being stigmatised or discriminated against. The narratives of the students in this pilot show that they have unanimously accepted this role and are aware of the challenges and opportunities of being agents of social change. Both *in-service* and *pre-service* groups gave similar responses with regard to this role.

The sense of urgency and commitment developed in the students in relation to promoting and teaching preventative practices, whether in the classroom or the community, was strong. Most of the students thought they were well informed about the facts of HIV transmission and the socio-cultural contexts and so would be able to teach relevant issues. This perception was not always supported by the quantitative results which highlighted many instances where students had not mastered the facts.

In terms of the challenges facing them as preventative agents *pre-service* teachers were skeptical about their potential impact because of perceived learner apathy as well as having reservations about the legitimacy they would be perceived to have in the community. They were realistic about the task of behaviour change, realising that it would not be easy and would take commitment from them. They also stated that, although they were not yet fully confident of their level of knowledge, they were committed to learning more to help them to teach effectively. Generally, these students felt uncomfortable addressing sexuality related issues, thus emphasising the need we have identified for teachers to consider their identity in terms of their sexuality as well as their position on teaching issues related to sexuality.

In comparison, in-service pre-service teachers did not display the reservations voiced by the pre-service teachers. They felt empowered by the pilot module, which served to remove any fears they had had previously about conducting HIV prevention education.

Caregiver role

The caregiving or pastoral role of the teacher takes on new significance when many learners are affected by HIV/AIDS.

The following letter to the Minister of Home Affairs is based on an interview with one of the female in-service teachers who teaches in a rural area and is enrolled in the NPDE. (Box 4).

Often the teacher is the only source of support for affected learners whose learning is placed in jeopardy because of the increased vulnerabilities the epidemic creates.

The responses of the students to this aspect of the model for professional practice are described below under the emergent themes.

There is a strong awareness of the need to provide care and support. Both *in-service* and *pre-service* teachers indicated a strong commitment to provide a caring environment for learners, where they could share their concerns and receive help. They were of the opinion that care-giving is a vital prerequisite to protect the quality of teaching and learning:

> … as teachers we have to be friendly with our learners so that if they have some problems we

Box 4 Letter to the Minister of Home Affairs

Dear Minister of Social Welfare and Minister of Home Affairs

I am a grade one teacher in a rural area and I want to let you both know that thanks to the mobile clinics in our area, the children in my class now have birth certificates and clinic cards. We need more services but this is a good start.

I realised as I was taking a course for teachers on HIV/AIDS that many of the children in my class are very stressed and once I started looking into the life histories of many of these children I discovered that some were born HIV positive. I also found out that many of them have no parents. Their parents are dead as a result of AIDS and the children have no birth certificates. They also don't have clinic cards. When I realised this I went to the community council to find out if they could please send in people from welfare or wherever to come and make certificates for these children because they don't have parents. They are often just living with other children – their brothers and sisters but they are also young. The counsellor came back to me and said that there are these mobile clinics that come to the area. The next time there was a clinic day I went and asked the nurses if they could please come to my school because there are children there with no clinic cards. They are often sick but because they have no clinic cards they can't use the clinic. What if you come and do the cards for them I said. So they came and they made the cards for the children, and the counsellor arranged with the people from Social Welfare to come and they made the birth certificates. They really helped me. I understand these children. They don't have parents, and I know I acted as a parent to all of them.

Yours sincerely,

Elizabeth Mkhulisi (pseudonym)

Grade One Teacher

> have to see whether those problems will be solved … because as teachers we have to work with parents and the community at large, so that we can solve these problems… So as a teacher we have to look to those children so that we can give them love, and so that they can trust us, if they got some problems, they can explain to us, so that we can understand their problems so that they can do better in classes.

The in-service and pre-service teachers indicated that should they be unable to support the learners adequately, other professionals (psychologists, counselors, social workers) or the school principal would be enlisted. Significantly, none of the students referred to the role of a school-based support team (SBST). A further concern was the suggestion that psychologists are an accessible resource:

> … psychologists are always available for everyone. They are. They are there for us as the nation.

That psychologists are available to most South Africans is debatable, particularly in rural areas.

The main difference between the two groupings of students with regard to the care-giving role was that the *in-service* teachers had had real experience of acting out this role and gave many examples of the care and support they had provided:

> This (stigma) does happen in schools, last year a child was raped by her father and psychologically the child was not okay, she used to sleep on the grass not talking and vomiting during break time. I spoke to the learner but the learner was scared to reveal all the facts to me as a teacher because the father said if she told anyone he would kill her. I spoke to the School Counsellor to have a conversation with the learner; she revealed everything to the Counsellor and went through a process of counselling and testing and the learner discovered that she is HIV positive. So we tried to create a support group to assist the learner, after that the learner changed the attitude of being quiet and sleeping on the grass, she gained confidence that although she is HIV positive she still has a chance to survive.

They also gave examples of providing practical care by means of initiating the planting of vegetable gardens, providing food and clothing, and linking learners to external professional help and to NGOs.

Pre-service teachers could only hypothesise about what they would do to provide care, but most expressed a willingness to take on this role and suggested ways that they could go about it. They described care-giving as demonstrating unconditional acceptance of children infected with, or affected by, HIV, creating a warm classroom environment, empathising compassionately, being emotionally available, being trustworthy, actively comforting children who were HIV challenged and positively engaging with them. The majority of the responses highlighted comprehension of, and commitment to, a caring attitude:

> I believe that compassion is a big thing … While the child is speaking to you, maybe put your arm around them, or, uhm, really nod, really listen and kind of show how you would also, uhm, empathise … just for the child to know that you are there for them.

Sharing personal experience of care-giving. In-service teachers were able to provide more examples of what they would do to create a caring environment and to provide practical help. Some in-service teachers felt that they could enhance the relationship by sharing their own personal experiences and traumas with the learners to show that they understood what they were going through:.

> …and share my experiences with her to let her know that she is not alone.
> I share with them what I have gone through. I cry and tell them why… they always say sorry.

One student indicated that disclosure needed to be extended to the parents or caregivers of learners, in an effort to help them understand what learners who are affected by HIV have to cope with:

> I had two sisters who were infected with HIV and I was devastated. My mother too was infected and passed away. I am the strongest in the family and provide support for them. So I use my experiences to comfort others. I will involve parents/ guardians if the situation affects the academic performance. I also assist them to accept death. One child could not cope when the father died; the family did not explain the cause of death to the child, so I called them and showed them the importance of disclosing.

Although some *in-service* teachers expressed insecurity about being able to provide adequate care and support, their descriptions of how they handled situations indicated that they in fact were able to create a caring relationship and did provide comfort:

> I had a learner in class who was good and suddenly her performance dropped and I asked her about that. She then revealed that her mother was HIV positive. I then realised that I did not have the necessary skills to help her so we prayed together. I talked with her and made her realise that she was not alone and she needs to accept the reality of HIV and AIDS.

Pre-service teachers had similar feelings of inadequacy:

> Well honestly, I don't feel experienced enough. So, at the moment all I can do is be kind to the student, uhm, talk to them, let them open up to me and listen to them … I don't wanna give advice that I'm not (pause) what's the word, um …qualified to give. So I just want to comfort them, listen to them (group nods).

They also thought that they could provide practical support, create a warm and caring environment, and refer to specialists. They talked about involving parents as well, but showed little awareness that many of the children may not have parents, or be living with caregivers who were not that concerned about their emotional needs.

There were also several references amongst pre-service and in-service teachers to the added burden that the care-giving role places on teachers, and, while willing to take it on, there was concern that they would not be able to cope because of the extra time needed and the added responsibility:

> Everybody is saying we should receive counselling training because we might end up teaching in these underprivileged schools where you will have to do so much counselling. But then how should we balance counselling with the teaching load?

Amongst *pre-service* teachers, it appeared that the anticipated counselling role was a challenge for them and they felt that they had not been prepared for it, although they did feel able to offer informal support:

> I will make him feel comfortable to talk about what the problem is, because I am just telling you that I realise you have a problem of any kind, you must feel free to talk about it. I would also suggest places he could go for counselling, obviously I am not

> qualified to deal with that kind of thing…just offer support in whatever way.

For *in-service* teachers, however, the module seemed to have taken away a lot of the fears associated with working with HIV positive people:

> Before this module I was afraid of people having HIV, I was even afraid to hug them but now I know how it is transmitted and how to handle it when you already have it.

> Now I can talk to the person, if she wants to open up I can support her. I won't have that attitude of I don't want to hear.

Summary comment: Caregiver role

Both *in-service* and *pre-service* teachers indicated a strong commitment to providing a caring environment for learners. They were of the opinion that care-giving is vital to protecting the quality of teaching and learning and indicated that, should they be unable to support the learner adequately, the aid of other professionals such as psychologists, counselors, social workers, or the school principal would be called upon to help.

The main difference between the two groups of students with regard to the care-giving role was that the *in-service* students had had real experience of acting out this role and gave many examples of the care and support they had provided. They described care-giving as showing unconditional acceptance of HIV affected or infected children, creating a warm classroom environment, empathising, being emotionally available, being trustworthy, actively comforting children who needed this and positively engaging with them.

Generally, *Pre-service* teachers expressed a greater degree of inadequacy. However, they did also think that they could provide practical support, were able to create a warm and caring environment and would call on specialists when this was needed. They talked about involving parents as well, but showed little awareness that many of the children may be orphans, or may be living with caregivers who were not particularly concerned about their emotional needs.

There were also several references amongst *pre-service* and *in-service* teachers to the added burden that the care-giving role places on teachers, and while they were willing to take it on, they were concerned that they would not be able to cope because of the extra time needed and because of the additional responsibility. Amongst *pre-service* teachers, it appeared that the anticipated counselling role was a challenge for them and they felt that they had not been prepared for it, although they did feel able to offer informal support as a result of the types of discussions they had had in their classes, and as a result of the case studies contained in the materials.

Collegial sensitivity

Since many teachers themselves are professionally and/or personally affected or infected by the epidemic, all competent teachers need to develop sensitivity towards the feelings and experiences of their colleagues. As can be expected, however, the *pre-service* teachers did not really touch on this aspect, since they had had little or no experience in actual teaching and interacting with colleagues. However, there were one or two references to the fact that the pilot module had raised their awareness about the importance of acceptance and non-discrimination against colleagues who might be HIV positive, and the need to be empathetic:

> *…ek dink dit het my laat leer om nie te diskrimineer teen kollegas of kinders wat met VIGS moet saamlewe [nie.]*

> (I think it eventually taught me not to discriminate against colleagues or children who have to live with AIDS.)

> ... to be able to understand the situation other people are facing and to be able to put myself in their shoes, to be able understand the feeling they are going through.

In some cases, the experience of practice teaching had actually made them aware that teachers in many schools are not educated about HIV and that very little is happening in the way of prevention education. In many schools, the principals and teachers tried to

censor what the pre-service teachers taught the learners; in others, only the Life Orientation teachers took any responsibility for HIV education, and then only because they had to:

> As much as the curriculum is forcing them to be interested in HIV/AIDS but they are just doing it, because the curriculum forces them to do but they are not interested. I didn't see the enthusiasm in participating in it.

None of the students mentioned coming across teachers who had disclosed that they were infected or affected by HIV/AIDS, nor that they were stressed by its impact on the school:

> In my interview with the principal, she outlined that the school has the policy to teach learners about HIV/AIDS in the school. However this policy is not implemented in the school since most of the teachers have little knowledge about HIV/AIDS.
> I really think that teachers in general need help in dealing with HIV since in the old system we did not have that training and most of them, when it comes to working with someone who is HIV positive, they are discriminatory and prejudiced.

This perception was also echoed by some *in-service* teachers. There was little mention of colleagues who might be infected or affected, but there were several references to the ignorance of colleagues and their resistance to teach about HIV/AIDS:

> The teachers, we are having a high rate of infection and what I would suggest is, I think teachers need more education, they need to be educated, because of their attitude. Even at school if you are raising something about AIDS they think it is nonsense.

However, there were others who had experienced working with infected colleagues and who displayed sensitivity towards the need to help them:

> I had a colleague who died (the) first week of October, I tried to help but she was in denial.
> I think the module will not only be helpful in class but with colleagues too. I already shared some of the information with colleagues and together we were able to support a colleague who is HIV positive.
> … I think that we should also teach parents about HIV because sometimes teachers are afraid to disclose. Maybe they think that parents will discriminate against them.

Summary comment: Collegial sensitivity

The pre-service teachers did not really touch on this aspect of competence since they had had little or no experience of actual teaching, nor of interacting with colleagues. However, one or two did refer to the fact that the pilot module had raised their awareness about the importance of acceptance of colleagues – without discrimination – who might be HIV positive, and the need to be empathetic.

Amongst the in-service teachers, there was little mention of colleagues who might be infected or affected, but there were several references to the ignorance of colleagues and their resistance to teaching about HIV/AIDS. However, there were others who had experienced working with infected colleagues and who displayed sensitivity towards the need to help them.

Reflexivity

In the age of AIDS, teachers need to develop the capacity to reflect on the challenges facing education, as well as on their own feelings, beliefs and behaviour in order to enable them to respond with competence to protect the quality of teaching and learning and promote a safe and caring environment. There is also a need for them to reflect on their social and professional identities as teachers, including the intersecting reality of race, social class, gender and other identities in the age of AIDS.

Students reflect on a personal level. There were various instances of pre-service teachers saying that the pilot had made them more aware of their own attitudes, beliefs and behaviour. Prior to the module, many of

them had not really thought about their attitudes. At its most basic level, many of the participants noted that they had come to think differently about HIV and AIDS and no longer viewed it simplistically:

> *... ek het baie dinge geleer, en ek is heeltemal anderster oor VIGS ... ek sien dit nou as 'n realiteit, nie meer as daai ding van, ag dit irriteer my en dis 'n siekte en kom net oor dit, so ja...*
>
> (I learnt a lot, and I am completely changed in relation to AIDS---I now see it as a reality, not only as that thing that irritates and is a disease and people should just get over it , so yes…)

The following remark from one pre-service teacher suggests that students saw the link between being a teacher and therefore being required to help others, and being a person and needing help for one's self:

> I think the module was really a step up because it stopped being about learners and it started to be about me and how I can be helped [our emphasis] and how I find myself in situations that could potentially lead me to get the virus. The life skills part really helped me develop as a person, because at the end of the day I'm a teacher but I'm also young and come across these situations.

Many students suggested that casual sex without consideration of HIV infection had become unacceptable to them and that they were willing to confront their friends about this, which implies some reflection about their own sexual behaviour:

> … en nou die dag vertel een van my vriende hy het met vier meisies geslaap en onmiddellik is ek soos 'HEY Ou! Dink jy nie jy gaan VIGS kry nie?' Voorheen sou ek nooit so daaraan gedink het nie; nou, nou kyk ek uit vir sulke goed en ek oordeel nie die mense wat rondslaap nie, maar ek kan nou vra: 'Is jy nie geworried oor VIGS nie? Dink jy nie eers aan dit nie?'
>
> (...and just the other day a friend told me that he had slept with four girls and my immediate response was, "How could you? Are you not afraid of getting AIDS?" Before all this I didn't give much thought to this subject but now I am on the look-out for this. I don't judge the people who sleep around but I do ask, "Surely you are worried about AIDS? Don't you even think about it first"?)

While the majority of students did not explicitly and directly refer to gender in their responses, for some of them reflections about their own sexuality and their position in their personal and social relationships included thinking about gender inequality and its impact on the spiraling rate of HIV infection:

> And with that case study, I will always refer to it because it really touched me with that mother...So now she died of the disease... And then I asked myself when that case study was being read in class I asked what if this woman was strong enough to tell her husband 'we should protect ourselves or maybe we should do umm, try to do something about it'. Because it is so touching to see, living around the community, cause where I live people are really dying of this disease, because of such things. Sometimes being scared to talk about them, sometimes as a woman, cause they believe 'ok I have to respect, the man is the head of the house and what if I have to divorce and all those things. I have to go back home, it's an embarrassment and all those things' so ja it really did touch me in a way.

The participants also reflected on the interaction among the factors of socio-economic status, power and gender dynamics, and on the implications of such interaction on HIV infection rates:

> To me it's that part of why women are more vulnerable, before I did not know that part, but know I know why women are vulnerable, because of poverty, because some of them are not working and they will go to find the man, so she can get money for that, sometimes they are in love with sugar daddies because they know these daddies will give them money, so then comes the HIV.

Referring to the HEAIDS materials in particular, one participant explained:

> I find that MaNdlovu is complaining in terms of saying, because Miss Margaret has been telling her, she has been teaching them about the importance of using condoms, and no it becomes difficult for MaNdlovu to tell her husband about this, you know the information that she has acquired, so it becomes now a real life situation because we find women being oppressed, and if women still oppressed and harassed, it becomes difficult for them to expose their feelings, and it doesn't matter if we … now we come to addressing part of it, if we address this part of having women in oppressed, it means in a relationship, it means the man and woman, when they are equal, both parties actually do have information, and they can assist each other in terms of saying, if this is happening, this what we need to do, in terms of holding these other by hand(unsure) and go on in a safe journey…

Obviously such analyses need to be encouraged and strengthened if the social drivers of HIV infection and the socio-economic impacts are to be effectively addressed.

However, there were also indications that participants have uncritically accepted the commonly held societal views about the superiority of men and boys over women and girls. For example, a male participant declared:

> Sometimes there is a difference between the thinking of a female and a male child, because usually female children focus on the environment and surrounding and boys usually look far because they go around for example a grade four boy can look for a job, after breakfast they disappear, you can meet them far away from home busy playing so they come back with various experiences from what they have seen out there. So we have to bear in mind that if we are talking of a male child, think more.

Another societal view uncritically accepted by the participants related to the belief that girls' clothing invites abuse from men, including rape, and that their bodies and dress need to be policed so as to protect them. For example, ignoring the gender and power dynamics involved in relationships between boys and girls and men and women, at one institution the participants in the focus group were vociferous regarding school uniform rules as a form of prevention. They believed that part of their preventative function was to promote and enforce rules that legislated the length of girls' school skirts. One participant in particular illustrated this point:

> **P2:** ..I will also encourage my school principal… if he can maybe use the uniform for the girls … Even in the class, just for instance, you as a male teacher, you can't teach while girls are sitting there with 2 cm skirts. When they sit down, they go up. … You can see everything. ..Even as a male teacher there it is very difficult. And the boys in the school in fact, also, they can't handle, err, their feelings in fact, while looking at the girls wearing like that. And, I have heard that, I have been reading, err, several newspapers, the boys were doing sex with girls in the toilets. I think it is because of, err, the way they wear…
>
> **Interviewer:** So, what you are saying is that if there are rules about uniform, it will make teaching about HIV/AIDS easy because you will be able to teach boys about abstinence.
>
> **P.2:** Yes. It shows that there is respect, a great respect, for both male teachers and school boys.

Another example involved a focus group discussion involving both male and female students, again on girls clothing and the need to use this to protect girls from sexual abuse and rape, and consequently from HIV infection:

> **F2:** The girls, if you walk through malls, there are little girls, little, I mean little, little girls with these miniskirts on.
> **F6:** Lipstick on.
> **F2:** And I'm thinking my daughter will never look like that (laughs). I can say I will never buy her clothes like that and I will, ja.
> **F1:** I'm with you there.
> **F2:** We are forcing kids to grow up too quickly.

This is perhaps a simplistic (and even sexist) approach to the complex issue of HIV prevention, but at the same time it suggests that the lived experience of the participants includes knowing about reports of the sexual abuse of school girls by their male peers and teachers, and that they feel they have a responsibility to curb this. To date no work has been done, as far as we know, on the suggestion that the enforced wearing of school uniforms by girls might be considered useful in curbing HIV infection rates.

A clearer and more encouraging picture in terms of the students' views and attitudes to gender equality and discrimination emerged in their responses in the pre- and post-test. In all the participating institutions, the pre- and post-tests asked students to indicate whether they agreed or disagreed with a set of statements related to gender attitudes that have a bearing on HIV/AIDS.

Most students gave the desired responses in the pre-test, and the matched data set yielded very little difference in the post-test. This may suggest that students' gender attitudes were generally aligned with those in the module from the outset. However, the interviews suggested that the students were not able or willing to directly talk about the significance of gender. Thus, it could also be that, while they had learnt the gender equality discourse from various sources in their lives, including this pilot module, they had not learnt to integrate what they knew and had heard in other spaces and situations into their lives, thus suggesting that more work needs to be done to enable them to make such links.

Given the concerning incidence of HIV infection among teachers in South Africa, it is very encouraging that students had begun to reflect on their sexuality and, more importantly, that they were willing to act as change agents in this regard.

Some of the *pre-service* teachers (both male and female) indicated that it was difficult to limit themselves to one partner (especially as they typically had partners in their communities of origin and partners in their current learning context), but they had begun to think more deeply about their sexual behaviour. Their candid responses suggest reflexive thinking which could potentially lead to personal behaviour change:

> I am this kind of person who would like to know new things… that I don't know. I want to know more about HIV/AIDS. I used to be like this kind of person who like girls, propose to them, right now I know more about HIV… things have changed. I have become more serious about life.

> Ja, this course came, once again when I changed my behavior. As a person there are times you change the way you do things, I have decided to do things in a certain way. When the course came it came in that time when I have changed and it made more sense and it made me realise more of the things that I needed to think about.

The students have not only thought about their behaviour as a result of the module, but also about their values and attitudes:

> The module on HIV/AIDS has made me to consider and change my attitudes and values. I realised that I would discriminate against someone with HIV/AIDS under certain circumstances for example if they are teaching my child.

> I have learnt to treat every one equally regardless of their status. Before that I do not know if I would help someone who is HIV positive, but now I know I have to help them and be open minded about it because they need love, support and care.

> Through this course I have gained a huge appreciation of differences between my values and values of others.

The *in-service* teachers also indicated that they had thought more deeply about their behaviour since doing the module and many of them mentioned that they now intended to get tested:

> It made me not afraid to get myself tested. It is easy for one to speak but to put the talking into action

> is not easy. I was just speaking about HIV but not aware that I must first know my status. That is very important because if you know your status, you know how to be able to live right now.

From the students' responses it emerged that they had begun to think more deeply about various HIV related matters. For one student, this related to his sexuality and how it needed to be different from that of his father:

> Sometimes you will hear people say that these children are sexually active but they do not realise that we are all sexually active. What counts a lot is the way we live our own lives… People too must learn to stick to one sexual partner. We must not be like our fathers who had extra wives. Our mothers have gone through pain of succumbing to such arrangements. One could see how she suffered.

His candour suggests that his thinking has gone beyond one of the messages of HIV prevention (i.e. being faithful as a means of ensuring an HIV negative status) to a next level (i.e. being faithful as a means of encouraging a partner's emotional security). This suggests that (at least for this student) participation in the pilot encouraged accountable sexuality.

However, one tutor felt that the module did not really help students to self-reflect and that this was something that was lacking in the module:

> Self-reflection, before they can be able to help someone else, I don't think it quite did that one. They are going to be at the centre of imparting knowledge and so if you have got to do that, you have to start and change your own way of thinking.

Students reflect on a professional level. The module helped *pre-service* teachers to become more aware of (and think about) their roles as teachers in the age of AIDS. On one level this related to an emerging sense that the demands on a teacher would be far greater than had been previously anticipated:

> Well, I guess I saw the whole HIV teaching in a different way.
>
> All that I do know now is that I probably have a lot more on my hands..

The Letter to a Friend (Box 5) is a composite letter constructed by a member of the implementing team from various comments made by PGCE students in their self-reflections.

Prior to this module, some students had not thought that they would probably need to fulfil a counselling role in the line of their professional duties:

> I never thought before of how much you're gonna actually need to counsel them … so it was for me, developing as a teacher, I really had to think what am I going to do, how am I going to do this…

They also demonstrated reflexivity with regard to how involvement with HIV positive learners might have an impact on them as teachers and the ramifications this might have for teacher involvement with learners:

> Uhm… okay, I'm thinking … what happens when an educator loses someone you love due to AIDS, they were in your class and you get attached to them … so how do you deal with that? … You might want to help the child, but at the same time have the fear of losing them... so how do you deal with it?
>
> After reading the HIV/AIDS in the study guide I was so touched to the extent that [I] look at myself as a future teacher… the challenges that are facing me. They are multiple. I mean, the challenges request not just a teacher who is good in a certain subject. This is challenges that … need a teacher to be a multifold person … a social worker, a teacher, a parent, a guider, a motivator and at the same time have to deal with your own personal lifestyle.

The module has helped them to think more deeply about how they would address HIV in the classroom:

> The emphasis for me on this module was, I kept seeing it from an educator's point of view, yes a personal sense as well, but I know myself and I know my own

Box 5 Now I need to take responsibility as a teacher

Hi Joe,

Thought I would just drop you a line and tell you about what is going on in my life. We have just completed a module on HIV/AIDS education as part of our PCGE training this year, and I need to share with you how it has influenced me, both as a teacher and on a more personal level.

Before I did this module, I had mixed feelings about HIV – I was not really sure if I would even want to help some one who is HIV positive – I suppose my fear and ignorance about the disease sort of made me want to avoid even thinking about my attitudes. But this module was a wake-up call – it revealed to me that maybe I would even discriminate against someone with HIV or AIDS under certain circumstances, for example if they are teaching my child – scary, when you think that I am now going to be a teacher!. But now I know that the most important thing we have to do is care and support HIV infected and affected people.

For the first time in my (self-centred!) life I now know that not all of us hold the same values, and that the values other people hold are just as important as mine. People come to hold certain values due to the social influences they have been exposed to and as a teacher I can now appreciate that I am in a pretty powerful position to be able to change attitudes and values towards HIV and AIDS. I have started to reflect on my own values and attitudes because I want to try to alleviate the stigma attached to HIV and AIDS. I know that I cannot just go into a classroom and impose my values on others – I have to take into account the local ways of knowing, gendered identities, gender violence and the link between poverty and HIV and AIDS – you could say the module has made me a much more tolerant and nicer person! I actually never thought about stigma before since it did not affect me in my "middle class" life – now I really have a good understanding of how we all contribute to stigma without even knowing we are doing it! We visited an HIV centre and it helped me to realise that the HIV epidemic is something we really need to take seriously – and then we played this game that showed me that NO-ONE is immune to HIV – really scary stuff and you know what, I went and got tested afterwards! Luckily, I am OK but I will need to really think about my own behaviour in the future, if you know what I mean!

Anyway, I guess I just want to say that I feel quite overawed by the responsibility I have as a teacher to help protect my learners from HIV – and from the stigma attached to it. School sure has changed even since I left – who would have thought that a maths teacher would need to be able to know all this!

Sharp!, Matt

> sexuality and I know my values and morals, so from a personal sense I am comfortable, but from an educator's perspective, it definitely came through, you kept thinking how you would address this, and different age groups and how you would come across.

An *in-service* teacher extended the idea of living positively to having learnt to cope with HIV related loss. To date, she had lost seven friends to AIDS and this has left her feeling bereft, anxious and afraid. However, in the course of the pilot she felt that she acquired knowledge that empowered her in terms of personal health promotion. Furthermore, having fellow teachers with similar experiences encouraged her to accept what had happened and to move on. At the close of the pilot her words were:

> It is as if I wrote a new story about HIV and AIDS.

With other *in-service* teachers, there was some indication that further reflection about HIV prevention was needed among the students. One example pertains to the multiple references to condomising, abstaining and being faithful – almost as if these would be enough to halt the HIV crisis. For example, one participant reported:

> There was this situation in my school when older boys sexually abused the younger boy, but used a condom. To a certain extent I think they have done a bad thing, but they remembered to condomise - meaning that sexuality education is working.

Her example suggests that extensive, sensitive HIV education is necessary if we are to encourage profound understanding among teachers of the convoluted challenges of HIV prevention, including gender-based and sexual violence as a barrier to such prevention. Her example also speaks to the broader issues of education and the idea that the issues are bigger than those that can be contained in one module.

Summary comment: Reflexivity

On a personal level, there were various instances of *pre-service* teachers saying that the pilot had made them more aware of their own attitudes, beliefs and behaviour in relation to HIV/AIDS. Many stated that casual sex without consideration of HIV infection had become anathema to them and that they were willing to confront others about this, which implies some reflection about their own sexual behaviour. Some of these students, both male and female, indicated that although it was difficult to limit themselves to one partner, they

had begun to think more deeply about their sexual behaviour as well as their values and attitudes.

The *in-service* teachers also indicated that they had thought more deeply about their behaviour since doing the module and many of them mentioned that they now intended to get tested.

In thinking about their professional role, pre-service teachers are becoming more aware of their roles as teachers in the age of AIDS. On one level this related to an emerging sense that the demands on a teacher would be far greater than had they had previously anticipated. Prior to this module, some students had not thought that they would probably need to fulfil a counselling role in the line of their professional duties. On another level, they also demonstrated reflexivity with regard to how involvement with HIV positive learners might have an impact on them as teachers and the implications of this for teacher involvement with learners. Thus, the module has helped them to think more deeply about how they would address HIV in the classroom.

For the *in-service* teachers, there was some indication that further reflection about HIV prevention was needed, thus suggesting that extensive, sensitive HIV education is necessary if a more profound understanding of the convoluted challenges of HIV prevention is to be encouraged.

Leadership

Given the reality that many of our schools are under-resourced and that poverty is endemic to many of the school communities, learners who are infected or affected by HIV have many socio-economic and psychological needs waiting to be met. Often the teacher is the only person who can identify these needs and act as a mediator to make sure that the learner receives the help he or she requires. This calls for every teacher to take the lead in addressing HIV related issues in school, regardless of their position in the hierarchy. The responses of the students indicated that they had begun to think about this role and the responsibilities it brought.

Teachers have to lead by example. Amongst the *pre-service* teachers, many indicated that they were aware that as leaders, they had to set an example:

> …I got to be careful, lead by example.

This included knowing their status and behaving in a responsible way. They felt that communities looked to them for leadership:

> … that when you go out to the communities, most of the community, they are looking to the teachers to bring the difference in their lives.

Although most students did not explicitly refer to taking leadership, their willingness to help others and address HIV issues was evident:

> …we as teachers are the people who are closer to the community and it may be there, for example the minister of health wants to make those community outreach, maybe talking about HIV and AIDS. I think teachers will be the good people to get that opportunity because we see that in the ministry of health, we are, we only talk about the ministry of health, we are looking at the nurses and doctors not noticing that teachers are also nurses and doctors because every problem that the learner is encountering in the class, the teacher is the first nurse to help the learner.

> If there is some way that I can help somebody out, I will do all I can do to do that.

One student did say that he would keep on trying to influence the school in terms of HIV/AIDS education, even if the school was resistant:

> You need to keep drumming at it and keep speaking about it to staff and the principal and irritating them pretty much until they allow you to do it, or some sort of compromise is reached. I would just keep going for it, you just have to be confident and you know how important it is. And we all know the impact we can have as teachers, so I think you have to keep drumming at it until someone will support you.0

They appeared to be excited about the possibility of being agents of change in their teaching:

> The best thing about the module was that we as young people could be change agents to change the minds or behaviours of those young people out there and set an example in preventing HIV.

In-service teachers were also aware that they had to be role-models. The phrase 'leading by example' was used often, both in relation to their professional role at school and their personal roles at home and in the community:

> Therefore, we need to lead by example at school and at home.

Teachers need to develop leadership skills. Both *pre-service* and *in-service* teachers expressed concern that they were not sure how to overcome resistance on the part of colleagues and principals, as well as parents and SGB members. It appears that they understand the leadership role, but do not have the skills or knowledge to actually enact it:

> I as a teacher have to have some books to read so that we can have a knowledge about this. And have some materials like posters and stories so that they can know symbols or many things about AIDS.

> There should be a part where we can learn how we can implement some projects when we reach the community or when we are at work… the projects that we can do to enhance those learners who are already infected and affected.

Many *pre-service* teachers said they would like to have had more time to learn how to take the initiative and provide leadership, since they were aware that HIV education was needed on both personal and professional levels for them:

> You know, I would like to have had more training on how to take the initiative, take time to do some research, see what you can find out and actually present a little Power Point or presentation to the actual staff at school, just maybe to enlighten them and make them aware of certain situation, who knows how many people you won't be helping even on a personal level regarding educators, so ja, I think I would really have enjoyed it if they had extended that section.

Amongst *in-service* teachers there were very few references to their taking leadership in their schools, although some mentioned that they had taken it upon themselves to invite outside agencies to come and speak to the learners, even in the face of opposition by colleagues:

> I went to LoveLife, and asked them to come and teach the children … so he came to school and the teachers said, 'no, this is nonsense because HIV doesn't affect us'. So I told them 'HIV doesn't affect us as persons, but what about the children?', and can I say I don't have HIV before being tested, I told them a person's appearance doesn't tell they are HIV.

Another student told of how she feels she can now be stronger in her family life and take more control of the situation at home:

> This module gave me strength because at home I have two HIV positive sisters and brother, and at the time I heard they were positive I was of the mind that they were going to die, but now I can, I am strong now I can tell them, take your pills, have you done this, have you done that? You see, it makes me want to challenge HIV now.

Summary comment: Leadership

The responses of the pre-service teachers indicated that they had begun to think about this role and the responsibilities it brought. This included knowing their status and behaving in a responsible way. They felt that communities looked to them for leadership. Although most students did not explicitly refer to taking leadership, their willingness to help others and address HIV issues was evident.

In-service teachers were also aware that they had to be role-models, but in a more concrete way. The phrase

'leading by example' was used often, both in relation to their professional role at school and their personal roles at home and in the community.

Overall, this was an area that was reflected more in the comments of the *pre-service* and *in-service* teachers than in the comments of the lecturers. Both pre-service and in-service teachers expressed concern that they were not sure how to overcome resistance on the part of colleagues and principals, as well as parents and SGB members. Their comments speak to the need for more direct references to leadership in the course of the module itself.

Quantitative findings

Biomedical HIV/AIDS knowledge: By the end of the pilot, there was an increase in the biomedical HIV/AIDS knowledge of the students. The average increase across the whole matched sample and across phases was from 7.94 to 9.16 correct answers out of 15. Even those institutions in which students scored highly in the pre-test, showed some improvement in the number of questions answered correctly in the post test – for example, in one institution there was an average increase from 9.11 to 9.59 correct answers. Substantial improvement occurred in items which required more technical knowledge which the students did not have to begin with, such as *A CD4-count of less than 200 does not mean that a person has a healthy immune system* (37% increase from pre to post test).

HIV/AIDS related activities: By the end of the pilot, there was also an increase in the numbers of HIV/AIDS related activities performed by students (an increase of 3.12 to 5.3 activities out of 10 performed on average across the sample). In particular, the pilot stimulated HIV/AIDS related discussion not only within the institutions, but in students' family and friendship circles.

Discrimination against people living with HIV/AIDS: Overall, there was little or no change in students' *gender attitudes* between the beginning and the end of the pilot, nor in the extent to which they were likely to *discriminate against people living with HIV/AIDS*. The attitudes of students were generally aligned with those in the module from the outset. When female and male responses are compared, female responses are more aligned than those of males. In the responses to some of the gender related statements, there is an indication that, even at the end of the pilot, male dominance in the home and in sexual relationships is endorsed. A marked number of males in the post-test (38%) agreed that it was not natural for a woman to take the lead in sexual intercourse, and a marked number of males (20%) agreed in the post-test that a man should have the final word at home. Critically, although issues of gender were addressed in the module, it is not an issue or set of attitudes that are typically 'undone' in an intervention over one semester.

Confidence in relation to professional practice: By the end of the pilot, students' confidence in relation to professional practice had increased, but trends are variable across institutions, and for different phases. For the sample as a whole, the greatest increase in confidence was in relation to integrating HIV/AIDS into the curriculum (between 0.23 for Upper FET phase and 1.35 for the Senior phase group) as well as providing students with HIV/AIDS information (between 0.17 for the Upper FET and 1.55 for the Senior phase group).

CHAPTER SIX

Conclusions and Lessons of Experience

This section synthesises conclusions drawn from the findings regarding the successes, failures and/or limitations of the HIV and AIDS module within teacher education programmes. It answers two questions:

1. What conclusions can be drawn from the findings about the effectiveness of the various **strategies for incorporation of HIV/AIDS** related education into teacher education used in the pilot?
2. What conclusions can be drawn from the findings about improvement in students' **personal and professional competence**?

The conclusions are used to point to *lessons of experience* which can inform the module's on-going development and refinement. These will be developed into recommendations in the next chapter.

Although there are multiple ways in which the target audience can be differentiated, the clearest distinctions are between

- Pre-service and in-service teachers
- Those with lived experience of HIV/AIDS, and those with little or no lived experience.

Wherever relevant, the conclusions will refer to these different groups. In addition, where a conclusion relates primarily to lecturing staff rather than students, this will be indicated.

CURRICULUM DESIGN AND IMPLEMENTATION – STRATEGIES FOR INCORPORATION OF HIV/AIDS RELATED EDUCATION INTO TEACHER EDUCATION

A distinctive feature of this project has been the wide variety of ways in which institutions incorporated the module and materials into the curriculum of existing teacher education programmes. Institutions made choices about whether to offer the module as a stand-alone, as part of an existing module, or whether to integrate it across a number of modules (cross-curricular integration). They made choices about the disciplinary area into which the module would be incorporated, about the intended outcomes and how they would assess whether the outcomes had been achieved. According to the needs of the target audience and the constraints within their institutions they decided how to use and adapt the materials, and when and how to teach the module. They also decided who would teach it, and how they would engage with the broader project through the OCF and the Colloquia.

This flexibility was seen as essential because of the range of programmes and the very different target audiences, as well as the different dynamics within the institutions themselves. This section summarises what has been learned about the adaptation of the module and materials that is a necessary part of effective curriculum design and implementation.

Content and outcomes in the module and the materials

Four outcomes are identified in the HEAIDS module and the Learning Guide, *Being a teacher in the context of the HIV/AIDS pandemic* piloted in HEIs. These are*:*

- To implement participative pedagogical approaches to teaching biomedical facts about HIV/AIDS;
- To understand how issues of poverty, gender, stigma and discrimination relate to HIV/AIDS in the South African and wider African context and to engage learners around these issues in a participative manner;
- To understand the physical, economic, social and emotional impact of the HIV/AIDS epidemic on teachers, learners and their communities; and
- To respond in sensitive, positive and holistic ways to the practical as well as psychosocial needs of learners and colleagues.

These four outcomes reflect the understanding of curriculum that has been developed in Chapter Four – that HIV/AIDS curricula need to be developed from three perspectives – the socio-ecological, that of inclusive education, and that of health promotion.

Some of the participating institutions chose to focus on all four outcomes, while others selected one or two. Yet others adapted some or all the outcomes so as to integrate them into existing modules. A key finding from individual pilot evaluations is that *institutions reported that they had achieved or partially achieved all four outcomes* during the pilot, even if they did not work systematically through each of the four units in the materials. This suggests that the outcomes are inter-related and that they work together to achieve the broader purpose of the module, which is to build the personal and professional competence of teachers in the age of AIDS.

Lesson of experience*: even if there is a particular focus on one or two of the outcomes, or one or two of the units of the materials, adaptations must take cognisance of the fact that a curriculum for HIV/AIDS has three perspectives – socio-ecological, health promotion and inclusive education, and each of these needs to be acknowledged and integrated.*

This said, most institutions (in their self-evaluation reports) as well as respondents in the institutional evaluations reported that the fourth outcome: 'respond in sensitive, positive and holistic ways to the practical as well as psychosocial needs of learners and colleagues' had been difficult to achieve fully. This was because achieving it fully would require a whole-school and multi-sectoral approach to HIV intervention involving other professionals such as social workers, psychologists and others, and the focus of the implementation of the module was in HEI-based teacher education programmes rather than school-based teacher development programmes. Even with in-service teachers, who might have been expected to work with whole-school approaches, there are a number of school-level barriers which made this difficult, such as hostility from principals to 'sex education' and fear of stigmatisation of disclosure in schools leading to silence.

Lesson of experience*: School-based work on HIV/AIDS is crucial if students are going to be able to practise what they have learned in professional settings.*

It can be concluded from the evidence that the understanding of HIV/AIDS as an 'issue' which incorporates different levels of knowledge, understanding, and practice was grasped in the pilots.

First, across the institutions, most students (both pre- and in-service as well as those with and without lived experience of HIV/AIDS) reported *increased levels of knowledge and/or understanding about various aspects of HIV/AIDS*. This included *understanding of the bio-medical aspects of HIV/AIDS from the materials and the module, and feeling empowered* by this new learning. Pointing to their initial 'sick-of-AIDS' attitude towards the module and the material, most reflected on how little they actually knew about HIV/AIDS before the module. In addition, for many, understanding the impact of the social and economic drivers of epidemic, the impact of HIV-related stigma, and for a few, the gendered character of HIV/AIDS, was also significant. For the lecturers, this knowledge also included an

understanding of the theory that framed the design and content of the module and the materials.

However, while the module had given students new insights into HIV/AIDS and a sense of *empowerment through knowledge*, actual attitudinal and behavioural change will need to be nurtured and built-upon over time if it is to result in permanent change. As noted in the previous chapter, one institution implemented the aspects of the module in a single workshop while others carried out their work over a semester but with relatively few hours available.

***Lesson of experience**: Attitude and behaviour change need a longer process than simply exposure to a single module that varies in length from a six hour workshop to a semester long course.*

Second, the module also resulted in *pedagogical learning* among respondents**.** Both lecturers and pre- and in-service teachers generally found the material and/or the module useful in terms of content and pedagogical strategies. In terms of the latter, it was the *participatory approaches* used in the materials and the module that were reported to have contributed to the positive attitudes towards the pilot. The use of case studies and the *visual* was cited as having contributed significantly to the positive experiences among the lecturers and students, and as likely to be sustained in future modules, and to be taken up in future endeavours of the students in their own future classrooms as teachers. Several institutions, for example brought in their own DVD material. Other institutions drew on role play and other types of performance as ways of using visual methods.

***Lesson of experience**: The way that the personal and professional have to come together in teaching HIV/AIDS means that it is critical to use approaches which allow for students to contribute from their personal experience. At the same time, however, this is threatening, and often the use of other people's experience (case studies) or other media, such as the visual, assist.*

Third**,** both pre- and in-service teachers reported *skills development* as having resulted from participating in the module pilot. In particular, most students (and lecturers) had learnt some practical participatory teaching skills, some generic across different levels of education (from primary to secondary and tertiary), and others specific to a particular level. For example, in a few institutions, students identified the importance of using *age-appropriate content and pedagogy* in the teaching of HIV/AIDS. Those training to be foundation phase teachers identified particular skills they had gained to make HIV/AIDS content (and other controversial or taboo topics) relevant and appropriate for younger learners. For them, this would help address parents' concerns about the controversial nature of HIV/AIDS education, particularly as it relates to issues of sexuality. However, at least at one institution, students felt that identifying age-appropriate content and strategies is not a clear cut process. For example, pointing to the varied ecological experiences of young children, with some experiencing rape, sexual abuse, orphaning, and other adult-like occurrences, students with lived experience of HIV/AIDS suggested that there needed to be some further debate about what content and *pedagogic approaches* would best suit the needs of learners at any level, including the foundation phase.

***Lesson of experience**: More opportunity needs to be given to discussion about how to treat HIV/AIDS in ways that are sensitive to the needs of learners in different phases – either in the materials themselves, or in the mediation of the materials in teacher education programmes.*

However, both pre- and in-service teachers as well as their lecturers pointed to a need for more attention to counselling skills development. This arose from the realisation that HIV/AIDS is highly charged emotionally and also that the devastating contexts of many of those living with HIV/AIDS require skills beyond those which teachers usually expect to develop. This will be discussed further in the next section.

***Lesson of experience**: The almost universal cry for more help with counselling needs to be addressed either in the materials or in the mediation of these materials through the courses.*

Fourth, for the lecturers in particular, the module and materials had contributed to their professional development. In particular, understanding the theory (ecological framework) informing the design, content and pedagogy of the module and materials helped to build their understandings not only as they related to the pilot, but as they relate to curriculum design and implementation across all their teaching.

***Lesson of experience**: HIV/AIDS is not simply an 'issue' to be taught. The content and pedagogy required for treating HIV/AIDS in appropriate ways assists with understanding of education and teaching more broadly.*

With regard to the materials themselves, both students and lecturers in various institutions generally responded positively to the materials. Not only did these positive responses emanate from in-service teachers, who applauded the materials for their *user-friendliness*, they were also from pre-service teachers and lecturers who were appreciative of the *authentic and relevant content* in the case studies and the *participatory pedagogy***,** including visual methods, used in them. The case studies were engaging to students with a variety of ecological experiences because:

- For some, they resonated with the real-life contexts of teachers and learners in schools; and
- For others, they opened up discussion, and allowed for the vicarious exploration of sensitive and taboo topics such as HIV/AIDS and related issues.

However, pre-service teachers and in-service teachers (and lecturers), also cautioned that the module and/or materials tended to perpetuate the myth that HIV is a poor African people's problem and not part of the (immediate) life-world of some groups (for example, white and middle class). While in some programmes discussions among students from different religious, cultural and class backgrounds allowed for sharing of diverse experience, in others, lecturers provided additional material (such as DVDs) which spoke directly to their largely white student target audience.

***Lesson of experience**: The materials need to be enhanced with case studies and/or visual material that position the variety of student/teacher target audiences as affected by HIV/AIDS.*

Course structure

As discussed above, among the decisions and choices that institutions participating in the piloting of the HEAIDS module and materials was *choosing an implementation option* (stand-alone, single module adaptation, or curricular integration). In this regard, first, there were various comments about *time* as either an enabling or a disabling factor in the implementation of the pilot, with those who opted for a stand-alone module having more time to cover the content than those who chose to 'bolt' the pilot content onto an existing module. A recurring cry from both students and lecturers regarding what did not work well in the pilot was *time constraints* and the inability of institutions to devote enough time to the very complex issues HIV/AIDS raises in the curriculum. A final point on this is that there was only one attempt at cross- curricular integration and this was combined with single module adaptation – HIV/AIDS content integrated into an existing module on curriculum.

***Lesson of experience**: The content of HIV/AIDS requires a 'home' – either in an existing module, or in a stand-alone module. This provides a base from which cross-curricular integration can be done successfully. The stand-alone option is preferable in that it provides more time for adequate addressing of all the outcomes, but it may not be possible in certain programmes (such as the PGCE). With good planning, however, the time problems can be addressed to some extent, even when the module is 'bolted' on to existing modules.*

In terms of the learning area into which HIV/AIDS was integrated, the three variations were life orientation/life skills, educational/professional studies, and, for curriculum integration, methodology courses. Institutions did not provide reasons for these choices beyond the pragmatic ones of who was available and willing to do the work.

***Lesson of experience**: Since the choice of a learning area will result in different emphases in the curriculum*

of the HIV/AIDS module, more careful thought needs to be given to this.

Delivery seems to have been most successful where institutions made *context-specific adaptations to the HEAIDS module.* For example, institutions which used the HEAIDS materials together with the institution's own course guide, added materials or readings and put very careful thought into assignments that led to the application of knowledge such as through research on the ground, lesson design, or interpretation in the students' own teaching contexts. Many of the modules demonstrate the effectiveness of the HEAIDS materials to support development of HIV education skills, knowledge and agency when used in conjunction with a pedagogic framework developed by university lecturers to suit the needs of their particular student contexts.

Pedagogy

The design of the module and the materials utilised *participatory pedagogy* as an approach. This, according to the respondents, not only made the pilot interesting, it also made it highly effective. In particular, the use of case studies, role play and other forms of performance, and in several institutions, their own DVD material, as well as experiential learning was seen to be addressing the gaps in understanding especially among those with little or no experience of HIV/AIDS in their communities. While some lecturers commented that the participatory methods did not work well in large classes, others saw them as useful in addressing the problems brought about by large numbers in classes. For example, the self-instructional character of the materials, as well as visual methods such as video documentaries was identified as significant in addressing such problems.

***Lesson of experience**: Successful pilots were characterised by the use of a combination of methods, tailored to the specific target audience, and enabling open discussion from varied life experiences.*

As discussed above, asked what the most important thing they had learnt from the module was, most of the students cited pedagogical strategies generally, and specifically *age appropriate strategies* relevant for teaching controversial issues such as HIV/AIDS. Selecting appropriate content was important for responding to parents' beliefs about what content and teaching methods are appropriate for their children's age, among other factors.

Work done in some pilots showed how the impact can be increased by drawing on wider campus initiatives, such as Peer Educator groups, or young people's research groups such as Youth as Knowledge Producer (YAKP), a group of students on one campus who, as noted in the previous chapter explore and promote the usefulness of arts-based approaches such as Hip-hop, Forum and Image theatre, poetry, video making, collage and photovoice.

***Lesson of experience**: The integration of student-led campus wide peer educator or research projects into the delivery of the HIV/AIDS module facilitates uptake not only of prevention messages, but also of innovative teaching approaches.*

Assessment

The types of assessment designed for the module varied widely from institution to institution. In one there was no assessment, in others there was one assignment per unit followed by an examination. In others again, there was only an examination, and yet again in others, there were simply oral presentations. Four distinct foci for the assessment emerge:

- *Assignments that get students to engage with the materials,* for example, a quiz, a peer presentation on an aspect related to Units 1-4, or a take home examination based on the case study used in the introduction to the materials. This was regarded as useful, because it enabled the students to get the most out of the materials.
- *Assignments that require lesson planning or critique of HIV/AIDS related lessons,* for example, at one institution, students were expected to source an HIV lesson in a subject-specific text book and critically analyse it according to set criteria.

- *Assignments that require school-based research*, for example, interviewing school personnel on the approach to HIV/AIDS; or creating an HIV/AIDS policy for the school.
- *Assignments that require reflection on experiential learning*, for example, a visit to an AIDS centre. This, among other outcomes, would address the knowledge gaps among those with little or no HIV/AIDS experience in their own lives, as well as provide real-life opportunities for students to learn to deal with the negative impacts of HIV/AIDS in their own and their learners' lives.

While in some institutions *assessment* was successfully linked to both content *and* pedagogy, in others this was not the case. Concomitant with authentic content and pedagogy, the students themselves identified the need for *authentic assessment strategies* in the module and/or the materials as important in HIV/AIDS education in their own education in the tertiary institutions as well as in the education of younger children in the schooling sector.

Lesson of experience: *Students with life experience of HIV/AIDS as well as those with little or none need to be assigned authentic experiences in the communities mostly affected by the epidemic so that they can learn from these and 'make a difference' in the lives of those affected.*

Staffing and support

Staffing for the implementation of the pilot varied across institutions, ranging from a single academic to a group of academics where there were large numbers, with at least one institution supported by trained tutors. Across the institutions, the enthusiasm of the lecturers echoed that of their students, suggesting that experiences in the module were positive all round. This has implications for the uptake of the initiative and its sustainability in the disciplines as well as across the faculties/schools of education.

However, several challenges face institutions in relation to staffing and support. First, while acknowledging that much creative work is happening across institutions, the evaluation revealed that some lecturers still expressed anxiety about teaching HIV/AIDS content. In some instances, lecturers or tutors on the courses described themselves as 'out of their area of expertise'.

Lesson of experience*: There is a need for professional development programmes to support implementing staff to address such issues as socio-cultural beliefs about HIV-related issues (sex, condoms, sexual orientation, etc.) or provide more in-depth understanding of the social and educational issues around HIV/AIDS.*

Second, there is evidence that both lecturers and students find themselves trying to make sense of their own lives and positions in relation to HIV/AIDS and this can be very daunting. A related challenge is the fact that most find HIV/AIDS content as well as dealing with the negative impacts of HIV/AIDS in their own, learners' and colleagues' lives emotionally taxing.

Lesson of experience*: The emotionally taxing character of HIV/AIDS related education suggests the need for the provision of counselling services within the institutions and training in counselling skills for lecturers, in-service teachers, and pre-service teachers in preparation for their own classrooms.*

Third, there is the need for support from colleagues in the teaching of the module. The pilot was reported as particularly successful in institutions where a group of lecturers and/or tutors felt supported and, in turn, supported each other throughout implementation. For example, where junior lecturers or tutors were well supported with initial training and ongoing support during the module, as for example in one institution where 17 tutors worked with over 500 students, the potential problems seem to have been largely overcome.

Lesson of experience*: The employment of tutors can enable effective delivery of the module to large numbers of teachers, but these tutors need initial training and ongoing support.*

Finally, there is the need for inter-institutional support, particularly for lecturers who are not supported

in their institutions. Lecturers, tutors and interns report that being linked into an inter-institutional community of practice for the duration of the pilot (largely through the Colloquia, but also through the Online Collaborative Forum) was important both in terms of growth in knowledge, as well as confidence in dealing with a subject as sensitive as HIV/AIDS. They also noted that the Colloquia facilitated a type of bench-marking in terms of the quality of HIV education.

***Lesson of experience**: Because lecturers/tutors teaching in this area are often unsupported within their institutions and do not have HIV/AIDS specific training, it is important to establish and nurture communities of practice for support and professional development.*

Use of technology

As was mentioned in the findings, despite generally positive support for the OCF from the HEIs, the potential of the OCF to support pedagogy was not realised during this pilot predominately because of *lack of time* and *access.* Lack of time was not limited to *users' lack of time* to engage with the OCF as mentioned above, but also to the *overall time* available for the pilot: most HEIs had either completed or were nearing completion of teaching the module before the OCF was ready to be launched – the number of participating HEIs during the second semester of 2008 rather than the first semester of 2009 was much higher than anticipated. *Lack of access* was an issue not only in terms of the *lack of hardware and connectivity* in a number of institutions, but also in terms of *restricted user access* to the OCF since only lecturers/tutors and interns had access to the Restricted OCF; students/teachers did not have access. This meant that the use of the OCF as a teaching tool was limited.

***Lesson of experience**: In order to ensure that OCF is both lecturer resource and teaching tool in HEI classrooms, design, training and support need to maximise access for both staff and students/teachers.*

CURRICULUM IMPACT - IMPROVEMENT IN PERSONAL AND PROFESSIONAL COMPETENCE

An overview of the themes of emerging competences in the individual pilot reports makes it possible to suggest that participation in the pilot encouraged nascent understanding of what professional practice in the age of AIDS involves and commitment towards the multi-faceted role of the teacher in the age of AIDS. This subsection addresses this aspect of the pilot evaluation.

The lessons of experience that are drawn out of the discussion give direction as to how the impact can be increased, and how personal and professional competence can be enhanced.

Awareness of Context

In summary, there were multiple themes that reflect growing awareness of an HIV-altered context, following pre- and in-service teacher participation in the pilot.

HIV/AIDS affects everyone

Both in-service and pre-service teachers showed a heightened awareness that HIV/AIDS affects everyone indiscriminately. Pre-service teachers demonstrated emerging awareness of this reality, whereas experienced in-service teachers revealed lived experiences confirming the reality of an HIV-altered educational landscape and sometimes lived experiences of an HIV-altered personal world. In the latter case, participation in the pilot confirmed experiential learning and encouraged awareness that as teachers they were positioned to address aspects of an HIV-altered context. In essence, this suggested that the pilot was instrumental in encouraging a realistic awareness of our HIV-altered context.

Some students suggested that without first-hand experience of the challenges of HIV/AIDS, it remained a problem that could be ignored or 'othered'. It was interesting to note that the use of the personal pronoun, as in "my" community, "our" people, was usual in the discourse of many in-service teachers, whereas among the majority of

pre-service teachers, it was apparent that their awareness was still related very much to life experience and ecologies that were often untrammelled by HIV/AIDS. Typically, when pre-service teachers did note prior experience, and acceptance, of HIV/AIDS knowing no boundaries, they were African students from rural or township areas. It was significant that many of the pre-service teachers (both white and African) indicated that their participation in the pilot had made them aware that their lived experiences of HIV and its challenges were limited and that this would form barriers to sensitive teaching if they did not take active steps to increase their understanding of how HIV challenged children and communities.

When students with more robust lived experiences of the personal and professional challenges of HIV/AIDS were willing to disclose these in a tertiary learning environment, fellow students with less experience were afforded vicarious opportunities of becoming more acquainted with the truths of an HIV-altered reality, and in so doing, their awareness of HIV/AIDS deepened. They noted, often for the first time, that HIV/AIDS would affect them as teachers in the age of HIV/AIDS. This suggested that HIV-related education needs narrations of real-life experiences in addition to case-studies, statistics and newspaper reports that can too easily be discounted.

***Lesson of experience**: Awareness of context is related to personal trajectories and student ecologies, and this needs to be considered in the adaptation of the module and materials.*

***Lesson of experience**: Middle class students need to be assisted to acknowledge their personal vulnerability to HIV/AIDS but also that, in order to be able to teach across different contexts in South Africa, an understanding of the gendered character and socio-economic antecedents of HIV/AIDS is crucial.*

Children are innocent victims

In some instances participation in the pilot was associated with the dawning realisation that children who were infected were typically defenceless and innocent – they could not be held responsible for their sero-status. There was further evidence of a newfound respect for affected learners that replaced previous prejudiced perceptions of learners-made-needy (by HIV-related challenges) as fonts of frustration or affliction. It seemed that participants (especially pre-service participants) had not always felt as empathetic towards children on whom HIV has had such a huge impact. HEIs need to make a concerted effort to encourage education students towards unconditional acceptance of their learners and of future learners.

***Lesson of experience**: Future teachers' attitudes to people living with HIV/AIDS are effectively challenged through focusing on the children who are innocent victims of the epidemic.*

Giving practical expression to awareness

The knowledge gained from the module was especially helpful in encouraging awareness of how various ecological factors (such as culture and socio-economic context) had an impact on how HIV/AIDS was perceived, understood, experienced and dealt with. Some of the pre-service teachers in particular had not realised how serious the impact of HIV/AIDS had been on education, or how many lives had been changed by it. Mostly, however, both in-service and pre-service teachers had become (more) aware of the socio-economic and emotional impacts of the epidemic on learners and communities and that this negatively influenced learning experiences. Both groups were also aware of the denial prevailing in many communities, the moral criticism of people living with HIV/AIDS (PLWHAs), the increased incidence of early sexual activity among numerous learners, the vulnerability of girls and women, and the fact that all of these have a detrimental impact on schooling. What was worrying was that in many instances pre- and in-service teachers appeared to be theoretically aware of the roles they needed to play to address the aforementioned challenges, but they often had little idea of how to respond practically to HIV-related needs and challenges such as how, for instance, to reach out to the community or to parents.

***Lesson of experience**: Much more time and focused attention needs to be directed towards supporting*

in-service and *pre-service teachers to translate their increased awareness into practical ways of intervening positively in the lives of learners, their parents, and communities affected by HIV/AIDS.*

An interesting anomaly was that for a few students their emerging awareness caused them to feel that as future teachers they might be more at risk, given their interaction with other human beings who might be infected. Varied levels of confidence were noted in the quantitative findings, too. By the end of the pilot, students' confidence in relation to professional practice had increased, but trends were variable across institutions, and for different phases.

***Lesson of experience**: Teaching of health-promoting behaviours in an age of HIV/AIDS perhaps needs to emphasise a solution-focused approach, rather than concentrating on the possible risks.*

Preventative Agent

Acceptance of role of key preventative agents

The narratives of the participating pre- and in-service teachers showed that they had unanimously accepted the policy-dictated role of teachers as preventative agents of HIV/AIDS; were often less inhibited to act as prevention agents; had understood that, ideally, preventative actions needed to be ecosystemic; and were mostly aware of the challenges and opportunities of being agents of social change. Essentially, they saw themselves as teaching their learners (and, particularly in respect of the in-service teachers, their communities as well) the basic facts of HIV transmission and prevention. The quantitative findings indicated that following participation in the pilot, most participating students showed increased HIV-related knowledge, especially biomedical knowledge. Substantial improvement was noted in relation to more technical knowledge which the students did not have to begin with. Evidence from *HEIs' own stories* suggested that in more than half of the participating HEIs implementing teacher-educators believed that the pilot outcomes had been achieved. This implies that the HEIs had a belief that students were comprehensively equipped to function as preventative agents.

Pre-service teachers in particular thought that it was important to be (and remain) well informed in order to function as preventative agent. There were also pleas that the role of preventative agent should not be laid at the door of Life Orientation educators only, a point also supported in the literature.

Interestingly, there were varied opinions on what should be taught in order to prevent further HIV infection. Amongst some, there was a sense that learners should be made aware that their personal choices would shape their HIV status. Whilst there is some merit in the debate about choice, emphasising this does not acknowledge that choice is not always possible in contexts of disempowerment.

***Lesson of experience**: HIV/AIDS teacher education courses need to assert that all teachers (not just Life Orientation teachers) need to be preventative agents, and knowledge is critical to their preparation to play this role. This is knowledge not only of the facts to support choice, but is also the understanding of contexts of disempowerment that impede choice.*

Being a preventative agent in the classroom

Although the overwhelming impression was that students felt empowered by the knowledge and understanding they had received through the module, some students still had reservations about their capacity to fulfill their role as preventative agents in schools, partly because of learner apathy, but for a range of other reasons as well:

- A perceived lack of knowledge and uncertainty about being able to integrate HIV into their learning areas, especially those who taught subjects other than Life Orientation
- Realisation of the need to involve parents, but lack of knowledge of how to do this practically
- Discomfort, or uncertainty, relating to how they would manage sexuality education, especially since they had no prior experience or pilot-facilitated opportunity to explore their own sexuality

Functioning as a preventative agent involves not only doing (teaching), but also being – modelling tolerance,

embodying healthy sexuality. This realisation did not emerge clearly among all students. One spin-off of this is that future HIV education needs to be unequivocal about this interconnection.

Lesson of experience*: HIV-related training of education students needs to include overt introduction to pedagogical strategies that facilitate the integration of HIV into the curriculum; overt strategies for involving parents and caregivers; encouragement of students to consider their identity in terms of their sexuality as well as their position on teaching sexuality-related issues; clear teaching of the importance of being (modelling), not just doing (teaching).*

Being a preventative agent in the community

There was a strong sense that prevention education should not be limited only to the classroom and school, but that teachers should educate the wider community. This was clearly linked (especially among in-service teachers) to having understood that schools and communities needed to speak as one voice if preventative efforts are to amount to anything. The quantitative findings endorsed this: by the end of the pilot, there was an increase in the numbers of HIV/AIDS -related activities performed by students, including preventative activities like HIV/AIDS -related discussion not only within the institutions, but in students' family and friendship circles.

There was, however, no consensus regarding the responsibility of teachers to be community preventative agents. Some pre-service teachers expressed reservations about community perceptions of their legitimacy as prevention agents. This intimated that it might not always be easy for educators (especially pre-service teachers) to function as community prevention agents, even if they are willing to, without formal endorsement of, and support for, this role, despite current education policy that positions teachers as community agents.

There was also some cynicism regarding the potential impact of preventative actions in conservative communities or communities that disparaged the reality of HIV/AIDS.

Lesson of experience*: There is a need for more thought about how students might be empowered to feel comfortable and capable enough to address HIV related issues in conservative and cynical communities. Possibly there are also cultural barriers that need to be overcome before preventative community action is possible or skills that students need to learn that will enable them to negotiate their way around these barriers.*

Caregiver

Strong commitment to and understanding of care-giver role

Both in-service and pre-service teachers expressed a strong commitment to the role of caregiver. Their commitment included an understanding that in the age of HIV/AIDS, teachers had to double as nurturers, surrogate parents, confidantes, counsellors and even social workers. Many students noted that caregiving was not just demonstrated in deeds, but also in words and in attitude. They demonstrated understanding that caregiving was a vital prerequisite to promoting and sustaining the quality of teaching and learning. There was a clear acceptance of the need to navigate towards, negotiate for, and make good use of, ecosystemic resources (such as professional service providers, parents, and the school principal). This insight is important to sustain teachers coping in the age of HIV/AIDS. Many in-service teachers shared experiences of having taught and cared for HIV positive learners. In such instances, they noted that following the pilot, they felt better informed regarding what they could do for infected and affected learners. All in all, the findings suggested endorsement of, and enablement towards, teachers-as-caregivers, which pointed to the pilot having played a positive role in encouraging emerging competence.

Lack of understanding of the context of care

There were some issues of concern.

- Significantly very few students referred to the role of a school-based support team (SBST) as a resource teachers-as-caregivers.

- A further concern was the perception that psychologists are an accessible resource, whereas psychologists are not a resource for most South Africans, particularly in rural areas.
- Many participants thought that it would be necessary to include a learner's parents in the caregiving process (even if only to access background information) when the school had noticed that something was troubling the learner. This raised the issue that some participants had not considered that in the age of HIV/AIDS, many learners may be orphaned. As noted previously, this suggests that personal contexts and lived experiences strongly shape student-teachers' perceptions of learners' contexts.

***Lesson of experience**: More needs to be done to prepare pre-service teachers for the complex and different contexts of South African learners, as well as the extent of the support available in schools.*

Perceived ability to perform the caregiver role

There were isolated incidences of students who understood the necessity of teachers acting as caregivers, but they expressed reluctance to do so personally. In these cases their contexts, cultures and/or personal make-up introduced barriers to their enactment of caregiving. Their stories and rationales were poignant reminders that there are personal and social complexities which make it difficult for some *in-service* and *pre-service* teachers to accept, and act on, the role of caregiver. There is still a need to engage all students in a way that will encourage them all to see the HIV/AIDS epidemic as an issue of 'public concern' that needs to be actively addressed (including through acts of caregiving and concomitant attitudes.

What was further noteworthy was that although most of the in-service and pre-service teachers indicated they were willing to fulfill a caregiving role, mostly they felt that they were ill-equipped to do so, especially in relation to feeling under-equipped to cope with the counselling needs of learners. Many expressed the wish that they had been equipped with some of these skills in the course of the pilot. There were also several references among pre- and in-service teachers to the added burden that the caregiving role placed on teachers, and while willing to take it on, there was concern that they would not be able to cope with the added responsibility or manage their time effectively. There were also concerns about how they would cope personally with challenging and/or troubling experiences introduced by their profession. This implies a deficit in the contents of the pilot, but also suggests that HIV-related education should provide opportunities for clarifying an appropriate balance between a teacher's pastoral role and his/her educator role.

Some students felt that they could enhance their caregiving role by sharing their own personal experiences and traumas with the learners to show that they understood what the latter were going through. One student indicated that disclosure needed to be extended to the parents or caregivers of learners, in an effort to help them understand what learners on whom HIV has a serious impact have to cope with. This raises a number of questions, including whether teachers need personal experience of the HIV crisis in order to provide sensitive care; what the impact of teacher disclosure on learners (and/or their caregivers) might be; and even whether disclosure to (especially younger) learners is appropriate? One further question relates to whether these teachers do not perhaps have a need to talk about their HIV-related losses and that if this need is not catered for, their classrooms may become a space in which this need is accommodated. Certainly, within other service professions (such as, for example, psychology) disclosure is recommended only when it will have therapeutic impact and even then the act of disclosure is guided by brevity and sensitivity to the context of the client. It was clear in many of the interviews that engagement with the module awakened feelings in the students that they did not necessarily know how to deal with.

***Lesson of experience**: Far more attention needs to be paid to the request for counselling skills, not only to help teachers engage sensitively with the issues their learners present, but also to understand how to manage the caregiver role appropriately and effectively. Attention also needs to be focused on enabling students to develop skills that will help them to navigate towards, and negotiate for, ecosystemic resources to care for themselves.*

Collegial Sensitivity

There was scant evidence of the pilot having encouraged collegial sensitivity.

As can be expected, the pre-service teachers did not really touch on this aspect, possibly because their lived experience of being a colleague was limited. There were random references to the fact that the pilot module had raised their awareness about the importance of acceptance of, and non-discrimination towards colleagues who might be HIV positive and the need to be empathetic. There were also references to having witnessed, in the course of their practical teaching, that many teachers were dismissive of HIV/AIDS. None of the students mentioned experiences of teachers who had disclosed that they were infected or affected by HIV.

A similar pattern was noted among the in-service teachers. There was limited reference to having worked with colleagues who were HIV positive and to any experience of subsequent acts of tolerance, concrete support and empathy. There were several references to the ignorance of colleagues and their resistance to teaching about HIV/AIDS. A single teacher, however informed and enlightened, has very little effect on an environment in which there is AIDS denialism or stigmatisation of those living with HIV/AIDS.

***Lesson of experience**: A possible lesson of experience is that collegial sensitivity cannot be directly taught as part of a HEI-based teacher education programme. For pre-service teachers, it might be possible to use teacher preparation to sensitise them to infected and affected fellow students who might well be their future colleagues. As a start this could perhaps be done through peer education programmes in their own institutions. However, this could also be done through a general helping skills approach so that students learn how to empathise, listen attentively and so on. The caregiver role could address both learners and colleagues. In-service teachers could be supported to understand and engage with policy aligned support structures in their schools, such as School-based Support Teams.*

Reflexivity

In the main, the pilot appeared to encourage personal and professional reflexivity.

Reflection on a personal level

On a personal level, reflexivity was related to some students becoming critically aware of their HIV-related attitudes and values. Most commonly, reflexivity was associated with students contemplating their sexuality and their sexual behaviours. In many instances this led to health-promoting actions such as being faithful to one partner or to being tested for HIV. In other instances such reflection encouraged other-directed agency, such as advocating safer sex to friends, peers and even to family members. As noted previously, this was borne out by the quantitative findings and by the reports of staff involved in pilot implementation. Given the concerning incidence of HIV among teachers in South Africa, it is positive that students had begun to reflect on their sexuality, take health-promoting steps and, more importantly, be willing to act as agents of change in this regard. In some instances reflection did not result in behaviour change, often because of cultural or contextual barriers, which once again serves as a reminder that learning and change are mediated by student ecologies and student trajectories. One tutor felt that the module did not do enough to encourage students towards self-reflection. This observation, coupled with that of students who experienced contextual and cultural barriers to reflexivity, raises questions about teacher education explicitly needing to promote formal and informal opportunities for self-reflection on being a person and on being a teacher in the age of AIDS.

A few students derived personal benefit in that participation in the pilot enabled them to come to terms with HIV-related losses. As noted in previous sections of this conclusion, this raises questions about the accessibility of therapeutic spaces for students grappling with such loss.

In relation to the gendered character of HIV/AIDS, the findings are not clear. On the one hand in the pre- and

post-tests, there appears to be alignment between the gender attitudes in the module and the gender attitudes of participants. On the other, there is evidence from the interview data that suggests acceptance of gender attitudes such as male dominance as well as victim-blaming for rape. This could be explained in the following way: while students had learnt the gender equality discourse from various sources in their lives, including this pilot module, unless direct questions were asked, they had not learnt to integrate what they knew and had heard in other spaces and situations into their lives. They were not able to use gender in any way to process experience.

***Lesson of experience**: Gender inequality runs very deep in our society, and internalisation of understanding that runs counter to convention requires concerted effort beyond what the pilot module and materials were able to afford.*

Reflection on a professional level

On a professional level, many pre-service teachers had been encouraged to ponder their roles (both preventative and caregiving) as teachers in the age of AIDS. On one level this related to an emerging sense that the demands on a teacher would be far greater than had been previously anticipated and that they were in need of specialised skills (such as counselling). Some students also wondered how engagement with HIV positive learners might have an impact on them as teachers and the implications of this for involvement with learners and acceptance of caregiving roles. Others began to think more deeply about how they would address HIV in the classroom. All of the aforementioned points suggest that the pilot was instrumental in encouraging reflexivity that could shape teacher practice and teacher identity.

For the in-service teachers, there was some indication that further reflection about HIV prevention was needed. For example, there were multiple references to condomising, abstaining and being faithful – almost as if these strategies would be enough to halt the HIV crisis. A concerning anomaly was reference to an incident in which learners had been sexually abusive towards another, yet this was coupled to the belief that this incident was less troubling because at least the perpetrators had used a condom. This suggested that extensive, sensitive HIV education is necessary if we are to encourage profound understanding of the complex challenges of HIV prevention among teachers.

***Lesson of experience**: Reflexivity in the age of AIDS requires relating the personal and professional, and it needs time and support to result in attitudinal and behaviour change.*

Leadership Role

There were indications that pre-service teachers had understood that teachers are positioned as leaders in the age of AIDS. Mostly this pertained to awareness of leading by example, and a commitment not to abuse the position of power that teachers have. In this regard, the pilot seems to have had a positive impact on participants.

There were some areas of concern. Both pre- and in-service teachers expressed inadequacy with regard to:

- Overcoming HIV-related resistance on the part of colleagues, principals, parents and SGB members
- The skills and knowledge to translate understanding and commitment into practice.

In some instances students noted that they carried the leadership roles into their homes. Both male and female students noted that they set examples for their families, exercised the right to safer sex or encouraged medication compliance, following participation in the pilot. In other instances, female participants lamented not being able to stand up for their rights at home. This reinforced awareness of the reality that there are multiple barriers to applying what is learned in HIV education to all contexts of daily living or to taking the lead on such matters.

***Lesson of experience**: It might be worthwhile researching what the ecological and personal assets and processes are that facilitate enactment of leadership roles, not just in the classroom, but also at home.*

CHAPTER SEVEN

Recommendations

These recommendations are directed at answering questions as to how the impact of the module can be increased and also how it can be implemented in a sustainable way.

The recommendations build on and elaborate on the lessons of experience in the previous chapter, and are organised according to three levels:

1. Programme level (recommendations for implementing staff for improvement in curriculum design and implementation)
2. Institution level (recommendations for management/heads of school for programme design and staffing for the integration of HIV/AIDS into teacher education in the institution)
3. Sector level (recommendations/suggestions arising from the experience of the pilot for how HIV/AIDS can effectively and sustainably be integrated into teacher education sector as a whole).

They incorporate the discussions held with the participating institutions at the final Colloquium held on 4 May 2009.

PROGRAMME LEVEL RECOMMENDATIONS FOR IMPLEMENTING STAFF

To be professionally competent in the age of AIDS requires a sensitive awareness to the nuanced reality of a sub-Saharan, and specifically South African, context. Such awareness needs to go beyond the consciousness of the reality of HIV/AIDS so as to incorporate appreciation of the multifaceted complexities that HIV and AIDS bring and that feed into the spiraling HIV crisis to include the recognition that disempowered people (for example, the poor, women and other disadvantaged groups) may cope less resiliently with the challenges of the epidemic given their paucity of resources and coping alternatives.

One iterative lesson of experience noted in this pilot was that sensitive awareness of the nuanced HIV contexts was often related to personal trajectories, student ecologies and intrapersonal student factors. Therefore, future HIV/AIDS education needs to take cognisance that learning is mediated by such multiple factors and in so doing, build on existing student and ecological assets that can be used to promote educator competence, but also seek to temper barriers arising from these factors. This suggests that lecturing staff members need to be familiar with their targeted student audience, but also that they purposefully structure contact sessions, inputs and pedagogical approaches in ways that maximise awareness of multiple contexts and sensitivity towards the complex realities of disempowerment; and discourage the scapegoating of certain population groups.

The recommendations in this section for staff who implement the module flow from these insights:

1. Adapt the module/materials to meet the needs of the target audience.
2. Enhance the module to meet particularly pressing needs – counselling skills and school-based support.
3. Use participatory approaches to teaching and assessment so that learning becomes a personal investment.

Adapt the module/materials to meet the needs of the target audience

Recommendation 1: *Based on knowledge of the target audience, make phase-specific adaptation to the module and materials.*

> *Lesson of experience:* More opportunity needs to be given to discussion about how to treat HIV/AIDS in ways that are sensitive to the needs of learners in different phases – either in the materials themselves, or in the mediation of the materials in teacher education programmes.

The module is meant to provide an overview - framing theory, policy, context, and information in relation to HIV/AIDS. It is not intended as a handbook of methods or a collection of phase-specific lesson plans. There is a need for programme specific adaptation of the materials to meet the specific needs of teachers of different phases. The following are suggested:

- Phase-specific case studies and examples
- Phase-specific assessment
- Phase-specific methodologies – for example, discussion of age appropriate information.

It is important to recognise, however, that what may be regarded as appropriate for a particular phase in one type of school, will not be regarded as appropriate in another. For example, while some foundation phase pre-service teachers believed in the text-book mantra of using age-appropriate content and strategies, other suggested that the approach would be irrelevant and counterproductive in contexts where children grow up too soon and their image as innocent does not hold, for example, where children's daily reality is abuse, death, and violence. In these contexts, censoring HIV/AIDS information in order to be age appropriate is not an adequate response. Rather, creative strategies that confront the real issues around HIV infection (sex, rape, abuse, etc) must be handled head-on.

Recommendation 2: *Enhance the relevance of the module/ materials for the diverse target audience.*

> *Lesson of experience:* The materials need to be enhanced with case studies and visual material that position the variety of student/teacher target audiences as affected by HIV/AIDS.

The evidence from data collected as well as the socio-ecological perspective adopted in this evaluation suggest that to be effective, HIV/AIDS content must be contextual (in the content, examples, images and materials used) and localised. No one size fits all. While many African participants applauded the module and materials for their focus on what they considered real-life issues, many felt that the focus was centred too much on African South Africans. Students from other racial groups, whose lives were not presented in the material and module found them alienating.

Hence, while it is crucial that curricula address issues relevant to the ecologies of those most affected by the epidemic (for example, poor African women), it is also important to balance the above with issues that affect the rest of the population, such as, for example, middle class individuals and groups. The materials and module could be localised and contextualised by:

- Selecting or developing content and materials that depict people and situations from diverse backgrounds (race, gender, sexual orientation, social class, religion and others);
- Using experiential learning for all students, but particularly for students with little or no lived experience of HIV/AIDS, through:
  - Self-study: engaging students in assignments that explore their own lives vis-à-vis HIV/AIDS and their own vulnerabilities to HIV infection;
  - Exploring HIV/AIDS in their own communities;

- Ethically appropriate site visits to organisations and communities linked to those mostly infected and affected by the pandemic;
- Real-life or realistic fictional case studies;
- Visual methods such as video-documentaries and films on HIV/AIDS and its social and/or educational impacts;
- Voluntary work and service learning situations.

Enhance the module/material to meet the need for counselling skills and school-based support

Recommendation 3: *Include counselling skills development more substantially in order to equip teachers to handle complex and sensitive HIV/AIDS issues.*

> *Lesson of experience:* Far more attention needs to be paid to the request for counselling skills, not only to help teachers engage sensitively with the issues their learners present, but also to understand how to manage the caregiver role appropriately and effectively.

To be professionally competent in the age of AIDS further entails acceptance and meaningful enactment of the role of educators as caregivers. Students/teachers generally endorsed this role too, but there was a strong sense across the individual pilots that in-service and pre-service teachers feel out of their depth when faced with the extent of the suffering and the complexity of the social and personal problems related to HIV/AIDS.

The existing materials could be enhanced by including a unit on basic counselling skills to address HIV/AIDS specific issues such as grief counselling. However, such a unit should not aim to equip teachers to be professional counsellors, but rather to provide a basic orientation to counselling skills such as listening, dealing with their own feelings, referral skills, and working in an inclusive environment.

In addition, a sensitive approach should be modeled by teacher educators by, for example, providing opportunities for de-briefing after lectures in which potentially disturbing issues have been discussed.

Recommendation 4: *Encourage asset-mapping activities.*

> *Lesson of experience:* More needs to be done to prepare student-teachers for the complex and different contexts from which South African learners may come, as well as the extent of support available in schools and communities.

This is related to the above points. In-service and pre-service teachers need clearer guidance on where they are able to help and where not and where they find support. This can be done through asset mapping (Kretzman and McGight 1993) i.e. documentation of accessible protective resources within their immediate and extended communities. Such resources might include NGOs, professional service providers, faith-based organisations and local welfare structures. In addition to introducing students to asset-mapping skills, it would be helpful to develop participatory skills that would encourage community collaboration. Furthermore, students need to be made aware that psychologists are not an accessible resource for most South Africans, particularly those in rural areas, but that there are alternatives (such as, for example, Childline; Lifeline; AIDSline; local counsellors; faith-based organisations that provide pastoral care). Institution-specific adaptation of the materials could include lists of support services which in-service and pre-service teachers could draw on in the areas in which they live and/or teach. Finally, there should also be a foregrounding of the roles of the School-based Support Team and the District-based Support Team, and how teachers can engage constructively with these.

Recommendation 5: *Support students on teaching practice and in schools and communities where they might experience resistance to implementation of HIV/AIDS teaching and positioning themselves as preventative agents.*

> *Lesson of experience:* There is a need for more thought about how students might be empowered to feel comfortable and capable enough to address HIV issues in conservative and cynical communities. In some contexts there are also

cultural barriers that need to be overcome before preventative community action is possible.

There were a number of references by participating students that it might be difficult for them to act as preventative agents within their communities, in part because communities are often skeptical of students and also because of HIV-related stigma. In this regard, HEIs might need to go beyond merely encouraging teachers to function preventatively in their communities (as required by education policy) and also encourage community structures and departments of education to endorse teachers and in-service and pre-service teachers as preventative agents in their communities. Simultaneously, it will be important to encourage them to accept that even if their communities are cynical towards preventative messages, they should persevere.

Some students noted that prevention messages would be sabotaged by cultural taboos, conservatism, inimical role models and HIV fatigue. In this regard, students need to be empowered to feel comfortable and capable enough to address HIV issues in conservative and cynical communities and to be equipped with strategies towards overcoming cultural barriers to preventative community action. In the age of AIDS, teaching of health-promoting behaviours needs to emphasise a solution-focused approach, rather than be focused on the possible risks and/or barriers.

Use participatory approaches to teaching and assessment so that learning is personally invested

Recommendation 6: *Use strategies to facilitate confidential sharing of personal experience.*

> *Lesson of experience:* The way that the personal and professional have to come together in teaching HIV/AIDS means that it is critical to use approaches which allow for students to contribute from their personal experience. At the same time, however, this is often threatening, and often the use of other people's experience (case studies) or other media, such as the visual, assist.
>
> *Lesson of experience:* Successful pilots were characterised by the use of a combination of methods, tailored to the specific target audience, and enabling open discussion from varied life experiences.

Participatory approaches are key to the development of the personal and professional competence of teachers in an age of AIDS. The sharing of personal experience, particularly in groups of students with different experiences of HIV/AIDS, is very powerful. However, this has implications for confidentiality, and a range of strategies can be used which protect the students while at the same time allowing for personally invested discussion.

Recommendation 7: *Integrate the offering of the module with student led campus wide initiatives wherever possible.*

> *Lesson of experience:* The integration of student led campus wide peer educator or research projects into the delivery of the HIV/AIDS module facilitates uptake not only of prevention messages, but also of innovative teaching approaches.

Some students in the pilot reported that their awareness of the varying and intricate shades of HIV/AIDS was kindled by fellow students who had a deeper experience of the realities of HIV/AIDS. Particularly for pre-service teachers, co-curricular projects often provide a better forum for in-depth discussion than the constrained time available in courses that are part of the curriculum. In addition, student involvement can extend over their whole career in the HEI, rather than being available only in a particular year or semester.

Recommendation 8: *Provide student-teachers with opportunities for experiential learning in communities affected by HIV/AIDS.*

> *Lesson of experience:* Students with life experience of HIV/AIDS as well as those with little or none need to be assigned authentic experiences in the communities mostly affected by the epidemic so that they can learn from

these and 'make a difference' in the lives of those affected.

Lesson of experience: Awareness of context is related to personal trajectories and student ecologies, and these need to be considered in the adaptation of the module and materials. Those students without lived experience of HIV/AIDS need to be shown through discussion and experiential learning not only that HIV/AIDS affects everyone, but also that, in order to be able to teach across different contexts in South Africa, an understanding of the gendered character and economic antecedents of HIV/AIDS is crucial.

This recommendation is an extension of the asset-mapping raised in recommendation 4. Students need not only knowledge but also experience of accessible health-promoting and health-affirming resources (such as community-based counsellors, or faith-based organisations and NGOs committed to AIDS-related activism). In this way, in-service and pre-service teachers can become aware not only of the challenges of HIV/AIDS, but also of potential ways of dealing competently with these challenges in a variety of contexts. This is particularly important for those without lived experience of HIV/AIDS.

Recommendation 9: *Implement strategies to increase in-service and pre-service teachers' ability to reflect personally as well as professionally so that they can model attitudes and behaviour rather than simply teaching.*

Lesson of experience: Reflexivity in the age of AIDS requires relating the personal and professional, and needs time and support to result in attitudinal and behaviour change.

Lesson of experience: HIV-related training of education students needs to include overt introduction to pedagogical strategies that facilitate the integration of HIV into the curriculum; overt strategies for involving parents; encouragement of students to consider their identity in terms of their sexuality as well as their position on teaching sexuality-related issues; clear teaching of the importance of being (modelling), not just doing (teaching).

To be professionally competent in the age of AIDS also entails acceptance and meaningful enactment of the role of educators as preventative agents. In-service and pre-service teachers as well as their lecturers generally endorsed this role. Functioning as a preventative agent entails more than teaching the facts, however. Future HIV education needs to be unequivocal that prevention is not just about doing (for example, teaching) but also about being (for example, modelling tolerance; embodying healthy sexuality). Understandably this is the more complex message to embed, and will require that lecturing staff model passionate ownership of HIV education and health promoting behaviour that is reflected in their very being.

In order to function competently as preventative agents, teachers need to be comfortable with their own sexuality and the roots of their sexuality. In-service and pre-service teachers need to be actively encouraged to consider their identity in terms of their sexuality as well as their position on teaching sexuality-related issues. Active encouragement could include formal opportunities for critical reflection (for example, class-or assignment-based activities) and informal opportunities (for example, visual or electronic messages posing reflective questions). Again, this implies that lecturing staff will be self-reflexive (also about their sexuality) and their own lives in the context of HIV/AIDS and their own vulnerabilities to HIV infection.

It is not only with respect to sexuality that reflexivity is critical to being an effective preventative agent. In the highly gendered context of HIV/AIDS in South Africa, unless those involved with HIV/AIDS education are personally aware of their own lived gender attitudes, they will unconsciously support attitudes that increase the vulnerability of girls and women, and feed the epidemic. This awareness needs to be tackled across all of teacher education, not only within the HIV/AIDS module.

Recommendation 10: *Use assessment and feedback on assessment activities, to deepen understanding and reflexivity.*

An often neglected form of support for reflexivity is through assignments. The pilot identified four types of assessment activities that can facilitate reflexivity:

- Assignments that get students to engage with the materials
- Assignments that require lesson planning combined with critique of HIV/AIDS related lessons
- Assignments that require school-based research
- Assignments that require reflection on experiential learning.

But reflexivity is also deepened if lecturers take the time to provide sensitive and supportive feedback on assignments.

Recommendation 11: *Collegial sensitivity needs to be cultivated in different ways for pre- and in-service teachers.*

> *Lesson of experience:* A possible lesson of experience is that collegial sensitivity cannot be directly taught as part of a HEI-based teacher education programme. For pre-service students, it might be possible to use teacher preparation to sensitise student-teachers to infected and affected fellow students who might well be their future colleagues – as a start perhaps through peer education programmes within their own institutions. In-service teachers could be supported to understand and engage with policy aligned support structures in their schools, such as School-based Support Teams.

INSTITUTION LEVEL RECOMMENDATIONS FOR MANAGEMENT/HEADS OF SCHOOL

The intention of this section is to address the concern of implementing staff that programme design for teacher education is not in their hands, but the authority rests at the level of programmes co-ordinators and deans/heads of school. However, in certain institutions, implementing staff will themselves be able to act on at least some of the recommendations in this section.

Recommendations for sustainable and effective integration of HIV/AIDS into teacher education programmes at an institutional level fall into the following areas:

1. Programme design considerations
2. Support for implementing staff
3. Service learning
4. Research to invigorate practice.

Programme design considerations

As pointed out in the findings and conclusions, the pilot was implemented in widely differing ways in widely differing programmes with widely differing target audiences. However, it is possible to distil recommendations to guide leadership in institutions in respect of integration of HIV/AIDS into teacher education programmes.

The fundamental lesson of experience from the pilot for programme design is the following:

> *Lesson of experience:* HIV/AIDS is not simply an 'issue' to be taught. The content and pedagogy required for treating HIV/AIDS in appropriate ways assists with understanding of education and teaching more broadly.

The recommendations for programme design flow from this insight. HIV/AIDS touches intimately core issues for education - teacher identity, considerations of social justice, the implications for inclusivity in an education system that is still divided along race and class lines. Because of this, a teacher education programme that does not provide students with an understanding of the 'landscape of suffering' (Kistner 2007) into which HIV/AIDS is inextricably woven is failing not only the students, but the education system as a whole. The content and pedagogical approaches necessary for effective integration of HIV/AIDS are instructive across disciplines in teacher education programmes.

Recommendation 1: *The module should have dedicated space in teacher education curricula.*

> *Lesson of experience:* The content of HIV/AIDS requires a 'home' – either in an existing module, or in a stand-alone module. This provides a base from which cross-curricular integration can successfully be done. The stand-alone option is preferable in that it provides more time for adequate addressing of all the outcomes, but it may not be possible in certain programmes (such as the PGCE). With good planning, however, the time problems resulting from integration into an existing module can be addressed to some extent.

> *Lesson of experience:* Even if there is a particular focus on one or two of the outcomes, or one or two of the units of the materials, adaptations must take cognisance of the fact that a curriculum for HIV/AIDS has three perspectives – socio-ecological, health promotion and inclusive education, and each of these needs to be acknowledged and integrated.

Without dedicated space to provide students with an overview of the interrelated challenges of HIV/AIDS for teaching and schools, cross-curricular integration is unlikely to work. Students also need an opportunity to consider the challenge of HIV/AIDS in a coherent way – with all three curriculum perspectives developed and understood.

Recommendation 2: *HIV/AIDS needs a champion within the faculty/school to facilitate cross-curricular integration but also to facilitate development of knowledge, skills and attitudes amongst staff more generally on the impact of HIV/AIDS on students and society.*

The staff member responsible for HIV/AIDS should also be given the space to work with programme staff to encourage broader curriculum integration. HIV/AIDS in teacher education does need a champion – a staff member who encourages staff and keeps HIV/AIDS on the agenda.

Recommendation 3: *Avoid linking the HIV/AIDS module to a disciplinary/learning area which will result in its being seen as the responsibility of life orientation/guidance teachers only.*

> *Lesson of experience:* Since the choice of a learning area will result in different emphases in the curriculum of the HIV/AIDS module, careful thought needs to be given to the disciplinary/learning area to which HIV/AIDS education is attached.

> *Lesson of experience:* HIV/AIDS teacher education courses need to assert that all teachers (not just Life Orientation teachers) need to be preventative agents, and knowledge is critical in preparation to play this role – knowledge not only of the facts to support choice, but understanding of contexts of disempowerment that impede choice.

If the module is linked to Life Orientation/Life Skills, it may give the message that teaching about HIV/AIDS is the job of the 'guidance lecturer' only rather than being everyone's responsibility. In addition, it may result in over-emphasising the caregiver role. This will undermine the understanding that in-service and pre-service teachers live and work in an HIV altered country, and that this has implications for every aspect of professional practice.

It may be preferable, therefore, to link the module to Education/Professional Studies. For example, as participants in the third Colloquium noted, in the PGCE, HIV/AIDS teaching may be incorporated into areas of education studies that deal with social justice or inclusion. This will then provide a framework within which HIV/AIDS can be integrated into the subject/learning area method courses, as well as into teaching practice.

Recommendation 4: *The time devoted to the module as well as the timing of the module within the programme and within the year need to be carefully considered so that the potential impact is not lost.*

Lesson of experience: Attitude and behaviour change need a longer process than simply exposure to a single module that varies in length from a six hour workshop to a semester course.

A clear finding is that the module is best implemented at a time that enables pre-service students to deepen their understanding of HIV/AIDS related issues in the schools in which they are placed on teaching practice. For in-service teachers, school-based support for HIV/AIDS related teaching, action and research (possibly through assignments) is important as well.

There is no clear evidence to provide a recommendation on whether the HIV/AIDS module should be taught in the first, second, third or fourth year of the B.Ed. The only recommendation about this is that the module will need to be adapted for the level and particular focus of year of study in which it is implemented. Some institutions are intending to implement the module in each of the four years of the B.Ed., and the effectiveness of this in allowing for attitude and behaviour change over time should be researched. In other institutions, the use of campus wide initiatives such as peer educator programmes ensures that HIV/AIDS is not simply dealt with once and then forgotten.

Recommendation 5: *In implementing the module, space needs to be created for research into school-based practice so that insights from the realities in the schools can be used to inform how the module is offered.*

Lesson of experience: School-based work on HIV/AIDS is critical if students are going to be able to practise what they have learned in professional settings.

The ethos and attitudes prevailing in the school environment are powerful enabling or constraining factors for in-service and pre-service teachers implementing what they have learned in HEI-based teacher education programmes. These realities have to be understood by implementing staff as well as students to inform curriculum revision.

Staffing

Recommendation 6: *Encourage staff involved in co-ordinating HIV/AIDS teaching within the school/faculty to make use of both formal and informal professional development opportunities, but do not make qualification a pre-requisite for involvement.*

Lesson of experience: There is a need for professional development programmes to support implementing staff to address such issues as socio-cultural beliefs about HIV-related issues (sex, condoms, sexual orientation, etc.) or provide more in-depth understanding of the social and educational issues around HIV/AIDS.

A key finding from the pilot in regard to staffing was that teacher educators with very little formal or informal training carried out the pilot, and with support, felt that they could teach in such a way that they achieved the outcomes. Enthusiasm and commitment in an area such as this are probably more important than prior qualification, because they lead to on-going self-generated professional development.

However, at the same time, a number of staff involved in the pilot expressed the fact that they were out of their area of expertise, so the provision of professional development opportunities is important.

In addition, professional development needs to be combined with support.

Recommendation 7: *Recognise the emotionally taxing character of HIV/AIDS related education, and provide access to counselling services as well as counselling training for staff involved.*

Lesson of experience: The emotionally taxing character of HIV/AIDS related education suggests the need for provision of counselling services within the institutions and training in counselling skills for lecturers and student teachers in preparation for their own classrooms.

The finding from the pilot that some educators engage in disclosure as acts of caregiving raises questions about whether educators are not in need of therapeutic or safe spaces in which they can come to terms with personal AIDS-related losses and HIV-linked professional challenges. For example, teachers themselves are often traumatised by the negative impacts of HIV/AIDS in their own lives (in addition to their learners' lives). This points strongly to the need for care for the caregivers. Both pre-service teachers and in-service teachers need to be afforded accessible and regular opportunities for disclosure and debriefing. Specifically, skills that teach them self-care competence need to be developed, and resources (services) that provide opportunities/spaces for such self-care and the skills to identify and access them are needed in HEIs as well as in schools. These could include counselling services for the school community (either in the school or in the community) which all stakeholders, including teachers can access.

Recommendation 8: *Support the continued involvement of implementing staff in the community of practice established through this project, and use it also for the professional development of interns.*

> *Lesson of experience:* Because lecturers/tutors teaching in this area are often unsupported within their institutions and do not have HIV/AIDS specific training, it is important to establish and nurture communities of practice for support and professional development.

Although it is clear from the evidence that the community of practice established in this pilot through the Colloquia and the OCF was valued, it is not yet clear how it will be sustained. It is important that it is continued, both because of the support provided for implementing staff and the professional development opportunities it provides for interns.

Recommendation 9: *In large scale programmes, select and use tutors to facilitate contact sessions, but ensure that they are adequately trained and supported not only to contribute to the HEI-led programme but also in the communities from which they come.*

> *Lesson of experience:* The employment of tutors can enable effective delivery of the module to large numbers of teachers, but these tutors need initial training and ongoing support.

In one of the pilots, this was done particularly well, and tutors (qualified school teachers) reported the added benefit that they were equipped through the module and the training they received to engage with learners and colleagues at their own schools in more sensitive and positive ways. The success of these qualified teachers as tutors supports the idea of HIV/AIDS specialists as envisioned by the DoE.

Service learning and community outreach

Service learning and other forms of community outreach did not feature strongly in the individual pilot reports, but a robust discussion at the final Colloquium on 4 May 2009 generated important insights.

Recommendation 10: *Service learning is recommended as a way of providing space for gaining better more nuanced understanding of HIV/AIDS education issues.*

> *Lesson of experience:* Much more time and focused attention needs to be directed towards supporting students/teachers to translate their increased awareness into practical ways of intervening positively in the lives of learners, their parents, and communities affected by HIV/AIDS.

Experiences should be provided for students to contribute through community/school-based projects. But there are a number of things that need to be borne in mind:

- Care needs to be taken to ensure that the institution and/or people who are visited also benefit. The reciprocity of service learning advocates this.
  - In order to ensure this, there needs to be focus on assessed tasks.
  - It is also important to supervise carefully, and this has implications for resourcing.
- Partnering in service learning is also critical.
  - Ethics around service learning must be taught. The voice of the community must be heard. It

> must not only be the HEI that decides what and how to do the work. There must be a shift from community service to community engagement.

In conclusion, one of the most important points about service learning is the message about service. As one participant in the Colloquium on 4 May put it, students must get the message that the reason they are being trained is 'to go back to [the] community and serve'.

Research to invigorate practice

The recommendation was made in the Colloquium on 4 May 2009 that this report should indicate areas for further research arising from the findings of this pilot.

Recommendation 11: *Further research arising from the pilot should be undertaken either within institutions, or preferably, collaboratively across institutions.*

The following are recommendations for further research arising from the pilot:

1. Expand research around the professional practice model (see Chapter Four) into one that that can guide the institution and which each HEI can adapt (not only in teacher education but into the university as a whole).
2. Research the ecological and personal assets and processes that facilitate enactment of leadership roles, not just in the classroom, but also at home.
3. Research and develop models of cross-curricular integration that also include work around co-curricular integration.
4. Conduct tracer or impact studies on the current cohorts of teachers who are involved in the module (i.e. follow up on teachers who participated to see if they practise what they learned).
5. Conduct research on how frequently teachers use disclosure as a means of providing care and whether/when such disclosures have a positive impact on learners. The findings of such a study might then inform future materials aimed at equipping teachers towards competent caregiving in the age of AIDS.
6. Conduct life-history and other studies related to the idea of "becoming a champion" in addressing HIV/AIDS in HEIs in the age of AIDS.
7. Further research needs to be done on issues of gender, age and generationality, race and class in relation to curriculum design, implementation and impact.

SECTOR LEVEL RECOMMENDATIONS/ SUGGESTIONS

In this section, key questions are asked, and suggestions are made about what could be done at a sector level to continue the work started in the pilot and ensure sustainable HIV/AIDS related education in teacher education. The questions are not comprehensively answered, but they provide pointers for future planning for sector-wide attention to HIV/AIDS.

In the evaluation of the third Colloquium, one participant commented:

> It became apparent that all institutions are keen in taking the initiative forward even if it means extending it to other academic offerings.

But another said:

> Beyond the colloquium phase was not addressed.

In response to this, and based on the recommendations in the previous two sections, a number of questions are asked, and answers are suggested.

Question 1: How can institutions be encouraged to continue offering the module for both the initial professional education of teachers (IPET), and the continuing professional development of teachers (CPTD)?

This question needs to be answered with the national teacher education environment in mind. There are two points about this environment which need to be highlighted by way of introduction.

The National Policy Framework for Teacher Education and Development (NPFTED) has asserted two main routes to initial teacher qualification, the B.Ed. and the degree plus PGCE. These qualifications need be aligned

to the qualifications descriptions in the Higher Education Qualifications Framework. (Department of Education 2007) This will require not only a name change for the PGCE (to the Advanced Diploma Postgraduate), but also particular focus on the practical component in both qualifications (teaching practice). It may also, in the case of the B.Ed., involve adaptation to accommodate serving under-qualified teachers, rather than simply pre-service teachers, as well as different modes of delivery. This would mean that the target audience for the B.Ed. would be more diverse than it is at present.

Secondly the NPFTED makes it clear that the life of the NPDE and ACE as upgrading qualifications reaching large numbers of remotely situated serving teachers is limited. In the future, the emphasis will fall much more on needs-driven shorter programmes offered as part of Continuing Professional Teacher Development. The following paragraph is instructive (Department of Education 2007, p.16):

> All teachers need to enhance their skills, not necessarily qualifications, for the delivery of the new curriculum. A large majority needs to strengthen their subject knowledge base, pedagogical content knowledge and teaching skills. All teachers need to acquire skills in recognising identifying and addressing barriers to learning and creating inclusive and enabling teaching and learning environments for all learners, including those with disabilities and other special needs. A sizeable proportion need to develop specialist skills in areas such as health and physical education, HIV and AIDS support, teaching learners with disabilities, diversity management, classroom management and discipline, and so on.

Offering the module in IPET programmes

As one of the participants commented in the evaluation of the third Colloquium:

> It became apparent that all institutions are keen in taking the initiative forward even it means extending it to other academic offerings.

The recommendations in the previous section on curriculum design and development for the B.Ed. and PGCE (particularly those relating to teaching practice) offer a number of suggestions arising from the pilot evaluation for how the impact of the module can be increased.

However, in an environment in which there is a push to 're-curriculate' (particularly the B. Ed.) in the light of the findings of the national teacher education review and alignment with the HEQF, there is a danger that HIV/AIDS could be back-grounded or sidelined. The crisis in schooling is perceived to be dominantly a matter of learner achievement in literacy and numeracy, and the response of teacher educators could be 'back to basics', to the exclusion of what is perceived to be one among many issues such as HIV/AIDS. HEAIDS needs to encourage a different perception – that an understanding of the impact of HIV/AIDS is critical to addressing the problems in education that are being demonstrated in poor learner achievement.

Recommendation 1: *Particularly in the environment of re-curriculation following the national teacher education review, encourage institutions to see HIV/AIDS not as an issue for which they may or may not have space in their curricula, but as an essential part of the context of education for which they are preparing future teachers.*

A further pointer for future curriculum planning particularly for the initial professional education of teachers is the finding from the module pilot both of the critical importance of awareness of the highly gendered character of HIV/AIDS in South Africa and of the difficulty of internalising health-promoting gender attitudes.

> *Lesson of experience:* Gender inequality runs very deep in the society, and internalisation of understanding that runs counter to convention requires concerted effort beyond what the pilot module and materials were able to afford.

This leads to the following recommendation:

Recommendation 2: *Gender awareness is not something that can be addressed in just one module or set of materials. It needs a broader curriculum strategy within teacher education.*

Offering the module in CPTD programmes /short courses

The lessons of experience from the implementation of the module in the NPDE and the ACE do not need to be lost when these programmes are discontinued. They could be used to develop CPTD programmes and/or short courses for serving teachers. The extract from the NPFTED referred to earlier indicates that not only HIV and AIDS support, but also diversity management and inclusive education should be key foci for CPTD. The module is ideally suited for in-service teachers for the following reasons:

- The best response to the content was from in-service teachers ('It spoke of our life');
- Teachers in schools who acted as tutors for one of the NPDE programmes spoke eloquently of how involvement as tutors helped them in their schools to support their learners and colleagues living with HIV/AIDS;
- The module is supported by self-instructional materials, and this facilitates coherent course development and part-time study;
- The materials incorporate a range of school-based activities and assignments.

Furthermore, there are good examples of successful delivery of the module to large numbers of teachers remotely situated.

The difficulty with running CPTD short courses is that they are not subsidy earning, and so they need to be funded either from external donors or provincial departments of education.

However, provincial departments of education may well be encouraged to work with the module if at the same it could be used for professional development of their own officials. In the module pilot there was an intern who was also a Life Orientation subject advisor in one of the provincial departments of education and he reported that the material and approaches underpinning the module were extremely useful in his work with both teachers and fellow departmental officials.

All of the above would require external brokering and championing.

Recommendation 3: *Support the sector to plan with provincial departments of education for the use of the module as a CPTD short course.*

Question 2: How can the reach of the module be extended effectively into schools and provincial departments of education?

A striking finding from the pilot evaluation was that a major constraining factor for pre-service teachers as well as in-service teachers in putting into practice what was learned in the module was the environment in the schools. Pre-service teachers and in-service teachers spoke of school environments in which HIV/AIDS was not considered to be important, or in which there was hostility to HIV/AIDS education as encouraging learners to be sexually active, or in which there was silence about, or stigmatisation of, people living with HIV/AIDS. In addition, a major aspect of personal and professional competence in the age of AIDS – collegial sensitivity – did not feature much in student responses in interviews.

These kinds of environments cannot be dealt with simply by pre-service courses, or even by CPTD courses. There have to be whole school interventions and engagement of school management structures. This is meant to happen in the roll out of the inclusive education policy through structures such as School-based Support Teams, and District-based Support Teams. There are also numerous donor-funded projects supporting whole school initiatives. But what appears to be missing at the moment is co-ordination between HEIs involved in the initial professional education of teachers and these whole school initiatives. The strength of NGOs is in policy advocacy and the management of practical and psycho-social support, but the HEIs should lead in professional development of teachers and school management teams.

Recommendation 4: *There is a need for sector-wide co-ordination of the work of HEIs, NGOs and provincial departments to support schools to deal with the impact of HIV/AIDS. If this does not happen, much of the benefit of successful HIV/AIDS work in pre-service and in-service teacher education will be lost.*

Question 3: How should the professional development of teacher educators/implementing staff in relation to HIV/AIDS be handled in the future?

It is clear from the findings and conclusions of this evaluation that there is no standard qualification for involvement in HIV/AIDS education, and that the implementing staff were for the most part relatively new to the area, though several were engaged in further formal study in HIV/AIDS. This, on the one hand, reflects the recency of attention to teacher education within HEIs in the context of HIV/AIDS. On the other hand, some of the lecturers expressed lack of confidence, while others said that engagement in the module supported their knowledge and skills development.

The challenge for teacher educators is a challenge of leadership. Competent teachers in the age of HIV and AIDS will have acknowledged that they are uniquely positioned as agents of change and as leaders. The evaluation showed that although many in-service and pre-service teachers had accepted this, they were not always sure how to translate theory into meaningful practice. In this regard it is necessary to encourage the development of skills and knowledge that will facilitate practical commitment to, and meaningful enactment of, the role and responsibility of teacher-leaders. As noted previously, this again implies that implementing staff need to accept that they, too, are uniquely positioned as leaders in the age of HIV and AIDS and they need to model (rather than just teach) such leadership.

Recommendation 5: *It is important to encourage particularly those staff who implemented the pilot to become leaders in the field, and engage in further qualification. This could be supported by the development of an HIV/AIDS module as part of the Postgraduate Certificate in Higher Education and a national effort to enroll those teacher educators involved in HIV/AIDS related teaching.*

Question 4: How can the use of the materials – the learning guide and the reader, as well as Curriculum-in-the-Making – be continued and expanded?

Recommendations have been made in the previous sections for enhancement and adaptation of the module and materials to meet the needs of a variety of audiences and to strengthen particularly the guidance provided on counselling.

It is important, however, to distinguish between the kinds of additions that should be made to centrally available materials, and the kinds of revisions that individual institutions do in order to tailor them for their particular target audience. It must be recognised that there will be no perfect set of materials for every audience and context. The issue to be decided is whether or not the materials are 'good enough'. (Welch and Sapire 2009) The results of the evaluation of the materials supporting the pilot suggest that the materials were indeed good enough.

The recommendation of the project is, therefore, that there is little point in extensive revisions and/or additions to the centrally available materials. An additional section on counselling might be useful, as would case studies that reflect a more diverse experience of HIV/AIDS. What is more important is to make the materials available in an accessible format so that institutions can adapt and use them easily.

Finally, it is critical that institutions are aware that all the materials – learning guide, reader and Curriculum-in-the-Making - are available and that HESA wants them to be used as widely as possible. The experience of other similar projects indicates (Welch and Sapire 2009) that it is important not only that the materials be digitally available, but that there be an advocacy strategy (for example, workshops at HEIs) to make people aware of their potential and the terms of their use.

Recommendation 6: *Revise the learning guide through the addition of a section on counselling as well as case studies that reflect a more diverse experience of HIV/AIDS. The learning guide can also give more prominence to gender.*

Recommendation 7: *Make the materials available to institutions in digital format, so that they can easily adapt, enhance and update them.*

Recommendation 8: *Ensure that HEIs are aware of the existence, potential and terms of use of all the materials produced by the project.*

Question 5: How can the community of practice that has been established through this project be sustained?

As was pointed out the findings and conclusions, participating institutions valued the community of practice established. As one participant commented in the evaluation of the third Colloquium:

> This was a first of its kind. It opened a good dialogue amongst HEIs, which thing is very rare indeed. Learning from other colleagues was quite amazing.

However, another cautioned:

> To my mind the inherent value of the pilot intervention would lie in its ability to sustain the community of engagement and not to allow such rigorous scholarship and practice to simply fizzle out. Furthermore, I think that much of the pilot's success can be attributed to the external support that the implementing institutions received. While continued engagement would be viable via the online forum, participation in other interactive colloquiums would also encourage institutions to continue to engage with the initiative.

The final recommendation can do no better than quote this.

Recommendation 9: *While continued engagement would be valuable via the online forum, participation in other interactive colloquia would also encourage institutions to continue to engage with the initiative.*

The sustainability of the OCF needs to be directly addressed, however. The following is our recommendation for taking this work forward.

Recommendation 10: *Move towards open access to the Online Collaborative Forum allowing learners access.*

Allowing open access to the OCF has the potential to enable all Web users, with a particular emphasis on learners, to access the material and engage with the community of practice. As pointed out in Appendix 6, this can be done in the following ways:

- Permit open access to the restricted site through automatic self-registration;
- Module materials and Curriculum-in-the-making (CITM) to be made available under a Creative Commons licence;
- Embrace Web 2.0 technologies more (e.g. folksonomy to replace taxonomy);
- Encourage users' own voice whilst ensuring balance with directed/mediated core material through different sections of the OCF.

Notes

1 One of the 21 HEIs implementing the module withdrew from the project after completing the module.

2 We use the term 'epidemic' to refer to the outbreak of HIV/AIDS amongst a group or population of a specific country and the term 'pandemic' to refer to a widespread epidemic that affects people in many countries.

3 The programme report of HEAIDS Phase 1 titled 'Turning the Tide' can be accessed on www.hesa.org.za.

4 This is not to say, of course, that there has been no sharing of experiences and resources through informal networks.

5 This was developed with funds from Development Co-operation Ireland and the UK Department for International Development.

6 7 November 2007. Further presentations to the EDF were made on 6 February 2008, 14 May 2008, 12 November 2008 and 25 February 2009. Throughout, the guidance and support of the EDF was crucial to the development of the project.

7 This modification to the project plan is outlined in the project Inception Report (HEAIDS February 2008).

8 Paul Bennell's work on the systematic devaluing of the role of teachers and teachers' voices is central to this critique.

9 This modification to the project plan is outlined in the project Inception Report (HEAIDS February 2008).

10 With their permission, a slightly modified version of Vergnani and Lees' University of Western Cape questionnaire was used to address the purposes of this specific evaluation. The questions were drawn from Vergnani and Lees' experience with training teachers as well from other surveys and related literature. The questionnaire had been used with ACE students and also as pre- and post test for the UWC InWent courses.

11 The number of 'institutions' mentioned includes those where there was more than one site.

12 See Chapter Three

13 Observations made by members of the implementing team in their individual HEI pilot evaluation reports have, where relevant, also been drawn upon.

14 While the data was analysed in terms of the originally designated categories of 'Content and outcomes'; 'Materials'; 'Course structure'; 'Target audience'; 'Pedagogy and support'; 'Assessment'; 'Enabling/constraining factors'; 'Monitoring'; 'Personnel'; and 'Technology', two of the categories – 'Assessment' and 'Monitoring'– overlapped considerably in terms of the emergent themes. These two categories have therefore been combined and dealt with under 'Assessment'. The findings under the section 'Personnel' are selected from part one of HEIs' own stories (Appendix 2). Since 'Enabling/constraining factors' are not strictly curriculum issues, comment on these factors has been dealt with separately under Section 5.1.5 below.

15 According to 19 HEIs' own reports, more than half of the HEIs 'fully covered' all module outcomes. Only two HEIs reported not covering one outcome.

16 For the most part interviews have been transcribed verbatim including grammatical infelicities and speech markers.

17 Norms and Standards for Educators (Government Gazette) vol. 415, no. 20844, February 2000.

18 One institution seemed to be uncertain about which of the options had been selected.

19 In the context of module materials and how they were structured for optimal reflective engagement and participative learning, the notion of contact time is perhaps not the best way of expressing the actual time required for covering fully the respective units of the module. For instance, the materials give an estimate if 15 hours per unit (including the relevant reflective and reading activities, but excluding the key assessment task). The feeling expressed by a number of lecturers/tutors that time was a constraining factor against their doing justice to the module may therefore have more to do with the actual time required for full student engagement rather than with contact time per se.

20 Polyvocals result when a qualitative researcher collates the comments of a number of transcribed voices on the basis of a particular issue to provide varied perspectives. (Bassey (1999), (Van Laren, 2009) In this case, even in our summative report we want to ensure that the perspectives of tutors and students on the ground are retained.

21 One example is that during the monitoring period September 2008 – May 2009, as a result of code changes made to the way in which

Google Analytics functions, there were two periods (October 2008 and February 2009) where data was not captured

22 Bounce rate is the percentage of single-page visits (i.e. visits in which a visitor leaves a website from the entrance page) and is considered to be a measure of visit quality or of the relevance of a webpage. A high bounce rate generally indicates that site entrance (landing) pages are not relevant to visitors. (Google Analytics)

23 Specifics in relation to the enabling nature of the materials and the OCF are given above in Categories 2 and 8 respectively. The evaluation of the implementing team's performance, and its enabling function in relation to the project, is given in Appendix 2 (HEIs' own stories). While details in relation to these enabling factors are not repeated here, they were very significant in assisting institutions to ameliorate or overcome many potential or actual constraining factors.

24 Evidence of this planning and implementation for 2009 is already evident in at least one institution in which the module is being phased in over successive years of its B.Ed. programme.

25 Those comparative results from the pre- and post-test questionnaire (see Appendix 3) – as pertaining to growth of student professional competence – that were integrated with the qualitative findings in the individual HEI pilot evaluation reports have, where relevant, also been integrated into this summative evaluation.

26 The differentiation is made between pre-service and in-service programmes, since the needs and experiences of in-service and pre-service teachers, particularly with respect to HIV/AIDS education differs in significant ways. Those on in-service programmes who participated in the pilot (for example, the three NPDE programmes) are mainly older and more experienced teachers, but have outdated qualifications, and are more likely to be teaching in rural or township areas. Those engaged in pre-service programmes, such as the B,Ed, and PGCE, by contrast, are generally younger students, may come from both advantaged and disadvantaged educational backgrounds, but tend to be more academically and technically literate. Despite their inexperience, as J. Agee reminds us in What kind if teacher will I be?: Creating spaces for beginning teacher's imagined roles, pre-service teachers have much to offer in terms of imagination and energy.

27 This and subsequent conecdotes are the product of researcher editorial reconstruction of transcribed interviews in order to discern thematic statements without distorting them into something more than was meant.(Hendriksson, C http://www.peddan.se/iped/publikationer/filer/69f1e8034a848f09304ef9a24d16ffda.pdf accessed 19 May 2009)

28 This comes straight from the transcription and the researcher adjusted it slightly so as to make it more coherent.

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