Faculty views of HIV and AIDS education in the curriculum at tertiary level

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Abstract
Although much has been written on the need to integrate HIV into tertiary education programmes, very little research has been done in terms of how it should be done. This article will report on the first phase of a larger action research project designed to research, develop and evaluate best practices for the transformation of the curricula of higher education programmes to make them more relevant and responsive to the realities of living and working in the age of AIDS. Using a phenomenological design, academics from three faculties were interviewed to generate baseline data around their feelings, perceptions, attitudes and practices regarding HIV education in their fields of study. The findings reveal that, while academics recognize the importance of HIV integration in principle, in practice several barriers exist. On the whole, a narrow conceptualisation of HIV and AIDS precludes them from recognising the many possibilities that exist for meaningful integration of HIV education. Implications are drawn from these findings to inform the intervention phase of the project.

INTRODUCTION
‘Why should HIV and AIDS be given so much attention? What about malaria, (or TB, or conservation issues ...)?’ Questions similar to these are often asked by academics when the subject of integrating HIV and AIDS into the curriculum at higher education in South Africa is broached. This article will provide robust answers to such questions and motivate for the need to work with faculty to develop their understanding of the place of HIV and AIDS education at tertiary level.

As part of a broader action research project, it reports on the first step of the process, namely problem identification and data gathering. This article describes how a qualitative study was adopted to investigate the perceptions of academics from three different faculties to answer the research question: how do faculty members think, feel and act in relation to the integration of HIV and AIDS into their teaching?

A discussion of the emergent themes follows, controlled by existing literature. Conclusions, based on the findings of this baseline study, are then drawn to propose suggestions for the purpose and content of the next step of the research process – developmental interventions to enable faculty to transform their curriculum content
and pedagogical practices to make them more appropriate and responsive to the needs of graduates who have to live and work in the Age of AIDS.

BACKGROUND

So why should HIV and AIDS be given attention in curricula at tertiary level? There is no denying that higher education is affected by the pandemic. The most at risk population for HIV infection is reported to be women between the ages of 20 and 34 (32.7%) and men between the ages of 25 and 49 (23.7%) (Shisana, Rehle, Simbayi, Zuma, Pezi 2009), a range which includes the ages at which people are either pursuing studies or have recently graduated. Although the reported mean HIV prevalence for students (3.4%) is lower than that for the general population (HEAIDS, 2010b), higher education institutions have a responsibility to help students become HIV literate for their personal protection. In order to keep students (and their current and future sexual partners) HIV free, and to help those who are infected to lead healthy lives, universities need to educate students about the biomedical facts of the virus and AIDS, about prevention measures, and also to develop a sense of compassion for those who are infected and affected. This is non-negotiable and the importance of this type of education cannot be denied.

The Higher Education HIV and AIDS Programme (HEAIDS) was established by Higher Education South Africa (HESA) in recognition of the fact that higher education 'has a critical role to play in the fight against the spread of the disease' (HESA 2008, 3 ). Policy formulated by this body calls for the prioritisation of prevention interventions by higher education institutions and provision of care and support for faculty and students (HESA 2008). The provision of voluntary counselling and testing services, medical care and implementation of human resource practices that protect and support those infected/affected by the pandemic is recommended, and, for the most part, has been well implemented in South African universities (HEAIDS 2010b).

However, the HIV and AIDS Policy Framework (HESA 2008) also stresses the need for higher education to provide leadership in the fight against AIDS via the production of graduates who will create knowledge and promulgate discourse conducive to the eradication of the factors that drive the pandemic (HESA 2008, 5). This call is in line with the mission of most universities, which is to not only prepare students for the market place, but also to equip them to be responsible citizens, people who are committed to contributing to and improving society, through the operationalization of values that promote the social good (cf.: http://ufh.ac.za/?q=ethical-principles-and-values; http://www.nmmu.ac.za/default.asp?id=163&bhcp=1; http://web.up.ac.za/default.asp?ipkCategoryID=1767&subid=1767&ipklookid=2; http://www.ru.ac.za/rhodes/introducingrhodes/visionandmission; http://www.uwc.ac.za).

Given the comprehensive impact of the pandemic, and its influence on many aspects of peoples’ personal and professional lives, every academic discipline should be able to find meaningful ways to integrate it into their programmes. However,
while the bio-medical, support and human resource initiatives seem to have been implemented on a comprehensive basis at most higher education institutions (HEAIDS 2010b), less attention has been paid to the transformation of the curriculum to ensure that it enables graduates to become ‘leaders in society ... able to address the impact of HIV and AIDS among all communities’ (HESA 2008, 15).

Educating students to prepare them for their future professional roles in society requires HIV and AIDS education that encompasses critical reflection on values, emotions, identities and behaviour, as well as the development of specific skills and knowledge. The following section explains the purpose of a critical approach to HIV and AIDS education – to reduce stigmatisation, marginalisation and indifference to suffering through the promotion of compassion, the protection of human rights and equal opportunity for all.

CONCEPTUALISING HIV AND AIDS EDUCATION

In the following paragraphs, I offer further answers to the question, why should we single out HIV and AIDS for inclusion into the curriculum at tertiary level? The response to this question becomes self-evident if HIV and AIDS education is viewed from a critical paradigm (Freire 1970). Such a paradigm recognises the complexity of the pandemic and acknowledges that there are no uniform and final solutions. It advocates continual critique and disruption of existing ideologies and structures (Fine 1994), as we strive towards social improvement and an eradication of the social inequalities that prevail in South Africa, and with which the causes and consequences of the pandemic are intricately intertwined (Baxen and Breidlid 2009).

Comprehensive HIV and AIDS education requires a global understanding of the material conditions that produce social inequalities and render some populations more vulnerable than others (Macedo 2006, xii). Racist and exclusionary practices make it easy to exploit others and I argue that it is the role of education, and particularly higher education, to intervene to raise awareness of such practices and foster true democracy. Graduates who will fill professional and/or managerial/leadership roles in society should be educated about the discriminatory political, social, economic and health practices within and across their disciplines that create fertile terrain for HIV transmission. For example, gendered social practices are one of the undisputed drivers of HIV infection (Brown, Sorrell and Raffaelli 2005; Dowsett 2003; Lesch and Kruger 2005; Sherr, Hankins and Bennett 1996) and the raising of critical awareness (Freire 1970) around these should be embedded into the curriculum of all students, in a discipline-appropriate manner.

A critical understanding of HIV and AIDS education would enable the challenging of faulty perceptions that stem from racist, moralistic and misinformed beliefs about marginalised populations – in such cases, AIDS is seen as a problem for ‘blacks’, ‘gays’, the ‘poor’ and ‘uneducated’, usually due to their ‘immoral’ behaviour (Wood and Webb 2008). Such beliefs ultimately result in unconscious prejudices and discriminatory discourses emerging, leading to ‘othering’ of the problem, reinforcing
the class and economic divisions that, in South Africa, are inevitably also linked to racial grouping. Unless these ideas are critically deconstructed, then graduates may leave tertiary institutions not only unable to play a role in reducing the incidence of HIV, but also unaware of how they may be contributing to fuelling stigmatisation and discrimination.

HIV and AIDS education should also encompass the development of values that promote compassion for our fellow men, respect for diversity, honesty and integrity (Muthurkrishna 2008; Wood 2010). If such values are not embedded into the pedagogy and content of the curriculum, then the danger is that the opposite will continue to be accepted as the norm – indifference to the suffering of others; continued stigmatisation and/or discrimination in terms of gender, class, race, disability, sexual orientation; lack of transparency and openness in relations with others, particularly with marginalised groups; and continued political and economic corruption, which ultimately deprives those most in need of health, housing and other services. A more holistic approach to HIV and AIDS education, which is not limited to addressing facts about the pandemic, but also encourages critical analysis of the social, political, economic and health drivers of the pandemic, as well as engaging students in reflection on their affective and behavioural responses to such issues, is therefore advocated.

HIV and AIDS education is complex, and necessarily touches on almost all aspects of our lives (Abdool Karim, Abdool Karim and Baxter 2010, 45) – our sexuality, our human rights, our social interaction and our role as responsible citizens. If the pandemic and education around it is framed in a critical paradigm as described above, inclusion into the curriculum can only help to transform higher education programmes to be more relevant to the current South African social, economic and health contexts.

In summary then, why is HIV and AIDS education so important at tertiary level? To assist students to protect their own health; to not only provide services for those who are infected, but to create a caring and supportive environment that will enable them to complete their studies or carry out their work; and to educate students to be caring, responsible members of society who are able to understand the complexity of the social, economic, political and health impacts of the pandemic from a wider perspective than only their own disciplines. Such education would require transformation of the curriculum in the majority of tertiary programmes currently in existence.

However, Jansen (2009, 179) states that any change in the curriculum requires a prior change in the attitudes, beliefs and practices of the curriculum makers. It was therefore necessary to first establish exactly how faculty viewed and experienced HIV and AIDS education.
METHODOLOGY

A qualitative, phenomenological design (Denzin and Lincoln 2008) was chosen to ascertain the perceptions of faculty members of the place of HIV and AIDS education in the curriculum, since it enables the depth and complexity of the phenomenon to be explored in detail (Baxter and Jack 2008) and allows meaning and influence to be interpreted in a multi-faceted way (Parker, Dalrymple and Durden 2000). Faculty members from 7 faculties were approached to volunteer to take part in face to face interviews, conducted by an independent interviewer – three faculties (Education, Health Sciences and Economic and Business Sciences) responded and eleven interviews were conducted before data saturation was deemed to have been reached (Morse 2001). Data were analysed using Tesch’s method of open coding (Creswell 2005) to identify themes, which were then controlled against relevant literature. Measures to ensure trustworthiness included the use of independent interviewers; re-coding of data by an independent coder; a literature control; and preservation of raw data as an audit trail (Denzin and Lincoln 2008). The ethical measures of informed consent, confidentiality, and voluntary participation were adhered to (Mouton 2009). The study also received ethical clearance from the university ethics board.

FINDINGS: DISCUSSION OF THEMES

The data analysis revealed that lecturers have a limited understanding of HIV education, that they hold definite (and differing) views of the need for HIV integration and that their personal ontologies and epistemologies influence the degree to which they integrate HIV in their teaching and the pedagogical strategies they choose to address it. However, they also reveal that innovative, critical and meaningful integration is being done in some cases. These findings were classified into three main themes: faculty conceptualisations of HIV education, barriers to HIV integration and examples of ‘best practice’. The themes will now be explained, and the implications for teaching around HIV and AIDS at tertiary level will be discussed.

Theme 1: Faculty conceptualisations of HIV education

All participants realised the need for students to be educated around HIV to protect their own health and to reduce stigmatisation. Students needed to know the ‘basics of avoiding it’ and ‘how to treat people who are infected ... because I think no matter what you say, there is a big stigma attached to it’. On a professional level, there were definite views on what was relevant for their field of expertise e.g. for business and economic science type courses: the need to know what policies should be in place; the legal implications for employers; how to plan for absences due to illness; how to make sure those with high skills are not lost. For health sciences the focus was on bio-medical aspects such as universal precautions, while education lecturers cited integration into the areas of citizenship, values and professional conduct.
There was evidence that most lecturers had not really thought deeply about what aspects of HIV education could be addressed in their programmes, and how they could be taught. When prodded by the interviewer to think more deeply about this, responses showed that the interview process itself did open them up to new possibilities.

So I would have to sit and think exactly where I could integrate it. The first thing was just the labour market, it is part of the labour market economics, but, um, there might be some management aspects also ...

Well, I can be creative, I just happen to believe and perhaps this interview is one of the most positive things and the timing is right because I have to change some modules ... and now perhaps the thought of doing it is revived because nobody asked over the last two years so I could just leave it and let it die.

Although most of the lecturers interviewed were integrating HIV to some extent in their teaching, the reasons for this varied from an understanding of how HIV is impacting on students, both professionally and personally,

I feel like that is very, very important and it is very relevant, especially in this generation we live in.

To more pragmatic reasons, such as,

I was doing that because it was part of the course when I took it over.

The most common approach adopted by faculty was to address it on a once-off basis in one ‘carrier module’ (Clarke 2008, 89) that they considered relevant, (e.g. Business Management – environmental risks to business (30 minutes allocated in one lecture); Biomedical Technology – professional risks (universal precautions to avoid contamination by blood); Education (Values in Education); Human resources – workplace policies). This type of inclusion encourages a narrow focus on HIV in the carrier subjects, resulting in ‘marginal additions’ (Clarke 2008, 88) to the curriculum, and precludes the opportunity for connections to be made between various academic disciplines and HIV and AIDS. Since most academics affiliate themselves with a particular discipline (Bayer and Baxton 1998), resistance to integrating something that is not seen as core knowledge is common. It is important, therefore, that learning ecologies (Kilfoil 2008) are created to enhance the development of connections between HIV and AIDS and specific disciplinary knowledge. According to the principles of connectivism (Kop and Hill 2008), interaction with colleagues around a specific topic enhances learning through the exposure to diverse opinions (Siemens 2008) and the involvement of both the cognitive and affective domains. Sharing information via these learning ecologies leads to continual learning and modification.
of ideas (Siemens 2005), which may go a long way in overcoming faculty resistance to integration of HIV and AIDS.

It appears that there is confusion among higher education faculty as to how to approach integration, or even what integration means (Van Laren 2009). While it is very important that students learn about the specific aspects of the pandemic that will impact on their professional practice, the inclusion of HIV in only one module may limit the student’s understanding of the complex nature of the pandemic (Clarke 2008, 89). The lack of cross-curriculum integration may mean that students forget what they have learnt, since it is not reinforced in other modules. As one lecturer, who realised this problem, put it:

Students learn to forget, I know that from personal experience ... they like to forget ... maybe it was a stimulating programme, it is going to help them at the time but second year, third year, when they go to work they have already forgotten about it because there is no sustaining of the programme.

The examples of HIV and AIDS education cited by the participants, with the exception of cases which will be discussed in theme 3 below, focussed on ‘telling’ students how HIV and AIDS might affect their future work life by presenting them with information and facts. As one Business Management lecturer revealed:

The business environment is one of the topics in which we touch on HIV/AIDS. But is it’s a very brief session ... I think this lasts for basically half an hour, if that much and what we do there is basically tell the students of the implications of AIDS ... of the threat to their business and that is about it. HIV/AIDS is just briefly touched on, but it is something that could be given, not twenty minutes, but maybe forty five minutes.

It appears that students are rarely given a chance to explore or reflect on their own feelings and understanding of HIV and AIDS and how these might influence their future personal and professional behaviour. If students are not engaged in their own learning, then the likelihood of retaining information or seeing the relevance of it for their own professional and personal lives will be minimal (Ramos 2008). Literature in HIV education suggests that critical self-reflection is a vital first step to shifting perceptions and subsequent behaviour (Stuart 2007; Pithouse, Mitchell and Weber 2009; Van Laren 2007). Literature around learning theories strongly supports the notion that deep learning is supported by being given the opportunity to reflect on connections formed ‘through actions and experience’ (Downes 2007) and to personalise it through internalisation, dialogue and reflection (Siemens 2006).

One of the reasons that some lecturers gave for the narrow focus on HIV, was their perception that students had been taught what they needed to know at school. They believed that ‘there is a lot of fatigue’, yet current literature suggests that students do not have a good understanding of HIV and AIDS (HEAIDS 2010b, Huang, Bova, Fennie, Rogers and Williams 2005), that they tend to ‘other it’ and feel invincible (Zhang, Li, Mao, Stanton, Zhao, Wang and Mathur 2008, 1), and that they have not
changed their behaviour as a result of knowing the facts (Harding, Anadu, Gray and Champeau 1999; Kelly 2002). Studies among teachers also indicate that HIV education is not being comprehensively addressed at school level for many reasons, including the reluctance of teachers to integrate it into their curriculum (Kelly 2007; Visser 2004).

It therefore appears that faculty struggle to find a meaningful way to integrate HIV and AIDS; that where it is being done, it is limited to a very narrow disciplinary focus; and that it is being taught in a clinical, technical and factual manner with little engagement with students, all of which reduce the possibility for deep learning to take place (Downes 2007). In addition to a limited understanding of what HIV education entails and how it can be included into disciplines, faculty also offered academic and personal reasons why they perceived integration to be problematic.

**Theme 2: Barriers to HIV and AIDS integration**

Lecturers, although mostly willing to find ways to address HIV and AIDS in their teaching, perceived many barriers to successful integration. These barriers stemmed from both academic and personal factors.

*Academic factors that impinge on HIV and AIDS education*

The one barrier that was cited again and again was lack of time and space in the curriculum, supporting the findings of the recent HEAIDS teacher education study (HEAIDS 2010a). More than one lecturer made statements similar to the following interviewee:

> I have kind of inherited some modules, so I develop those modules but I have not introduced new modules ... I have a lot of ideas on nice things you can introduce but it is a daunting process, it takes about 2 years ...

This quotation implies that most lecturers do not realise that HIV and AIDS can be integrated without changing the core content so much that it requires to be submitted for re-approval through the formal university channels. The repeated assertion that ‘there is not really space to add anything’ to existing modules, again indicates that there is little understanding of what constitutes integration (Van Laren 2009), or of the various ways that it can be infused into the curriculum (Clarke 2008). Lecturers appear to equate HIV and AIDS education with talking specifically about HIV and AIDS, and do not link it to content and outcomes that deal with the drivers of the pandemic, such as critical teaching around gender, poverty, economic development, politics, history, legal aspects, social development, governance, and the many other factors that intersect with HIV and AIDS. Recent literature is pushing for a move away from simplistic understandings of the pandemic, based on positivist paradigms (Baxen, Wood and Austin 2011).

Although there was evidence of a realisation of the need to change the way HIV and AIDS education is approached,
I think there is always room for improvement, at least I don’t think you should just say this is what we have, we have to do it and we are sticking with it and then you kind of stagnate ...

I think it is good to start thinking about what else do we need to incorporate here ...

perceived barriers seemed to preclude the possibility of change:

Cognisance needs to be given to the fact that we have got so much time to give our students a huge amount of information and in the world of business HIV/AIDS is a threat but only one of a whole lot. I feel there is a need for it, but um, whether it is practically possible or not is a bit of a challenge.

Therefore, although lecturers had the will to change, the transition into action was lacking, due to feelings of being unable to assimilate any more work or find a place in the overloaded syllabus (HEAIDS 2010a). Any curriculum change requires a high amount of energy and interest on the part of faculty (Perin 1998), therefore this is a concern that has to be taken seriously. However, research has indicated that, once engaged in the process of change, the advantages are usually perceived to outweigh any disadvantages (Lattuca and Stark 1994). There was also a hint that not everybody would be interested in addressing HIV in their teaching:

I think people are just so busy with what they are focussed on. The problem is getting agreement with everyone, so we are all committed to doing this, we are all seeing the same idea and we are all doing this.

Cross curriculum, we are not enmeshed, we are not interrelated or interconnected.

We need to sit down and discuss, there was a bit of overlap in some modules and we are going to have to decide where it fits in, I think that is my main concern.

The above quotations highlight the importance of approaching HIV and AIDS education, or any curriculum change, at a programme level. There were repeated references to the fact that they were unaware of what their colleagues were covering in other modules of the same programme, and that HIV and AIDS had not been discussed from a curriculum perspective. The importance of basing curriculum development on a definite theoretical framework was identified as a critical need by the HEAIDS study (2010a) and, for this to happen in a coherent way, faculty would need to engage in discussion to allow the connections between HIV and AIDS and the theoretical frameworks guiding their programme to emerge (Kilfoil 2008).

Personal factors that impinge on HIV and AIDS education

Apart from the academic arguments presented above with regard to faculty ability to integrate HIV and AIDS education into their teaching, personal factors also emerged as constraints. Faculty were able to identify and voice some of these personal factors,
but remained unaware of others. One of the main factors that influenced the way that
lecturers addressed (or did not address) HIV and AIDS was fear that they would not
be able to cope with the emotions that this may evoke in their students. Even although
they were aware that they were paying ‘lip-service’ to HIV and AIDS, by keeping it
clinical and devoid of emotion, the fear of not being able to contain student feelings
was powerful enough to deter them from exploring other pedagogical strategies and
curriculum content:

We have far too much emphasis on AIDS in a very impersonal way, and particularly
in mathematics we teach AIDS ... with statistics. But the old adage really stands,
statistics don’t bleed, and I am finding in our maths courses that we are paying lip
service to AIDS ... but unfortunately I have not got to the emotion behind it, I think
that is because I am a little scared of the emotion ...

Literature does indicate that there are meaningful ways to integrate HIV into
mathematics education (Van Laren 2007), but it appears that the fear of creating a
space where emotions and possibly disclosure of status by students might emerge
was hindering further exploration of this issue. There was real fear of disclosure,
based on the perception that lecturers were not trained to deal with it and that they
might make things worse. The importance of helping faculty to identify and contain
their own emotions around HIV and AIDS integration is highlighted by an increasing
body of emerging literature (Baxen 2005; Khau and Pithouse 2008; Kirk 2005).
Another barrier was the fear of transgressing cultural norms. One lecturer, for
example, brought up the topic of circumcision and linked it to HIV prevention,
without realising that the male students in the class would take offence and refuse to
participate:

I brought this up in class and there was this deathly silence ... although I knew the
group well and it was a small group ... eventually one student stood up and said ...
we cannot talk about this in class because there are ladies and men together. And you
know it was awkward, and so I apologised and I have never been able to do that again.

This example highlights the fact that HIV education is also closely intertwined
with an understanding of how to teach in multicultural contexts (de Kock and Willis
2007). One lecturer said that she avoided discussion of HIV related issues because
she did not want to ‘alienate certain people and alienate myself from them’. This
lecturer was of the opinion that because the students were black, they might take
offence if she raised the topic, because, for her, HIV infection was something mostly
associated with the black population.

This leads to the finding that the personal attitudes and discourses of faculty
influence and taint messages about the pandemic and those affected by it. There
were examples of equating HIV with morality,
We can integrate it into religious education, because all religions advocate clean living.

One lecturer described how, while critiquing teaching practice, she was amazed and shocked at the number of Grade 11 learners who said they knew their serostatus:

Every kid in that class knew their status, so what does that tell you ... that means they are sexually active or promiscuous, or they have done drugs, you know, scary ....

This quotation is an example of how misconceptions, unconscious biases, stereotyping and moralising can result in discriminatory discourses which infuse teaching. It also reminds us that HIV and AIDS brings into the education, and therefore public arena, a facet of our lives that is usually kept private and disassociated from formal education – our sexuality. Our beliefs around this are loaded with moral, emotional and behavioural implications that are inevitably embodied in our teaching and learning practices. This ‘hidden curriculum’ (Hoadley and Jansen 2009, 57), wields tremendous power over curriculum content and pedagogical approach, as well as influencing the overall climate of the institution. The (dis)comfort level of the lecturer and student with their own identity as a sexual being cannot be omitted when developing programmes to address curriculum integration of HIV and AIDS (Khau 2009).

Theme 3: Examples of best practice
There were three examples where HIV and AIDS were being addressed in an infused way. Two of these examples were in language education, where HIV specific material was selected for comprehension tasks or language analysis, and one in health sciences. However, what was important in these cases was that the lecturers were not afraid to discuss student beliefs, needs and cultural understandings of HIV and AIDS that emerged during their class discussions.

I think it is my social responsibility as a lecturer to make sure that students are aware of issues and that they can talk about them. So, in other words, instead of only focussing on language skills, I could come up with questions that will raise discussion around these.

Or I can say I want an oral assignment and I can assess language skills while facilitating a discussion around stigma, and other HIV related issues.

Examples presented by these lecturers supported the notion that, when students are allowed to discuss issues related to HIV and AIDS, personal stories emerge and engagement occurs, without jeopardising completion of the formal syllabus. Connectivism states that deeper learning can occur when a student can connect with others, both acquiring information to change their thinking and feeding changed opinions and theories back into the learning community (Kop and Hill 2008). I
argue that such enhanced learning will be of more use to students, than transmitting knowledge in a non-engaged manner, simply to ensure that the syllabus is covered.

A common thread connecting these three lecturers was the willingness to experiment and try new innovations in their teaching. They were also open to admitting that they do not have all the answers, and that students are an important source of information. They have embarked on a journey of learning about HIV and AIDS themselves and how to integrate it.

I realised that there are books on HIV/AIDS, so the only thing I need to do is use those books, so I thought to myself, this could work ...

When I started, we had to teach HIV with the students, but over the years I have tried to juggle and see what works for me and what does not work for me. I even got a certificate for HIV.

An important point was raised by one of these lecturers, that the decision of whether to integrate of not is,

affected by his/her own epistemology, his/her own attitude and denial of course ... I have my own understanding of this based on where I have come from so I think if we are to integrate this HIV/AIDS discourse into our modules, all these factors would have to be considered.

This is a common finding in recent literature (Baxen 2005; Leclerc-Madlala 2002) around HIV and AIDS education and a vital lesson that we cannot ignore.

The teaching approach adopted by these lecturers was also more participative, allowing students to really engage and construct their own understandings of HIV and related issues (Forster 2007). Drama, role plays and critical debate help the students to critically examine different aspects of HIV and AIDS as it affects their lives and that of others. This, according to one lecturer is very effective

because students tell me that are able to identify and empathise with the characters (in the drama), they have a greater sense of understanding and awareness of HIV/AIDS and how it affects society at large, and communities, and men ....

This greater understanding then helps them to design lessons (in the case of student teachers) that will help to foster the same deep understanding in their learners.

What was particularly noticeable in reading the transcripts of these participants, was the enthusiasm and excitement they conveyed when talking about their teaching and student interaction:

so this year I changed the angle and actually it was very stimulating to them, and I thought, Wow, this is definitely it, the response I got from students was fantastic.
This seems to support the claims made in other studies, that actively researching one’s own practice and seeing how it can be improved, for whatever reason, increases personal engagement and motivation among lecturers (McNiff and Whitehead 2006; Wood 2010).

However, these ‘champions’ appear to be working in isolation, which limits the opportunity they have to share their expertise with colleagues. As one pondered:

> It would be really nice to find out form the others (colleagues on the programme) how they actually integrate it, but I am just speaking from my own perspective and how I do it and believe that we could.

This is further support for the suggestion that integration should be done on a programme level and within learning ecologies that encourage learning as a,

> ... continual process in which knowledge is transformed into something of meaning through connections between sources of information and the formation of useful patterns, which generally results in something that can be acted upon, appropriately, in a contextually aware manner (Siemens 2006,1)

Another finding, which is really an outlier for this study, highlights the need for sensitivity towards faculty who are personally affected by the pandemic. According to the participants in this study who said they were personally affected, it has made them more aware of the importance of discussing HIV and AIDS, in an attempt to increase student awareness and to reduce stigmatising attitudes and beliefs. They openly share their experiences with students and find this to be therapeutic for themselves and that it engenders student trust and reciprocal openness. However, it was also disturbing to discover the severe emotional stress that they experienced (it took a toll on me, such a toll; it was horrible emotionally for me) and how it affected their ability to do their job. Prolonged stress led to physical illness and absence from work.

It can be concluded from the above findings, that faculty are mostly willing to integrate HIV and AIDS into the curriculum, but that there are many factors that have to be addressed before this can be accomplished in an effective manner.

**SUGGESTIONS FOR DEVELOPING HIV AND AIDS EDUCATION AT TERTIARY LEVEL**

The data analysis of this study reveals interesting findings that have implications for future work with faculty to develop their capacity to address HIV and AIDS in their teaching in a meaningful and relevant way. These implications will now be discussed.

The finding, that faculty tend to view HIV and AIDS education as an ‘add on’ that requires extra space and credits in the curriculum, rather than seeing it as something that can be infused into their current curriculum, implies that they need to work
towards a broad and holistic view of HIV education, as discussed in the earlier section.

The current practices of integration do not create space for critical discussion of the social/economic/historical/political drivers of the pandemic that are relevant to that discipline. Faculty would therefore benefit from rethinking their curriculum content and pedagogical processes, to determine how they can transform their curriculum to be less compartmentalised and more accommodating of critical discussion around the drivers of HIV. The integration of HIV and AIDS into the curriculum could be the catalyst for change towards a transformed and humanising pedagogy (Freire 1970). A humanising pedagogy aims to develop the whole person (in contrast to only developing their knowledge/skills in one particular discipline), and their awareness of self in relation to others and context (Price and Osborne 2000). As Macedo (2006, xii) states, university lecturers are in an ideal position to:

... create effective pedagogical spaces ... (to) deconstruct the intricate interplay of race, ethics and ideology, – a practice that ... programmes, by and large, fail to take on rigorously.

As academics we should be engaging students in critiques of the social (dis)order and acknowledging our roles as gatekeepers who reproduce the dominant social values (Macedo 2006, xiii). This would require a broadening of the curricula to also recognise the value of indigenous knowledge, including issues such as the cultural and religious discourses of communities and how these discourses frame understanding of HIV. The knowledge assimilated at institutions of higher education ‘continues to be contradicted by African epistemologies, local customs, taboos and traditional beliefs and practices’ (Semali 2006, 238) and such contradictions need to be recognised and opened up for further discussion and exploration. A humanising pedagogy recognises the importance of, ‘the students’ background and knowledge, culture and life experiences and creates learning contexts where power is shared by students and teachers’ (Bartolome 1996, 174).

AIDS education has to be embedded in a pedagogy which is based on real respect and solidarity and that teaches that by dehumanising others, we dehumanise ourselves. If compassion is not a guiding value in curriculum design, then the danger is that indifference will dominate. As, Wiesel (2010, 204) warns us, indifference to the suffering of others is what makes us inhuman:

Not to respond to their plight ... is to exile them from human memory. And in denying their humanity, we betray our own. Indifference, then, is not only a sin, it is a punishment.

A humanising pedagogy informs us that we can learn from those we may deem to be inferior and furthers the wellness of all human beings, rather than only transferring academic knowledge. It limits a clinical, technical approach to HIV education, which,
while perhaps appropriate in a lecture context, needs to be balanced by offering students insight into the human face of the pandemic. It is a pedagogy that prepares graduates for the real world and not some idealised version of it.

However, for faculty to agree on a common paradigm through which to view HIV and AIDS education, collaboration and sharing on a programme level would be necessary. This would be enhanced by the creation of learning ecologies (Siemens 2005), real and/or virtual, that offer opportunities to connect with others around HIV and AIDS education, enhancing deep, reciprocal learning. Such a space would allow discussion and debate of how a critical, humanising pedagogical approach would lessen the incidence of ‘lip service’ being paid to HIV integration, since it has no real or lasting value in terms of preparing graduates to play an active role in the fight against the pandemic, as policy suggests they should be doing (HESA 2008, 15).

Self-study and experiential work around identification and containing/working through the emotional barriers that lead to lecturers avoiding real engagement with HIV and AIDS should also be brought into the discussion. Self-reflection is also needed to reduce the incidence of harmful discourses around HIV and AIDS and to build sensitivity and compassion. The pandemic requires academics to possess these qualities in addition to academic expertise. The mental well-being of both students and staff, which ultimately has implications for their respective academic performance, depends on this.

**CONCLUSION**

Although this study was very limited in scope, and the findings cannot be generalised to all university faculty members, it does provide important insights into the needs of faculty regarding the integration of HIV and AIDS into their teaching. In order to minimise the barriers to effective integration, the findings imply that the next step in the process of transforming the curriculum to make it more relevant to teaching and living in the Age of AIDS, is to begin with shifting the mind sets of faculty members. There is a clear need to encourage and facilitate critical assessment of what they are doing and why, to find new and better ways to do it. The pandemic has forever changed the face of our society and if tertiary education is to be relevant and meaningful in this post-modern age, then it also has to transform to take into account the different contexts and life experiences of our graduates and those they interact with on a professional and personal level. Echoing Jansen’s quotation, this transformation will not happen unless the curriculum makers, the university faculty, first transform their epistemology, ontology and pedagogical practices to accommodate the new demands that the pandemic has placed on teaching and learning at tertiary level.
REFERENCES


Faculty views of HIV and AIDS education in the curriculum at tertiary level


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