‘Close to the bone’?: Catalysts for integrating HIV and AIDS into the academic curriculum

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Abstract
Integrating HIV and AIDS into the academic curriculum remains a challenge which, for various reasons, is not fully taken up by academics at universities. Although much is being done in the health arena, and education is often put forward as the ‘antidote’ for the epidemic, only a few academics have introduced HIV and AIDS into their curricula. In this article, the authors explore why some academics have integrated HIV and AIDS into their curricula; what the catalyst was for doing so; and how these academics see this integration. This qualitative study within an interpretivist framework consisted of a collective case study design, using individual interviews as well as drawings to elicit responses from the purposively selected academics. Themes that emerged were: ‘It’s here, it’s not somewhere out there’; ‘People matter’; ‘Buying into the idea’; and ‘It’s a directive’. The findings led us to conclude, using a theory of social proximity as a lens, that the vigour of integrating HIV and AIDS is linked to how ‘close to the bone’ the pandemic is experienced, not only personally but also at community level. This clearly has implications for working with academics to integrate HIV and AIDS into their curricula.

Keywords: academic curriculum, HIV and AIDS education, integrating HIV and AIDS, social proximity theory, university

INTRODUCTION AND RATIONALE
The HIV and AIDS epidemic is one of the greatest socio-economic challenges globally – and notably the worst epidemic in 600 years (HEAIDS 2012). South Africa is currently the country with the highest number of people living with HIV and AIDS
(UNAIDS 2012), and has not managed to curtail the spread of HIV sufficiently. When considering the HIV and AIDS prevalence rate – which is 12.3 per cent of the South African population (Shisana 2013), with an unequal spread between men and women, young and old, in rural and urban areas – it becomes clear that the problem of HIV and AIDS is not yet resolved and cannot yet be ignored: neither by politicians and health practitioners, nor by education practitioners, including academics at universities. It is, indeed, as a participant in the Learning Together project (De Lange et al 2010, 45) indicated, ‘... a challenge. It’s a call to everybody. Nobody [may] neglect that call. Everybody has to respond positively to it’.

The title of the article points to querying whether there is a positive response to HIV only if it is ‘close to the bone’ and affecting those near and dear to a person. How ‘close to the bone’ should HIV be before a university community responds to the challenge? How ‘close to the bone’ should HIV be before an academic considers the need to initiate the integration of HIV and AIDS into his or her particular discipline?

Addressing HIV and AIDS is clearly positioned as one of the seven key developmental and transformation priorities of the Department of Higher Education and Training (HEAIDS 2012), and underpins what is set out in the Policy Framework on HIV and AIDS for Higher Education in South Africa (HESA 2008) and the revised Policy and Strategic Framework on HIV and AIDS for Higher Education (HEAIDS 2012). The first objective presented in the HEAIDS policy framework (2012, 35) focuses on the importance of ensuring that there is ‘comprehensive and appropriate use of the Higher Education mandate and intellectual response’ in responding to the epidemic. A result statement of this objective notes the need to develop ‘an integrated HIV and AIDS Curriculum across all disciplines in HEIs [higher education institutions]’.

Here we draw on the experiences of academics in addressing this objective through integrating HIV and AIDS into their curricula. Turning to how academics might come to invest in integrating HIV into their curricula, we draw on the notion of a ‘catalyst’ as ‘an agent that provokes or speeds significant change or action’ (Merriam-Webster Dictionary 2012). In applying the notion of a ‘catalyst’ to integrating HIV and AIDS into the academic curriculum of a university, we wondered what might have acted as a catalyst to provoke academics to include HIV and AIDS in their curricula. We therefore formulated the following two research questions:

• What are catalysts for academics to integrate HIV and AIDS into their curricula?
• How do these academics view/construct the integration of HIV and AIDS into their curricula?

WHY ACADEMICS AT UNIVERSITIES SHOULD INTEGRATE ASPECTS OF HIV AND AIDS INTO THEIR CURRICULA

We know that prevention is critical in stemming the tide of the epidemic, and that globally much money is being spent in response to it. Schwartländer et al (2011)
argue that if the amount of money invested in response to the epidemic in 2011 remains the same through to 2020, the number of new infections will also remain the same and not be reduced. In South Africa, the proportional spending (public, external and private) on HIV and AIDS in areas of health, education, human rights, social mitigation and labour amounts to a substantial investment, but is clearly insufficient to stem the epidemic. Three of the nine provinces (Northern Cape, Western Cape and Limpopo) apparently spend sufficient amounts on HIV and AIDS per capita, while the other six lag behind.

With no more or extra funding being available, Schwartländer et al (2011) argue for more sustainable investment in prevention, which in the long run will be much more cost-efficient. This call to do better in terms of prevention with the money at our disposal resonates with the argument put forward in the article, that university academics should invest in integrating HIV and AIDS into their curricula in order to deepen the understanding graduates have of this phenomenon, and so contribute to HIV and AIDS prevention. We consider this to be imperative, and in line with the simple but strong position which Odora-Hoppers and Richards (2011) put forward: that the status quo of the university is unsustainable without transformation.

Academics may argue that universities have been around for centuries and have tried and tested ways of teaching and researching, and that these need not be rethought. However, within the context of HIV and AIDS, these tried and tested ways demand rethinking as ‘it is about life and death’ and university teaching needs to ‘consider humanity first’ (Odora-Hoppers 2012, personal communication). Her argument that we are so ‘locked in our disciplines’ and that ‘we are imprisoned where we are’ requires us to rethink how we do our work and to push for more vigorous interdisciplinary and transdisciplinary work, such as integrating HIV and AIDS into the curriculum. Universities cannot remain ‘ambivalent to society’ and need to consider exactly what is required to ‘serve society’ (Odora-Hoppers 2012, personal communication) and to help stem the tide of HIV and AIDS.

HIV AND AIDS INTEGRATION AT UNIVERSITIES

There are numerous definitions for the term ‘integration’; there is also confusion between the terms ‘integration’ and ‘infusion’. Sometimes the term ‘infusion’ is used interchangeably with ‘integration’, as both can be considered as appropriate when a combination of two or more disciplines occurs. The meaning of ‘integration’ that is appropriate and used as our interpretation is summed up by Roughley and Salt (2005, 3) as the bringing together of ideas, knowledge and methods from different disciplines ‘to bear on a particular problem in a particular place at a particular time with a common purpose’.

The HEAIDS (2010) report provides a ‘snapshot’ of curriculum integration of HIV and AIDS at 16 South African universities, and points out that further exploration of the work of academics who are integrators of HIV and AIDS into their disciplines, is required. The HEAIDS (2010, 6) study framed integration as
taking up HIV and AIDS into the curriculum by creating ‘a credit bearing stand-alone’ module, an ‘online or a direct delivery module’, or the ‘development (or adaptation) of courses or modules to include some components of HIV/AIDS’. Various models of integration are suggested, where ‘HIV/AIDS is “mainstreamed” and infused throughout the module’, or ‘a “bolted on” approach ... include[ing] one or two “units” ... on to an already existing curriculum’, or simply having students do a ‘major project or several assignments’ related to HIV and AIDS (HEAIDS 2010, 6). This ‘base-line’ (HEAIDS 2010, viii) information on integration indicates that ‘professional, personal and social (humanitarian)’ (HEAIDS 2010, 46) explanations are offered by academics as reasons for taking up HIV and AIDS in their curricula.

The integration of HIV and AIDS research has been explored in South Africa by several authors (Lesko 2007, 2010; Van Laren et al 2012; Wood 2011; Wood, De Lange and Mkumbo 2013). Wood (2011) writes about how academics perceive and regard HIV and AIDS education in their particular disciplines. Wood et al (2013) explore teachers’ representations of HIV and AIDS as a starting point for the re-curriculation of an undergraduate teacher-education programme. In addition, Van Laren (2007, 2011) explains how to initiate integration in an undergraduate mathematics teacher education curriculum using metaphor drawings. She also describes the use of HIV and AIDS statistics to integrate HIV and AIDS education into a mathematics education curriculum (Van Laren 2012). However, there seems to be a dearth of research providing detailed information on the catalysts which academics see as influential in initiating the integration of HIV and AIDS into their higher education teaching and how they position themselves in engaging with HIV and AIDS issues in the lecture halls. The current research, part of an ongoing project funded by the National Research Foundation, aims to understand and further HIV and AIDS integration initiatives at universities. It is thus important to understand more about catalysts that facilitate academics’ integrating of HIV and AIDS into their teaching contexts.

Turning to the vision and mission of the three universities with which we are involved, we wanted to see whether these made any reference to the importance of addressing HIV and AIDS, and we found that no direct mention is made of HIV and AIDS. However, the strategic plans were more forthcoming. The strategic plan of the first university identifies HIV and AIDS as a research focus requiring fostering of collaborative partnerships in research and innovation in the area of HIV and AIDS, because of the ‘social afflictions and the ravages of [this] disease’ (UKZN 2013, 13). The strategic plan of the second university does not specifically refer to HIV and AIDS as an area of research or concern in terms of curriculum, only as an issue that needs to be looked into to promote the well-being of staff (University of Fort Hare 2009, 56). The strategic plan of the third university, however, explicitly refers to the HEAIDS (2010) seroprevalence study highlighting ‘a prevalence of ... 3.4 per cent among students in the higher education sector’ (NMMU 2010, 14). It further unpacks the statistics pertaining to students of this particular university, indicating that ‘certain campus sub-populations [are] ... more vulnerable to HIV infection, namely female
students, older students, male staff, and African staff and students’. With this context in mind, the strategic plan states that the university ‘cannot afford to relax its efforts to prevent the spread of HIV and AIDS and to offer care, support and treatment to students and staff living with HIV’, and furthermore that the university has

... a vital responsibility in providing intellectual leadership in the way in which HIV/AIDS is embedded in the curriculum, the comprehensiveness of HIV/AIDS services and workplace programmes for students and staff, and locating itself at the forefront of knowledge generation and transmission to provide the nation with working solutions to curb the spread of the virus, both clinically and socially (NMMU 2010, 14).

The two provinces in which the three universities are located, namely Eastern Cape and KwaZulu-Natal, have estimated HIV prevalence rates of 29.9 per cent and 39.5 per cent respectively (AVERT 2012). This underscores the importance of ensuring – as the NMMU indicates – that HIV and AIDS are firmly embedded in the curriculum. We therefore wondered why some academics might take up integrating HIV and AIDS into their curricula and others not, and what the catalysts for such integration might be.

THEORETICAL FRAMEWORK: SOCIAL PROXIMITY

We draw on the theory of social proximity to understand why some academics have come to integrate HIV and AIDS into their curricula. We think that exploring catalysts for behaviour change might be helpful in this regard: Understanding the reasons for successful behaviour change (eg, as in Uganda) could benefit other communities. Macintyre and Kendall (2008) posit that few theories can explain the changes in behaviour in relation to HIV and AIDS in Uganda which caused the prevalence rates to plummet. These authors suggest that the success (or failure) of projects, such as initiatives in Uganda which brought about positive behaviour change, could be explained in terms of what they have labelled as ‘social proximity’.

We chose to use the theory of ‘social proximity’ as a lens (Knoben and Oerlemans 2006) to explore catalysts for academics to ‘change their behaviour’ and to integrate HIV and AIDS into their curricula. Social proximity is often used by researchers in the field of management to understand organisational changes in commerce and industry (Bradshaw 2001; Knoben and Oerlemans 2006), and we therefore offer it as being useful in looking at change in the ‘teaching behaviour’ of academics. Macintyre and Kendall (2008, 58) note that in the field of social science, ‘proximity is a contextual variable – an underlying topographical reality’. Knoben and Oerlemans (2006), in their literature review exploring ‘proximity’, consider ‘social proximity’ to be a dimension of non-spatial proximity. They note that social proximity is akin to what other researchers refer to as ‘personal proximity’ and ‘relational proximity’, which can lead to changes in perceiving personal as well as communal risk. According to Knoben and Oerlemans (2006, 78), social proximity usually refers to ‘actors that belong to the same space of relations’. Boschman (2005, 9) considers social
proximity to be socially embedded relations between agents at the ‘micro-level’ and explains that ‘[r]elations between actors are socially embedded when they involve trust that is based on friendship, kinship and experience’. This does not necessarily include situations where people share sets of values.

These relations are categorised by Macintyre and Kendall (2008, 59) according to whether proximity (or nearness) to the epidemic is either ‘high’ or ‘low’. If the relation to the epidemic is high – threatening both individuals and communities – then, according to these authors, this increases the possibility of transformative experiences and actions; if the relation to the epidemic is low, distancing and denial of the threat decrease the chances of developing innovative strategies to respond to it. Macintyre and Kendall (2008) explain that people who consider HIV and AIDS to be socially proximate, will see the need to take action and support or initiate necessary innovative changes, whereas those who consider HIV and AIDS to be socially distant, will not see the need to take action since they do not consider the epidemic to be a threat.

In the context of HIV and AIDS, social proximity reveals a complexity which takes in various interacting ecologies, such as the individual, intra-household, inter-household, family, and kin level, as well as at a communal level, such as the close community, neighbourhood, village, or religious or ethnic group, and extending to regional and national level (Macintyre and Kendall 2008). They also emphasise that social proximity is ‘not just a description of an internal psychological state’, defined by ‘processes of fear, denial, acceptance and change’, but that it is ‘created and influenced by a range of cultural features, including interpersonal, subjective, and community variables’ which ‘interact in unusual and nonlinear ways’ (Macintyre and Kendall 2008, 62). According to these authors, states of mind and ‘behaviours are tested and reinforced’ in ‘dyadic, family and community settings’ (Macintyre and Kendall 2008, 62).

If there is denial of and silence about the risk of HIV and AIDS in these ecologies due to stigma (fuelled by fear and ignorance – HIV and AIDS being associated with sin, sex and low morals), nothing much will be done or changed to protect community members from the threat. If, however, there are many personal and communal experiences of HIV and AIDS risk and threat (deaths of family members, friends, colleagues, students and high-profile people, more orphans, loss of workforce, etc), chances are slim that the threat will be ignored and denied, as members of the community will endeavour to protect themselves and their community (Macintyre and Kendall 2008). In other words, when the social proximity is high, the effect of the epidemic cannot be denied, yet ‘how communities respond to the proximity of the illness, discuss the deaths, and react to the illnesses will help determine how, when and among whom behavior changes’ (Macintyre and Kendall 2008, 63).

We were therefore interested in understanding how a particular community – in this instance a community of university academics – views and reacts to the social proximity of HIV and AIDS, and how they respond to it in their academic context.
RESEARCH DESIGN

This section outlines the research design and methodology, sampling, data generation, data analysis, trustworthiness of the data analysis, and ethical issues.

Qualitative and interpretive research

A qualitative and interpretive research design was adopted for the current study. A qualitative research design was deemed important, especially in an empirical inquiry that investigates a contemporary phenomenon within a real-life context using multiple data generation methods (Cohen, Manion and Morrison 2007). We adopted a case study as our research strategy (Creswell 2007) in order to explore how academics at three universities integrate HIV and AIDS into their curricula. The specific case study was what Stake (1995) calls a collective case study; in our case the selected issue was why academics integrate HIV and AIDS into their curricula. To explore this issue we selected multiple sites – two faculties and one school from three universities – to illustrate different perspectives. However, while this does not allow us to generalise our findings, it does offer some insight into what happens in specific yet different contexts (Stake 1995).

Sampling strategy and participants

Purposeful sampling was used to select participants for the study. This is considered the most appropriate non-probability sampling technique in qualitative research; there was intentional selection and inclusion of participants who displayed the specific criterion, that is, integrating HIV and AIDS into their curricula (Creswell 2007). Because we did not know of all the academics in the participating faculties and school who were integrating HIV and AIDS into their curricula, snowball sampling was also used to find more participants. Hence, academics who knew of other colleagues who were integrating HIV and AIDS in their curricula assisted us in finding further participants.

We used the data of 10 of the 13 participants who took part in the study, as only 10 had made drawings (one of our data generation methods) – three male and seven female academics. At the first university, participants from the School of Education integrated HIV and AIDS into the Commerce and Life Orientation curricula. At the second university, participants from the Faculty of Social Sciences and Humanities integrated HIV and AIDS into the Social Work/Social Development, Psychology and Sociology curricula. At the third university, participants from the Faculty of Education integrated HIV and AIDS into Science Education, Language Literacy, Life Orientation, Educational Psychology and Mathematical Literacy.

Data generation

Two data generation methods, namely individual interviewing and drawing, were used to explore why academics integrate HIV and AIDS into their curricula.
A structured individual interview schedule with open-ended questions was used to elicit data. Although a variety of interview questions were posed in the larger collaborative research project, we drew on only one for this article: ‘What was the catalyst for you to start including HIV and AIDS in the curriculum?’ The participants were interviewed individually, and we probed and explored issues that elucidated and illuminated HIV and AIDS integration in their discipline, encouraging them to talk at length about the topic (Chenail 2009). This method of data generation is flexible, as participants’ ideas guide the process (Gillham 2000).

We used a second data generation method of drawing, which has many advantages (Theron et al 2011). These include the fact that drawing is accessible and inexpensive, enables powerful visual metaphors that speak loudly, offers an entry-point into a range of critical issues, provides insight into the viewpoints of participants, and makes use of meanings that participants give to images rather than simply reading the readers’ interpretations (Rivard et al 2009, 6–8). We prompted the participants to ‘Draw how you see HIV and AIDS education in your own teaching. Please give your drawing a caption. Speak to your drawing explaining what you mean by particular parts/ideas in your drawing.’ The interviews and talking about the drawings were audio-recorded with written permission from the participants and transcribed for further analysis.

**Data analysis**

The process of data analysis involves structuring and bringing logical order to the vast volume of data (interviews, drawings and discussion of the drawings) collected. Thematic analysis was used to analyse the data. According to Braun and Clarke (2006), this method captures important themes from a data set that can be related back to the research questions. Thematic analysis tends to be theoretically driven; it draws on theory to elicit themes that relate to particular areas (Braun and Clarke 2006). This involves identifying latent themes and not just describing themes as they appear on the surface, but examining the possible underlying meanings, assumptions, strategies and ideologies at play (Gillham 2000).

Participants’ responses to the questions were transcribed and tabulated to facilitate analysis. After carefully reading and interpreting participants’ interview responses, each researcher searched for common patterns (Merriam 2002). We then met as a team to discuss the patterns that we had identified. At our consensus discussion we refined and adjusted our interpretations to finalise the codes and themes. The trustworthiness (Guba and Lincoln 1989) of our findings was enhanced by the fact that we three researchers independently analysed the data and worked closely together in finalising the analysis to ensure that our findings were credible. Constant reflection and refining of the themes was thus a collaborative effort. In addition, as members of the faculties and school where the research was conducted, we were able to act as insiders to authenticate our findings and conclusions.
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After confirming the themes, we linked responses to each participant’s drawing in an attempt to understand why academics at universities chose to integrate HIV and AIDS into their curricula and how they constructed this integration.

Ethics
The principal investigator applied for ethical clearance at her university for the collaborative research project, while the other two researchers obtained permission from their deans to interview academic staff members. Academics participated voluntarily upon signing an informed consent form which guaranteed their privacy, confidentiality and anonymity. We used pseudonyms for the participants.

Findings
Each of the four themes that emerged from the data is discussed, based on selected excerpts of participants’ interview responses that informed the particular theme. The themes are further illustrated using participants’ drawings.

Theme 1: ‘It’s here, it’s not somewhere out there’
This theme draws on responses of two participants who experienced close relationships with HIV and AIDS through interactions either with students or family members. These relations affected the participants. John indicated that he does not formally plan how he wishes to include issues related to HIV and AIDS in his discipline, and that conversations about HIV and AIDS occur incidentally. His discipline lends itself to include aspects of HIV and AIDS from a scientific perspective, where the biology of HIV and AIDS as well as the spread of the epidemic is discussed. An incident that John highlighted as having served as a catalyst for his inclusion of HIV and AIDS occurred after one of his students had been tested for HIV. John commented on the incident as follows:

... when the student walked in here with a little piece of cotton wool still on his finger ... Because his girlfriend had just died and he literally had just gotten his test, he threw his piece of cotton wool in my bin ... And we went down to counselling, then I realised, sjoe, there’s a lot more to it than this, it’s here, it’s ... it’s not somewhere out there.

John experienced a close relationship with the epidemic through observing the actions of one of his students, and he therefore realised the need to integrate HIV and AIDS issues into his discipline.

Another participant’s response indicated that she has an even closer relationship with HIV and AIDS, as she pointed out that her sister was diagnosed with HIV. As Jenny explained: ‘It’s more personal, my sister was diagnosed with HIV, so I actually experienced it.’ Jenny integrates HIV and AIDS issues into two different modules in her discipline, drawing on the biomedical model in one of the modules she teaches,
and on the social model in the other. Jenny makes an effort to include issues of HIV and AIDS wherever possible, to ‘make a contribution in one way or the other’.

In terms of social proximity theory, both John and Jenny have close, first-hand relationships with HIV and AIDS. This means that their close relational experiences with people affected by HIV and AIDS have made them realise that it is no longer feasible to position HIV and AIDS as affecting ‘others’ out there.

Although much could be done by academics, there seem to be only a few who see the need to change what they teach. Odora-Hoppers and Richards (2011) reiterate that academics should rethink ways of teaching and researching and should engage with HIV and AIDS in interdisciplinary and multidisciplinary ways. Their call thus supports the need to use HIV and AIDS integration as an alternative strategy to address the pandemic.

In order to explore links between participants’ interview responses and their views or constructs of integration of HIV and AIDS in the curriculum, we selected Jenny’s drawing and related explanations. She titled her drawing ‘Eye opener’ (see Figure 1).

![Jenny’s depiction of HIV and AIDS teaching as ‘Eye opener’](image1.png)

Figure 1: Jenny’s depiction of HIV and AIDS teaching as ‘Eye opener’
The drawing is of a large sun and inside the sun is a face with two eyes and a mouth that represents a smiling person. Jenny considers the smiling person to be a reflection of her feeling happy that she is able to engage the students in discussion of pertinent HIV and AIDS issues, and so she is satisfied that she is doing ‘something’ about the HIV and AIDS epidemic. Jenny contextualises HIV and AIDS education in her teaching in such a way that students may ‘begin to see things that they were not really aware of or were ignorant of’. Through this ‘positive’ image of a smiling person she is showing her emotional relationship with HIV and AIDS. The fact that her sister was diagnosed as HIV positive probably made her see the need to take action, and she is eager to engage with HIV and AIDS issues in her university teaching.

**Theme 2: ‘People matter’**

This theme refers to four participants’ responses of self-initiated actions to promote the integration of HIV and AIDS issues into their disciplines because they consider themselves as caring about others. The fact that they care about others served as a catalyst for integration. Furthermore, these participants considered the integration of HIV and AIDS to be the social responsibility of academics in the South African context. They did not specifically mention any face-to-face incidents or close relationships with HIV and AIDS, but consider people in general to be worthy of care and concern.

For example, Musa considered the impact of HIV and AIDS to be felt in the work environment of most South Africans, due to the discrimination against HIV-positive people living with HIV. He does not deliberately set out to integrate HIV and AIDS into his discipline, but when contextual factors are raised by students, he does not ignore them but rather carefully manages discussion of the issues in his lecture settings. Musa indicated:

> Well, I did see that it is an important part because the module deals a lot with the people. And when you deal with the people, people are not separated from their environment and one of the environmental factors affecting people is HIV and AIDS. Then I decided to say, well, this is the correct aspect to be included in the module where one deals with the people.

Musa further indicated that HIV and AIDS is a socio-economic issue affecting the workers in society, so he integrates HIV and AIDS issues into the modules he teaches. Another participant, Thandeka, who teaches in the same discipline, pointed out that an interdisciplinary approach to teaching at a university is a prerequisite. She noted that for this approach to be successful, integration of social issues related to HIV and AIDS ought to be considered in her discipline. She emphasised that she considers herself to be a compassionate person, and said, ‘I think because ... caring, it’s me, I really love to care.’

Zandi includes not only social but also cultural aspects related to HIV and AIDS in her discipline. She expressed concern about the disastrous impact of HIV and AIDS in sub-Saharan African countries and explained:
In 2005 AIDS deaths were expected to account for 13% of all deaths in Africa ... So it made a lot of sense for me to educate our students about the dangers and challenges that this pandemic posed.

Musa, Thandeka and Zandi highlighted general community and society relationships with HIV and AIDS. This means that these academics’ relational experiences are not as close and are thus more distanced from HIV and AIDS than those of the participants in the previous theme. However, the responses identified in this theme clearly indicated that academics consider it important to ‘create awareness about HIV and AIDS’ in relation to social, cultural and/or economic issues surrounding HIV and AIDS.

We selected Thabi’s drawing and related explanation to depict how the participants’ interview responses in this theme link to these academics’ views or how they construct integration of HIV and AIDS into their curricula. Thabi’s drawing is titled ‘A drop in the ocean’ (see Figure 2), and she drew waves and a drop of water. The ocean’s waves are drawn at the base of the page with one drop suspended in the air, poised to fall into the ocean. The drop, for her, symbolises the small contribution she is making to address the HIV and AIDS pandemic in the modules that she teaches.

Figure 2: Thabi’s depiction of HIV and AIDS teaching as ‘A drop in the ocean’
She considers her contribution to HIV and AIDS significant in relation to the seriousness of the large ‘ocean’ that represents the epidemic. Even though this contribution is small, Thabi sees her role, through integration of HIV and AIDS social issues, as noteworthy. Every contribution is valuable because of the seriousness of the pandemic in South Africa, where the prevalence rate is 12.3 per cent and where the highest number of people are living with HIV and AIDS (Shisana 2013; UNAIDS 2012).

**Theme 3: ‘Buying into the idea’**

The two participants’ responses in this theme indicated that the integration of HIV and AIDS issues in their disciplines was not self-initiated. However, their responses indicated that they were open to suggestions and have taken up the ideas offered by colleagues to integrate HIV and AIDS into their curricula. This means that the catalyst for integration was being persuaded by others to take action in their disciplines.

Nomsa integrates social aspects related to HIV and AIDS and includes gender issues, violence against schoolgirls and women, and barriers to learning in her discipline. Her catalyst for taking action and integrating HIV and AIDS stems from suggestions made by other colleagues who mentioned inclusion of HIV and AIDS in their disciplines. Nomsa mentioned that:

> ... somewhere down the line [a colleague] was asking what are we doing about it ... [so I] sort of decided it needs to be included and addressed.

Maggie too initially seemed reluctant to integrate HIV and AIDS into her discipline, and only initiated integration after being encouraged to do so by a colleague. Maggie indicated that she makes use of statistics for integration, and stated:

> The mere fact that we were encouraged to do it, that [a colleague] spoke about it all the time ... That we can’t just hide away as we did before. I did! I hid away and said ‘It’s in the curriculum’. ‘I don’t have to do it, it’s in the curriculum’ [so someone else is taking care of it].

This participant needed to be convinced by a colleague to consider ways of integrating HIV and AIDS into her discipline. However, after being motivated, she bought into the idea and made steps towards integration. Initially she tried to ignore the issue of HIV and AIDS and saw no need to take action in her discipline, as she was of the opinion that academics in other disciplines were responsible for teaching about HIV and AIDS.

In this theme, the academics’ responses indicated that their relationship with HIV and AIDS is somewhat distanced, yet they could see the importance of not ignoring it. However, these participants were willing to take up the suggestions offered by colleagues, and sought ways that they themselves considered appropriate for HIV and AIDS integration within their own particular disciplines.
We selected the drawing by Nomsa to depict how responses to interviews in this theme link to integration of HIV and AIDS in the curriculum. Nomsa’s drawing is titled ‘Victory over AIDS fatigue: successfully opening eyes’ (see Figure 3).

Her drawing consists of a sword pointing upwards with the word ‘sword’ written on its blade. She indicated that the ‘sword’ shows the need to cut through or beat AIDS fatigue. She considers that ‘slashing’ with the sword is necessary to decimate ‘whatever there is in the way of keeping our eyes shut’. In other words, new ways of engaging with knowledge about HIV and AIDS need to be sought so that people can take notice of ‘something that cannot be ignored’. She indicated that she makes use of controversial magazine articles to ‘give a new angle’ to the teaching of HIV and AIDS. Furthermore, Nomsa acknowledged that she required external motivation before she managed to ‘buy into the idea’ to integrate HIV and AIDS in the modules she teaches.

Making use of drawings is a relatively new angle used to explore re-curriculation vis-à-vis HIV and AIDS integration and to encourage buying into the idea (Van Laren 2011; Wood 2011; Wood et al 2013). Academics could, for example, use drawings as a starting point to integrate HIV and AIDS into their curriculum.

Theme 4: ‘It’s a directive’

Two participants’ responses indicated that the integration of HIV and AIDS issues in their disciplines was not self-initiated, and they considered their integration to be a top-down directive. In other words, their responses appear to indicate that they do not personally perceive integration as necessary, but are merely following instructions.
This means that the catalyst for integration was mandated from ‘above’.

Khumbulani integrates social and biomedical aspects of HIV and AIDS into the module he teaches, and explained why he does so as follows:

When I was hired for my job as a lecturer I was told by the panel that was interviewing me that the fact that I had a background of HIV training made them look at me as a suitable candidate, as they were looking for someone who would develop an HIV course for the department.

Khumbulani implied that it was because of his existing knowledge of HIV and AIDS gained through training that he was appointed, and was therefore obliged to teach HIV and AIDS. However, he had presented a conference paper on curriculum integration of HIV and AIDS, which indicates that he is knowledgeable on the area of integration and has an academic interest in it.

Mandy teaches HIV and AIDS from a biopsychosocial perspective in her discipline through ‘implicit infusion’. She does not teach HIV and AIDS education directly but realises the relevance of integrating issues related to HIV and many other topics such as gender and religion in her discipline. Mandy said:

I think it was a directive and it’s actually part and parcel of a societal ill, and seeing it was coming from a psychological view, it needed to be included.

Mandy also pointed out that:

It has to do a lot with identity and so for a lot of people their religious and cultural identity dictates that you actually can’t talk about HIV and AIDS ... so it is trying to help people deconstruct their identities and to see the need to address things head on.

These responses appear to indicate that Mandy considers it challenging to include HIV and AIDS issues in her discipline due to the sensitivity in talking about sex, sexuality and HIV. She indicated that some students do not want to engage in discussions about HIV and AIDS due to cultural and religious taboos. However, she does include some aspects of HIV and AIDS because she sees it as a necessity to deal with HIV as a social illness. Furthermore, she considers the inclusion of HIV to be a directive, and that she is required to infuse HIV into the modules that she teaches.

In this theme, the academics’ responses seem to indicate that their relationship with HIV is distant or remote. While they appear to be knowledgeable in the area of HIV and AIDS issues, they indicate that integration or infusion in the modules that they teach does not occur because they have close relationships with HIV, but because it is mandated.

The responses of these academics are in line with the mandate of the DHET as well as its key developmental and transformative priorities as set out in its policy framework on HIV and AIDS (HEAIDS 2012; HESA 2008). However, this top-
down approach is contrary to responses in the other themes, where more bottom-up catalysts emerged as reasons for initiating HIV and AIDS integration. We selected Mandy’s drawing to depict how responses to interviews in this theme link to their integration of HIV and AIDS. Mandy’s drawing is titled ‘Social conversation’ (see Figure 4). The drawing consists of a bowl-shaped arc with seven circles attached to lines inside the arc. Five of the circles are labelled as ‘HR’ (human rights), ‘Gender’, ‘RE’ (religious education), ‘Const’ (constitution) and ‘Identity’. The label ‘HIV/AIDS’ is attached to one of the lines.

According to Mandy, the arc represents the ‘social development of learners [students]’ and the circles represent different topics such as ‘human rights, gender, identity, religion, education’ and others associated with social development. Mandy often includes HIV and AIDS in each topic as ‘the social ill will raise its head through the various topics’. This means that for her all of the topics in social development have links to HIV and AIDS, which she addresses through ‘social conversation’ as ‘HIV and AIDS is a social ill’. The drawing indicates that Mandy is able to link HIV and AIDS to many aspects associated with the social development of learners. She does not identify any personal relationships with the HIV epidemic, as her connection to the epidemic is mainly through academic knowledge of HIV and AIDS in many social issues.
DISCUSSION

Considering the findings described in the four themes, we return to the theoretical framework of social proximity of Macintyre and Kendall (2008) to make meaning of the catalysts for these academics to integrate HIV and AIDS into their curricula. The four themes demonstrate how the ‘high’ or near social proximity influences some academics to integrate HIV and AIDS into their curricula when HIV and AIDS are seen as personally close. When the social proximity is ‘low’ or distant, a directive from above seems to drive their integration of HIV and AIDS.

While we might seem to have ‘plotted’ the catalysts for integrating HIV and AIDS linearly into our themes, we have come to realise that social proximity advances the integration of HIV and AIDS in a complex manner – particularly in relation to catalysts for HIV and AIDS integration into the curriculum. Central to understanding how social proximity acts as a catalyst (or not) is the idea that HIV and AIDS is real and that it cannot be denied. Also emerging then is the idea of overriding AIDS denial, realising that something has to be done as the epidemic affects the academics at a personal level – in fact is ‘close to the bone’ and very personal. More importantly, academics are beginning to see and experience the effect which HIV and AIDS has and could have at community level – in this instance among the university community of students and staff. The threat to the personal, the interpersonal, the community and society collectively – and in unexpected ways – adds to the complexity of the notion of social proximity and allows for a rich and varied interpretation as to what serves as a catalyst for integrating HIV and AIDS into the curriculum (see Figure 5).
Figure 5: Summary of the findings showing the themes in relation to social proximity

Figure 5 illustrates the social proximity to HIV in terms of concentric circles that are not necessarily distinct distances that can readily be ‘measured’. The circles have ‘broken’ boundaries indicating the possibility of particular academics being situated at a variety of ‘distances’ from the epidemic. In other words, the research findings indicate that the academics’ responses are not always bounded or confined to a specific distance along the proximity continuum.

The findings also imply that the integration of HIV and AIDS aspects into the academic curriculum – even if given as an imperative in the strategic plan of a university – is not a homogeneous project, but is dependent on the experiences of academics as individuals; their own meaning-making of the social proximity of
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the epidemic; and whether they can overcome the denial that the epidemic is an epidemic of the ‘other’.

CONCLUSION

The current article was informed by the urgent need of higher education institutions to respond to the HIV and AIDS epidemic, and explored what the catalysts were for academics to integrate HIV and AIDS into their curricula. Using a theory of social proximity to make meaning of the themes which emerged in response to the research questions enabled us to offer new insight into the complex issue of integrating HIV and AIDS into the academic curriculum. While we only engaged with academics from the fields of education and social work/social development, it is necessary to ensure that academics from other disciplines – for example business economics, natural science, fine arts and law – also recognise the social proximity of HIV and AIDS and see it not as a personal problem of the ‘other’, but as a collective public concern. This study highlights how academics’ concern and caring, at a personal and community level, serve as significant and important catalysts for integration of HIV and AIDS in the curriculum.

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HEAIDS see Higher Education HIV/AIDS Programme.

HESA see Higher Education South Africa.


NMMU see Nelson Mandela Metropolitan University.


