

**AN INVESTIGATIVE STUDY INTO WAYS OF
INCORPORATING HIV/AIDS EDUCATION INTO
ACADEMIC CURRICULA AT THE
UNIVERSITY OF NATAL**

By

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of the requirements for the degree of
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DECLARATION

I, Ann Marie Williams, declare that this dissertation represents original work that has not been previously submitted in any form to any university. Where use has been made of the work of others, this has been duly acknowledged and referenced in the text.

Signed: A.M. Williams

Date: 14th March 2003



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SUMMARY

The aim of this research was to investigate the different methods incorporating HIV/AIDS education into formal academic curricula at the University of Natal. This research aimed to flag up examples of ways of incorporating HIV/AIDS into the different curricula, and also to look at some of the obstacles the different academic departments may have encountered in trying to incorporate such education into their curricula. I had guessed that a variety of HIV/AIDS awareness programmes, initiatives and education were being undertaken at the university and that on the whole students and staff were well aware of the basic information regarding the disease. What I wanted to look at in particular was how the university was responding to HIV/AIDS within the curricula. Were academic curricula being altered in any way to allow for the impact of HIV/AIDS and how was this being undertaken?

The key issues to be addressed and the main questions posed by this research were:

- What are the different ways that HIV/AIDS education is incorporated into academic curricula?
- What do lecturers consider to be the specific links between their subject matter and HIV/AIDS?
- What is the purpose of such education? Why are lecturers choosing to incorporate HIV/AIDS education into their programmes?
- What aspects of HIV/AIDS are being covered within the programmes?
- How do lecturers attempt to get students to relate disciplinary knowledge to HIV/AIDS in order to inform future decision-making?
- What are the main positive features of the current HIV/AIDS programmes being undertaken?
- What are the main difficulties/concerns encountered by the different schools in incorporating HIV/AIDS education into the curricula?

Through examining different schools within the university it was hoped to come up with a variety of different and innovative ways that HIV education can be incorporated into the curricula.

This research started with a search of the HIVAN database to find lecturers with programmes that are undertaking some form of HIV/AIDS education. From this initial search I gained a number of contacts, who were then able to direct me to further contacts within the university. I ended up with an initial sample of seventeen lecturers based across fourteen schools or programmes and spanning seven faculties. The sample included lecturers from the faculties of Community & Development, Human Sciences, Law, Management Studies, Engineering, Medical Sciences, and Education. (See appendix I)

For this research I used a number of methods of data collection. The first data collection method used was to carry out semi-structured interviews with the lecturers in the sample. This method was the prime method and the vast majority of the data was collected using this method. The following methods were mainly used for triangulation purposes although a number of new insights were made from these. The second method used then was to review printed material made available to me from a number of the lecturers interviewed. This was mainly course outlines but in a small number of cases also included reports on the HIV/AIDS modules. The third method used was to observe a number of the chosen programmes and following this observation to interview students about the HIV/AIDS education. (See appendix II – Interview Questionnaires)

Initially I have presented the findings of this research by documenting and summarizing the responses to each research question. In order to make for an easy overview of the findings for the reader I have drawn up a table under each research question, these tables list the responses to the research questions. I then go on to look at the different models this research has shown for teaching HIV/AIDS education. I have taken each model in turn and shown how it works in practice through giving a detailed description of the example cases. Following this I have attempted to outline the main features of these HIV/AIDS programmes and to document the main insights emerging. Looking back at the literature reviewed in this field, I have then attempted to review the responses in terms of what was said in the literature regarding HIV/AIDS education. I have also outlined the questions and surprises brought to light by this study and have attempted to draw some conclusions regarding the teaching of HIV/AIDS within academic curricula. Finally, in the light of the findings, I have made recommendations for future work in this field. It was impossible from this study to say which programmes work better than others with regards to the teaching of HIV/AIDS education. What I have merely attempted to do is to describe the methods and approaches used at present in order that others wishing to undertake similar programmes may review these.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

I came at this topic after eight years of working in the field of health promotion in the UK. Health promotion is generally taken to be an umbrella term that includes all those activities intended to prevent disease, improve health and enhance well-being. One aspect of health promotion is that of health education and health information – activities aimed at enhancing health and preventing disease through learning. In a university setting where much learning is taking place each day, I saw this as a unique opportunity for HIV/AIDS education.

I had guessed that a variety of HIV/AIDS awareness programmes, initiatives and education were being undertaken at the university and that on the whole students and staff were well aware of the basic information regarding the disease. What I wanted to look at in particular was how the university was responding to HIV/AIDS within the curricula. Were academic curricula being altered in any way to allow for the impact of HIV/AIDS and how was this being undertaken?

Universities and Technicons are at the core of creating the future for South Africa. If education to prevent the spread of HIV/AIDS cannot have an impact here then what hope is there for future generations? Being myself a student at the University of Natal, this presented an ideal opportunity to study HIV/AIDS education at the university. In this situation I hoped that access to information and subjects would be more easily accessible.

1.1 The Aim Of This Study

The aim then of this case study was to identify the responses of university staff and management regarding HIV/AIDS, in order that these responses may help develop effective practices for the future. The focus of this research was to investigate the different methods of developing and incorporating HIV/AIDS education into academic curricula at the University of Natal. This research aimed to flag up examples of ways of incorporating HIV/AIDS into the different curricula, and also to look at some of the obstacles the different academic departments may have encountered in trying to incorporate such education into their curricula.

The key issues to be addressed and the main questions posed by this research were:

- What are the different ways that HIV/AIDS education is incorporated into academic curricula?
- What do lecturers consider to be the specific links between their subject matter and HIV/AIDS?
- What is the purpose of such education? Why are lecturers choosing to incorporate HIV/AIDS education into their programmes?
- What aspects of HIV/AIDS are being covered within the programmes?
- How do lecturers attempt to get students to relate disciplinary knowledge to HIV/AIDS in order to inform future decision-making?
- What are the main positive features of the current HIV/AIDS programmes being undertaken?
- What are the main difficulties/concerns encountered by the different schools in incorporating HIV/AIDS education into the curricula?

The object of study in this research was the ways in which HIV/AIDS education is taking place. Through examining different schools within the university it was hoped to come up with a variety of different and innovative ways that HIV/AIDS education can be incorporated into the curricula.

1.2 The Rational And Context For This Study

I chose this study because of the enormity and relevance of this topic in South Africa today. It seems that one cannot open a magazine or newspaper, turn on the TV or radio, or even drive to the supermarket without the topic of HIV/AIDS being discussed. But coupled with this is the deadly stigma which is still attached to HIV infection in South Africa. This was tragically demonstrated in December 1998 when Ms Gugu Dlamini, a volunteer health worker in KwaZulu Natal was beaten to death by members of her own community for publicly disclosing her HIV positive status.

Work being undertaken here in South Africa is also a great contrast to the HIV/AIDS work being undertaken in the UK where I worked in health promotion. The focus of the HIV/AIDS work in the UK is very much targeted at the different high infection rate groups in the population. Here in South Africa the target group for HIV/AIDS information is the whole population! This is not to say that different sectors of the population should be targeted in different ways with different information and this is another reason why I was interested in looking at the different examples of HIV/AIDS education. I believe that the only effective method of curbing the tide of HIV/AIDS infection is through the appropriate targeting of information and education to different groups throughout the whole community. The university setting offers a unique opportunity for reaching a large audience with health information. An audience which should be in the prime of their lives but who are at present in the most at risk age group as far as HIV infection goes.

A further interesting aspect of this topic is that in South Africa the response to this subject from the government is also somewhat controversial. In 1999, of South Africa's total population of 42 million, 78% are racially classified as African, 61% of who live in poverty. Meeting their needs in terms of housing, sanitation, water provision, education and health is a mammoth task. Co-ordination efforts across the bureaucracies have often faltered, while individual efforts to bypass the logjams have resulted in mudslinging. These have been coupled with President Thabo Mbeki's impatience with knee jerk compliance with international conventions on aids causation and treatment.

Most controversial of all has been his recent intellectual flirtation with the arguments of an internationally discredited group of dissident Aids scientists who assert that there is no direct causal link between HIV and AIDS.

(Statistics South Africa, cited in Barnes, 2000).¹

Barnes explains that South Africans have not ignored the AIDS pandemic. In 1992 in the transitional period between the end of apartheid and the onset of majority rule, the old government initiated the National Aids Co-ordinating Committee of South Africa (NACOSA), which by 1994 produced "The South African Strategy and Implementation Plan". Four years later the National Aids Programme, within the Department of Health was in place nationally and in each of the nine provinces. In 2000, the National Minister of Health launched the HIV/AIDS /STD strategic plan for South Africa, in conjunction with the South African National AIDS Council (SANAC). These bodies are relatively well financed; for example, R40 million (approximately US \$6 million) was allocated over a three year period nationally for education, health and welfare work on children affected by AIDS. South Africa can boast SANAC, SANAC Technical Teams, an Inter Ministerial Committee on HIV/AIDS, an Inter Departmental Committee on HIV/AIDS, and NACOSA continues as first among a host of Non-Government Organisations as a Centre for

¹Statistics South Africa, mid year estimates, <http://www.statssa.gov.za/releases/docgrap/99>, pg9, cited in Barnes, 2000

AIDS related research and activism. In new South Africa speak; these national structures are replicated down to provincial, regional and municipal level. (Barnes 2000)

Barnes states that the growing HIV/AIDS pandemic has already had a marked impact on higher education and will continue to do so as the disease intensifies. This in turn will have multiple effects on society. Higher education institutes therefore have a crucial role to play in developing effective mechanisms to deal with this impact. This is further reiterated in a speech by the Education Minister, Prof. Kader Asmal. He states

All our planning will come to naught unless we take seriously the impact of HIV/AIDS on the education system and indeed, on society as a whole. The projections of the extent of this pandemic are mind-boggling. If the prevalence of HIV/AIDS is as high as 32% in some parts of the country, what does this, for example, mean for future student enrolments?

What impact will the declining life expectancy rate have on the future viability of the National Student Financial Aid Scheme? Concrete and substantive mechanisms must be in place at an institutional level in order to respond to the crisis. I am not in the habit of using the word crisis loosely. Sadly, the HIV/AIDS epidemic can only be described as a crisis of enormous dimensions. I am aware that many universities and technikons have already developed policies to respond to the situation and that work is underway to craft national policy in this regard. Higher education also has the responsibility to mobilise its resources and capacity to support research into every aspect of the scourge.

(²Asmal, 1999, cited in Barnes 2000)

The impact of HIV/AIDS on the education sector is not altogether straightforward. At one level evidence is emerging that education remains virtually the only vaccine currently available for warding off HIV infection. Beyond the early stages of the AIDS pandemic, education reduces the risk of HIV, with better educated persons exposing themselves less to the risk of infection. The positive side of this is that providing more extensive and better quality education – even if not dealing directly with reproductive health - AIDS education – is likely to make a population less vulnerable to HIV infection. The negative side is that new HIV infections will gradually become concentrated among illiterate and poor people as the epidemic spreads among the population. Both aspects highlight the importance of universalising education of good quality so that this social vaccine is available to all persons. The relevance for universities is that they must see the education sector in

² Keynote Address by the Minister of Education, Professor Kader Asmal, at the Consultative Conference of the Council on Higher Education, 29 November 1999, Benoni, Gauteng, South Africa, cited in Barnes 2000)

its totality, with themselves as one of its parts. It may be that the models of good practice set up in universities can then be extended to other forms of education.

At another level, however, AIDS is playing havoc with education systems. It is reducing the number of children in school, not merely because it leads to fewer children in need of education, but also because sick parents are taking their children, especially girls, out of school. Orphans are not attending school, households are becoming more reliant on children's labour and the economic contribution they can make, and AIDS costs are reducing family ability to meet even modest educational expenses. On the supply side the disease is constraining the ability to provide educational services, with high levels of morbidity and mortality among teachers. UNICEF has estimated that in 1999 alone 860,000 children in sub Saharan Africa lost their teachers to AIDS (UNICEF, 2000, p8 cited in Kelly, 2001, p7))

Kelly explains that HIV/AIDS relentlessly undermines three of the main determinants of economic growth, namely human, physical and social capital. These effects are directly related to universities in Africa in the following ways:

- The reduced GDP and the growth of competing claims could lead to fewer public resources being available for the education sector as a whole, and for higher education in particular.
- The extensive impact aids makes on household economics means that families and individuals tend to have fewer cash resources at their disposal, whether for education or for other purposes. As a result universities will be constrained in their efforts to generate income through student fees.
- As the expectation of a lower life span takes hold families may become less inclined to invest in education or training programmes where the returns lie in the distant future.
 - Families and individuals may also become less inclined to invest in training for teachers, health workers, and other professions which historically have been associated with high levels of HIV infection.

(Kelly, 2001)

Research by Kelly also found that although AIDS related student deaths are reported, it seems likely that the real impact of AIDS on students will not unfold until students have graduated from university and entered the world of work. HIV/AIDS related services in universities focus mostly on students. More over they are essentially health centred. They provide mainly public information, together with a modicum of prevention, some health treatment and some counselling. They do not appear to be very comprehensive in either scope or coverage. (Kelly, 2001)

Throughout Africa much research in recent years has taken place on the subject of HIV/AIDS and the university sector. The Association of Commonwealth Universities (ACU) substantive involvement in providing leadership in the area of HIV/AIDS began in 1999. In parallel with the Commonwealth Heads of Government meeting, the ACU and the University of Natal hosted a symposium in Durban, South Africa, to address higher education's response to HIV/AIDS. At that meeting, Professor Michael Gibbons, Secretary General of the ACU and Dame Veronica Sutherland, Deputy Secretary General of the Commonwealth, challenged the leadership of the higher education institutions across the Commonwealth to make meaningful contributions to the fight against HIV/AIDS. The proceedings of that event reflected the need for the development of coherent policies and strategies in the university sector to adequately address the threat of HIV/AIDS. (ACU, 1999, cited in Department for International Development, HIV/AIDS: Towards A Strategy for Commonwealth Universities, 2001)

South African Universities Vice Chancellors Association, SAUVCA and the Committee of Technikon Principles, CTP between them reach all 36 higher education institutions in South Africa and a combined total of nearly 500 000 students. Realising that the AIDS epidemic will affect both types of institutions in much the same way and that common interest unites them, both organisations joined forces in 2001 to begin addressing the problem of HIV/AIDS. They have set up a project with two components. Component 1 is driven at national level by SAUVCA and CTP and is focused on building core expertise, mobilising support and programme development across the sector. In component 2 the onus is on the institutions to drive internal changes. Universities and Technikons will be required to respond to the agreed results of the project by developing and implementing a plan which prioritises institutional needs. The plan must aim to put in place policy, programmes and procedures for the prevention, mitigation and management of HIV/AIDS. (SAUVCA and CTP, 2001)

In a document presented by the Office of the Vice Chancellor, University of Natal in 2001, it states that HIV/AIDS presents sub Saharan Africa with what is undoubtedly the regions greatest social and health crisis in living memory. Of the 34 million people infected with HIV worldwide, approximately 71%, or 24.5 million people are inhabitants of the sub-Saharan region. Locally, KwaZulu Natal has the unfortunate distinction of being the epicentre of the HIV/AIDS epidemic in southern Africa. Research suggests that between 33% and 40% of the population of KwaZulu Natal is HIV positive. (The Office of The Vice Chancellor, University of Natal, 2001)

The University of Natal has begun to address some of the issues. In its mission statement the University of Natal exposes equal opportunities, serving the community and satisfying community needs. The HIV/AIDS Plan 2002-2004 states that the university has a responsibility to provide HIV/AIDS prevention, care and support programmes for its staff and students, and to mitigate the impact of HIV/AIDS on the university. This is further outlined in Component four of the plan: Mitigating the impact of HIV/AIDS on the university. This states that 'The impact of HIV/AIDS on staff, students and the functioning of the University will be assessed and ameliorated through the following objectives'. Objective 16 of this section is 'Mainstreaming HIV/AIDS into the curriculum', it states that 'Course leaders will be encouraged and assisted in mainstreaming HIV/AIDS issues into the curriculum offered at the University of Natal. For example, literacy programmes could include words and concepts used in HIV/AIDS prevention; statistics courses could use HIV/AIDS statistics for analysis; research methods courses could incorporate HIV/AIDS research examples, etc. These curriculum development projects will draw upon the experience of academics already involved in such initiatives'.

(HIV/AIDS plan: 2002-2004, 2002)

Here in the University of Natal the KwaZulu Natal Centre for HIV/AIDS Networking (HIVAN) has been established, dedicated to promoting excellence, efficiency and effectiveness in HIV/AIDS related research, training and intervention, in the province of KwaZulu Natal. HIVAN operates from a central office within the university's Faculty of Health Sciences and also has a Biomedical arm and a Social and Behavioural Science arm. Key outputs of HIVAN will include: a globally accessible data base of information, resources and networking tools, virtual and face to face forums that encourage interaction and co-operation between local and international researchers, an in-house unit for dealing with AIDS that might serve as a model for other tertiary institutions and other organisations in South Africa.

Nesting within HIVAN as one of its key programs, and interacting closely with the Biomedical and Social and Behavioural networking arms, will be an in house university HIV/AIDS unit, tasked with managing the epidemic on campus, and equipping staff and students with the knowledge, attitudes and skills necessary to operate in a society grappling with the HIV/AIDS epidemic. It is anticipated that the programs developed on campus will provide models for other universities and tertiary institutions in the country. One of the objectives of the in-house unit is to ensure that all graduates leave the university with an adequate appreciation of the nature and implications of the disease, and with a sensitivity to the plight of people living with HIV/AIDS. One of the ways of achieving this objective has been stated as "encouragement of academic staff to incorporate HIV/AIDS into curricula in innovative and useful ways". (The office of the Vice Chancellor, University of Natal, 2001, p14)

HIVAN also houses the University of Natal's Campus Support Unit. One of the objectives of this unit is to "provide support for curricula innovation in the area of HIV/aids". The methodology to this is explained in a statement from HIVAN, "This initiative has begun with an audit of existing efforts to mainstream HIV/AIDS and programmes currently being offered on the Durban campus. A meeting has already been held with deans at the university to introduce the integrating HIV/AIDS into the curriculum. It was suggested at this meeting that further meetings be scheduled with heads of school. It is anticipated that once links have been established with heads of school, HIVAN will facilitate a series of consultative workshops to be held with teaching staff to discern how best HIV/AIDS can be incorporated into the curricula". (Leclerc-Madlala & Frizelle, 2002)

Following on from this, the vision statement of the University of Natal can be quoted as follows:

The University of Natal... dedicates its excellence in teaching, research and development to progress through reconstruction...it undertakes quality research to national and international standards and provides development services which meet community needs...it aims to be a socially responsive institution, reacting ethically and intellectually to the many problems of South Africa and the rest of the world.

(Vice Chancellor, University of Natal, 2001)

Never has there been a more dire need for the university to actualise these commitments than in the context of the HIV/AIDS crisis in KwaZulu Natal, and in sub-Saharan Africa.

Research already conducted by universities is impressive and significant. Clearly there is need for more research at university level and for the university to address critical issues posed by HIV/AIDS and to connect its teaching and research in creative and effective ways with people and communities.

Cohen states that

Activities implemented now, that focus on behaviour change and that are based on realistic understanding of the changes required to reduce the spread of infection, will generate enormous benefits in terms of avoidance of future costs.... The returns from effective HIV prevention activities in all countries, with high or low seroprevalence, will in most cases substantially exceed those from other investments.

(Cohen, N.D., cited in Otaala, 2001, p51)

1.3 Overview Of The Dissertation

The following chapters document how this research was carried out and what the main findings were. In chapter two you will find a description of the methodology used to undertake this research, this includes the selection of the sample, collecting the data, and how the data was used. In chapter three I have reviewed the literature pertaining to this topic. This chapter begins with an introduction, looking at literature supporting HIV/AIDS prevention programmes, it then goes on to discuss HIV/AIDS and education and HIV/AIDS and higher education. It then examines the literature on mainstreaming HIV/AIDS education and the teaching methods that might be applied. Chapter three finishes with some conclusions regarding the literature. In chapter four I have outlined the main research findings. This chapter begins with an introductory section in which the individual cases are introduced, it then goes on to present a summary of the data collected from the interviews; this summary is presented under each research question. In part three of this chapter I have described the different models of HIV/AIDS education currently being undertaken by using the case studies as examples. This chapter concludes by drawing out the main insights and by looking at the questions and surprises that arose. The final chapter, chapter five, draws out the main conclusions from this research and makes some recommendations for further work.

CHAPTER TWO METHODOLOGY

2.1 Paradigms

Adult Education is based on theories about how adults learn, what influences that learning and what is effective practice. Such theories are based on research. The term research may be used to describe any systematic information gathering activity, which is used to explore, explain or describe an issue, in order to generate knowledge. Research is an investigation into the real world; it is informed by values about the issue under investigation, it asks meaningful questions and it usually follows agreed practices. Research can also support, challenge, or generate new theory.

All research findings need to be interpreted within the specific theoretical framework in which that research was grounded. The particular use of theory will depend on the paradigm or 'school of thought' in which the researcher is working. When we look at the different methodologies used in research we are also looking at different paradigms – either an attempt to explain phenomenon following the procedures of natural science or an attempt to understand the world from the point of view of the people in it.

The positivist paradigm – explaining phenomena using principles of natural science – is associated with quantitative research methods. This is the gathering of hard data, which can be quantified in some way. Quantitative research attempts to measure aspects of a situation and to explain any differences in variables between groups or over time. Quantitative research tests a hypothesis, which is a suggested explanation of why differences occur. The interpretative paradigm aims to explore the meaning of phenomenon as experienced and perceived by the individual and is associated with qualitative research methods. These methods are about 'coming to know' the ways in which an issue is perceived by the people whom it affects. Through methods such as interviews, observation and case studies the researcher can 'come to understand' the perspective of the participants.

In addition to the different research paradigms there are also three different ways in which 'types' of research have been distinguished and the distinction between them focuses on the goals of the research. Firstly exploratory studies are used to make preliminary investigations into relatively unknown areas of research. Secondly descriptive studies aim to describe phenomenon accurately and thirdly explanatory studies aim to provide causal explanations of phenomenon. Each of the three types of research can be undertaken through quantitative or qualitative research strategies. (Durrheim, 1999)

This research was conducted in the interpretive paradigm and is a descriptive study aiming to describe in depth a small number of cases.

2.2 Quantitative & Qualitative

Durrheim explains that quantitative researchers collect data in the form of numbers and use statistical types of data analysis. Qualitative researchers collect data in the forms of written or spoken language, or in the form of observations that are recorded in language and then analyse the data by identifying and categorising themes. (Durrheim, 1999)

With Qualitative research methods, in contrast to quantitative methods, there is no assumption about what are the important issues, which are then confirmed or disproved. Instead qualitative methods are inductive. Plausible explanations for people's views and experiences are induced from the mass of data these methods can generate. This approach has also been called 'grounded theory' because the theory is grounded in and emerges from real life experience. (Glaser and Strauss, 1986)

This research represents a qualitative study. Merriam and Simpson also state that qualitative research is primarily an inductive research strategy. Typically the researcher presents the findings in the form of categories, concepts, hypothesis or theory, which have been inductively derived from the data and that sample selection in qualitative research is purposeful not random. Qualitative research is especially well suited to investigations in applied fields such as adult education because we want to improve practice. Qualitative research has also been termed naturalistic inquiry, interpretative research, field study, phenomena-logical research, participate observation and inductive research. The key philosophical assumption, upon which all types of qualitative research are based, is the view that reality is constructed by individuals in interaction with their social worlds. The overall purposes of qualitative research are to achieve an understanding of how people make sense out of their lives, to delineate the process of 'meaning – making' and to describe how people interpret what they experience. (Merriam and Simpson, 1995)

As explained by Merriam and Simpson, qualitative research is an umbrella term that covers several distinct forms of research. Three of the most common types are ethnography, case study and grounded theory. The three methods are described briefly below:

- Ethnography is the research methodology developed by anthropologists to study human society and culture. Ethnographic techniques are the methods researchers use to uncover the social order and meaning a setting or situation has for the people actually participating in it. The five procedures commonly used in this type of investigation are: participant observation, in depth interviewing, life history, documentary analysis, and investigator diaries. In

ethnography the account of the data interprets that data within a sociocultural framework. Ethnography has as its intent the interpretation of a situation that incorporates the participant's symbolic meanings and ongoing patterns of social interaction.

- The 'Case Study' is an intensive description and analysis of a phenomenon or social unit. By concentrating on a single unit or 'case' this approach seeks to uncover the interplay of significant factors that is the characteristic of the phenomena. The case study method can be appropriately used in many fields, as the case study is a basic design that can accommodate a variety of disciplinary perspectives. Case study, which has as its purpose the description and interpretation of a unit of interest, can result in abstractions and conceptualisations of the phenomenon that will guide subsequent studies. We shall go on to discuss the case study method in more detail later in the text.
- Grounded theory is a distinctive research method in which the mode of investigation is characterised by inductive fieldwork rather than testing a hypothesis. The end result of a grounded theory study is the building of theory – theory that emerges from or is grounded in the data. Grounded theory research emphasises discovery and description and verification are secondary concerns.

(Merriam and Simpson, 1995)

The fact that with qualitative research, selected issues can be studied in depth, openness and detail is explained also by Durrheim. He states that the themes of qualitative research are that it is:

- Naturalistic, real life situations as they unfold naturally.
- Holistic, the whole phenomenon under question is taken as a complex system that is more than the sum of its parts and
- Inductive, immersion in the details and specifics of the data to discover important categories, dimensions and interrelationships. It begins by exploring genuinely open questions rather than testing theoretically derived, deductive–hypotheses.

(Durrheim, p43, 1999)

2.3 Research Into HIV/AIDS

If we look at the example of research into the spread of HIV/AIDS we can see how different paradigms or schools of thought determine what is to be studied. Most research into the spread of HIV/AIDS has been concerned with discovering the incidence, prevalence and distribution of HIV/AIDS in the population over time. By comparing the proportion of infected people engaging in different risk activities, attempts are made to correlate risk of infection with behaviour. This knowledge can be used in the targeting and design of health education messages. Epidemiologists can also evaluate the effectiveness of health promotion activities by charting rates of HIV infection against interventions.

Gary Dowsett who designed research programmes for the World Health Organisation (WHO) 'Global Programme on AIDS' has commented on the need for more close focus research which looks at contexts and social situations in which people make sexual decisions:

“Utilising precious research resources to maximise the measurement of HIV infection and AIDS in any one country will not greatly enhance the prevention and care/support response. A less exact and more general idea of HIV/AIDS prevalence/incidence will, when coupled with well-theorised understanding of sexual and drug use cultures or contexts, offer far more useful starting points for action than all the surveillance data in the world”. (Dowsett, 1995, p31)

As I have said this research study in the field of HIV/AIDS education was approached from an interpretative paradigm, with the aim of understanding the multiple issues in context and interpreting meaning from these issues. The object of study in this research was “the ways in which HIV/AIDS education in academic curricula is taking place”. I have examined the specific links between subject matter in the different disciplines and HIV/AIDS. I have looked at how different disciplines relate to HIV/AIDS issues, what chunks of knowledge different disciplines select and whether they attempted to get students to relate disciplinary knowledge to HIV/AIDS in order to make really useful new knowledge. Through researching different schools within the university I have document a variety of different and innovative ways that HIV/AIDS education can be incorporated into the curricula and site these as examples of good practice.

I hope that the findings from this research will have a practical application, in that they can contribute towards practical issues of developing policy on HIV/AIDS education within academic curricula. In order to carry out this research an inductive, qualitative approach was required. I used an exploratory study to make preliminary investigations into this area of research. In Kevin Durrheims paper on research design he describes this type of study as open and flexible. He says exploratory studies adopt an inductive approach as the researcher makes a series of particular

observations, and attempts to patch these together to form more general but speculative hypotheses. (Durrheim, 1999)

2.4 The Case Study Approach

The type of qualitative research carried out for this study was the case study approach. One of the reasons I chose this method was that with a case study the selection of the sample is done purposefully, not randomly. Stake states that a case study is not a methodological choice, but a choice of object to be studied; we choose to study the case. Ultimately we may be more interested in a phenomenon or a population of cases than in the individual case. We cannot understand this case without knowing about other cases, but for the time being we are concentrating on this case. (Stake, 1994)

Stake also goes on to explain different types of case studies. Firstly is the 'intrinsic case study', in which a study is undertaken because one wants better understanding of a particular case, the case itself is of interest. Secondly, is the 'instrumental case study', in which a particular case is examined to provide insight into an issue or refinement of theory? The case is of secondary interest. The case may be seen as typical of other cases or not. Thirdly, researchers may study a number of cases jointly in what is termed a 'collective case study'. The cases are chosen because it is believed that understanding them will lead to better understanding, perhaps better theorising, about a still larger collection of cases. Other forms of case study worth mentioning are the 'teaching case study', used to illustrate a point, also television documentaries and biographies and case studies used in the practice of law. (Stake, 1994)

In this study I used what Stake describes above as an 'instrumental case study'. Although the cases being studied were modules offered at the University of Natal, the issue that I was interested in was HIV/AIDS education. I hoped to gain insights into the linking of HIV/AIDS education and academic curricula.

The case study method, as a legitimate research tool, has been somewhat criticised in the past. In the paper 'Evaluating and Rethinking the Case Study', Randy Stoecker explains how the case study fell out of favour and was critiqued as lacking internal and external validity. She then goes on to explain that by clarifying the purpose of case studies, emphasising theory and history and by insuring quality of information, the case study is the best way by which we can refine general theory and apply effective interventions in complex situations. (Stoecker, 1991)

We could also ask the question "Are case studies only useful to the particular case or are they also useful to others? Can generalisations be made from them?" John Elliot discusses this point and the external validity of case studies. He states that one criticism often made of case studies operating at an experiential level of description, is that they can only have validity for the participants in the situation described. In

other words they cannot be generalised to other instances. He states that the more objective a study the more externally valid it may be for outsiders. He also states that the theory embodied in an experiential study can be useful in other situations i.e. in ways, which throw new light on the situation and help them to generate a new theory about it. (Elliott, 1991)

2.5 Dilemmas Of The Case Study Approach

Although I have used the case study method I am aware of the dilemmas involved. In Rob Walkers paper entitled, 'Rethinking Educational Research' (Walker, 1980) he looks at the dilemmas in carrying out case study research. He explains that the central dilemma starts from a double-bind. First is the commitment to studies of the individual instance, to confront what is actually happening in some level of detail. This problem is less about theory and more about access to information. Second is a commitment to forms of research that start from educational practices. This involves us in a form of action research that attempts to inform decision taking and policy making. These aspirations conflict, in that the first tends to push us towards long-term immersion in the field and the second towards short-term styles of reporting with little time to check interpretations. This was, to some extent, the case in this research and I have attempted to overcome these dilemmas.

A further dilemma when carrying out case study work is the issue of confidentiality. For the case study worker confidentiality represents a continuous concern at every stage of the research including interviewing people and writing up responses. At the interview stage, with almost every encounter the case study worker must continually monitor what is said in order not to breach the confidentiality given to other participants. Clearly there is a need for continual negotiation regarding confidentiality throughout the process. Many case studies rely heavily on unstructured interviews. Often in this sort of interview situation most people will reveal things they do not intend. It is only by allowing retrospective control of editing and release of data can the case study worker protect subjects from the penetrative power of research as well as checking misinterpretations or misunderstandings. Ethically this involves taking the view that people own the facts of their lives and should be able to control the use that is made of them in research.

Other dilemmas that may pertain to case study research include: To whose needs and interest does the research respond? Who owns the data? Who has access to the data? What is the status of the researchers interpretation of events vis-à-vis the interpretations made by others? What obligations does the researcher owe to his subjects, his sponsors, his fellow professionals, and others? And lastly, Who is the research for?

Although there are many considerations to take into account with the case study method of research, it was my preferred method of research for this particular issue. Robert Yin states that,

‘Case Studies are the preferred strategy when ‘how’ or ‘why’ questions are being asked, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real life context’. When comparing case studies with other research strategies it was once thought that case studies were appropriate only for the exploratory phase of an investigation, that surveys and histories were appropriate for the descriptive phase, and that experiments were the only way of doing explanatory or causal inquiries. Researchers now feel differently and it is generally agreed that case studies can be used for description and explanation also. (Yin, 1994)

In investigating other research in this field it is interesting to note that the case study method has been the preferred method throughout. I would like to link this back to what Dowsett noted earlier in the text

“Utilising precious research resources to maximise the measurement of HIV infection and AIDS in any one country will not greatly enhance the prevention and care/support response. A less exact and more general idea of HIV/AIDS prevalence/incidence will, when coupled with well-theorised understanding of sexual and drug use cultures or contexts, offer far more useful starting points for action than all the surveillance data in the world”. (Dowsett, 1995, p31)

The case study approach is ideal for such ‘close focus’ research.

2.6 My Approach

I will now move on to look at how I used the case study method of research for my study. The focus of my research was to ‘investigate the different ways of linking HIV/AIDS education with academic curricula at the University of Natal’. This research aimed to flag up ‘examples of good practice’ in linking HIV/AIDS with the different curricula, and also to look at some of the obstacles the different academic departments may have encountered in trying to incorporate such education into their curricula.

The case study method highlights some major responsibilities and options for the researcher; these are listed by Stakes and include:

- Bounding the case, conceptualising the object of study
- Selecting phenomena, themes or issues – research questions to emphasise
- Seeking patterns of data to develop the issues
- Triangulating key observations and bases for interpretation
- Selecting alternative interpretations to pursue
- Developing generalisations about the case.

- How much to make the report a story
 - How much to compare with other cases
 - How much to formulise generalisations or leave that to the readers
 - How much to include description of the researcher as participant
 - Whether or not and how much to anonymise
- (Stakes, 1994)

Throughout this chapter I have attempted to deal with the first of these options. I will now move on to looking at some of the others. Below I have outlined how I proceeded with this study:

2.6.1 Sample Selection

Even though the case is decided in advance, there are subsequent choices to make about persons, departments, processes etc to sample. Often with quantitative research the main concerns in sampling are representativeness and the size of the sample. In reality sample size is often determined by practical constraints i.e. access, time, money. This research did not draw large or random samples; purposeful sampling was used.

This research started with a search of the HIVAN database to find lecturers with programmes that are undertaking some form of HIV/AIDS education. I then sent an Email to the lecturers on this list explaining my study. From this initial search I gained a number of interesting contacts, who were then able to direct me to further contacts within the university. In a number of circumstances I made contact with lecturers by ‘cold-calling’ the school or faculty. I ended up with an initial sample of seventeen lecturers based across fourteen schools or programmes and spanning seven faculties. The sample included lecturers from the Faculties of Community & Development, Human Sciences, Law, Management Studies, Engineering, Medical Sciences, and Education. (See appendix I)

As Durrheim states “ It is better to focus your research question in such a manner that you can explore in detail a small instance of a phenomenon rather than attempt to study a large issue with an inadequate sample”. (Durrheim, 1999, p45)

2.6.2 Data Collection

Merriam and Simpson explain that in all forms of qualitative research the researcher is the primary instrument for data collection and analysis, this carries with it a responsibility to identify ones shortcomings and biases that might impact on the study. One does this not to make a qualitative study more objective, but to understand how ones subjectivity shapes the investigation and its findings. (Merriam and Simpson, 1995)

Another characteristic of qualitative research is that it usually involves fieldwork. The researcher physically goes to the site, the group, the people or the institution to collect data. There are three basic ways to collect data in qualitative research – interviewing, observation, and documents. For this research I used a number of methods of data collection. The first data collection method used was to carry out semi-structured interviews with the lecturers in the sample. This method was the prime method and the vast majority of the data was collected using this method. The following methods were mainly used for triangulation purposes although a number of new insights were made from these. The Second method used then was to review printed material made available to me from a number of the lecturers interviewed. This was mainly course outlines but in a small number of cases also included reports on the HIV/AIDS modules. The third method used was to observe a number of the chosen programmes and following this observation to interview students about the HIV/AIDS education. (See appendix II – Interview Questionnaires)

The semi structured interview technique is a good technique for assessing facts, attitudes and opinions. The advantages of this method are that the researcher interacts directly with the participants, which permits assessment of non-verbal communications and encourages participation. Semi structuring the interview can make it easier to code and analyse. Allowing for some unstructured part of the interview requires intuition from the researcher but allows the researcher to probe for a more in depth response and richer data. The disadvantages are that the researcher has less control of the interview and data can be difficult to code record and analyse.

I did not distribute a questionnaire throughout the university. One reason for this was the poor response rate and the lack of interaction between the subjects and myself as the researcher. It is worth mentioning here the constraints experienced in undertaking the case study at the University of Namibia, outlined in chapter three. A questionnaire on the impact of HIV/AIDS and department responses was sent out to all academic and administrative staff, including the top administration of the university. Of the four hundred questionnaires sent out, only four returns were received. The reasons for the poor response rate are not evident in the report but one can only guess at apathy. This exercise was then followed by individual visits to identified persons.

2.6.3 Data Analysis

In an interpretative study there is no clear point when data collection stops and analysis begins, rather there is a gradual fading out of one and fading in of another. During this phase researchers often begin to formulate hypothesis about what the data might mean.

Data analysis involves reading through the data repeatedly to enable the researcher to immerse themselves in the data and become fully familiar. Breaking down the data and inducing themes, coding, building up the data – elaboration, interpretation

and checking are all important. As soon as you begin to collect data you can start to explore what it is telling you, although the picture will probably keep changing as you collect information.

A good method for doing this is the index card method described by Guba and Lincoln (1981, cited in Merriam and Simpson, 1995). In this method items of information from interviews are abstracted onto index cards. The first card begins the first pile and the subsequent cards are assessed to determine whether they are similar or different from the first. If similar they are placed onto the first pile, if different a new pile is formed. Each pile is given a name, which becomes the category. As new data is collected the categories become refined and reinforced. This procedure is essentially inductive and results in the uncovering of new categories and concepts.

Initially I have presented the findings of this research by documenting and summarising the responses to each research question. In order to make for an easy overview of the findings for the reader I have drawn up a table under each research question, these tables list the responses to the research questions. I then go on to look at the different models this research has shown for teaching HIV/AIDS education. I have taken each model in turn and shown how it works in practice through giving a detailed description of the example cases. As this is a largely descriptive study the findings are presented in a very descriptive manner. Following this I have attempted to tease out the main features of these HIV/AIDS programmes and to document the main insights emerging. Looking back at the literature reviewed in this field, I have then attempted to review the responses in terms of what was said in the literature regarding HIV/AIDS education. I have also outlined the questions and surprises brought to light by this study and have attempted to draw some conclusions regarding the teaching of HIV/AIDS within academic curricula. Finally, in the light of the findings, I have made recommendations for future work in this field.

It was impossible from this study to say which programmes work better than others with regards to the teaching of HIV/AIDS education. What I have merely attempted to do is to describe the methods and approaches used at present in order that others wishing to undertake similar programmes may review these.

2.6.4 Triangulation

Triangulation is a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation. Triangulation serves to clarify meaning by identifying different ways the phenomenon is being seen. There are a number of ways that triangulation can take place, these include:

- Data triangulation – variety of times, different locations, different people.
- Investigator triangulation – many researchers

- Methodological triangulation – combination of methods to generate data
- Theory triangulation – more than one approach different eyes.

In this research I have used data triangulation, through speaking to lecturers and students within departments and methodological triangulation, through looking at documentation and attending lectures.

2.6.5 Data Presentation - Reporting

Case study narratives should be highly readable, descriptive pictures of the phenomenon under investigation. It should take the reader into the case and offer rich detailed information. Case study narratives can often be lengthy documents, which policy makers and others have little time to read. I have endeavoured to present the facts in a clear and concise manor, and to present what is happening in each department. I have also tried to cite examples of what is happening in practice with regard to the different responses and to outline the main features of these programmes. There is a need to share experience and foster initiatives that have the greatest chance of impacting on the university population and its HIV infection rate.

2.6.6 Ensuring Confidentiality - Ethical Considerations

With qualitative research those whose lives and expressions are portrayed may risk exposure and embarrassment or loss of standing, employment, and self esteem. Issues of observation and reportage should be discussed in advance. Limits of accessibility should be suggested and agreements heeded and I have already discussed confidentiality to a degree earlier in the text, (see page six).

2.7 Conclusion

As Stakes (1994) says, “The purpose of case study is not to represent the world, but to represent the case”. I hoped that by following the above approaches, the information gathered from this research has been useful and that I have represented the cases as fully and accurately as possible.

CHAPTER THREE LITERATURE REVIEW

3.1 Introduction

When heads of state and representatives of governments assembled at the United Nations from the 25th to 27th June 2001, for the 26th Special Session of the General Assembly, to review and address the problem of HIV/AIDS, they made the following Declaration of Commitment on HIV/AIDS:

‘Prevention must be the mainstay of our response, by 2005, (we will) ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV/AIDS education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers’ (United Nations, 2001, p2)

The World Health Organisation also agrees that prevention of HIV infection is a priority, particularly amongst young people. WHO has stated one of its aims as working with partners to meet international development targets, including reduction of HIV incidence among young people by 25% in the worst affected countries by the year 2005. WHO states that it is supporting its Member States in ensuring that young people have the knowledge and skills they need to protect their sexual and reproductive health. (WHO, 2001)

These statements from the UN and WHO are bold indeed but clearly get the message across that prevention is a top priority. Whiteside and Sunter, in the book ‘AIDS the challenge for South Africa’ state that ‘each year a new cohort of young people are growing into adulthood and sexual activity. They can, and should, be kept HIV-free’ (Whiteside, Sunter, 2000, p137) Preventing new infections must remain our top priority, but as they point out, identifying prevention as a goal is the easy part, the difficult part is knowing what to do. Most adults today are sufficiently aware of HIV/AIDS but we need to move beyond awareness to a deeper understanding.

The literature shows that various organizations and institutions have attempted to respond to the prevention of HIV/AIDS. Different sectors have responded to the HIV/AIDS crisis in different ways. In 1998 the South African Department of Health commissioned a booklet entitled ‘Communicating Beyond AIDS Awareness - A Manual for South Africa’. The overall emphasis of this manual involves the understanding that for social change to take place, a carefully planned integrated approach must be taken. It states that if we are to inspire a social movement where people feel passionately about health, human rights and self-empowerment, there needs to be an environment that supports this consciousness. There is a need to

provide a framework of support for social action, where individuals and communities are in a position to mobilize around issues that affect their lives. (Parker, Dalrymple and Durden, 1998)

Within the higher education sector, 'Higher Education Against HIV/AIDS' is South Africa's first nationally coordinated programme, designed to improve the capacity of higher education institutes in preventing, managing and mitigating the impact of the HIV/AIDS epidemic. Launched in November 2001, the programme involves a partnership of three higher education organizations: the South African Universities Vice-Chancellors Association (SAUVCA), the Committee of Technikon Principals (CTP) and the National Department of Education (DoE). The programme provides support to all public universities, technikons and SADC partners. These institutions comprise more than 500 000 students and thousands of members of staff.

At university level there have also been a number of responses. The University of Natal has set up the Health Economics and Research Division (HEARD) and the KwaZulu Natal HIV/AIDS Networking Center (HIVAN) and the University of Pretoria has established the Center for the Study of AIDS. The Health Economics and Research Division at the University of Natal has assisted in putting together a range of documents entitled 'AIDS Toolkits'. The toolkits aim to assist Government Ministries or Departments to develop a sector specific response to the HIV/AIDS epidemic, to identify areas where they are vulnerable to the impacts of HIV/AIDS and to suggest steps that can be taken. (HEARD, 1999) Also as part of the current USAID project "Operationalising HIV/AIDS Issues for Development" which commenced early in 1998, HEARD identified a need for a much wider, expanded and more detailed series of documents. These were to encompass more aspects of AIDS interventions and preventions and would be targeted at specific groups. There are twenty-eight AIDS briefs in all, each written by an expert in the field, which offer sector-specific guidelines and responses for those involved in various professional, commercial and industrial endeavors. Checklists are a standard feature, enabling operatives to plot their progress against requirements unique to their sphere of activity, and suggesting innovative approaches. (HEARD, 2002)

The Center for the Study of AIDS at the University of Pretoria was established in February 1999, with the mission: 'To improve the quality of the response to HIV/AIDS in South Africa through the generation of innovative and relevant inter disciplinary research, to train the students and the wider community in HIV/AIDS education, counseling and conceptual skills... and to mitigate the effects of AIDS on individuals and society.' Ms Crewe, the Director of the center, believes that there is an urgent need for intellectual leadership in South Africa in order to develop and implement policy. Universities and Technikons have both a moral and economic imperative to act. The University of Pretoria is promoting AIDS courses in the curricula, integrating courses into the different degree structures and ensuring that when students move into the workplace they are able to make a valid contribution to workplace forums. (Crewe, 2001a) Crewe also says that in her experience when people hear that AIDS is the topic on the agenda there tends to be one of three

responses. The most common response is boredom – ‘we have heard it all before’, the second response is prejudice and hostility, and the third response is a kind of desperation, i.e. what about the orphans, the crisis, what about ‘them’? She goes on to state that she would hope there can be a forth response, that of ‘fascination and engagement’. She explains that all of us must overcome the fear of the disease, as this is a disease that is not simply a collection of physical symptoms, but it is also a disease that carries a collection of socially constructed meanings. She believes that the first crisis of HIV/AIDS is the crisis of our response. Crewe states ‘Only when we start to get young people to debate AIDS as a social, cultural, fascinating reflection of our times and who we are, disassociating it from sex and judgement, only when we find the ways to talk amongst ourselves about sex and diverse sexuality will we unlock the fascination about who we are and our real identities. Only when we can debate HIV/AIDS in the context of optimism have we moved out of myth and into reality’. (Crewe, 2001b)

3.2 HIV/AIDS And Education

There has been a substantial amount of research undertaken in the field of HIV/AIDS in sub Saharan Africa in recent years. Most of this research mentions the role education has to play in the new AIDS infected world we live in. Learning institutions cannot be the same as those in an Aids free world – challenged by this pandemic the paradigm of education is changing.

The foreword of the July 2002 edition of ‘Perspectives in Education’, states that the general agreement, at both national and international levels, is that there are four principal areas of concern for educators. These are:

- Prevention, helping prevent the spread of aids
- Social support, working with others to provide care and support
- Protection - protecting the education sectors capacity to provide adequate levels of education and responding to new learning needs
- Management – managing the education sectors response to the crisis.

Educators must of necessity move from a narrow ‘HIV Education Curriculum Campaign’ towards a broader ‘HIV and Education’ campaign. A broad multidisciplinary approach by educators to the pandemic is essential. (Coombe, 2002, p viii)

Moving from a narrow health and life skills curriculum approach towards a new perception of ‘HIV and education’ in its broadest sense requires a clearer understanding of what that broader sense entails. Carol Coombe of the University of Pretoria envisages things such as: creating an HIV/AIDS knowledge bank serving all disciplines, training for a predicted labour shortage, coping with changing training requirements (more specialists required in health and social welfare etc) and planning to mitigate HIV’s impact through labour law, codes, regulations, counseling, testing and treatment, to be at the core of what is required. (Coombe, 2001)

Coombe also believes that we need to understand the pandemic in a more orderly way and to look at what are the practical questions that must be asked about 'HIV/AIDS and education' She states that we need much more quantitative and qualitative information specific to the education sector, this includes: rates of prevalence for various groups of learners and educators; attrition, attendance, enrolment, dropout and completion rates; education costs; changing education requirements; the complexity of grade cohorts; how existing knowledge and value systems complicate life skills teaching; and the current state of AIDS orphans. Such information needs reporting, disseminating, collating and archiving information. Even more important, such information must be analysed if it is to contribute to our understanding of how the pandemic threatens the education sector. We need to be able to evaluate potential strategies and programmes, as well as implementation procedures and practical success stories. Only in this way will it be possible to be creative and flexible in providing education in increasingly complex environments, to increasingly complex cohorts of learners. Together a holistic approach by the sector to problems in the sector is now required. (Coombe, 2000a)

Coombe asks the question 'What do we need to achieve in practice in the next decade, 2000-2010?' She answers that education has a long-term contribution to make to HIV/AIDS impact reduction by helping to reduce poverty and ignorance, discrimination and inequality. Within the next decade, Coombe states that there are perhaps four very specific practical goals for the education sector with regard to HIV/AIDS. These are:

- (a) *Learning*: to collect as much information as possible about the pathology of the disease, and disseminate what is known through the education sector.
 - (b) *Preventing and controlling*: to continue to support government policy on preventing and controlling the spread of HIV/AIDS by making systematic interventions: teaching the principles of safe sex to learners in schools and institutions (Life Skills curriculum for example); providing guidelines to all educators about the disease and how they can protect themselves and children under their care (HIV/AIDS Emergency: Guidelines for Educators; workplace policy and regulations for example); providing support for learners and educators who are infected or affected by HIV/AIDS (counselling; culture of care in schools and institutions; school support units for example); applying constitutional, human and other rights related to HIV/AIDS prevalence rigorously and consistently in schools and institutions (analysing the law; applying the law and regulations which interpret it; providing guidance to all those responsible for interpreting and applying the law for example).
 - (c) *Understanding*: to accept that the pandemic has not been halted or even slowed, that we have to learn to live with it, that it is not 'business as usual', and in so doing, to understand how HIV/AIDS affects our educational environment and make plans for factoring it into educational planning for the future.
 - (d) *Responding*: to seek ways to stabilise the education system before it is further compromised by the pandemic, in such a way as to sustain an adequate and acceptable quality and level of education provision.
- (Coombe, 2000b, p4)

The World Education Forum held in Dakar in April 2000, noted that a key objective of an international strategy must be to realize the enormous potential that the education system offers as a vehicle to help reduce the incidence of HIV/AIDS and to alleviate its impact on society. (UNESCO, 2000a, p23, cited in Coombe and Kelly, 2001) But more soberly the Forum Final Report also recalls UNAIDS Executive Directors statement that AIDS constitutes one of the biggest threats to the global education agenda. In other words, what HIV/AIDS does to the human body, it also does to institutions, it undermines those institutions that protect us. (Coombe and Kelly 2001))

These two perspectives – education as a vehicle for reducing the incidence of HIV/AIDS and education as itself being threatened by the disease – run through much of the literature on the role of education in a world with AIDS. (Cf Coombe, 2000a, Kelly 2000) It could be suggested then that education systems must first secure themselves against the onslaught of HIV/AIDS before coming to the assistance of their clientele. An education system which does not protect itself against HIV/AIDS will not be able to serve as a vehicle for reducing the incidence of the disease.

Coombe and Kelly (2001) state that at the level of pedagogy and the curriculum, responding creatively to HIV/AIDS necessitates considerable adjustment and reform. In the context of HIV/AIDS, curriculum must extend further than the development of knowledge, and address attitudes, values and lifeskills needed for making and acting on the most appropriate and positive health related decisions. This is critically important in equipping individuals for their personal combat against HIV/AIDS. They also state that other responsibilities such as: Replenishing the skills being lost through premature deaths of skilled and qualified adults, transmitting skills to young people when the practitioners who should pass on the training are no longer alive, and preparing young people, for the immediate assumption of adult economic responsibilities e.g. as heads of households, are equally important.

Evidence is accumulating that education helps individuals protect themselves against HIV infection, (Fylkesnes et al, 1999). But how does education protect against infection.

Vandemoortele and Delamonica (2000) provide some direct and indirect evidence that points to a changing social profile in the disease, and assert that this is due to the increased knowledge, information and awareness which education provides. However they are at pains to point out that the evidence does not allow us to conclude exactly how the education- vaccine against HIV works. In Coombe and Kelly (2001) the question has been asked ‘does education protect against HIV infection because of the health skills and HIV/AIDS education that are provided, or is there something inherent in the very process of becoming more educated that equips individuals with the skills and motivation to protect themselves against infection?’ They go on to explain that there is no universally agreed answer, though

clearly both aspects are important. Almost certainly, however, the general impact of education in itself is the most significant factor. The reason for this view is that the positive correlation between level of education and HIV infection or high risk behaviour is changing even among those whose formal education included little if any health skills and AIDS information. But what seems to be the greatest significance in reducing HIV/AIDS vulnerability is the fact of being educated, of having attended school for a certain number of years.

Before trying to unravel some of the mechanisms that may be at work here, it is worth noting somewhat similar effects in relation to both poverty reduction and improved health. It may well be the same in the case of HIV infection. Vulnerability declines with years of education, but how exposure to education and training works to bring about this decline is far from being clear. Part of the reason, however, may lie in the way that education brings about changes in the information handling, affective and socio-cultural domains. As education becomes more widely diffused in a community, it becomes more acceptable that women and girls should be more involved in decisions affecting themselves and ultimately affecting their sexual and social lives. It was interesting to note that the literature on HIV/AIDS and educated focused almost entirely on prevention with no specific mention of education regarding treatment.

3.3 HIV/AIDS And Higher Education

Higher Education is shifting away from elite and insular institutions towards more open and responsive systems of teaching and learning. A new mode of knowledge production has emerged – different from disciplinary science and research. It's intrinsically trans-disciplinary, trans-institutional and heterogeneous. This new mode of knowledge production has been referred to as Mode 2 and is stated as 'problem-solving knowledge'.

One of the key features of this new system is responsiveness to society and economy and a move away from insular knowledge to socially useful knowledge and social accountable knowledge. (Kraak, 2000)

Some of the most important research that has taken place, regarding HIV/AIDS in Universities, is explained in a report by Kelly (2001) entitled '*Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV/AIDS*'. Kelly explains that, in response to concerns expressed by the Association for the Development of Education in Africa (ADEA), at its Johannesburg Biennial in December 1999, the ADEA Working Group on Higher Education (WGHE) commissioned a number of case studies on the impact of HIV/AIDS on universities in Africa. The purpose was to generate understanding of the way the disease is affecting African universities and to identify responses and coping mechanisms that might profitably be shared with sister institutions in similar circumstances.

This report draws upon case study reports commissioned by the WGHE at seven universities in six countries – Benin, Ghana, Kenya, Namibia, South Africa and Zambia. Each of the case studies follows the same format and addresses the same six questions:

- In what ways have the universities been affected by HIV/AIDS?
- How have the universities responded to the presence of the disease?
- What steps are they taking to control and limit the further spread of the disease in their communities?
- What HIV/AIDS-related teaching, research, publications, and advisory services have the universities undertaken?
- How do universities propose to anticipate and address the larger impact of HIV/AIDS on the national labor market for university graduates?
- Should universities increase access to their courses, including distance education courses, to compensate for expected national losses in skilled professional personnel?

The seven case studies generally agreed that no one knows exactly what the HIV/AIDS situation is at their respective universities. A thick cloak of ignorance surrounds the presence of the disease on campus. The study also found that, although university students seem to be generally aware of the existence of HIV/AIDS and to know the basic facts about its transmission, they did not regard themselves as being seriously at risk of HIV infection. It also found that HIV/AIDS related services in universities focus mostly on students and they are essentially health centred. The main thrust of university information, education and communication efforts in relation to HIV/AIDS tends to occur in the brief period of student orientation at the beginning of the academic year. The report also found that no substantive changes in university academic policies or practices have yet occurred in response to the disease.

The report closes by outlining a two-pronged strategy for African universities to consider in shaping their own responses to HIV/AIDS. The two thrusts reflect the inward looking and outward-looking dimensions of the traditional university mandate and mission. The inward-looking dimension pursues the concern that a university should have to sustain itself as a functioning institution and keep itself in good working order. To this end, the report summarizes what inward-looking actions and strategies are needed. The outward-looking dimension relates to the university's core functions of teaching, research, and community service. Its discussion focuses on what is needed to produce quality graduates who have the skills and flexibility needed to understand and manage the HIV/AIDS crisis in their country. (Kelly, 2001)

One of the seven case studies, from the above study, carried out at the University of the Western Cape to investigate the impact of HIV/AIDS on the university was carried out internally by Dr Teresa Barnes of the Education Policy Unit at the University of the Western Cape. As above, The aim of the study was to develop an

understanding of how the disease is affecting universities and to identify responses of staff, students and management that will help develop effective policies and practices in other institutions facing similar circumstances. The ultimate goal of this study was to stimulate African universities to integrate HIV/AIDS fully into all aspects of their planning and operations. This study found that there was a 'silence' about HIV/AIDS on campus, in fact despite the fact that there are most probably thousands of HIV positive people on campus the study found that only one person had publicly declared their status. The study also found that concerned staff members have been at work for nearly the past two years developing a policy document on HIV/AIDS and that there are significant pockets of academic expertise in AIDS education and outreach in the university community. So far these have been largely initiatives directed only at specific groups of students. These initiatives are often completely unconnected with each other, due to the lack of a co-ordinating impulse across faculty and department barriers. (Barnes, 2000)

In a separate case study on the University of Namibia, Otaala reflects in the summary that the need for visible leadership from above (university administration) and resonance from below (the whole university community) is needed. It also states that there is a need for more co-ordinated research, more university wide workshops on HIV/AIDS, and the need for inter-faculty networking. (Otaala, 2001)

A more recent document, commissioned by the Association of Commonwealth Universities, entitled 'Commonwealth Universities in the age of HIV/AIDS: Guidelines Towards a Strategic Response and Good Practice', was put together by Chetty in April 2002. This document is designed to pose some key questions for institutional leaders such as: Why is HIV/AIDS an issue for Universities and what role can the university play? It goes on to explain that HIV/AIDS concerns universities for a number of reasons, namely, it is a development issue, not just a health issue, it affects not just individuals, but institutions and systems, it affects human resource development, the struggle against HIV/AIDS requires knowledge and lastly resources and successful institutional and societal responses to HIV/AIDS require leadership. (Chetty, 2002, p7)

Chetty also poses the question 'Why the need to change teaching and learning?' and says that the simple answer is: because living in a world affected by HIV/AIDS means that the needs of students and graduates and societies requirements of them are being fundamentally changed. It is only when this question of 'why teach HIV/AIDS' has been resolved that we can move onto a more sustained discussion about 'how we teach HIV/AIDS'. Providing knowledge, skills and values about HIV/AIDS through the curriculum has benefits that are both personal and professional. The personal benefit comes from being informed about how to understand HIV/AIDS, how to avoid infection, to reduce risk, manage living with HIV/AIDS and how to act as a responsible citizen in a world affected by HIV/AIDS. Though there is some consensus on the need for this level of intervention, it is fair to say that the results are unsatisfactory. The professional benefits to students and staff derive from being able to work effectively in an

HIV/AIDS infected society. To do this they must of necessity know how HIV/AIDS affects their discipline, profession and world of work and be able, in turn, to deploy their professional expertise to the betterment of that society. There are essentially two different imperatives here - prevention strategy or academic requirement. In some instances these can be addressed by a comprehensive approach, but the question will be raised and needs resolution in every case: what is our *raison d'être* for teaching HIV/AIDS? (Chetty, 2002, p25)

3.4 Mainstreaming HIV/AIDS Education

Mary Crewe believes that when the education sector did try to do AIDS education it did not think carefully enough how it should be done. What was not paramount was how to save lives, what was paramount in thoughts was how to maintain dignity and how to push a certain value system and ideologies. Crewe says she has no doubt that if people understand the disease in terms of their own professions they will start asking the question what can one do to avoid getting AIDS. That is what needs to happen to triumph over the disease. Crewe explains that at the University of Pretoria they are not going to tell students how not to get infected, instead they are going to prepare students and staff for a society that is going to be radically different from what is known. They are going to mainstream HIV/AIDS through every facet of campus life, including curricula. (Crewe, 2000)

In the same paper Crewe (2000) explains that the fundamental mistake we have made is to have targeted education at personal behaviour and risk taking. She says that given our failure to have effective sexuality education in the past and our failure in the smoking and alcohol campaigns, it is extraordinary that we tackled HIV/AIDS education in this way. What we need is to challenge our existing curricula and integrate HIV/AIDS education through all the subjects we are teaching – from the principles of coffin making in design and technology to the obvious ways in which it fits into all subject disciplines. HIV/AIDS is far too fascinating a subject in terms of its history, what it tells us about society, culture, racism and ourselves and its effects on our present and future to be relegated to the easy options. It also places an undue burden on lifeskills teachers. All teachers need essential training in the legal and ethical issues that the epidemic poses for their careers, their rights, duties and obligations in a world of HIV/AIDS. Many teachers have this already, but they will need greater skills as society comes to realise that it is teachers who are at the interface of this epidemic far more than nurses and doctors. (Crewe, 2000)

In the journal 'Perspectives in Education' (2002, p3) Kelly states that HIV/AIDS is too great to be merely bolted on as some additional consideration within the programmes. This is the most devastating disease that humanity has ever experienced. Responding to it is not an optional extra, but must be an integral and accountable part of concerns and programmes at all levels. Kelly also says that HIV/AIDS affects all sectors of society and responding to it demands the widespread participation and interaction of players from various areas of the public

sector, as well as the involvement of the numerous organs of civil society. It is paramount that in the struggle with HIV/AIDS the education sector manifest the full cooperation with these and other partners.

We also need to consider clearly the objective of preventive education programmes. Literature nearly always speaks about changing behaviour, but rarely about maintaining behaviour. The presumption appears to be that sexual behaviour, especially amongst young people is almost bound to be risky and hence needs to be changed. UNESCO's strategy for HIV/AIDS preventative education speaks of prevention as 'the most patent and potent response i.e. changing behaviour by providing knowledge, fostering attitudes and conferring skills' (UNESCO, 2001, 10, cited in Kelly 2002, 5). A more comprehensive approach is to see the ultimate objective as being to promote behaviour that will not put an individual or any partner at risk of HIV infection. Hence the thrust of educational efforts should be to empower those who participate in programmes to live sexually responsible, healthy lives. This implies understanding leading to practice, in two areas, sexuality and healthy living. These are the two areas around which programmes should be developed. (Kelly, 2002)

Moving on to look at the context for preventative education programmes, if it is to be effective a preventative education programme must be rooted in the context of the lives and circumstances of the target audience. According to Kelly the content of education programmes should include:

- Sexuality and relationships
- Respect and regard for others – equality and power sharing
- Knowledge and understanding of HIV/AIDS
- Popular myths and errors
- Psycho-social lifeskills for the promotion of health and well being – decision making, interpersonal relationships, self awareness, stress and anxiety management, coping with pressures, negotiation of contentious situations, assertiveness, self esteem and self – confidence
- Reproductive health
- The role and value of abstinence
- The meaning of protected sex
- Fidelity in marriage
- Information about counseling and testing
- The meaning of a healthy lifestyle

(Kelly 2002, p8)

Rugalema and Khanye believe that mainstreaming HIV/AIDS is a process of policy change in a systematic manner in order to achieve broad social goals of controlling the spread of the epidemic and mitigating its effects. In the context of the education sector we conceptualise mainstreaming as a deliberate and strategic change in policy to address the effects of HIV/AIDS in the education sector. Mainstreaming HIV/AIDS in education is basically an attempt to systematically integrate AIDS issues in education policies, programmes and projects in order to have an impact on

the epidemic. It is a process of designing programmes and putting in place structures to deliver such programmes. There have to be structures and resources to ensure that programmes are followed through and delivered, ideally a good mainstreaming exercise should adhere to three principles, namely:

- It should be systematic
- It should be based on a good situation analysis
- It should be dynamic – an evolving process

(Rugalema and Khanye, 2002, p 29)

In April 2000 the ADEA Secretariat invited African Ministries of Education to analyse the different interventions being implemented to control HIV/AIDS. The broad objective of the initiative was to identify promising approaches with the view of sharing knowledge and experience. Over 30 countries expressed the intention to join the initiative, less than 20 have submitted proposals to ADEA for funding. Information in the proposals submitted indicates that a lot of emphasis has been placed on programmes targeted at learners and most programmes are school based. The vast majority of approaches were curriculum based, however the most popular programmes for pupils were the extra curricular ones, ones organized for young people by young people. Evidence shows that while ministries of education have been strong in designing and implementing programs for learners little has been done for teachers and education managers. While programs for learners are justified their success depends on teachers and managers. Monitoring and evaluation of programs was generally weak and this is an area in need of urgent attention.

The ADEA exercise is still ongoing and lessons are emerging as many more countries complete their case studies. The implications of HIV/AIDS for the education system are also still emerging and so are the responses the concept of mainstreaming and its application are still evolving. However it is fairly clear that ministries of education have not completely grappled with the issues involved in mainstreaming HIV/AIDS in the education system. (Rugalema and Khanye, 2002)

3.5 Teaching Methods For HIV/AIDS Education

Traditionally, Educational Institutions have been in the business of transmitting knowledge. The most common practice is one of scientific experts presenting discipline specific knowledge, to be internalized by individual students and transferred at some point in the future to whatever new situations they face. (VonKotze and Cooper, 2000, p216) Educators and educational institutions are under pressure to design curricula that will serve national priorities to become more economically effective, efficient, competitive and flexible, and which favour instrumentalism and vocationalism over critical faculties. (Smyth 1996, cited in VonKotze and Cooper, 2000, p212) But university institutions can attempt to develop curricula that work towards greater inclusivity, combining the short-term goals of self-improvement with the longer-term goal of changing the social order. In such curricula, University Adult Education should not simply service the national

plan, it should foster in students critical questions, a desire to seek alternatives, and a sense of civic responsibility.

One method of education which is breaking with this tradition is that of 'Project Based Learning' (PBL), PBL offers a break with the cognitive learning model because the primary site of learning moves beyond the academy to organizations within civil society. It has been argued that 'Project Based Learning' has the potential of allowing students to construct new knowledge which is action oriented and socially relevant. (VonKotze and Cooper, 2000)

It is obvious that HIV/AIDS education must follow this route if it is to be successful.

Kelly, talks about 'Methodology, channels and communicators' and states that it is crucial that programmes on HIV/AIDS are interactive and participative, there is no room for passive learning. He believes that comprehensive programmes should include a number of the following:

- Formal classroom teaching-learning activities of an interactive nature
- Programmes for learners and educators provided by outside agencies
- Extra curricula activities and programmes
- Purpose designed programmes within communities
- Broader community education activities
- Intensive short workshop like activities
- Programmes organized by other organisations i.e. sports, youth, church and social service.

They should also take into account the important contributions that peer influence and people living with the disease can make to such programmes. (Kelly, 2002, p9)

In a review in 'Impilo' a Primary Health Care Magazine, it mentions that the frightening spread of HIV/AIDS has blown apart any assumption that it is enough simply to provide factual health information. Surveys particularly among young people brought the message home that just because a person is informed of the importance of using a condom does not mean they will use one. Efforts need to be made to find ways to engage more deeply with the views beliefs and feelings of young people. (Impilo, 2001)

A method that has been used successfully in HIV/AIDS education is 'Empowerment Theory'. Empowerment theory enhances collective action, provides opportunities to develop knowledge and skills, creates needed resources and shared control among teachers and learners. In Zimmerman's paper on an empowerment approach for prevention it states that a sense of control, skill development and supportive social networks are associated with health behaviour. (Zimmerman m et al, 1997)

Service learning is another approach that has been used in HIV/AIDS programmes. Service learning programs aim to equally benefit the provider and the recipient of the service as well as ensuring that it focuses on both the service being provided and

the learning that is occurring. It is this balance that distinguishes service learning from other experiential education programmes. (Furco, 1996)

In the document by Chetty (2002), there is also debate between proponents of formal and non-formal approaches to dealing with HIV/AIDS in the curriculum. Chetty states that though there is widespread agreement that university curricula should in some way reflect the impact of HIV/AIDS on our understandings of, and approach to, all disciplines, the mechanics of changing what is taught and how it is taught are far less straightforward. The range of options includes the following:

- provide education on HIV/AIDS through non-formal means as part of a prevention strategy (workshops, peer education programmes, extra curricular activities). If formalised, the skills gained in these activities could lead to a career path.
- infuse issues of HIV/AIDS across the curriculum as both prevention strategy and as an academic requirement
- devise core compulsory courses across all disciplines (prevention and academic requirement)
- implement compulsory courses which include HIV/AIDS issues within a life skills curriculum.

(Chetty, 2002, p25)

Chetty (2002, p27&28) outlines four of the various options that are now being tried in a number of institutions, these are:

- *An Integrated Model.* This places the onus on every faculty to ensure that students and teachers are AIDS literate and that HIV/AIDS is integrated into their degree structures. It is based on the proposition that HIV/AIDS must be made relevant to the life and career prospects of every student and that every university educator must take cognisance of the ways in which HIV/AIDS affect their discipline. Skills related to preventing and managing HIV/AIDS are developed in relation to career paths and marketability (Crewe, 2001). Engineering students, for example, have developed working models of home-based care kits, and human resource management students are ready to handle the reality of preventing and managing HIV/AIDS in the workplace immediately. These students represent the university as an institution producing socially responsible, flexible and professional graduates with skills that can be deployed immediately in the work environment. In the final analysis, this is approach at the University of Pretoria that depends heavily on executive leadership from the vice chancellor, AIDS specialists and executive deans.
- *Compulsory Model.* The *Sex and Risk Programme* at the University of Durban-Westville involves a foundation level course for all incoming students in which HIV/AIDS is part of a credit bearing life skills and risk reduction programme (UDW, 2001). The approach challenges both educators and students to work with a range of issues, which are much wider

than the biomedical aspects of the epidemic, and is targeted at providing students with knowledge about HIV/AIDS, increased awareness of risk and skills to make better choices in their social and sexual relationships. The requirement that students treat the subject as a conventional academic topic involving research, assignments and tests, has yielded very important feedback to the university on their levels of knowledge, their attitudes and skills to deal with HIV/AIDS. It also provides a conduit through which students can approach the network of services (such as counselling, testing and care) that are otherwise treated with some skepticism. In Kenya, Kenyatta University has also adopted the approach of requiring all undergraduates to complete compulsory courses on HIV/AIDS as well as offering certificate, diploma post graduate training in HIV/AIDS to teachers (Owino, P, 2001).

- *Non-Formal Model.* This involves recruitment and training a yearly cohort of students in various roles to work with their peers. Recruitment is through special interest activist groups; HIV/AIDS support groups or groups with a community outreach orientation. The programmes are typically voluntary, unpaid and target more senior students to work with new incoming students. Peer education and peer counselling approaches to HIV/AIDS have been especially successful in these initiatives and exemplify the strength of non-formal interventions. Peer education has numerous advantages. It has been used in institutional settings for many years to tackle substance abuse and other risky behaviours and can therefore be easily adapted to focus on HIV/AIDS. Experience proves that students learn more readily from their peers. Peer education strategies are low cost, flexible and can reach substantial numbers with little infrastructure. India's *Universities Talk AIDS* programme (UTA), initiated by government, is heavily reliant on peer education (Bhatt et al, 1997). A number of examples are to be found in African institutions, including the use of peer educators in a structured community engagement model. For example, *In But Free*, the prisons outreach programme of the Copperbelt University in Zambia uses peer educators and counsellors (Simooya, 2001). Non-formal peer education programmes can also run alongside a formal model. In some examples moves are being made to set formalised standards of practice and credentials which might define a career path based on the skills students gain in non-formal programmes (SAUVCA, 2001).
- *Specialised Courses* – There are two possible options: the first is that programmes can be offered within any faculty or discipline as a qualification-bearing programme with a specific focus on HIV/AIDS. The programme may include content from a range of disciplines. The second is that elective or compulsory modules are built into degree structures as a discrete requirement with a specific focus on HIV/AIDS.

The report also mentions 'Distance Education' and asks what opportunities does Distance Education offer in a HIV/AIDS strategy? New distance education technologies and pedagogies now enable universities to reach a massively expanded number and range of students. Existing distance education infrastructure using print materials or electronic media can be adapted so that the same technology and the pedagogical power of distance education can also be harnessed against HIV/AIDS: to provide information and education on HIV/AIDS, to provide support services, to link distance learners to networks and to reach new communities where learners are located. (Chetty, 2002, p28)

3.6 Conclusions

Preventing HIV/AIDS has proved to be difficult. It has meant amongst other things, forging new links between sex, illness and death and encouraging the belief that solidarity, compassion and understanding are more appropriate to HIV/AIDS than discrimination and ostracisation. Early responses fed into the categories of marginalisation and social rejection, it was a disease of white gay men, of drug users and of prostitutes, of poor (black) people and foreigners. In meetings and in educational and social gatherings AIDS is discussed, but always at one removed.

As Kelly says,

'People have become so confused about aids, where it originated, what causes it and how it can be prevented, that they have ceased to hear the messages being conveyed. Senegal and Uganda have shown a better way forward. They agreed to sink difference by approving a common menu of approaches from which every group could choose and agreed to stay silent about approaches that caused misgiving or offence. This allowed government, civil society, traditional leaders and faith organizations to convey non-conflicting messages'. (Kelly, 2002, p11)

Gudmund Hernes, the HIV/AIDS coordinator for UNESCO's HIV/AIDS programmes and projects, reports UNESCO's ten lessons on HIV/AIDS. Lesson 6 states that inadequate or flawed knowledge is a major reason why the pandemic is out of control. Messages must be customized to recipients, taking cognisance of the understanding they already possess and the material context and social environment in which they live. Lesson 7, states that knowledge is not enough to change behaviour, the specifics of the social and cultural context within which communication takes place must be taken into account. Lesson 8 points out that preventative education works, if done right it is effective, if done immediately, it will have long term impacts, if done massively – intensively and extensively – it can turn the tide. Lesson 9 says there is no inherent conflict between prevention and treatment strategies. Treatment supplements and complements prevention, to create a holistic approach to management of the pandemic. And lastly Lesson 10 states that the response required is no single point programme and no single factor affair - we must all do our utmost to stop the spread. (Hernes, 2002, p 117)

This literature review has shown that developing educational responses to HIV/AIDS is as complicated as it is fascinating. We have seen that educational programmes that are striving to engage with the learners in a way that is real and relevant to their lives are what is required. This research aims to document such programmes in the hope that the ideology behind them can inspire others to do likewise. One of the main tasks of UNAIDS is to identify practices that work in responding to the HIV/AIDS epidemic, and to examine how and why they work. For UNAIDS the term 'Best Practice' means accumulating and applying knowledge about what is working and not working. In other words, it is both the lessons learned and the continuing process of learning, feedback, reflection and analysis. One approach to best practice is that it can be seen as anything that works, in full or in part and that can be useful in providing lessons learned. In summary the best practice process helps to identify and describe the lessons learned and the keys to success of any given project, programme or policy. (UNAIDS, 2002)

In undertaking this research study I have aimed to fill part of the gap that is the detailed information of how individual lecturers and programmes have responded to HIV/AIDS education. This research continues the work being undertaken by such people as Kelly, Crewe and Chetty and such organisations as HIVAN and SAUVCA, UDW and the University of Namibia.

CHAPTER FOUR RESEARCH FINDINGS

4.1 Introduction

This research really began with a search for a sample of lecturers within the university who were involved in teaching HIV/AIDS within academic curricula in some way. In order to find such a sample I began by speaking with the HIVAN team. The HIVAN Team had previously emailed questionnaires to every school and department throughout the university. The questionnaires were used to gather data with the aim of promoting cooperation and networking between people and organisations active in the field of HIV/AIDS. This exercise involved three different questionnaires, depending on the nature of the HIV/AIDS work being undertaken, one form was for individuals, one for organizations and one for specific projects. The forms collected data regarding the contact person, a description of the work being undertaken, who the work is aimed at and what specific activities the work is focused on i.e. awareness, counseling, medical. At the time of my contacting the HIVAN team, they had received only a small number of replies regarding the teaching of HIV/AIDS in the curricula. I then proceeded to contact the people on this list via email. From this initial search I set up interviews with eight of these respondents. With the help of these people I was able to make contact with other lecturers and set up interviews with them. (For a contact list see appendix I)

Data was collected using semi-structured interviews with both lecturers and students, (see appendix II) followed in some instances by observation. The student interviews were used to triangulate the findings from the lecturer interviews. In a number of cases I also gained access to documentation regarding the courses to review. (See appendices IV - X)

The findings outlined in this chapter represent the data collected from interviews within thirteen programmes throughout the university. For the purposes of writing up the results I have not included the schools of Mechanical Engineering and Electrical Engineering, as these schools were not actively involved in HIV/AIDS education within academic curricula at the time of speaking to them. The results that follow then represent the data from Eleven 'Case Studies'. As the purpose of this study was to look at different ways of teaching HIV/AIDS I selected these eleven cases as they appeared to represent a selection of different models of such education. These Eleven case studies fall into a number of faculties and schools across the university. Figure 1 shows the faculties and schools within which the lecturers and students I interviewed were based.

FACULTIES	SCHOOLS:
COMMUNITY AND DEVELOPMENT DISCIPLINES -	PSYCHOLOGY, ARCHITECTURE, URBAN PLANNING, COMMUNITY DEVELOPMENT AND ADULT LEARNING – ANTHROPOLOGY PROGRAMME,
ENGINEERING -	MECHANICAL, ELECTRICAL, CHEMICAL,
HUMAN SCIENCES -	INDUSTRIAL AND ORGANISATIONAL LABOUR STUDIES
LAW -	LEGAL STUDIES
MANAGEMENT STUDIES -	ECONOMICS
EDUCATION -	TEACHER TRAINING – EDGEWOOD CAMPUS, GENDER EDUCATION (M.Ed) – DURBAN CAMPUS
HEALTH SCIENCES -	MEDICINE

FIGURE 1

Although from the table above it may appear that the data collected fitted neatly into set schools and faculties in reality this was not the case. In many instances the lecturers I interviewed were based in one particular programme of a school but taught courses in other programmes and schools also and even in other faculties in a number of cases. For instance the lecturer I interviewed in the school of Industrial and Organisational Labour Studies (IOLS) teaches courses at both undergraduate and post graduate level, also teaches a variety of Masters Programmes and teaches Sociology. The Anthropology lecturer interviewed teaches in a variety of programmes, including research methods modules and stand-alone modules open to students across all faculties. This was also the case with the Economics lecturer who teaches a popular first year statistics course open to all students at the university. The results of the research interviews then are not so cut and dried and clearly defined as one might expect but rather a picture of what is happening in several faculties of the university.

The semi-structured questionnaire used was set around an introduction and eight main questions, which were based on my initial research questions. (See appendix III). The rest of this chapter has been divided into four parts. In Part One I have introduced the lecturers interviewed for this research. In Part Two I have given a brief overview of the main findings to the research questions. In Part Three I have gone on to explain the different 'Models' of integrating HIV/AIDS education in detail, including the purpose of the education, the aspects of HIV/AIDS covered, the teaching methods used to get students to relate disciplinary knowledge to HIV/AIDS, the positive features of the model and the problems and difficulties with such a model. In Part Four I have summarised the main insights gained from the research and also examined some of the questions and surprises the research has shown.

4.2 Part One - Introduction To The Cases

I began each interview by explaining the research being undertaken and then asked each interviewee to tell me a little about themselves and their work in general. As I had already established beforehand that each interviewee had an interest in HIV/AIDS and was including it in some way I did not need to ask if this was the case. During this introductory phase of each interview it was interesting to observe the degree of interest and engagement with HIV/AIDS the interviewees described.

In my very first interview I met with Ms Kerry Frizelle, lecturer in the School of Psychology. Kerry co-ordinates a community based learning module for 3rd year undergraduate psychology students (See appendix IV). Kerry is also the Counselling Coordinator for the Campus HIV/AIDS Support Unit at the University of Natal, Durban, and is very involved in HIV/AIDS issues at the university.

My second set of interviews was with a number of lecturers in the School of Law. Initially I met with Mr Jerome Singh, he explained that at the end of 1999 he sent a memo to the head of the school suggesting that they should do something about linking HIV/AIDS with the curricula. Jerome was then asked to begin work on this area. Jerome went on to tell me about the first year HIV/AIDS module for law students (see appendix V), but he also explained that there were other things happening within the department regarding HIV/AIDS education i.e. BIO/ethics, Law in medical practice, Insurance and Agency. Jerome introduced me to his colleague Ms Leslie Greenbaum; Leslie coordinates a first year module on HIV/AIDS for law students. Leslie explained that they were in the process of writing a student textbook on this subject but that it was not completed yet. Leslie then took me to meet Prof. Alan Rycroft. Alan is a professor in the law school and wrote the course for the first year module on HIV/AIDS as it is today and is the person writing the student textbook. Alan explained that he felt very responsible that this module should be run for students in the first year, woven in with legal cases/components, as it is such an important issue. Alan lectures on undergraduate and postgraduate courses and also co ordinates masters programmes. At the Undergraduate level he teaches: - Labour Law, Alternative Disputer Resolution, and Foundations of South African Law. At the Masters level he teaches: – Advanced Labour Law, Employment Disciplinary Law and oversees many research projects.

In the School of Education, Durban Campus I met initially with Prof. Robert Morrell who teachers a Masters Programme in Gender Studies. This programme includes an HIV/AIDS component. (See appendix VI) In the School of Education, Edgewood Campus, I met with Ms Thabisile Bhutelezi, a lecturer at the Campus. Thabisile explained that her remit is for HIV/AIDS issues within teaching. She has been looking into the curriculum of teacher training, the 4-year undergraduate course, and the PGCE course, and is developing modules to reinforce existing HIV/AIDS teaching (see appendix VII).

When I visited the Medical School I initially met with Ms Linda Hiles who is a part time counsellor for the Student Counseling Services, and also on the task force on HIV/AIDS in Medical School Curricula. Linda chaired the task group and designed and implemented a HIV/AIDS programme for first year medical students, the intention of this programme was to get everybody's knowledge of HIV/AIDS up to the same level (See appendix VIII). Secondly I met with Prof. Steve Reid also at the Medical School, Steve is appointed as an Associate Professor of community based education and rural health, and he runs a research unit called 'The Center for Health and Social Studies'. He teaches community oriented primary care, family medicine and rural health and teaches undergraduate curriculum in 1st – 6th year programmes (see appendix IX). I also met briefly with Dr Dorothy Apalsamy and Dr Janet Giddy who are both lecturers in the Medical School with an involvement in the HIV/AIDS modules.

Within the Faculty of Community and Development Disciplines I met with Prof. Alison Todes, based in the School of Urban and Regional Planning. This is a two years masters programme in which the needs of future populations are considered, therefore HIV/AIDS issues play a role in this course. Alison also suggested I meet with Mr Kevin Bingham in the School of Architecture. Kevin is a Lecturer and Masters student in Architecture and also examines at other institutions. He is also carrying out research into the impact of HIV/AIDS on selected building sites in the region and has recently held a workshop at the Institute of Architecture on HIV/AIDS. He is also the editor of a journal on architecture, of which the latest issue covered HIV/AIDS and Architecture. Through his interest and research he incorporates HIV/AIDS into the degree course.

In the School of Community Development and Adult Learning I met with Prof. Suzanne Leclerc-Madlala, a lecturer in anthropology. Suzanne is very involved in HIV/AIDS teaching and research at the university and is also the Deputy Director for Campus Support and Outreach for HIVAN. Suzanne teaches a number of undergraduate and postgraduate courses, including a postgraduate module entitled 'Understanding HIV/AIDS in Africa' (see appendix X). Because of her research and knowledge in the HIV/AIDS field she is also invited to speak about HIV/AIDS in many other schools and programmes throughout the university as a guest lecturer.

In the School of Economics I met with Mr Chris Brown. Chris lectures on a number of economics courses but his main area of interest is Health Economics. He is also doing a PHD on the economic evaluation of medicines – in particular antiretroviral drugs for adults with HIV/AIDS in South Africa. He has a great interest in HIV/AIDS so tries to incorporate it into all his courses.

In the Faculty of Engineering I spoke with various people. In the school of Mechanical Engineering I spoke to Professor Govender the acting head of school. He explained that HIV/AIDS is not included in any of their courses at present, although he would be very interested to get ideas about including it in the future. I also spoke to Mr Charlie Robinson who is on the support staff but he also said he

wasn't aware of anything happening regarding HIV/AIDS in the school. In the School of Electrical and Electronic Engineering I spoke to Professor Broadhurst. He stated that apart from what is covered in the student orientation week HIV/AIDS is not really covered. He mentioned that it may sometimes be covered informally in lectures on health and safety issues or industrial management issues but nothing is being done formally at present.

In the School of Chemical Engineering I spoke to Professor Arnold. He explained that HIV/AIDS is highlighted in a final year course on management and that it is covered from an industrial labour point of view. He suggested I contact Mr John Buzzard who is a consultant and comes in to lecture on labour relations. I then contacted Mr Buzzard and he said that he doesn't really include it formally but asked me to email him the research questions and said he would get back to me. In his email reply John explained that he teaches the legal and managerial side of engineering covering long term planning, personnel development and union relationships to final years students. He stated, "If the course is to have any relevance it is impossible not to cover the effect HIV/AIDS will have both on the workforce and managerially".

In the Faculty of Human Sciences I met with Prof. Ari Sitas, a lecturer for the Industrial and Organisational Labour Studies (IOLS) programme. Ari Sitas lectures on a number of undergraduate and post graduate courses and is involved in research. He explained that HIV/AIDS issues are included in many of the courses and that there is also a great deal of interest in research in the HIV/AIDS field within the Sociology Department.

4.3 Part Two - Summary Of The Main Findings To Each Interview Question

4.3.1 Question One:

In what ways is HIV/AIDS Education incorporated into curricula?

When asked how the lecturers incorporate HIV/AIDS education into curricula the responses to the question tended to fall into one or more of the categories listed in table one below. A number of the cases did not use one method exclusively but a number of methods combined.

METHODS USED TO INCORPORATE HIV/AIDS INTO CURRICULA
MODEL 1 - Through Community Based learning
MODEL 2 - Through Research/Project Work
MODEL 3 - Through integrating into existing/other modules
MODEL 4 - Through a stand alone module

In three of the cases studied HIV/AIDS issues were not being formally integrated into curricula at present. In these cases the HIV/AIDS education was being undertaken informally and incidentally within the classroom.

In part three of this chapter I have gone on to discuss these models in detail and to explain how they are being undertaken within different programmes.

4.3.2 *Question Two:*

Is such education an examinable component of your curricula?

When asked if HIV/AIDS education was an examinable component of the curricula, the answer was mainly 'yes'. For most of the cases they were examined in more than one way and only two of the cases were not examining the HIV/AIDS component.

Examinable
Yes – using formal exam questions
Yes - examined through research projects
Yes - examined through assignments
Not examined specifically

4.3.3 *Question Three:*

What are the specific links between HIV/AIDS Education and the subject matter?

When asked what the specific links between their particular subject matter and HIV/AIDS were the responses tended to fall into different categories of learning i.e. learning specific information, understanding the information, using the information to learn specific skills, and finally to examine behaviour and attitudes. All of the cases linked with both theoretical understanding and practical understanding of the disease.

LINKS
Theoretical Understanding – society, culture, economics, gender, environments
Practical Understanding – counselling, coping with grief, legal issues, planning issues, management, medical treatment, employment

4.3.4 Question Four:

What was the Purpose of the HIV/AIDS Education?

When asked what the purpose of the HIV/AIDS education was, each case came up with a number of purposes; many of these were similar and are listed below.

PURPOSE
To make the subject matter seem more real e.g. Using a real world problem can help learners to see the relevance of statistics in everyday life
To look at the economic impact - also what, if anything, can be done about it?
Look at effects on society - social questions of crisis, citizenship issues, able people acting responsibly and issues around making informed opinions.
Think about future employment - In many of the cases one of the purposes was to get the learners to think about their future employment or to equip them for employment in an HIV/AIDS world. This is particularly evident in the School of Education where the stated aim of the modules is “to train students to be the resources person for their future school for all HIV/AIDS matters”.
To equip senior planners of the future with knowledge – the students could potentially reach quite high positions in future employment – they could be the planners of the future
To develop informed attitudes and opinions - For instance in the Medical School the purpose was stated as “to diffuse fear, as learners will have to deal directly with AIDS patients in their jobs. Also to break down judgmental attitudes and challenge attitudes”
To get students to own HIV/AIDS issues - students see the problem as ‘out there’ and happening to other people.
To attempt to influence behaviour - what lecturers hope is that through the education they can have an influence on the students awareness, attitudes and behaviour

4.3.5 Question Five:

What aspects of HIV/AIDS were covered?

When asked what different aspects of HIV/AIDS were covered in their education the lecturers responded with the following:

ASPECTS of HIV/AIDS COVERED
The basics – what is it and how is it transmitted,
Effects on future society - in particular the effects on future employment prospects.
The statistics - to highlight to the students the relevance of the topic.
Attitudes - learners attitudes towards HIV/AIDS issues
Behaviour – taking risks, having multiple partners, safe sex
Economic impacts – education, housing etc
Interventions that could be made by government –providing drugs, changing migrant labour, care of orphans and national policies on health care
South African context - Cultural / historical factors – migrant labour, sex workers
Myths - how it is transmitted, how to treat it, and how to rid oneself of it!
Gender issues – masculinity
Prevention - sexual behaviour and needle stick injuries
Treatment - treatment options for HIV/AIDS were also covered in a small number of the cases
Policies – national, workplace - A number of the cases are including national, provincial, local, workplace and educational policies on HIV/AIDS as an important educational aspect
Management of HIV/AIDS in the workplace
Counselling Skills

4.3.6 Question Six:

What teaching methods are used to get students to relate HIV/AIDS to disciplinary knowledge in order to inform decision-making?

The two main teaching methods used were those of presenting information and of participative learning. The participative learning took on a number of forms as shown in the table below.

Teaching methods used
A: PRESENTATION METHODS
Didactic Teaching – using formal lectures, written assignments
B: PARTICIPATIVE LEARNING
Involvement of the learners – for example in investigative project work or research regarding HIV/AIDS and their chosen subject
Critical Reflection – e.g. of project experiences, of own life and experiences
Role-play plus reflection – using role play to teach counselling skills or to get students to think critically about their attitudes
Through group activities – Group activities such as community interventions and group presentations were used to get students to consider HIV/AIDS issues and their discipline
Discussion – involving the students in group discussion about HIV/AIDS issues
Using real life case studies - In the Department of Economics they are running a number of statistical courses and quantitative research courses. In these courses they are using HIV/AIDS statistics to make the course seem more real to the students.

4.3.7 Question Seven:

What were the main features of current HIV/AIDS Education?

When asked what they would consider to be the main positive features of the HIV/AIDS education that they were involved in at present, lecturers came up with a number of ideas. These are listed in the table below.

Features of HIV/AIDS education
It is supported from the top
It uses a systematic, planned process
It is based on a situation analysis within their discipline - carrying out an analysis of how HIV/AIDS was affecting their particular school, speciality, field, industry and ensuring that the HIV/AIDS education was relevant to students in their discipline.
It involved the learners in the learning and the process - many of the lecturers stated that involving the learners is important. This included not only involving the learners in the learning e.g. with role-play and reflections, but also in the process of developing the HIV/AIDS education. This was happening in a number of departments where they were using more senior students as facilitators, or groups of students were developing educational interventions.
It was challenging the learners –challenged the learners knowledge, attitudes and beliefs regarding HIV/AIDS.
It has been a dynamic, evolving process - Many of the lecturers felt that HIV/AIDS education is a dynamic evolving process and that this should be seen in a positive light. In particular those who were fairly new to the subject were keen to let the education evolve with time and with further evaluations.
It was monitored and evaluated in some way - The vast majority of the cases agreed that the constant monitoring and evaluation of their work was necessary in order to continually develop and improve the quality of the HIV/AIDS education on offer.
It covered life skills - A number of the cases felt it was important to cover 'life-skills' education as part of the ongoing HIV/AIDS education. This included such things as assertiveness, communication, responsiveness, being able to say no, being critically aware, and dealing with gender issues.
It a number of cases the overall purpose was that it attempted to empower individuals to live responsive and healthy lives - It was stated in the majority of the case studies that the HIV/AIDS education should work towards empowering individuals to live responsive and healthy lives.
It was rooted in the interests and lives of the students - it was felt that unless the HIV/AIDS education was rooted in the interests and lives of the students, through the engagement with their chosen discipline, it would not be successful.

4.3.8 Question Eight:

What were the difficulties encountered by lecturers in incorporating HIV/AIDS Education into curricula?

Below I have listed the main difficulties and concerns the lecturers had in carrying out HIV/AIDS education.

Difficulties Encountered
Unclear guidelines / no guidelines - many of the cases that were new to this type of education felt that there were no clear guidelines for teaching about HIV/AIDS within their discipline. In contrast, one case mentioned that having guidelines that are too controlling might limit some of the creative initiatives that are happening.
Difficulty in examining - It was also expressed that there was difficulty in examining the HIV/AIDS education. What exactly is to be examined? Is it knowledge and understanding, attitudes, ethical issues?
Difficulty in ensuring continuity of HIV/AIDS education/knowledge - It was expressed as a concern that if the HIV/AIDS education is not continued throughout the students life i.e. in the workplace, then it may all have been in vain.
Student reactions – silence, racial, attitudes, boredom, and helplessness - All of the cases felt that they were concerned about the students reactions towards the education. The racial dynamics of HIV/AIDS was also mentioned as a concern. Many of the students see HIV/AIDS as focused on African people, the lecturers were concerned with making the issues about everyone. A further difficulty in confronting HIV/AIDS education is that the lecturers are aware that many students are HIV positive and know it. The feelings of these people must be taken into account and respected.
Ethical issues of research i.e. control groups, community work - There was concern about the ethical issues around some of the students projects. A number of the lecturers felt that we are still learning at the expense of the community, with the community not seeing the benefits, just the inconvenience. Also when working with the community mistakes are made ‘in the community’.
Practical issues – i.e. finding facilitators, costs, time.

4.4 Part Three – Explanation Of Each Model

4.4.1 Model One – Teaching HIV/AIDS Through Community Based Learning

Example 1 – ‘HIV/AIDS and service learning: Transforming theory into practice’, an example from the School of Psychology

The School of Psychology is using community based learning as one of their attempts to integrate HIV/AIDS into the curricula. This programme is entitled ‘HIV/AIDS and Service Learning: Transforming Theory into Practice’ and the main aim of this programme is to make the students more socially aware as service learning is all about social awareness. The programme is sponsored by CHESP – Community Higher Education Service Partnership and is run for third year undergraduate students. It is a sixteen-credit module, conducted over eleven weeks in the second semester. (Interview with Kerry Frizelle, 13TH May 2002)

Purpose

The purpose was not mainly about educating about HIV/AIDS but more about transforming theory into practice. Any change in behaviour/ attitudes that the learners had was secondary and not an explicit objective of the programme. The main aim of this programme was to make the students more socially aware and this happened in this instance to be linked to HIV/AIDS.

The learning outcomes for the module included:

- To get students to understand the potential dangers of entering a community without having carefully considered the motives.
- To help the students to develop cultural competence to prepare for entry into communities with different backgrounds to their own.
- To equip students with interpersonal skills that would facilitate and enhance their work in the community.
- To get students to explore the difficulties they may have around talking about sexual issues.

(Interview with Kerry Frizelle, 13TH May 2002)

Format

In the first two weeks the students learn the theory regarding service learning and are required to do extensive reading on such concepts as help and development and critiques of the concept of service learning.

The third week was dedicated to developing cultural competence and during weeks four and five the students underwent an extensive basic counselling skills workshop.

During the sixth week the students had a workshop on sexuality and in addition an external person (in the previous year a woman living positively with HIV) came in to speak to the students.

Week seven was dedicated to the development of the respective projects. Early on in the course the students were asked to choose a project, these projects are described in the documentation as:

- The memory box project – creating memories for orphans
- Stigma reduction project – again for children in orphanages
- Youth focus project - running focus groups with school pupils
- Home based care project - working alongside community workers
- Basic life skills project - engaging in learning activities with children of all ages
- Orphan questionnaire design

The students worked together in groups on their particular project and each group received training from an individual with expertise in the area of their project, the students then presented their outlines to a supervisor and more theory and skill preparation was given to them.

In weeks eight to ten it was the implementation phase of the projects in the respective community sites. The students had already chosen their projects early on and were working in teams. Depending on the project the students engaged in a number of different activities, these included: running focus groups with school pupils, engaging in learning activities with children of all ages, working alongside community workers and designing questionnaires. Community mentors were used to accompany the students into the community, to inform them about the community they were entering, and to ensure safety and assist with translation where required.

Finally week eleven was dedicated to debriefing the students about their experience and for them to prepare for the mini conference. This was a small conference, for everyone who had been involved in the programme, at which each group of students presented a paper on their project and its implementation.

(Interview with Kerry Frizelle, 13TH May 2002)

Teaching Methods

In order to undertake this programme a variety of teaching methods were being used. These included weekly reflections to make direct links between theory and practice, and role-play to get the students to examine their own beliefs and attitudes.

Observation of a role-play session

There were 12 third year undergraduate psychology students present at the lecture. The students were assigned a role that they had to take on. Each role was a person with a particular stance on HIV/AIDS. The students then got together in their roles and pretended they were at an AIDS conference and meeting each other for the first time. They then spent about 30 minutes mingling and introducing themselves to each other. They also had to put across their point of view with regard to HIV/AIDS. The roles included; abstinence, religion, anti-abortion, homosexuality, prostitution, believed in identifying/marketing the positive, ostracizing the positive (sending them away), that HIV/AIDS does not exist, and 'for anti retrovirals'.

Afterwards the students sat in a circle and carried on the discussion, still in their roles. Following that they came out of the roles and a lengthy debriefing session took place. The debriefing session was excellent, as the students had all acted so well. Many points were brought out in the debriefing session: these included attitudes, stigma, stereotyping, dealing with situations, positive uncertainty, and recognizing your own fears and prejudices. The debriefing sessions gave rise to some many insights from the students; they opened up and spoke about sexuality, HIV/AIDS and their own prejudices. I think we were all moved by one student's account of their reactions to learning of a friend who was HIV positive.

(Observation of Psychology session, University of Natal, Durban, 10th September 2002)

Assessment

On the theoretical side, the students had to undergo a theoretical component on HIV/AIDS on which they were tested. Before going out into the community the students have to get above 75% in this test. This is to prepare students to answer questions and to challenge myths. They are also tested on other areas of service learning. Reflection was an essential part of the implementation phase and separate reflection sessions were ran for each project. During these sessions the students were free to express their concerns, achievements, frustrations and learning experiences. It was hoped that the reflection also had a role to play in assisting the students to make links between theory and practice and to facilitate a process of debriefing.

The documentation outlines the assessment for the students undertaking this programme; this was conducted in the following way:

A basic HIV/AIDS test (7% of the final mark). This was a written test.

A basic counseling skills assessment (7% of the final mark) - a role play situation

A theoretical essay (16% of final mark)

A presentation at the conference (20% of final mark)

A reflection paper (16% of mark)

A Final exam pulling together all they had learnt in theory and practice (34% of final mark)

(Psychology Programme – Service Learning Report, K Frizelle, no date)

Learning/Impact of this module on the students

After my observation of the role-play session I interviewed a number of students. They explained that although all the psychology students cover HIV/AIDS in an anthropology course in the first year this is the first time they have really explored it in depth. They told me that they particularly enjoy this module because they are able to put into practice some of the theory they have learnt and it all seems more real now. They also like the fact that they are doing it in a ‘safe way’ that they are being guided all the way and not left on their own. They expressed how it has made them confront things about themselves that they never would have and are grateful that they have had this opportunity to do so.

(Interview with Psychology Students, 10th September 2002)

From the latest report on the module I have taken the following students quotes on the project to highlight the impact this programme has had on the students.

‘Before I started this course I was under the impression that people were seriously suffering with AIDS out there and there was not much that could be done about. However I found that yes they are suffering but there is so much that can be done and is being done. There are people who are making a world of difference to these peoples lives. The work that I witnessed by the home based caregivers was nothing short of amazing’

‘ Having studied various aspects surrounding HIV/AIDS in south Africa during the theory component of our course, I was aware of the existence of fear surrounding it and believed that I did not hold this sense of fear myself. I was therefore surprised when on arrival at the center I was welcomed and hugged by the young children and felt a little nervous about the possibility of contracting the virus from them. However the knowledge that I had been equipped with about the transition of HIV/AIDS as well as physically

interacting with the children helped to dissipate these fears.....I was thankful to have the opportunity to confront and dissipate this fear.’

‘In terms of my own attitude change, I began this course with a cynical attitude, I believed that focusing on HIV/AIDS was a waste of time when bigger issues such as poverty made it a secondary rather than a major concern of the community. I have come to realise however, that the HIV/AIDS epidemic is multifaceted and cannot be addressed one dimensionally’

‘At the beginning of the course I had difficulties in adapting to what I was being taught as it challenged how I have been viewing life in general. It challenged me at all levels from sexuality to culture to intellectuality. I have been ignorant to HIV/AIDS and thought that it was not my problem but through this course I was proven wrong. I learnt that it was my problem, and not just me but everyone’

The report shows that overall many of the students felt despair at the enormity of the problem and a great deal of debriefing was provided to students regarding this. The lecturer felt that one couldn’t just send students out to the front line of HIV/AIDS and then leave them to deal with their own feelings. However the report shows that the students were able to see some short term benefits, for example how the children they worked with had thrived on and responded to the attention given to them by the students. (Psychology Programme – Service Learning Report, K Frizelle, no date)

Disciplinary Link

Community Psychology is about addressing social issues and also about challenging knowledge and looking at social change and responsibility. The main disciplinary link is with the social and psychological aspects of HIV/AIDS and this is one of the reasons why the students are taught counselling skills and to explore their own attitudes. (Interview with Kerry Frizelle, 13TH May 2002)

This was explained by a student as:

‘Prior to my entry into the community I was told that in order to combat the HIV/AIDS epidemic it needs to be fought on a number of fronts since it is embedded in a social, political, economic and historical matrix. I did not realize just how much this was true until I saw it with my own eyes. While I was in the community I was able to see how issues around gender, poverty, politics, stigma and denial can exacerbate the HIV/AIDS epidemic. This experience gave a face to the theory I have learned throughout this course.’

(Psychology Programme – Service Learning Report, K Frizelle, no date)

Example 2 – Community Based Selective Module - The New Curriculum Medical School Example

A second example of community based learning was that being run for second year medical students. These students were part of the new outcomes based curricula for medicine. As the new curriculum grows up this programme will be run each year through to 6th year but at present it has only been run for second year students. This is a hands on programme run over a period of four weeks, held throughout the year.

The basic idea is sequential:

- 1 Exposure of students to patients and community
- 2 Engagement of students in a community project
- 3 Intervention in that project
- 4 Assessment to determine if the intervention was effective

(Interview with Steve Reid, 20th August 2002)

Purpose

The aim of this programme was to bridge the gap between clinical medicine and community-based health care, by addressing the issue of HIV/AIDS in a specific community. The specific objectives for students are stated as:

- To engage with individuals, families and a community, outside of a health facility
- To gain the understanding and skills necessary to assist that community in the prevention of HIV/AIDS
- To analyse the gap between the community's needs and the services available
- To plan and implement an appropriate intervention project in that community
- To reflect on and learn from the experience, together with the community and health service partners, and your peers at other sites.

The learning outcomes are stated as: By the end of the programme students should have:

- A detailed understanding of a community perspective on HIV/AIDS
- An integrated knowledge of Primary Health Care
- An understanding of the obstacles and resources for HIV/AIDS prevention and health promotion
- An awareness of the value of Home Based Care
- Skills in health promotion and health education
- An appreciation of community involvement in health
- Respect for fellow health professionals and clients
- An ability to work in multi-disciplinary teams
- An ability to reflect on and learn from your experiences

(The interim report on the community based selective, S Reid, J Giddy and D Appalsamy, no date)

The students said they thought the purpose of the education was mostly awareness raising but then they got confused and started to talk about them educating 'others' i.e. making people more active regards HIV/AIDS and also mentioned prevention and targeting the youth. I got the impression that the students had failed to see that the education was aimed at changing there attitudes and behaviour and thought it was for them to change others. (Interview with medical students, 27th august 2002)

Format

The structure of the programme is that a total of 4 weeks were planned for activities during this second year of study. The 4-week period was divided into two 2-week periods, one in May/June and the other in November. This allowed an initial introduction to a project, during which the students were expected to make an assessment and plan for an appropriate intervention, which was carried out in November. Between these periods, it is anticipated that a certain proportion of students would remain in contact with the projects, and contribute to them outside of curricular time.

Eight project sites were finally selected following a year's preparation and negotiation with a number of possible partners. The theme of the module was "HIV/AIDS in the community", and the projects selected were mostly community-based or non-governmental organizations dealing with HIV/AIDS.

In the first week the students carried out a number of home and family visits of people living with HIV/AIDS and assess and reflect on the learning. In the second week the students were split into groups and were assigned to one of eight projects, these included: the Hillcrest AIDS Centre, The Valley Trust, Home Based Care Projects, Church Based Projects, A Hospice, and Teaching Programmes. Initially the students were asked to conduct a community assessment to identify gaps in what the local community needed and what the project delivered. They then wrote a plan of action. The students then went on to implement their planned intervention, assess the intervention, write a report and present it to colleagues.

(The interim report on the community based selective, S Reid, J Giddy and D Appalsamy, no date)

Teaching Methods

The students are required to undertake an assessment of a patient who is HIV positive, an assessment of the patients family/living situation and an assessment of the community the patient lives in. They then go on to plan and implement an educational intervention in the patients community. (Interview with Steve Reid, 20th August 2002)

During my observation of one of the second year group briefing sessions, the students were given feedback on their work so far as they had already carried out an intervention in the community and written a report on the experience. The students were now undertaking a family study and were planning their educational interventions. They were preparing to present these at the end of the year. The students in the group that I observed were termed the initial 'crossroads' group, this apparently was an educational programme and so they had already had experience in teaching and training. The students in the group discussed how they might be able to assist their peers who have not had this experience by holding some workshops for them. This was encouraged by the facilitator. (Observation of medical students tutorial session, Medical School, 27th August 2002)

Assessment

Students were required to submit 3 reports: one of a patient and family that they had visited (in pairs), another about the project and activities that they were involved in (as a group), and a third regarding their planned interventions in November (as a group).

The patient/ family reports were marked according to standardized marking criteria and had to include: details about the patient, family details, contextual details, and a description about what had been learnt as a result of doing this study – how it had affected the student personally. (The interim report on the community based selective, S Reid, J Giddy and D Appalsamy, no date)

Learning/Impact of the module on the students

The student project reports contained a detailed description of each day's activities with reflections. It was explained in the evaluation report that what came through very strongly from all student reports was the appreciation that students expressed for having had the opportunity of real hands-on experience of people and communities struggling with HIV/AIDS. (The interim report on the community based selective, S Reid, J Giddy and D Appalsamy, no date)

The students made some suggestions about what would benefit them in the way of learning about HIV/AIDS. They suggested that they could meet HIV positive people and talk to them about it. They also felt they could do with more teacher training/training the trainers. One student suggested that 'everyone on the medical course thinks they know it all but really they don't so it would be useful to have a dedicated AIDS module'. (Interview with medical students, 27th august 2002)

Disciplinary Link

These medical students will be our doctors of the future and will be at the cutting edge of dealing with the HIV/AIDS pandemic. We can see how important it is for these students to be exposed to a variety of HIV/AIDS education throughout their time at university.

When interviewing the students they explained that in the first year they had had workshops throughout the year on HIV/AIDS and they were also required to do a major project/ assignment in the community. They also explained that in the second year they were required to do an HIV/AIDS based elective in the community, and that HIV/AIDS issues also come up in other courses. In fact the students were adamant that HIV/AIDS is part of everything they do i.e. reproductive health, clinical medicine, ethical issues, and counselling. (Interview with medical students, 27th august 2002)

Example 3 – Community Oriented Primary Care - The ‘Old Curriculum’ Medical School Example

A further example of community based learning also being used in the medical school was the programme being run for fifth year students, this programme was based on the old curriculum. Although this module was entitled ‘community oriented primary care’, the theme of the module was HIV/AIDS in the community. The programme was run in conjunction with the Valley Trust, who runs community wide HIV/AIDS programmes aimed at addressing the need for prevention of HIV/AIDS and the promotion of healthy lifestyles in the Valley of 1000 Hills. It also supports a network of some hundred community health workers in the selected areas, through the employment and support of six community health facilitators. These facilitators and the AIDS team at the Valley Trust have had training in home based care for AIDS patients and are trying to help people living with the disease. However, it was identified that little had been done on a primary preventative level and that this is where this student module could be of benefit to them. (Report, Fifth Year Block: Community Oriented Primary Care, S Reid, no date)

Purpose

The documentation shows that the objectives of this programme could be divided into three groups

Students:

- To give students the opportunity of understanding health and illness in the context of the family and the community, through real interactions with patients at their homes

- To stimulate self learning in a small group, drawing on their own resources and experiences
- To encounter community based programmes first hand and experience the influence of community attitudes to health care.
- To learn about the influence of local beliefs and customs on health, particularly with respect to HIV/AIDS
- To overcome some of the obstacles and fears of working outside of an urban health facility.

Community oriented

- To assist in preventing HIV/AIDS in the community
- To engage in a health promotion activity related to the prevention of HIV/AIDS
- To assist patients with chronic problems, including HIV infection and TB to manage their illness optimally within their home contexts
- To support individuals living with HIV/AIDS

Service oriented

- To assist TB patients to find appropriate treatment supervisors and enable them to be discharged from hospital
- To support the valley trust HIV/AIDS programme development
- To plan and carry out a health education session in primary schools, with the aim of encouraging teenagers to live a healthy lifestyle
- To support and encourage community health workers and facilitators in the selected areas.

(Report, Fifth Year Block: Community Oriented Primary Care, S Reid, no date)

Format

The programme was run over four days and was split into two main parts. The first two days were spent on the home visits and community assessment and days three and four are spent planning and implementing the primary school HIV/AIDS health promotion activity. (Interview with Steve Reid, 20th August 2002)

Teaching Methods Used

The programme was carried out in small groups of around seven per group.

In the first part of the programme i.e. the family visits, the students met with a patient and their family. They visit the home and do a detailed assessment of the home conditions. Then using the home as the starting point the students are asked to investigate the neighbourhood by visiting all relevant points of interest i.e. water source, local shop, sanitation, shebeen, traditional healer, clinic, and community health worker. The students are then asked to critically analyse the factors which

may have generated the patients illness in the first place, or that sustain the disease in the community. They then have to outline a management plan which is realistic and implementable in the family and community context and give feedback to the service providers at the health centre.

In the second part of the module the students went on to the health promotion activity. The students were required to meet with the AIDS Programme Coordinator at the Valley Trust and plan the school-based intervention entitled 'healthy living'. The students then go in groups to the primary schools identified by the Valley Trust and conduct the sessions. The school session should last 45 minutes and they do it for a number of classes at the school. The students are asked to aim for as much participation of the children as possible and to be sensitive about sex education messages. They are also asked to record what they learnt from the experience and to work together to analyse the events, to build a framework for other groups of students to build on and to present a summary of all of this on the final day. (Report, Fifth Year Block: Community Oriented Primary Care, S Reid, no date)

Assessment

The students then go on to write up a detailed report. All groups will be expected to submit a written report and to give a presentation at a later date. (Interview with Steve Reid, 20th August 2002)

Learning/Impact of this module on the students

The evaluation form for the block asked the students to look at what things had made an impact on them during the block, how might they apply what they have learnt in their future career and any suggestions that they have for future modules. Unfortunately I have not had access to any of the feedback from the evaluations. (Report, Fifth Year Block: Community Oriented Primary Care, S Reid, no date)

Disciplinary Link

Again the students were expected to learn specific HIV/AIDS information, to show that they understand the information through using what they learnt to develop and carry out an intervention. The students are also asked to look at their own attitudes and reflect on what they have learnt. During this module the students learn practical skills of planning, management and communication, these skills will be valuable to them in their future careers.

Limitations and Possibilities of Community Based Learning

Community based learning is not an easy option and can be difficult to undertake. There are usually many partners involved, facilitators for tutorials need to be identified, and community projects found, working across multiple sites is required, time constraints are limiting, and costs and budgets play a part! There is also the concern that it puts added pressure on the community workers who already have incredible pressures on them. It is also a complex issue to address the project as having an added outcome for the organisation or community involved and it is difficult to make assumptions about how communities have benefited from such projects, as the nature of the projects does not allow for one to see visible outcomes or benefits to the communities. Some of the students involved felt that their interventions had little impact on the communities they worked with. Other students were aware that they would never get to see first hand the impact of their work. For example, in the psychology module, the basic life skills project, aimed to challenge gender constructs in young people, the results were only likely to be seen as these children are forced into situations where they are required to reflect back on the lessons taught by the students. The stigma reduction project, aimed to assist children deal with stigma as the result of having to live in an orphanage, the results of this project would only be apparent as the children encounter and grapple with future stigmatization. And the memory box project was also difficult to see or predict, as it is largely psychological in nature. (Psychology Programme – Service Learning Report, K Frizelle, no date)

The medical school modules also highlight that when undertaking such a programme relationships with partners need to be considered. The various organizations which hosted students for their CBME site visits were very gracious and accommodating in allowing the students to participate in their work and projects. In many cases it meant one or more staff members giving up valuable time to orientate, help and teach the students. It was felt that these people were assisting with a vital component of the new curriculum and the Faculty of Medicine needs to recognize a reciprocal responsibility to assist these organizations, which are often struggling. This assistance can take many forms, such as faculty staff attending meetings, advising, being on the board of trustees, participating in research projects and workshops. What need to evolve are true partnerships between the academic institutions and service organizations. Universities need to be available and accountable to the communities they serve and represent, so time spent by faculty members in supporting and assisting CBOs and NGOs should be recognized as part of the job. (The interim report on the community based selective, S Reid, J Giddy and D Appalsamy, no date)

The positive features of this HIV/AIDS education model was the practical exposure of the students to the realities of people living with HIV/AIDS, through home/community visits and work and/or a thorough involvement in projects and programmes aimed at prevention.

In the examples looked at it appears that this model of HIV/AIDS education can have a clear purpose and disciplinary link making it easy to assess. It also involves the full breadth of teaching methods i.e. giving information, ensuring understanding, learning skills, and looking at attitudes and behaviour.

It was felt by the schools involved that although this is a luxury model it is worthwhile as it is such a deep learning experience for those involved. It also appears to be a significant learning experience for some of the so-called “soft skills”, or attitudes, but the degree of reflection and deep learning appears to be very variable. (Interview with Kerry Frizelle, 13th May 2002)

Overall these community based learning modules provided an ideal opportunity for the schools to integrate HIV/AIDS into curriculum while at the same time respond to the epidemic in a practical way through community outreach. However it has been said that a community based learning module like this is in fact a ‘luxury module’ and there may be issues around sustainability due to financial and time constraints.

4.4.2 Model Two – Teaching HIV/AIDS Education Through Set Project Work and Research Work

Example 1 – Project Work - The Urban Planning Model

In the department of Urban and Regional Planning, a two-year masters programme, students carry out project related work in the first year. This project work includes physical planning of new areas and integrated development planning and requires that the students make links with the community outside of the university. This project work must take into account the needs of future population. (Interview with Alison Todes, 26th July 2002)

Purpose

The main aim was to look at the economic impact of HIV/AIDS and its effect on society, also what, if anything, can be done about it? The purpose of this HIV/AIDS Education was stated as;

‘The students need to understand the demographic impacts, the economic impacts, social impacts, facility impacts, and the needs that will emerge, due to the HIV/AIDS crisis. We also want them (the students) to think about the critical interventions that that the government could make, for example, thoughtful housing and health care’. (Interview with Alison Todes, 26th July 2002)

Format/ Teaching Methods

Lessons are taught throughout the two years on issues such as: demographics, economy, and social issues. External lecturers are also brought in to talk about HIV/AIDS issues. The students then carry out project related work and the HIV/AIDS information learnt must be taken into account. (Interview with Alison Todes, 26th July 2002)

Assessment

The projects are all marked and the mark will reflect that the students have taken into account the HIV/AIDS issues discussed. But it was stated that there were difficulties encountered with examining, these were stated as:

‘We are not sure that we are entirely on top of how to carry the HIV/AIDS knowledge through to the project work, so when marking projects we are not always certain that we are picking up on HIV/AIDS issues properly. Maybe as a discipline we have not worked through this enough yet.’ (Interview with Alison Todes, 26th July 2002)

Learning/Impact of this module on the students

I did have the pleasure of speaking with one past student on this course over the telephone although it was a very brief discussion. The student confirmed what Alison had explained regarding the project work and also went on to describe the work they were doing at present. This student had gone on to work in architecture that was very involved in HIV/AIDS issues as they were designing medical facilities and housing projects aimed at HIV positive people. The student explained that the Urban Planning course had been an enormous asset regarding learning about HIV/AIDS issues in planning. (Interview with Urban and Regional Planning student, 30th July 2002)

Disciplinary Link

HIV/AIDS is one of the important social and economic factors that the students need to consider in Urban and Regional Planning. The HIV/AIDS education is linked to the needs of populations in the future and the nature of these needs i.e. housing (the fact that its current form could be problematic), issues about home ownership and future employment issues. (Interview with Alison Todes, 26th July 2002)

Example 2 – Research Work - The IOLS / Sociology Example

In Industrial and Organizational Labour Studies and Sociology the HIV/AIDS education is included mainly in research projects in the third year.

Purpose

The main purpose of the HIV/AIDS education is that they are hoping to help the learners to make informed opinions regarding HIV/AIDS. (Interview with Ari Sitas, 30th July 2002)

Format

Due to the fact that a large majority of students are interested in research in HIV/AIDS related fields; HIV/AIDS issues are arising informally in lectures. The main HIV/AIDS issues discussed in lectures were:

‘Macro Social Relations – what produces silence about it? What is the role of social science in understanding and helping give a voice about HIV/AIDS?’

‘Institutional Level – what kinds of institutions need to be created to cope with this phenomenon as existing models tend to isolate the phenomena and institutionalize people?’

‘Problem Solving – HIV/AIDS demands a transformed civil society to cope with it. We need non repressive ways of dealing with HIV/AIDS.’

Following this informal teaching around HIV/AIDS issues the students then go on to undertake research in the field in their 3rd year as undergraduates. The research covers many of the issues discussed above, but mainly deals with the social aspects of the disease. (Interview with Ari Sitas, 30th July 2002)

Teaching Methods

Case Studies are used to get students to think about HIV/AIDS issues, for example, a sugar mill, with a high staff sickness level. The students then need to find organizational solutions that also take into account human rights issues. The students also use HIV/AIDS to look at social questions of crisis, citizenship issues, able people acting responsibly and issues around making informed opinions. It was felt that the students were more at ease discussing issues in the third person to explore their own attitudes and so external case studies were used for this purpose. (Interview with Ari Sitas, 30th July 2002)

Assessment

There are some questions on the formal exams that cover HIV/AIDS, but it is not taught or examined as a separate module. Research projects are examinable through a standard marking criteria but again HIV/AIDS information is not necessarily examined. (Interview with Ari Sitas, 30th July 2002)

Learning/Impact of this module on the students

It was hoped by the lecturers that this would go some way to challenging the student's attitudes and sensitising students to the problems of HIV/AIDS, that they won't just disappear and cannot be solved easily. In some instances the students were resistant to discuss HIV/AIDS issues as 'it is not cool stuff for youth to talk about, it conflicts with freedom, the right to silence and externalizing'. (Interview with Ari Sitas, 30th July 2002)

Disciplinary Link

As with Urban and Regional Planning the main disciplinary link here was with planning issues. Learning to plan and manage a workforce and take into account the social, economic and demographic factors of HIV/AIDS.

Limitations and Possibilities of the Project Work/Research Module

This model appears simpler to undertake than that of community based learning, mainly due to time constraints, the number of partners involved, and budgets. But it still involves linking with the community and bringing in external people to discuss HIV/AIDS issues in the classroom. It appears from these two examples that this is a more straightforward model as students can be given a HIV/AIDS topic to research and can go ahead and undertake this research without much prior teaching of HIV/AIDS education taking place. The difficult part of this model comes with examining:

What exactly is to be examined and how will lecturers know if the purpose of the exercise has been met. Will for example the students go on to make informed opinions regarding HIV/AIDS? How do they know if the students are prepared for working in a HIV/AIDS society?

Neither of the examples mentioned that the students were required to formally reflect on their own attitudes and opinions within the research. It may be that the more formalized the project work is the easier it is to examine with relation to HIV/AIDS issues. Also although this point does not arise with these examples I feel it is important to note other HIV/AIDS research concerns those of ethics, control groups, and confidentiality.

4.4.3 Model Three – Through Integrating HIV/AIDS Education Into Existing/Other Modules

Example 1 - The First Year Medical School Example

In the Medical School, in the first year, they are new working with the new ‘Outcomes based curricula’. With this curricula the 200 first year students are divided into 20 groups. Each Monday the students are given a task to complete as a group and they feed back from the task on the Friday. Each week of term the students cover a different topic and HIV/AIDS education fits through a number of modules. (Interview with Linda Hiles, 13th August 2002)

Purpose

The main purpose of this first year module was to give students a basic grounding on the HIV/AIDS issue and to begin to get them engaged in the issue. The Medical School felt it was important to start with the basics to bring everyone to the same level. (Interview with Linda Hiles, 13th August 2002)

When I met with students in the Medical School they told me that ‘everyone here thinks they know it all (about HIV/AIDS) but really they don’t so it is important to start with the basics’. (Interview with Medical Students, 27th August 2002)

Format

This year they held nine sessions on the topic of HIV/AIDS; these were run throughout the year and came to a total of approximately 16 hours of teaching. Five of these sessions were workshops held in small groups, these workshops required trained facilitators. The facilitators for the workshops were all trained together and were given the same workplan. The workshops covered different things i.e. basic teaching/training methods and presentation skills, myths and realities, social/cultural issues, sex and sexuality, attitudes and perceptions, prevention, living with HIV/AIDS, training techniques and workshop planning. The students also attended a two-hour lecture which covered: transmission, statistics, testing, clinical features, treatment, antiretrovirals, prevention, epidemiology, gender issues and mother to child transmission. These workshops and lectures were given to enable the students to then do an assignment. The students were given an assignment to work in groups and to plan a workshop in the community on HIV/AIDS and to evaluate their work. The Medical School tries to mix each group of students by race, age, culture, religion etc, to attempt to break down stereotypes and assumptions. (Interview with Linda Hiles, 13th August 2002)

Teaching Methods

The students are required to present a HIV/AIDS awareness workshop in the community. The workshops last year included talks at schools, churches, hospitals and other community groups. The students have to write up and feedback on their projects. The students were asked to include information about their target group, when the workshop was held, information about the venue, a detailed planning process and a list of the objectives for their workshop. They also had to include a list of all the points addressed during the workshop and document any questions that arose. They then had to evaluate the workshop with the participants and include a report on this. Finally the students were asked to reflect on the process and experience and how it has impacted on them. (Interview with Linda Hiles, 13th August 2002)

Assessment

The written assessment of the projects are marked using a framework with the majority of marks being allocated to the content/ delivery of the intervention and the reflection / evaluation. (1st Year Medical Students: HIV/AIDS Curriculum Overview, L Hiles, no date)

Learning/Impact of this module on the students

In one of last year's assignments the students had conducted a play/drama in a school about HIV/AIDS and hosted a talk show to get some of the relevant points across and also to examine some attitudes about HIV/AIDS. The students had also designed posters and leaflets for the school they were involved with. My overall impression from seeing this project report was that the assignment had been tackled with a great deal of creativity and enthusiasm and was most probably a worthwhile exercise for the school involved. (Interview with Linda Hiles, 13th August 2002)

Disciplinary Link

During this teaching of first year medical students the lecturers are looking for indications that the students have thought about HIV/AIDS as an epidemic that has medical and social implications, and that the students have learnt practical skills from the process of carrying out the awareness projects. (1st Year Medical Students: HIV/AIDS Curriculum Overview, L Hiles, no date)

Example 2 – The Anthropology Example

In Anthropology three undergraduate courses, these include:

- Health and a Sociocultural Context, a second year course.
- Understanding Families and Households, also a second year course that looks at issues that effect domestic arrangements and family life.
- A Research Methods Course, to third year undergraduate students.

In each of these modules HIV/AIDS issues are integrated.
(Interview with Suzanne Leclerc-Madlala, 5th August 2002)

Purpose

In the Health and a Sociocultural context course it is concerned with the range of issues that surround the meanings people attach to health and illness. The course is to introduce the students to some of the most important theoretical paradigms in medical anthropology and to consider some of the most crucial contemporary issues in medical anthropology and public health. These include the AIDS pandemic. The documentation states that the overall purpose of this course is to demonstrate that scientific biomedicine, although a most powerful and dominant medical system, is not the only approach to healing the body and mind. (Course Overview, S Leclerc-Madlala, and no date)

In the Families and Households course it includes a section on the impact of HIV/AIDS on local families and households. The documentation for this course explains the overall purpose of the course as:

‘To foster an awareness of the various challenges confronting families and households as they adapt to the modern world’ and ‘to foster greater tolerance and acceptance of other peoples ways of arranging their domestic lives’.

(Course Overview, S Leclerc-Madlala, no date)

In the Research Methods course it includes a section on the impact of HIV/AIDS on local families and households. The documentation for this course explains the overall purpose of the course as:

‘To foster an awareness of the various challenges confronting families and households as they adapt to the modern world’ and ‘to foster greater tolerance and acceptance of other peoples ways of arranging their domestic lives’.

(Interview with Suzanne Leclerc-Madlala, 5th August 2002)

Format/Teaching Methods

The Health and a Sociocultural context course is run over 13 weeks, with three hours of lectures each week. Week seven of the course is dedicated to the HIV/AIDS epidemic. The documentation states the themes of these lectures as: a general overview of the AIDS pandemic, social science contributions, AIDS and the allocation of blame, myths and cures. Week eight of the course looks at 'Gender and AIDS' and the themes for this week are stated as: socio cultural constructions of femininity and masculinity, sexual politics, negotiating safe sex, barriers to risk reduction. In week twelve of the course the theme is 'traditional healing and modern medicine', and AIDS treatment is considered in this section of the course. (Course Overview, S Leclerc-Madlala, no date)

The Families and Households course is conducted over twelve weeks with three hours of lectures each week. Weeks ten and eleven of the course are dedicated to 'HIV/AIDS and the family' and includes home based care, AIDS orphans, child-headed households, social impact and repercussions of AIDS. (Course Overview, S Leclerc-Madlala, no date)

In the Research Methods course there is a section that covers participatory research in health and that HIV/AIDS issues are included in this section. (Interview with Suzanne Leclerc-Madlala, 5th August 2002)

Assessment

The Health and a Sociocultural context course is examined using two tests, an assignment and formal exam questions.

For the Families and households course, all students taking the course must complete two tests, an essay assignment and formal exams. The topic for the essay assignment was an HIV/AIDS based topic, stated in the documentation as:

'Drawing upon your knowledge of social organization and kinship systems, discuss how the lineage structure of many west African societies (many of which are matrilineal) may be a factor mediating against rapid spread of HIV/AIDS and helping to protect women against this sexually transmitted disease. Clearly describe and elaborate upon the kinds of family and social dynamics that may explain why HIV/AIDS infection rates are comparatively low in this part of Africa.'

(Course Overview, S Leclerc-Madlala, no date)

Learning/Impact of the module on the students

Due to the timing of these modules and research time constraints I was unable to speak to students taking these modules

Disciplinary link

In the Health and a Sociocultural context course there is a clear disciplinary link between health and social issues. In the Families and Households module there is a link with the impact of HIV/AIDS on the family, and the role family structures play in the spread of HIV/AIDS. With the Research Methods course the link is with the role of research in fighting HIV/AIDS and with ethical considerations of such research.

Example 3 – The Gender Education Example

In the School of Education, a Gender in Education course entitled ‘Masculinity and Schooling’ is taught.

Purpose

The documentation for the module outlines the purpose of this module, it does not mention HIV/AIDS specifically but the purpose relates more to issues of masculinity, gender power and why these are important issues. Again the learning outcomes for the course do not mention HIV/AIDS specifically but outlines that students will understand how certain constructions of masculinity are implicated in unequal power relations. (Masculinity and Schooling: Course Outline, R Morrell, 2002)

Format/Teaching Methods

This Masters course is run on an open menu system with modules being optional to students but that this module is one of the compulsory modules in the ‘Gender Education M.Ed’ specialisation. Rob stated that this course teaches about social behaviour and hopefully about respect. The course is run for the duration of the first semester, with one, two-hour session each week. (Interview with Rob Morrell, 10th June 2002)

Assessment

The assessment for the course is continuous and there are no formal examinations. There are three written assignments, one major assignment and two minor. The weekly sessions are conducted so as to facilitate student involvement, interaction and debate and students will need to prepare in advance for each session. One of the weekly sessions is entitled ‘AIDS and Masculinity: how will a consideration of masculinity affect a gendered analysis of AIDS and education’ and the essay question for this session is documented as ‘Why is AIDS a problem for men and how might schools develop gender inclusive, preventative programmes?’ (Masculinity and Schooling: Course Outline, R Morrell, 2002)

Learning/Impact of the module on the students

Due to the timing of these modules and research time constraints I was unable to speak to students taking these modules

Disciplinary Link

The Students taking this course are schoolteachers who need to take gender issues in the classroom seriously and know the implications of such issues. Rob stated that 'There are specific links between gender and HIV/AIDS, due to inequality and power relations, we don't yet understand why people behave in the way that they do when they know the risks about HIV/AIDS'. (Interview with Rob Morrell, 10th June 2002)

Throughout many of the interviews undertaken for this research the issue of gender was mentioned time after time as a cultural issue in South Africa. HIV/AIDS education in many of the cases was linked to gender issues.

Limitations and Possibilities of the ‘Integrated Into Other Education’ Module

This model appears to work very well for those subjects and disciplines that lend themselves to the inclusion of a HIV/AIDS component.

It may be that many programmes and courses, throughout the university, integrate HIV/AIDS education into their curriculum in this way but the models shown here have formalised this integration. They have done this by documenting what HIV/AIDS education will take place, what the purpose of the education will be and how it will be examined. I believe this to be the key to successful integration of HIV/AIDS education.

The main difficulties with this module for the medical school were the recruiting of facilitators and there were also some costs incurred in setting up the community projects. It had also been a concern that HIV/AIDS education would not be continued in consecutive years, that it would just be another first year subject.

4.4.4 Model Four – Taught Through A ‘Stand-Alone Module’

Example 1 – A Compulsory Module -The Law School foundation course

In the School of Law they are running a course entitled ‘Foundations of South African Law’. This is a first year, 3-week module, for all law students. This course is facilitated by lectures and by postgraduate students. The number of students attending this course is approximately 170; these are split into small groups (of approx 16) for tutorials and interactive periods. Attitudes and values are brought out in tutorials through discussing different Law Cases. (Interview with Alan Ryecroft, 15th August 2002)

Purpose

Week one is entitled ‘HIV/AIDS in the South African context’ and the specific outcomes for this week are documented as follows:

Knowledge Outcomes: It is intended that students will know and understand:

- The meaning and cause of HIV and AIDS
- The relationship between masculinity, men’s behaviour and the spread of HIV/AIDS
- The requirements as regards non-discrimination of persons with HIV / AIDS
- What constitutes unfair discrimination against a person living with HIV / AIDS

Skills Outcomes: It is intended that students should be able to:

- Distinguish between two court judgments and pinpoint the main differences

Value Outcomes: It is intended that students should show an appreciation of:

- The urgency of the AIDS pandemic
- That responsibility requires a change in behaviour
- The need to remove the stigma from people with HIV/AIDS
- The importance of support for people infected and affected by HIV/AIDS

Week two of the programme is entitled ‘AIDS and the Law’ and the specific learning outcomes for this week are documented as:

Knowledge Outcomes: It is intended that students will know and understand:

- What constitutes unfair discrimination?
- The legal consequences of unsafe sex
- The consequences of unlawful delictual behaviour
- Aspects of the Code of Good Practice

Skills Outcomes: It is intended that students should be able to:

- Assess those situations in which testing is permissible
- Assess how confidentiality is to be treated

Value Outcomes: It is intended that students should show an appreciation of:

- The need to remove the stigma from people with HIV / AIDS
- The need to respect a person's privacy as it applies to testing for HIV and the handling of confidential information

Week three of the programme is entitled 'HIV / AIDS and Intervention' and the learning outcomes for this week are documented as:

Knowledge Outcomes: It is intended that students will know and understand:

- That intervention has three elements: prevention, treatment and care;
- That all three forms of intervention are highly controversial;
- That it is possible for groups in society to engage in civil disobedience;
- That civil disobedience is an established approach in certain situations;
- That constitutional rights can be used to win the right to treatment

Skills Outcomes: It is intended that students should be able to:

- Understand the concept of civil disobedience and measure its defining characteristics against the facts of the TAC Defiance Campaign
- Evaluate if there has been discrimination in the provision of treatment.

Value Outcomes: It is intended that students should show an appreciation of:

- The importance of public disclosure of HIV/AIDS status as a way of de-stigmatizing HIV/AIDS; The moral imperatives driving the TAC campaign
- The inequities in current provision of treatment

(Course Outline, A Ryecroft, 2002)

As well as the more practical purpose of the module, what they really hope is that they can have an influence on the student's awareness, attitudes and behaviour.

(Interview with Alan Ryecroft, 15th August 2002)

In the lecture Alan explained to the students how crucial this subject is to law students and said that the purpose was to make 'you budding lawyers really explore and express who you are and where you stand on the HIV/AIDS crisis'.

(Observation of Law Lecture, Durban, 30th August 2002)

Format

Week one of the course looks at the meaning of HIV and AIDS, the urgency of the AIDS pandemic and support for people living with the disease. Week two looks at AIDS and responsibility, the impact of sexual culture, legal issues and

consequences. Week three looks at prevention, treatment and care, and also looks at hot legal issues such as smuggling of antiretroviral drugs. This three-week first year module is taught in the second semester (September). Students have one lecture per week, one tutorial and one interactive period, they also have assignments to complete. (Interview with Alan Ryecroft, 15th August 2002)

Teaching Methods

In each of the three weeks the students receive a formal lecture covering the main points for that week, they then have a tutorial (in the small groups) in which the students test their knowledge and attitudes and discuss these with the group. In the interactive period for that week (again in the small groups) the students are required to study real case studies concerning the issues for that week and to discuss these with the group. (Interview with Alan Ryecroft, 15th August 2002)

On starting the first of the formal lectures Alan stated:

“During the next three weeks we will be talking about HIV/AIDS – you might have different reactions to this subject for example you may be bored, self righteous, or scared, All of us are infected or affected”

Alan then went on to the context of the crisis and showed the figures for the prevalence of HIV/AIDS. The lecture moved on to orphans and how as generations we have all got our values from our families and homes and now there will be a whole generation growing up without this value system.

We then did a short exercise in pairs – comparing the diagnosis of cancer and HIV/AIDS and the reactions to it. I had an interesting discussion with the student next to me. We talked about the fear of infection, catching HIV/AIDS from an infected person, about the public shame and about how it is perceived as ‘a gay or promiscuous’ infection.

Alan then went on to look at personal conduct and individual responsibility. We looked at sexual culture and how each society and culture constructs masculinity. Alan explained three approaches that have been used to try to change Men’s behaviour:

- The informative approach – providing info about HIV/AIDS – this approach is failing at changing behaviour
- The supportive approach – get men to change attitudes
- The social approach – shift an understanding of masculinity towards protecting oneself, ones partner and ones children.

The lecture then proceeded with the factors that affect the spread of HIV/AIDS, these included:

- Pessimism
- High levels of premarital sex
- Extramarital relations
- Sexual violence
- Denial and silence
- Complicity of women in using sex to obtain goods and favour of men.
- Inequality, poverty and aids

(Observation of Law Lecture, Durban, 30TH August 2002)

Assessment

The students are given assignments, these assignments are marked formally. The first assignment is given in week two and requires the students to put themselves in the place of a labour court judge. They then give a written judgement on issues of HIV/AIDS testing in workplace situations. The second assignment is concerned with the student's familiarity with the laws surrounding HIV/AIDS issues. The documentation explains this as:

'The purpose of this assignment is to assess if the students are able to locate very accurately the relevant section of a statute, the code of good practice, and/ or a decided case, relevant to the scenarios given'.

The scenarios given included such things as:

'An employer refuses to employ an applicant because she is a person with HIV'
'A pregnant women with HIV living in a rural area is refused Nevirapine at her local clinic'

(Course Outline, A Ryecroft, 2002)

Learning/Impact of this module on the students

The students explained to me that this was the first time they had touched on HIV/AIDS issues within their course but they thought it was good that they were learning about it. They felt they would definitely need the information in their future careers as lawyers. They had all enjoyed the lecture and had learnt things they didn't know before i.e. gender issues and facts and figures. They felt the main purpose of the lecture and of learning about HIV/AIDS is to get them talking and thinking and they stated that they really saw it as affecting them and not just other people.

The students said they thought it would be a good idea to include HIV/AIDS education in other courses for all students and in things like the compulsory first year meetings that everybody has to attend. One student came up with an interesting point regarding HIV/AIDS education:

‘It is pointless to have optional sessions on AIDS for students, no one would go anyway as there would be too much stigma attached and people might wonder why you are going’.

(Interview with Students, 30th August 2002)

Disciplinary Link

As we see in the assessment section above there are clear disciplinary links between HIV/AIDS Education and the training of lawyers. These include the issues of HIV/AIDS testing in workplace situations, the laws surrounding HIV/AIDS issues; these include such things as unfair dismissal and treatment options for HIV/AIDS patients.

Example 2 – Dedicated HIV/AIDS module – Understanding AIDS in Africa, CODAL

In the School of Community Development and Adult Learning a postgraduate course entitled ‘Understanding AIDS in Africa’ has been developed.

Purpose

This course is designed to give students a holistic understanding of the factors and forces that shape and sustain the HIV/AIDS epidemic. The overall aim of the course is to introduce students to some of the more significant contextual factors that underlie and sustain the epidemic in this part of the world. The course aims to expand upon the students basic knowledge of HIV/AIDS by adding depth and insight into some micro and macro dynamics that make African societies especially susceptible to HIV/AIDS. (Understanding AIDS in Africa: Course Outline, S Leclerc-Madlala, 2002)

The students are given the opportunity to reflect on their own life, selves and experiences i.e. the patrilineal structure, and to relate them to HIV/AIDS issues in South Africa. Suzanne explained that the main purpose of all her teaching was:

“We have a captive audience in the prime of their lives, so I feel a moral obligation to do what I can, we can’t just sit back and do nothing, we need to wake up the students to HIV/AIDS, even if it sometimes means going outside the curricula i.e.

using guest speakers etc. We must try to get them to talk about HIV/AIDS and make it a more comfortable subject. It is very rewarding when students bring their friends along to specific classes on HIV/AIDS, for example when they know there will be a guest speaker”.

(Interview with Suzanne Leclerc-Madlala, 5th August 2002)

Format

One week dedicated course specifically on HIV/AIDS

Teaching Methods

The course is run over one week with lectures and talks for the first three days, on the fourth day the students on the course each do a presentation on an HIV/AIDS topic of their choice and on the final day they will look at education and prevention and work in groups to develop an intervention. The lectures start with an overview of HIV/AIDS in Africa. This includes an explanation of the different types of the disease and the different types of epidemic. It also looks at graphs of HIV/AIDS statistics and treatment and anti retroviral drugs, including the ethics of treatment are discussed. (Interview with Suzanne Leclerc-Madlala, 5th August 2002)

Assessment

This course is examined through an assignment, through a presentation that the students prepare and present to the others on the course and through the development of an educational intervention. (Interview with Suzanne Leclerc-Madlala, 5th August 2002)

Learning/Impact of this module on the students

It was hoped that this course would impact on the knowledge and attitudes of the students and on their future work and research. (Interview with Suzanne Leclerc-Madlala, 5th August 2002)

Disciplinary Link

This module was interesting in that the students taking part were from a number of disciplines. The link the students had was that they all had a particular interest in some part of the HIV/AIDS field and many of them were going on to undertake research into HIV/AIDS issues. (Interview with Students, 23rd September 2002)

Example 3 – Future Plans - The Education Modules

This example is somewhat different to the other examples in that the courses outlined here have not yet been taught and have only just been developed. It is therefore difficult to ascertain what the positive and negative attributes of these courses will be once underway.

In the Department of Education a post was created to look at HIV/AIDS issues particularly, as previously HIV/AIDS has been covered only in the first year 'Foundations for Education' module. This module included a section on professional life orientation, which dealt with HIV/AIDS issues. (Interview with Thabisile Buthelezi, 21st August 2002)

Four new teaching modules for students have been developed. Three of the modules will be taught in the second year and are elective modules so not all students will take them. Each module is 160 hours and 16 credits. The four modules developed are run through lectures, tutorials (in small groups), assignments and exams.

The first three modules include a module for students undertaking the foundation and intermediate phase teaching, a module for students undertaking the senior and FET phase teaching and a third module open to students who have undertaken one of these first two, this will be a skills based module on counseling skills.

The first two modules are for Bachelor of Education students specialising in the different phases. The titles of these modules are 'HIV / AIDS and Gender in Education: Issues and Strategies for Foundation and Intermediate Phases/ Issues and Strategies for Senior and Further Education and Training Phases'. In order to undertake the modules, students must have successfully completed the HIV / AIDS and Gender awareness section in Professional Life Orientation (PLO) Module in First year. (Module Templates, T Buthelezi, 2002)

Purpose

The main purpose of these modules is to train students to be the resource person for their future school for all HIV/AIDS matters.

The purpose of these modules was: To equip educators with adequate knowledge base which will enable them to:

- Implement sexuality education relevant to the foundation and intermediate phases, HIV/AIDS and gender programmes in schools
- Implement national and provincial policies and strategies that relate to HIV/AIDS, gender and sexuality education
- Function as resource persons for transformation who play a major role in creating a climate in schools where learners learn freely and educators are trusted and accessible sources of advice for individual problems

- relating to sexuality and HIV/AIDS
- Fulfil their extended role as leaders in community, caregivers and mentors

The statement of specific learning outcomes for the module are that students will:

- Demonstrate knowledge of the skills, attitudes and values involved in sexuality education
- Demonstrate knowledge of the qualities of the educator responsible for sexuality education
- Demonstrate knowledge of the disease (AIDS) transmission, progression and treatment as well as opportunistic infections
- Demonstrate knowledge about child abuse and the understanding of the educator's role in the management of child abuse in schools
- Demonstrate knowledge about the concept of gender and gender stereotypes and the equal rights for male and female as they relate to education
- Demonstrate knowledge about the care and support of learners and educators who are affected/infected by HIV/AIDS

(Module Templates, T Buthelezi, 2002)

Format

The documentation describes a long list of topics that will be covered in the modules, these are: Sexuality Education, Reproductive Health and HIV / AIDS, Conceptualisation, Child health/ adolescent health, Sexuality education during foundation and, intermediate phases in schools/ senior and further education training phases, Skills, attitudes and values in sexuality education, The sexuality education teacher, Managing HIV / AIDS in education, Prevention programmes in schools, Clinical AIDS, HIV / AIDS and other infectious diseases, HIV / AIDS and National Policies and Strategies, Care and support of learners and educators who are affected and infected by HIV / AIDS, Peer education counselling and mentoring, Available resources, Gender in education, Mainstreaming Gender and HIV / AIDS in education, Child abuse: Legislative framework and prevention programmes, Management of Child abuse in education, Teenage pregnancy, and Drug and substance abuse.

(Module Templates, T Buthelezi, 2002)

Teaching Methods

The types of delivery for the modules; these include lectures, practicals, tutorials, field trips, placements, test and exams, and resource-based learning. There will also be assignments and self directed study to make up the 160 hours.

The teaching methods used on the module include:

- Lecture presentations
- Seminar presentations and workshops based on student self study
- Tutorial discussions based on case studies
- Discussions based on completed project work

(Module Templates, T Buthelezi, 2002)

Assessment

When examining the students the examiners will look for such things as knowledge of the skills, attitudes and values involved in sexuality education, knowledge about the qualities of the educator responsible for sexuality education, knowledge of the disease (AIDS) transmission, progression and treatment as well as opportunistic infections, knowledge about child abuse and the understanding of the educator's role in the management of child abuse in schools, gender sensitive attitudes in small group situations, knowledge about the care and support of learners and educators who are affected/infected by HIV/AIDS. The methods of assessment used will include assignments and projects, test on case studies, assessment in tutorials and formal exam questions.

(Module Templates, T Buthelezi, 2002)

A third module, as I mentioned above is one which is offered to students who have completed one of the previous two. It is entitled 'HIV / AIDS and Gender in Education: Facilitation, care and counseling skills for educators'. (Interview with Thabisile Buthelezi, 21st August 2002)

Purpose

The learning outcomes for the module are documented as:

- Students will be able to teach sexuality education in schools
- Students will demonstrate skills to organise and facilitate workshops and seminars on controversial topics like teenage pregnancy, gender issues and sensitivity training on stress management
- Students will be able to demonstrate basic counselling and management skills that relate to care and support of educators and learners affected/infected with HIV/AIDS, sexual harassment, trauma/crisis/ grief and mortality, pre- and post test counselling
- Students will demonstrate skills of identifying stereotypes and evaluating learner support material for their gender sensitivity and bias.
- Students will demonstrate skills of developing intervention strategies and programmes for youth and communities that will reduce the spread and impact of HIV/AIDS
- Students will be able to do peer education, counseling and mentoring

(Module Templates, T Buthelezi, 2002)

Format

Again there is a long list of content topics these mostly focus on counselling skills and the management of HIV/AIDS in education. They also include Gender and AIDS in education and Legal and Ethical considerations (e.g. confidentiality) (Module Templates, T Buthelezi, 2002)

Teaching Methods

The types of delivery for the course and teaching methods used are similar to the previous modules i.e. Lecture presentations, Seminar presentations and workshops based on students self-study and discussions based on completed practical projects and case studies. (Module Templates, T Buthelezi, 2002)

Assessment

Again the assessment criteria and types of assessment are similar to that stated above. (Module Templates, T Buthelezi, 2002)

A fourth module has also been developed, this will be offered to honours students who have already completed their Bachelor of Education Degree. This module is entitled 'Management of HIV/AIDS and Reproductive Health in Education'. (Interview with Thabisile Buthelezi, 21st August 2002)

Purpose

The purpose of this module is: to enable educators to develop the abilities to function as:

- Resource persons in schools and education management, with a strong understanding of the disease and its dynamics, of reproductive health and of national and provincial policies.
- Facilitators of programmes designed to increase the understanding of the disease and its dynamics or Lay counselors who are trusted and accessible sources of advice for individual problems relating to sexuality and HIV/AIDS.

The specific learning outcomes are:

- Demonstrate knowledge of the disease and its dynamics,
- Use basic counseling skills to interact with people on HIV/AIDS and reproductive health issues
- Demonstrate skills to facilitate designed programmes to help clarify issues that relate to HIV/AIDS

- Demonstrate an understanding of gender being central in the prevention of HIV/AIDS
- Demonstrate knowledge and understanding of the educators role in the management of HIV/AIDS and related issues in education

(Module Templates, T Buthelezi, 2002)

Format

The content topics for this course are: Dynamics of HIV/AIDS, Reproductive health, Gender issues, Policies and Management issues, Facilitating workshops and programmes, and basic counseling skills.

(Module Templates, T Buthelezi, 2002)

Teaching Methods

The delivery again includes lectures, tutorials and placements and the teaching methods used include lecture presentations, seminar presentations and workshops based on student self study, tutorial discussions based on case studies and discussions based on completed project work

(Module Templates, T Buthelezi, 2002)

Assessment

The module will be assessed using assessment in tutorials – of case study situations, assignments and projects, tests based on case studies, and formal tests.

(Module Templates, T Buthelezi, 2002)

Disciplinary Link

These modules are aimed at training the teachers of the future, teachers who will have to deal with HIV/AIDS issues in their classrooms and schools. These teachers will require a sound knowledge of the disease and its dynamics, knowledge of reproductive health and policies, and practical skills such as: basic counseling skills, skills to facilitate HIV/AIDS programmes, skills to carry out the educators role in the management of HIV/AIDS.

It was stated that ‘These modules aim to equip educators with skills so that they become sources of advice for individual / institutional problems relating to sexuality education and HIV/AIDS in their schools and establishments and that they become initiators and facilitators of HIV/AIDS programmes which aim at reducing the epidemic’. (Interview with Thabisile Buthelezi, 21st August 2002)

Limitations and Possibilities of the 'Stand Alone' Module

The three modules examined are all quite different. The first module in the School of Law was a compulsory module for all first year law students. The module was heavily linked in with the Law degree syllabus, so that there was a clear disciplinary link for the students. The purpose of the module was also made clear and the students understood why they had to undertake this module.

The second of the modules was truly a 'stand alone module' in that it was not a core compulsory module for any particular degree, but was an optional module open to students across all faculties. For this reason there was no set disciplinary link. Students attending this module are expected to form their own links with their disciplines and research work. A module such as this may provide an excellent choice for those disciplines which do not lend themselves easily to the integration of in-depth HIV/AIDS education, but I feel that it is still important for those programmes to still make clear the disciplinary links between HIV/AIDS and their discipline. All current and future students will be looking for employment in a HIV/AIDS affected world.

The third set of modules – for teachers, had not yet been undertaken, although they were well documented with clear purpose, outcomes and assessments. It was surprising to note that these are not compulsory modules but are part of the optional modules for future teachers.

It appears that although these modules required a great deal of background work and preparation the modules themselves are then fairly easy to undertake and administer. These modules do of course require support from the top of the school or faculty in integrating into the curricula. We have seen that the testing and examining of these models has been documented and standardised to a great degree and this helps make the process run smoother.

4.4.5 Other HIV/AIDS Education - Taught Informally/Incidentally

Although not included as a model of formally integrating HIV/AIDS Education into academic curricula, it is worth highlighting a number of examples of informal education.

Example 1 – The Engineering Example

In the School of Chemical Engineering I initially spoke to Professor Arnold the head of the school. He explained that HIV/AIDS is not taught formally at the school but is highlighted in a final year management course and that it is covered from an industrial labour point of view. He then suggested that I contact John Buzzard who is a consultant and comes in to lecture on labour relations. (Telephone conversation with Prof Arnold, 1st August 2002)

Purpose

To get the students to think about the long term planning and management issues in a HIV/AIDS world and ‘to wake up the students to the realities of the HIV/AIDS pandemic’. (Interview with John Buzzard, 8th August 2002)

Format/Teaching Methods

HIV/AIDS issues are covered, but with difficulty. In the lectures it is covered in a mainly anecdotal way i.e. the problems of HIV/AIDS in the workplace, particularly staffing issues. John stated that ‘I do not officially cover HIV/AIDS in any of my lectures, it is mainly anecdotal as I have had considerable exposure to he problems.’ (Interview with John Buzzard, 8th August 2002)

Assessment

When I asked about the examination of HIV/AIDS issues it was explained that this education was not examinable at present. (Interview with John Buzzard, 8th August 2002)

Learning/Impact of this module on the students

It was stated that ‘The attitude of the students are either straight disbelief or a lack of comprehension of the size of the problem, I find both attitudes really scary’. (Interview with John Buzzard, 8th August 2002)

Disciplinary Link

The main disciplinary link is with the legal and managerial side of engineering, covering long term planning, personnel development and union relationships. It was stated that 'if the course is to have any relevance it is impossible not to cover the effect AIDS will have both on the workforce and managerially'. (Interview with John Buzzard, 8th August 2002)

Example 2 – The Economics Example

In the School of Economics a number of courses are including HIV/AIDS Education. These included the 'Quantitative Management Course', the 'Business Statistics Course' for second year students, undertaking the Bachelor of Business Science Degree, and the Postgraduate Health Economics Course. (Interview with Christopher Maxwell Brown, 7th August 2002)

Purpose

The purpose of the HIV/AIDS education in the Quantitative Management Course was simply to highlight statistical concepts, using an important subject, in order to raise awareness of the problem.

The purpose of the Business Statistics Course was to give the students a real world problem so that they can see the relevance of statistics, for example the prevalence rates of HIV/AIDS by province, and then is able to look at what the data tells them about the statistics for KZN compared to other provinces.

At the Postgraduate Health Economics Course the students already have the statistics knowledge, so the purpose of the health economics course is to teach students general health economic principles and applications, this includes HIV/AIDS issues.

(Interview with Christopher Maxwell Brown, 7th August 2002)

Format/Teaching Methods

The Quantitative Management Course is a first year undergraduate course, designed for students who need to brush up on their statistics skills. It is open to students from all faculties and has about 1000 students per year. It is a 13-week course. The first half of the course is descriptive statistics and HIV/AIDS issues are introduced into the course using statistical data so that the course seems more real to the students. With this course HIV/AIDS issues are used as a vehicle for teaching statistics to first year students.

In the Business Statistics Course they use real life case studies from the ministry to show that HIV/AIDS has a real role to play in informing business planning.

In Health Economics they are looking at major diseases in South Africa today i.e. HIV, malaria and TB. HIV/AIDS issues were integral to the health economics course, and the main aspects of HIV/AIDS covered on this course were economic aspects, treatment and prevention and cost effectiveness of drugs. (Interview with Christopher Maxwell Brown, 7th August 2002)

Assessment

When I asked about examining the HIV/AIDS education within the School of Economics, it was explained that such knowledge is not really examined at present. It is intended though that such knowledge can be examined (certainly at the postgraduate level) in the future through, project work, research and case studies. (Interview with Christopher Maxwell Brown, 7th August 2002)

Learning/Impact of this module on the students

I contacted a third year economics student and asked what they had covered regarding HIV/AIDS as part of their course. The student felt that they hadn't covered HIV/AIDS in any depth but said that it definitely had covered been brought up in most subjects over the three years. (Interview with Economics Student, 12th August 2002)

Disciplinary Link

It was explained that there is a shortage of health economic specialists at present so it is possible that these students could potentially reach quite high positions in future employment – they could be the planners of the future. It was therefore felt that they need to be equipped to handle the HIV/AIDS crisis in South Africa. (Interview with Christopher Maxwell Brown, 7th August 2002)

Example 3 - The Architecture Example

In the School of Architecture HIV/AIDS education is incorporated into the research projects for third year students.

Purpose

The main purpose of the HIV/AIDS education was to get Students to think about their future work/employment as architects. (Interview with Kevin Bingham, 2nd August 2002)

Format/Teaching Methods

Although there is no formal lecturing on HIV/AIDS the students are encouraged to include it in their research and many of the students undertake research into this field. (Interview with Kevin Bingham, 2nd August 2002)

Assessment

Although the research is examined and marked, at present there are no guidelines drawn up for examining on HIV/AIDS issues and this poses a problem for examining on such issues. (Interview with Kevin Bingham, 2nd August 2002)

Learning/Impact of this module on the students

It was explained that the School of Architecture is very socially driven, and some students sometimes get fed up with such issues and want to move on to more 'glitzy' projects such as Office buildings and Luxury apartments. (Interview with Kevin Bingham, 2nd August 2002)

Disciplinary Link

It was stated that within architecture there is a real need for a new type of work and thinking. The need is becoming greater for work in less glamorous roles in architectural terms, this type of work may not pay as much and may not be as glamorous as some learners are hoping. The main link was that architects provide buildings for every walk of life and the students will need to think about new designs for a future HIV/AIDS society, prisons for example will require more medical facilities or will need cells designed for people living with HIV/AIDS. (Interview with Kevin Bingham, 2nd August 2002)

Limitations and Possibilities of teaching HIV/AIDS Education informally/incidentally

I feel that for a vast majority of schools and programmes throughout the university, this is probably how they are undertaking HIV/AIDS education. HIV/AIDS issues are arising on an informal incidental basis, but we are not yet quite sure how we can take it that one step further and begin to formalise it.

The main problems with this type of teaching are firstly that there is no structure to the education and no documentation and therefore it is not consistent. Secondly, the purpose and outcome of the education is not defined and the education is very much dependant on the lecturers own interest. Lastly the examples here have shown that such education is difficult to examine and at present goes unexamined.

Mike Newman, when writing about adult education, has documented this type of learning as:

‘This sort of learning occurs when people consciously try to learn from experiences. It involves individual or group reflection on experience, but does not involve formal instruction. There is no planned and structured educational program, but learning is consciously done. Such learning is incidental to the activity in which the person is involved, and is often tacit and not seen as learning. Incidental learning often occurs during action and can be very real and empowering, but it is incidental to the action taken, and may not be accredited as learning.’ (Newman, 1995: 247-248, paraphrased)

The challenge now is for universities to find ways of documenting, recognising and accrediting this learning and giving it the value it deserves.

4.5 Part Four

4.5.1 Main Insights

The main insights that came out of this research are summarised below.

The Inclusion of an HIV/AIDS component into academic curricula often depends on initiatives from individuals.

Of the cases I interviewed, the interest and enthusiasm of the lecturers involved in integrating HIV/AIDS education seemed to be the key driving force. The lecturers interviewed were all genuinely engaged in the struggle to halt the spread of HIV/AIDS and were deeply motivated by their own interest in the topic. In the majority of the cases the initiative was not particularly coming from faculty level, even though for many it was supported by faculty, but was due largely to initiatives by lecturers themselves.

The HIV/AIDS education is being covered in an accurate manner

We have seen that throughout the majority of the cases studies it was clear that the lecturers had gone to great lengths to provide the students with accurate information. From the interviews and the observations undertaken it was seen that much of the information used by the lecturers had been taken from university initiatives such as the HEARD AIDS Briefs or publications by Alan Whiteside.

The education being undertaken is responding to a future HIV/AIDS society

All of the evidence shows that HIV/AIDS will not just disappear anytime soon, it will be with us for generations to come. In the cases studied it was clear that the lecturers were keen to respond to a future HIV/AIDS society and prepare students for life in such a society. Throughout the interviews the emphasis on social responsibility and the effects of HIV/AIDS on society arose time and time again.

HIV/AIDS education is introducing new fields of study into university education and is increasing the interest in HIV/AIDS related research.

Throughout all of the departments studied it was clear that HIV/AIDS education is introducing new fields of study in all faculties of the university. This includes the social perspective, economic perspective and the medical perspective. It was also evident that many students are now engaged or interested in undertaking research in the HIV/AIDS field. It was also mentioned that many overseas students are coming to South Africa to undertake research in the field.

Getting Students to own the problem of HIV/AIDS is an ongoing process

Attempting to get students to Own HIV/AIDS issues is an ongoing struggle for many lecturers. It was explained that students see the problem as 'out there' and happening to other people. By using some of the teaching methods described in this research many of the lecturers were attempting to break down such attitudes and perceptions.

All students interviewed felt that the HIV/AIDS education was important

It was interesting to note that all of the students interviewed felt strongly that HIV/AIDS education should be integrated into academic curricula. The students felt that this was the only way to begin to overcome the stigma and attitudes associated with the disease.

4.5.2 Questions and Surprises

The research also brought into light some questions and surprises.

The emphasis on ‘behaviour’ and ‘attitudes’ with regard to HIV/AIDS.

Before undertaking this research I expected that HIV/AIDS education was taking place within curricula at the university. I expected that the majority of this education would be factual and taught in a didactic manner. I expected that the reason such education was taking place would be to equip the students for future employment and to make the links with their discipline. It was therefore surprising to learn that in the majority of cases the HIV/AIDS education was much more than this in both its content and the teaching methods being employed. It was particularly surprising to find so many of the cases looking at attitudes, behaviour and critical thinking.

Why Counselling Skills for some and not for others?

It appeared from the research that counselling skills are currently only being taught to students in the community based learning model. The taught education modules state that they intend to teach counselling skills to our future teachers to prepare them for what lies ahead. When we consider the wider impact of HIV/AIDS for the future maybe we need to all learn those counselling skills to help us to cope, and to help us to help others to cope.

What makes some Schools/Programmes able to integrate HIV/AIDS education into curricula and others not?

I have put forward this question as in my mind I can hear lecturers saying ‘oh well it’s easy for them to do it, its much more difficult/complicated for us though’. Maybe I am just being cynical. My thoughts on this matter is that the factors making such integration easy or difficult are mainly one of two points:

The Discipline Itself

It is obvious that some disciplines lend themselves more readily to HIV/AIDS education than others. For example we can see easily how such education fits with social sciences, community development, medicine and law. What we have also seen from these case studies is that there are methods for integrating HIV/AIDS education into for example: Mathematics (using statistics), Engineering (making equipment for HIV positive people), History (looking at diseases) or Art (through bringing art into people living with AIDS lives).

Lecturers Personalities / Teaching Backgrounds

It may be that some lecturers have had more experience in teaching about such topics and feel more comfortable with the topic. For those lecturers who feel they don't have the information or the experience then it may be wise to try other methods. For example a number of the cases have shown that using guest lecturers to speak on the subject works well, that setting up initiatives with other schools or with the community can be successful. There is even the possibility of using more senior students as facilitators for peer education on HIV/AIDS issues.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The literature review undertaken for this research showed that, although there is much literature around HIV/AIDS and its importance in education, there are gaps in how such education should or could be integrated into curricula. This research has attempted to go some way into that gap by showing a number of models used for integrating such education into academic curricula and how these models work in practice.

We saw in the literature review that Chetty (2002, p25) looked at the options and models for teaching about HIV/AIDS. He stated that the range of options included the following:

- Provide education on HIV/AIDS through non-formal means as part of a prevention strategy – *Non-Formal Model*.
- Infuse issues of HIV/AIDS across the curriculum as both prevention strategy and as an academic requirement - *An Integrated Model*
- Devise core compulsory courses across all disciplines (prevention and academic requirement) - *Compulsory Model*
- Implement compulsory courses which include HIV/AIDS issues within a life skills curriculum - *Specialised Courses*.

In this research I have focused on Chetty's second option, the 'integrated models' in which HIV/AIDS is integrated into the formal academic curricula. Within this integrated model there were a number of modes of delivery, these included: Community based learning, Project work and Research, Stand Alone modules within the curricula and those modules that are incorporated into other teaching/discourses.

Looking at the teaching methods used we saw that there were also different ways of integrating HIV/AIDS i.e. through input /presentations (lectures- usually aimed at giving information), through discussion (usually aimed at deepening understanding or dealing with attitudes), or simulations (case studies/ role plays). The choice of method was usually linked to the purpose of the education.

Also when speaking about Adult Education in general, Mike Newman refers to formal education as

‘The form of adult learning with which we are most familiar. Its distinguishing characteristics are that it is organised by professional educators, there is a defined curriculum, and it often leads to a qualification’.

(Newman, 1995)

The first formal model we looked at was the 'Community Based Learning Model', although an excellent model for involving students in the learning experience it has also been considered a 'luxury model' in that it requires enormous coordination, commitment and resources.

The second model looked at used 'Project Work' and 'Research Work' to teach about HIV/AIDS. This type of model appeared simpler to undertake than that of community based learning, mainly due to time constraints, the number of partners involved, and budgets. But it still involved linking with the community and in the examples looked at they also brought in external people to discuss HIV/AIDS issues in the classroom. It also appeared simpler in that students could be given a HIV/AIDS topic to research and could go ahead and undertake this research without much prior teaching of HIV/AIDS education. The difficult part of this model came with examining: What exactly was to be examined and how would lecturers know if the purpose of the exercise had been met.

The third model was where HIV/AIDS education was 'integrated into other modules throughout the year'- these courses were not taught as a separate module, but were integrated into other modules. The examples we looked at in medicine, anthropology and gender studies appeared to work well for those subjects and disciplines that lend themselves to the inclusion of a HIV/AIDS component. As I have said, it may be that many programmes and courses, throughout the university, integrate HIV/AIDS education into their curriculum in this way, but the models shown here have formalised this integration. They have done this by documenting what HIV/AIDS education will take place, what the purpose of the education will be and how it will be examined. I believe this to be the key to successful integration of HIV/AIDS education.

The fourth model was that of the 'stand alone module' where the module was a separate HIV/AIDS module. This model took on a number of forms i.e. the compulsory module for first year Law students, the optional/specialized module open to students across the university, the future planned modules for the School of Education – also optional modules but tied in closely with the undergraduate curricula for teacher training. This model of HIV/AIDS Education appeared to work particularly well when it was integrated with the particular curricula, e.g. using case studies from law, using role play and group work. It appeared that although this model required a great deal of background work and preparation the models themselves were then fairly easy to undertake and administer and as the assessment process was formalised this was also easier.

Although not a model of formal, integrated HIV/AIDS Education, we also looked at examples where HIV/AIDS was being taught 'informally/incidentally' to the subject being taught. The examples looked at were those of Chemical Engineering, Architecture and Economics but for a vast majority of schools and programmes throughout the university, this is probably where they are at. HIV/AIDS issues are arising on an informal/incidental basis, but we are not yet quite sure how we can

take it that one step further and begin to formalise it. As I have said the challenge now is for universities to find ways of documenting, recognising and accrediting this learning and giving it the value it deserves.

5.2 Answers To Research Questions

The answers to the main research questions posed by this research in chapter one are outlined below.

5.2.1 What are the different ways that HIV/AIDS education is incorporated into academic curricula?

When asked how the lecturers incorporated HIV/AIDS education into curricula the responses to the question tended to fall into one or more of the categories listed below. A number of the cases did not use one method exclusively but a number of methods combined.

- Through Community Based learning
- Through Research/Project Work
- Through integrating into existing/other modules
- Through a stand alone module

In three of the cases studied HIV/AIDS issues were not being formally integrated into curricula at present. In these cases the HIV/AIDS education was being undertaken informally and incidentally within the classroom.

5.2.2 What do lecturers consider to be the specific links between their subject matter and HIV/AIDS?

When asked what the specific links between their particular subject matter and HIV/AIDS were the responses tended to fall into different categories of learning i.e. learning specific information, understanding the information, using the information to learn specific skills, and finally to examine behaviour and attitudes. All of the cases linked with both theoretical understanding and practical understanding of the disease.

- Theoretical Understanding – society, culture, economics, gender, environments
- Practical Understanding – counselling, coping with grief, legal issues, planning issues, management, medical treatment, employment



5.2.3 What is the purpose of such education? Why are lecturers choosing to incorporate HIV/AIDS education into their programmes?

When asked what the purpose of the HIV/AIDS education was, each case came up with a number of purposes; many of these were similar and are listed below.

- To make the subject matter seem more real e.g. Using a real world problem can help learners to see the relevance of statistics in everyday life
- To look at the economic impact - also what, if anything, can be done about it?
- Look at effects on society - social questions of crisis, citizenship issues, able people acting responsibly and issues around making informed opinions
- Think about future employment - In many of the cases one of the purposes was to get the learners to think about their future employment or to equip them for employment in an HIV/AIDS world. This is particularly evident in the School of Education where the stated aim of the modules is “to train students to be the resources person for their future school for all HIV/AIDS matters”.
- To equip senior planners of the future with knowledge – the students could potentially reach quite high positions in future employment – they could be the planners of the future
- To develop informed attitudes and opinions - For instance in the Medical School the purpose was stated as “to diffuse fear, as learners will have to deal directly with AIDS patients in their jobs. Also to break down judgmental attitudes and challenge attitudes”
- To get students to own HIV/AIDS issues - students see the problem as ‘out there’ and happening to other people.
- To attempt to influence behaviour - what lecturers hope is that through the education they can have an influence on the students awareness, attitudes and behaviour

5.2.4 What aspects of HIV/AIDS are being covered within the programmes?

When asked what different aspects of HIV/AIDS were covered in their education the lecturers responded with the following:

- The basics – what is it and how is it transmitted,
- Effects on future society - in particular the effects on future employment prospects.
- The statistics - to highlight to the students the relevance of the topic.
- Attitudes - learners attitudes towards HIV/AIDS issues
- Behaviour – taking risks, having multiple partners, safe sex
- Economic impacts – education, housing etc
- Interventions that could be made by government – providing drugs, changing migrant labour, care of orphans and national policies on health care

- South African context - Cultural / historical factors – migrant labour, sex workers
- Myths - how it is transmitted, how to treat it, and how to rid oneself of it!
- Gender issues – masculinity
- Prevention - sexual behaviour and needle stick injuries
- Treatment - treatment options for HIV/AIDS were also covered in a small number of the cases
- Policies – national, workplace - A number of the cases are including national, provincial, local, workplace and educational policies on HIV/AIDS as an important educational aspect
- Management of HIV/AIDS in the workplace
- Counselling Skills

5.2.5 What teaching methods are used to get students to relate HIV/AIDS to disciplinary knowledge in order to inform decision-making?

The two main teaching methods used were those of presenting information – didactic teaching, using formal lectures and written assignments, and that of participative learning. The participative learning took on a number of forms as shown below.

- Involvement of the learners – for example in investigative project work or research regarding HIV/AIDS and their chosen subject
- Critical Reflection – e.g. of project experiences, of own life and experiences
- Role-play plus reflection – using role play to teach counselling skills or to get students to think critically about their attitudes
- Through group activities – Group activities such as community interventions and group presentations were used to get students to consider HIV/AIDS issues and their discipline
- Discussion – involving the students in group discussion about HIV/AIDS issues
- Using real life case studies - In the Department of Economics they are running a number of statistical courses and quantitative research courses. In these courses they are using HIV/AIDS statistics to make the course seem more real to the students.

5.2.6 What are the main positive features of the current HIV/AIDS programmes being undertaken?

When asked what they would consider to be the main positive features of the HIV/AIDS education that they were involved in at present, lecturers came up with a number of ideas. These are listed below.

- It is supported from the top
- It uses a systematic, planned process

- It is based on a situation analysis within their discipline - carrying out an analysis of how HIV/AIDS was affecting their particular school, speciality, field, industry and ensuring that the HIV/AIDS education was relevant to students in their discipline.
- It involved the learners in the learning and the process - many of the lecturers stated that involving the learners is important. This included not only involving the learners in the learning e.g. with role-play and reflections, but also in the process of developing the HIV/AIDS education. This was happening in a number of departments where they were using more senior students as facilitators, or groups of students were developing educational interventions
- It was challenging the learners –challenged the learners knowledge, attitudes and beliefs regarding HIV/AIDS.
- It has been a dynamic, evolving process - Many of the lecturers felt that HIV/AIDS education is a dynamic evolving process and that this should be seen in a positive light. In particular those who were fairly new to the subject were keen to let the education evolve with time and with further evaluations.
- It was monitored and evaluated in some way - The vast majority of the cases agreed that the constant monitoring and evaluation of their work was necessary in order to continually develop and improve the quality of the HIV/AIDS education on offer.
- It covered life skills - A number of the cases felt it was important to cover ‘life-skills’ education as part of the ongoing HIV/AIDS education. This included such things as assertiveness, communication, responsiveness, being able to say no, being critically aware, and dealing with gender issues.
- It a number of cases the overall purpose was that it attempted to empower individuals to live responsive and healthy lives - It was stated in the majority of the case studies that the HIV/AIDS education should work towards empowering individuals to live responsive and healthy lives.
- It was rooted in the interests and lives of the students - it was felt that unless the HIV/AIDS education was rooted in the interests and lives of the students, through the engagement with their chosen discipline, it would not be successful.

5.2.7 What are the main difficulties/concerns encountered by the different schools in incorporating HIV/AIDS education into the curricula?

Below I have listed the main difficulties and concerns the lecturers had in carrying out HIV/AIDS education.

- Unclear guidelines / no guidelines - many of the cases that were new to this type of education felt that there were no clear guidelines for teaching about HIV/AIDS within their discipline. In contrast, one case mentioned that having guidelines that are too controlling might limit some of the creative initiatives that are happening.

- Difficulty in examining - It was also expressed that there was difficulty in examining the HIV/AIDS education. What exactly is to be examined? Is it knowledge and understanding, attitudes, ethical issues?
- Difficulty in ensuring continuity of HIV/AIDS education/knowledge - It was expressed as a concern that if the HIV/AIDS education is not continued throughout the students life i.e. in the workplace, then it may all have been in vain.
- Student reactions – silence, racial, attitudes, boredom, helplessness - All of the cases felt that they were concerned about the students reactions towards the education. The racial dynamics of HIV/AIDS was also mentioned as a concern. Many of the students see HIV/AIDS as focused on African people, the lecturers were concerned with making the issues about everyone. A further difficulty in confronting HIV/AIDS education is that the lecturers are aware that many students are HIV positive and know it. The feelings of these people must be taken into account and respected.
- Ethical issues of research i.e. control groups, community work - There was concern about the ethical issues around some of the students projects. A number of the lecturers felt that we are still learning at the expense of the community, with the community not seeing the benefits, just the inconvenience. Also when working with the community mistakes are made 'in the community'.
- Practical issues – i.e. finding facilitators, costs, time

5.3 Conclusions

It is clear from this research that many faculties and departments, as well as individuals have incorporated aspects of HIV/AIDS education into their programmes. Obviously the information obtained from this small investigation does not provide a complete picture of the HIV/AIDS work at the University of Natal but shows examples of some of the attempts to provide HIV/AIDS education. Success in overcoming HIV/AIDS in a university demands exceptional personal, moral, political and social commitment on the part of the top university executives. The responsibility for mainstreaming HIV/AIDS into all of a universities operations, including teaching and research, should rest not only with the senior university executives and their officers, but also with all staff and all lecturers. Having said this support must come from the top and in the absence of such leadership, the efforts of staff and students could remain uncoordinated and often go unresourced. Moreover, because they are vested in individuals, such efforts could lack sustainability. In this case study it appears that since integration has not happened 'universally' (i.e. in all schools/ faculties / modules) it could happen that a student emerges without having had any exposure to HIV/AIDS Education. It is also clear that HIV/AIDS education places additional burdens and responsibilities on lecturers and as a consequence a strong support system needs to be developed and maintained. The University of Natal HIV/AIDS Plan goes some way to meeting these commitments but needs now to follow with steps that convert these statements into action.

In a university setting it seems that an appropriate course would be to follow the example of some of the case studies and to integrate relevant HIV/AIDS concerns into all teaching programmes and courses, underlining their relevance to subsequent professional life. This mainstreaming should not be confined to the formal learning situations of lecture rooms and laboratories, but should extend to include fieldwork, practical attachments and research investigations that are integral to them. So that these efforts will not degenerate into a series of uncoordinated and department or person specific initiatives, it may be necessary for university senates to mandate this mainstreaming, to monitor its implementation and to ensure accountability in its regard.

It is also clear that the students of today will need to be more flexible in their future employment so that they can easily resume responsibility outside of their field. The narrow academic preparation of graduates was never a good thing but it is even less so in an HIV/AIDS dominated society. This can easily be seen in the teaching profession. A secondary school teacher competent in only one subject is of much less value to an HIV/AIDS stricken school community than one who in addition to the major subject possesses more minor subjects and is flexible. Perhaps more than ever before universities should concentrate in their undergraduate programmes on ensuring that students master the skills of learning – in the jargon, that they learn how to learn – so that they will be flexible, adaptable and hopefully innovative in response to today's fast changing and unpredictable HIV/AIDS world.

5.4 Recommendations

Following on from these conclusions I would also like to put forward some particular recommendations for educators, regarding HIV/AIDS education that need consideration in the near future:

- At present very few people are designated with full time responsibility for dealing with HIV/AIDS in the curricula, but we can see that this is a growing trend, for example in the Faculty of Education. It may be that the longer HIV/AIDS remains an add-on function, the lower the profile it has and the lower the chances of success in addressing the problem. HIV/AIDS is a new field and requires expertise; a real danger exists in putting more pressure on already overburdened individuals.
- The Budgets for HIV/AIDS education within curricula will need to be seriously reviewed. A number of the models shown incur expense and this will need to be budgeted for.
- Good HIV/AIDS related research work and publications are emerging but these need to be made more available e.g. the HEARD AIDS Briefs – some lecturers were not aware of them.
- New areas of study and research are emerging as HIV/AIDS seeps through university life. These include such topics as sexuality, risk taking, theology, human rights, life skills, and counselling in all professions. Academic curricula will need to reflect these topics.
- All educators are involved in the fight against HIV/AIDS and they need to be constantly aware of its threat. Educators should never waste the opportunity to talk about HIV/AIDS to their learners, colleagues and even their bosses.
- Educators should seek to create an environment where learners can talk freely about HIV/AIDS issues
- Educators need to find creative ways to teach HIV/AIDS awareness and skills to students.
- Educators must be thoroughly equipped with knowledge and insights to enable them to develop appropriate programmes to teach about HIV/AIDS.

5.5 Recommendations for future research

I have viewed this as a preliminary study into HIV/AIDS education at the university. The implications of HIV/AIDS for university education are still emerging and the concept of mainstreaming still evolving. I feel that this research does not have an end in itself as it in fact begs more questions than it answers. These questions include:

- What models and methods of teaching HIV/AIDS are more effective and efficient?
- How can guidelines be drawn up to help other programmes develop their own models?
- How can such guidelines be disseminated?
- How can the barriers and difficulties expressed be overcome?
- What do we do about Distance Education?
- What are the attitudes of lecturers who are not yet involved in HIV/AIDS education?

5.6 Final Conclusion

From this small study I have shown how different teaching methods have been applied to the cases in order to undertake the HIV/AIDS education. When we look at the learning theories that may underpin the cases we can see that there is a good deal of overlap between the various theories and that the cases cannot easily be slotted into one particular learning/teaching theory.

The teaching methods used in the cases included:

- Didactic teaching
- Discussion
- Groupwork
- Involvement of the learners
- Using weekly reflections
- Through group activities
- Critical Reflection on own life and experiences
- Role-play plus reflection
- Investigative project work
- Written assignments

Each of us from our own experience of education will know which teachers and which ways of teaching were most effective for us. Most of us would conclude that whenever our own involvement in learning occurred, the message was more likely to be received and remain. It is important that lecturers think about why things are done in the way they are done, how they could be done differently and what they are trying to achieve. When lecturers decide the form of their education activity they are also choosing to frame the issue in a particular way, which may mean reconciling, integrating or choosing among different interpretations and approaches. The action that lecturers take reflects particular aims and values – particular beliefs about learning, about the influences on people's learning and about the role of the lecturer. Adult Education theory and practice does have an important part to play in informing such education, with regard to advising on the methodology of teaching and the theories and concerns that underpin it.

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APPENDICES

**AN INVESTIGATIVE STUDY INTO WAYS OF INCORPORATING
HIV/AIDS EDUCATION INTO ACADEMIC CURRICULA AT THE
UNIVERSITY OF NATAL.**

By

Ann-Marie Williams

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Master of Adult and Community Education,
University of Natal, Durban.

December, 2002
Supervised by Professor Astid Vonkotze

APPENDIX I

CONTACT LIST FOR RESEARCH

CONTACT	DATE INTERVIEWED	PLACE INTERVIEWED
Suzaane Leclerc-Madlala, Anthropology, CODAL	30 th July 2002 and 5 th August 2002	Durban Campus
Alison Todes, Urban and Regional Planning, CADD	26 th July 2002	Durban Campus
Kevin Bingham, Architecture, CADD	2 nd August 2002	Durban Campus
Kerry Frizelle, Psychology, CADD	6 th May 2002 and 13 th May 2002	Durban Campus
Leslie Greenbaum, School of Law Alan Ryecroft, School of Law Jerome Singh, School of Law	20 th May 2002 and 15 th August 2002	Durban Campus
Linda Hiles, Medical School	13 th August 2002	Medical School, Durban
Dorothy Apalsamy, Medical School Janet Giddy, Medical School Steve Reid, Medical School	20 th August 2002	Medical School, Durban
Ari Sitas, Industrial and Organisational Labour Studies, Human Sciences	30 th July 2002	Durban Campus
Christopher Maxwell Brown, Economics, Management Studies	7 th August 2002	Durban Campus
Thabisile Buthelezi, Teaching at Edgewood Campus, Education	21 August 2002	Edgewood Campus
Robert Morrell, Gender Studies, Education	10 th June 2002	Durban Campus
Prof Govender, Mechanical Engineering Charlie Robinson, Mechanical Engineering	1 st August 2002	Telephone Interview
Prof Arnold, Chemical Engineering John Buzzard, Chemical Engineering	1 st August 2002 and 8 th August 2002	Telephone + Email Interview
Prof Broadhurst, Electrical and Electronic Engineering	1 st August 2002	Telephone Interview

APPENDIX II

INTERVIEW SCHEDULES

LECTURER INTERVIEWS

INTERVIEW QUESTIONS

Introductory question

Could you explain a little about your work as a lecturer/researcher.

What subjects do you teach

What courses do you teach i.e. under/post graduate

- 1 In what ways are you incorporating HIV/AIDS education into your courses?
Prompts if necessary
I.e. is it run as a separate module? Or built into existing lessons?
Are there specific sessions on HIV/AIDS or is it less formal?
How many sessions/modules per course etc?
- 2 Is such education an examinable component of your curricula?
Yes?
Possibly?
Never?
- 3 What do you think are the specific links between your subject matter and HIV/AIDS?
- 4 What (in your view) is the purpose of your HIV/AIDS education?
Prompts if necessary
Awareness raising?
Behaviour change?
Economic impact?
Change attitudes?

- 5 What aspects of HIV/AIDS do you cover in your Courses?
Interviewer prompts if necessary
Medical
Economic
Social behaviour
Prevention
- 6 How do you attempt to get students to relate disciplinary knowledge to HIV/AIDS in order to inform their future decision making? What teaching methods do you use?
- 7 What are the main positive features of your current HIV/AIDS education?
In terms of the process of running the course and of the course content.
- 8 What have been the main difficulties and concerns for you, in incorporating such education into your curricula?

STUDENT INTERVIEWS

INTERVIEW QUESTIONS

Introductory question

Could you explain a little about yourself and what you are studying/ have studied at the university of natal

Did any of the courses you take include a HIV/AIDS component?

- 1 In what ways was HIV/AIDS education incorporated into the courses?
I.e. was it run as a separate module? Or built into existing lessons?
Were there specific sessions on HIV or was it less formal?
If it was run as sessions, how many sessions/modules per course etc?
- 2 Was such education examined or tested in any way?
- 3 What do you think are the specific links between your subject matter and HIV/AIDS?
- 4 What (in your view) was the purpose of learning about HIV/AIDS ?
Eg Awareness raising?
Behaviour change?
Economic impact?
Change attitudes?
- 4 What aspects of HIV/AIDS did you cover in your Courses?
Interviewer prompts if necessary
Medical
Economic
Social behaviour
Prevention
- 6 Do you have any suggestions about how learning about HIV/AIDS could be improved within your course?
- 7 Any further Comments?

APPENDIX III

RESEARCH QUESTIONS

- What are the different methods being used to incorporate HIV/AIDS education into academic curricula?
- What do lecturers consider to be the specific links between their subject matter and HIV/AIDS?
- What is the purpose of such education? Why are lecturers choosing to incorporate HIV/AIDS education into their programmes?
- What aspects of HIV/AIDS are being covered within the programmes?
- How do lecturers attempt to get students to relate disciplinary knowledge to HIV/AIDS in order to inform future decision-making?
- What are the main positive features of the current HIV/AIDS programmes being undertaken?
- What are the main difficulties/concerns encountered by the different schools in incorporating HIV/AIDS education into the curricula?

APPENDIX IV

DOCUMENTATION

PSYCHOLOGY PROGRAMME

1. Background to the Module

As early as 1990 it was recognised that KwaZulu-Natal (KZN) had an HIV prevalence twice that of the national level with 1.6% in KZN versus 0.76% nationally, and since then has maintained approximately 10% higher prevalence compared to South Africa nationally. There are a number of reasons for this higher-than-average HIV prevalence in the KZN province. To mention a few: the poor employment structures, the impact migrant labour has had on the family structure and extreme poverty in KZN (Smith, 2000). It was these horrifying national and provincial statistics that motivated two social Science academics to develop a HIV/AIDS module for psychology students at the University of Natal, Durban campus. As a result, a six-week theoretical course was developed and taught for the first time in the second half of the first semester of 2001. The purpose of this module: **HIV/AIDS in the South African Context** was to provide potential psychologists with a basic understanding of the sociology of HIV/AIDS with specific reference to South Africa. The aim was to encourage students to begin to think of HIV/AIDS as more than a medical issue; to recognise that HIV/AIDS is embedded in a social, political, economic and cultural matrix, that there is a dynamic relationship between HIV/AIDS as a disease, the social impact of HIV/AIDS and the way in which culture and gender constructs are related to HIV/AIDS.

At the same time that the preceding module was being developed the **CHESP** initiative on campus was taking form. Psychology, who had students register for the first time for a service learning course the previous year with COSL (Community Outreach and Service Learning), was approached to run one of the CHESP pilot programmes with its students. An academic, Kerry Frizelle, was selected to attend the CHESP training (13-16th March 2001) at Valley Trust. It was here that a partnership was formed between a community representative, Makhosi Mkhize, and a service provider, Yvonne Sliep. As a result the **HIV/AIDS and Service Learning: Transforming Theory into Practice** course came into being.

2. Process of Conceptualisation and Development

The process of conceptualisation began at the workshop (13-16th March) at Valley Trust. During this workshop each partnership was given the opportunity to engage in dialogue with each other to begin the process of partnership. At this point Ms Mkhize acted as a representative for her community (Cato Manor, Umlazi and Botha's Hill), Dr Sliep acted as a representative for her service provider (Valley Trust) and Ms Frizelle acted as representative for her students (Psychology Three University Students).

It was decided in early discussions that all three partners would be equally involved in the design, implementation and assessment of the University module. A number of meetings proceeded at which time the course structure was decided on in collaboration. The course content, lecturing responsibilities, mentoring/supervision responsibilities and method of assessment were decided on. The following responsibilities were allocated as follows:

- **Theoretical component of the course:** Ms Frizelle
- **Reflection sessions:** Ms Frizelle
- **Practical skills preparation:** Ms Frizelle, Ms Mkhize, Dr Sliep
- **Training in project area:** various, including Ms Frizelle, Ms Mkhize, Dr Sliep
- **Supervision and mentoring:** community mentors and Dr Sliep, Ms Mkhize
- **Academic assessment:** Ms Frizelle, Ms Mkhize, Dr Sliep

Through joint discussions the academic, community and service provider partnership identified the following areas that they felt were in need of enhancement in the relevant communities. As a result it was decided that the students would be given the opportunity to choose to work on one of the following projects:

- **The Memory Box Project**
- **Stigma Reduction Project**
- **Youth Focus Group Project**
- **Home-Based-Care Project**

- **Basic Life Skills Project**
- **Orphan Questionnaire Design**

Early on in the course it became evident that some of the students were really fearful about engaging with HIV/AIDS on a more practical level. There was great honesty about it. It was decided that it would be counterproductive for both the students and the community if fear stayed around and that the pace of the students would be important. The projects that were identified allowed for the opportunity for every student to choose a project and topic with which they would feel comfortable. If direct contact with people infected with HIV was still a problem an option like generating questionnaires or doing focus groups with young people was an option. The point was clearly made that everyone is able to make a contribution to fighting the impact of HIV/AIDS in some way they would be comfortable with.

At the start of the process of conceptualisation it was anticipated that the students would complete the service component of their course in one of the areas for which Ms Mkhize was acting as a representative or at one of the projects that fell under the responsibility of Valley Trust (Dr Sliet). However, once the course commenced the term 'community' was challenged by both the students and members of the partnership. It became apparent that the term 'community' was problematically being associated with 'black impoverished rural areas'. The students began to question this association as they had already been taught that the way in which HIV/AIDS has been represented has contributed to the construction of a myth that assumes that HIV/AIDS is a disease of poor black people. The black learners in the course were especially outspoken about the fact that the communities we were aiming to target were predominately black and economically disadvantaged. Their concern was that we were reinforcing and perhaps even perpetuating the myth that HIV/AIDS is a black persons disease by focusing only on these communities. Through partnership discussions it was decided that we would challenge and expand the concept of community. For example, initially three focus groups were going to be run in three historically black schools, after our discussions it was decided that three focus groups would be run in three different schools. One would

be run at a predominately black school, one at a predominately Indian school and one at a predominately white school and that a comparative analysis would be done on the findings to identify similarities and differences between the different groups.

During the process other additional changes occurred. Due to unforeseen circumstances the students who were going to do home based care in the Cato Manor region had to be relocated. In addition Dr Sliep's place of employment changed. As a result of these changes the partnership engaged in discussions to find new and appropriate sites for the implementation of the projects. It is suggested that an attitude of flexibility between the partnership made these changes relatively uncomplicated and successful!

One factor that can perhaps be loosely defined as a "prohibiting factor" to the conceptualisation and development process is that of 'time' and 'space'. That is, each of the partners are involved on a full-time basis in three different locations and organisations. This made it difficult for all three to meet with each other regularly which would have aided the process of conceptualisation and development.

3. Programme Activities and Delivery

The practical component of the course was implemented by students and members of the trio partnership.

- **Students:** Students were asked to select the project they wanted to work on early on in the course. Knowing what project they were going to engage in was useful in terms of getting a good theoretical background both within and outside of the classroom. Students were never alone in a project and worked in teams who worked collaboratively. The first step for the different groups were to design to design their projects. They presented the outlines of the projects at a reflection session with a supervisor for their specific project. More theory and skill preparation was given during these sessions. The next step was to implement the projects in the respective community sites. Depending on the project the students engaged in a number of different activities. These activities included, inter alia, setting up and running focus groups with groups of Grade Eleven learners, engaging in a number of learning

activities with children of all ages, working alongside community workers and designing questionnaires. Every project was designed to have a specific measurable outcome.

- **Partnership:** All three of the partners were involved in one of the projects. Their responsibility was one of supervision and mentoring. This included working with the students as they prepared their projects, accompanying the students to the community sites, assisting in the implementation of the projects and providing feedback to the students during and after the process of implementation and dealing with the project sites.
- **Community Mentors:** Community mentors assisted the students on two of the projects. Their role was to accompany the students into the community, to inform them about the community they were entering, to ensure their safety and to assist with translation where it was required.
- **Reflection:** Reflection was an essential part of the implementation process. Each week during the implementation phase Ms Frizelle ran separate reflection sessions for each project. During these sessions the students were free to express their concerns, achievements, frustrations and learning experiences. The role of Ms Frizelle was to assist the students in making links between theory and practice and to facilitate a process of debriefing.
- **Partnership Reflection:** Although no time was officially schedule for this reflection process the partnership was in constant contact with each other to ensure that the projects ran as smoothly as possible.
- **Co-ordination:** This responsibility rested primarily with Ms Frizelle as the academic partner towards the students and included confirmed placement sites, purchasing required equipment and resources for the project, marking weekly reflections, setting and marking tests, arranging and co-ordinating assessment processes. The students were allocated to a variety of sites:
 - A home-based-care mission/organisation in Claremont (1 x project)
 - An house for children impacted by the AIDS epidemic in Waterfall (2 x projects)
 - A local primary school (1 x project)

- Three High Schools (1 x project)

Already established links and relationships with most of these organisations ensured that they were happy to have the University students work with them. Where there were no pre-existing links or relationships with these sites, open communication and letters stating our objectives facilitated an opening for the students to enter the sites, this was the case with the three high schools.

The partnership decided that the students should be involved in designing and implementing relatively short, but high quality, projects in the respective community sites. However, in retrospect the students have suggested that in future the students should be given more time to meet with and familiarise themselves with the community site in which they will work. It is agreed by the partnership that the students did require more time scheduled on their timetable for their community work. This became evident when uncontrollable factors like the weather prevented students from visiting their sites on the scheduled days. In addition it is argued that it is essential that the students themselves spend time with representatives from the sites to discuss the prospective projects, rather than relying solely on the arrangements made by one of the partners in the trio partnership.

Again, due to issues of 'time' and 'space', discussed under the previous heading, a large proportion of the co-ordination responsibilities of the implementation phase rested with the academic partner. More projects than partners were identified and it became the responsibility of the academic partner to facilitate the other projects which resulted in more work and recruitment of additional community mentors. Primarily community and service partners that could accommodate placement of all the students is recommended.

In future it is suggested that much of the planning around the sites take place prior to the commencement of the entire module so as to avoid last minute rushes which was a problem in the implementation of this module.

Please find a copy of the course timetable and reader attached. In addition to the reader, the students were required to read a novel: **Things Fall Apart** (Achebe, 1986). The course outline requires some explanation:

- **Week 1 – 2:** These two weeks made up the theoretical component of the course. During this phase the students were asked to think critically about service learning. The students were expected to read extensive literature which ranged from definitions of service learning to critiques of the concepts like ‘help’ and ‘development’. *Things Fall Apart* (Achebe, 1986) was given to the students as a case study of a situation where ‘service’ and ‘help’ led to the destruction of an entire tribe. The aim was to encourage students to see the potential dangers of entering a community to service without having carefully considered their motives. (Ms Frizelle). In the previous semester the students had already been given an orientation to the course and had been introduced to the service and community partner who both gave an introduction lecture (Dr.Sliep and Ms Mkhize).
- **Week 3:** This week was dedicated to developing cultural competence and aimed to prepare students for their entry into communities with different backgrounds to their own. (Ms Mkhize and Dr Sliep)
- **Week 4 – 5:** During these two weeks the students underwent an extensive basic counselling skills workshop. The objective was to equip each student with interpersonal skills that would facilitate and enhance their work in the community. (Ms Frizelle)
- **Week 6:** During this week the students had a workshop on sexuality which encourage them to explore the difficulties they may have around talking about sexual issues. In addition, a women living positively with HIV came to speak to the students (External People)
- **Week 7:** This week was dedicated to the development of the respective projects. Each group received training from an individual with expertise in the area of their project. After this initial training each group was expected to work together to design the specifics of their projects. (Ms Mkhize, Dr Sliep, Ms Frizelle and External People)

- **Week 8 – 10:** Implementation phase (already discussed above)
- **Week 11:** This week was dedicated to debriefing and preparation for the mini-conference at which each group presented a paper.

4. Results of the First Implementation

Community:

It is difficult to make assumptions about how the communities benefited from the projects of this module. The nature of the projects does not allow for one to see visible outcomes or benefits to the communities. Some of the students felt that their interventions had little impact on the communities they worked with. For example, the group that was asked to develop a questionnaire to identify children orphaned by AIDS were unable to finalise their questionnaire as they were unable, due to inexplicable reasons, link up with the community member who requested the questionnaire.

Other students were aware that they will never get to see first hand the impact of their work. This is the case with three of the projects: the basic life skills course aimed to challenge gender constructs and the results are only likely to be seen as these children are forced into situations where they are required to reflect back on the lessons taught by the students. The stigma reduction project aimed to assist children with dealing with stigma as the result of having to live in an orphanage, the results of this project will only be apparent as the children encounter and grapple with future stigmatisation. Although one outcome was making a visual group project with the children which they were all extremely proud of and will be used to counteract teasing. The memory box project helped children who have lost their primary caregivers collect and store memories, the outcome of this project is also difficult to see or predict as it is largely psychological in nature. Here too one concrete outcome was the physical construction of the memory boxes. The focus group project engaged in genuine dialogue with young adults, providing them with an opportunity to identify factors that prevent youth from engaging in safe sex. The results of this project are also difficult to identify for reasons already discussed.

However, the students were able to identify some **short-term** benefits of the projects. They were able to see how the children in particular thrived on and responded to the time that they spent with the students. A teacher at the primary school commented that the children responded very well to any external recognition. The women working in the home-based-care mission were encouraged by the validation that they received from the students that worked alongside them and witnessed the valuable work they are doing in their community. The students working at the home where the children impacted by HIV/AIDS live, were encouraged to see the excitement and appreciation of the children in response to them. It was also clear that a sense of belonging for the children increased during the work that was done. The youth from the focus groups expressed gratitude at having had the opportunity to talk to someone young about their sexual concerns. Each member of these groups also received correct information about HIV/AIDS and if they read it the project succeeded in distributing correct information. One of the students who worked on this project also suggested that these youth were likely to have taken the discussion from the focus groups back to their peers and thus contributed in educating other youth in their peer groups. It would be dishonest not to comment that at times the students themselves felt that they were learning at the expense of the community. This occurred despite every attempt to avoid it and is an area of great concern for everyone in the partnership!

Long –term benefits are not easily articulated for reasons already discussed. However, it is hoped that the long-term benefits for the respective projects will be:

- **Life Skills:** increased self-esteem and the ability to deal with difficult life circumstances, not only in the near future but also as they grow older. It is hoped that the project may have contributed to changed gender perceptions that will improve relations between the genders and so increase the ability for them as adults to make equal and mutual decisions in their relationships.
- **Stigma:** an increased ability to deal with experiences of stigma not only in the near future, but also as they grow older. It is hoped that they will have developed skills that they can use to deal with any experience of stigmatisation in their lives

- **Focus Groups:** it is hoped that the results from these focus groups will be published in a magazine that deal with HIV/AIDS issues and will inform future interventions aimed at young adults. In addition it is hoped that the youth who participated in these focus groups will themselves engage in safe-sex and prevent themselves from becoming another statistic of HIV infection.

Students

The following methods of assessment were used to assess the students

1. **A basic HIV/AIDS information test (7% of the final mark):** The students were required to repeat this test until they achieved a pass rate of 75% or above. However, their first mark was the one entered into the mark register. The objective for getting them to repeat the test until they passed with a mark of 75% or above was to ensure that each student who went out into the community had updated and correct information about HIV/AIDS.
2. **A basic counselling skills assessment (7% of the final mark):** Each student was given the opportunity to put their skills into practice with someone who role played as a client.
3. **Essay 1 (16% of the final mark):** This was the theoretical essay of their course where they were asked to pull together the main themes in their course reader.
4. **Presentation at conference (20% of the final mark):** Each group was expected to put together a paper on the community experience in which they were expected to make links between theory and practice.
5. **Reflection paper (16% of the final mark):** Each student was expected to work with their weekly reflections and put together a short reflection paper.
6. **Exam (34% of the final mark)** this exam was set to pull all of their theory and practice together.

The following extracts from the students final reflection essays will hopefully act as evidence of the student benefits of this module.

The following quotes illustrate how the service-learning experience provided the students with an opportunity to directly **challenge preconceived ideas or stereotypes** about HIV/AIDS and/or the community:

- Something that had a profound impact on me was the resilience of the orphans and abandoned children at (...). Before going there I had a preconception that orphans are sad, insolent and aggressive children. I felt almost embarrassed about these expectations upon meeting the children, because, during our visits to (...) I noticed that the children were happy, pro-active and took care of one another, whether they were related to each other or not
- I've witnessed the sincerity, genuine, hospitality, care, love, support, respect and humility that the team from (...) provides. It is rather unfortunate that these women who have produced such excellent progress in their work have not been acknowledged by the wider community or by society on the whole. The factors that strike me the most is that this team of black women, who have been oppressed and discriminated against in the most severe manner, are the very same individuals who have donated a piece of their love and devotion to more than fifty households.
- Before I started this course I was under the impression that people were seriously suffering with the AIDS epidemic out there and that there was not much that could be done about this. However, I found that yes they are suffering, but there is some much that can be done to see this and is being done. There are people who are making a world of difference to these people's lives. The work that I was being done by the home based caregivers was nothing short of amazing
- Yet, even though I had done a lot of reading and attempted to condition myself not to enter the community with preconceived ideas, I found myself surprised that those children were not emotionally needy. It challenged my beliefs.
- Although our proposed outcomes were not achieved, the ability to be flexible, which I acquired through this course, helped me gain knowledge from the community while at the same time challenging my beliefs and attitudes that I had had about going there to help and save the people in the community
- My experiences taught me some valuable things and have changed certain aspects of my behaviour and my attitude towards the community. It also helped me to confront

strongly held stereotypes and to face up to the reality and harshness of the life that many people in South Africa have had to lead.

The following extracts highlight how the **theoretical component of the course informed the students practical experience** and how the students were able to make links between theory and practice:

- My expectation of the service-learning course was to have my academic knowledge illuminated by practical experience. This was particularly portrayed in relation to issues around gender stereotypes, where girls were submissive and boys were more dominant. Due to the prevalence of these stereotypes, we tended to give the boys more attention, reinforcing their dominant behaviour. This highlights the fact that we unconsciously supported gender stereotypes, indicating that it is an embedded construct which is almost inescapable
- Another example of how active participation helped to supplement the learning processes is the exposure of fear surrounding HIV/AIDS. Having studied various aspects surrounding HIV/AIDS in South Africa during the theory component of our course, I was aware of the existence of fear surrounding it and believed that I did not hold this sense of fear myself. I was, therefore, surprised when, on arrival at (...) and being welcomed and hugged by the young children, for a short while I felt a little nervous about the possibility of contraction the virus from them. However, the knowledge I had been equipped with about the transmission of HIV as well as physically interacting with the children helped to dissipate these fears. I was surprised that I had initially felt fear about contracting the virus, but on reflection realised that my physical interaction with the children had made me aware of my unjustified fears and I was thankful to have had an opportunity to confront and dissipate that latent fear
- Prior to my entry into the community I was told that in order to combat the HIV/AIDS epidemic it needs to be fought on a number of fronts since it is embedded in a social, political, economic and historical matrix. I did not realise just how true it was until I saw it with my own eyes. While I was in the (...) community I was able

to see how issues around gender, poverty, politics, stigma and denial can exacerbate the HIV/AIDS pandemic. This experience gave a face to the theory I have learned throughout this course.

- The learning that we had undertaken before our entrance into the community was also vital as it informed our experience and guided our service. It prepared us for the complex and multi-faceted experience we were about to undertake cognitively and practically.

The following extracts describe how the learners had to grapple with the transition from their previous learning frameworks that place emphasis on outcomes to a **learning framework that places emphasis on process. Integral to this is the process of reflection:**

- Being able to reflect on the process is what makes constructive learning possible during service learning. At the beginning of the course I was focussed on the outcomes. However, this fixation on results drove my attention away from the process and my commitment to it. Being able to realise this was very helpful to my experience during the project.
- I also found out that what is important in learning is not necessarily the outcome, but the process. This was hard for me to grasp at the beginning, as we have always been evaluated according to our outcome.
- Weekly reflections helped me a lot especially after our second visit to the community. I got the chance to normalise my feelings, explore them and express them that helped alleviating feelings of anxiety, guilt, hopelessness and helplessness.

The following extracts suggest that service-learning course impacted on the students **personal and professional development:**

- In addition, the experience gained from my exposure to Service-Learning has enlightened and expanded my comprehension of what practical work really entails. Behavioural changes have been initiated where I intend to make a concerted effort to learn Zulu.

- In terms of my own attitude change, I began this course with a cynical attitude. Believed that focusing on HIV/AIDS was a waste of time when bigger issues, such as poverty made it a secondary rather than a major concern of the community. I have come to realise however, that the HIV/AIDS epidemic is multifaceted and cannot be addressed one dimensionally.
- Even though our survey program had failed, with the guidance of theory, I have learnt to understand why this has happened. I would like to leave you with this quote given to me by my dad to wish me luck in everything I do: 'if you fail do not worry because that is what it costs to succeed'.
- At the beginning of the course I had difficulties in trying to adapt to what I was being taught because it challenged how I have been viewing life in general. It challenged me at all levels from sexuality to culture to intellectually. I have always been ignorant towards HIV/AIDS and I always thought that it was not my problem but through this course I was proven wrong. I learnt that it was my problem, and not just me, but everyone.
- Undoubtedly I have gradually transformed into a more insightful and open-minded person at the end of this course... Thus service learning has played a crucial character building role in my life specifically.

The staff of the School of Psychology at the University of Natal Durban have undoubtedly responded very positively to the service-learning course and have made sure that it is integrated into the curriculum for next year, and possibly for years to come. Members of the school were asked to attend the conference at which the students presented papers on their experiences and the feedback from those who attended has been very affirming. The service-learning module provided an ideal opportunity for the School to integrate HIV/AIDS into its curriculum while at the same time respond to the epidemic in a practical way through community outreach. It is suggested that the School has, through its engagement with this pilot study, recognised the importance of this course and the way in which it has contributed to the development of socially aware students.

This service-learning course has also facilitated the formation of partnerships within the University. Academic staff from all disciplines and Schools on this campus and the Pietermaritzburg campus were invited to the student conference. In addition, HIVAN (The Centre for HIV/AIDS Networking) worked very closely with the School of Psychology and CHESP in this initiative. HIVAN paid the salary of the academic staff member who co-ordinated and taught on this course for the School of Psychology, in addition it helped with other financial costs where they were needed. HIVAN will also benefit in that 10 students from the course have been selected to become certified HIV/AIDS volunteer counsellors at the Campus Support Unit which aims to open its doors on campus early in the year 2002.

Service Agencies

Due to the number of projects that were run it is difficult to give a combined report back on the benefits of the service-learning module to participating service agencies. It appears that the service agencies benefited primarily through the development of new connections/networks with the University and other community groups (medium-term and short-term benefit). In addition the service module made it possible for the agencies to identify additional volunteer expertise (medium-term benefit). The service-learning module did not benefit the service agencies in any material way, that is it did not increase leverage of financial and other resources.

It is suggested that that the service agencies benefits were primarily short-term and medium-term in nature. Many of the agencies commented that the project time period was insufficient for there to be any real or long term benefits to the agencies. An example is the home-based-care project where the service agency felt that the students required more time in the setting to familiarise themselves with the service agency and its roles before going out into the field. It has already been decided by the partnership, based on the feedback for the agencies and the students, that more time will be allocated for the practical component of the course next year.

One concern is that some of the agencies, but not all, felt that the module put a lot of increased demands upon their staff time. Time will have to be spent next year meeting with the agencies well in advance of the practical to ensure that the service provided by the students enhances the work being done by the staff at the agencies rather than increasing demands on the staff time. Many, if not all, the agencies have incredible pressures on them as is and find having to deal with issues such as placements without enough time in advancement very stressful. It is argued that the partnership must all work collaboratively to ensure that this does not happen in future modules.

From a service providers and community point of view it remains a complex issue to address the project as having an added outcome for the organisation or community involved. Somehow it may be more honest to say that partners are found that will facilitate the learning of the students and not try to identify direct benefits to the organisation or community. The benefits are probably secondary and more on an individual level. By individual is meant that the service provider and community co-ordinators are in the position of better networking and having access to ideas and resources but not directly the organisation or community they serve. The service and community however demand to see the direct benefit which becomes difficult for the co-ordinators to deal with. With the students being the main beneficiaries of the work being done it is also expected that the academic co-ordinator will do the most work which leads to a different kind of frustration. It would be useful to reflect on these experiences more fully in other service learning modules to see if there are shared experiences that could lead to better clarity in the future.

5. Partnership

- CHESP brought the partnership together at the training on 13-16th March 2001. Prior to this no communication or contact had been made between the partnership.
- The partnership worked together to identify different projects
- The academic partner took on the role of co-ordinator for the entire module
- The academic and interspersed contact with the other partners once the module began

CHESP took initial responsibility in selecting and introducing our partnership. Prior to the training workshop held at Valley Trust (13th-16th March 2001) no communication or contact had occurred between the partnerships. During this training period the partnership discussed what they saw as their overreaching roles and objectives as a partnership.

During the module development phase of the partnership, all three of the partners equally participated in identified community areas that would be worked in, identifying areas in need of enhancement in the different settings, designing the course outline, making decisions about the course focus, deciding on the assessment process and mark weighting for the course. In addition some decisions were taken on the responsibilities of each respective partner. (These roles and responsibilities have already been discussed earlier in the report).

The **academic component of the module** was co-ordinated primarily by the academic partner who took full responsibility to book venues, schedule test and exams, set up assessment days and book equipment for these days. In addition the academic partner took on the responsibility of managing the budget for the project as the other two partners felt that they would not be available on campus frequently enough to sign any relevant forms.

The **practical component of the module** was co-ordinated and implemented by the partnership. The actual time in the communities was overseen by each respective partner. However, again a lot of responsibility during this component rested on the academic partner who ran weekly reflection sessions with each group, purchased necessary resources for each groups projects and read and commented on their weekly written reflections.

The **closure phase of the module** was overseen by the academic member who made sure that claim were submitted and processed for people who had worked on the module, submitted transport claims, organised the student conference, marked the students final reflection papers, marked the students final examinations and submitted their marks to

the School for entry into the mark system. In addition the academic took responsibility for distributing and ensuring the return of the questionnaires that had to be completed by service agencies, community representatives and students. The academic also took primary responsibility for ensuring that this case study was written up and completed. The service provided issues of importance and comments throughout the report. Again, the reasons for this are largely due to time constraints, difficulty in meeting with the partnership due to the additional responsibilities and pressures on each individual in the partnership.

Due to the fact that we had so many projects and had also reworked our notion of community, the partnership was very beneficial in working to identify various community placement sites for the students. This was a result of the pre-existing relationships that these partners had with a number of community sites or service agencies.

The skills and experience of the three partners were also extremely beneficial in the design and implementation of this service-learning module. The community and service partners were able to contribute significantly to the preparation and training of the students prior to their field work as a result of the years of experience these two partners have had in the field of community work and the development of community partnerships. It is argued that the experience of these two partners contributed significantly to the success of the module. In addition, the practical training skills and knowledge of the academic supported the work of the partnership.

Please note that challenges and lessons learnt have already been discussed in the course of the case study, in particular please note under point 4: **Results of the First Implementation.**

6. Higher Education Policy and Practice

At this stage of the process it is difficult to comment on potential implications of this module for higher education policy. However, as it has already been noted the School of Psychology has recognised the importance and merit of the service-learning module and has planned to have it integrated into the third year psychology course on an on-going basis.

7. Support and Capacity Building

- The financial support from CHESP was certainly a huge enabling factor to the service-learning module.
- In addition the training provided at Valley Trust in March 2001 played a critical role in the partnership formation and conceptualisation of the project.

(It was decided that suggestions about what kinds of support and capacity building would be helpful to the different partners should be discussed under the following heading so as to avoid unnecessary repetition)

8. Suggestions/Recommendations

- The workshops were helpful, however it was not always easy working with a westernised, American model in the South African context. For example, what is considered to be a community changes from one context to another.
- A separate workshop for community representatives, over and above the first workshop, would also be beneficial where community concerns that emerge from the first workshop can be acknowledged and debated openly.
- It would be very helpful to have the students involved in the process right from the start. The way the project ran this time meant that the students had no idea of how the partnerships had come about.
- It would be helpful to have another training workshop half way through the year where other partnerships are able to share their experiences, difficulties and accomplishments with each other.

- A conference at the end of each pilot phase would be extremely beneficial where all partnerships are able to present papers on their experiences and findings
- We felt that we provided a lot of feedback to the researchers and CHESP leadership but received very little feedback from them.
- We believe that a service-learning module like the one that has just been completed is in fact a luxury module. It is not a true reflection of the way in which course like this would be run without the financial and capacity building support. Our concern is around sustainability!
- We would like to recommend that in the future the case-study be completed over a two or three day workshop where all partnerships can work in collaboration and should include student voices.

9. Resources and Information

Useful information resources and comments:

- The academic partner found that there was very little relevant reading material around service learning. The most useful information resource was the Introduction to Service Learning Toolkit, provided by Campus Compact.
- What appears to be missing is contextualised service-learning material, that is material developed in the South African context
- In addition there was very little information that was 'critical' of the notion of service-learning, it is important to get students to think critically about service-learning and not sell it to them as an unproblematic initiative. Service-learning can go seriously wrong if students are not encouraged to think critically about their motivations and intentions. The academic had to borrow literature from the discipline of development to provide readings to the students that would engage them in critical thinking (please see a copy of the course reader attached).

Information dissemination:

- A newspaper article appeared in the **Sunday Tribune** on the Stigma Workshop

- A video presentation was made at an **HIV/AIDS conference in Zambia**. The video outlined the course and its objectives, promoting service-learning as an ideal course in which HIV/AIDS can be integrated.
- A newspaper article is expected to be published in **The Witness** in the near future which will cover the service-learning conference
- A paper was presented at the **Annual HIV/AIDS Conference on Pietermaritzburg Campus**, this paper outlined the course, promoting service-learning as an ideal course in which HIV/AIDS can be integrated.
- **NU Partners** (a Natal University publication for external audiences) will be publishing an article on the HIVAN and Service Learning Partnership in the near future
- **NU Info** (an internal Natal University publication) will be publishing an article on the students Red Ribbon Drive and Service-Learning Conference
- The partnership plans to publish a paper on their reflections early in 2002 in a relevant journal.
- One of the students conference presentations is currently being worked on for submission for publication in the **AIDS Bulletin** magazine.

(Please note that copies of these articles will be forwarded once they have been published)

10. Cost Implications

(Please see Appendix)

11. Completion of this Report

Although the academic partnership took primary responsibility for the completion of this report the service partner was actively involved in the process by reading drafts and making valuable comments, additions and suggestions. The community partners valuable ideas and concerns, that emerged in the form of discussion, were integrated into the report throughout the process.

APPENDIX V
DOCUMENTATION
LAW PROGRAMME

HIV / AIDS in the South African context

Outcomes, Assessment and Reading

Outcomes

KNOWLEDGE OUTCOMES

It is intended that students will know and understand:

- 9 the meaning and cause of HIV and AIDS
- 9 the relationship between masculinity, men's behaviour and the spread of HIV
- 9 the requirements as regards non-discrimination of persons with HIV / AIDS
- 9 what constitutes unfair discrimination against a person living with HIV / AIDS

SKILLS OUTCOMES

It is intended that students should be able to:

- 9 distinguish between two court judgments and pinpoint the main differences

VALUE OUTCOMES

It is intended that students should evidence an appreciation of:

- 9 the urgency of the AIDS pandemic
- 9 responsibility requires a change in behaviour
- 9 the need to remove the stigma from people with HIV / AIDS
- 9 the importance of support for people infected and affected by HIV/AIDS

Assessment

There will be self-assessment during the tutorial.

Reading

J C Hoffmann v SAA (2000) 21 ILJ 2357 (CC)

Tutorial

There is no preparation that you need to do before this tutorial. All tasks will be completed during the tutorial.

Tutorial exercises

Task 1

5 minutes

How well do you understand HIV and AIDS?

Test yourself with these multiple-choice questions. Tick the correct answer.

1. AIDS stands for:

1	Altered immune delinquency system	
2	Aggressive illness disorder symptom	
3	Acquired immune deficiency syndrom	
4	Anti-inflammatory disease structure	

2. AIDS is caused by:

1	A virus which attacks the body's nervous system	
2	A bacteria which infects the body's lymph glands	
3	A germ which infiltrates the body's brain cells	
4	A virus which destroys the body's ability to fight infection	

3. HIV stands for:

1	Human immunodeficiency virus	
2	Hazardous immune virulance	
3	Harmful illness variance	
4	Haematic infector vesicle	

4. AIDS describes a stage when:

1	A person acquires a disease like tuberculosis	
2	A person can transmit HIV to another person	
3	A person's T cell count falls below 200/mm ³	
4	A person's body weight reduces drastically	

Task 2

10 minutes

After completing the test above, please read the following information to check your answers.

AIDS is an acronym for "**acquired immune deficiency syndrome**".

AIDS is a fatal illness that:

1. is **acquired** or transmitted (ie not hereditary);
2. occurs in those individuals whose **immune systems** (the body's natural defence mechanisms) were previously normal but have become severely deficient;
3. is characterized by a **syndrome** (or collection) of symptoms and signs that may differ from person to person, but result from opportunistic diseases or infections (pneumonia, tuberculosis or certain cancers). They are called "opportunistic" because they attack the body when immunity is low.

AIDS is **not** a specific disease. It is a collection of several conditions that occur as a result of damage the virus causes to the immune system.

AIDS, it is generally accepted, is caused by the **human immunodeficiency virus (HIV)**. (A **virus** is a micro-organism which infects its host.) HIV is a fragile virus that cannot survive outside of the body. But once HIV takes hold in the body, it can "hide" for months or years, doing serious damage to the immune system. This is why people who appear perfectly healthy may, without knowing it, be able to transmit the virus to others.

The body's immune system

Our bodies contain cells called CD4+ T cells. These cells, sometimes called "T-helper cells," play a central role in the immune response, signalling other cells in the immune system to perform their special functions. Healthy adults usually have a CD4+ T-cell count of 1,000/mm³. These crucial immune cells are disabled and killed during the typical course of infection by the HIV virus. HIV thus attacks and destroys the body's immune system and therefore the body cannot offer resistance to conditions that usually do not involve danger to healthy people.

During HIV infection, the number of CD4+ T cells in a person's blood progressively declines. When a person's CD4+ T cell count falls below 200/mm³, he or she becomes particularly vulnerable to the opportunistic infections and cancers that typify AIDS, the end stage of HIV disease.

Task 3

5 minutes

In which of the following is there a high risk of the transmission of HIV? Tick or cross the box:

1	A mosquito bite	
2	Mother to child during pregnancy	
3	Sneezing	
4	Swimming in the same swimming pool as a HIV-infected person	
5	HIV infected blood passing into the body via a blood transfusion	
6	Mother to child during breast feeding	
7	Kissing	
8	Vaginal sex without the use of condoms	
9	Sharing of eating utensils	
10	Hugging	
11	Oral sex	
12	Coughing	
13	HIV infected blood from a wound or injury infecting a third party	
14	Sweat	
15	Tears	
16	HIV infected blood passing into the body via a used syringe	
17	Infection from toilet seats	
18	Anal sex without the use of condoms	

Task 4

25 minutes

Read the extract from the Employment Equity Act 55 of 1998 in the box below and then answer the questions which follow.

6. Prohibition of unfair discrimination.--

(1) No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including ... disability, ..., HIV status, ...

- a. Give an example of fair discrimination against an employee who is HIV-positive.
- b. Give an example of indirect discrimination against an employee who is HIV-positive.
- c. Give an example of an employment policy which might discriminate against an employee who is HIV-positive.
- d. Give an example of an employment practice which might discriminate against an employee who is HIV-positive.

Interactive lecture

How to prepare for this interactive lecture:

1. Read the case study and answer the two questions which follow it.

**Do you think that the employer discriminated against the applicant?
Do you think this was unfair discrimination? Why?**

2. Read the summary of the High Court's decision.
3. Read the Constitutional Court's judgment and prepare answers to the questions you will find at the end of the judgment.

How would you summarize the differences between the judgments of Judge Hussain and Justice Ngcobo? Use the chart below to record how the Constitutional Court dealt with the High Court's reasoning. YOU MUST MAKE REFERENCE TO THE PARAGRAPH NUMBER IN THE CONSTITUTIONAL COURT JUDGMENT, as in the example given below.

HIGH COURT	CONSTITUTIONAL COURT
<p><i>EXAMPLE</i></p> <p>1. The judgment assumes that all persons with HIV should be treated the same, irrespective of the stage of the disease.</p>	<p>1. The fact that some people with HIV may be unsuitable for employment does not justify the exclusion of ALL people with HIV. (Para 31)</p>
<p>2. The judgment assumes that managerial prerogative allows the employer alone to decide whether a workplace is unsafe or unhealthy for a prospective employee.</p>	<p>2.</p>
<p>3. The judgment assumes that public perceptions may justify discrimination.</p>	<p>3.</p>
<p>4. The judgment assumes that if there is a commercial rationale, discrimination is justified.</p>	<p>4.</p>
<p>5. The judgment assumes that there is no obligation on an employer to make "reasonable accommodation" in its requirement that all crew must be fit for worldwide duty.</p>	<p>5.</p>

According to Justice Ngcobo, what is the determining factor in deciding if discrimination is unfair? (see para 26) Should we assess this **subjectively** (how it affects that particular person) or **objectively** (how it affects the average or normal or reasonable person)? Why?

Why does Justice Ngcobo say that discrimination against person with HIV is an assault on their dignity?
(see para 27)

AIDS and the Law

Outcomes, Assessment and Reading

OUTCOMES

KNOWLEDGE OUTCOMES

It is intended that students will know and understand:

- 9 what constitutes unfair discrimination
- 9 the legal consequences of unsafe sex
- 9 the consequences of unlawful delictual behaviour
- 9 aspects of the Code of Good Practice

SKILLS OUTCOMES

It is intended that students should be able to:

- 9 assess those situations in which testing is permissible
- 9 assess how confidentiality is to be treated

VALUE OUTCOMES

It is intended that students should evidence an appreciation of:

- 9 the need to remove the stigma from people with HIV / AIDS
- 9 the need to respect a person's privacy as it applies to testing for HIV and the handling of confidential information

Additional Reading

The Code of Good Practice on HIV/AIDS and Employment is to be found at the end of this Chapter.

Assessment

An assignment is set out at the end of this Chapter.

Tutorial

Before the tutorial, you must read the extract from the Employment Equity Act set out below, as well as Section 7 of the Code of Good Practice, set out above.

Task 1

20 minutes

During the tutorial, students should break into pairs. They should assume that they are judges in the Labour Court. Using the guidelines from the Act and Code, in which of these situations is testing for HIV justifiable? Discuss together and decide.

	Y or N	Why?
1 Staff in emergency ambulances not only come into frequent contact with blood, but are often injured themselves coming to the relief of victims trapped in vehicles. There is a reasonable chance of their blood touching an accident victim. The ambulance service seeks permission for pre-employment and regular HIV testing of its ambulance staff.		
2 Employees in a large mill work with dangerous machinery. Industrial accidents are frequent. The employer seeks permission for pre-employment and regular HIV testing of its mill staff		
3 A fast-food chain wishes to prevent a boycott of its products threatened by bad publicity that 25% of its food workers are HIV positive. The employer seeks permission for pre-employment and regular HIV testing of staff in regular contact with food.		
4 The owner of an escort agency / massage parlour seeks permission for pre-employment and regular HIV testing of sex workers in its employment.		
5 An employer of a domestic worker seeks permission to test her because, as the children's nanny, her duties include the preparation of food, elementary first-aid for cuts, etc.		

Task 2

20 minutes

Read this case study. Working alone, complete the questions which follow. When you have finished, compare your answers in pairs.

An employee voluntarily disclosed her HIV status to her immediate manager. Although the manager was initially supportive, it was soon discovered that the manager had disclosed the employee's HIV status to other staff members, making her working environment difficult and uncomfortable. She requested and was granted a transfer to another branch of the firm. When she arrived at the other branch, the employee discovered that 2 staff members already knew of her HIV status and she felt forced to return to her former branch. The stress of moving back and forth, the continual disclosures and the lack of support impacted on her mental and physical health and she resigned.

[based on an actual case, reported in The Aids Law Quarterly (1999) p 20]

What does confidentiality mean to you?

		Yes or No?	Why?
a.	Could the manager have informed the Human Resources Director without a breach of confidentiality?		
b.	Can a HR Director put this information in the staff member's personal file if others in the HR department have access to the file?		
c.	Can an employer discipline an employee for disclosing the HIV status of another employee?		

Task 3

5 minutes

Assess your answers by reading Section 7.2 of the Code of Good Practice on Key Aspects of HIV / AIDS and Employment, printed at the end of the previous chapter.

Interactive lecture

In preparation for the Interactive lecture, read these 2 case studies, answering the questions at the end of each case study:

Case Study One: (Taken from the *Sunday Tribune* 21 November 1999)

A 33-year old assistant manager of a fast-food chain (where he had worked for 5 years) claims he was unfairly dismissed.

He was diagnosed as HIV positive two years previously and disclosed this to his employer six months later. He said the employer was initially supportive. A year after he was diagnosed he was hospitalized for pneumonia for 4 days. Some months later he was given 2 days off a week in place of annual leave because of chronic fatigue. Soon after he picked up a stomach bug and he was given two weeks leave. Three days after he returned from leave he was called to the manager's office to discuss concerns over his health. In a state of "panic and confusion" he signed a payout agreement. Two days later he advised the employer that he intended to fight his dismissal. The employer invited him to return to work. He declined, saying: "How could I possibly go back into that job after this humiliation? My HIV status was supposed to be confidential...now everyone stares at me."

The manager said: "We have no axe to grind with him. We're concerned about his health and are so sad it's gone this way. But X had lost a lot of weight and was vomiting every day. He wasn't anywhere near coping with his duties and we were coming up to our busy December season. I suggested to him that he go on a retainer of two weeks pay for the next six months and if he felt better he could come back full-time." But he claimed that he said he would prefer to leave, so another arrangement was made which he signed. "When he told me he was unhappy with the agreement, I told him if he felt he could cope in December, he should return to work."

The following questions are adapted from the Code. *The answer to some of them are not clear from the newspaper report, but answer where you can:*

		Y or N
1	Was the dismissal simply because the employee is HIV positive or has AIDS?	
2	Were accepted guidelines regarding dismissals for incapacity followed before terminating?	
3	Were the employee's duties adapted?	
4	Was the employee's disability accommodated?	

5	Was the employee allowed to work under normal conditions in their current employment for as long as medically fit to do so?	
6	Was the employee governed without discrimination or distinction as regards to existing sick leave allocations?	
7	Were possible alternatives undertaken when the employee exhausted or was close to exhausting sick leave allocation? (Such as the possibility of further sick leave on an unpaid or reduced pay basis)	
8	Did the employer attempt to find alternative employment?	
9	Was the employee's right to confidentiality regarding their HIV status maintained during any incapacity proceedings?	
10	Was the employee compelled to undergo an HIV test or to disclose their HIV status as part of such proceedings?	
11	Did the employers take steps to assist employees with referrals to appropriate health care facilities within the community if health care services are not provided at the workplace?	

Case Study Two: *N and Minister of Defence* (2000) 21 ILJ 999 (Namibian Labour Court)

The applicant had been a member of SWAPO's national liberation struggle from 1976 to 1989 and whilst in exile had undergone military training. In 1996 he sought enlistment in the Namibian Defence Force (NDF). He was tested for HIV, found to be infected with HIV and refused acceptance into the NDF. A medical report certified that he was in sound health.

It was clear that the sole and only ground for refusing to enlist the applicant was because he was a person with HIV. The applicant alleged that he had been discriminated against on the basis of (a) his HIV status and (b) his disability.

The Defence Force admitted the discrimination but denied that it was unfair because of the strenuous and exacting work of the fighting units of the military. It was argued that a person with AIDS, because of deteriorating health, is incapable of meeting these demands. It conceded that there were a large number of persons with HIV in the NDF and that there was a policy of not testing members of the NDF on an ongoing basis. It was conceded that the pre-employment test was not linked to attempts to keep the NDF an "AIDS-free workplace". It was also conceded that NDF members with HIV were transferred to departments with less physical stress.

Do you think that discrimination is fair in jobs, such as the military, where there are strenuous

physical demands?

How do you think the court should have decided this case?

Assignment

In Task 1 in your tutorial this week, you were required to imagine yourself as a Labour Court judge confronted with 5 different situations. You must now give a short written judgment on any three of the five situations. In each judgment you are expected to:

- (a) briefly state the facts of the case;
- (b) state what the Employment Equity Act and/ or Code of Good Practice state as regards those facts;
- (c) apply the legal requirements to the facts; and
- (d) give your decision, with reasons.

HIV / AIDS and Intervention

Outcomes, Assessment and Reading

OUTCOMES

KNOWLEDGE OUTCOMES

It is intended that students will know and understand:

- 9 that intervention has three elements: prevention, treatment and care;
- 9 that all three forms of intervention are highly controversial;
- 9 that it is possible for groups in society to engage in civil disobedience;
- 9 that civil disobedience is an established approach in certain situations;
- 9 that constitutional rights can be used to win the right to treatment

SKILLS OUTCOMES

It is intended that students should be able to:

- 9 understand the concept of civil disobedience and measure its defining characteristics against the facts of the TAC Defiance Campaign
- 9 evaluate if there has been discrimination in the provision of treatment.

VALUE OUTCOMES

It is intended that students should evidence an appreciation of:

- 9 the importance of public disclosure of HIV status as a way of destigmatizing HIV;
- 9 the moral imperatives driving the TAC campaign
- 9 the inequities in current provision of treatment

READINGS

The judgment in *Treatment Action Campaign and others v Minister of Health and others* (2001) is part of the Interactive Lecture notes.

ASSESSMENT

There is an assignment set out at the end of this Chapter.

Tutorial

How should law students respond to an individual who or organization which deliberately breaks the law?

If we condone lawlessness we risk a society where there is no respect for the law or legal institutions or the rule of law. However, there have been occasions in history where disobedience to the law is seen as an appropriate response.

Your tasks for this tutorial are:

- 9 *Before the tutorial* to read through and think about the list (below) with the traditional defining features of civil disobedience - ie what distinguishes civil disobedience from criminal lawlessness;
- 9 *Before the tutorial* to read the statement put out by the TAC to explain their Defiance Campaign;
- 9 *Before the tutorial* to complete the table by assessing whether the TAC Defiance Campaign measures up to the defining features of civil disobedience.

The list of defining features of civil disobedience include:

	DEFINING FEATURES OF CIVIL DISOBEDIENCE	HOW DOES THE TAC DEFIANCE CAMPAIGN MEET THIS REQUIREMENT?
1	The law is publicly disobeyed	
2	The disobedience is done for moral reasons	
3	The disobedience is done as a deliberate protest	
4	The disobedience aims to have a political effect	
5	The disobedience is non-violent	

6	There are no other means by which the protest can be made; all reasonable possibilities have been attempted	
7	Those who engage in civil disobedience must be willing to submit without protest to the punishment prescribed for the act of disobedience	

Interactive lecture

Before the interactive lecture, read the following extracts from a judgment and then answer the questions which follow.

***Treatment Action Campaign and others v Minister of Health and others* (2001)**

Task 1

In a newspaper advertisement in February 2002, the Government explained why it was appealing the decision taken by Judge Botha. The advertisement said:

“Government is appealing this judgment. This is not because we are against expanding the current mother-to-child programme - that process continues. It is because we need to gain clarity on whether the courts or the elected government decides on the detail of providing health services. This is a critical question about the division of powers in our democracy. The wisdom of the Constitutional Court should be applied to it...”

Judge Botha dealt with the division of powers in this way:

*“The court does not assume the task of the executive when it pronounces on the reasonableness of steps taken by the executive in the fulfilment of a constitutional obligation of the State. In *Mohamed and another v President of the Republic of South Africa and others* 2001(3) SA 893 CC at paras 69 to 71, it was said that it would negate the supremacy of the Constitution if a court could not pronounce on the validity of executive action. The same would apply if the court could not pronounce on the reasonableness of steps taken by the state in the fulfillment of its constitutional obligations. The argument that to make an order as prayed would be tantamount to a policy decision does not take account of the fact that the court is required to pass a value judgment as to whether steps taken in order to effect a gradual realisation of a constitutional right were reasonable.”*

1. List reasons why you think courts **should not** be involved in policy making.
2. List reasons why you think courts **should** have the right to decide on whether the implementation of state policy is reasonable.
3. What does Judge Botha say is the role of courts as opposed to the role of government?

Task 2

In your tutorial you discussed TAC's civil disobedience campaign. In this interactive lecture you have studied TAC's court application to compel the government to provide Nevirapine to pregnant women with HIV who give birth in public health institutions.

What are the differences between the campaign and the court application in terms of (a) aims; (b) effect; (c) public opinion?

What does this say to you about how the law can be used to achieve change?

Assignment

The purpose of this assignment is to assess if you are able to locate **very accurately** the relevant section of a statute, **and/or** the Code of Good Practice, **and/or** a decided case referred to in the three Chapters on AIDS in this book, which deals with the scenario described in the left-hand column of the table below. You **MUST** give the exact section and sub-section of a statute or the Code.

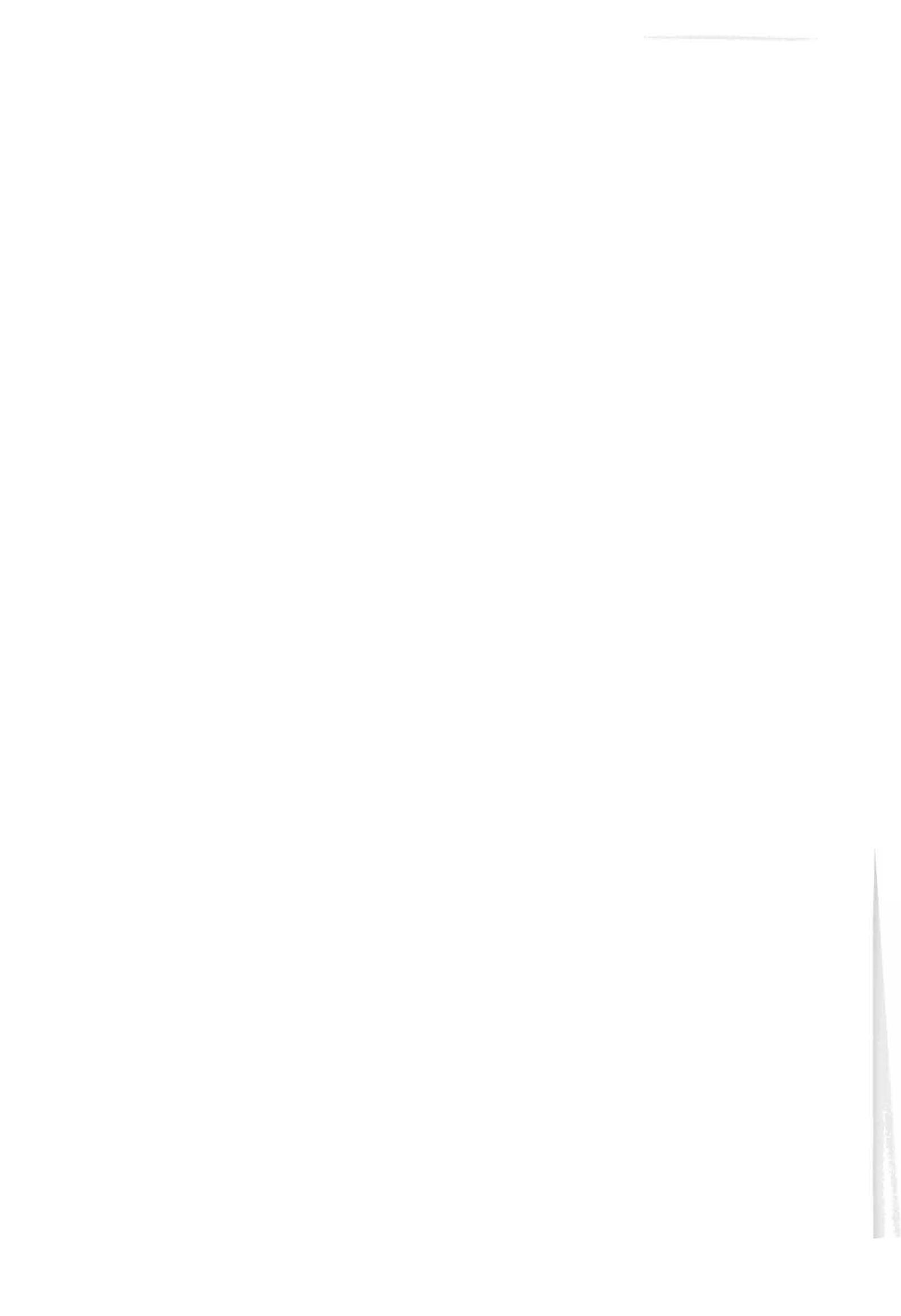
It is suggested that you photocopy this table to hand in for marking. In the right-hand column you must write the relevant section, as has been done in the example given in No 1.

No.	Scenario	Relevant law
1.	<p>Example:</p> <p>An employer refuses to employ an applicant for a position because she is a person with HIV.</p>	<p>a. Section 9(3) of the Bill of Rights</p> <p>b. Sections 6(1) & 9 Employment Equity Act 55 of 1998</p> <p>c. Section 6.1(ii) of the Code of Good Practice on Key Aspects of HIV/AIDS and Employment</p> <p>d. <i>Hoffman v South African Airways</i> (2000) 21 ILJ 2357 (CC)</p>
2.	<p>An employer dismisses a person with AIDS because he no longer has the strength to do his job.</p>	
3.	<p>A pregnant woman with HIV living in a rural area is refused Nevirapine at her local clinic.</p>	

4.	The Defence Force says it has a policy of not recruiting persons with HIV because of the dangerous situations in which soldiers find themselves.	
5.	An employer refuses to send an employee with HIV on an expensive training course.	
6.	A hospital requires nurses who wish to work in a TB ward to have HIV testing because it fears that nurses with HIV will have reduced immunity to TB.	
7.	A Human Resource Manager is told by an employee to keep confidential the fact that she has HIV. One day, when the employee is off sick, the manager lets slip the employee's HIV status. The news is soon all over the office.	

8.	An employee requests a HIV test but the employer deviates from policy and gives no pre-test counselling.	
9.	A nurse suffers a needle-stick injury after taking blood from a patient known to have HIV.	

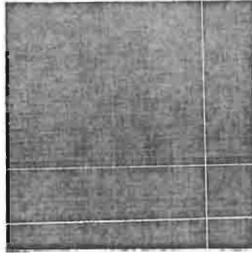
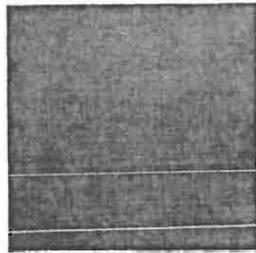
APPENDIX VI
DOCUMENTATION
GENDER EDUCATION PROGRAMME





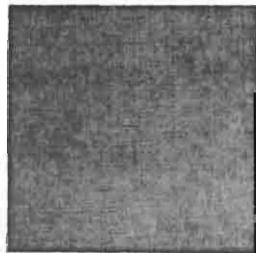
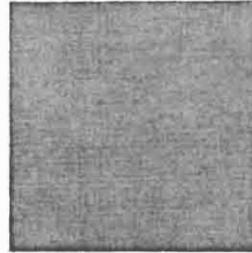
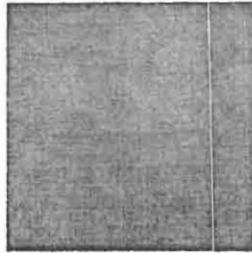
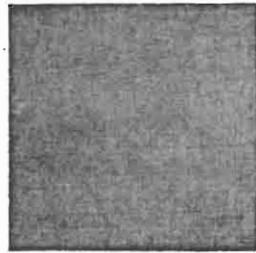
UNIVERSITY OF NATAL DURBAN

M.Ed.



2002

Semester 1



Masculinity and Schooling
Course Code DED8MSM

Prof. Robert Morrell

Study the newspaper extracts provided and try and identify different perspectives on or representations of men and masculinity. You should divide into groups of 3 or 4 and produce a typology of masculinities which will be discussed with the class as a whole in the plenary session.

Debbie Epstein, Jannette Elwood, Valerie Hey and Janet Maw, *Failing Boys? Issues in Gender and Achievement* (Buckingham, Open University Press, 1998), Chapters 1, 2, 3, 4, 5, 6

Gilbert and Gilbert, *Masculinity Goes to School*, 1998, Chap 1 (Reserve – EGM)

Jane Kenway, "Masculinities in Schools: under siege, on the defensive and under reconstruction?", *Discourse: studies in the cultural politics of education*, 16, 1, 1995 (Reserve – Educ Resource Centre)

Jane Kenway and Sue Willis, *Answering Back: girls, boys and feminism in schools* (London, Routledge, 1998) (Reserve – EGM)

Bob Lingard and Peter Douglas, *Men Engaging Feminisms: Pro-feminism, backlashes and schooling* (Buckingham, Open University Press, 1999), Chap 1. 301.411 LIN; 00/06686

Mac an Ghail, *The Making of Men* (Reserve – EGM)

M Mac an Ghail, "What about the boys?": schooling, class and crisis masculinity", *Sociological Review*, 44, 3, 1996 .pp.381-397 (Reserve – Educ Resource Centre)

Lyn Yates, "The 'Facts of the Case': Gender Equity for Boys as a Public Policy Issue" in Lesko, 2000. (Reserve – EGM)

Essay Question: Identify and critically discuss different discourses in your school that relate to, 'explain' or position boys.

13 AIDS and Masculinity: How will a consideration of masculinity affect a gendered analysis of AIDS and education?

Key Words: health, risk, violence, consent, inequality

Special issues of *Agenda* on AIDS (No 39, 1998; No 44, 2000)

Catherine Campbell, "Going Underground and going after Women': Masculinity and HIV Transmission amongst Black Workers on the gold mines" in Morrell, *Changing Men*, 2001

Martin Foreman, *AIDS and Men: Taking Risks or Taking Responsibility* (London, Zed Press, 1998) (Reserve – EGM)

A Harrison, Nonhlanhla Xaba and Pinky Kunene, "Understanding safe sex: gender narratives of HIV and pregnancy prevention by rural South African school-going youth", *Reproductive Health Matters*, June 2001

Catherine MacPhail and Catherine Campbell, "I think condoms are good but, aai, I hate those things': Condom use among adolescents and young people in a southern African township", *Social Science and Medicine* (in press, will be out in 2000) (Reserve – ERC)

R Morrell, "Boys, Men and Questions of Masculinity in South Africa", in L King (ed), *Questions of Intimacy: Rethinking Population Education* (Hamburg, UNESCO, 1999) (Reserve – Educ Resource Centre)

R Morrell, Elaine Unterhalter, Lebo Molletsane and Debbie Epstein, "Missing the Message: HIV/AIDS Interventions and Learners in South African Schools", *Canadian Woman's Studies*, 21, 2, 2001, p 90-95.

Deryck Onyango Omuodo, "Male Friendly Approach to Family Planning", *Development and Cooperation*, 2, 1997

Essay Question: Why is AIDS a problem for men and how might schools (and your school specifically) develop gender inclusive, preventative programmes?

14 Being a male teacher: Confronting the patriarchal dividend.

Key Words: privilege, patriarchal dividend, refusal, contestation.

Connell, *Masculinities*, Chapter 3. (Reserve – EGM)

Jane Kenway and Sue Willis, *Answering Back: girls, boys and feminism in schools* (London, Routledge, 1998) (Reserve – EGM)

Michael Messner, "White Guy Habitus in the Classroom: Challenging the reproduction of privilege", *Men and Masculinities*, 2, 4, 2000. (Reserve – ERC)

Paul Sargent, "Real Men or Real Teachers? Contradictions in the Lives of Elementary Teachers", *Men and Masculinities*, 2, 4, 2000 (Reserve – ERC)

Essay Question: Define and discuss Connell's concept of the patriarchal dividend, and show how it might be used to explain authoritarian and sexually predatory behaviour on the part of some male teachers.

APPENDIX VII

DOCUMENTATION

**EDUCATION PROGRAMME
AT EDGEWOOD CAMPUS**

3.2 Template for the Internal Approval of Modules at the University of Natal

(This form should be completed using the accompanying Notes, see p.34 ff.)

A. Academic Quality of the Module

1. **Title of module**
HIV / AIDS and Gender in Education: Issues and Strategies for Foundation and Intermediate Phases
2. **Module code** _____
3. **NQF Level** 6
4. **Credit value of the module** 16 credits
5. **Field / sub-field** *Education, Training and Development: Teacher Education Discipline Education*
6. **School offering the module** *School of Education, Edgewood Campus*
7. **7.1 Programme(s) on which the module will be offered**
Bachelor of Education (Elective Module)

7.2 Pre-requisites for the module
Successful completion of HIV / AIDS and Gender awareness section in Professional Life Orientation (PLO) Module in First year..
8.

1	Date of submission (to Faculty Board)	<i>August 2002</i>
2	Date of 1st offering	<i>February 2003</i>
3	Date of evaluation and review	<i>December 2005</i>
9. **Purpose of the module**
To equip educators with adequate knowledge base which will enable them to:
 - ✓ *implement sexuality education relevant to the foundation and intermediate phases, HIV/AIDS and gender programmes in schools*
 - ✓ *implement national and provincial policies and strategies that relate to HIV/AIDS, gender and sexuality education*
 - ✓ *function as resource persons for transformation who play a major role in creating a climate in schools where learners learn freely and educators are trusted and accessible sources of advice for individual problems relating to sexuality and HIV/AIDS*
 - ✓ *fulfil their extended role as leaders in community, caregivers and mentors*
10. **Statement of specific learning outcomes for the module**

Students will:

- ✓ demonstrate knowledge of the skills, attitudes and values involved in sexuality education
- ✓ demonstrate knowledge of the qualities of the educator responsible for sexuality education
- ✓ demonstrate knowledge of the disease (AIDS) transmission, progression and treatment as well as opportunistic infections
- ✓ demonstrate knowledge about child abuse and the understanding of the educator's role in the management of child abuse in schools
- ✓ demonstrate knowledge about the concept of gender and gender stereotypes and the equal rights for male and female as they relate to education
- ✓ demonstrate knowledge about the care and support of learners and educators who are affected/infected by HIV/AIDS

11. List of content topics

Sexuality Education, Reproductive Health and HIV/AIDS

- ✓ Conceptualisation
- ✓ Child health
- ✓ Sexuality education during foundation and intermediate phases in schools
- ✓ Skills, attitudes and values in sexuality education
- ✓ The sexuality education teacher

Managing HIV/AIDS in education

- ✓ Prevention programmes in schools
- ✓ Clinical AIDS
- ✓ HIV/AIDS and other infectious diseases
- ✓ HIV/AIDS and National Policies and Strategies
- ✓ Care and support of learners and educators who are affected and infected by HIV/AIDS
- ✓ Available resources

Gender in education

- ✓ Conceptualisation
- ✓ Mainstreaming Gender and HIV/AIDS in education
- ✓ Child abuse: Legislative framework and prevention programmes
- ✓ Management of Child abuse in education

12. Types of delivery and estimated notional study hours per type

Student activity	Number of notional study hours (for the whole module)
Lectures	25
Practicals	
Tutorials	25
Field-trips	
Placements	

Tests / exams 10 hours

Other (specify)

Sub-total: No. of contact hours 60 hours

Resource-based learning 30 hours

Self-directed study 30 hours

Study on assignments 25 hours

Exam preparation 15 hours

Other (specify)

Sub-total: No. of notional self-study hours 100 hours

Total: No. of notional study hours required to complete the module 160 hours

13. Teaching-learning methods used on the module

- *Lecture presentations*
- *Seminar presentations and workshops based on student self study*
- *Tutorial discussions based on case studies*
- *Discussions based on completed project work*

14. Statement of assessment criteria

Students will:

- ✓ *demonstrate by way of assignments and projects knowledge of the skills, attitudes and values involved in sexuality education*
- ✓ *demonstrate by analysing case studies knowledge about the qualities of the educator responsible for sexuality education*
- ✓ *demonstrate knowledge of the disease (AIDS) transmission, progression and treatment as well as opportunistic infections*
- ✓ *demonstrate in projects and analysis of case studies knowledge about child abuse and the understanding of the educator's role in the management of child abuse in schools*
- ✓ *demonstrate gender sensitive attitudes in small group situations, analysis of case studies and evaluation of learner support material used in schools for their gender sensitivity*
- ✓ *demonstrate in assignments and tests knowledge about the care and support of learners and educators who are affected/infected by HIV/AIDS*

15. Methods of assessment to be used in the module (indicate the weighting for each method)

<i>Assessment in tutorials -- case study situations</i>	<i>15%</i>
<i>Assignments and projects</i>	<i>15%</i>
<i>Tests based on case studies</i>	<i>10%</i>
<i>Formal test</i>	<i>10%</i>
<i>Exam questions which require analysis and synthesis of issues</i>	<i>50%</i>

16. What educational provision is made on the module to support students from diverse / disadvantaged backgrounds?

The module will operate in small groups where individual performance and progress will be monitored. Students whose performance is low will be given the opportunity to rework the assignments and projects.

3.2 Template for the Internal Approval of Modules at the University of Natal

(This form should be completed using the accompanying Notes, see p.34 ff.)

A. Academic Quality of the Module

1. **Title of module**

HIV / AIDS and Gender in Education: Issues and Strategies for Senior and Further Education and Training Phases

2. **Module code** _____

3. **NQF Level** 6

4. **Credit value of the module** 16 credits

5. **Field / sub-field** *Education, Training and Development: Teacher Education Discipline Education*

6. **School offering the module** *School of Education, Edgewood Campus*

7. **7.1 Programme(s) on which the module will be offered**

Bachelor of education (Elective module)

7.2 Pre-requisites for the module

Successful completion of HIV / AIDS and Gender awareness section in Professional Life Orientation (PLO) Module in First year.

8. Date of submission (to Faculty Board)	<i>August 2002</i>
Date of 1st offering	<i>February 2003</i>
Date of evaluation and review	<i>December 2005</i>

9. **Purpose of the module**

To equip educators with adequate knowledge base which will enable them to:

- ✓ *implement sexuality education relevant to the senior and further education and training phases, HIV/AIDS and gender programmes in schools*
- ✓ *implement national and provincial policies and strategies that relate to HIV/AIDS, gender and sexuality education*
- ✓ *function as resource persons for transformation who play a major role in creating a climate in schools where learners learn freely and educators are trusted and accessible sources of advice for individual problems relating to sexuality and HIV/AIDS*
- ✓ *fulfil their extended role as leaders in community, caregivers and mentors*

10. **Statement of specific learning outcomes for the module**

Students will demonstrate:

- ✓ knowledge of the skills, attitudes and values involved in sexuality education
- ✓ knowledge of the qualities of the educator responsible for sexuality education
- ✓ knowledge of the disease (AIDS) transmission, progression and treatment as well as opportunistic infections
- ✓ knowledge of the difficult and controversial topics like teenage pregnancy, contraception, gender-based violence and drug and substance abuse as they relate to education
- ✓ knowledge about the concept of gender and gender stereotypes and the equal rights for male and female as they relate to education
- ✓ knowledge about the care and support of learners and educators who are affected/infected by HIV/AIDS

11. List of content topics

Sexuality Education, Reproductive Health and HIV / AIDS

- ✓ Conceptualisation
- ✓ Adolescent health
- ✓ Sexuality education during senior and further education and training phases
- ✓ Skills, attitudes and values in sexuality education
- ✓ The sexuality education teacher

Managing HIV / AIDS in education

- ✓ HIV/AIDS Prevention programmes in education
- ✓ Clinical AIDS
- ✓ HIV/AIDS and other infectious diseases
- ✓ HIV/AIDS and sexually transmitted diseases
- ✓ HIV/AIDS and National Policies and Strategies
- ✓ Care and support of learners and educators who are affected/infected by HIV/AIDS
- ✓ Introduction to peer education, counselling and mentoring
- ✓ Available resources

Gender in education

- ✓ Conceptualisation
- ✓ Gender and HIV/AIDS in education
- ✓ Teenage pregnancy, contraception and prevention programmes in education
- ✓ Gender-based violence in education
- ✓ Mainstreaming gender and HIV/AIDS in education
- ✓ Drug and substance abuse and prevention programmes in education

12. Types of delivery and estimated notional study hours per type

Student activity	Number of notional study hours (for the whole module)
Lectures	25 hours
Practicals	
Tutorials	25 hours
Field-trips	

Placements

Tests / exams 10 hours

Other (specify)

Sub-total: No. of contact hours 60 hours

Resource-based learning 30 hours

Self-directed study 30 hours

Study on assignments 25 hours

Exam preparation 15 hours

Other (specify)

Sub-total: No. of notional self-study hours 100 hours

Total: No. of notional study hours required to complete the module 160 hours

13. Teaching-learning methods used on the module

- Lecture presentations
- Seminar presentations and workshops based on student self study
- Tutorial discussions based on case studies
- Discussions based on completed project work

14. Statement of assessment criteria

Students will:

- ✓ demonstrate by way of assignments and projects knowledge of the skills, attitudes and values involved in sexuality education
- ✓ demonstrate by analysing case studies knowledge of the qualities of the educator responsible for sexuality education
- ✓ demonstrate knowledge of the disease (AIDS) transmission, progression and treatment as well as opportunistic infections
- ✓ demonstrate in projects and analysis of case studies knowledge of the difficult and controversial topics like teenage pregnancy, contraception, gender-based violence and drug and substance abuse as they relate to education
- ✓ demonstrate gender sensitive attitudes in small group situations, analysis of case studies and evaluation of learner support material used in schools for their gender sensitivity
- ✓ demonstrate in assignments and tests knowledge about the care and support of learners and educators who are affected/infected by HIV/AIDS

15. Methods of assessment to be used in the module (indicate the weighting for each method)

<i>Assessment in tutorials – case study situations</i>	<i>15%</i>
<i>Assignments and projects</i>	<i>15%</i>
<i>Tests based on case studies</i>	<i>10%</i>
<i>Formal test</i>	<i>10%</i>
<i>Exam questions which require analysis and synthesis of issues</i>	<i>50%</i>

16. What educational provision is made on the module to support students from diverse / disadvantaged backgrounds?

The module will operate in small groups where individual performance and progress will be monitored. Students whose performance is low will be given the opportunity to rework the assignments and projects.

3.2 Template for the Internal Approval of Modules at the University of Natal

(This form should be completed using the accompanying Notes, see p.34 ff.)

A. Academic Quality of the Module

1. Title of module

HIV/AIDS and Gender in Education: Facilitation, care and counseling skills for educators

2. Module code _____

3. NQF Level 6

4. Credit value of the module 16 credits

5. Field / sub-field *Education, Training and Development: Teacher Education* *Discipline Education*

6. School offering the module *School of Education, Edgewood Campus*

7. 7.1 Programme(s) on which the module will be offered

Bachelor of education (Elective module)

7.2 Pre-requisites for the module

Students taking this module should have completed Module I / II on HIV/AIDS in Education: Issues and Strategies

- | | | |
|------|--|----------------------|
| 8. 1 | Date of submission (to Faculty Board) | <i>2 August 2002</i> |
| 2 | Date of 1st offering | <i>February 2004</i> |
| 3 | Date of evaluation and review | <i>December 2007</i> |

9. Purpose of the module

To equip educators with skills so that they become:

- ✓ *Sources of advice for individual / institutional problems relating to sexuality education and HIV/AIDS*
- ✓ *Initiators and facilitators of HIV/AIDS programmes which aim at reducing the epidemic*

10. Statement of specific learning outcomes for the module

- ✓ *Students will be able to teach sexuality education in schools*
- ✓ *Students will demonstrate skills to organise and facilitate workshops and seminars on controversial topics like teenage pregnancy, gender issues and sensitivity training on stress management*
- ✓ *Students will be able to demonstrate basic counselling and management skills that relate to care and support of educators and learners affected/infected with HIV/AIDS, sexual harassment, trauma/crisis/ grief and mortality, pre- and post test counselling*
- ✓ *Students will demonstrate skills of identifying stereotypes and evaluating learner support material for their gender sensitivity and bias.*
- ✓ *Students will demonstrate skills of developing intervention strategies and programmes for youth and communities that will reduce the spread and impact*

- of HIV/AIDS
- ✓ Students will be able to do peer education, counseling and mentoring

11. List of content topics

1. Teaching sexuality education in schools

2. Counselling skills

- ✓ basic counselling skills
- ✓ pre- and post test counselling
- ✓ crisis and trauma counselling
- ✓ grief counselling
- ✓ mortality counselling – dealing with one's own death
- ✓ suicide assessment
- ✓ peer education, counselling and mentoring skills

3. Managing HIV/AIDS in education

- ✓ Care and support of educators and learners who are affected/infected with HIV/AIDS
- ✓ Infection control in schools

4. Gender and AIDS in education

- ✓ Facilitating programmes on gender-based violence in schools
- ✓ Management of child abuse in education
- ✓ Gender sensitivity training skills
- ✓ Gender analysis
- ✓ Mainstreaming gender in educational programmes

5. Legal and ethical considerations (e.g. confidentiality)

12. Types of delivery and estimated notional study hours per type

Student activity	Number of notional study hours (for the whole module)
Lectures	20 hours
Practicals	20 hours
Tutorials	
Field-trips	5 hours
Placements	10 hours
Tests / exams	5 hours
Other (specify)	
Sub-total: No. of contact hours	60 hours

Resource-based learning	<i>30 hours</i>
Self-directed study	<i>30 hours</i>
Study on assignments	<i>25 hours</i>
Exam preparation	<i>15 hours</i>
Other (specify)	
Sub-total: No. of notional self-study hours	<i>, 100 hours</i>

Total: No. of notional study hours required to complete the module *160 hours*

13. Teaching-learning methods used on the module

- ✓ *Lecture presentations*
- ✓ *Seminar presentations and workshops based on students self-study*
- ✓ *Discussions based on completed practical projects and case studies*

14. Statement of assessment criteria

- ✓ *Students will demonstrate in practical projects the ability to teach sexuality education in schools*
- ✓ *Students will demonstrate in projects skills to organise and facilitate workshops and seminars on controversial topics like teenage pregnancy, gender issues and sensitivity training on stress management*
- ✓ *Students will demonstrate in practical projects and analysis of case studies basic counselling and management skills that relate to care and support of educators and learners who are affected/infected with HIV/AIDS, sexual harassment, trauma/crisis grief and mortality, pre- and post test counselling*
- ✓ *Students will demonstrate in projects skills of identifying stereotypes and evaluating learner support material for their gender sensitivity and bias.*
- ✓ *Students will demonstrate in tests and exams skills of developing intervention strategies and programmes for youth and communities that will reduce the spread and impact of HIV/AIDS*
- ✓ *Students will complete projects and assignments on peer education, counseling and mentoring*

15. Methods of assessment to be used in the module (indicate the weighting for each method)

<i>Assignments</i>	25%
<i>Projects</i>	25%
<i>Formal tests</i>	25%
<i>Exam</i>	25%

16. What educational provision is made on the module to support students from diverse / disadvantaged backgrounds?

The module will operate in small groups where individual performance and progress will be monitored. Students whose performance is low will be given the opportunity to rework the assignments and projects.

3.2 Template for the Internal Approval of Modules at the University of Natal

(This form should be completed using the accompanying Notes, see p.34 ff.)

A. Academic Quality of the Module

1. **Title of module**
Management of HIV/AIDS and Reproductive Health in education
2. **Module code** _____
3. **NQF Level** 7
4. **Credit value of the module** 16 credits
5. **Field / sub-field** *Education, Training and Development: Teacher Education*
Discipline *Education*
6. **School offering the module** *School of Education (Durban)*
7. **7.1 Programme(s) on which the module will be offered**
Bachelor of Education (Honours)
7.2 Pre-requisites for the module
Initial BEd or Equivalent
8.

1	Date of submission (to Faculty Board)	<i>2 August 2002</i>
2	Date of 1st offering	<i>February 2003</i>
3	Date of evaluation and review	<i>December 2005</i>

9. Purpose of the module

To enable educators to develop the abilities to function as:

- ✓ *resource persons in schools and education management with a strong understanding of the disease and its dynamics, of reproductive health, and of national and provincial policies*
- ✓ *facilitators of programmes designed to increase the understanding of the disease and its dynamics*
- ✓ *lay counsellors who are trusted and accessible sources of advice for individual problems relating to sexuality and HIV/AIDS.*

10. Statement of specific learning outcomes for the module

-Students will demonstrate knowledge of the disease and its dynamics, reproductive health, and national and provincial policies that relate to HIV/AIDS

-Students will use basic counselling skills to interact with people on HIV/AIDS and Reproductive Health issues.

-Students will demonstrate skills to facilitate designed programmes to help clarify issues that relate to HIV/AIDS

-Students will demonstrate an understanding of gender being central in the prevention of HIV/AIDS

- Students will demonstrate knowledge and understanding of the educator's role in the management of HIV/AIDS and related issues in education

11. List of content topics

1. *The dynamics of HIV/AIDS*
2. *Reproductive Health: Child and adolescent health, teenage pregnancy and contraception, sexually transmitted diseases and HIV infection*
3. *Making gender central in HIV/AIDS prevention programmes*
4. *National and provincial policies and the school policy on HIV/AIDS*
5. *Managing HIV/AIDS and related issues in education and the educator's role*
6. *Facilitating workshops and programmes on HIV/AIDS and related issues*
7. *Basic counselling skills*
8. *Resources*

12. Types of delivery and estimated notional study hours per type

Student activity	Number of notional study hours (for the whole module)
Lectures	<i>24 hours</i>
Practicals	
Tutorials	<i>34 hours</i>

Field-trips	<i>4 hours during vacation</i>
Placements	
Tests	3 + 3 = 6 hours
Other (specify)	_____
Sub-total: No. of contact hours	68 hours
Resource-based learning	36 hours
Self-directed study	36 hours
Study on assignments	30 hours
Exam preparation	
Other (specify)	_____
Sub-total: No. of notional self-study hours	92 hours
Total: No. of notional study hours required to complete the module	160 hours

13. Teaching-learning methods used on the module

- *Lecture presentations*
- *Seminar presentations and workshops based on student self study*
- *Tutorial discussions based on case studies*
- *Discussions based on completed project work*

Statement of specific learning outcomes for the module

- 14.** -*Students will demonstrate by way of assignments and projects knowledge of the disease and its dynamics, reproductive health, and national and provincial policies that relate to HIV/AIDS*
- Students will demonstrate in small group tutorials basic counselling skills needed to interact with people on HIV/AIDS and Reproductive Health issues.*
- Students will demonstrate in projects skills to facilitate designed programmes to help clarify issues that relate to HIV/AIDS*
- Students will demonstrate by analysing case studies an understanding of gender being central in the prevention of HIV/AIDS*
- *Students will demonstrate in assignments and projects knowledge and understanding of the educator's role in the management of HIV/AIDS and related issues in education*

15. Methods of assessment to be used in the module (indicate the weighting for each method)

<i>Assessment in tutorials - case study situations</i>	25%
<i>Assignments and projects</i>	50%
<i>Tests based on case studies</i>	10%
<i>Formal test</i>	15%

APPENDIX VIII
DOCUMENTATION
FIRST YEAR MEDICAL PROGRAMME

2001

1ST YEAR MEDICAL STUDENTS: HIV/AIDS CURRICULUM OVERVIEW

Date	Time	Format	Content
23 April	08:30	Facilitators	Pre-test questionnaire
*10 May	9:00-12:30	Workshop	Educators' Orientation
21 May	2:00-3:00	Lecture	Prof Smith: History Transmission Statistics Testing
	3:00-4:00	Lecture	Prof Coovadia: Clinical Features Treatment Prevention Universal Precautions Condoms Controversy
*08 June	08:30-10:30	Workshop	Myths: Identification and demystifying social/cultural issues assertiveness Sex and sexuality
*15 June	8:30-10:30	Workshop	Training techniques
*15 August	8:30-10:30	Workshop	Attitudes, perceptions, needlestick injuries, stigma, fears, universal precautions, safer sex
*19 September	8:30-9:30	Lecture	Accepting, coping and living positively with HIV/AIDS
	9:30-10:30	Workshop	Accepting, coping with HIV/AIDS
25 September	Assignment	Due date	Write on Community Education Project
07 November	8:30-10:30	Lecture	Feedback on projects, Certificate, Post-test questionnaire evaluation

* - Educators will be facilitating small group workshops.

Lunch time forums, open to the whole Faculty will be arranged

Topics to be confirmed, include

- Traditional healing
Patience Koleka + academic
- Women and gender
Dr Q Abdool Karim
- Panel of PLA :
The way forward
- Poster presentation
current Medical School Research

1ST YEAR MEDICAL STUDENTS 2002: HIV/AIDS CURRICULUM OVERVIEW

Date	Time	Format	Content
*11 April	08:30 - 11:30	Workshop: (S3)	Educators' Orientation
*16 April	08:30 - 10:30	Workshop 1	Myths and Realities Identification and demystifying Social Cultural Issues Sex and Sexuality
25 April	14:00 - 16:00	Lecture: (Steve Biko)	Prof. Smith: Transmission Statistics Testing Prof. Coovadia Clinical Features Treatment Antiretrovirals Prevention Prof Q Abdool Karim Epidemiology Gender issues MTCT
*30 April	08:30 -10:30	Workshop 2	Attitudes and Perceptions Prevention
*03 May	08:30 -10:30	Workshop 3	
*17 May	08:30 -10:30	Workshop 4	Coping with AIDS
*30 May	14:00 - 16:00	Workshop 5	Training Techniques Workshop Planning
13 August	16:00	Assignment Due date	Write on HIV/AIDS Awareness Project
27 September	08:30-09:30	Feedback	(to be confirmed)

* Workshops

Assignment

HIV/AIDS Education Project

Write about your experience in giving an HIV/AIDS awareness talk for a community group. What has been the impact on your community and yourself?

Requirements: 3 – 5 typed pages (12 font; margins)
 Work in pairs/ Write in pairs
 Handed in by Tuesday, 13 August 2002 at 16:00 Medev Office

Your project needs to reflect your awareness of HIV/AIDS issues and sensitivity to the group.

Guidelines to be addressed are:

- Target group: Who are the members of the group? What are their ages, background, purpose of the group, etc.
- Time : When was the workshop held? Why was that time selected? How long was the actual workshop?
- Venue : Where was the workshop held? Why was that venue selected? Was it suitable? Why/why not?
- Planning : Detail your planning process (e.g. If you used a video – did you check that a video machine was available or did you take one to the workshop? Why you decided to use a video etc.)
- Objectives : List your objectives for the workshop
- Content : Write down all the points you addressed during the workshop
- Questions : What questions were asked? How did you answer them?
- Evaluation : Was the workshop evaluated by the participants? How was it evaluated? How did you evaluate it? What worked for you? What didn't work?
- Reflection : How did the experience impact on you as a person? Has the project influenced the community in any way.

Honesty is the best policy. There is no right or wrong answer. We are looking for indications that you have thought about HIV/AIDS as an epidemic that has medical and social implications, and that you have benefited from the process.

Pictures, photographs, diagrams etc will make it more interesting for the markers, but are by no means compulsory!

Enjoy the process.

MARKING CRITERIA : ALWAYS BE AWARE OF MARK FRAMES

	MARKS	COMMENTS
Introduction	/ 5	Contextualise your project
		Work from general to specific
		Do not ignore the introduction
Description	/20	Description of the project
		How many people did you reach out to
		Where, when why, what etc.
		Time frame, logistics
		Permission from stakeholders
		Were teachers present?
		Workshop/presentation
Objectives	/ 10	Purpose
		Aim vs objectives
		Succinct, specific
		Do not have too many objectives as objectives impact on content
Content [Delivery]	/ 30	Tell us exactly what happened
		Format of project (briefly)
		Focus on transmission of knowledge
Reflection / Evaluation	/ 30	Evaluation from the target group
		Reflection involves self evaluation
		Positives and negatives for you
		Reasons for the above
		What would you change to make it more effective?
		Be honest
Presentation	/ 5	Structure/style/effort
		Referencing
		Details
	TOTAL 100	

APPENDIX IX

DOCUMENTATION

SECOND AND FIFTH YEAR MEDICAL PROGRAMMES

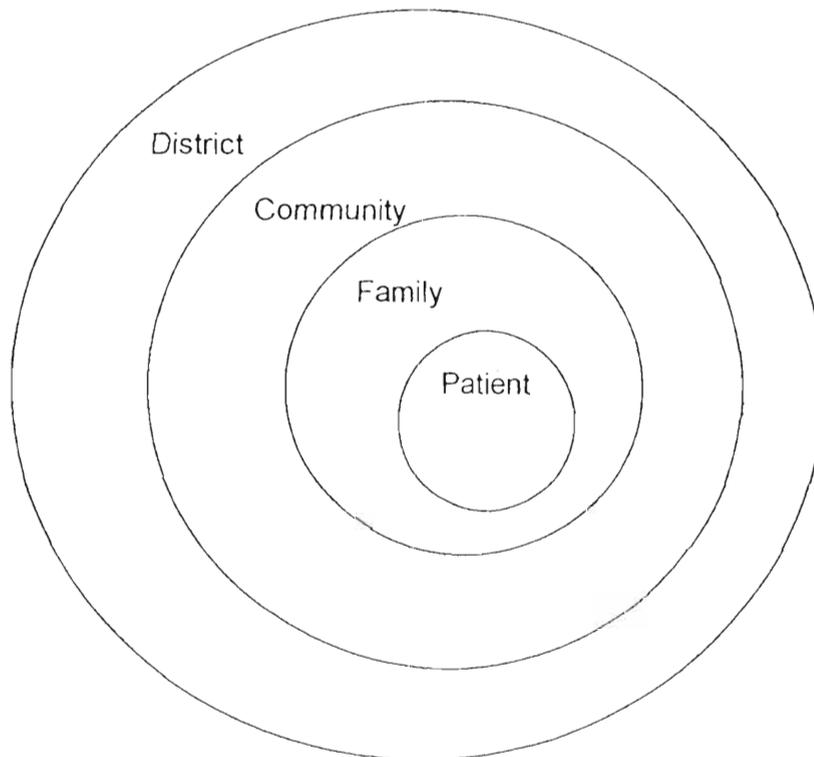
2nd year

INTRODUCTION

WELCOME to the Community-Based selective programme.

This is a hands-on programme ! The emphasis will be on experiencing community-based health-related issues first-hand, through home and family visits, and working with a community-based project. Then we will spend some time reflecting on the experiences, through written feedback, as well as presentations to your colleagues. The library, the internet and your books will be replaced these weeks by the classroom of real life. How useful this theme will be is really up to you as an individual – the more you put in, the more you will get out of it. It will require initiative and creativity, as each student's experience will be different.

Every man, woman and child in this country is challenged by the epidemic of AIDS. As a nation we need to respond to it as if it were a war. Hospitals and medical care cannot address the AIDS epidemic adequately. Part of the solution involves Home Based Care. Many Community Based projects are working in this field and there are many lessons for medical students to learn in this component of the module.



ELECTIVES - CBME TASK TEAM

Task Team :

1. Mrs Dorothy Appalsamy – MeDev (Medical School)
2. Dr Kala Naidoo – Community Health
3. Sr. Kay Naidoo – Department of Health
4. Mr Lucky Ndlovu – Valley Trust
5. Professor Steve Reid – Rural Health (Medical School)
6. Dr Janet Giddy – MeDev (Medical School)

Consultants: CHESP

1. Mr Clive Bruzas
2. Mr Victor Mkhize
3. Mrs Frances O'Brien

AIM OF THE PROGRAMME

The aim of this programme is to bridge the gap between clinical medicine and community-based health care, by addressing the issue of HIV/AIDS in a specific community.

OBJECTIVES OF THE PROGRAMME

- To engage with individuals, families and a community, outside of a health facility
- To gain the understanding and skills necessary to assist that community in the prevention of HIV/AIDS
- To analyse the gap between the community's needs and the services available
- To plan and implement an appropriate intervention project in that community
- To reflect on and learn from the experience, together with the community and health service partners, and your peers at other sites.

LEARNING OUTCOMES

By the end of the programme you should have:

- A detailed understanding of a community perspective on HIV/AIDS
- An integrated knowledge of Primary Health Care
- An understanding of the obstacles and resources for HIV/AIDS prevention and health promotion
- An awareness of the value of Home Based Care
- Skills in health promotion and health education
- An appreciation of community involvement in health
- Respect for fellow health professionals and clients
- An ability to work in multi-disciplinary teams
- An ability to reflect on and learn from your experiences

ACTIVITIES DURING THE PROGRAMME

WEEK 1 (27-31 May)

By the end of the first week, you will have:

- Had two small-group tutorials
- Been introduced to the project and key people in the community
- Conducted a number of home and family visits
- Made a detailed assessment of one family's situation
- Understood the clinical, contextual and individual assessment
- Written a patient study as a group, capturing your learnings

WEEK 2 (3-7 June)

By the end of the second week, you will have:

- Had two small-group tutorials
- Conducted a community assessment
- Evaluated the project to which you are assigned
- Identified gaps between what the community needs and what the project delivers
- Written a plan of action, as a group
- Presented one aspect of your experience to the rest of your colleagues.

WEEK 3 (11-15 November)

By the end of the third week, you will have:

- Had two small-group tutorials
- Received feedback on your plan of action
- Modified your plan in consultation with your project managers
- Begun to implement your plan
- Written a document stating how you will assess the impact of your plan

WEEK 4 (18-22 November)

By the end of the final week, you will have

- Had two small-group tutorials
- Completed your intervention
- Completed the assessment of your intervention
- Presented the outcome to the local project and community members
- Presented one aspect of your project to your colleagues
- Written a report of your whole project

DETAILED ACTIVITIES GUIDE

Note: this is a guide only, and actual activities will need to be modified according to the particular situation at each site. You need to use your own initiative and creativity in order to achieve the goals for each week, and not necessarily be constrained by the guidelines.

Monday 27 May: Small group tutorial at Medical School & Travel to sites

8.30am to 10.30am Small-group tutorial with a case scenario

11am-1pm: Large Group resource session re logistics – groups, transport, final arrangements.

2pm: Travel to sites and orientation

Tuesday 28 May: Health Facility tour, introductions to project staff, patient consultations

The idea here is to be introduced to the health facility or project, and to start meeting the clients of the project. Work in pairs, and if home visits are happening, you should go out with a team. Otherwise spend the day seeing clients of the project.

Wednesday 29 May: Patient consultations / Home visits

Working in pairs, sit in on consultations, observe what goes on, and request a patient or patients to visit them at their homes. Go out with the teams, and try to understand that individual's context in as much detail as possible, including all the family relationships, and their ways of seeing and doing things. Try to understand your patient as if you were in his or her shoes. What is the experience of being ill? Arrange to visit again.

Thursday 30 May: Home and Family visits

Return to the same home if possible, and revisit one patient and family. Draw a genogram of the family, showing all the members and relationships of at least 3 generations. Discuss this with the family itself, and ask them to tell you more about their beliefs and ways of dealing with illness, while completing the genogram. Ask about the neighbourhood and the community around them.

Friday 31 May: Family study and travel back to Medical School

Use the three-stage assessment tool to write up your patient study. Complete the study, and travel back to Medical School for a small-group tutorial in the afternoon at 2pm.

Monday 3 June: Community survey

08h30-10h30 Small-group tutorial

11h00 Travel to sites

Using your index family as a starting point, explore the neighbourhood from there, linking with the community health worker or home-based care giver. Try and visit the local traditional healer, the local clinic and shop, and any other resources in the area. Draw a map of the neighbourhood or community, including all the resources related to health. If you were ill in this community, what would you do ?

Tuesday 4 June: Home-based care Project assessment

Revisit the project that you are attached to and assess what they are doing to meet the needs of the community. Identify any gaps between what the project provides and what the community needs, and prioritise these.

Wednesday 5 June: Planning of intervention in November

Based on the gap analysis, decide on an issue that you feel needs to be tackled, and plan an intervention that you can get involved in during November or even in your own time before then. This could be a group exercise.

Thursday 6 June: Writing of report & Travel back to Durban

Complete your action plan for November and write it up. In addition write a 4-page report on your experiences as a group, and prepare a 10-minute presentation by your whole group of only one issue which you learnt the most about in the 2 weeks.

Friday 7 June: Small group tutorial & Presentation to whole group

08h30-10h30: Small-group tutorial

Here you will be meeting back up with students from other sites who have had different experiences, and answering the questions that you raised on the Monday, (based on your experiences rather than the books)

11h00-15h00: Group presentations to the whole class.

Each group of 4 students will be given 5 minutes to present one aspect of their experiences that they feel their colleagues should know about.

CASE SCENARIO 1

Dr Ntsaluba, a newly qualified doctor from Pretoria University, was allocated to Hlabisa Hospital, a rural district hospital in KwaZulu-Natal, for her year of community service. She soon found herself overwhelmed by the number of terminally ill AIDS patients in the medical ward that she was responsible for, and the difficulty that she had in speaking to most of them about their partners and families. Despite the best efforts by her and the staff involved in voluntary counselling and testing (VCT), most refused to be tested or to disclose whether they have been tested, although she suspected that they know their diagnosis.

On one afternoon when she was off duty, our young doctor was invited to accompany the Zulu-speaking hospital physiotherapist on a home visit to a paraplegic patient who had recently been discharged from her ward on TB treatment. She agreed to go, in order to learn more about the community that she served, as she herself was from the Northern Province and did not speak Zulu as a first language.

On the way driving to the patient's home, the physiotherapist explained the correct way of greeting and of entering a Zulu homestead. The homestead was a 200m walk from where they left the vehicle, and consisted of three mud and wattle structures, one of which was used as a kitchen. They found their patient, a 25-year old man, confined to bed with a fever, but happy to see the visitors. The family, including the patient's mother and 2 sisters, were surprised and interested in the visitors, and Dr Ntsaluba noticed that a number of the 6 children present were thin and had a persistent cough. She made a mental note to find out more about the home-based care project that the community matron had started, wondering if she could link this family into it.

KEY WORDS

- community service
- HIV testing
- disclose
- paraplegic
- Zulu-speaking
- TB treatment
- community
- family
- home-based care
- community matron

LEARNING OUTCOMES

The students should be able to demonstrate an understanding of:

1. The stigma around HIV
2. Infectivity of TB
3. Cross-cultural interactions
4. Voluntary counselling and testing
5. Home-based care
6. The family context of patients
7. The community context of patients

CASE SCENARIO 2

On returning to the hospital, Dr Ntsaluba found her ward completely full of patients with AIDS, many of whom were terminal, with some patients having to sleep on mattresses on the floor because there were not enough beds. Speaking to the community matron, she learnt that the home-based care project had not really got going as there was no vehicle available, so she could not refer patients to them. She felt depressed and hopeless, and wanted to leave, but felt that she must do something about the situation.

With the encouragement of the Hospital Manager, she decided to get involved and wrote to a donor agency requesting funds for a HIV/AIDS project. To her surprise they answered positively, and agreed to donate a vehicle to the hospital for home-based care. She organized a team of people including an active induna in the area, the community matron and a HIV-positive patient of hers who was trained as a lay counsellor and was prepared to be open about her status. They drew up a list of known AIDS patients in the community, and arranged a visiting schedule to each home every two months. Dr Ntsaluba started a weekly AIDS clinic and HIV Support Groups at the hospital, and became involved in the use of Nevirapine in the antenatal clinic, to prevent mother-to-child transmission of the virus. She was also approached by a local church to assist them in a prevention programme for the youth in the area.

KEY WORDS / ISSUES

- Full wards
- Terminal care
- Home-based care programme
- Deciding to do something
- Team
- Lay counsellor
- Open about HIV status
- Support groups
- Nevirapine
- Prevention programme

LEARNING OUTCOMES

The students should be able to demonstrate an understanding of:

1. Inpatient care / the medical model approach is not the answer to the problem of AIDS.
2. The importance and benefit of Team Work.
3. Resources available for HIV/AIDS.
4. The concept of COPC (community orientated primary care)
5. A motivated individual can make a difference
6. There are different levels of intervention which a doctor can get involved with.

SITES AVAILABLE IN 2002

1. Hillcrest AIDS Centre, Hillcrest

LOCATION

The Hillcrest AIDS Centre is based in Central Hillcrest (at the Methodist Church, on the corner of Morningside and Nqutu Road)

SITE FACILITATOR

Dr. J. Giddy

Supervisor: Julie Hornby (Director) – 031 7655866

ACTIVITIES OF THE CENTRE

It focuses on AIDS Education and Care which involves counselling, employment generation, providing food parcels and home based care. They work closely with a community based hospice called Kayaliboma (House of Rest), in the Valley of a 1000 Hills.

COMMUNITIES SERVED

They serve the community living in the Valley of a Thousand Hills.

LOGISTICS

Number of Students: 4

Transport: Students will be taken to Hillcrest AIDS Centre and from there to the Hospice. They would do home visits walking from the hospice or else using local transport.

2. The Valley Trust, Botha's Hill

LOCATION

The Valley Trust is situated 40km from Durban near Botha's Hill, off the Old Main Road past the Rob Roy Hotel.

SITE FACILITATOR

Prof S Reid

ACTIVITIES OF THE CENTRE

The Valley Trust is a non-governmental organization involved in the training and implementation of Primary Health Care.

COMMUNITIES SERVED

The communities of the area known as KwaDedangendlala, comprising KwaNyuswa, Qadi, Embo and Ngcolosi. These are all peri-urban and rural communities in the Valley of a Thousand Hills.

LOGISTICS

Number of students: 12

Transport will be provided by the Faculty to the Valley Trust at the beginning and the end of each week. Local taxi's will be used for home visits in the area.

Accommodation is available at the Valley Trust in shared rooms, and a canteen provides all meals.

3. Philangezwi Project, Cato Crest

LOCATION

Situated in Bellair Road, Cato Manor. About 300 metres from the intersection (on your right) – Francois and Bellair Road.

SITE FACILITATOR

Mrs D Appalsamy

Supervisor: SR. Siki Tsekiso

Mr Ben Ntsinkanye

ACTIVITIES OF THE CENTRE

It focuses on AIDS Education and Care involving Home based care, food parcels and counselling and teach sewing to groups in the community.

COMMUNITIES SERVED

They serve the Cato Crest and Fast Trek (informal settlement) areas within a 10km radius.

LOGISTICS

Number of Students: 4

Transport: Students will use local transport to the clinic. They will be transported to the patients homes by Mr Ben Ntsinkanye

4. Sinosizo Project, Durban

LOCATION

Situated in Bayview (Unit 2), Chatsworth

SITE FACILITATOR

1. Contact person: Dr Liz Towell – (031) 4006500

2. Sister Celestine Mtshali (North) - 0824930396

3. Mrs Vusi Magwaza (South) – 0823578636

ACTIVITIES OF THE HOSPITAL

Community based Church programme (Catholic) involved with training and home based care, for people with AIDS. The project also works with orphans and vulnerable children and their educational needs.

COMMUNITIES SERVED

The rural community of Umbumbulu, the Northern and Southern Regions, Groutville (Etete), Wentworth, Newlands East, Bhambayi, Lamontville and Hambanati.

LOGISTICS

Number of Students : 12

Transport : Will be available to homes and back to the site – dropped of to the nearest transport facility. Bring own lunches.

5. Siyabona project, Umkomaas

LOCATION

Near Umkomaas, in the Ugu North sub-district

SITE FACILITATOR
Mrs Molly Bailey

ACTIVITIES OF THE CENTRE

Siyabona is a community-based NGO inland of Scottburgh, involved in community development activities such as the building of school classrooms, youth development, and preschool education. One of their projects is called "Siviselela Isizwe" and is targeted specifically at reducing the risk of HIV/AIDS in young men. 12 Youth leaders have been chosen and they have requested help to start working with the youth.

COMMUNITIES SERVED

The rural communities of Dududu, Ndonyane and Dumisa, inland of Scottburgh and Umzinto. They relate to the GJ Crookes Hospital, which is also the site of the Ugu North District Office.

LOGISTICS

Number of students: 12 MALES

Transport: Transport will be provided by the Faculty to the project at the beginning and the end of each week. Local transport will be available during the week for community activities.

Accommodation is available at the project in a converted farmhouse, including meals.

6. South Coast Hospice, Port Shepstone

LOCATION

The South Coast Hospice is located in the centre of Port Shepstone, close to the provincial hospital.

SITE FACILITATOR
Dr Laura Campbell

ACTIVITIES OF THE CENTRE

3 Teams of experienced professionals conduct home-based care on a daily basis, in a network with hospitals and clinics in the Ugu South sub-district. In addition, the hospice provides a small in-patient facility for terminal care and a training centre for home-based care volunteers.

COMMUNITIES SERVED

Communities in the area of the Ugu South sub-district, extending from Hibberdene to Harding.

LOGISTICS

Number of students: 4

Transport will be provided by the Faculty at the beginning and the end of each week. Accommodation is available in private facilities near Port Shepstone if necessary, however, preference will be given to students from the area who would be able to stay at home.

7. Crossroads Programme, Pinetown

LOCATION

The Crossroads office is in Everton (near Hillcrest) and is part of the Campus Crusade organisation.

SITE FACILITATOR

Dr J. Giddy

Supervisor : Dr J. Templehof (Director) – 031 7672022

Administrator: Ms Martie Erasmus

ACTIVITIES OF THE CENTRE

This is an AIDS prevention aimed at senior primary students through involving teachers, parents and peers. The main focus is empowering school teachers to teach a specially designed Life Skills program which focuses on abstinence.

COMMUNITIES SERVED

Students would be linked with schools in one of the following 3 areas:

KwaMashu

Umlazi

Pinetown

They would attend the curriculum training and thereafter work with the teachers to help in teaching the curriculum, as well as supporting meetings with parents and scholars after school. They would visit the homes of pupils with family members infected with HIV.

LOGISTICS

Number of Students: 12

Transport: Will be arranged flexibly.

Note:

Students working with this project will have to use their CBME time in a more flexible way. They will start work with the project in March and do various activities over the next few months, for which they will be accountable. They will receive credit for all the time which they spend on the project and this would be deducted from the time allocated from the blocks in May and November.

8. Church of Scotland Hospital, Tugela Ferry

LOCATION

Church of Scotland Hospital is on the banks of the Tugela river at Tugela Ferry in the Msinga district, about 3 hour's drive from Durban.

SITE FACILITATOR

Dr Tony Moll

ACTIVITIES OF THE HOSPITAL

The hospital established one of the first rural Home-based care programmes in the country 6 years ago. More than 300 patients with AIDS are cared for at home by volunteers, and visited on a regular basis by a team in a vehicle from the hospital, consisting of a professional nurse and a staff nurse. There is a busy HIV clinic at the

hospital run by Dr Moll, and each patient is followed up individually. In addition, a number of preventative activities are taking place in the community, particularly at schools.

COMMUNITIES SERVED

All communities within the Msinga district, mostly very rural and inaccessible.

LOGISTICS

Number of students: 2 (maybe 4)

Transport to Tugela Ferry will not be provided by the Faculty, but a transport subsidy will be given to cover costs.

Accommodation will be provided in the hospital at one of the doctors' homes, and students will be expected to contribute to the costs of meals.

Preference will be given to students whose homes are in that area or nearby.

ASSESSMENT

The assessment of the first part of this selective (May-June) will be based on the following:

1. A written patient/family study (first week) – 10 marks
 - Make sure that each group member's name is at the top of the
 - Use the "grid" on page x as a guide
 - This is a group effort, so each group member will be given the same mark
 - It must be typed using single-spacing
 - It should not be more than 4 pages long, excluding diagrams or photo's
2. Your group presentation (end of second week) – 10 marks
 - Originality and creativity will be taken into account
 - Accuracy of content
3. Feedback from your community site facilitator – 10 marks
 - This will include attendance, punctuality, courtesy, sensitivity to community and project members, etc.
4. Your group's plan for an intervention (by end of June) – 10 marks
 - Feasibility of the intervention
 - Degree of cooperation with local groups and individuals
 - Total = 50 marks

Similarly, the assessment of the second part (November) will be based on the following:

1. Written report of the intervention
 - Introduction
 - Description
 - Objectives
 - Recommendations
 - Reflection / Evaluation - 25 marks
2. Report from the community site facilitator or project leader
3. Reports from community members
4. Your group's final presentation
 - Duration
 - Content
 - Structure
 - References
 - Format (powerpoint) - 25 marks

- Total =50 marks

Guidelines will be given for each of these requirements.

They will be marked according to the following criteria:

- Degree of engagement with the community
- Accuracy of the content
- Originality and initiative
- Audience participation (for presentation)
- Feasibility of the plan for intervention
- Analysis of successes and failures

THREE-STAGE “GRID” FOR PATIENT/FAMILY STUDIES

	CLINICAL	CONTEXTUAL	INDIVIDUAL
Subjective	Clinical history	What you were told by the patient, family and others	What the patient says about him/herself and the illness
Objective	Physical examination	What you observed and examined in the patient’s environment	What you observe and hear from others about the patient
Assessment	Diagnosis & differential diagnosis	A family assessment and a community “diagnosis”	What it feels like to be in your patient’s shoes
Plan	Clinical management & treatment plan	How you could intervene to make a difference at the family or community level	How you could be of most help to this person

FIFTH YEAR BLOCK: COMMUNITY ORIENTED PRIMARY CARE

THE VALLEY TRUST: 2002

Dates:

2, 3, 4, 5 April
25, 26, 27, 28 June
16, 17, 18, 19 July

Groups: ~55 students per group

Theme: HIV IN THE COMMUNITY

Objectives:

1. Student-oriented

- To give students the opportunity of understanding health and illness in the context of the family and the community, through real interactions with patients at their homes.
- To stimulate self-learning in a small group, drawing on their own resources and experiences.
- To encounter community-based programmes first hand, and experience the influence of community attitudes to health care
- To learn about the influence of local beliefs and customs on health, particularly with respect to AIDS and HIV.
- To overcome some of the obstacles and fears of working outside of an urban health facility.

2. Community-oriented

- To assist in preventing HIV in the community.
- To engage in a health promotion activity related to the prevention of HIV.
- To assist patients with chronic problems, including HIV infection and TB, to manage their illnesses optimally within their home contexts.
- To support individuals living with HIV

3. Service-oriented

- To assist TB patients to find appropriate treatment supervisors, and enable them to be discharged from hospital.
- To support the Valley Trust HIV/AIDS programme development
- To plan and carry out a health education session in primary schools, with the aim of encouraging teenagers to live a healthy lifestyle.
- To support and encourage the community health facilitators and workers in Qadi, Embo, Nyuswa, Molweni, and Ncolosi.

Plan:

Day 1- Tuesday

08h00-09h00	Travel to Valley Trust: meet in Main Hall
09h00-10h00	Introduction to the programme
10h00-13h00	Home visits in 8 groups of 7 students
13h00-14h00	Lunch
14h00-15h30	Feedback and Video presentation
15h30-16h00	Travel back to medical school

Day 2 - Wednesday

08h00-09h00	Travel to Valley Trust
09h00-13h00	Home and neighbourhood visits: 8 groups of 7
13h00-14h00	Lunch
14h00-15h30	Group work: preparation for school visits
15h30-16h00	Travel back

Day 3 – Thursday

08h00-09h00	Travel to Valley Trust
09h00-10h00	Meet with HIV/AIDS team
10h00-13h00	Primary school visits: 4 groups of 14
13h00-14h00	Lunch
14h00-15h30	Group preparation for presentation
15h30-16h00	Travel back

Day 4 – Friday

	Seminar Room S4 at Medical School
08h00-10h00	Group work – preparation
10h30-12h45	Presentations: 15 minutes + 5 minutes discussion per group
12h45-13h00	Feedback evaluations

Student Evaluation

Attendance	20
Participation	40
Presentation	20
Report	20
Total	100

Objectives – Days 1 and 2: COPC

BACKGROUND

This programme is intended to allow you to engage closely with a patient and his or her family, in the context of their family and community, so that you can think about issues that influence health and illness, and the delivery of health care in the community. The second objective of this programme is to encourage and stimulate different sectors of the community to think about how they may respond to the emerging problems around HIV/AIDS, e.g. stigmatization, spread of HIV, orphans. Finally, the programme has been linked with the goals of the Halley Stott Health Centre, the Don MacKenzie TB centre, and the Valley Trust. This year's activities seek to assist the AIDS Programme of the Valley Trust, by planning and implementing a health promotion exercise in a number of primary schools.

TASKS

- Meet with a patient and family
- History and examination at the clinic
- Visit the home: detailed assessment of home conditions and their likely impact on the genesis and maintenance of the illness.
- Understand the whole family and each member's perception of the illness and its management: why it happened, what caused it, what maintains it, what makes it better ?
- Make an appointment for a return visit on day 2. On the second day, revisit the same home and check on the condition of your patient
- Using the home as a starting point, investigate the neighbourhood of the home by visiting all relevant points of interest, e.g. water source, local shop, sanitation, shebeen, traditional healer, clinic, community health worker.
- Build up a picture of local resources available to the family of your patient
- Critically analyze the factors which may have generated your patient's illness in the first place, or sustain the disease in the community.
- Outline a management plan which is realistic and implementable in the family and community context.
- Give feedback to the service providers at the Health Centre

PRESENTATION AND REPORT

- All groups will be expected to submit a written report outlining the clinical problem and management plan in the home context; the influence of community and context should also be explored and reflected in the report. A description of the surrounding homes and environment should be included and form the basis of the context for health care provision. Some references can be included but your own impressions and thoughts should represent the core of the report.
- On day 2 in the afternoon, after returning to the Valley Trust centre, groups will discuss the details of their case with the other students and the tutor.
- Day 4 in S4 (6th floor Medical School): Groups will work over the first hour to prepare concise summaries of their cases and the problems which face that patient and family. The presentation should reflect more of what you have learned about the health and health care of your patient, rather than a detailed account of their home

circumstances. Those details can be discussed on the afternoon of day 2 and outlined in your report.

- A management strategy should be prepared which must be applicable and feasible in that family. The steps towards this should be clearly defined, in a stepwise manner.
- Time will be given for discussion of the whole week's experiences, including the activities of day 3, after each group has presented.

Objectives 2 and 3 – day 3

BACKGROUND

The Valley Trust runs a community-wide HIV/AIDS programme aimed at addressing the need for prevention of HIV and the promotion of healthy lifestyles in the Valley. It also supports a network of some 100 community health workers in the areas of Qadi, Nyuswa, Embo, Ncolosi and Molweni, through the employment and support of 6 community health facilitators. These facilitators, and the AIDS team at the Valley Trust, have had some training in home-based care for AIDS patients, and are trying to support those who have the disease and their families in the most appropriate way. However, little has been done on a primary preventative level, and the HIV/AIDS programme is involved in various health promotion strategies in the area this year, particularly amongst the youth. They have asked our help in this.

TASKS

- Meet with the AIDS programme coordinator at the Valley Trust, and plan the intervention. "Healthy Living" is the title that has been chosen for this session.
- Divide into 3 groups, and work out what you need to say, and how best to get the message across.
- Identify exactly who will do what, and when.
- Go out to 3 separate nearby primary schools.
- Conduct the health education session in different classes for 45 minutes.
- Aim for as much participation of the children as possible.
- It is important to be sensitive to parents' concerns about "sex education", and to make your message as appropriate as possible.
- Record your impressions and the things that you learn from this experience, because you will probably find yourself in a similar situation in the future !

EVALUATION AND PRESENTATION

- Record the events of the day as fully as possible
- Analyse the events, pooling your experiences with those of the other groups of students.
- Build a framework for the groups of students who will follow you in June and October, to use in further health promotion activities in these schools.
- Outline any other steps that need to be taken in the way forward
- Present a only a summary of this on the final day of the block

Be creative and have fun !

5TH YEAR COMMUNITY-ORIENTED PRIMARY CARE BLOCK – VALLEY TRUST

END OF BLOCK EVALUATION

1. In what ways has this week met the programme objectives ?
2. What were the most striking things that have made an impact on you this week ?
3. How might you apply what you have learnt to your future career ?
4. What were the best and the worst aspects of the week ?
5. What changes to the block could you suggest for future groups of students ?

APPENDIX X

DOCUMENTATION

CODAL PROGRAMMES

SCHOOL OF COMMUNITY DEVELOPMENT AND ADULT
LEARNING

UNDERSTANDING AIDS IN AFRICA

(An Anthropological Perspective)
DAT7UAM and DAT8UAM

Course Coordinator: Prof. S. Leclerc-Madlala
Office: Rm. 187 MTB
Telephone: 260-2387

Course Administrator: Kogan Naicker
Office: Rm. 130 MTB
Telephone: 260-2340

A systemic way of thinking is required to understand the AIDS pandemic in Africa. HIV/AIDS on this continent has presented itself as a complex disease where social dynamics, entrenched poverty, political mismanagement and cultural belief systems have colluded to accelerate the spread of the disease and block effective interventions.

This course is designed to give students a holistic understanding of the factors and forces that shape and sustain the HIV/AIDS epidemic. With the highest proportion of HIV positive people in the world, the African pandemic has become synonymous with threatened economies, overburdened women and a growing mass of orphaned children that do little to inspire hope for the future. For these reasons it is vital that understand the nature of the various interlocked components that act to propel this disease, and then seek ways to unlock these parts to mediate against the disease's rapid growth.

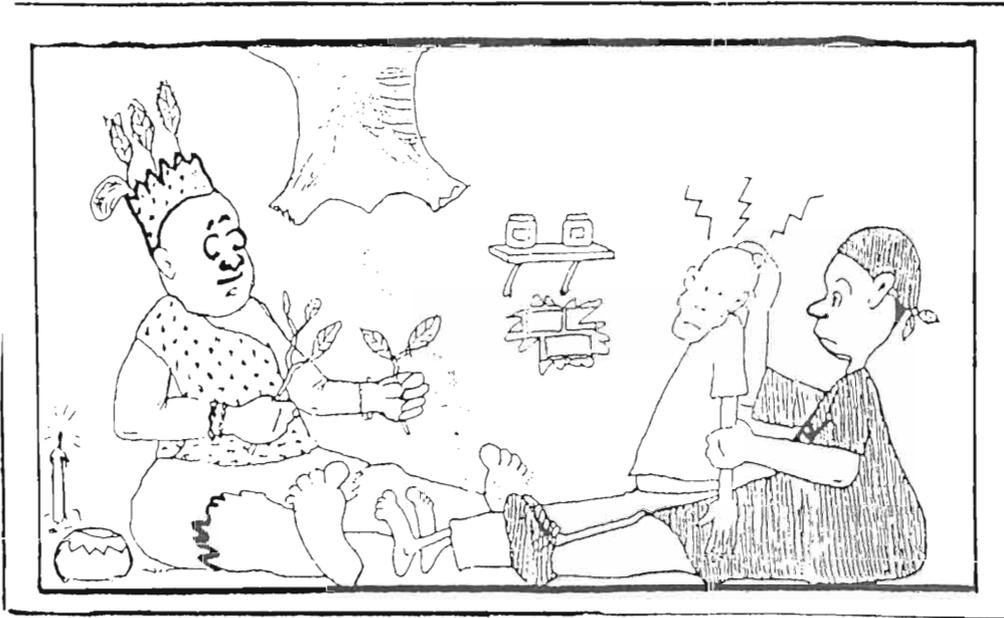
The overall aim of the course is to introduce students to some of the more significant contextual factors that underlie and sustain the epidemic in this part of the world. As an upper level course students are expected to have a basic working knowledge of HIV/AIDS. This course will expand upon that knowledge by adding depth and insight into some micro and macro dynamics that make African societies especially susceptible to HIV/AIDS.

RULES AND REGULATIONS

1. This course has been offered at both the honours and Masters levels.
2. The course will take place during the week of 23-27 September. Each day will have two sessions. One in the morning from 9:00 to 12:15. One in the afternoon from 13:30-16:00. Ten-minute tea breaks will be included.
3. The venue is C4 unless otherwise advised by the lecturer.
4. All students taking the course must complete one lecture presentation plus one long assignment on a selected topic.
5. The long assignment will be due by Friday 18 October.
6. The required readings for each student's lecture presentation will be obtainable from KOGAN NAICKER in Rm. 130 MTB, the School's main administrative office. Students will be responsible for obtaining any other readings and are naturally expected to use the library and other resources when seeking materials for their long assignments.

SCHOOL OF COMMUNITY DEVELOPMENT AND ADULT LEARNING

(Second Year Anthropology Course)



Health and the Sociocultural Context DAT 2SH1

HEALTH AND THE SOCIOCULTURAL CONTEXT
(DAT 2 SH1)

COURSE DESCRIPTION

Course Coordinator
Prof Suzanne Leclerc-Madlala
Room 187 Memorial Tower Building
Tel 260-2387

Welcome to the School of Community Development and Adult Learning's second year level course "Health and the Sociocultural Context". This is a course in medical anthropology – a rapidly expanding sub-field within the broader field of Anthropology. Situated at the margins of the clinical and social sciences, medical anthropology considers the wide cultural and social aspects of the body, health, sickness and healing. In brief it is concerned with the range of issues that surround the meanings people attach to health and illness, the therapeutic process, and the ways in which social and cultural dynamics shape expressions of sickness, suffering and recovery and often the course of a disease's progression. Medical anthropology is a comparative endeavor and is based on fieldwork in a wide range of social contexts – from pre-industrial New Guinea to post-industrial Japan. Such knowledge may be of crucial importance and critical relevance to rapidly developing countries such as South Africa, especially in the field of public health.

This course has two concerns. First, to introduce students to some of the most important theoretical paradigms in medical anthropology. Second, to consider some of the most crucial contemporary issues in medical anthropology and public health. These include studies on mental illness, the AIDS pandemic, and the political economy of health and development.

Throughout the course the emphasis shall be comparative. Readings focus on diverse social contexts in North and South America, Europe, South East Asia and Africa. The emphasis shall also be on works that ground theoretical models in empirical observations, rather than on works which construct theoretical models out of thin air. The overall purpose of the course is to demonstrate that scientific biomedicine – although it is a most powerful and dominant medical system – is not the only approach to understanding and healing the sick body and mind.

RULES AND REGULATIONS

- 1 This course is offered at the second year level and can only be taken at the third year level if special arrangements are made with the School.
- 2 There will be four formal lectures each week. These are to be held on Monday (2.10 - 3:40), Tuesday (1.15 - 2.00), and Wednesday (8.40 - 10.20). Lectures will cover broad theoretical and conceptual themes. Only by attending lectures regularly will students be able to attain an adequate grasp of the material that we have covered and achieved a good pass mark in the exams.
- 3 Two formal time slots are set aside for revision and consultation. Students taking the course can meet with their respective lecturer on Mondays (between 1.15 and 2.00). Please do all the required readings, carefully revise the material we have covered, and think critically about it. Only then would you be able to ask meaningful questions.
- 4 Lectures will be held in Room MTB 200, located at the end of the Social Anthropology corridor, and students' consultations will take place in Room 187, between the disciplines of Social Work and Social Anthropology.
- 5 All students taking the course must complete the following three (3) assignments: Test 1 on Monday, 25 March, Test 2 on Monday 13 May, Essay due on Wednesday 29 May.
- 6 All students are expected to make photostat copies of their essays before submission. This will save a great deal of trouble and effort in case the essays are lost.
- 7 Essays topics are given below. Note that the essays should not exceed ten pages in length. All essays could contain a well thought-out argument. Essays that merely comprise a summary of the various readings will most definitely receive failing grades.
- 8 No extensions will be granted unless a valid medical certificate is produced. All tests are compulsory and will cover material dealt with in lectures and in the required readings.
- 9 The course shall be assessed as follows: Tests (10% each), Essay (20%) and the June Exams ED(60%). Students are expected to attain a passing grade in their exams to pass the course.
- 10 I have divided all readings into those that are required (marked with an asterisk*) and those that are recommended. All the required readings are contained in the course reader. These readings are a necessary background to the lectures and are essential for in-class discussion and tests.

COURSE OUTLINE

WEEK ONE

18 - 22 February

THE SCOPE AND AIMS OF MEDICAL ANTHROPOLOGY

THEMES OF LECTURES. The development of medical anthropology, theoretical paradigms and their importance, concepts and methods in the study of sickness and healing.

*Kleinman, A.

1985 Medical Anthropology. In A. Kuper and J. Kuper (eds.) The Social Science Encyclopaedia. London: Routledge, 511-512.

*Lambert, H.

1996 Medical Anthropology. In A. Barnard and J. Spencer (eds.) Encyclopaedia of Social and Cultural Anthropology. London: Routledge, 358-361.

Firth, R.

1978 Social Anthropology and Medicine - a personal perspective. Social Science and Medicine 12 B, 237-245.

WEEK TWO

25 February - 01 March

MEDICAL SYSTEMS AS CULTURAL SYSTEMS

THEMES OF LECTURES. The works of Arthur Kleinman Medical systems as cultural phenomena, medical pluralism, towards the lived experience of suffering.

*Kleinman, A.

1978 Concepts and a model for the comparison of medical systems as cultural systems. Social Science and Medicine 12, 85-93.

*Kleinman, A and L. Sung

1979 Why do indigenous practitioners successfully heal? Social Science and Medicine 13 (b), 7-27.

MID SEMESTER BREAK 30 March – 07 April

WEEK SEVEN

08 – 12 April

THE AIDS EPIDEMIC

THEMES OF LECTURES. A general overview of the AIDS pandemic. Social Science contributions, AIDS and the allocation of blame, myths and cures

*Fränkenburg, Ronald

1994 Learning from AIDS: The Future of Anthropology. In C Akhbar and C. Shore (eds). The Future of Anthropology. London. Athlone Press

*Farmer, P.

1991 AIDS and Accusation: Haiti and the Geography of Blame. Berkeley. University of California Press, 208-243

Green, Edward

1992 AIDS and STD's in Africa. Pietermaritzburg: University of Natal Press

Varga, Christine and Lindiwe Makubalo

1995 Sexual non-negotiation. Agenda 28 (march) 31-38

WEEK EIGHT

15 – 19 April

GENDER AND AIDS

THEMES OF LECTURES. Socio-cultural constructions of femininity and masculinity, sexual politics, negotiating safe sex, barriers to risk reduction.

*Haram, Live

1996 The Gendered Epidemic: Sexually Transmitted Diseases and AIDS among the Meru People of Northern Tanzania. In Steffan Bergstrom and Gerd Holmbee-Otlesen (eds.) Reproductive Health Research in developing Countries. Oslo Centre for Development and-Environment.

Leclerc-Madlala, S

2001 Main Target in fight against AIDS. Sunday Tribune, Perspectives Independent Newspapers: KZN 14 January

Orubuloye, I., J. Caldwell and P. Caldwell

1993 African Women's Control over their sexuality in an Era of AIDS. Social Science and Medicine 36 (7), 859-875

*Whitehead, T L

Urban Low-Income African American Men, HIV/AIDS, and Gender Identity. Medical Anthropology Quarterly 11 (4), 411-447

WEEK NINE

22 – 26 April

PHENOMENOLOGY OF THE BODY

THEMES OF LECTURES. The emergence of anthropological perspectives of the body. From the symbolic structures to phenomenology. Images of the body in folk healing and in biomedical practice

*Scheper-Hughes, Nancy and Margaret Lock

1986 The mindful body: A prolegomenon to future work in medical anthropology Medical Anthropology Quarterly 1 (1), 6-41

Helman, C

1991 The Body of Frankenstein's Monster: Essays in Myth and in Medicine. New York. W.W. Norton, 1-28

Helman, C

1991 The Radiological Eye: Essays in Myth and in Medicine. New York. W.W. Norton, 1-28

2002

FAMILIES AND HOUSEHOLDS
ANTHROPOLOGY 2B
(DAT2FH2)



NAME:

STUDENT NO:

FAMILIES AND HOUSEHOLDS

An Anthropological Perspective

Course Co-ordinator: Prof. Suzanne Leclerc-Madlala
Office: Room 187, Memorial Tower Building (MTB)
Tel: 260 2387
Email: leclercmadlals@nu.ac.za

Course Administrator: Kogan Naicker
Office: MTB 130
Tel: 260 2340
Email: Naickerk14@nu.ac.za

Welcome to the course FAMILIES AND HOUSEHOLDS, a course designed to give students an appreciation for dynamic nature of the forms and functions of human families and households.

The course will introduce students to some perennial topics in the anthropological study of domestic life, including the origins of the family, kinship, descent systems, the process and the meaning of marriage, and bridewealth. In addition, some related contemporary (and often controversial) issues will be considered. These will include:

- The impact of urbanisation on "traditional" family relations
- The changing costs / benefits of child-rearing
- Power and authority in the home
- Domestic violence
- The impact of HIV / AIDS on local families and households

The course will take a cross-cultural approach, with readings selected to cover a diversity of socio-cultural contexts as well as a focus on South Africa. The overall purpose of this course is twofold:

Firstly: to foster an awareness of the various challenges confronting families and households as they adapt to the modern world.

Secondly: to foster greater tolerance and acceptance of other peoples' ways of arranging their domestic lives. As we enter a new century with multicultural and multiracial societies increasingly becoming the norm, it is important that we develop the appropriate attitudes and understandings to successfully negotiate the future.

RULES AND REGULATIONS

1. This Course is offered at the second-year level and can only be taken at the third level if special arrangements are made with the School.
2. There shall be three formal lectures each week. These are to be held on **Mon. (14h10 – 15h40), Tues. (13h15 – 14h00), Wed. (08h40 – 09h25)**. Lectures shall cover broader theoretical and conceptual themes. Attendance is highly recommended. Only by attending lectures regularly will students be able to attain an adequate grasp of the material that we have covered and achieve a good pass mark in the exams.
3. A formal time-slot is set aside for revision and consultation. Students taking the course can meet with their respective lecturer on **Wednesdays between 09h30 and 11h30**. Please do all the required readings, carefully revise the material we have covered, and think critically about it. Only then would you be able to ask meaningful questions. Attendance at these meetings is voluntary, but highly recommended.
4. All students taking the course must complete the following three assignments:
Test 1: Monday, 2nd September 2002
Test 2: Monday, 14th October 2002
Essay; Monday, 4th November 2002 (hand in by 16h00)
5. No extensions will be granted unless a valid medical certificate is produced. All assignments are compulsory and shall cover material dealt with in lectures and in the required readings.
6. The course shall be assessed as follows:
Test 1: 10 %
Test 2: 10 %
Essay: 20 %
Exams: 60 %
7. All the required readings are contained in the course reader.

WEEK 4 AND 5 (August 26th to September 6th)

Locality and Descent

Lecture Themes: Consanguinity and affinity, matrilineal and patrilineal descent, double descent, residence patterns.

Readings:

- Keesing, R. (1981) "Descent", in Cultural Anthropology New York: Holt, Reinhart and Winston (including case studies).
- Howard, M. (1983) "Sex, Marriage and the Family", in Contemporary Anthropology. Toronto: Little, Brown and Co.
- Leach, Edmund (1982) Marriage, Legitimacy and Alliance. Social Anthropology. Harmondsworth: Penguin.

WEEK 6 AND 7 (September 9th – 20th)

Marriage and Alliance

Lecture Themes: Defining marriage, monogamy, polygyny, and polyandry. Marriage in South African rural areas, bridewealth and matrilineality.

Readings:

- Fieldler, K. (1988) For the sake of Christian Marriage: Abolish Church Weddings. In J. Cox (ed.) *Rites of Passage in Contemporary Africa: Interaction between Christian and Traditional Religions*. Cardiff: Academic Press.
- Niehaus, Isak (1994) Disharmonious spouses and harmonious siblings: Conceptualising household formation among urban residents in Qwaqwa. *African Studies* 53 (1)
- Vallenga, D. (1983) "Who is a Wife? Legal expressions of Heterosexual Conflicts in Ghana", in C. Oponong (ed.) Female and Male in West Africa Boston: Allen and Unwin

COURSE OUTLINE

WEEK 1 (August 5th – 8th)

The Emergence of the Family

Lecture Themes: The mother-child unit, home base, the importance of food-sharing, male-female bonds.

Readings:

- Campbell, B. (1993) "The Evolution of the Family," in Humankind Emerging. New York: Harper Collins.
- (Film) Goodall, J. (1970) "Amongst the Wild Chimpanzees". New York: National Geographic Films.

WEEK 2 AND 3 (August 12th to 23rd)

Kinship

Lecture Themes: Defining kin and non-kin, diagramming kinship relations, kinship rules, regulations, meanings and changing significance.

Readings:

- Howard, M. (1986) "Kinship", in Contemporary Cultural Anthropology. Toronto: Little, Brown and Company
- Ngubane, H. (1981) "Marriage, Affinity and the Ancestral Realm: Zulu Marriage in Female Perspective", in E. Krige and J. Comaroff (eds) African Marriage in Southern Africa Cape Town: Juta & Co.
- Monaghan, J. (1996) "The Meso American Community as a Great House", Ethnology 35: 181-194

NOTE: Essay topic to be given in Week 3

WEEK 8 (September 23RD – 27th) HOLIDAYS

WEEK 9 (September 30th – October 4th)

The changing Value of Children

Lecture Themes: The costs and benefits of rearing children, conceptions of childhood, contraception, abortion and infanticide.

Readings:

- Harris, M. (1993) "The Economy of Parental Love", in Culture, People, Nature New York: Harper Collins
- Mo-Yee, L.; Chi-Kwong, L. and Kwok-Kwan, T. (1999) "Parenthood and Life Satisfaction", International Social Work 42: 139 - 162
- (Staff writer) 1995 "The Miseries of Motherhood", Newsweek, April

WEEK 10 and 11 (October 7th – 18th)

HIV / AIDS and the Family

Lecture Themes: Home-based care, AIDS orphans, child-headed households, social impact and repercussions.

Readings:

- Leclerc-Madlala, S. (2001) "Compounding Cruelties: Reflections on Children's Rights in the Context of AIDS" African Journal of AIDS Research (forthcoming).
- Stein, J. (1997) "The Impact of HIV /AIDS on the Household", AIDS Bulletin 6: 20-22
- Jackson, H. (1994) "Family Coping and AIDS in Zimbabwe: A Study", Journal of Social Development in Africa, Report No. 4

- Desmond, C. et al (2000) "The Hidden Battle: HIV / AIDS in the Household and Community", South African Journal of International Affairs Volume 7: 39-59

WEEK 12 (October 21st – 25th)

Gender Politics and Domestic Struggles

Lecture Themes: Household power and authority, changing role expectations, domestic violence and the cultural context.

Readings:

- Ilcan, S. (1996) "fragmentary Encounters in a Moral World: Household Power Relations and Gender Politics", Ethnology 35: 33-49
- Baker, P. (1997) "And I Went Back", Journal of Contemporary Ethnography 26: 55-74
- Almeida, R. and Durkin, T. (1999) "The Cultural Context model: Therapy for Couples with Domestic Violence", Journal of Marital and family Therapy 25: (3) 313-324

WEEK 13 REVISION WEEK – SUBMISSION OF ESSAY (04 NOV.)

ESSAY TOPIC

Sub-Saharan African is home to nearly 2/3 of all HIV people in the world. Ongoing research of the past decade is revealing that women are exposed to the greatest risk of infection through their relationship with their husbands or stable partner. Indeed the majority of seropositive women in Africa have been infected by their steady partners. In these circumstances the extent to which women can control their sexual activity, either by refusing sexual relations or insisting on safe sexual practices, has become a major public health concern.

Drawing upon your knowledge of social organization and kinship systems, discuss how the lineage structure of many West African societies (many of which are matrilineal) may be a factor mediating against rapid spread of HIV AIDS and

helping to protect women against this sexually transmitted disease. Clearly describe and elaborate upon the kinds of family and social dynamics that may explain why HIV / AIDS infection rates are comparatively low in this part of Africa.

Essential Readings:

- Oppong, C. (1993) Who is a Wife? In Female and Male in West Africa. Allen and Unwin: London. **(In Course Reader)**.
- Orubuoye, I. ; Caldwell, J. and Caldwell, P. (1993) African Women's Control over their Sexuality in the Era of AIDS. Social Science and Medicine Volume 37: 859-872 (The Yoruba of Nigeria) **(Lecture Hand-out)**.

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