CREATING ACCESS AND INCLUSION OF HIV EDUCATION INTO CORE CURRICULA

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ABSTRACT

While the demand for HIV integration into higher education curriculum remains consistent, common challenges experienced by practitioners identify research gaps, in 'how' one gains access into core curricula and if successful, 'what' content is considered relevant and integral to the discipline. This article offers an HIV curriculum integration conceptual framework that responds to these challenges, and seeks to guide the process of access and integration. Based on the organisational management theory of collaborative engagement (Daft 1999), the authors describe how they adapted Daft's (1999) four stage process and applied it in one faculty's foundation course. The purpose of this article is to generate 'user-orientated research' (Cooper 2011) that invites HIV educators in South African universities to apply the conceptual framework in their curriculum integration practice.

Keywords: creating access, curriculum integration, HIV, research, South Africa, universities

INTRODUCTION

Since 1994, South African universities have been developing institutional responses for the prevention and management of the Human Immunodeficiency Virus (hereafter HIV) among the student population. With the highest prevalence of HIV being found in the age group 15–24 years old (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios and Onoya 2012), universities have a critical role in providing holistic responses to the prevention and management of this epidemic on campus. Responses to HIV management include understanding the barriers to HIV curricula integration and facilitating the removal of obstacles for the development of successful graduate competencies.

There have been fundamental shifts in the university's mission in recent years from academic teaching and research contribution to 'use-orientated' research which seeks to provide

practical applications and responses to issues of social justice in the broader South African context (Cooper 2011). Led by the Ministry of Higher Education and Training, the university's role, in responding to HIV on campus, was redefined in terms of the goals of transformation and social cohesion (Department of Education 1997). The purpose of this shift was to progressively develop a values-led culture within universities that encouraged students to be critically aware about issues of access; governance; the management of the curriculum; pedagogy; inclusion; and the kinds of support services that would promote the development and success of students (Department of Education 1997). This transformation ethos was premised on the need to utilise the lessons left in the wake of HIV to build community engagement; objectivity; inclusion and self-acceptance within the university environment (Volks 2012).

Concerted efforts to increase transformation responses in higher education have continued since 1994, in some universities where teaching HIV in the academic curriculum was encouraged. Progressive pedagogies have been used to integrate HIV into the curriculum and 'transform the nature of the learning experience, which exposes both staff and students to economic and social challenges and conditions' (HESA 2010). The critical role of educators in reshaping norms and perceptions about HIV has been emphasised by researchers who articulate curriculum could act as a medium for this type of engagement (HEAIDS 2010, 2015; Volks, Abrahams and Reddy 2015). However, accessing space within curriculum and the inclusion of HIV content has been a challenging process.

While various interventions have shown that HIV education can be integrated into academic curricula successfully (Volks 2012), the common challenges experienced by practitioners that arise during the practical application include staff loyalty to their area of expertise (Bernstein 1975; Mead 2000), and the concern about diluting the content of the discipline by including HIV education into the curricula (HEAIDS 2010).

In addition, in many instances, practical barriers have prevented access to and the inclusion of HIV content within the academic curriculum (HEAIDS 2010). Some of these practical barriers include resistance by lecturers who are unconvinced by the relevance of HIV in their disciplines or argue that HIV and its related intersections do not fit succinctly within the core course objectives. Two interrelated structural barriers often occur for practitioners who want to include HIV content into the university curriculum. The first barrier is that of access – which is related to the course convenor and/or lecturer's 'cultural differences, values, interests and commitments' towards HIV integration (Axelsson and Axelsson 2006, 84; HEAIDS 2010). The outcome of the first barrier directly affects the permeability of the second barrier which is

that of, what we call, inclusion. Inclusion in this sense speaks to reviewing what model of curriculum integration would work best for a specific course and then what content could be infused within the curriculum design.

These challenges, notwithstanding, concerns about AIDS fatigue and inflexible course design have been assuaged by findings that show the '[introduction] of a compulsory examinable course on HIV will not automatically lead to AIDS fatigue' (Volks 2012, 22). Secondly, Volks (2012) found that compulsory HIV and AIDS courses which cannot fit into packed curricula and innovative ways of curriculum integration may occur in more accessible times during the week. A third key finding was that information for personal use can be successfully integrated with academic learning (Volks 2012). Lastly, peer education, and its inherent pedagogical design, can be used not only in co-curricula education but also within discipline specific curricula activities (Volks 2012).

This article contributes to the existing knowledge gap by describing an HIV curriculum integration approach used in a large comprehensive research university. This approach has achieved proven results in gaining access in the academic curriculum to include HIV content. Whilst there is evidence of what integration has occurred, there is a lacuna in knowledge about what methods were used to create access where there were obstacles and what type of negotiation results in the inclusion of HIV content in the academic curriculum.

Utilising the experience of practitioners who have acquired access and inclusion of HIV curricula in four out of six faculties in one university setting, this descriptive article shares the methods used to gain access, the practitioners' self-reflection and the process evaluation completed by the course convenors. The practitioners propose a conceptual framework for HIV curriculum integration that is comprised of six stages. The first being a needs assessment; secondly the application of Daft's (1999) four phased collaborative engagement process and lastly an evaluation.

SELF-REFLECTION

In the university, the practitioners work within a unit that is structured under the transformation services office. This means the practitioners are not part of the academic staff – which is beneficial as this geographical and functional distance ensures that the practitioners 'use-orientated research' (Cooper 2011, 6) can be flexibly applied in both the institutional and the academic systems. However, there are limitations being distanced from the faculties and/or the subject matter. The first of these limitations is locating the appropriate HIV content within the academic material. Often this is not an easy task, particularly, when one is attempting to define

the relevance, before actual consultation with the course convenor occurs. One's own position within the university may limit access into academic spaces. Previously, there was an institution-wide mandate that HIV education is taught within curriculum, however this obligation was rescinded in order to protect academic freedom. Thus, in order to maintain credibility, one often has to immerse oneself into each discipline's course content, which is at times not as accessible to practitioners from unrelated disciplines. The success of the proposed approach rests on one's ability to appropriately convey the legitimacy of the HIV content as it relates to the profession and/or discipline. Sometimes this approach is not always successful, despite efforts to demonstrate synergy with the academic curriculum. In such cases, it is either the academic's pejorative to not include the HIV content, and/or the HIV content lacks relevance, to the core content.

In considering the process of curriculum integration the practitioners applied a conceptual framework of collaboration that defined the process of engagement between the practitioners' unit and the specific course convenors identified within each faculty. The methods used prior to the engagement are as important as the engagement itself. Both are crucial to access within curriculum and the inclusion of the HIV content.

CONCEPTUAL FRAMEWORK FOR HIV INTEGRATION

The term 'creating access' implies that there are restrictions to what is included in core curricula. As described earlier, core curricula include content that is responsive to a specific discipline, which often leaves little room for adaptation. However, the practitioners found that 'how' one creates access in the hard to reach disciplines (Science, Engineering and Commerce) requires strategic preparation and engagement. On the occasions where integration could not occur – co-curricula interventions were proposed – with greater success. Outlined below is the process used to create access and inclusion of HIV content into core curricula. The diagram also shows the co-curricula option, as this type of curriculum integration is also a useful way of engaging with students outside of lecture hours.

NEEDS ASSESSMENT

Prior to engaging with course convenors, the practitioner acquired knowledge about the faculty's current interests and previous teaching and research strategies (Huxham 1996) via a desktop review (approximately 40 hours). Considerations were made about the type of courses available, and whether there were any foundation courses that all students within the

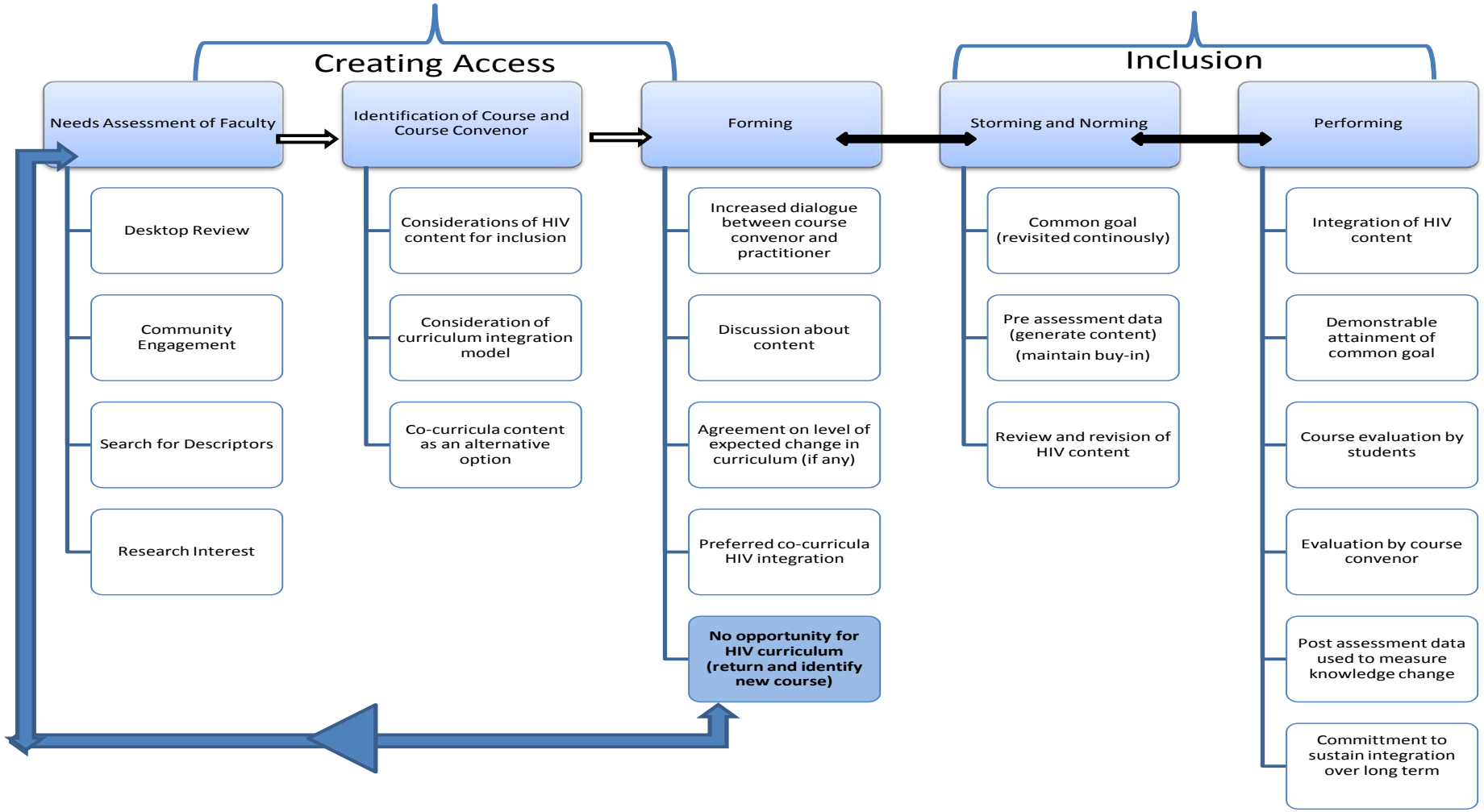

Figure 1: Conceptual Framework for HIV Curriculum Integration

faculty would have to complete. A foundation course is favourable because if HIV curriculum integration is successful, then all students within the faculty would be exposed to the HIV curriculum content.

On completion, the results of the review identified courses that used a combination of one or more of the following descriptors: HIV, gender, climate change, sexuality, violence, social justice, community engagement, health, safety, teamwork, management practice or inclusivity. These descriptors signalled potential areas of synergy where HIV could be taught from a transformation lens (Volks 2012).

The practitioner then utilised the findings of the desktop review to formulate content that was responsive to the course objectives and simultaneously engaged the students in a manner that was relevant to HIV and their careers. Through this review, the practitioner identified a foundation course in the faculty that could lend itself to the exercise of integration. Considerations were then made by the practitioner about potential models of HIV curriculum integration (HEAIDS 2015) and the HIV content itself (including assignment objectives; research output and aspects of community engagement) to ensure 'goodness of fit' (Campbell and Cornish 2010, 1570) with the course objectives.

The next four phases of creating access within curriculum was guided by the four stage process of collaborative engagement conceived by Daft (1999) which are identified as 'forming,' 'storming,' 'norming' and 'performing.' Although each phase of collaboration is distinct, the phases can occur simultaneously and be revisited more than once (Huxam and Vangen 2005).

Forming creates opportunities for 'increased dialogue' between the practitioner and the course convenor (Axelsson and Axelsson 2006, 84). The second stage of storming 'heralds the conflict' that arises between the practitioner and the course convenor, 'as negotiations, mutual understanding and common interests are formed' (Axelsson and Axelsson 2006, 84). The third stage, norming, establishes group trust, maintenance of the trust and commitment between the collaborators, through open dialogue and communication (Axelsson and Axelsson 2006, 85). The last stage is comprised of facilitating the attainment of the identified common goal and is referred to as performing (Axelsson and Axelsson 2006, 85).

Forming

To initiate the forming stage, the relevant course convenor was approached firstly via email to request an introductory meeting to discuss the potential synergies between their course and the inclusion of the HIV content. Once a meeting date was established, the practitioner attempted

to utilise her knowledge from the desktop review to propose what HIV content would be relevant to the course. Furthermore, she shared the model of curriculum integration to reassure the course convenor that the structure of the course would not be changed, nor would there be more components for the student to deliver. Lastly, the practitioner explained how this integration could respond to the faculty's strategic outputs of teaching, learning and social responsiveness.

During this one-on-one discussion the practitioner attempted to be transparent about establishing a common purpose for the course convener in an attempt to generate trust and commitment towards a common goal; and to avoid an external, top-down approach to integrating the HIV content (Campbell and Cornish 2010). Collaboration in the forming stage between the practitioner and the course convenor resulted in willingness to incorporate HIV content and contextual issues into core curricula based on negotiations about ensuring the relevance of HIV content; the agreement to not detract from the original course objectives; and to not change the course structure by extending the duration or students deliverables of the course. These agreements were adhered to and were reported on via the process evaluation.

There is evidence in the process evaluation that respondents indicated that the method used during the forming stage was appreciated. A respondent wrote, '[The engagement] has brought the topic right back up to first place on our curriculum agent. BUT MOST IMPORTANTLY (participant's own emphasis) it has been done through enthusiasm and choice, not prescription.' Further importance on the 'goodness of fit' was reiterated by respondents who found that it is possible to 'integrate the info [sic] very directly with the course being studied'. While another course convenor indicated that she would commit to doing 'more research ... to include info [sic] about HIV industry/management/how it will relate to [the students'] professional lives'.

Where a common goal could not be established, co-curricula interventions were proposed to utilise available time outside of the conventional lecture period (Volks 2012). Using the same conceptual framework, the practitioner did develop an additional co-curricula intervention which was conducted within a different Engineering course to that described above. The flexibility of the co-curricula intervention provided a platform for inter-disciplinary collaboration (and in one case inter-faculty collaboration) between the engineering departments; which could not have been achieved during the normal lecture periods due to different course timetables. The co-curricula intervention was managed by the groups who were set a task to provide a detailed research report; design and building project plan and budget around a sculpture symbolising a commitment to HIV education and support. The groups then

had to orally present their work to a panel of academics from the Engineering Faculty and industry members who interrogated their research and design work. For the course convenors who did agree to the integration of HIV content, the second and third phase of collaboration was initiated.

Storming and norming

During this process, storming and norming was interlinked organically due to the 'misinterpretation of purpose and the introduction of policies and new members to the group' which catalysed the merge between storming and norming (Axelsson and Axelsson 2006, 82). What also became evident during this stage was that the practitioner often found herself having to revisit the norming and storming stage (Vangen and Huxham 2003), particularly when new course convenors, lecturers or previously unknown institutional policies influenced the programme and/or its expected output. While this stage had potential for conflict, it also provided the opportunity for the course convenors to gain clarity of purpose, and solidify their end goal (Vangen and Huxham 2003). There was a cycling back to forming at times and then an attempt to bring everyone back to norming.

On self-reflection, the practitioner found that clear communication, through minutes of previous meetings and clarification of intent, assisted the collaborators through the second and third stage of engagement. Part of the communication process included presenting the concept to other course convenors associated with the faculty to those who were key collaborators. It was critical to clarify the concept, establish their commitment to the process and provide consistent dialogue that included all course convenors. This type of communication facilitated the development of 'shared goals and [defined the] culture of the group' (Axelsson and Axelsson 2006, 82).

In establishing a common goal, the practitioner's objective was to equally preserve the original course objectives and invoke critical thinking about HIV and AIDS as it related to industry through integrating HIV education into the course. This was done by promoting the use of a pre- and post-quantitative educational assessment tool that measured levels of HIV knowledge change that had occurred among students in the course. The results of the pre-assessments were shared with the course convenors to emphasis the knowledge gaps and to propose what content could be included to address the gaps in personal and industry specific HIV prevention methods.

The pre-assessment tool was therefore a useful way of defining what knowledge would be relevant for the students in the course. The post assessment results consolidated that the

course had indeed increased knowledge. This informed the development and implementation of the courses in the following years and assisted in further HIV integration curriculum discussions with other course convenors in other departments and faculties.

Performing

The fourth stage of collaboration is the attainment of the common goal which was driven by the practitioner and the course convenors. In this stage, the practitioner maintained individual relations with each team member and provided relevant feedback between the group (Daft 1999). This was found to be a successful strategy. The course was evaluated to ensure that the goal to develop and sustain the collaboration (Mitchell and Shortell 2000) was achieved. The course evaluation provided further feedback from the course convenors about their experience of the HIV curriculum integration and the relevance of the content used. The evaluation emphasised areas that could be improved during the next rollout of the course as demonstrated by one course convenor who stated that she 'liked the idea of bringing healthcare examples into the practical application of her workshop [as] she often poses scenarios but don't [sic] use healthcare example [sic], this will be really useful'.

Reframing the role of the educator in reshaping norms about people living with HIV was highlighted by one respondent who critically engaged with '[her own] ability in this role [to] (educate others)'. Goal attainment was also demonstrated through the students' course assessments as well as the lead course convenor's commitment to 'bring the topic into the ... module' that has resulted in HIV been integrated into the module between 2012 and 2015.

CONCLUSION

Unexpected findings that emerged from the application of the conceptual framework was the knowledge change and reflexivity that occurred with the course conveners. The reflexivity of the course conveners assisted in sustaining the integration of HIV content in the long term. Whilst access and inclusion of HIV content in core curricula is not guaranteed, the HIV curriculum integration conceptual framework invites practitioners to think laterally about 'what' content is relevant to core curricula. The framework encourages practitioners to evaluate the curriculum output and process to provide data that could be used to measure knowledge change and relevance of the HIV content within the discipline. In addition, the evaluation data can be used to advocate for HIV curriculum integration in other courses and/or faculties.

Bennett and Reddy (2009) write that 'integration of social justice issues [can be] organically introduced into the syllabi regardless of discipline, specifically when the teacher

has had intellectual and activist experience in issues' (Bennett and Reddy 2009, 53). Creating access into and inclusion of HIV content into the curriculum requires multi-disciplinary skill of advocacy, negotiation and intellectual engagement. These sets of skills were guided by a proposed conceptual framework for HIV curriculum integration which is a six stage process that begins with a needs assessment that precedes collaboration which increases dialogue, establishes a comon goal and results in achievement of the course objective as well as HIV curriculum integration.

Kessi, a psychologist who has written on the curriculum, makes the important point that rethinking the role of the university promotes questions about who the teachers are, what is being taught, how it is taught, for whom and for what purpose (Kessi 2015). HIV curriculum is one platform that encourages academics to rethink their role and the role of the university in responding to issues of social justice. HIV curriculum has shifted beyond that of basic lifeskills – to the provision of content that grapples with transformation and its related intersections such as gender, sexuality, violence, race, class, and community adaptation. Through the conceptual framework, the practitioners begin to nudge the critical consciousness in both educator and student to become reflexive practitioners who activate their role in reshaping norms and perceptions of the relevance of HIV not only within the academic curriculum but also as graduates who can competently respond to the complex challenges experienced by many in South Africa.

The efficacy of the conceptual framework is dependent on overcoming a number of interdependent variables. One of the important variables is the practitioner's ability to define where in the curriculum the HIV infusion can occur. This is quite an important part of the approach, as the practitioner is often not expert in the subject matter and as a result may not identify relevant areas in the academic material where HIV education could be infused. Another variable rests on the academic's willingness to pilot the infusion of the content into their core curricula. Often, this infusion does require more time from the practitioner to assist in the rollout of the infusion and adapting assessments if required, so that the HIV education can be graded within the formative assessments. As a practitioner, the challenge is sustaining the programme beyond the pilot. One finding that will influence curriculum design and development of HIV curriculum, was the need to rotate between the intersectional themes of HIV, for example, educators could not use the same theme, lesson plan, lecture content and/or related assignments year after year. The shift between the intersectional areas of HIV and their related oppressions was necessary in order to pique the interest and the enthusiasm of both the academic course convenors and the students. However, sustainability, is constantly negotiated,

and without an institutional mandate to infuse HIV education into the academic curriculum, it is probable that the dependency on the practitioner, to create access and negotiate HIV education infusion into core curricula, will remain.

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