INTRODUCING HIV AND AIDS EDUCATION INTO THE FIRST YEAR OF A PROBLEM-BASED LEARNING CURRICULUM: A TEMPLATE FOR HEALTH SCIENCE EDUCATION

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Keywords: community; health science education; HIV and AIDS; medical students; problem-based learning

ABSTRACT

The HIV and AIDS epidemic will continue to impact medically, socially and financially on sub-Saharan Africa. It is therefore imperative that health science students in Africa experience the reality of the impact of this virus on communities. This article describes an HIV and AIDS education programme instituted at a South African medical school in parallel with the first year of a problem-based learning (PBL) curriculum. In line with the PBL philosophy, the HIV and AIDS programme was largely experiential. Students interacted directly with HIV positive individuals, and through their educational workshops, with local communities. By means of small group sessions facilitated by trained community educators, students explored myths surrounding HIV and AIDS and engaged frankly with colleagues about sensitive issues such as having an HIV-infected family member. Although expensive in terms of human resources, the outcomes of this intervention exceeded the organisers' expectations, particularly in terms of students openly engaging with the reality of being HIV positive and the community organisation networks established. This type of experiential intervention with considerable community exposure has application to other health science curricula.

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INTRODUCTION

The HIV and AIDS epidemic

HIV and AIDS present a unique challenge to society. No disease of recent times has produced more ethical dilemmas, been responsible for such destruction of family life or placed greater demands on health, education and social services than has this viral affliction and its complications. Globally, the HIV and AIDS epidemic has become manifest in Africa, with 25 million people living with HIV and AIDS in sub-Saharan Africa. In the region in 2003, an estimated three million people became newly infected with HIV and 2.2 million have already died of the disease (75% of global AIDS deaths) (UNAIDS, 2004:3). South Africa has the greatest number of infected people, as well as one of the highest rates of infection in the world (Human Sciences Research Council, 2003:1). Already in 1996, almost half of child mortalities at the Chris Hani Baragwanath Hospital were reported to be HIV-related (Zwi, Pettifor, Soderland & Meyers, 2000:227), while recent South African Government statistics show a 57% increase in the number of deaths between 1997 and 2002, attributed largely to AIDS (Sidley, 2005:438).

As many public hospital admissions are now HIV-related (Sidley, 2004:366), the HIV and AIDS epidemic has changed the face of medical practice in South and Southern Africa. The training and education of medical and other health science students must therefore take cognisance of this in striving to meet the evolving health care needs of the communities these students will serve. At King Edward Hospital, adjacent to the Nelson R Mandela School of Medicine, which is used as one of the primary training sites for the University of KwaZulu-Natal medical students, it is estimated that 60% of hospital mortalities are HIV and AIDS-related (Jinabhai & Ramdas, 2003:2). Not only will students, as future health care practitioners, be faced with an increasing number of AIDS-related illnesses and deaths, but they will also be at risk of needle stick injury and will have to deal with the disillusionment and frustration of the lack of treatment recovery satisfaction. As part of their education and training, medical and other health professionals students should therefore be made aware early in their studies of the impact of the HIV and AIDS epidemic on South African communities. In addition, as future community leaders, they should be able to communicate effectively with those whom they will serve, as well as being able to devise and implement education programmes that contribute to a better life for the citizens of South Africa. Institutions that train health care practitioners therefore have a social responsibility to prepare their graduates to provide equity in and accessibility to health care, as articulated by the World Health Organisation’s ‘health-for-all’ goal that has been endorsed by most nations (Boelen, 1999:S11).

HIV is an excellent example of a biopsychosocial phenomenon and as such, efforts to understand and deal with this disease should take cognisance of its multiple dimensions. This article describes and informs curriculum co-ordinators and developers of an HIV and AIDS education programme, set up largely by student counsellors and support staff, that was integrated into the first year of a problem-based learning (PBL) curriculum at the Nelson R Mandela School of Medicine (University of Natal, Durban, South Africa) in January 2001. This descriptive account provides a template that has application to health science education in general.

PBL and the HIV and AIDS education programme at the Nelson R Mandela School of Medicine

In 1997, the Nelson R Mandela School of Medicine Faculty Board resolved to replace the traditional discipline-based medical programme with a PBL curriculum, in line with the global trends in medical education reform. This reform was driven by two main forces: the global development of more student-centred curricula (for example, problem-, case- and community-based learning) and the need for the training and education of graduates who were able to deal with the changing health care needs of local communities (World Federation for Medical Education, 1994:S142).

PBL, first introduced at McMaster University (Canada) in the 1960s, has been implemented worldwide in many different educational settings (Camp, 1996:1). Despite the many variants of PBL, essential elements have remained. Typically, a small group of students (usually 8-10) collaboratively, with the aid of a tutor or a facilitator, work through a carefully constructed case or problem. In the first tutorial, students identify the observable phenomena (the triggers) that need to be explained. These are then discussed in the light of their prior knowl-
edge, and hypotheses are generated to explain the phenomena. Learning goals (that is information needed to explain the hypotheses) are then generated by the group, and after a period of self- or group study, the students return to discuss their findings, which may result in a re-evaluation of earlier hypotheses (Norman & Schmidt, 1992:557; Mennin & Majoor; 2002:1-2; Wood, 2003:328). The strengths of PBL lie largely in its constructivist, self-directed approach to foster deep learning, the integration of basic sciences with clinical disciplines, its motivating effect on students and facilitators and the generic skills (for example, communication, respect for others, critical thinking) that it engenders in learners (Wood, 2003:331).

The 1999 Health Professions Council of South Africa’s guidelines for the education and training of doctors in South Africa advocated the introduction of PBL to make teaching more practical, relevant and stimulating. Public health (for example, strategies for health promotion; defining environmental and social factors contributing to poor health, and evaluating the effectiveness of health interventions) should feature prominently in the curriculum such that future practitioners are sensitive to the unique needs of South African communities (HPCSA, 1999:9). In addition, clinical training needs to take place in different settings: primary health care facilities, hospitals and in communities (HPCSA, 1999:10).

A Curriculum Development Task Force was therefore established at the Nelson R Mandela School of Medicine to construct the blueprints and matrixes for all six-week integrated themes (six per year for Years 1 to 4) for the programme. Early exposure to real-life situations, taking cognisance of the many factors that impact of human health (for example, psychological, social, financial), was considered a key element of this new PBL curriculum (McLean, 2004:42). In January 2001, the Faculty introduced its PBL programme, Curriculum 2001, after more than 50 years of a traditional programme, with its primary objective to educate and train general practitioners who have the appropriate knowledge, skills and attitudes to service the health care needs of all South African communities. In the current context, HIV and AIDS form one of the core elements of Curriculum 2001.

While the emphasis of the PBL programme is on self-directed learning, with the small group tutorials overseen by a facilitator being one of the cornerstones, large group resource sessions (interactive lectures), provide students with some of the principles and concepts relating to each theme. Community involvement and patient contact is strongly emphasised from Year One in this new programme, in line with the recommendations of the HPCSA (1999).

**DETAILS OF THE HIV AND AIDS EDUCATION PROGRAMME**

**The organisers**

Cases in three of the six themes in the first-year of the mainstream PBL curriculum involve some aspect of HIV and AIDS. To complement first-year students’ introduction to PBL and to medicine and to ensure that they become familiar with social, biological and medical aspects of HIV and AIDS, a task team was formed to design an HIV and AIDS education programme to run in parallel with Curriculum 2001. The team comprised a representative from the Curriculum Development Task Force, a specialist paediatrician in private practice who was also an honorary lecturer in the Department of Family Medicine, and two student counsellors (Hiles is one of the authors) at the Medical School. Student counsellor involvement was important as they were dealing with increasing numbers of students seeking personal support and counselling relating to HIV and AIDS.

The brief of this task team was to develop and implement an introductory HIV and AIDS programme which would pedagogically complement and run parallel with the mainstream PBL curriculum. The HIV and AIDS issue could then be addressed through the five years of medical study, either in cases or as electives. In order to comply with the PBL format, this programme needed to comprise small groups overseen by a facilitator, large group resource sessions, self-directed learning, and community or patient contact. In addition, the multi-faceted nature of HIV and AIDS, spanning many disciplines, both medical and social, had to be addressed, in line with the integrated nature of the PBL programme (hence the biopsychosocial focus of this education programme).

The primary objectives of the HIV and AIDS education programme were therefore directed towards address-
ing the complexities of this epidemic such that stu-
dents
- gain a comprehensive understanding of HIV and
  AIDS as a social, biological and medical prob-
lem;
- become aware of their own risks of infection;
  and
- are able to educate others in their communi-
  ties about HIV and AIDS.

The learning outcomes of the programme thus included students
- acquiring an integrated knowledge of HIV and
  AIDS as a social, biological and a medical
  problem with psychological and financial im-
pacts;
- developing skills in relation to communication
  about HIV and AIDS and related issues;
- becoming aware of current research and inter-
 ventions regarding HIV and AIDS; and
- developing the appropriate attitudes which
  would enable them to work as team members,
  displaying respect for the community, espe-
  cially towards people living with HIV and AIDS.

HIV and AIDS education programme de-
tails

In line with the mainstream PBL curriculum, this HIV
and AIDS education programme comprised large group
resource sessions and small group tutorials, the latter
overseen by a community facilitator, some of whom
were HIV positive (Table 1). These small group tutorials
provided students with an opportunity within a non-
threatening environment to learn facts about HIV and
AIDS and to examine their own attitudes in this regard.
It was hoped that together with direct engagement with
HIV positive persons, this would contribute to a deeper
understanding of the biopsychosocial complexities of
HIV and AIDS (Table 1).

a) Large group resource sessions: These interactive
lectures provided broad-based background information
pertaining to HIV and AIDS and were undertaken by
Faculty staff of international repute in the field of HIV
and AIDS. These included a virologist and a
paediatrician, and the scope included HIV and AIDS
history, transmission statistics, HIV testing, clinical
features, prevention, precautions and treatment (Table
1).

Perhaps the most influential aspect of this HIV and
AIDS programme involved exposing students to an HIV
positive woman, who, in the presence of 200 students,
shared her story of discovering she was HIV positive
just prior to her marriage and how she currently lives
positively with the virus. Students were inspired by her
openness and courage as well as the fact that she was
healthy despite being infected for eight years. Ironically,
this woman was white, which helped to dispel one of
the myths that HIV and AIDS is a problem affecting
Black Africans.

b) Small group tutorials and facilitators: Twenty HIV
and AIDS educators from the community volunteered
to serve as facilitators on the programme. As their skills
and experience varied from working with people with
AIDS and their families, to arranging HIV and AIDS
workshops, a three-hour orientation workshop was
organised to familiarise educators/facilitators with the
aims and objectives of the Faculty’s PBL curriculum to
ensure uniformity of content within the tutorial sessions.
This was essential, as the content covered in this
programme would form part of the summative assess-
ment of the mainstream curriculum. Facilitators were
provided with a comprehensive resource manual cover-
ing the content of the HIV and AIDS education
programme as well as the timetable, group lists and
venues. Facilitators were assigned the same group of
students for the duration of the HIV and AIDS programme
(± six months), to facilitate the development of trust
and for continuity.

The small group tutorials were designed to address
pertinent issues relating to HIV and AIDS, including
some of the myths surrounding the disease and as
well as first-hand experiences of living with HIV (Table
1). The first session, “Addressing the Myths”, encour-
aged students freely question and explore aspects of
HIV and AIDS which they needed to deal with from a
personal perspective. The session included exercises
to assist them in getting to know and trust one another
as well as clarifying frequently asked questions about
HIV and AIDS, sexuality, gender and sexual decision-
making.

Attitudes and perceptions were the focus of another
small group tutorial, giving students the opportunity to
explore their attitudes and prejudices which could potentially serve as barriers to learning about and protecting themselves from HIV and AIDS in a personal and professional capacity (Table 1). It is important that as future doctors and health care workers they are aware of their attitudes towards people with HIV and AIDS to avoid discrimination and to increase their sensitivity towards the circumstances of affected individuals.

c) Additional resources: A WebCT HIV and AIDS course was set up, with resources such as appropriate websites and the pre- and post-test counselling schedules. Relevant books and pamphlets were placed on reserve in the library.

d) Community education component: A frequent query during the orientation presentation was why, when the general public is provided with information regarding HIV infection, was the infection rate still increasing? It was decided that a community-based experience might address this issue. Pairs of students were tasked with designing an HIV and AIDS awareness/education presentation for their communities. In the session on preparing educational material, students were provided with scenarios (for example, “Prepare an introductory HIV and AIDS talk for 100 high school learners between 15 and 18 years of age”). They then had to prepare lesson plans to assist them with their community talks which were discussed by the organisers to ensure the appropriateness of language, as well as details of the in-

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**Table 1: Details of HIV and AIDS education programme: Overview of training of educators and first-year medical students**

<table>
<thead>
<tr>
<th>Format</th>
<th>Details</th>
<th>Summary</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop (3 h)</td>
<td>Educators’ orientation</td>
<td>HIV and AIDS programme (format and content); Introduction to PBL,</td>
<td>Organising task team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>including facilitating small group sessions</td>
<td></td>
</tr>
<tr>
<td>Large Group Resource Session (2 h)</td>
<td>Student orientation and introduction</td>
<td>Introduction to the HIV and AIDS education programme (content; format, etc.) Questions and answers</td>
<td>Organising task team</td>
</tr>
<tr>
<td>Large Group Resource Session (2 h)</td>
<td>Introduction to HIV and AIDS</td>
<td>History, transmission of HIV, statistics, testing, clinical features, treatment, prevention, precautions</td>
<td>Expert virologist and expert paediatrician</td>
</tr>
<tr>
<td>Small Group Tutorial 1 (2 h)</td>
<td>Myths and realities</td>
<td>Introduction to HIV and AIDS Questions about HIV and AIDS</td>
<td>Facilitators + groups of 9-10 students</td>
</tr>
<tr>
<td>Small Group Tutorial 2 (2 h)</td>
<td>Developing educational presentations</td>
<td>Designing a presentation: target audience, audio-visual aids, etc.</td>
<td>Facilitators + groups of 9-10 students</td>
</tr>
<tr>
<td>Small Group Tutorial 3 (2 h)</td>
<td>Perceptions and precautions regarding HIV and AIDS</td>
<td>Safer sex–abstinence, use of condoms Needle stick injuries</td>
<td>Facilitators + groups of 9-10 students</td>
</tr>
<tr>
<td>Large Group Resource Session (1 h)</td>
<td>Living positively with HIV and AIDS</td>
<td>HIV positive speaker discusses her experiences of being HIV positive</td>
<td>Educator</td>
</tr>
<tr>
<td>Small Group Tutorial 4 (1 h)</td>
<td>Living positively with HIV and AIDS</td>
<td>Discussion of speaker’s experiences</td>
<td>Facilitators + groups of 9-10 students</td>
</tr>
<tr>
<td>Assignment (1 h)</td>
<td>Educating the community</td>
<td>Discussion of community education project</td>
<td>Organisers</td>
</tr>
<tr>
<td>Large Group Resource Session (1 h)</td>
<td>Evaluation</td>
<td>Feedback on assignments; evaluation of programme</td>
<td>Organisers</td>
</tr>
</tbody>
</table>
tended audience (for example, age, gender, size of group). Each group was provided with a detailed assessment rubric to assist with the assignment. The basic skills required for the assignment were addressed in the second small group tutorial which was held before the vacation, enabling the students to run workshops during the vacation close to their homes and in their mother tongue, if they so chose. Many visited schools, often those they had attended as learners.

e) Evaluation: As the aim of this article is to describe details of the HIV and AIDS education programme, evaluation is only briefly mentioned. Evaluation included:

- assessing students’ knowledge acquisition through a pre- and a post-test (True/False format);
- gauging student response to the various activities (small groups tutorials; community involvement) by means of questionnaires; and
- canvassing HIV educators regarding the value of the facilitator training.

Unsolicited responses (for example, telephone calls and letters to the organisers) from headmasters or educators following the community intervention could also be considered as qualitative evaluation.

IMPLEMENTATION, APPLICATION AND SUSTAINABILITY OF THE HIV AND AIDS EDUCATION PROGRAMME

General comments

From student comments in the evaluation, the overall objectives of the programme appeared to have been met. They had been able to freely ask questions and discuss sensitive issues within their small groups. They also had to reflect on their views of HIV and AIDS by discussing issues such as confidentiality, doctor/patient rights, risks and precautions, and they had an opportunity to share the knowledge and insights they gained with their communities. The small group discussions were enjoyed as they provided an opportunity to unravel HIV and AIDS issues and for everyone to offer an opinion. Students commented that appropriate knowledge leads to maturity in decision-making, which directly relates to personal empowerment. The major criticism from students, however, was that the programme was too short, and they requested that, in the future, each tutorial be longer.

On reflection, the outcomes of this HIV and AIDS programme far exceeded the expectations of the task team. In meeting the original objectives of the task team, there were additional unanticipated benefits. These included empowering students with valuable life skills through open discussions relating to sexual behaviour and decision-making, increasing student openness regarding personal experiences of living with HIV and AIDS, establishing a valuable community network and empowering ‘support’ staff (especially student counsellors) in terms of developing their expertise in the philosophy of PBL, which would be invaluable in dealings with students presenting with academic difficulties in Curriculum 2001.

Response from the communities

With the community-based project, it is estimated that almost 2000 individuals from various social settings, but importantly including rural communities and schools, were exposed to education component of the HIV and AIDS programme. Perhaps the most valuable aspect of this outreach aspect was the fact that much of it was peer education, as most students chose to visit schools. There were several invitations from principals, educators and learners for the students to return, either to provide additional information or to make presentations to other classes so that most of the school would be exposed to the information.

Potential sustainability shortcomings

While it would appear that the HIV and AIDS education programme encountered no difficulties, this would not be true. There are issues that may persist beyond implementation. Just as PBL is considered to be labour-intensive in terms of providing competent facilitators for the small group sessions (Mennin & Majoor, 2002:7), so too was this programme. In order to accommodate the 200 students into manageable groups, 20 volunteer community educators were trained as facilitators. While they were not remunerated for their time, funding had to be sought for transport costs as most earned very little in their current posts. Furthermore, the same individuals may not be available on an annual basis and so facilitator training may have to take place each year. Involving institutional departments such as Fam-
ily Medicine, Community Development or Rural Health may assist with continuity.

As with mainstream PBL, the same HIV and AIDS education programme should be available for each incoming cohort of students such that the foundations can be added to in a spiral fashion as they progress through their studies. For this reason, blueprints and matrices need to be developed for the programme so that in the event of members of the task team leaving the institution (which has already happened), there is some degree of continuity. This would certainly contribute to the sustainability of such a programme.

CONCLUSIONS

Notwithstanding some of the difficulties encountered along the way, there can be no doubt of the value of exposing young students to the stark reality of HIV and AIDS, both in their personal capacity and as future practitioners on developing the appropriate attitudes and behaviour towards patients. As many students engaged first-hand with HIV and AIDS in the real world, it became a personal issue for those who may have had family members infected or were themselves HIV positive. As HIV and AIDS will continue to impact on the resources of the South African health care system for many decades (Human Sciences Research Council, 2003:56), this early introduction to the real world experiences of the epidemic should provide students with insight into some of the dilemmas in the current and future practice of medicine. This HIV and AIDS education programme should also have made students aware that since clinical solutions may not always exist and a cure may take years to develop, social and psychological issues assume greater importance. The authors are of the opinion that such an education programme could be incorporated into health science curricula, with appropriate contextually and locally relevant modifications.

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