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ABSTRACT

This report synthesizes the findings of a week of focused group discussions during which Australian health care workers currently caring for people with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and tertiary educators involved in designing/delivering curricula in various health and social disciplines shared their views on developing an integrated curriculum to train health care workers in caring for HIV/AIDS patients. The following emerged as major themes of the focus group discussions: (1) HIV/AIDS is, for many reasons, special and distinct from other infectious diseases; (2) health care curricula must include training in both the medical science of HIV/AIDS and the human relations aspects of caring and communication; and (3) it would be better to incorporate HIV/AIDS into existing health care curricula as an exemplar of both clinical practice and the gamut of psychosocial issues of health care work than to establish a separate HIV/AIDS curriculum. Specific ideas for tertiary education curriculum development are also presented. Appended are an executive summary of the first report of HIV/AIDS Program Unit of the South Australia Health Commission and a list of groups represented in the focus group discussions. (MN)

Ideas for curriculum development in the tertiary education of health care workers involved in caring for people living with HIV/AIDS

Making Connections

A report evolving from
Knowing Both: Towards integrating two main approaches to the tertiary education of health care workers involved in caring for people living with HIV/AIDS

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This second research project and report is a joint initiative between the HIV/AIDS Programs Unit of the South Australian Health Commission and the University of South Australia.

Abstract

This second report is based upon and evolved from the first one, ***Knowing Both. Making Connections*** argues that HIV/AIDS merits special attention as a body of core knowledge and practical applied skills for health care workers. This means that considerable effort needs to go into thinking about a design for curriculum and learning in tertiary education that fits the special needs of workers in HIV/AIDS and the complex backgrounds of thought and action that forms the health and welfare, socio-cultural, political-economy and other structural and situational contexts of confident and competent practice. We have learned that HIV/AIDS work cannot be effectively undertaken without a comprehensive acquaintance with a host of interesting and challenging ideas that go beyond a narrow approach to health care practice, hence our use of the term ***Making Connections*** as the title for the report.

In writing the report we have taken a broad view and stirred a few ideas that really require more time and space to develop. In essence, though, the spirit of our approach is to advocate taking a fresh look at tertiary curriculum and learning about HIV/AIDS as a number of opportunities, rather than admit to finding the challenge of new ideas and revamped old ones too hard to consider.

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INTRODUCTION

THE MEANING BEHIND THE FIRST *KNOWING BOTH* REPORT

In the first report, *Knowing Both: towards integrating two main approaches to the tertiary education of health care workers involved in caring for people living with HIV/AIDS*, (1) we presented the basic argument, on the basis of the needs assessment, that for health care workers (HCWs) to work confidently and competently with people living with HIV/AIDS it was necessary to have a grounding in two forms of knowledge and practical skills and these leading ideas should become the foundations of curriculum development in tertiary education programs.

One of these forms of knowledge we generally characterised as having a workable grasp, according to the requirements of the particular health care discipline, of the medical science of HIV/AIDS, as a disease of the late twentieth century, with all that it implies for an understanding of causes and transmission, treatments and effect on human beings living with the virus. From this standpoint we were emphasising the respected values of highest learning grounded philosophically and practically in the traditions of verifiable, empiricist and positivist knowledge.

At the same time we equally stressed the importance of having a person centred approach to people living with HIV/AIDS, calling upon knowledge of a different kind, that is, focused on the human relations aspects of caring and communication, which emphasised the normative values of positive human sympathies and sensitively seeing and understanding the person within their social and cultural context. This kind of knowledge we regarded as being about coming to terms with personal fears and prejudices, easier said than done, and transcending behaviour which might be discriminatory to reach a high level of personal and professional integrity based on fair and open mindedness.

We advanced these dual approaches to knowledge and understanding for learning and study in tertiary education, because that is what we gathered from our extensive focused discussions with all kinds of HCWs who consistently reported these views on the basis of their practical experiences and thoughtful reflections drawn from caring for people living with HIV/AIDS. We also came to personally appreciate the learning and applied practical value of these two sides to knowledge and understanding. Hence the use of the term *Knowing Both* to give a thrust and

strong focus to the first report. *(see appendix one for an executive summary of the first report)*

THE NATURE AND SCOPE OF THE SECOND REPORT: *MAKING CONNECTIONS*

This second report picks up the story from the simple summary of *Knowing Both*, expressed above. The ideas that follow comprise our understanding of a week of focused group discussions with some of the HCWs that provided such valuable insights from the initial needs assessment, and the views and experiences of tertiary academics particularly involved in the design, management and delivery of curricula in the various health and social welfare academic disciplines that provide the basis for professional status, work roles and practices in health care for people living with HIV/AIDS. It should be noted, in passing, that we chose to report the findings at this second stage of the project in a first person and personal storyline way, as it best reflected our person centred approach to the task and the respondents.

RESEARCH PROCESS AND REPORTING METHOD

THE UNDERLYING RESEARCH PARADIGM

As with the *Knowing Both* report we continued to base our understanding and approach to knowledge on the interpretive paradigm, owing much to the sociological ideas of the social action perspectives in an honourable line from Max Weber to the modern day symbolic interactionists, phenomenologists and ethnomethodologists, sharing in a broad common way the view that human action, meaning and interpretation is built upon the shifting grounds of everyday situational role exchanges and discourses. Hence our valuing of the narratives and perspectives of learned experiences and perceptions of others as the source of our understanding and interpretation of their knowledge of HIV/AIDS and related tertiary education matters.

FOCUS GROUP DISCUSSION PARTICIPANTS FROM HEALTH CARE AND TERTIARY EDUCATION

We talked to practitioners and academics in the knowledge discipline areas of nursing, dentistry, medicine, physiotherapy, radiography, social work, counselling and community services, in that order, representing the four tertiary sector institutions in South Australia. Throughout the five morning sessions we were joined by the two staff from the SA Health Commission HIV/AIDS Programs Unit whose views were noted in the first report and whom we regarded as important to help focus our discussions the second time around. *(see appendix two for the details of the disciplines and institutions of the respondents and what they were required to do)*

THE TWO MAIN FOCAL POINTS OF THE DISCUSSIONS

The focused discussions were structured in a simple manner as we only required the group members to talk about two aspects of the first report, that is, the overall **plausibility** of the leading ideas and the **practicalities** of implementing them into the raw material for curricula. We deliberately sought to understand the difficult problems and controversial issues as our respondents saw them, as such experienced reflections would help us keep the second report focused on practical realities as well as lofty ideals that were bound to get a ventilation whenever active thinkers get together. We were not disappointed on both scores. Essentially we

had enough sense to know that putting up ideas for curriculum development, especially as outsiders looking into the territories of other academics, was bound to get a cool reception on the various grounds of economic cost; the problems of taking space in already over-crowded programs that were set fair for a five year haul; the problem of finding sufficient staffing expertise of HIV/AIDS; and other equally convincing reasons. Nonetheless, even against such known practical problems of curriculum development and change we had the privilege to discuss many ideas that could provide the basis of **new thinking** or the **reinforcement** to ideas already in being and it is to these that we shall shortly turn.

RECORDING AND REPORTING THE FOCUS GROUP DISCUSSIONS

As for the reporting of the discussions, we kept notes and gathered those of the respondents as an aid to memory after each session. We also employed an ***independent observer and notetaker*** who was not required to join in the discussions, unless personally moved to do so, but was asked to keep a recording, in note form, of each session. Our original intention was to blend these notes with ours, and we have done some of that, but we preferred mainly to use them as a kind of independent witness to the proceedings, adding another valuable, triangular dimension to the report findings. ***The interpretive contribution of the independent notetaker appear in clearly identified sections closely related to the same sections in the main report. Some editing has been done to avoid too much repetition***

The perspective of the independent notetaker as to the purpose of the second stage of the HIV/AIDS project is usefully inserted at this point, (reported in italic font for the first sentence of each contribution for easy identification)

The purpose of this report is to provide briefly a critical outsider's view of the main themes and directions suggested in a series of feedback discussions on the plausibility and practicality of implementing HIV/AIDS in tertiary education for health care workers in South Australia. The feedback was in response to the recent report, **Knowing both: towards integrating two main approaches to the tertiary education of health care workers involved in caring for people living with HIV/AIDS**, which has been produced as part of an ongoing research project at the University of South Australia assessing the tertiary education needs of health care workers likely to be working with people with HIV/AIDS. The

report identified the need for relevant understanding of the medical science of the disease and therefore appropriate practice in terms of the health care discipline of the worker as well as an understanding of the human-affective or sociological aspects of working and/or living with HIV/AIDS.

THE NATURE OF THE FOCUS DISCUSSIONS

The nature of this kind of naturalistic research reporting almost always means that notetaking and script translation involves a high degree of selectivity and transformation of the raw data through editorial licence. This invariably results in some loss of data and the dominance of the ideas of the writers about what constitutes the most important points to emphasise. This is not an apology but rather a statement of the realities of this kind of reporting. We did, of course, run our main ideas, expressed as broad headings and sub-headings, past our two colleagues from the HIV/AIDS Programs Unit and the independent notetaker, as a rather general overview and they were quick to suggest ideas, including some amendments and additional refinements to the basic thinking. We repeated the exercise at the draft stage of the report.

PERCEPTIONS OF THE INDEPENDENT NOTETAKER ABOUT THE NATURE AND FORMAT OF THE FOCUS GROUP DISCUSSIONS

My role was as observer and to note what seemed to me to be the salient points of the discussions in order to draw out any themes across the five days. As an outsider to the project, I was also a fresh eye to the proceedings, since unlike the project members and the participants from the Health Commission, I had met none of the other participants previously and I was also unfamiliar with tertiary curriculum development specifically for health care workers.

The format of the discussions was informal and centred on a number of questions:

- what makes HIV/AIDS special as a disease that warrants its development as part of tertiary curricula for health care workers?
- is there a perceived need for special HIV/AIDS education identified within the different health care disciplines and is the dual approach identified in the report appropriate as a framework for the curriculum development?
- how would HIV/AIDS be best incorporated into current health care tertiary curricula?

- what would be the best-case scenario for future health care curricula to educate about HIV/AIDS—what changes would be necessary, are they possible to achieve, how would they be implemented?
- how can the Health Commission's HIV/AIDS Programs Unit best assist this process towards developing HIV/AIDS education in tertiary curricula?

REPORTING THE MAIN IDEAS OF THE FOCUS DISCUSSIONS

In her introduction to the book version of her film script *The Last Days of Chez Nous* (McPhee Gribble and Penguin Books Australia, 1992), Helen Garner wrote about her way of getting into the subject matter and making a start.

> "I never plan. I circle round the dark area of life.....to which my curiosity is attracted, and I search for a way in" (page viii).

This report is like that for we had so much to digest and make sense of before daring to write our way into the heart of the topic. Serendipity helped for on the last session one of our respondents talked about "making connections" and we quickly converged on the term as illuminative of what we were seeking to convey, both as an expression of the main theme of the discussions and our understanding of the complex patchwork of ideas in circulation.

ONE STARTING POINT

The concept of social role and professional/client relations based on social action theory perspectives and human centred values and norms to refocus the paradigm and add value to care provision

Two perspectives on the concept of social and professional role

We have chosen to start by using the sociological concept of role as the "way in" to an understanding of the nature of social and inter-personal relationships, principally between the roles of HCWs (used in a very generic sense for the time being) and people living with HIV/AIDS, in their role as client/patient. We use the concept of role in this report not as some rigid, structural device for organising relationships and dealing with expectations and needs, in that sense as a form of social control through the maintenance and manipulation of relationships (based upon systems theory in sociology), but much more as a fluid and very situational means of conducting the diverse nature of social interactions between people. In this latter sense, which derives from the social action schools of sociological theory, role and relationship is a composition of many kinds of interactions which do not follow a pre-determined pathway of carefully controlled interpersonal exchanges but are alive with the flux and fluidity of everyday situational

discourses, some based on language and others on non-verbal communication, which are ever changing and essentially dynamic, made up like an improvised tune as the drama of people interacting with each other unfolds.

Advocating a more fluid meaning of role in HIV/AIDS work

It should be clear that this is an ideal type model of role relationship but it is our assumption that it comes closer to the everyday nature of health care and social work with real people than the sometimes wooden concept of role that is often described in the textbooks. The difference might be characterised as the concept of professional role as disinterested and objective involvement and the more modern ideas of positive advocacy and empowerment on behalf of clients. It means, within the context of caring for people living with HIV/AIDS, that the concept of role is based on an honest and frank meeting and exchange between human beings, first and foremost, not as poor actors talking to an unreal script that is not their own true self work. Put in a negative way, this is not the idea of social role as like a puppet on a string, externally driven and determined and using a check list to tick off permissible interactions. but as close as possible to the ideas of the genuine and authentic self expressed through roles without the coverage of the mask of professionalism and the underpinning r. rms of objectivity and social distance.

This approach by putting a strong meaning and purpose to the nature of tertiary education challenges it to become very person centred, bringing knowledge and learning on close terms with real people, which is much more than the sum of the professional roles they are trained into and expected to play through the long process of occupational socialisation. The concept of role is a key mediator in the process of making a human connection between HCWs and their HIV/AIDS clients/patients, founded upon a knowing and understanding that goes beyond mechanical relationships and the codified learning of textbooks and other academic readings. What needs to be learned is that the nature of role relationships has to become more situationally based to persons responding more openly and flexibly to the needs of clients/patients in what is for them a changing set of intensely personal feelings and relationships, health and welfare conditions and socio-economic circumstances. At no point do we underestimate the very real challenge involved for tertiary educators in designing a learning environment that fosters understanding, confidence and competence in working to such a complex meaning of social role.

Behind these ideas lies the value normative assumptions of professional roles and relationships which enter the individual life worlds of clients and patients, within the reasonable boundaries of what is politic and polite, on the basis of human acceptance and empowering others, and certainly not judgementally and in a discriminatory way. This is the role of the professional as guide, philosopher and friend, working from the premise of a helpful customer focus, suggesting ideas and care options as a consultant and facilitator, quite different in spirit and form from more control focused work behaviour. Again, we are fully aware of the challenges associated with such an approach to caring and how to translate them into quality learning experiences and the basis of reflective practice.

As a background to these ideas, it has to be recognised that the early history of HIV/AIDS, from the time when it became a widespread public concern and media event, has been characterised by the language and behaviour of fear, ignorance and discrimination, aimed at victimising and censoring the gay community where the disease exacted its early and greatest toll. (2) In that sense HIV/AIDS provided an ideal opportunity for pumped up moral outrage and hypocrisy from the standpoint of the so called sexually "straight" communities of various vested interests, which gave to the processes of health and social welfare provision a sharp political and emotive dimension. It is very likely that as HCWs are drawn from the rest of common humanity, that is, sexually active, some using drugs and generally sharing the propensity for risk behaviours, and they were neither above or immune from the controversies that surrounded their work with HIV/AIDS clients/patients. This is what we understood by the use of the term "baffles" getting between HCWs and their work responsibilities as expressed through the position paper written by a member of the HIV/AIDS Programs Unit in the first report.

Within this approach to education, that is, into a more comprehensive and humanistic concept of social role, lies the importance of helping HCWs attend to the value of using language accurately and sensitively with people who feel marginalised and exposed to social stigma because they have HIV/AIDS. Similarly, HCWs can be socialised into thinking more accurately about risk behaviour by individual people rather than sticking to out dated and mildly combative language of "target groups", for knowledge about HIV/AIDS has gone beyond such crude classifications. The role of HCWs in this context becomes explicitly concerned with self expression and the empowering of clients/patients to make positive health and related life choices. It entails a shift of the teaching and learning paradigm to one in which, at the very least, HCWs acknowledge that

much of the significant learning about HIV/AIDS derives from first hand experience and close encounters with the lives and lifestyles of people living with the disease and that this must extend beyond the traditional thought frameworks of the positivist and empiricist approach to knowledge, with the assumptions of maintaining objectivity through socially distant role relationships. Such a paradigm shift in the delivery of HCW curricula offers a perspective that legitimises the value of interactive social action theories and interpretive approaches to knowledge and learning. It also makes practical sense of the view expressed in the first report that the significant learning HCWs do in HIV/AIDS comes from the lessons of experience and the reflections of action, better than the reading of textbooks, and this is more easily achieved through an open and flexible approach to role relationships.

ANOTHER STARTING POINT

Understanding HIV/AIDS from a global and changing trends perspective

Thinking about HIV/AIDS in a global context as a basis of tertiary education

Nobody among the panel of HCWs and academics we invited to discuss the first report and the tertiary education curriculum implications agreed with the proposition that HIV/AIDS had a sufficient knowledge base to "stand alone" as a learning program, from undergraduate through postgraduate and continuing education. The reasons were for a mixture of educational judgements, economic and resource considerations. We are in no position to argue with these reasons on local and pragmatic grounds but the evidence derived from projections about the global spread of the disease, principally into the heterosexual and female populations and possibly carried by new strains of the virus, suggest that worse is yet to come and although Australia has a commendable record of government and non-government action the country is not beyond reach for a virus that knows no boundaries, based on present levels of understanding with currently available preventive and palliative measures and limited treatments.

From the perspective of global warnings, as it were, Australian HCWs need to be educated and trained in readiness for the future of HIV disease, in which the view is presented that new forms may emerge and there is some anticipation that worse may yet come, which we concede is difficult to act upon within the straitjackets of

economic rationalism that would have great problems agreeing to pay for an investment type of learning in advance of a catastrophe that may not happen. But the essential message of the most recent research and conference deliberations is that the HIV/AIDS pandemic is well on its way to an increase in escalation and devastation and that both sound preparatory and continuing education for the general public and HCWs makes sense as a contingency measure for what will become an emergency on a world wide scale (3). Yet in spite of such a grim scenario the anticipated policy of the Australian government is to reduce the amount of funding and generally mainstream HIV/AIDS health care provision, regarding and treating the disease as an incorporated part of other services. In our view the HIV/AIDS pandemic scenario is so worrying that any tertiary curriculum for HCWs must have a futures vision to give learning a long term and strategically purposeful focus.

Thinking about the global perspective on HIV/AIDS, in relation to a possible international marketplace of HCWs as learners undertaking tertiary level programs on Australia or delivered to them in their own countries and workplaces, it strikes us that here is an opportunity to develop curricula for learning consumption by overseas students which takes account of current and projected estimates of the pandemic within each country and geo-political region and its likely impact upon national populations and the health and welfare service infrastructures underpinning the work of HCWs. This means thinking about and designing curricula that goes far beyond the localism of the Australian context, while at the same time being culturally sensitive to the philosophies and social values, health and welfare systems and other characteristics that provide the frameworks for organised approaches to HIV/AIDS. Naturally such an internationally market focused strategy, with all that it implies in co-operation between tertiary institutions and international aid agencies, requires considerable academic expertise which is founded upon "in country" experience and certainly not just bookish knowledge, for that would be a form of colonialism of the most cynical kind.

A THIRD STARTING POINT

A broad perspective on the significance of HIV/AIDS as a catalyst for promoting ideas for tertiary curriculum development for HCWs

The unique socio-cultural impact of HIV/AIDS

Linking with the worse case scenarios of the HIV/AIDS pandemic, it appears to us that the disease magnifies wider issues of human behaviour that need to be understood in terms of their impact on the future stability of the social fabric as well as the personal experiences and meanings for those infected by the virus. In that sense HIV/AIDS intersects with us all as a unique disease of the late twentieth century, which is still a long way from being either understood or even treated effectively. More than that, HIV/AIDS poses questions and raises controversies about the value-normative or moral and ethical foundations of the nature of human sexuality and the use of drugs to modify behaviour, posing the need for a widespread understanding and action upon risk behaviours that threaten the lives of a widening circle of people, no longer confined to so called marginalised "target groups" in the community.

Understanding HIV/AIDS from several knowledge perspectives

From an educational perspective HIV/AIDS can only be sensibly learned within the comprehending conceptual frameworks of knowledge and academic disciplines such as **sociology and psychology**; the principles and practices of **health** and **social welfare services**; the **ethical** and **philosophical** foundations and the frameworks of the **law**; and **cultural studies** with their interest in **language** and **modes of discourse** as the means to understanding the pandemic from the standpoints of various **political interests** and **ideologies** of social relations. Altogether an understanding of HIV/AIDS within a social context calls for an inter-disciplinary intellectual approach linked to an appreciation of the need for human values education as the basis of ideas of client/patient advocacy and holistic conceptions of professional roles and practices focused on the real lives of people having to cope with the disease. Such an approach is a far cry from a curriculum presented and delivered as a package of predetermined and possibly unrelated modules or "suites of courses", to use the tortured language of industry and technology.

Advocating a holistic approach to learning about HIV/AIDS in

tertiary education

What we are persuaded to advocate is an integrated or holistic approach to learning about HIV/AIDS which acts as a catalyst for educational change by helping people think and act within more than one paradigm of health care; one principally based on the positivist-empiricist traditions, for an appreciation of medical science and the ideas of systems or structurally focused social studies, and two, more inspired by the ideas of human relations knowledge and the underpinning theories from the social action and cultural studies perspectives which are much more focused on the everyday and situational interactions and meanings of social relations under fast changing conditions. Instead of regarding these bodies of knowledge as separate spheres or paradigms of understanding and learning we are interested in how to bring them into a clear and workable connection so that HCWs can operate confidently and competently, comfortable with such a varied contextual background to the theory and practices of professional roles focused on the expressed and felt needs of clients. Put in a complementary way, we are looking for a tertiary education that can enable HCWs to become practical and grounded in what they do, drawing upon an eclectic perspective of generally understood knowledge to foster confident and competent reflection under difficult and demanding human circumstances. In advocating this perspective we are only reaffirming a shared view among many tertiary educators. In that connection HIV/AIDS highlights what needs to be done to ensure that curricula is fresh and alive to the flow and ventilation of ideas relevant to the changing roles and experiences of HCWs.

HIV/AIDS knowledge as a catalyst for curriculum change and development

In several ways HIV/AIDS adds value to theory and practice in tertiary education curriculum and therefore as a catalyst for change and development. First, the relative marginality of HIV/AIDS as a field of health care practice means that experienced HCWs are more free to explore other ways of thought and action, beyond the conventional wisdoms of their major disciplines, to search outwardly for meaningful frameworks for their ideas to flourish. Such searching allows various health care disciplines to converge on new ground, make new connections and promote a synergy of ideas to occur freely. Second, as HIV/AIDS has been learned, and shared with fellow professional workers and clients, on the basis of diverse situations and practical experiences, such an accumulation of grounded knowledge fosters the approaches of interpretive, action focused and learning

based on reflection, again extending the boundaries of conventional thinking and acting as a catalyst for curriculum development. Third, the practice of HIV/AIDS work, because of the nature of the disease and its inter-personal and social context, means that theory applied to practice has to be drawn from several knowledge and inter-disciplinary perspectives and paradigms of thinking as it intersects with them all in some way.

Altogether these situations and experiences have shifted the centre of gravity of the role of HCWs from an emphasis on diagnosis, treatment and curative thinking, important as they undoubtedly are, to that of personal choices enabler or learning facilitator or empowering professional, through to palliative carer, as "guide, philosopher and friend". Our *Knowing Both* title to the first report made the point, which is repeated here, that we need to avoid either/or thinking and appreciate the value of several knowledge perspectives as the foundations of a holistic understanding of HIV/AIDS set within its socio-cultural context and a more comprehensive view of professional role grounded in a sympathetic approach to individuals living with the disease. There is added value in this approach in terms of the professional comfort and safe working of HCWs as well, which helps foster confident and competent practice and good quality care.

HIV/AIDS promoting different ways of teaching and learning and being less the agents of social control and selection in tertiary education?

Before passing to the next section, there is perhaps one additional remark to make about the significance of these ideas to the values and practices of the role of teachers and educators generally, which has been prompted by thinking about tertiary level programs on HIV/AIDS for HCWs. Traditionally the role of the educator is to convey knowledge and understanding through a systematic process of serious thought and study, not always but often linked to applied learning. Although it is no longer fashionable to talk about the quest for truth, entertaining the possibility of the existence of some absolute meanings and values to guide us through life, at least the working assumption is that education, based on serious study and learning, confronts fear and ignorance, giving a sense of confidence and certainty in a confusing and complex world. In that sense educators are the modern priests, as scientists are the modern form of the magician, with their passions for understanding through the construction of agreed meanings and rational outcomes. Hence the perspective on education as cultural transmission, with teachers as trainers and socialisers, using knowledge and learning as the

means of social selection and control. Education and teachers in this scenario act principally as a delegated function of the business of organising and managing society, mainly in the interests of those who have the power to construct society according to their meanings and values. In a pluralist and somewhat democratic and rough and ready egalitarian society, which Australia likes to believe it is, such a function for education and role for teachers appears reasonably agreeable and not too oppressive.

But the lesson of HIV/AIDS is that society is not such a tidy construct and is certainly neither fair, reasonable or just for those who are and have become marginalised and do not easily fit into the mainstream value-normative social order. This poses a problem for educators sensitive enough to look beyond their human resource management tasks, (essentially the hit and miss process of selection and control exercised through their very considerable control and regulation of ambition duties) to the very real challenge of providing education under conditions of uncertainty, contradiction, paradox and an increasing breakdown of the social order which manifests itself in the condition of anomie or value-normative disintegration the French sociologist Emile Durkheim wrote about and forecast in the last century.

All this means for educators is to stop pretending to have the answers and rather to admit to not knowing and understanding, to climb down from the pulpit and the trainers stool, to give up acting as gatekeepers and become instead open and skilled facilitators of learning on a shared and honest basis with others, commonly and democratically searching for insights and forms of personal and social action from the "bottom up" and the "ground floor", to re-use well worn cliches This world of ideas and learning is much richer, being composed of multiple and pluralist meanings, mainly because education is freed from its deterministic management tasks and processes and no longer is part of the apparatus of manipulation and control.

Clearly the scenario above is understood as an ideal one, consciously naive and deliberately not pragmatic, for that would destroy its potency as an idea of education that hardly gets a hearing in the oppressive climate of economic rationalism and the outcome obsessions driven by the sovereignty of the marketplace. But it is people centred and strives to find a way of working that gets close to the worlds they are in and the meanings they seek in a context where old formulae's appear irrelevant, broken down and no longer a useful part of the lives of people under sentence of a slow death and palliative measures.

This is where we return to the theme of "making connections" for it seems to us that a very valid role for the educator is to help people, whether as HCWs or in some other capacity, to see the world as both **macro level and functionally driven social system and structure**, (with its ideologies, value-normative orders, apparatus for social compliance and control, mediated through various institutions such as the family, education, religion and social welfare agencies) and **micro level, sub-cultural and individualised phenomenological worlds** (made up of everyday symbolic interactions, variable situations, remedies for survival based on made up meanings and all the other myriad ways and means people use to make sense of the worlds they are actually live in), beyond the rhetoric constructed by others, usually to give them power and control of the ideology and social relations of political economy and the cultural spheres of society.

Moving from this generalised perspective to a more specifically educational one, confined to matters of theory, method and learning strategies, the excellent higher degree study by Marilyn McCarthy, *Speaking the Unspeakable: the themes, issues and concerns of seven HIV/AIDS educators in South Australia*,(4) introduces the reader to the complex world of their roles, based on self perceptions of tasks and purposes and underlines the point that confidence and competence springs from having a good grasp of theories of adult learning, human needs and motivation, inter-personal relations, communication and persuasion. She also highlights various models of teaching and learning that progressively moves from information giving, to empowering individuals and finding the grounds for collective social action on the basis of participatory learning and reflection, all strongly focused on the idea of changing behaviour through addressing attitudes and values, whether held individually or collectively, set within a context of developing personal skills and a soundly supportive policy framework of health promotion which enables people. This places the role of the educator solidly within a complex and pluralist social context moving from one level of social interaction and meaning to another in a fluid way equipped rather than armed with flexible learning skills.

The point will be reinforced again, and it is worth establishing here, that in our view members of the South Australian Health Commission HIV/AIDS Programs Unit, in their current strategic management role and certainly in their former educational roles and responsibilities, as well as others probably in comparable positions, such as a growing number of non-government and community based action groups, including some HIV positive people, have both the insights and

skills needed by tertiary education to design and effect quality programs for HCWs. The point is that they are not bound by the conservatism of traditional academic thinking and have had real experience of operating in educational roles that relate HIV/AIDS to the contexts of life concerns and decision making skills that have a clear grounding in inter-personal relationships, personal values and self esteem that provide the proper setting for the roles of HCWs as empowering agents of change, not as controllers and gatekeepers.

THE VIEWS AND INTERPRETATIONS OF THE INDEPENDENT NOTETAKER PROVIDE AN OVERVIEW OF THE MAIN THEMES EMERGING FROM THE FOCUS GROUP DISCUSSIONS

HIV/AIDS is special

During the five days of feedback and discussion, the question arose many times as to whether and how HIV/AIDS can be viewed as special, distinct from other infectious diseases. With some exceptions most respondents among the health care groups emphasised that HIV/AIDS is special because at the very least it shakes the fabric of our society as well as now belonging to modern day lives. The disease affects the broadest cross-section of the community because of the range of behaviours that risk infection and because of the possibility of the disease being medically acquired. In fact, the epidemiology of HIV/AIDS points to a potential widening of that broad cross-section of population that may be affected, since overseas travellers are seen to be at risk due to lack of blood screening in many countries, in addition to running the same kinds of high level risks in sharing needles and having unprotected sex.

HIV/AIDS has required a conceptual shift unlike any other disease and has been the push for transformation in certain social attitudes and behaviours. HIV/AIDS concentrates the import of issues that already exist, such as safe sex to avoid sexually transmitted diseases, and as its impact is more widely felt, it foregrounds previously backgrounded issues like community attitudes to marginalised groups, such as men who have sex with men, or intravenous drug users, or people with a terminal illness. Its strength as a social catalyst lies in the alternative role model it provides for marginalised groups in our society. Community-based demands for greater understanding of the disease and its effects, for better health care, for more research and funding, and for modification of risk behaviours within our society have imbued such marginalised groups with a voice and an explicitly recognised strength in the face of great odds, a movement away from the concept of victim.

HIV/AIDS acts as an intersection point in health care and provides enormous potential for comprehensive learning It is linked to other diseases, since it is of opportunistic infections or other manifestations that a person dies, not the virus itself. It acts as a catalyst in standard clinical practice, because of the serious ramifications if universal precautions are not used. The disease also shines a light on many social aspects of health care work, such as the interpersonal skills, the attitudes,values, and beliefs, and the issues about identity, death, and the meaning of life of health care workers. HIV/AIDS inextricably connects the personal and professional practice of health care workers in a way no other infectious disease does. It therefore exists as a unique educational tool by which to re-examine basic issues of health care and the tertiary education of health care workers.

The need for a dual approach in health care curricula

The perception common to nearly all health care groups that participated was that HIV/AIDS education needed development within health care curricula because of the increased likelihood of health care workers' coming into contact with and having to deal with infected blood and therefore increasing the risks of HIV infection. Many health care workers currently work to the 'challenge of the close call' and block out their close personal feelings, beliefs, and attitudes until they arise through specific contact with a client living with HIV/AIDS.

The development of HIV/AIDS and the exploration of issues surrounding it within current curricula were perceived to be an essential component of the personal preparedness of health care workers as part of best practice, especially in the light of the disease's impinging on all aspects of health care work—the psycho-social domain, universal precautions, clinical practice of particular disciplines, and ethics and legalities related to health care work. Health care is intimate practice. HIV/AIDS, with all its associated 'witch-hunt'–type fears, brings to the fore whether this preparedness and training are adequate. Inadequate preparedness on the part of the health care worker can result in trauma for both the patient and the health care worker. For instance, the ability of dentists to talk to patients about a potential problem of HIV/AIDS is crucial since oral manifestations are often the first and only signs of the possibility of HIV/AIDS. A dentist's interpersonal skills, ability to take the patient's sexual history as well as medical and dental histories without judgement, the nature of how she or he refers the patient and follows up with the general practitioner will all colour the patient's experience of the disease, whether or not the patient actually has the disease. So education for 'confident and

competent' practice must ensure that health care workers have the opportunity to explore their own psycho-social issues surrounding HIV/AIDS in a supportive environment in order that they can establish the necessary balance between the personal and the objective to provide intimate service.

The current health care curricula do embrace both the medical science and psycho-social aspects of health care, and HIV/AIDS is touched on in most curricula. The workshop discussions identified the need for a shift in the focus of health care education, however, that also points to the need for a reassessment of the role of human values education and the depth to which it is taught.

A greater focus on preventative health care is seen to be necessary, especially in respect of HIV/AIDS in order to educate community values to avoid risk behaviours rather than to be able to identify risk groups. Such a focus requires greater emphasis on all issues up to the point of recognition of the disease that will affect health care practice and client care.

The implications of such a shift are twofold. First, human values education would need to be foregrounded more than it currently is. For example, changes in medical technology indicate that the traditional 'human mechanic' mentality of certain health care disciplines, like medicine for instance, is inappropriate. An illustration is the movement to less invasive surgery, which will mean surgeons must be able to interrelate with their clients at all points of contact. With such interaction comes the responsibility to provide information so clients can make informed choices about their health care options, objective advice about the consequences of different options, and compassionate and non-judgemental communication with clients. Greater exploration of values, beliefs, and attitudes towards certain behaviours and resolution of personal problems as part of human values education could go a long way towards alleviating potential problems of communicating with clients as well as allowing health care workers the scope to reflect on their attitudes to their life work choices and their provision of intimate service.

Second, human values education will have to recognise explicitly the duality of the health care worker' role and emphasise a more holistic approach to client care. HIV/AIDS has illustrated that it is no longer sufficient for health care workers to approach their education and clinical practice from the perspective of 'what do I need to know'. Instead, a more holistic approach to client needs is necessary, including some part in community education at the point of client contact, and a

willingness to take on the psycho-social aspects surrounding HIV/AIDS. The more appropriate perspective for health care workers to achieve from their tertiary education might be 'what can I do', which reflects the underlying duty of care that cuts across all disciplines and all components of health care.

It is recognised that this will require a greater level of personal knowledge in health care workers themselves; and for many health care workers already stretched thin and under pressure due to the logistics of funding and demand, this may seem like an unreasonable shift in what is required of them, especially older health care workers faced with the prospect of such a change in practice late in their careers.

There is also the factor of employer demand in terms of what is necessary for competent practice. Some employers will no doubt see an increased emphasis on human values education for health care workers as commendable but inessential. This only serves to highlight, however, the important bridging role that health care workers can perform in the transmission of information and in helping to transform community attitudes to health care and HIV/AIDS.

Such a change in focus must be seen to be less a role-shift as an adding-to the current role of health care workers. The existence of a human-affective side of health care is hardly new, but in the face of HIV/AIDS, it requires reinterpretation and greater emphasis in health care practice, and consequently, tertiary curricula. In this context, HIV/AIDS provides a unique opportunity both to fine-tune human values education and to expand it to all levels of health care curricula.

The use of HIV/AIDS as an exemplar in existing health care curricula

Discussion about how to build HIV/AIDS into curricula focused on the nature, logistics, and ease of curriculum change, and the implications for tertiary educators. It was agreed that HIV/AIDS can be best incorporated as an exemplar both of clinical practice and of the gamut of psycho-social issues of health care work in existing curricula, rather than attempts being made to establish a separate HIV/AIDS curriculum in each discipline with perhaps some multidisciplinary interaction. So many of the basic clinical issues associated with HIV/AIDS are identical to general issues of health care practice that the overlap even within each discipline would be too great.

There would be difficulties, however, in inserting HIV/AIDS into existing curricula even as an exemplar due to the gaps and differences that exist in tertiary educators' knowledge and experience of HIV/AIDS. The best way to learn about HIV/AIDS is via experiential learning, which provides ample scope for exploration of the many psycho-social aspects associated with human values education. There is the problem that many health care educators themselves have little experience of HIV/AIDS or of the personal issues the disease brings up. As a result, acknowledgement of the importance of HIV/AIDS as an exemplar is likely to be piecemeal, not the least because of educators' own personal attitudes towards the disease and people living with HIV/AIDS.

Then there is the problem of the gap between knowledge acquisition and personal practice for educators, even if there is acknowledgement of the importance and value of using HIV/AIDS as an educational exemplar. Some of the personal issues that arise through exploration of the disease can increase discomfort to such a point that many educators will not be prepared to take on HIV/AIDS education once they begin to explore the disease, or they will not persist with its complexity. Even if they do, unless educators themselves have the opportunity to work through some of their own beliefs and attitudes about the disease and its meaning-of-life issues, it is possible they will experience some personal trauma whilst exploring the issues with students and/or they may pass on inappropriate misconceptions and stereotypes in their own educational practice.

There is the difficulty too of the perceived number of knowledge bases educators would have to take on in order to teach HIV/AIDS adequately in health care curricula, because of the disease's impinging on so many areas and the complexity of the psycho-social issues surrounding HIV/AIDS. Many educators will not feel equipped to explore these psycho-social issues with students in their full complexity and with the attendant personal responses from students.

Information on HIV/AIDS is seen therefore to be difficult to access for some, although another view is that there is perhaps too much information, posing problems in integrating and effectively using the knowledge in a practical and applied way. This is partly because of the sheer weight of information needed to address the different knowledge bases, and partly because it is unclear to educators how to access appropriate information that is up-to-date and objective.

Given the current workloads of health care educators, HIV/AIDS is perceived to be too much and too hard to take on in any more significant way than that which

already exists. Many educators are practising clinicians also. Those that are full-time educators are expected to keep abreast of clinical developments, which is time-consuming. And staffing is tight to the point that there are few educators or clinicians with available time to take up HIV/AIDS education in curricula in greater depth.

One conclusion from the feedback discussions was that any push to expand HIV/AIDS education in health care curricula should target the 'converted', that is, those people with sufficient knowledge, interest, and experience of HIV/AIDS already. These educators are quite possibly responsible for the existing HIV/AIDS education in health care curricula, so the precedent exists to expand their use of HIV/AIDS as an exemplar. The base of expertise could then be broadened gradually to avoid the 'converted' being stretched thin, to ensure more flexible curricula, and to ensure HIV/AIDS is addressed in different health care contexts.

It has also been proposed to assist health care educators by making available consultants to supplement HIV/AIDS education. These consultants may be people living with HIV/AIDS and various advocacy and community based groups, who can give students first-hand and individual experience that makes the issues they have been exploring more real and immediate through relevant training skills and peer education. Consultants can also include members of the Health Commission's HIV/AIDS Programs Unit, who are experienced facilitators of workshops, addressing the meaning-of-life questions surrounding the disease, and operationally placed in the management of matched funding, in keeping with state and nation wide HIV/AIDS sstategies. Both kinds of groups may help to avoid stereotyping. Other consultants include clinicians experienced in working with people living with HIV/AIDS. In fact, one recommendation to come out of the discussions is collaborative partnerships between educators and clinicians to provide both with feedback, support, and information that promotes best practice in health care, especially in respect of HIV/AIDS.

The invitation to people living with HIV/AIDS to talk about their experience must entail a re-examination of the choices, support, and information that will be available to such incomers and what mechanisms like policy development exist to ensure these incomers are not overused or targets of abuse and discrimination when in educational institutions. Amongst the community there will be people living with HIV/AIDS who choose to participate in education and others who do not. In either case, these people must not be made to feel like guinea pigs because they are targetted too specifically or narrowly. Choices must be left open as to

what they wish to talk about and how. Unless they have specific background that they wish to draw on in health care work or education, it is more appropriate to invite them to contribute as informal life-storytellers rather than to expect them to be formal educators per se.

The question of how to incorporate HIV/AIDS into existing curricula is largely dependent of the nature of each curriculum. For example, the medical curriculum at one SA university is changing to a graduate, problem-based, student-driven curriculum with more emphasis on broad-based social and cultural issues related to health. The school of dentistry curriculum is similar and already in place. There is plenty of scope for incorporating HIV/AIDS as an exemplar into this type of curriculum because it allows for specific examination of particular aspects of the disease and for students' exploration of their own attitudes and beliefs in association with HIV/AIDS. The medical curriculum at one university has some problem-based learning but HIV/AIDS is always taught in the broader context of sexually transmitted diseases or infectious diseases. There is some possibility for the use of HIV/AIDS as an exemplar, but this would be dependent on agreement across departments, since different departments 'own' different parts of the curriculum. It was concluded that it would be better to focus on developing HIV/AIDS at post-graduate level at the same university to enable specialisation that could embrace the complexity of the disease.

The medical education approach at one university is also more traditional with 'need to know' driving the curriculum. The perception of HIV/AIDS in this context is that it is a rare disease in South Australia with which most general practitioners will not come into contact. This constructs a curiously limited vision of the role of the university, which may have been a misrepresentation in discussion. It suggests that the university is educating its medical students only to work in South Australia, which is hardly an accurate summary of its mission or likely to be the case. Tertiary institutions exist to ensure and promote the exchange of ideas and information world-wide as well as to educate professionals in the application of these ideas and to participate capably in such international exchange. This would place HIV/AIDS firmly on the 'need to know' agenda, especially considering the epidemiology of the disease.

Other health care curricula such as those in schools of Radiography, Physiotherapy, Occupational Therapy, and Pharmacy incorporate HIV/AIDS already haphazardly, but there is scope for its greater use as an exemplar with the collaboration of consultants to flesh out the human values aspects of the curricula.

For health care work like social work and counselling, greater emphasis on HIV/AIDS was seen to be very important because the disease affects such a broad cross-section of the community that the issues surrounding it are likely to arise in many contexts. For example, workers at the Housing Trust will service people living with HIV/AIDS, from which could arise the same personal questions and meaning-of-life issues that come up for anyone faced with the disease. Social workers and counsellors are perhaps more likely than any health care profession to work with people for whom HIV/AIDS has triggered personal issues needing resolution. It is essential therefore that these health care workers themselves have the opportunity to gain some experience with HIV/AIDS and to resolve their own personal issues with the disease as part of their preparedness to be of service to the community.

SPECIFIC IDEAS FOR TERTIARY EDUCATION CURRICULUM DEVELOPMENT FOR HEALTH CARE WORKERS INVOLVED IN CARING FOR PEOPLE LIVING WITH HIV/AIDS

THE INTERPRETATIONS OF THE INDEPENDENT NOTETAKER OPEN THIS SECTION OF THE REPORT

Future curricula development

These feedback discussions have pointed to the need for future curriculum development to incorporate HIV/AIDS education in a more holistic fashion. Human values education, interpersonal skills of health care workers, and awareness of ethics and legalities require greater foregrounding in tertiary health care education. This in turn will require better facilitation by health care educators to enable the kind of experiential learning that the disease requires. Resocialisation of the culture of each health care discipline is necessary in order to acknowledge more explicitly both the issues that arise when health care workers provide intimate care to people living with HIV/AIDS and the social paradigm that underpins these issues.

Systemic support lies at the centre of health care curriculum development. Policy development to support curriculum initiatives is essential to provide links and consistency of provision between all those involved in tertiary curricula. It is as important for curriculum designers, educational bureaucrats, and institutional administrators to have an understanding of HIV/AIDS issues as tertiary educators themselves. Policy development to support HIV/AIDS education is also essential since HIV/AIDS intersects with policy issues such as equal opportunity and anti-discrimination. For example, if people living with HIV/AIDS come into institutions—whether as consultants, students, or other workers—they are likely to experience discrimination and there will be legal, political, and social ramifications both for the institution and for the success of health care curricula addressing HIV/AIDS.

Systemic support in the way of staff professional development is also crucial. Discussions have identified that the success of HIV/AIDS education lies in a greater emphasis on experiential learning and thus the facilitation skills of educators. Opportunities for educators to explore their own personal beliefs, attitudes, and barriers associated with HIV/AIDS are an important component of

systemic support for curriculum development. This staff development will also have to extend to anyone within the institution instrumental in HIV/AIDS development in health care curricula.

Due to the complexity of the disease and the potential for overload of those involved in teaching HIV/AIDS, a review of systemic support could target restructuring of curriculum design to enable greater collaboration with external consultants, both clinicians and people living with HIV/AIDS.

Educational resources dealing with HIV/AIDS will have to be developed, which will require systemic support also. Educators with experience of HIV/AIDS are ideally placed to assist in the development and review of such resources but will require opportunities for collaboration with curriculum designers. There is also a wealth of personalised knowledge that could be drawn from the very consultants recommended as collaborators within health care curricula. These people could provide valuable assistance, from the development of case studies to experiential learning workshop design. Health care education systems will have to review how links across and within disciplines can be established or maintained to facilitate exchange of resources and expertise in order to incorporate HIV/AIDS into curricula.

There are a number of problems that health care education systems will have to address in order to develop HIV/AIDS in curricula. Flexibility of curriculum is a selling point in terms of both student demand and professional excellence. Most tertiary curricula have provision for distance education for example, which caters for professionals in the country, for instance, wanting to upgrade their knowledge. The emphasis on human values education as part of HIV/AIDS education for health care workers, however, creates a problem for distance education. Opportunities to experience and resolve personal issues for which HIV/AIDS acts as a catalyst are clearly crucial for health care workers and educators, but how will this be incorporated into distance education? What sort of assessment and accreditation will be used? Simply shelving HIV/AIDS education on the supposition that health care workers in the country are unlikely to come into contact with the disease is unrealistic, firstly because HIV/AIDS impinges on so many areas, secondly because it is not just an urban disease, and thirdly because the choices health care workers make about where they will work can change, so they need to be equipped to work anywhere. There are clearly implications for a review of the structure and requirements of distance education if HIV/AIDS is to be addressed properly.

There is also the problem of mainstreaming something as broad and sensitive as HIV/AIDS in tertiary curricula. It can get integrated in such a way that its value to illuminate and expose issues is lost. There may be problems because there are no links to a clinical complement because HIV/AIDS education has been part of other wider health care educational components. There is also the nature of mainstreaming itself in respect of what is selected, by whom, and for what purpose. If HIV/AIDS is incorporated as an exemplar, will all the complexity of the issues surrounding it be covered?

One recommendation to result from the discussions of this problem is to extend mainstream HIV/AIDS education via specialised electives, as well as post-graduate courses and undergraduate experientia! workshops. This could provide scope for ongoing education of health care professionals as well as students. Accreditation for ongoing education would provide encouragement for professional to engage in HIV/AIDS in this way. There is already potential to link into other certificates and different awards in lieu of the spectrum of HIV-related diseases that exist and the government push towards competency-based training and workplace education.

This raises the problem of teaching HIV/AIDS to health care students from varying cultural contexts. Teaching ideally needs to recognise different ways of 'knowing and doing', but this becomes more difficult and complex when teaching human values education for health care practice. Problems of stereotyping cultural values always exist, but there is the added problem of how students can and will engage in the issues of HIV/AIDS depending on their cultural backgrounds. The question of duty of care becomes even more significant if some overseas students are likely to return to HIV/AIDS–high risk areas and communities in which HIV/AIDS education is perhaps ignored for cultural reasons. Assessment of health care workers' confidence and competence in relation to human values education is difficult, but it will be even more complex in circumstances involving students from varying cultural backgrounds. Systemic review of policy development and curriculum design will have to address this issue.

THE VIEWS OF THE PRINCIPAL AUTHORS

One of the points of common agreement throughout the focus group discussions was the need to ensure that any proposals for curriculum development was preceded or dovetailed with **staff training and development** provision. The

need is obvious for knowledge and leading ideas about best practices in HIV/AIDS are not only complex but rapidly growing.

Moreover it is necessary to add that within the universities the tradition has been that the personal academic interests of teaching staff have to be the driving force for the development of new curricula, for without their motivation nothing much will happen. In that regard it was recommended that provision should only be made for those with a keen interest in HIV/AIDS as a knowledge and learning activity.

Without rehearsing all the reasons why curriculum change cannot occur, we acknowledge the very real difficulty some academics perceived in teaching about HIV/AIDS where it was unusual to approach the subject matter from the basis of being close to or inside students interests and life experiences, touching on their personal values and norms of behaviour, as the starting point of learning and occupational role socialisation. From this standpoint knowledge is still regarded as being "out there" and not amenable to being personalised. Finally, it bears repeating that the number of academics with knowledge and extensive practical experience of working in the HIV/AIDS field, at least in the context of South Australia, is very small, which underlines the point that tertiary education needs a critical mass of suitably qualified and competent staff to provide quality learning programs. Hence our remarks, expressed later in this report about the valuable support role available through the considerable knowledge and expertise of the current staff in the SA Health Commission HIV/AIDS Programs Unit, as well as other previously named agencies.

The knowledge core of HIV/AIDS tertiary studies

The main learning, knowing and understanding needs, as the foundations of a possible core and generic curriculum for HCWs, are summarised below as a number of related items. The order in which they are presented does not reflect an imagined hierarchy of importance and priority but rather a commonsense approach.

A clear baseline for confident and competent practice is a foundation of working ***knowledge about the facts of HIV/AIDS***, albeit different in kind and extent for the range of HCW professional disciplines according to relevance and their need to know requirements. Some understanding of the nature of the virus and its transmission is clearly important, along with trends and developments in

treatments, as well as projections about the pandemic on a national and global scale. At a very practical level it is clearly important for some kinds of HCWs to know how to work safely with HIV/AIDS using universal precautions sensibly and sensitively.

Related to the factual knowledge base is the need to come to terms with personal fears, phobias and prejudices so as to deal with the dangers of discriminatory behaviour within professional roles and work behaviour. We term this ***knowledge of the personal challenges of HIV/AIDS work***. The essential ideas about such a personalised approach to understanding oneself both within the context of professional role and self are summarised under the broad heading of Human Values Education (HVE) we used in the *Knowing Both* report.

It follows quite naturally to ***know and understand how to relate effectively and positively with people living with HIV/AIDS*** as the basis of quality focused care and the normative-values of commitment and professionalism. Such knowledge is reinforced with good quality inter-personal communication skills to achieve comfortable relationships with clients/patients. In this context it is valuable to appreciate the importance of being able to empower people living with HIV/AIDS to make personal and life choices as independently as possible.

It is also important to understand the ***psycho-social context of HIV/AIDS*** especially where it relates to the sexual, drug and needle use practices and other lifestyle behaviours of various social group sub-cultures that are deemed to be most at risk. Such an understanding helps shift the focus of HIV/AIDS work to the role of education and prevention strategies with their attendant concerns with human relations and people in their everyday living contexts. Just as importantly is the need to be able to work confidently and competently with the many personal and social issues; legal, ethical and political controversies that surround HIV/AIDS.

It should be clear from the above that we have slightly extended the meanings attached to the references to Human Values Education (HVE), Universal Precautions (UP) and other points about the general and specific knowledge domains of HIV/AIDS work and learning made in the first report

Attention turns now to the more specific aspects of the report identifying recommended teaching and learning methods and the organisation of the HIV/AIDS curriculum into different levels of tertiary education provision.

Teaching and learning strategies and methods in HIV/AIDS

There is a growing body of excellent teaching and learning materials, usually in packaged and module form which has been intelligently developed by people, inside and outside the tertiary sector, with better knowledge and experience of the specialist field. Although we are aware of such materials we were in no position to make proper connections with it, for the purposes of reviewing and assessing their relevance to this study, which is a pity. Clearly there is scope for such work to take place, to further expand upon the ideas in this report, possibly through the development of information and learning resource kits adaptable to all kinds of HCW needs and marketed in such a way as to be consistent with the ideas and practices of open and accessible learning. Indeed there seemed to be considerable support for the idea that an information kit or learning resource pack could be designed and developed from existing materials. It could also be developed in such a way as to be both generally and specifically applicable to all kinds of HCWs involved in HIV/AIDS work, with the former taking account of generic knowledge and skills and the latter focused on specialist learning needs related to each discipline.

Allowing for these present limitations, we are enthused by the search for interesting ideas for teaching and learning in HIV/AIDS and we heard many during the focused group discussions, which are outlined below.

Whatever form the design of an HIV/AIDS curricula takes, that is, whether in open learning or conventional modes of delivery, we repeat the point made in the first report about ***the value of basing the learning around practical experience and the benefits of personal reflections drawn from direct involvement in health care provision to people living with the disease.*** This approach is consistent with tried and tested methods of adult education, with typically strong emphasis on the practical value of immediacy and relevance to the work role interests and needs of HCWs as both workers and learners. Similarly the location of learning in very practical activities, such as talking to clients, taking blood, giving treatments and doing tests of various kinds, leads to the construction of a wider frame of knowledge from experiences which are linked to both the medical science and human relations paradigms. We particularly wish to stress the importance of such an approach as the basis of constructing a curricula that introduces the ideas and principles of human values education and challenges

learners to base their professional practices on explicit values that are as sound on human sympathies and understanding as they are on empirical, factual knowledge.

Clearly there is a place for ***conventional teaching and learning methods*** such as the use of the lecture to convey information and ideas about HIV/AIDS, typically in the transmission mode of one way communication, from the knowledge of the expert (and those with inside experience and insight of living with the disease), to the neophyte student, and associated with the traditional professions (medicine) and older universities. For all the virtues and economies of this time honoured method the subject matter of HIV/AIDS lends itself to complementary approaches, to diversify and enrich the "duck feeding" diet. Important among these is the value of a ***problem based and discovery approaches to learning*** which fits comfortably around experiential learning and locates the HCW in discovery learning from knowledge drawn from actual or simulated case studies, thus giving their studies real life relevance and human dimensions. We were informed of major developments in basing medical, dental and other curricula on problem based learning which provides implicit support to our proposals.

With the rapid developments in open learning , facilitated by advances in educational technology by audio and visual mediums, there is definitely much value in thinking about the curricula for HCWs in HIVAIDS work ***based on distance modes of delivery***, notably suited to the needs of workers located in rural and remote parts of Australia. Additionally, it is necessary to think about designing ***a curricula for multi-cultural learning groups***, that is, sensitive to variations in socio-cultural contexts, especially religious and ideological beliefs, which HCWs both come from and work within. This was clearly illustrated in the case of dental education which attracts large numbers of overseas students with a commitment to cultural values that are basically out of sympathy with the free style behaviours of people from the West.

The importance of the last point cannot go unnoticed for it is central to our thinking that the learning of HIV/AIDS has to be grounded in ideas that go beyond factual and technical knowledge, that is, the positivist and structured knowledge basis of role and client relationships, to a more open way of thought and action (flexible and situational) that is comfortable with facing one's own values and behaviours and is able to deal intelligently with controversial issues of sexual politics and morality; human hypocrisy and double standards; the marginalisation of some social groups by those with the power to do so; the grinding bureaucracy and economic rationalism of health and welfare services; and

many other matters of the politics of life that are rather unpleasant to confront and very difficult to obtain a sweet result. We are not sure if many tertiary education programs for HCWs approach knowledge and learning in such a "real world", context based way, although many making the delivery believe they are doing so. Our view is that such an approach provides substance to the ideas of the critical and reflective practitioner and to the leading notions of what constitutes confident and competent practice, by giving meaning to the skills of human communication and interpersonal relations in a complex and changing environment. That is why we emphasise the importance of a good grounding in the values and practices of HVE.

Another clear implication of this thinking is the ***staff training and development requirements*** for tertiary academics involved in programs for HCWs in HIV/AIDS. It was put to us several times that there was little purpose in persuading staff to teach and supervise in HIV/AIDS if they were not interested in and challenged by the subject, especially in the way we have addressed it. We acknowledge the very real power academics have to say no to knowledge and curricula outside their ken or motivation. Hence it only makes sense to introduce new curricula, complete with a staff development plan, focused on the keenly interested. We naturally share the view, of course, that curriculum and staff development are indivisible aspects of the change management process.

As for the organisation of the HIV/AIDS curricula into different levels, from initial and preparatory at the non-graduate and undergraduate stages through to postgraduate and continuing professional-vocational education (CPVE), our thinking was no more advanced than in the first report. The focus group discussion informants agreed that the initial stages were ideally suited for much of the curriculum ideas expressed in the first report, being focused on establishing confidence and competence in the basic knowledge of the medical science of HIV/AIDS and the human relations aspects and based as much as practicable on real life experiences as the means of active learning and reflection.

It would appear that maybe the real springboard for HIV/AIDS curriculum development lies outside the mainstreams of tertiary education with their "locked in" and other constraints to program provision, which is likely to be more open to possibilities in the sphere of CPVE. The developments in open learning and the fact that experienced HCWs practically involved in health care provision for people living with HIV/AIDS and needing to update their knowledge and skills on a recurrent basis are only likely to get part time study opportunities lends itself to

an adult continuing education approach. CPVE also lends itself to a fee-for-service and market based approach to HIV/AIDS knowledge as learning product if it is sensibly related to the interests and needs of HCWs. This approach suggests the value of a collaborative partnership with health care agencies and professional bodies representing HCWs, a process well understood by more customer and market focused tertiary institutions.

It is highly recommended that the key collaborators in these imagined curriculum developments must be the HIV/AIDS Programs Unit, which in the case of South Australia has been translated into a bureaucratic and co-ordination function rather than the original educational one. But they do have control of some "kick start" financial resources, and, probably more significantly, are networked throughout Australia to the wider resources of thought and action in the field. Equally important, at the time of writing, is the fact that the small staff in the HIV/AIDS Programs Unit are enthusiasts about innovative ideas and think like adult educators with a wide range of skills ideally suited to an advisory and occasional input role.

A COMPLEMENTARY VIEW OF THE ROLE OF THE HIV/AIDS PROGRAMS UNIT FROM THE INDEPENDENT NOTETAKER

The Health Commission's HIV/AIDS Programs Unit can play an important role in assisting with the implementation of HIV/AIDS education in existing health care curricula as well as future curriculum development. Apart from its seed-funding role, the unit is an excellent resource for ideas, information, and contacts to help establish HIV/AIDS education as well as in the expansion of human values education through workshop facilitation and negotiation to bring in consultants. In the case of the new Flinders University medicine curriculum, the unit can play an important role in assisting with the development of case studies. The unit could also work to develop an information and resource kit covering issues, background on HIV/AIDS, names and contacts, and ideas for ways for educators to engage empirically in different aspects of HIV/AIDS issues. This role in resource and curriculum development would help to cut through problems of information access and 'infoglut' as well as providing valuable insight into approaches to HIV/AIDS education.

The unit also has an important advocacy role to play in supporting HIV/AIDS curriculum and policy development across tertiary health care education systems. It can assist by formalising links between clinical and educational needs to help cut

through the bureaucratic 'red tape' that has the tendency to snarl curriculum change and to ensure that the appropriate people to engage in HIV/AIDS education in health care curricula do not get side-tracked because of different institutional or agency mandates or different perceptions of those mandates. The unit therefore has a pivotal role to play in endorsing, supporting, and promoting curriculum and policy development to incorporate HIV/AIDS education in tertiary health care curricula in South Australia.

CONCLUSION

The conclusion to this report comprises two parts, the first being the interpretations of the independent notetaker which so accord with the views of the other authors that additional commentary is not required. We have, though, finished the report on a second and very practical note by suggesting an immediate course of action to continue to develop the ideas of the two reports.

INTERPRETATIONS OF THE INDEPENDENT NOTETAKER REGARDING THE MAIN THEMES TO EMERGE FROM THE FOCUS GROUP DISCUSSIONS

- *HIV/AIDS is special in that it has galvanised the community like no other disease and it has been illustrated to affect the broadest cross-section of the community*. Health care must be able to meet this broad community need for servicing.

- There is a need perceived by health care educators for the development of HIV/AIDS education because all health care disciplines and workers are likely to face people living with HIV/AIDS and workers have to be equipped professionally to be able to care for people with HIV/AIDS safely and compassionately. This requires that more emphasis be placed in tertiary curricula on the sociology of the disease than perhaps currently occurs. There are also certain legal and ethical issues that warrant its having a high profile in tertiary education for health care workers. Thus the identification in the report of the need for a dual approach in health care curricula is both necessary and desirable.

- HIV/AIDS requires areas of education be covered that are similar to those covered in general health care education approaches across different disciplines: human values education, universal precautions, ethics and legalities, interpersonal skills, clinical management. The nature of the disease, however, requires a specialised emphasis within these areas, and in future, greater development of certain among them, chiefly, human values education, interpersonal skills, and ethics. AIDS is therefore best incorporated into existing curricula as an exemplar dealing with best practice, with some scope for extension via electives.

- The use of HIV/AIDS as an exemplar would continue to be the best-case scenario for future health care curricula rather than the establishment of a separate HIV/AIDS curricula, since there would be much overlap with general curricula within the different disciplines, and resources to teach HIV/AIDS as a separate curriculum would be limited. Rather, development could focus on the teaching approach and could incorporate more experiential learning, which is highlighted as being crucial for health care workers who care for people living with HIV/AIDS. Professional development for tertiary educators would also be essential in order that development occur in the key areas of curriculum identified. Systemic support is also recognised as important for health care educators and for workers undertaking further education in the area of HIV/AIDS as well as restructuring of awards to enable greater ongoing education of health care workers and formal recognition of further qualifications undertaken by health care workers to embrace HIV/AIDS professional development.

- The Health Commission HIV/AIDS Programs Unit can best assist by directing funding towards the 'seeding' of HIV/AIDS development in tertiary health care education as well as by lending the weight of its political support and high-profile position in order to ensure educational development occurs, as well as its expertise to assist with staff development, curriculum design, development of information and resources, and access to consultants.

The overall conclusions of the independent notetaker

The incorporation of HIV/AIDS in tertiary health care curricula in South Australia has important implications for the education of competent and confident health care practitioners because of the ability of the disease to illuminate and link the many components of health care work: clinical standards, universal precautions, communication skills, the knowing of oneself, awareness of the social context of behaviours, the medical science of different diseases, and the specialised knowledge of different disciplines.

The report, Knowing both, emphasised the importance of education about the human-affective side of health care work as well as the medical science. Feedback from discussions with various groups associated with health care education endorsed the need for increased education of HIV/AIDS in health care curricula

and the need identified in the report for increased emphasis on human values education and an experiential learning approach to HIV/AIDS.

It is recommended that HIV/AIDS be incorporated into existing curricula as an exemplar to illuminate best practice and the complexity of psycho-social issues associated with health care work. Use of external consultants and clinician–educator partnerships is also recommended both to breach gaps in the respective practitioners knowledge bases and to prevent overload. Staff development to address the personal issues associated with HIV/AIDS is essential in order that educators be able to facilitate experiential learning for students.

Future curriculum development needs to focus on restructuring curriculum design and policy development in order that good work already achieved in the area of HIV/AIDS education in health care curricula is supported and expertise gradually extended. Ideally, curriculum design should focus on developing health care curricula to emphasise the duality of health care work as both human-affective and clinical practice of an intimate nature. A change in focus in health care curricula is necessary that helps people make connections in their minds and actions with both the subject matter and their practice. This shift needs to be understood as a value-adding process, a reinterpretation of health care work with implications for the role of health care education, rather than rejection of current practice and education.

THE VIEWS OF THE PRINCIPAL AUTHORS

The need for a third stage to the project

We have chosen to write the second report in a wide ranging and provoking way, but at the same time have always kept a clear head about the need for at least one practical recommendation, which the HIV/AIDS Programs Unit might be able to act upon and show the way forward to tertiary staff. To that purpose our most important immediate recommendation is to identify and examine the existing published learning resources available through such official bodies as the HIV/AIDS Programs Unit in South Australia, and comparable government and non-government agencies elsewhere in Australia and further afield

The practical purpose of the exercise would be to match the thinking of our two reports to the body of learning resource material that has already been developed, but not, to our knowledge, widely known and used for HCWs in tertiary

education and training programs on HIV/AIDS. We believe that a rich source of learning material already exists and some adaptation to the specific requirements of tertiary education can quite easily be effected with minimum cost and time. Naturally, for the purposes of open and distance learning, more adaptation time will be required, similarly for focusing such materials for specific health care disciplines. Our recommendation is mostly concerned with the development of curriculum for general purposes, that is, as basic foundations of theory and practice across the HCW disciplines, recognising that each would have specialised learning needs related to the particularities of the work they do in HIV/AIDS.

Executive Summary of the *Knowing Both* report

Tertiary Education Needs Assessment for Health Care Workers involved in HIV/AIDS Services Provision

In a short paper all that can be reasonably expected is a summary account of the highlights of the study and a brief description of the research design and method that shaped the findings. This is done under a number of headings below.

The purpose and scope of the research project

The purpose of the project was to present to the SA Health Commission (AIDS Programs/Education Unit) the views and experiences of various groupings–

- *health care professional workers in HIV/AIDS provision*
- *some HIV positive people and others in the affected community*
- *health and welfare service providers, policy and advocacy groups*
- *and other commentators able to represent complementary interests and perspective's on the subject matter of HIV/AIDS*

Regarding their thinking about what health care workers need to learn, through tertiary level education and training programs, to acquire the knowledge and skills for confident and competent working in the HIV/AIDS field.

From its inception the focus of the study was firmly on the experiences and views of health care practitioners working with people living with HIV/AIDS. This primary interpretive material was the data base for thinking about the tertiary level continuing education curriculum development implications, as seen by teaching/learning facilitators responsible for the design and content of programs.

Background paper from the HIV/AIDS Programs Unit

The importance of a background paper from the HIV/AIDS Programs Unit of the SA Health Commission should be noted in shaping the purpose and scope of the research project. In sum, the paper described the background to the research project and its funding, largely based on the perceptions of the authors about the need for an independent study arising from their innovative work as educators, taking knowledge of HIV/AIDS to a wide range of people. The paper quite astutely identifies the barely hidden personal agendas of learning about HIV/AIDS, which like no other disease of the late twentieth century, confronts people with the disturbing, and often fearful, related deep issues of the complexities of human sexuality;

social and psychological deviance; moral judgements and discrimination; and slow death.

The paper argued for the need to continue to equip health care workers with education and training provision that both constructs a learning environment that accurately transmits the basic knowledge of HIV/AIDS as a viral disease but more significantly addresses and facilitates the exploration of these meaning of life type issues so that health care workers (and others) are able to relate to and help the HIV positive person in a constructive manner, without the baffles of their own fears and prejudices getting between their role responsibilities as an empowering carer. The paper points out that the SA tertiary education institutions were mostly left to their own devices in dealing with this deeper knowledge material in their HIV/AIDS program provision for health care workers and that not much is known about the nature of their thinking regarding these curriculum matters.

Two key features of the research design

Before presenting the key findings, drawn from a series of focus group discussions, it is necessary to describe the ways in which the research was designed, that is, from the identification of the sample of respondents for the focus group discussions, to the ways in which the search for data was framed and the results summarised. Before outlining these matters it should be noted, especially by the positivist and empiricist inclined readers, that the research approach was decidedly **interpretive** and **existential** in spirit and form, as this was clearly the most appropriate given the nature of the task and the timeline within a restricted budget.

Identifying the sample

Advice was principally taken from the advisory/steering group members as to who they considered best represented the local field of knowledge, bringing together professional workers across the more applied and involved health care disciplines in the practice and provision of HIV/AIDS care in SA, and the various other people and community interests. This consultative process inevitably and rightly took time and sometimes occurred during the data gathering, as it became clearer who had something of particular practical value to add to an understanding of views and experiences from the field. The type and number of consultations representing the actual sample are shown in ***figure 1***.

The Focus Group Discussions

These were, as the name suggests, closer to an open ended discussion than a formal interview, especially as there was no schedule to follow with set questions but rather a format within which respondents were asked to express their views and experiences about HIV/AIDS in general and what they considered HCWs needed to know and be able to do as a practical task for confident and competent work performance (see ***figure 2***). It was understood, and made plain at the beginning of every meeting, that we were

interested in their views and experiences of working with HIV/AIDS and what they thought on the basis of those insights should comprise the agenda material for subsequent discussions about curriculum development for HCWs in tertiary education institutions.

The second major phase of the fieldwork involved focus group meetings with two other sets of people, as shown in ***figure 1***. For these meetings we used a simpler format focused on questions dealing with their perceptions and experiences of the health care services and professional workers at the delivery end of HIV/AIDS provision. We regarded this data as important supplementary material to that obtained from the professional practitioners, throwing light on the personal aspects of provision and care, which we considered as valuable anecdotal as well as concrete data on the psycho-social domain of HIV/AIDS.

The key findings

The thematic concerns for HIV/AIDS tertiary education identified by the professional workers and other respondents, as important knowledge for confident and competent practice by health care workers, is summarised below-

The Affective Domain
- Human Values Education

The General Knowledge Domain
- Universal Precautions
- Clinical Management
- Knowledge and Use of HIV/AIDS Services and Supports
- Continuing Professional Education of HIV/AIDS Workers
- The Legal and Ethical Background of HIV/AIDS

The Specialised Skill Domain
- Interpersonal and Communication Skills
- Skills in Teaching and the Facilitation of Learning
- Specific Discipline Skills

Main conclusions

Based on the summary above we regard the following leading ideas as broad matters of consensus for an imaginary common core curriculum for all kinds of HCWs involved in HIV/AIDS work with a strong orientation to "hands on" care in a client/patient setting.

Experiential learning: One of the most often stressed was the need to learn about HIV/AIDS on the basis of practical and first hand experience through involvement with patient/client care, to extend and make more real the lessons of the textbook and the lecturing of the experts, as it were, and to form the basis of problem centred learning. This view was not intended to diminish the importance of formally acquired learning but to complement it in tertiary education. It was acknowledged that as the actual numbers of identified HIV/AIDS people is quite small in SA one of

the problems for the education and training of health care workers is getting enough practical experience to learn from cases.

Understanding personal responses to direct involvement in HIV/AIDS work: so that personal attitudes about the sexual and social behaviour of others does not become discriminatory and get between the provision of equal quality care and services to patients/clients and their close others.

This perspective is the foundation stone of an holistic approach, and specifically, Human Values Education (HVE) in HIV/AIDS education and should be the basis of all kinds of health care work (both individual and team based) irrespective of the specialised knowledge and skills of particular disciplines. It was expressed to us several times that the problem of relating to HIV/AIDS patients/clients in an open, non-judgemental and non-discriminatory manner was still a major concern, some years after the high levels of fear and ignorance among HCWs, other workers and the general public had peaked.

Essentially HVE in this context is seen to be about helping the HCW at any stage of their professional development confront and better understand their own reactions to people whose health condition and background of psycho-social behaviour disturbs one's personal sense of the normative and value order underpinning human life. There are many disturbing and confronting situations in the world of health care but HIV/AIDS has been prominent in recent years as the issue to challenge ideas of professionalism and personal integrity in relation to those in need who may spark off deep fears and feelings of rejection, just like the plague did hundreds of years ago, in less informed times. In a much wider sense HVE is about the process of transcending ignorance and developing a world view.

Consulting and collaborating with HIV positive people as sources of "inside knowledge" and everyday experience of living with the virus. This point is not universally shared or understood as a practical action but there seems to be some agreement that in the learning and teaching process, at least, there is value to be added from such an approach in the tertiary education and training of HCWs. Such an approach should be regarded as complementary to their experiential learning and generally as a practical means of fostering human values education.

Focusing on the person and the disease as an integrated approach to the management of treatment and care. Expressed in the most basic way, and as an illustration of what is meant, the dentist, in the early and preventive maintenance of the oral health of the HIV positive person, needs to know the person through the mouth, as it were, and not only focus on dental treatment. This means the best of the dental chair and care approach, that is, time naturally and comfortably spent talking to the person sitting in it about whatever comes to mind and exercising universal precautions with tact and awareness. The same goes for every other kind of HCW, relating to the person, as a fully fledged human being, not as the carrier of a viral and deadly disease and nothing but.

Implicit in this picture, but worthwhile highlighting as an active and unifying principle for the education and training of HCWs and their

professional practice, is the **commitment to quality care**. As an abstract idea it has appeal, for who could resist its value? It also translates into a set of criteria or benchmarks as the basis of an understanding of best practice, dangerously so if the spirit of quality care gets reduced to a set of rigid and aridly deterministic competency standards, which are a long way from the fostering of human ordinariness we mean by working towards positive relations with HIV/AIDS people. Hence the operational aspect of quality care needs to be approached with sensibility and sensitivity to fit around the human value world that seems to be desired by HCWs.

Related to the ideas expressed above is the value of approaching HIV/AIDS work on a **team basis**, extending outwards to a **network of others** with knowledge and resources to share and exchange. This process is clearly under way but needs to be constantly supported and activated.

Concluding remark

These background ideas appear to be acceptable key elements of a curriculum for HCWs involved in HIV/AIDS work and in that way they provide the building blocks for any change and development process that might ensue, after due consultation which is essentially the purpose of stage two of the project.

Tertiary Knowledge and Skills Disciplines Identified in Needs Assessment

Medicine	Dentistry	Nursing	Allied Health Services	Social Work	Counselling

Specific Focus on HIV/AIDS Education for the following Health Care Workers:

• General Practitioners • Doctors in Gynaecology and Obstetrics • Doctors in Palliative Care • Specialised Doctors in STD	• Dentists	• General Nurses (Hospital and Home/ Community based) * Specialised Nurses in Infectious Diseases and Midwifery	• Radiographers and Physiotherapists	• Social Work/Counsellors

Focused Group Discussions with Health Care Workers in HIV/AIDS Service provision and Field Based Practice

• General Practitioners • Doctors in Gynaecology and Obstetrics • Doctors in Palliative Care • Specialised Doctors in STD	• Dentists	• General Nurses (Hospital and Home/ Community based) * Specialised Nurses in Infectious Diseases and Midwifery	• Radiographers and Physiotherapists	• Social Work/Counsellors

Focused Group Discussions with HIV/AIDS Affected Community Groups

Sex industry workers

Gay and Lesbian Rights

People living with HIV/AIDS

Injecting drug users

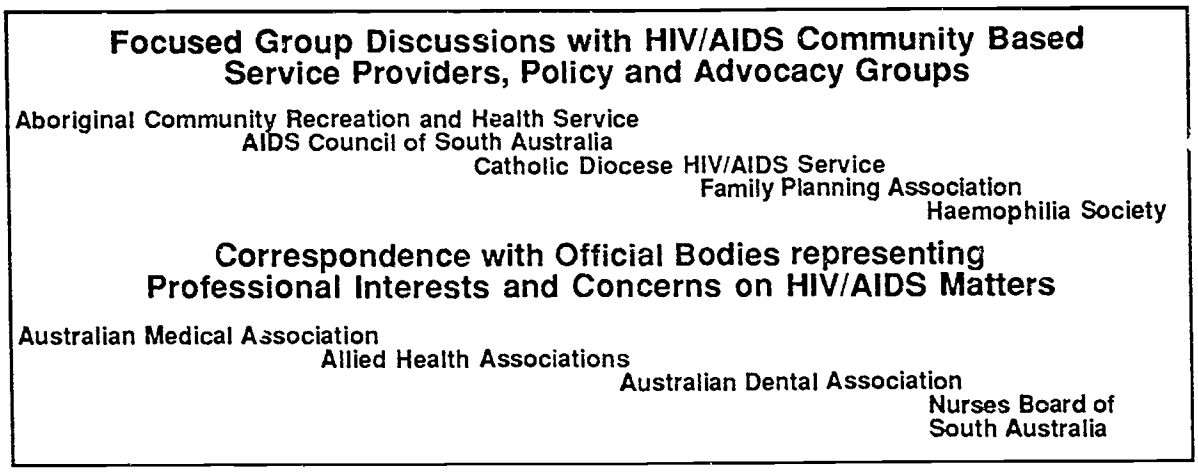

Figure 1: Framework for Focused Group Discussions: South Australia Tertiary Education Needs Assessment for Health Care Workers in HIV/AIDS Service Provision and Practice

Memorandum to key contact people in health care discipline areas

With regard to the content and proposed process of the focus group discussion with yourself and other colleagues the following notes are intended to provide a guide to the key questions and the structure of the activity, which is based on an hour and a half timetable.

Our purpose is to tap into your thinking and experience based knowledge, to represent the view of your discipline as to what tertiary education providers ought to take into account in the design and development of curriculum in preparing workers to perform their duties both confidently and competently in the HIV/AIDS field.

The first part of the focus group discussion deals with your thinking in a general overview way on three related topic areas-

- **THE AFFECTIVE DOMAIN**, that is, the ways you think HIV/AIDS education programs provided by tertiary education institutions for health care workers in the discipline area should set about socialising them (through education, training and professional development) to deal with the highly personal nature of HIV/AIDS work involving the feelings, emotions, self concept and identity of clients and others closely involved.
- **THE GENERAL KNOWLEDGE DOMAIN**, that is, that of a "must/need to know" kind relevant to the discipline for confident and competent work in HIV/AIDS which you might reasonably expect tertiary education programs to cover.
- **THE SPECIALISED SKILLS DOMAIN**, that is, those very specific discipline related skills involved in HIV/AIDS work with clients, partners, families and others which you might reasonably expect tertiary education programs to cover.

The second part of the focus group discussion is intended to get you thinking much more specifically about these three areas of curriculum design and development by asking you to focus attention on the following types of learners and levels of tertiary education programs-

- Health care workers in the discipline **new** to HIV/AIDS work
  - (1) Neophytes
  - (2) Experienced workers learning about HIV/AIDS for **the first time**
- Health care workers in the discipline with experience of HIV/AIDS work who are seeking some **updating** of their knowledge and skills.
- Learners about HIV/AIDS undertaking education programs at the **undergraduate level**
- Learners about HIV/AIDS undertaking education programs at the **postgraduate level**
- Learners about HIV/AIDS undertaking **"in-house" and in-service** education programs at any level
- Learners about HIV/AIDS undertaking **pre-service and/or non-graduate award education programs** (if this is applicable to the discipline area)

Figure 2: Tertiary Education Institutions Curriculum Needs Assessment: HIV/AIDS Health Care Workers

Participants at the focused group discussions with tertiary staff and some HCWs who contributed to the first stage of the project

Nurses from the University of South Australia, Flinders University of South Australia and the Royal Adelaide Hospital

Dentists from the University of Adelaide and the Dental Hospital

Doctors: from the University of Adelaide, the Royal Adelaide Hospital and Flinders Medical Centre

Physiotherapists: from the Royal Adelaide Hospital and the University of South Australia

Radiography: from the Royal Adelaide Hospital

Counselling/Social Work/Community Services: from the AIDS Council of South Australia, Flinders University and TAFE (now Institutes of Vocational Education) Community Services Programs

INVITATION

Focused Discussion of HIV/AIDS Report

Knowing Both: towards integrating two main approaches to the tertiary education of health care workers involved in caring for people living with HIV/AIDS - a needs assessment of HIV/AIDS Tertiary Education in SA.

The above report, which was commissioned by the AIDS Programs Unit of the SA Health Commission, is enclosed with this letter. The purpose in writing is to invite you, as one of the important contributors to the research to assist us complete the second stage of the action learning project. The second stage is focused on discussing the findings and leadings ideas of the report with tertiary education staff who have program and teaching responsibilities for HIV/AIDS education and training courses for health care workers in South Australia.

Our dual concerns are, first, with the ***plausibility*** of our ideas, as the basis of a common core curriculum (both generally for all kinds of health care workers and for specific disciplines and professions)), and, second, the ***practicalities*** of managing the implementation process, into what is probably a crowded curricula with competing demands and scarce resources.

The purpose of the meeting is to discuss these matters on the basis of pooling our views and experiences with those best placed to respond to them. That is why we have invited you as one of the people who helped shape the thinking and the findings of the report, along with nominated tertiary education workers interested or directly involved in HIV/AIDS curriculum, and the two co-investigators who did the research and wrote the report The total number in the group will not exceed ten and is likely to be less.