CHAPTER 13

LEARNING TOGETHER: TEACHERS AND COMMUNITY HEALTHCARE WORKERS DRAW EACH OTHER

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INTRODUCTION

Vulindlela is a rural district in the lower foothills of the Southern Drakensberg, a district in South Africa ravaged by the HIV&AIDS pandemic. In one area of the district, a vibrant clinic addresses the health issues of the surrounding community as best it can. Adjacent to the clinic is the ever-expanding Centre for the AIDS Programme of Research in South Africa (CAPRISA). The Centre is committed to finding a medical solution to the pandemic, especially for the benefit of this particular community. The many schools in the area are an indication of the large number of young people living in the community, all eager to learn and to make progress in life. However, these same young people are also the most affected by the pandemic. Worldwide, young people between the ages of 15 and 24 account for 40% of all new infections, with young women between the ages of 15 and 19 being the most vulnerable (UNAIDS, 2008). In 2007 in South Africa, 13% of females and 4% of males in the 15–24 age range were living with HIV (UNICEF, 2009). In the context of Vulindlela, the young people reflect these same statistics. In a sense, the clinic, with its community healthcare workers, and the neighbouring schools, with their educators, have a shared vested interest in keeping these young people alive and healthy. In this chapter, we focus on an 'entry point' intervention in which we asked community healthcare workers and teachers to draw pictures of each other. In order to contextualise the relationship between AIDS and young people, we provide a lengthy background to the very complex issue. We focus on how the use of drawings, as a participatory visual method, served to evoke discussion and, at the same time, offered a window into key issues to be addressed in multi-sectoral work. The chapter ends with a consideration of some critical concerns about using drawings as a research method in working with adults.

KEEPING YOUNG PEOPLE ALIVE IN THE AGE OF AIDS

Given the magnitude and complexity of issues of youth and sexuality in South Africa in the age of AIDS, no single intervention or sector can address all of the central factors such as poverty and the high rates of gender-based violence. Moreover, although several sectors might be focusing on the same target population, they might not actually be working in tandem; indeed, they might even

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be working at cross purposes (De Lange et al., 2003). If communities are to play an effective role in AIDS prevention and care among youth, they need to consider ways of integrating the efforts of those working in various sectors: health, safety/security, community development, education, etc. However, although an integrated multi-sectoral approach to HIV&AIDS intervention may be key, community, school, and healthcare workers often lack a space in which to explore tactics and strategies and to share lessons learned. Hence, despite greater recognition by healthcare and community workers of the importance of schools in addressing the health of young people, attempts to date to deliver integrated sexual and reproductive health education in schools have often been hampered by the divisions that exist in the public service, such as the separation of Education, Health, and Social Services departments. A good example of this (and indeed the inspiration for our work in the first place) could be seen in a three-day conference in 2003 at what was then the University of Natal. The conference was on school-based approaches to healthcare and included primarily policy makers and practitioners from health and social services. However, almost no one involved in education attended, even though schools were being targeted as the entry point for service delivery. Oddly enough, cutting through the various bureaucratic layers to ensure that nurses were available to visit schools seemed to be viewed as the most important outcome. Instead, they should have realised that having all the support services available, such as well-trained healthcare professionals, age-appropriate materials, and transportation is only the beginning! The context of the school site, the particularities of the community, and classroom interactions are often overlooked as important features of program delivery. However, it is well established in fields such as pedagogy and curriculum development that these features are at the very heart of the teaching–learning process.

There is a possibility that both healthcare workers and educators run the risk of being demonised because of their work with young people. On the healthcare side, access to counselling and care through public health clinics is often very uneven for girls and young women in rural areas (Delius & Walker, 2002; Kelly & Parker, 2000). Equally problematic, however, are the attitudes and gendered assumptions by healthcare workers about young women seeking information related to safer sex practices. As Wood, Maforah, and Jewkes (1998) pointed out, attitudes of community healthcare workers often reinforce harmful stereotypes, and young women may even be made to feel ashamed of their requests for information. Although there is an emerging body of literature about youth-friendly clinics (Mitchell, 2004), these recommendations are still to be put into practice in most rural districts in KwaZulu-Natal. In addition, it is important to note that some of the more successful youth-friendly clinics outside South Africa (as in the case of Mozambique) are attached to schools (Mitchell, 2004). A study by Senderowitz (1999) confirmed the negative experiences of young people who seek HIV testing, pregnancy testing, and information on safer sex practices. Ninety-five percent of the respondents stated that the attitude of healthcare staff was the reason for their avoiding local clinics. Another study, by Vetten and Bhana (2001), suggested that the response of staff in rape crisis centres is particularly problematic since staff

members often lack basic training, especially regarding the link between HIV and AIDS and gender-based violence. This is supported by Wood et al. (1998), who noted that health practitioners often feel inadequately equipped to converse with young people.

The importance of the school as a site for integrating services is of prime concern because it is both part of the solution and often a central part of the problem. Schools can serve as key points for delivery of services since they are community-based in terms of governance, and even 'out-of-school youth' are defined in terms of school units. However, schools are a particularly vulnerable site for affecting change in relation to HIV and AIDS. A study of the devastating effects of AIDS on the teaching population in KwaZulu-Natal clearly illustrates this point (Kahn, 2005; UNAIDS, 2006). It could be argued that teachers might not be in the best position to speak with young people about HIV and AIDS. Not only are teachers also vulnerable, but learners regard them as lacking both personal credibility and 'street cred' when it comes to discussing issues of sexuality. Indeed, as noted in a study by ActionAid regarding the challenges faced by schools in Tanzania and Kenya in implementing HIV prevention programs (Boler, Adoss, Ibrahim, & Shaw, 2003), the teachers felt that not only did they lack expertise in HIV&AIDS issues, education, and so on but that they often felt that they lacked the support of the parents to deal explicitly with issues of sexuality in the classroom. Furthermore, the teachers simply did not have the time to consider HIV&AIDS education because of their involvement in various curricular activities; they struggled to fit it into the content that they were obliged to cover. In some schools reported in the ActionAid study, teachers did not even participate in sexuality lessons provided by Community Based Organisations (CBOs) because it was thought that their presence could inhibit student participation. In other studies, teachers are the very predators who are responsible for putting young women at risk in the first place (De Lange, 2008; Human Rights Watch, 2001). Notwithstanding the crisis of AIDS, schools in many districts are still often barely functional when it comes to offering even basic education services such as providing textbooks and ensuring school attendance.

If schools have not necessarily played a key role to date in combating the AIDS crisis, they remain, as noted above, at the nexus of service delivery and also bring to the table a particular knowledge base in relation to youth, gender, and pedagogy. Indeed, even if the implementation of a learner-centred pedagogy still remains only a goal of the new curriculum and not an actuality, it should nevertheless be pursued. At the same time, and as is well-established in the research literature, AIDS is a result of a multiplicity of social, economic, pedagogical, and medical factors that extend beyond the knowledge base of any one professional group. Public nurses, for example, may have a more sophisticated medical knowledge about AIDS than teachers, even if teachers have a much better understanding of what pedagogy to use in discussing the pandemic and what is age-appropriate for the classroom. Those working in communication, particularly in relation to health promotion, are likely to understand the complexity of issues at play in trying to get the message across. Community and social welfare workers are likely to have a

much more sophisticated understanding of the links between and among such factors as poverty and human security. Even from the perspective of the school itself, AIDS is not just a curricular area (for example, Life Skills) but also a management issue, one of human rights and protection and so on. It cannot be addressed easily through fragmentary one-off and disparate information sessions conducted by groups outside the school setting.

PICTURING EACH OTHER THROUGH DRAWINGS

Clearly, teachers and healthcare workers in rural settings need to understand each other. We, as researchers, were interested in how participatory methodologies could be used to bring together the various sectors and partners working in the area of gender, youth, and HIV prevention and care in one community. We wondered how we might first enable the community healthcare workers and the teachers to begin to understand each other's work and then to collaborate in addressing HIV and AIDS. In this context, we turned to art or, more specifically, drawings as an entry point for exploring professional identity. As a number of researchers have noted, drawing, although often associated with work with children, can be a very effective research tool with adults, particularly when it is framed within discussion and not in a competitive mode (Combrinck & Van Wyk, in press; D'Amant, 2009; Weber & Mitchell, 1995, 1996). Teachers from three senior secondary schools and community healthcare workers from the nearby clinic were invited to participate in the Learning Together project.[i] A group of 18 teachers and 18 community healthcare workers volunteered. They were all isiZulu-speaking. Half were male and half were female. Very simply, we asked the participants to draw how they saw each other (i.e., how the teachers 'saw' the community healthcare workers and how the community healthcare workers 'saw' the teachers).

It was arranged for the participants to meet at the local district clinic one afternoon after working hours. Once the participants were introduced to each other and told the purpose of the project, we engaged them in the 'entry point' drawing activity. They were given 15 minutes to work with the prompts: 'Teachers, draw how you see the community healthcare workers' and 'Community healthcare workers, draw how you see the teachers' Each participant was given an A4 sheet of white paper as well as a stick of charcoal. No further instructions were provided. Once their drawings were completed, the participants were invited to share their drawings with all the participants, if they so wished. In a follow-up discussion, later in the session, participants were divided into smaller groups composed of both teachers and healthcare workers. They shared more thoughts on their drawings and went on to compile questions they wanted to ask each other. Having obtained the participants' consent, the drawings were retained for analysis. The entire session was recorded on video.

To analyse the participants' perceptions of each other and the way drawings facilitate the emergence of these perceptions, we made use of the 'products', or material drawings, and, where possible, the associated sharing 'process' as captured on video. The process of analysing drawings always raises the issue of

bias. At the first level of analysis, the participants' own interpretations were prioritised, voiced, and presented, with the participants sharing 'how we see each other' and formulating questions towards deeper understanding.

Now, several years after the event, we turn once again as researchers to the evidence in order to consider what the data reveals and to identify some critical issues in the methodology itself. Our analysis here draws first on the artists' own interpretations of their drawings and then on our reading of the drawings. Fortunately, most of the drawings have some text or captions anchoring potential interpretation and revealing the participants' points of view. Not all participants were captured on video presenting their drawings, yet where a participant's point of view was not clear to us in the drawing, we went back to the video recording to check against the participants' presentations and explanations of their drawings.

Altogether, we worked with 36 drawings by the participants and also with the video footage of the two-hour session. We began by scrutinising the visual and verbal content of the set of drawings, using a process of close reading (see, for example, Moletsane and Mitchell, 2007, on working with a single photograph) and a system of open coding to identify units of meaning and categories (Tesch, as cited in Creswell, 1994). In so doing, we began to identify emerging themes in the two sets of images.

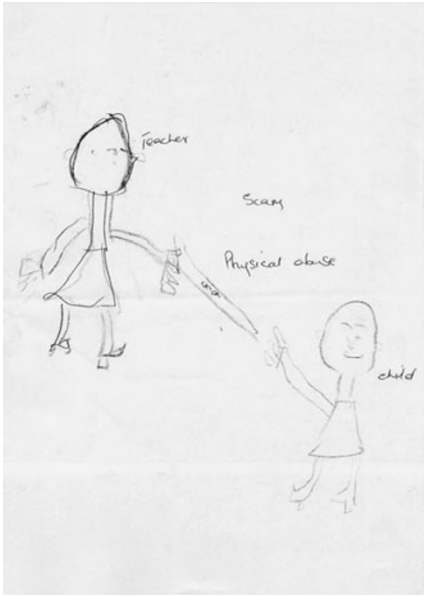
EMERGING PERCEPTIONS

Starting with the images of the teachers produced by the healthcare workers, we saw positive depictions and less than positive depictions. On the positive side, the healthcare workers identified such points as "teaching for a better life", "bringing light", "respect[ing] each other", "good speaking", "expanding knowledge", "prevention through condom use" and "safe sex" in addressing HIV and AIDS. They also spoke about "caring and supportive" teachers acting as parents and sympathising with children. On the negative side, they noted that teachers "abuse children" with the stick, and sexually. Interestingly, they also noted that teachers drive nice cars.

Teachers depicted community healthcare workers in a variety of mostly positive ways. For example, the teachers said that "money is not the motivating factor". They also said that the healthcare workers' "heart is in the people they work with". They said that the healthcare workers are "dedicated", "supportive", "sympathetic, accepting, loving", and "hard working from early till late". However, they also stated that they can be "impatient, angry, and ill-treating". They identified the "caregiver role" and "drawing on skills and knowledge from books and experience" as well as the use of "injections, tablets, medication, bandages, first aid box", "nutrition", and that "gloves are their priority". Finally, the teachers' images of healthcare workers spoke of "giving hope" and made reference to the fact that they too need "love and protection from the community".

The themes just referred to are useful as indicators that show how both groups were viewed from a variety of perspectives with both positive and negative elements emerging for sharing and discussion. For closer scrutiny of how drawings

can represent perceptions, we consider two drawings of teachers in which the image of a stick is central.



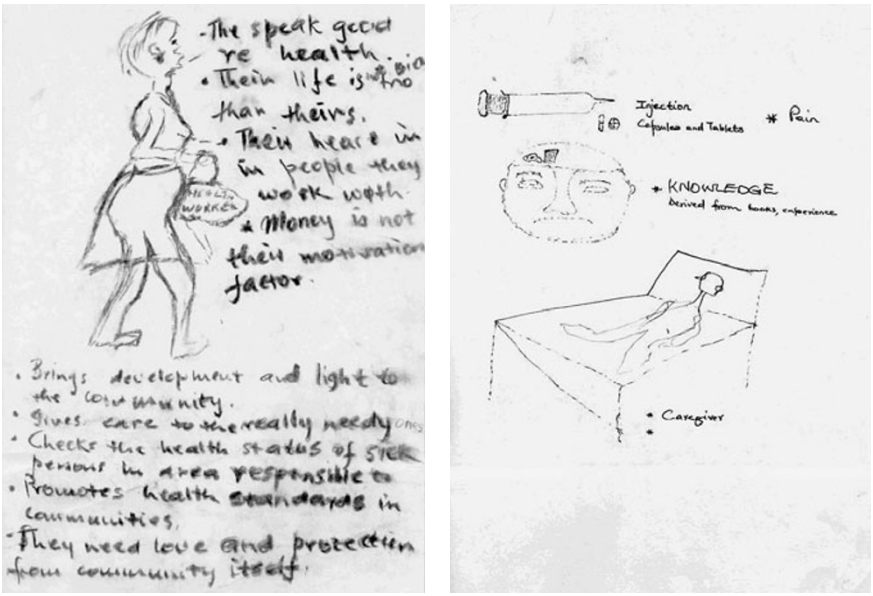
Figures 13.1 and 13.2. Community healthcare workers' drawings depicting teachers.

Figure 13.1 is a drawing of a male teacher by a healthcare worker. It is significant that the teacher is centred in the middle of the page since this placement displays the power he has in the classroom. The healthcare worker who drew the picture confirmed that this was indeed a central focus of the drawing and emphasised two aspects of the picture: the stick and the teacher's words. The teacher is raising a stick to point to alphabetical lettering on a chalk board. A speech bubble shows his didactic delivery, which has him commanding the learners to "Say it. These are small letters." The absence of hands on this teacher is intriguing and may possibly be interpreted as significant. However, nothing was mentioned in this regard.

In Figure 13.2, a stick appears again in the hands of a teacher and is prominent because of its central placement. However, in this case, its usage is more sinister because it is pointing directly at a child, and the words 'scary' and 'physical abuse' clarify the situation. The healthcare worker's presentation of this drawing made clear that it was the teacher's physically abusive nature that was being emphasised. Interestingly, the emphasis is on corporal punishment rather than on the teacher's delivery of knowledge. Also, the teacher is given large hands but no mouth, and the child is depicted with only one arm to ward off the 'scary' stick and 'physical abuse'. Unfortunately, without a further opportunity for elaboration from the

healthcare worker, we can only guess if this was done consciously or not. However, for us as researchers it intensifies the impression of unequal power relations between child and teacher. During this study, it emerged that the healthcare workers felt that the teachers were better equipped to lead a discussion group than they were. Hence, it is noteworthy that in these drawings they depict teachers with a different and not necessarily admirable style of leadership. Their drawings bring a contentious subject, such as abuse, to the table.

Although the recurrence of themes across drawings was not examined, teachers were less inclined than healthcare workers to represent their subjects in a negative role. In fact, only one teacher's drawing depicted a healthcare worker negatively. It showed her being impatient, angry, and treating patients unkindly. The teacher depicted this worker with an unhappy face. Yet, even in this drawing the representation is balanced with a 'happy face' image and the words "love—listens, accepts and care[s]". Figures 13.3 and 13.4 are typically representative of the teachers' perceptions of healthcare workers.



Figures 13.3 and 13.4. Teachers' drawings depicting community healthcare workers.

In Figure 13.3, we are presented with the side view of a female healthcare worker apparently in motion as indicated by the positioning of her feet, the forward thrust of her upper body, the way she holds the 'health worker' bag in front of her body with arm bent at a right angle to the ground, and the way in which her face is lifted and a prominent eye shows that her gaze is focused outside of the frame. The female figure is barefoot and her clothes are functional rather than decorative.

Overall, then, this figure signifies to us someone who is on a mission and who is unconscious of herself. On video, the artist/teacher presenting this drawing said that he had tried to list next to the figure all the things that a healthcare worker does, and this list seems to reinforce the reading of the figure as being in action beyond herself rather than being in any way self-interested. He portrays the perception of healthcare workers as people (specifically a woman, in this case) whose "heart is in the people they work with", for whom "money is not their motivation", who "speak good re health", who "bring development and light to the community", who "give care to the really needy", who "check the health status of sick persons in area", and who "promote health standards in communities". Because such people are obviously busy, it is unsurprising that the figure is in action, but the last bullet point below the drawing indicates the teacher's perception of the vulnerability of this community role player: "They need love and protection from community itself." This is an observation from the perspective of the teacher that our recorded data does not explain.

In Figure 13.4, the active nature of healthcare workers is also represented but this time purely through images associated with three roles: the pain reliever (depicted through the syringe and pills), a carrier of knowledge that has been gained partly through experience (conveyed by the serious-looking head), and a caregiver (signified by the bedbound figure). Although teachers' drawings predominantly showed dedicated healthcare workers in an active and positive light, the teachers' questions in the mixed groups showed that they also had other perceptions since they began to challenge possible stigma and shortcomings associated with their methods. One of the teachers observed:

> The acceptance of HIV/AIDS is not common to everybody, we are not sure about the acceptance of this thing ok—confidentiality. Some of the health workers, maybe they expose, you come to them and they just expose—I mean whispering with somebody or backbiting that somebody has got AIDS yet you don't know you are talking confidentially, yet people are pointing fingers at you that this person has got AIDS.

Healthcare workers' questions generally sought answers from teachers in relation to learner needs. One of the healthcare workers commented:

> Why do teacher refuse to use health worker if you want to talk the youth at the school? Do teacher have time to teach children about HIV&AIDS? If there is a student being abused by a teacher do he get help from other teacher? How do you take a situation like that?

As can be seen, various interesting (and contentious) issues emerged through participants' drawings and questions, and these allowed them and us insight into their understanding of each other. Using their drawings and discussions about their perceptions of each other, we were in a better position to develop a 'research as intervention' strategy in this rural community (see Mitchell, De Lange, Moletsane, Stuart, & Buthelezi, 2005).

SOME CRITICAL ISSUES IN THE DRAWING PROCESS

What Are the Power Dynamics and the Power of Play?

When we are engaging in participatory research with a social change focus in a community, it is necessary for us to be aware of possible power dynamics, not only between researchers and participants but also among the participants themselves. In this research, the participants were community healthcare workers and teachers. The community healthcare workers were ordinary village people who had been recruited to be trained in basic healthcare service delivery, in particular to address HIV and AIDS in their rural community. Most had only a Grade 12 qualification. The teachers recruited into this group were all senior secondary school teachers. Some lived in the community but most commuted from the nearby city, and some had university training. We were therefore sensitive in our attempts to create a space in which the participants could learn about, and from, each other, and we envisaged that using drawing could be a 'playful' tool to create this space. Ultimately, drawing led to photovoice work, and both activities were done in a very low-key and playful way: This supported a climate of collaboration.

Who Gets to Speak and Write?

One of the related challenges in the drawing activity, which also involved writing captions and later engaging in brainstorming activities on flip-chart paper, came out of small group work involving mixed groups of teachers and community healthcare workers. Community healthcare workers often deferred to the teachers when it came to writing on the flip-charts or reporting back to the whole group. "You are the teachers", they said. In fact, the drawing activity had very little to do with level of education or writing ability, but the deference displayed was a reminder that as researchers we need to take notice of perceived differences among the participants.

Who Has Access to Resources and What Are They Doing with These Resources?

As noted above in the analysis of the drawings, the drawing activity that started out in a somewhat uncritical, admiring way with each group recognising the strengths of the other, also created a space for a more honest appraisal by each group. The teachers, for example, who come to work in taxis every day, noted that the community healthcare workers have access to clinic vehicles to travel around the rural area to visit their patients. The community healthcare workers, most of whom would not be able to afford a vehicle, commented that teachers often have nice cars. Their perceptions of each other were often not quite accurate, but what they signalled was a deeper mistrust. Yet, it was not just the material differences they noted. Community healthcare workers noted that teachers are often not doing their job when it comes to educating children about sexuality and, further, that they may be guilty of sexually abusing children.

What Are the Dynamics of Interpretation Using the Drawing, the Caption, and the Artist's Explanation?

One of the advantages of having recorded the whole process on video is that we were able to go back over the session and bring back, in a sense, the moment. In addition, we were also able to see if there were aspects of the process that we had perhaps overlooked at the time. A review of the video-taped proceedings in which the healthcare workers shared the drawings of the stick-wielding teachers (see Figures 13.1 and 13.2) shows that although there was much laughter, there was also almost a sense of daring on the part of the healthcare workers in depicting their perceptions. In replaying the video, we also observed how a male teacher led every mixed group feedback session while a female healthcare worker stood quietly by, often, it appeared to us, exhibiting body language associated with unease and discomfort. It is quite surprising that through the drawings, the healthcare workers were able to expose some challenging issues. At the risk of over interpreting the interpretive process of teachers and healthcare workers working together, we acknowledge that the video footage offers additional data that is not that apparent in what was drawn or said.

Whose Interpretation? Engaging Participants Themselves in the Interpretive Process

One of the limitations of our work with this particular set of drawings in the data production stage was that the participants worked primarily with their own individual drawings or the drawings in their small mixed groups. What would have happened if we had set up an exhibition of all 36 drawings in the clinic and had given the group as a whole the opportunity of engaging in a 'walk about' in order to view the collection? We ask this question because in subsequent projects involving drawings this is one of the steps that we have added, and, indeed, groups have collaborated in creating a curatorial statement and a title for the exhibition (see Chapter 4 in this volume).

We draw attention to these critical issues because they highlight the pedagogical space afforded by the 'drawing each other' activity, a space that is far from being trivial, and, as in several other studies involving adults drawing (see, for example, Weber and Mitchell's [1995] work with beginning teachers), the participants enthusiastically took up the drawing activity. We had no sense that this was something they regarded as being 'just for children'. This is important to note because in methodology courses when we first refer to drawing as an activity to carry out with adults, we are frequently met with concerns from our university students and colleagues that they would feel uncomfortable asking adults to draw. Our response to this is to engage new researchers (and ourselves) in drawing. Students then tend to come around to seeing this as an appropriate activity for adults as well as for children.

At the same time, the drawing activity should not be romanticised. The whole point of engaging in this kind of 'learning together' work in this particular project

came out of the fact that teachers and healthcare workers were not learning together when a shared focus on the sexual health of the young people in the area was needed. And it would be a mistake to think that possible suspicions would simply go away with one drawing activity. Significantly, as a team, we had to be prepared to ensure that discussion and genuine exchange was possible during the drawing workshop and in the subsequent sessions.

We also caution against reading too much into any one drawing, but rather, as noted above, we advocate considering the emerging discussion as the most critical component of the activity.

CONCLUSIONS

This chapter has highlighted what we can learn when we get two different groups of adults who work with children and young people to begin to work together. The foundation of this is a variation on the 'starting with ourselves' agenda (Kirk, 2005) focusing on 'how we see each other'. We think that this is a particularly appropriate and relatively easy way to begin to get groups talking to each other. From teachers and parent groups to healthcare workers and agricultural extension workers to the present example of teachers and healthcare workers, there is a rich potential for various government departments and civil society groups to be working together and learning together. For example, in the latest plans for rolling out HIV Counselling and Testing in South Africa, it is key that health and education officials work together. HIV and AIDS cannot be understood solely as a health issue or solely as an issue in the education sector (Motsoaledi, 2010). This was evident when we first started this work in 2004. Now that it is the beginning of a new decade, the demands for healthcare workers and educators to work together, especially in rural areas, are even greater. But South Africa is not alone in suffering the consequences of the silo effect of government departments and of splits between civil society and government departments. As is explored in Chapter 16 in relation to storyboarding in Rwanda, bringing groups together to draw solutions is yet another way in which drawing, as a relatively simple and inexpensive tool, can be a highly participatory and a potentially powerful force for policy and social change.

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NOTE

[i] The project titled "Learning Together: Towards an Integrated Participatory Approach to Youth, Gender and HIV/AIDS Interventions in Rural KwaZulu-Natal Schools" (2004–2006), with N. de Lange, T. M. Buthelezi, M. N. Mazibuko, C. Mitchell, R. Moletsane, J. Stuart, and M. Taylor, used

various visual participatory methodologies in addressing gender and HIV&AIDS issues in a district in rural KwaZulu-Natal.

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