Using the Arts to Spread Health, Peace and Community Wellbeing in Rural Kenya

El uso de las artes para la difusión de la salud, la paz y el bienestar comunitario en la Kenia rural

Araceli Alonso Rodriguez[1]
University of Wisconsin-Madison (USA)

Recibido: 30-05-2021
Aceptado: 15-08-2021

Abstract

This article tells the empirical story of women from seven villages of Kwale, the most southeastern county in the Coast Province of Kenya that borders with Tanzania –Lunga Lunga, Godo, Perani, Umoja, Maasailand, Mpakani and Jirani– as they searched for community health, equity, gender equality and peace on their own terms. This article shows that creative health initiatives can be successfully used as mechanisms for peace building. Since 2010, the *Nikumbuke*-Health by All Means (N-HbAM) projects from the University of Madison-Wisconsin in the United States, have trained 57 health

[1] (aalonso@wisc.edu). PhD in Medical Anthropology, Director of the UNESCO Chair on Gender, Wellbeing and Culture of Peace at the University of Wisconsin-Madison, and Faculty member in the Department of Gender and Women's Studies and the School of Medicine and Public Health. Director of Gender, Health, and Clinical Practice of the 4W Program STREETS (Social Transformations to End the Exploitation and Trafficking for Sex) in the School of Human Ecology. Selected bibliography: "¿Pueden hablar las 'víctimas' de trata? Una etnografía multisituada sobre la construcción del silencio y su confrontación en la trata nigeriana con fines de explotación sexual" *Journal of Iberoamerican Anthropology*. *Health by All Means: Women Turning Structural Violence into Health and Wellbeing. Philosophy and Theory of Global Health Practices*, Deep Education Press, June 2019. *The Time is Now: Feminist Leadership in the New Era* (ed.) Global Network of UNESCO Chairs on Gender, Paris Headquarters. E-Book July 2019. "Lifelong Wellbeing for Survivors of Sex Trafficking: Collaborative Perspectives from Survivors, Researchers and Service Providers. Collaboration," *Dignity: A Journal on Sexual Exploitation and Violence*, University of Rhode Island, 2018. "Gender and Community Wellbeing: Women Reversing Global Health Challenges and Gender Inequalities" in Foundations of Global Health Practice, Lori DiPrete Brown Jossey-Bass, A Wiley Imprint, November 2017.

promoters and 32 female actors on disease prevention and health promotion that have outreached approximately 120,000 inhabitants around the county enhancing unity in diversity, and breaking down the walls of ethnic hostilities and prejudice. Because of its low cost and high effectivity, the United Nations awarded *N*-HbAM[2] the 2013 Public Service Award as a model of best practice in gender, community development and sustainable wellbeing.

Keywords: Kenyan women, women's health, theater for health, theater for peace, health for peace.

Resumen

Este artículo cuenta la historia empírica de las mujeres de siete aldeas de Kwale, el condado más al sudeste de la provincia costera de Kenia que limita con Tanzania: Lunga Lunga, Godo, Perani, Umoja, Maasailand, Mpakani y Jirani, en su búsqueda hacia la salud comunitaria, la equidad, la igualdad de género y la paz, en los términos por ellas elegidos. Este artículo muestra que las iniciativas creativas de salud pueden utilizarse con éxito como mecanismos para la construcción de la paz. Desde 2010, los proyectos *Nikumbuke*-Health by All Means (N-HbAM) de la Universidad de Madison-Wisconsin en los Estados Unidos, han capacitado a 57 promotoras de salud y 32 actrices de teatro para la prevención de enfermedades y promoción de salud que a su vez han entrenado aproximadamente a 120,000 habitantes dentro del condado, mejorando así la unidad dentro de la diversidad y derribando muros de hostilidades étnicas y de prejuicios. Debido a su bajo costo y alta efectividad, en 2013, las Naciones Unidas otorgó a N-HbAM el Premio al Servicio Público por su modelo altamente funcional en prácticas de género, desarrollo comunitario y bienestar sostenible.

Palabras-clave: Mujeres de Kenia, salud de la mujer, teatro y salud, teatro y paz, salud para la paz

To many, gender equality, and the empowerment of women might seem too massive to even start thinking towards the achievement of a minimum goal. If we add to those aspirations the procurement of women's health, and sustainable development and peace building, an overwhelming uncertainty would discourage many while the mistakes and the damages of the past inflicted in the name of progress and development would prevent others from moving forward. Apparently, challenges are too vast and fears too many; so, there is a tendency to predict that our work towards the achievement of equity, the empowerment of women, and sustainable peace and development would bring

[2] In 2013, at the time of the UNPS Award the projects were still called Nikumbuke-Health by Motorbike (N-HbM). The name was changed in 2018 as the projects broadened in scope and geographical location.

nothing positive at all. As a result, as Martínez Guzmán (2005) points out, our apprehension and fearfulness often put the mechanism of the Prophecy of Nothing into action: if "nothing" is the ineludible outcome of our work towards a better and fairer world, we will do nothing to remediate the establishment and change the status quo, therefore there will be no change, nothing will happen and consequently the predicted Prophecy of Nothing will, once again, be indisputably fulfilled.

In order to counter-"act" that Prophecy of Nothing, the *N*-HbAM pedagogy used a subversive, imperfect, and impertinent imagination informed and nourished by an interdisciplinary body of knowledge to ignite a transformative movement that resulted in women turning structural violence into health and a culture of peace.

To illustrate that pedagogy, next is the story of three *N*-HbAM programs in action, based on characteristics that according to MacQueen and Santa-Barbara (2000) can be identified as "unique of health care" but that can help promote a culture of peace—altruism, science, and legitimacy (293). "Altruism" is expressed in these programs as "extended altruism" associated to a broad form of humanitarianism that extends the boundaries of care. In opposition to delimited altruism, extended altruism is not only associated with own communities but rather connected to universal conceptions of compassion and care, and identified with goals that transcend human differences, refusing to accept hate-based identities and searching for meaures that stimulate cohesion across different ethnic groups and religion affiliations. The *N*-HbAM programs rely on modern "science", the second characteristic identified by MacQueen and Santa-Barbara (2000), and it is based on objective facts and empirical studies of the needs, wants, and health concerns and outcomes of Kwale County's population, more particularly of its women. The third basis of health-peace initiatives, according to McQueen and Santa Barbara is "legitimacy" referring in this case to the considerable influence that the health promoters and the women actors have achieved in the creation of community cohesion and peace keeping.

Our *N*-HbAM approach to health and peace has followed Johan Galtung (1996) distinction between "positive" and "negative" peace, allowing us to use notions of "positive health" as an alternative to structural violence that affects women's health and well-being. According to Galtung, although peace denotes "non-violence", peace cannot be achieved in a community regardless of being "peaceful," that is regardless of not being actively involved in violence or war. In other words, peace cannot be achieved as long as there is a single human being that does not have their most minimum wants and needs satisfied. Using the same philosophical approach, and as the World Health Organization acknowledges, health goes beyond the absence of disease and it is defined as

a state of complete physical, mental and social well-being. For *N*-HbM, a way to construct positive peace and health among these communities has consisted of substituting structures of dominance, marginalization and exclusion that are produced in structural violence for others that consist of promoting physical and mental health, general well-being, and sustainable development.

The story of these *N*-HbAM health-peace initiatives began at the beginning of 2012, almost one year after we (a group of UW-Madison students and myself the first Train the Trainers Health Promotion program in Kwale County. In 2009, a simple health-based assessment had helped Dr. Mwangi and I to detect a number of direct and indirect health related issues in the area: 1) Low life expectancy by Western standards. 2) Child marriage of girls and adolescents, a fact that implied a number of health-related matters, such as early pregnancy, high maternal and infant mortality rates, vesico-vaginal fistula, severe anemia, miscarriage, stillborn babies, premature and low weight babies; higher exposure to diseases (malaria and HIV). 3) Female Genital *Circumcision* , very extended among some ethnic groups, with severe risk of hemorrhage, sepsis, tetanus, trauma of adjacent structures, urinary tract infection, HIV. 4) Myths, legends and culturally-based beliefs that may have had dangerous consequences for health; for instance, the belief on a disease caused by bad spirits or *degedege*, which could only be treated by a traditional healer, and stopped people from receiving timely medical treatment for other illnesses. 5) The lack of basic resources, like medicines, drinking water and latrines, clearly had a negative impact on people's health. 6) Lack of public services, or services that were out of reach for the majority of the population made access to health services and hospitals very difficult for patients or for health professionals; sometimes there were no means of transportation at all and the roads were very difficult to transit. 7) Tribal differences and animosities that contributed to the fragility of the social coexistence of the region, generating government mistrust and suspicions of the local healthcare system.

A Global Health expert would have immediately deduced that there were two major health problems to address: on the one hand, infectious diseases spread rapidly in the community, and on the other hand common illnesses that could be easily prevented became endemic. The main question was how to address these problems so that positive change, and positive health, would last and be sustainable.

The Background

In general terms, the Kenyan Coast Province has struggled with poverty-related health concerns and higher-than-average rates of child mortality when

compared to the national average (MLDPP 2011: 49). Malaria in particular has been ranked the number one cause of death and morbidity in Kwale County, followed by respiratory diseases, skin diseases, and diarrhea (MLDPP 2011: 41). There is a single county hospital that is inaccessible to many residents who cannot afford transportation costs. This hospital, located 75 kilometers from the main road in Lunga Lunga, lacks a theater and x-ray department and is surrounded by poor road networks (MLDPP 2011: 128). Thirty nine percent of the county residents (and 45% of the Lunga Lunga population) have no formal education and only 10% of the county population has a secondary education level or above (KNBS, 2013: 12).

In terms of environmental quality, the Kwale County's ecosystem has been quickly declining. Kwale County's land is semi-arid, receiving between 500 and 1,200mm of rainfall per year and facing challenges associated with semi-desert areas—reduced access to safe drinking water and decreased crop production due to poor soil quality (MLDPP 2011: 20; UNDP 2013: 8-9). Average rainfall decreases with distance inland, putting Lunga Lunga and nearby villages at a geographical disadvantage. The current forest cover is a mere 7%, and with a 0.25% per annum deforestation rate—a loss of 19,580 hectares every 10 years, Kwale County's forest cover is expected to be almost non-existent by 2034 (MLDPP 2011: 30-31). As a result, food is likely to become scarcer, as already infertile soil becomes even less able to produce crops (MLDPP 2011: 24).

The social composition in Kwale County reflects the diversity of the country in which it is located. Two main ethnic groups populate Kwale County: the Digo (60%) and the Duruma (25%) (MLDPP 2011: 53). Other ethnic groups include Kamba, Luo, Taita, Luhya, Giriama, Kisee, Makondo, Shirazi, and Maasai. Each tribe has its own unique language, customs, traditions, and history, as well as history of relations and interactions with other tribes in the area. Survey data also demonstrates the role of religion in this area, with 43.9 percent of the population identifying as Christian, 50.6 percent identifying as Muslim, and 0.1 percent identifying as "other" (MLDPP 2011: 59). Family organization centers on male clan leaders and respected village male elders who are tasked with making important community decisions (MLDPP 2011: 59).

Research-Action Approach

Collaborating with the local government of Kwale County and with Dr. Mwangi, I designed a program on disease prevention, health promotion and wellbeing to serve the most isolated and difficult to reach communities of the county. Together, we created a model of integral and sustainable health

especially for girls and women at low cost that could be easily transferrable to other communities. The model consisted of four primary components implemented simultaneously: 1. Build a Community Health Center for women and girls with a permanent Health Post; the center was created jointly by the women and the UW-Madison team, and the women called it *Nikumbuke "*Remember Me" in Swahili; 2. Offer health services through both the *Nikumbuke* Health Center and the newly created *Mama-Toto* Mobile Clinic that gave rise to a larger long-term health initiative and to the creation of the non-governmental organization Health by Motorbike (HbM) which included disease prevention, health promotion, basic treatment of disease, and a referral mechanism for major illness; 3. Create a structure of health literacy for a vast number of people through summer health camps for women and girls; 4. Develop a system of sustainable health from within through a four-year "Train the Trainers" health program; 5. Implement an initiative of community engagement, sometimes called "service learning," at UW-Madison for students to apply their knowledge to real challenging life situations.

This model took women as agents of social change, as carriers of culture, and as keepers of health and peace, wellbeing and sustainable development for their families and communities. To conceive and implement the delivery of all programs, women internalized the term *umoja, w*hich means "unity" in Swahili and that expresses the basic characteristics of peace—unity and solidarity needed to successfully achieve any kind of human relationships and sustainable development and peace from within. Unity and solidarity, not because women were good or had good feelings and sentiments, but because this particular group of women understood unity and solidarity as intrinsic to their human relations and communication, using the *N*-HbAM pedagogy to promote responsibility about what they said, what they acted and what they did to themselves, to others, and to the environment.

Afya Ukumbi, Health-Peace Theater Counter-"Acting" the Prophecy of Nothing

From the very beginning, women in the villages had recognized their historically marginal place in their respective communities. Individually, women expressed their desire to raise their own voices, but as a group they understood that their collective echo might more strongly reverberate to make long lasting social change impact.

The women from Lunga Lunga took the genuine initiative to start performing "dramas," as they call their acting, using their inner knowing and motivated by the knowledge acquired through the health training of the previous summer. Although the UW-Madison team had nothing to do with this impulse

of the women to perform, the new scientific knowledge previously shared by our academic team may have acted as a catalyst for the women to disseminate the treasured information in a more culturally appropriate way.

The women developed the scripts, collected the garments, rehearsed for several months and in June of 2012 eleven women starred as female actors performing in the streets of Lunga Lunga in front of several hundred people, including our UW-Madison team. Although only one out of the eleven women actors had basic skills in reading and writing, the lack of literacy was not a constraint to advocate for women's health and to change the community's perception of health and disease; acting gave women a platform to discuss how different factors could help or hinder health, and explain specific implications of healthy lifestyles and habits. The genuine desire of women for advancing health in their communities led them to the formation of what Sloman (2012) called Theater for Development. It was as if the women had somehow been inspired by the theories of Brazilian educators and activists Paulo Freire (1970) and Augusto Boal (1979, 1995) as they started integrating health education and entertainment to construct not only a healthier society but also a more cohesive and peaceful community.

The first drama was non-participatory in the sense that there was no interaction between women actors and public; the actors acted the play in a didactic way while the audience listened and watched, mesmerized as the health information was sinking into their souls. Although non-participatory, this first drama could be understood as one of the forms of what Boal (1979) denominated "Theater of the Oppressed," in which performers enact their plays in places where people do not expect to see any kind of public acting. This first malaria play was performed in the streets of Lunga Lunga where several hundred surprised people gathered around forming a gigantic circle to witness what Boal would have called "Invisible Theater."

First act of the malaria play: a pregnant woman and her husband are sleeping on a mattress, without a net. The crowd bursts in laughter when Mama Damaris[3], dressed as a mosquito, appears in the scene buzzing around the pregnant Mama while she is asleep. The mosquito bites the Mama who starts feeling sick. When the Mama cannot stand on her own, her husband takes her to a traditional witchdoctor that performs rituals and starts dancing and singing frantically around the woman. The crowd could not contain itself, rejoicing with every histrionic movement of the witchdoctor. The couple goes back home, but the Mama does not improve. When the husband finally decides to take his wife to the clinic, it is too late to save the baby. The spectators looked at each other with complicit gestures, unfortunately recognizing the scene, and

[3] The term "Mama" is popularly used to refer to Mrs. and sometimes it is used as synonymous of "woman" (normally a married woman, a mother).

related it to their own lives. Applauses! Second act: The same pregnant woman with the same husband sleeping under a blue net. The mosquito comes again and the crowd yells and cries out *Unaweza si! Unaweza si!* (You can't!). Mama Damaris in her big mosquito dress tries several times but the net interferes and the pregnant Mama cannot be bitten; eventually the mosquito dies while the observers scream in victory and congratulate the Mama for sleeping under the net, *Hongera! Hongera!*

For our UW team, observing this malaria skit meant much more than anyone could have anticipated; it was a fantastic demonstration of the way the health promotion training of the previous summer had been incorporated into the acting, furthermore into daily life. The fact that the Mama did not die also meant that the health promoters and the women actors had perfectly understood that *Plasmodium falciparum* infections in pregnant women who live in malaria endemic areas, like Kwale County, have a direct risk for infant mortality rather than for maternal mortality (Steketee et al. 2001).

At the end of 2012, the women and the UW-Madison team decided to establish the Street Health Theater as one of the permanent programs of *N*-HbAM; thanks to a grant from the UW-Madison Morgridge Center, the *Afya Ukumbi* (Street Health Theater in Swahili) was born and became permanent. Since 2012, the number of women actors has grown dramatically because other villages wanted to do the same. Godo was performing, Perani was performing, Jirani was performing as well. Each village, except the two Maasai communities which expressed their learning through songs instead of through theater, were acting health dramas. The groups of women actors incorporated skits based on all the health promotion workshops: maternal health, infectious diseases, HIV/AIDS, and even domestic violence and the trafficking of girls. In sum, the women created dramas that reflected their own health struggles, problems, and experiences within their communities.

The *Afya Ukumbi* became a good example of what Doris Sommer (2014) calls the utility of arts and humanities in civil engagement. In her book, *The Work of Art in the World* (2014), Sommer explains how bottom up creative and unconventional activities, like the *Afya Ukumbi*, can generate powerful dynamics of social change and hence play an essential role in promoting political participation and even in changing the status quo. The *Afya Ukumbi* emerged as a provocative and fun tool for civic education, health promotion and social justice; a subversive means to incite, confront and interrogate spectators, but also to unify, celebrate and heal audiences and communities.

In 2013, the women made the *Afya Ukumbi* more participatory, asking the audience to collaborate after the play and analyze it all together step by step, giving rise to a form of Forum Theater (Boal 1979) in which the audience would eventually become spect-actors allowing knowledge and learning to

flow reciprocally between actors and spect-actors. This new approach helped initiate reflection and discussion about solutions to past, present, and potential health problems.

A decisive moment for the *Afya Ukumbi* was when during a health camp training a year earlier, Mama Veronica said out loud:

-"I assisted the birth of my own twins, but one of them died days later, his neck stiff and his body bent like this [showing her body curved backwards]"

Mama Veronica's comment had triggered a heated discussion about giving birth at home or in the clinic. A year after, the health promoters and the *Afya Ukumbi* acting team took advantage of that opportunity to incorporate the debate into their acting.

A single act with only three women acting: A Mama gives birth to a healthy baby, and a traditional birth attendant is assisting the Mama and cutting the umbilical cord with her thumbnail; the movement of the birth attendant's hand as she was cutting the umbilical cord was exaggeratedly grotesque to make sure that the audience did not miss the detail. Few days after the birth, the baby cannot eat and starts convulsing. The Mama takes the baby to a traditional healer that performs several cuts on the skin of the baby to introduce herbal remedies. The act ends when the Mama buries the body of her baby.

-"Why did my baby die?" howled the Mama-actor, imploring an answer from the enthralled audience.

Some women knew right away, "Tetanus!" shouted two of them.

-Because she used her nail! One Mama said.

Another Mama added that the problem was not cutting with nails but having dirty hands. She explained that the traditional way to cut the umbilical cord with the thumbnail could sometimes be a contributor of disease if the hands were not cleaned. Another Mama commented that not only the umbilical cord was cut with the thumbnail but also sometimes the perineum of the mother:
-"That's why some women around here keep their fingernail long and strong like a knife."

Nonetheless, the women were not blaming anybody for bad habits or behavior. Through their discussion, they realized that the lack of tools and the lack of water were two of the main causes of using fingernails to cut the umbilical cord.

-"We can't use a knife to cut because we had no clean water to prepare the knife," the women went further.

"But that baby died because he was not vaccinated when he was born," one Mama commented.

-"Why wasn't he vaccinated," the Mama-actor asked trying to elicit more answers.

-"Because the Mama didn't know that a vaccine could be used," said one.

-"Because she didn't know that the vaccine was her right," said another

-"Because she had no transportation to take the baby to the clinic," said another one.

-"Because the clinic was too far away," added another Mama.

-"Because the Mama didn't trust vaccines," said another one.

-"Because the Mama didn't trust the clinic, maybe she was mistreated in the clinic before and she didn't want to go back."

-"Who can go to the clinic if it's far? The clinic should be closer to our homes," protested one Mama.

The main goal of the *Afya Ukumbi*, as well as of the health summer camps, was not to change women's "bad" habits or behaviors but rather to facilitate their own learning process by which they could understand by themselves the many variables and circumstances that could cause poor health and how to tackle those variables in order to promote wellbeing. None of us questioned women's values, believes or habits since that would have meant to put into question women's own identities and to challenge the way they define themselves within their groups. However, the *Afya Ukumbi* facilitated the conversation about traditions, values and beliefs that the women wanted to discuss in an open and welcoming environment. It was often the audience who challenged traditions as the women listened to the points of view of other ethnic groups. At that point, the *Afya Ukumbi* did not seek answers yet but rather a valid interlocutor/audience that would listen and discuss without judging.

That *Afya Ukumbi* act gave us the chance to start a discussion that went beyond life and death, beyond health and disease; it took us to a place in which women discovered by themselves what was needed, at individual and structural levels, in case another Mama had to go through the same situation. It seemed that the women were able to link health with other aspects of social development. The second time this skit was performed, we went a step further exploring the causes of poverty and poor health, as they are closely associated. The audience realized that cutting the cord was not the only lethal decision they had encountered:

- "My neighbor died bleeding after she delivered her baby; no one could save her," one Mama said.

- "That happened to my neighbor too!" added one, "Mine too!" added another one, and the voices of other women resonated like an endless echo in the room "Mine too, mine too, too, too…!"

The women talked about bleeding, about the placenta not coming out entirely, about fever and convulsions, about spirits that come from the water and make women sick, about the snake that often comes to kill the mother and steal the baby. The women one by one and all-together deciphered the "Three Delay Model" that we often use in our university courses to explain maternal mortality around the world:

-"My mother-in-law said that women are cowards if they go to the clinic to have babies," said one of the young Mamas. The other women giggled looking at each other, recognizing themselves in the comment, some as mothers-in-law and some as daughters-in-law.

The debate began. Some mentioned that husbands were mostly absent when babies were born and that their mothers-in-law were very insensitive to their pains of labor and that some lives could have been saved if the mothers-in-law would have helped in the first place. For the first time women in the villages were talking together about issues that had never been discussed before. Although at first mothers-in-law protested, they soon realized that they were also daughters-in-law themselves and that the claim sounded way too familiar for them too. The women, young and old, made a pledge to overcome some of the difficulties that pregnant women confronted in their communities, starting at home. The women themselves had deciphered the First Delay: recognizing the potential problem at home.

The second delay was easy for the audience to talk about without the actors eliciting the conversation:

-"But, what do I do?" protested one Mama. "I pretend I don't care because what else can I do if I see my daughter-in-law struggling and my son is not home?"

-"Call the healer!" answered one with a mischievous tone while the others laughed hard.

-"You have to take her to the clinic!" said one.

-"How?" kept protesting the first Mama.

Silence… The women had decoded the Second Delay: getting from home to the clinic; transportation!

-"But sometimes the clinic can't help either. My sister had to be taken to the hospital after she reached the clinic and the clinic couldn't help. She lost a lot of blood in the way, but the hospital had no blood for her, and we had no money to buy blood, and couldn't give her our blood; we had no money to pay the hospital anyway."

The Third Delay decoded: difficulty at the clinic and hospital levels.

The audience discussed the Three Delays, acknowledging that the forms of the delays may vary according to different circumstances. Some of the women were able to look far beyond the immediate causes of maternal complications and showed very critical attitudes towards the third delay, saying that sometimes the hospital is closed for admissions when the Mama arrives, or that the doctors are not available, or that women are often mistreated or treated like children to be scolded. Without knowing it, the women were talking about obstetric violence.[4] The women were clear, the fear of mistreatment in hospitals keeps women preferring to deliver at home assisted by a neighbor or by themselves.

There they were, women from at least nine different ethnic groups and three different religions[5] discussing issues that cut across ethnicity and religion in a country divided and brutally confronted along tribal animosities. Maternal health was a common thread that interweaved the lives of the women in all the villages; soon, the women would discover many other common threads that would drive them to work together in their desire to overcome structural neglect and violence. Health started to be seen among the women as a state of wholeness and wellbeing; achieving that state of wellbeing would require to work together to meet women's needs in a self-reliant and responsible way. The ultimate purpose of the new participatory *Afya Ukumbi* was to conceive action through solidarity and community consciousness. The *Afya Ukumbi* did not only maximize our scarce resources but also guaranteed sustainability and ownership, and it benefited the women in their roles as producers and reproducers of knowledge. That happened already at the end of 2013 when the Lunga Lunga *Afya Ukumbi* acting team, after watching and analyzing a

[4] Term coined in the United States to refer to the inhumane treatment of women in labor and delivery wards during childbirth.

[5] The ethnic groups presented during the first health training in the villages were Kamba, Duruma, Digo, Giriama, Luhya, Kisee, Makondo, Luo and Taita. In some of the villages the majority of the population is Christian—Lunga Lunga and Godo. In other villages—Perani and Mpakani, approximately half of the population is Muslim and half Christian. Nevertheless, people still believe in spirit possession and still hold traditional values and customs that permeate many levels of their daily lives.

four-minute play created by the UW team, decided to perform skits on intimate domestic disputes, a subject that had been completely taboo until then. The four-minute piece that sparked the desire to perform on domestic disputes was a play acted in Kiswahili by one of my senior students and by myself. After much self-reflection and work within, the student and I put ourselves out there in front of the women, acting from the inside out, embracing and sharing our own vulnerability.

Husband-- *Hodi, Hodi*
(Knock, knock; greeting to enter the house)
Wife-- *Karibu, Karibu sana*
(Come in, welcome; greeting to get into the house)
Husband-- *Umeshindaje?*
How is everything?
Wife-- *Salama, Salama*
Fine, fine

To our surprise, the women burst into laughter seeing the two *wazungu*[6] women speaking and acting in Kiswahili.

Husband-- *Nimeleta nyama leo.*
I am bringing meat today.
Wife-- *Nyama choma, nyama choma. Asante sana, asante sana mume yangu.*
Mimi ni bibi mzuri. Mimekubali makosa yangu yete ambato yalisababaisha kunipiga usiku. Nitabadilisha tabia ynagu na kwa mke mzuri.
Oh, meat, meat, thank you so much my husband. I'll be a good wife. I deserved to be beaten last night but I'll be good.

The women were not laughing anymore.

Husband-- *Nimekusameje, nimekusameje. Chakula kiko tayari?*
I forgive you, I forgive you. Is the food ready?
Wife-- *Ndyo! Nimetayarisha ugali na kuku.*
Yes! I prepared ugali[7] and chicken.
Husband-- *Watoto wako wapi?*
Where are our children?
Wife-- *Minewakeleka kwa nayana yao!*

[6] *Wazungu* is the plural form of *mzungu*, a word that the locals use to refer to "white people."
[7] A semi-hard cake made of maize flour or millet flour. It is a staple food, the favorite meal for all Kenyans to accompany fish, meat, beans, stews, vegetables, etc.

I've taken them to their grandmother.
Husband-- *Unasema nini!!!????*
What!!!!????
Nimekwanbia usiwapeleke watoto wangu kwa mama yako?

How can I tell you not to take the children to your mother?
Wife-- *Nisemehe mume wangu. Siturudia tena*. I am so sorry my husband, forgive me.
Husband-- *Wewe nimkinga sana!!!*
You are so stupid!!!
Lete chakula haraka!
Bring me the food!
Wife-- *Haya, mumu wangu. Chakula hiki hapa.*
Here you have, my husband. Here is the food.
Husband-- *Ugali iko baridi!! Kuku imeungua!!*
Nimara ngapi nimekupiga na bado hujarekebisha tabia yako?
The ugali is cold, the chicken is burned! How many timehave I beat you and you have not adjusted your character?

(He violently hit her and left the house)

Although completely unintentional, it seemed that by making ourselves vulnerable, the student and I had made a space for the women to open up. That play gave rise to an "aesthetic space," as Boal (1995) would name it, a liminal zone where reality and fiction converged in one single universe. Through the physicality of acting out this play in Kiswahili, women in the audience who in daily life were silent became protagonists on the stage, and their feelings of oppression became as tangible and solid as their own physical bodies. It was within that liminal space where everything became possible, where transformation took place between what "it was" and the "next."

It took four minutes and four questions for the women to feel a tight knot in their guts, a sense a deep inner pain, but also a sudden urgency to speak and act out. The audience became activated spectators, and I took the role of the "Joker," as Augusto Boal (1995) called the facilitator of the Forum Theater:

-"Is this the fault of the Mama? Is the Mama stupid?" I asked
-"Noooooooo!!!!!!" The women shouted as loud as they could
-"Why does the husband bring a chicken?"
-"Because *kuku* is sweet[8]; he wants to be forgiven, but he is not saying the truth,

[8] In this context the word "sweet" refers to a most delicious food. Also, locals use the word "sweet" to refer to something beautiful, to a very pretty person; "sweet" is used as synonymous of

he is not repented and does it again and again"
-"Why are the children at the grandma's place?"
-"Because the Mama doesn't want her children to see what is going on in the house"
-"Do you think the *ugali* is cold and the chicken burned?
-" Nooooooooo!!!!!!"

The conversation started being run by the women, challenging one another, asking and answering to each other, shouting, crying, deciphering the legacy and evils of a patriarchal system where violence against women takes many forms and is normalized in everyday life; and the conversation continued for hours:

-"No man has the right to beat his wife."

-"Beating is not love, it's violence!"

-"Isn't it violence also when your husband brings home another woman and you have to sleep on the floor while they sleep in the bed and then in the morning you have to prepare *chapati*[9] and *chai*[10] for them?"

-"Isn't it violence when your husband keeps all the money for himself leaving you and your children with nothing?"

-"Isn't it violence when your husband forces you every night? And if you don't do it he takes the children and you are in the street!"

-"What about when your husband ignores you sexually?"

-"And when the girls are cut? Isn't that violence?"

-"And when your baby is the son of your uncle and you cannot talk because he would kill you? And then you tell no one because no one believes you anyway and people would blame you and your family would kick you out."

-"And when a woman only gives birth to girls and her husband takes a second wife to have sons with her?"

"best."

[9] *Chapati* is a round, flat unleavened bread cooked on a griddle to a soft brown color. It can be eaten alone or with meat, beans, stews and vegetables.

[10] *Chai* is the typical Kenyan tea prepared with milk.

-Women are blamed and beaten for having too many kids, or for not having kids at all, isn't that violence too?

-"Not letting a woman to have family planning; that's violence!!

-"And when a woman overstays in the market and her husband beats her up when she gets home?"

-"Some men take drugs and cannot get satisfied and force women and the women get hurt, they try the anus and the vagina, and over again."

-"After having a baby, men don't want to wait the six weeks and demand sex to their wives right away, I think that's violence."

-"When a woman is sick, she is the last one to be taken to the hospital until her illness kills her, that's violence because she dies."

The atmosphere got tenser as the women turned the conversation into a discussion on rape and sexual violence. It was then when one of my own students stood up and said: "I was raped when I was 18, the first year of my studies at the University of Wisconsin-Madison; this is the first time I speak about it." Another student intervened: "I was 20 when I was raped on campus. I thought it was my fault because I was drunk, I never told anyone." A total of four out of my twelve students confessed there, in front of the women, being raped on our own campus. The silence became thicker than ever, until one of the women, a spect-actor, asked: "So, rape happens in America too?"

Through this *Afya Ukumbi* "drama", the women, my students, everyone, could perceive the complex global web of women's oppression, but we also started realizing that anyone can become an agent of change. Two more hours of discussion on gender-based violence concluded in a giant human circle where all of us, standing up and holding hands, prayed in silence first and later voiced our commitments to ending violence against women and girls.

The same year, before 2013 ended, the Jirani *Afya Ukumbi* group of acting women went a step further performing a drama on structural and gender-based violence inflicted on girls. In the play, a girl gives up going to school due to a cascade of facts and events: lack of money to pay school fees, lack of sanitary pads for the days of her period, lack of time because she has to fetch water, fear of rape if she walks alone to school, fear of her father who disapproves her going to school and beats her up, fear of her mother being beaten for allowing her to go to school, more fear of her father when he gets drunk. Although the play presented a real drama, the women actors found a way to make the audience laugh. The viewers could identify themselves with the play as the

reflection of a mirror; the laughter, however, diminished the pain, increased intimacy and strengthened community engagement and cohesiveness.

The women actors had taken every bit of information given during the health promotion program, every scientific information, every common knowledge, every cultural belief and converted them, translated them into a "drama" adapting it to the specific circumstances of each community. For example, when the Lunga Lunga acting team performed its drama on HIV, the whole audience cracked-up as a Mama tried to convince her husband to use a condom. Condoms were unknown in the villages before 2010 and although they were still seen as something not desirable, thanks to the *Afya Ukumbi* more and more people were demystifying them. In the play, the Mama insisted to her uncooperative husband that he put a condom before engaging in intercourse. The husband rejects the condom several times claiming that "This is only for prostitutes! *Mimi ni mwanaume!* I am a man! You don't dare to give me this" "You do what I say!" The Mama, however, did not appear intimidated, but neither did she push her husband to do something he did not like or want. On the contrary, the Mama was using all her skills for him to change his mind, showing him how to put the condom on and even telling him that she could try to do it with her mouth; the spectators did not look embarrassed or ashamed, or showed any discontent or disapproval of the women's audacity and insolence. The audience seemed mesmerized and laughed harder and louder as the Mama tried to put the condom on a wooden penis attached to the "husband's" pants. The Mama did not mention HIV to her husband at all, neither she mentioned that she was trying to protect herself from other sexually transmitted infections or from unwanted pregnancies. The Mama was presenting the condom to her husband as something desirable for his own enjoyment.

Through the medium of performance and storytelling, community health promoters, turned into actors, freely expressed the particular health issues that affected their communities. The *Afya Ukumbi* intelligently used laughter as a subversive language to discuss sensitive health topics, contest structural violence, and even reverse gender roles. Besides, laughter brought people together, serving as a great unifier and creating an atmosphere of acceptance among groups of different ethnic backgrounds and religions, thus allowing actors to reach marginalized groups in their communities.

Spreading Peace and Wellbeing Through Cardboard Books and Rural Community Libraries

In the summer of 2013, a one-room library was built on the grounds of *Nikumbuke* Community Health Center with the intention to further our

Health and Peace training and provide reading materials to women, men and children from the seven villages. For two main reasons, this would become a very challenging and audacious task. On the one hand, most of the books we had, donated by people from Europe and the United States, were based on a model that only reflected western worldviews, very far from the lifestyle of people in the villages. On the other hand, the majority of people in Kwale County were not literate and would not be able to read either western or non-western materials; we knew that we would have to enhance our imagination to compensate for those challenges.

"If you don't have it, you invent it!" Those were the words of my mother that resonated in my brain. And that is exactly what we did; we invented books! The women and the UW team made-up stories illustrated with drawings that depicted local health concerns and local-global solutions, producing reading materials where there were none.

The lack of printed resources gave us the freedom to conceive and give birth to an extraordinary collection of hand painted recycled cardboard books, with very few and simple words written in both languages Kiswahili and English, but with many illustrations that addressed issues like "what to do when cholera strikes; how to build a latrine; how to clean children's teeth; or how to eat a balanced diet." The UW team along with local girls and women painted hundreds of cardboard covers, some with simple colorful brushstrokes and others with the most sophisticated African figures, symbols and landscapes. For ideas on the inside illustrations, we turned to Hesperian Foundation books[11], the Internet, and to our own creativity.

Opening this library would give us the unintended opportunity to document the theater dramas of the *Afya Ukumby* that the women had been performing for several years. Since most women actors had no formal education, they created their health dramas orally, kept the scripts in their memory and acted them out over and over again without leaving any written record. The UW team transcribed most of the *Afya Ukumby* dramas and published them with the collaboration of *Kutsemba Cartão*[12].

Although creating a culturally sensitive collection of printed materials seemed an appropriate step forward, it was not enough to honor the traditional and rich oral culture of the many tribes of Kenya, so we decided to publish dozens of oral stories that one year before, in the summer of 2012, one of my students

[11] The Hesperian Foundation books have been our source of knowledge in many circumstances and for many years. We acknowledge that we are deeply in debt with the Hesperian Foundation.

[12] Through collaboration with *Kutsemba Cartão*, http://kutsembacartao.wix.com/kutsemba the first *Cartonera*, Cardboard Book Publishing, created in Africa, in Mozambique, by UW-Madison Professor Luís Madureira and Saylín Alvárez. Thanks to *Kutsemba Cartão*, we learned how to create cardboard covers, how to print the stories, how to ensemble the books, and everything else we needed to fill the *Nikumbuke* Library with several hundred books. These titles are also kept in a special collection at the University of Wisconsin-Madison.

had collected in the villages. This student recorded stories told by women from different ethnic groups. The stories were told and recorded in Kiswahili, and transcribed and translated into English. Titles like "The Frog and the Millipede," "The Path of a Liar is Short," "The Toad's Ambition," "Selfish Woman," "The Rabbit and the Giraffe," and "Why the Ostrich has no Neck Feathers," among others were published through *Kutsemba Cartao* in both English and Kiswahili, with the name and the picture of the women who had told the story, as the authors of the books. This very simple strategy generated a synergy and a ripple effect among those who wanted to tell, those who wanted to write, those who wanted to read and those who wanted to be read.

The *Nikumbuke* Library did not function like a western library in the sense that the books could not be checked out by people; simply, there were not enough books to lend and no personnel to control a borrowing system. The library, however, became an alive and dynamic space, always changing; people read books but also wrote books, people removed books but also created books. Children scribbled over existing drawings but they also illustrated new books. The people of the seven villages were the ones who gave life to this library, creating and recreating its content, giving it an identity of its own, and using the library in a way that fitted their needs and wants.

One year after the opening of the *Nikumbuke* Library, we built a Little Free Library[13] (literally a small wooden box supported by a pole stuck in the ground) that could be used twenty-four hours a day and the seven days of the week. The purpose of this wooden box was very different from the original idea of the Little Free Libraries created in the United States, whose motto "Take a book, return a book" would not work in this part of the world. The purpose of this particular Little Free Library was to leave pamphlets, flyers and small handmade cardboard books containing important health messages for the community that the people could freely get to share with their families and neighbors. Seeing the *Nikumbuke* Free Library empty meant the greatest victory for us; our motto should have been "take as many books and pamphlets as you wish, but make sure you share them with your neighbors."

Playing for Peace and Health

Part of Doris Sommer's (2014) Pre-Texts pedagogy and holistic education, rests on the idea that there cannot be sustainable development without

[13] The first Little Free Library was built in 2009 by Todd Bol in Hudson, Wisconsin. In 2012, the Little Free Library became a nonprofit organization. The main idea of the libraries was "take a book, leave a book," becoming a tool for book exchange and free knowledge sharing. The libraries became a global sensation and as per 2018 there are more than 60,000 libraries, present in all 50 of the United States and over 80 countries; millions of books are exchanged each year.

enjoyment, without pleasure, and in our *N*-HbAM programs we have taken that conviction very seriously.

Back in 2011, we started celebrating the equator of the health promotion training by going to the beach all together—the teaching team from UW-Madison, the new cohort of health promoters and the staff of the *Nikumbuke* Health Center, spending an entire day at Diane Beach in Ukunda, around 15 kilometers from Lunga Lunga. This celebration became a rite of passage for all, and the days at the beach were probably the most memorable for many of us. Most of the women had never been at a beach before and the excitement was always high. Some of them were dismayed seeing the water coming inland and getting to them, wondering why the water was contained within the limits of the sea and did not invade the surrounding villages.

Our beach days started around 7am at the *Nikumbuke* Community Health Center with the women trying bathing suits on and deciding which one fit their body type the best; they giggled first and soon started laughing louder and louder. "I'm not wearing this!" one of the health promoters said almost choking, to what Mama Bendettah would respond with her authoritarian voice "These are our uniforms for the day! Our health promoters' uniforms for the day!" They all laughed even louder. In a tiny room there were around fifteen women, sharing the parts of their bodies that they so prudently covered in the outside world. It was obvious that they were having a blast. The women were not laughing about their bodies or anybody else's bodies; they were laughing *with* their bodies. Some of these women had their own difficult challenges: two were HIV+; another was a third wife and had just been rejected by her husband, losing custody of her two children; another barely survived malaria the previous month; another had a daughter that had been taken to Mombasa "to work at a hotel," but she knew well what kind of a place that hotel was. All the women, however, as they tried their bathing suits, seemed to have their sorrows suspended.

When the Maasai joined the Train the Trainers, some of us were apprehensive thinking about their reaction towards coming to the beach. Imposing my western views, I thought they surely would not come. Once again, our own prejudices, stereotypes, and partial knowledge gave us a limited understanding of human behavior and made us assume that the Maasai were peculiar, strange, atypical people. The Maasai came, all of them; every single year they came. The Maasai women did not behave in any way differently from the other women, they wore bathing suits, even Mama Joyce selected a bikini for her but also wore her red and white *chukka* on top. The two Maasai men health promoters, Isack and Isaya, wore blue shorts under their red *chukkas*.

Regardless of our bathing suits, regardless of our myriad skin tones, of our different body abilities, body types and shapes, regardless of our cultures,

ethnicities, languages, challenges, desires, and in spite of all our separations we all found unity and attachment through an uncontrollable eagerness for enjoyment; a state of frenzy captured us all as we approached the beach. None of the health promoters knew how to swim, but it did not matter, since swimming was not the purpose of our field trip. Some feared the water, but some did not. Some got into the water without thinking, while others practiced in a preparatory swimming lesson lying face down on the sand and moving their legs and arms while the observers burst in choking laughter. We all came into the water screaming and jumping, intoxicated with happiness and living a surreal experience. We were loud, very loud. We played together, with each other and with ourselves, laughing until we were exhausted, swallowing water as we were laughing and chasing each other. We invented games: blindfolded, one of us would shout *Twiga!* giraffe! while chasing the others as they screamed *Simba!* Lion! *Twiga! Simba! Twiga! Simba!* When we were exhausted, we came out of the water, ate together, played volleyball together, walked around the shore together. At the beach, we lost any former trait of identity as we unleashed the power of unity, the plenitude of oneness.

Personal Reflection

The above are just a few examples of how the *N*-HbM program uses a subversive methodology to transform the status quo within a particular socio-geographical and cultural context, specifically in the seven villages of the Kwale County that border Kenya and Tanzania; in the last three years, from 2017 to 2020, the *N*-HbAM program has expanded to 13 villages, making these bold health-peace projects more challenging but also more exciting and daring.

In order to re-encounter women's inner power, or to recover their suppressed empowerment, the projects of *N*-HbAM have taken a participatory approach as a conceptual framework that acknowledges that women can perform and reform their bodies, and their environment in different ways, using not only scientific knowledge but also care, tenderness, kindness, compassion, empathy and love. At the same time, our programs recognize historically marginalized women as valid interlocutors in their communities, recovering the 19th century etymological meaning of women as *persons,* "*per*" as a prefix of intensification plus the verb "*sonare*" to make a sound, to sound through[14]. This notion validated each woman as a person: "I am a person and I am here!" "I can hear, but I can also be heard!" "I am speaking, and through acting I can also amplify my voice!" This position led to the self-analysis and self-reflection

[14] The etymological meaning of *person* has been long debated. This narrative uses the meaning of the Oxford Etymology Dictionary https://www.etymonline.com/word/person, also used by Spanish peace philosopher Vicent Martínez Guzmán (2005).

of all the *Afya-Ukumbi* participants involved—those who prepared the dramas, those who performed them, and those who receive them, with unity, solidarity and empathy.

Although I acknowledge that the *N*-HbAM projects are not a panacea to solve particular sets of social ills, I maintain that these projects can be used as alternatives to mainstream development practices that help promote health, peace and general community wellbeing. For example, these programs were used in Kenya with deep awareness of ethnicity and conflict, aiming to unite historically confronted groups to work together for a common cause. As Charles Hornsby (2001) said, ethnicity in Kenya is "about shared communities…but also about conflict and difference" (2). The UW-Madison team and the women from the seven villages were well aware that tribal differences and religious fundamentalist groups like Al-Shabab had been threatening stability in the region as they were planting seeds of hatred in a country where ethnic conflict surfaces rapidly and easily gets out of control. The *Afya Ukumbi* and the beach games, provided a problem-solving space that subsequently contributed to increased communication and interconnectedness among ethnic groups and among community members. The interaction of women and men from different ethnicities, languages and religions through these initiatives generated a group consciousness and social identification, what Lederach (2005) refers as to minimizing the tendency to dehumanize the "Other". For instance, spending time together enjoying on the beach, collecting women's stories, or rehearsing for the *Afya Ukumbi* dramas, the seven communities produced spaces that recognized that self-peace and self-health are greatly dependent on the health and peace of others.

Works Cited:

Boal, Augusto: *Teatro do oprimido e outras poéticas políticas*, Rio de Janeiro, Civilização Brasileira, 1979.

Boal, Augusto: *The Rainbow of Desire: The Boal Method of Theatre and Therapy*, London, Routledge, 1995.

Freire, Paulo: *Pedagogy of the Oppressed*, New York, Herder and Herder, 1970.

Galtung, Johan: *Peace Through Peaceful Means*. *Peace and Conflict, Development and Civilization*, London, Sage Publication Inc., 1996.

Hornby, Charles: *Kenya: A History Since Independence*, I.B. Tauris & Co Ltd, London, 2012.

Kenya National Bureau of Statistics (KNBS): *2009 Population and Housing Census Results*, Kenya, 2010. Lederach, John Paul: *The Moral Imagination: The Art and Soul of Building Peace*, Oxford University Press, New York, (2005).

MacQueen, Graeme and Joanna Santa-Barbara: "Conflict and Health: Peace Building Through Health Initiatives", *British Medical Journal,* volume 321, 29 July, 2000, pp. 293-296.

Martínez Guzmán, Vicent: *Podemos hacer las paces: reflexiones éticas tras el 11-S y el 11-M.* Coleción Etica Aplicada, Publidisa, Sevilla, 2005.

Ministry of Lands Department of Physical Planning (MLDPP), and United Nations Centre for Regional Development: *Kwale District and Mombasa Mainland South Regional Physical Development Plan 2014-2034*, Nairobi, 2011.

Sloman, Annie: *Using participatory theatre in international community development*. Oxford University Press and Community Development Journal Advance, January 27 2011.

Sommer, Doris: *The Work of Art in the World: Civic Agency and Public Humanities*, Duke University Press, 2014.

Steketee, Richar W. and others: "The Burden of Malaria in Pregnancy in Malaria-Endemic Areas*",* in Breman JG, Egan A, and Keusch GT (eds.): *The Intolerable Burden of Malaria: A New Look at the Numbers*, *American Journal of Tropical Medicine and Hygiene*, Volume 64, 12001.