Two Days in Tevele
Community Participation

By Gerri Dickson

1. Introduction

In 2001, the Centre for Continuing Education in Health in Massinga (the Centre) formed a partnership with the rural municipality of Tevele, Mozambique. Through this union, the Centre began to develop community partners who would assist in training health workers. At the same time, Tevele improves its own well-being through mutual learning and community development.

The Centre-Tevele partnership has since grown into a rich, mutually beneficial relationship. By sharing and utilizing each other's unique experiences, knowledge and expertise, Tevele's 7,500 residents are developing sustainable solutions to their critical health issues.

The community representatives take what they learn from their regular meetings with the Centre and mobilize their community to take decisive action against self-identified, local health threats such as malaria and HIV/AIDS. In return, the community has helped the Centre team to strengthen its skills in facilitating community development, enabling them to better perform their jobs as health practitioners and educators. The mutual benefits enjoyed contribute to the partnership's sustainability and help to ensure its future continuation.

This document follows the events of the partnership meeting in Tevele on October 26th and 27th, 2004. Using a typical two day encounter between the Centre and the Tevele working group, this description introduces the reader to the Centre's community participation program. It outlines the six general steps of this approach while highlighting some of the major achievements of the partnership.

2. Steps of Community Participation

The community participation approach employed by the Centre can be broken down into six basic steps which each incorporates a cycle of planning, action, and reflection: pilot community selection; relationships and partnerships; community assessment; mutual learning; capacity-building; and documentation, reflection, and dissemination.

Step 1: Choosing Pilot Communities

A partner community must first be chosen. Once a potential partner is identified, the Centre team meets with representatives from the community to discuss the nature of the partnership and further assess the community's realities. The community must demonstrate interest and leadership in establishing a relationship with the Centre. They must be committed to improving their own well-being and general health worker practice. As well, it must be located within a reasonable distance from the Centre.

Step 2: Building relationships and Partnerships

Next, strong relationships and a partnership must be fostered. By spending time together, engaging in dialogue and learning about each others' lives, work, values and goals, participants of the

partnership develop familiarity, appreciation and respect for one another. The promotion of mutual trust is further aided by the formation of a written agreement which clarifies the terms of the partnership, including the purpose, expectations, guiding principles, time period, frequency of meeting, contributions of each partner, and approaches to evaluation. The development of relationships is a continual process that is maintained throughout the partnership.

Step 3: Community Assessment

As a relationship of trust and understanding is being established, the partnership conducts a collaborative assessment of the community's needs, resources, strengths and opportunities. Such an assessment is essential to a strong and mutually beneficial relationship. It compels the community to engage in self reflection and identify its particular issues of importance while helping the Centre trainers and students understand the realities of rural Mozambicans. Participatory action research (PAR) is the methodology employed in the partnership to study and take action on problems affecting the community. PAR is a process that is both collaborative and appreciative.

Step 4: Mutual Learning

The relationship between the Centre and its community partners is one of mutual learning and benefit. By engaging in experiential learning sessions with the community, the Centre team encourages the community participants to recognize their existing knowledge. The Centre contributes its own perspective on issues, thus together generating new knowledge and ideas. The community provides the Centre's trainers and trainees with a learning laboratory in which to study and observe the process of community health and development. Mutual learning is one of the core operating principles of the Centre's community participation program

Step 5: Building Capacity

In addition to developing mutual learning opportunities, the Centre supports the community and related institutions in building their capacity to carry out locally defined action against community health risks. This includes helping the community to build individual and group confidence, competence, knowledge, skills, experience, and material and financial resources. The community likewise takes an active role in developing the capacity of the Centre. By providing its trainers and trainees with opportunity to engage in good community health practices in an incremental way; it helps them to work more closely and effectively with the people they serve and gain the experience and confidence to train others to do similarly.

Step 6: Documentation, Reflection and Dissemination

Regular documentation of how the community participation program benefits the partner communities and the Centre's trainers and trainees is critical. With a clear record of the process of community participation, the Centre can contribute to the development of a new community health practice. The experiences of the Centre and its partner communities are recorded in different media formats to increase accessibility.

These six steps serve as a general outline of the Centre's approach to community participation. They have been presented here in a logical progression; however, it is important to note that the order of these steps is not sequential. All of the steps are interrelated and thus it is likely that many

steps will be practiced simultaneously. For instance, mutual learning cannot be achieved without continual relationship building and strengthening. Furthermore, as the partnership is constantly evolving, it is necessary to continually document its progress. The interplay between each step and the necessity of moving back and forth between them is more clearly illustrated in the following description of the Centre-Tevele partnership.

3. Basic Structure

The rural municipality of Tevele is located in Mozambique, in the southern province of Inhambane, and is divided into five administrative areas. Each area nominated six people to represent them in the Centre-Tevele community health working group. A core group of approximately two to four staff and advisors along with different various visitors and trainee groups represent the Centre on different occasions. To signify their commitment to working together to improve the general well-being of the community and improve training of health workers, the partners prepared and signed an agreement outlining each party's respective responsibilities and both the general and specific objectives of the partnership. Reflecting the changing needs of the Tevele community, the content of this agreement is collectively reviewed each year and appropriate revisions made. This process contributes to developing strong relationships and maintaining a level of transparency and trust between the Centre and its community partners.

In the early phase of developing the partnership, the working group proposed that they meet with the Centre each month for two consecutive days of discussion and coordination. The participants would be expected to gather at 8am to prepare for the day and eat a simple breakfast before commencing the meeting at 10am. Activities would take place until about 2pm whereupon the entire group would enjoy a hot meal together. Following the meal, the Centre staff and guests would return to the homes of the working group members who generously host them for the night.

The monthly meetings take place in Tevele in the local government gathering area. It is a simple arrangement consisting of a small number of logs and woven mats laid down on a cleared piece of earth under the shade of large trees. Originally only a single thatched structure serving as the local maternity lined the gathering place. However, as part of their contribution to the partnership, the working group has since expanded the area, constructing a meeting house, latrines, and two small huts that serve as a kitchen and a basic health post. The health post is managed by Catarina, a young local woman. The working group, with the support of the Centre, appealed to the district health authority to obtain training for Caterina. She runs Tevele's sole health post alone, with basic monthly supplies and treatments from the district health authority. The next closest health post is 8 kilometers away, and the nearest hospital is even further away in the town of Massinga, 40 kilometers from the community.

The week prior to each gathering, two trainers from the Centre travel to Tevele to meet with a co-planning subgroup selected by the working group. Together, they prepare the program of the upcoming meeting. They define the overall purpose and objectives of the meeting, lay out the daily program and activities and delegate facilitating responsibilities. This type of collaboration is an important component of capacity building and mutual learning. By consulting with one another ahead of time, the Centre team gains a better understanding of its community partner's views and immediate needs, while the community builds capacity in leadership.

3. Day One: October 26th

The meeting of October 26th and 27th, 2004, began as every monthly meeting does. Representatives from the working group arrived early to prepare the fire and bring water for the morning's tea. Staff from the Centre soon followed with education materials and the food for breakfast and the afternoon meal. While the community's volunteer cooks prepared tea and bread and jam, the rest of the working group slowly began to arrive, more than a few having walked many kilometers in order to attend this monthly gathering. As they waited for the cooks to finish their preparations, the people settled themselves on mats to chat and discuss local events and politics. Large gatherings like these are infrequent, so many people make use of them to catch up and do business.

The president of the working group, Sr. Calisto,* blows a whistle and the people line up to receive their bun and cup of tea. As stipulated in the partnership's accord, each member supplied his/her own cup, plate, and spoon. The meal took longer then usual, with the presence of two groups of trainees from the Centre.

The first of these groups was made up of Mozambican nurses who were trained over 20 years ago and were in a continuing education short course at the Massinga Centre. The focus of this portion of their course was to see and discuss how the community views health workers and learn how they can work with the community to improve their own role as health practitioners. The second set of trainees was a group of five nursing students from Canada. These nurses were spending six weeks of their program's final semester at the Centre, taking part in a unique international health practicum. Completing the group of visitors was a sixth young woman, a journalist from Canada, who was spending time at the Centre to learn and write about global issues.

The integration of trainee groups into the Centre's community participation program is integral to the program's goal of mutual learning. The trainees are able to contribute their experiences and skills as health practitioners while the community provides them with valuable information concerning the health and social realities of rural Mozambicans.

**** Think back to a time when you were in a new place for the first time. How did you feel? What did people do to make you feel welcome or unwelcome?*** * See work book question #1

After breakfast was finished, Sr. Calisto opened the meeting by leading the members of the working group in a song. In perfect harmony, the members sang about the importance of health and the partnership between Tevele and the Centre. They recognized the visitors and enthusiastically welcomed them to the community. The opening song was then followed by a hymn and a prayer in the local language of Xitsua (*pronounced she-tswa*).

Once the formal greetings were finished, Sr. Cándido, a working group member checked attendance. There are 30 nominated members in the working group along with a number of elders and local leaders. At this gathering, counting the visitors, there were close to 70 people present. Since the formation of the Tevele working group in 2001, the membership has stayed fairly constant. Some members, however, have moved away while a few have died. Attracting younger representatives has proved a constant challenge as many rural youths move to the cities to find work. Several newcomers have joined the working group, including traditional healers.

Following custom, two members of the working group were chosen to act as the documenters for this session. Each was given a notebook and pen and immediately began working to record the

* All personal names have been substituted.

meeting's events, one writing in Portuguese and the other in Xitsua. This regular practice, as well as the creation of learning materials such as "Two days in Tevele," is all part of recording the experiences of the Centre-community partnership.

The agenda for the October 26-27th meeting had been co-planned the previous week by the Centre and working group representatives. They identified the two goals of this month's gathering as: further opportunity to learn about HIV/AIDS; and the successful integration of the visitors into the ongoing Centre-Tevele community participation program.

Specific objectives defined by the co-planning group were:

1. To create an atmosphere that brings new people into the process of community participation and mutual learning.
2. To exchange views and experiences between health workers and community members.
3. To encourage dialogue between health workers and their community 'clients' about what really happens in the health posts, health centres and hospitals.
4. To recognize difficulties from last month regarding language and ways used to demonstrate condom use.
5. To integrate gender issues into the discussion on HIV/AIDS.
6. To promote preventative methods for combating HIV/AIDS.
7. To identify HIV/AIDS risk factors which exist in Tevele.
8. To look ahead to next month.

The co-planning group had identified the following teaching methods for the sessions:

- Explanations and individual presentations.
- A drama on health worker-client interactions that would involve both community members and visitors.
- Analysis of the drama in mixed groups (community, visitors, the Centre).
- Further analysis in unmixed groups.
- Boats of Hope: a participatory activity on HIV/AIDS prevention.

Necessary preparations and resources included:

- Poster paper, coloured markers, tacks, nursing uniforms, Boats of Hope kit
- People needed to be selected and briefed to participate in the drama

Each student group also underwent specific preparation the day before going to Tevele. The group of Mozambican nurses spent a two hour session of their course reflecting how health services should be provided and what qualities are particularly desirable and undesirable in a nurse. These trainees identified trust as an essential component to a good nurse-patient relationship. They further identified the attitude of the nurse as being a principle contributor to establishing this sense of trust. The nurses concluded that they must build and work in relationships where open and constructive dialogue occurs between health professionals and the community.

**** How does trust enable a health worker to better serve his/her patients?***
**** Why is developing a relationship of trust important when working with communities?***

The Canadian students also prepared themselves prior to going to Tevele. The Centre staff introduced them to the Centre's community participation program and gave a brief history of the Centre-Tevele

partnership. They emphasized the importance of mutual learning and bringing health workers and civil society together. The students also engaged in a brief discussion of gender, HIV/AIDS and the community's sensitivity to the disease, and practiced the Boats of Hope exercise.

After Sr. Cándido took attendance, the first task on the agenda was a short presentation by Sr. Casimiro, Secretary of the municipality of Tevele. Sr. Casimiro had just returned from a national meeting on Community Participation in Maputo where he and Domingos, the Director of the Massinga Center were well received. The working group was very pleased to hear that their efforts and initiatives were being recognized on a national level. Sr. Casimiro relayed the events of the national meeting in Xitsua, the local language.

Language barriers and differing literacy levels are a common, ongoing, challenge to effective communication and consequently, effective community participation. The Centre however is fortunate to have several trainers that are skilled in both Xitsua and Portuguese and have the ability to translate much of the conversation into Portuguese for those who cannot understand Xitsua. Many of these trainers also have a good working knowledge of English and are able to convey the substance of most discussions to Canadian trainee groups who cannot understand either language.

Following Sr. Casimiro's presentation, Fátima, a trainer from the Centre, asked each student to introduce him or herself and asked the community's permission for the journalist to record some sounds and interactions for radio pieces to be sent back to Canada. The members of the working group readily agreed to the taping and expressed their delight in meeting each visitor with an enthusiastic round of applause.

For the benefit of the visitors, Pastor Gabriel, a member of the working group briefly recounted the history of the partnership. He explained how the community was initially skeptical of the Centre's intentions as Tevele had been previously "abandoned" by a different group that had come from provincial health. He further elaborated on how the working group decided to focus on malaria and how the partnership's agreement was formulated.

Hearing a first hand account of how the Centre-Tevele partnership was formed and the reservations and concerns that the community had is important for the both the Centre team and others to hear. It helps both parties to understand the perspective of the community and illustrates how working *with* the community rather than *for* the community can help to build both health worker and community capacity.

**** What is the difference between working <u>for</u> the community and working <u>with</u> the community?***
* work book question #2

Drama

Thanking Pastor Gabriel, Florência, another trainer from the Centre, introduced a drama as the day's first group activity.

Three members of the working group took on the roles of a family in Tevele with a very sick child. The parents did their best to care for their daughter at home. During the night, however, while everyone was stretched out on a mat trying to sleep, the mother woke the father. The daughter had a high fever. It was night and the health post was very far away, so the mother soaked a cloth in water and tried to

reduce the fever. A cock's crow was made to indicate that it was morning and the parents and their sick child tiredly made their way to the hospital.

The family was greeted by two nurses in white uniforms sitting at a table. The roles of the nurses were played by two of the Mozambican trainees who were invited to join the drama. The objective of the drama was to examine how families and the health care workers interact. The working group had previously expressed concern over how members of the community are attended to by health workers. People often feel that their needs are not being served and that they are not treated with compassion and care.

During the drama, the nurses acted in an appropriate manner. The family was well received and the nurses gently inquired about the child and what had been done at home. They were impressed by the mother who knew to reduce the fever with a wet cloth and commended her initiative. The mother in the drama then tried to tease the health workers. When one of the nurses asked if they were keeping their house and yard clean, the mother indignantly replied, "Of course we do! Whenever my husband gets drunk and leaves coconut shells out, my daughter will turn them over so that water doesn't collect and attract mosquitoes." This response had the whole crowd in laughter.

The nurses gave advice respectfully. They diagnosed the little girl with malaria and carefully explained to the parents how to administer the medication and how to prevent malaria by using mosquito nets. The family thanked the nurses and returned home where they talked about their treatment at the hospital. Two days later one of the nurses came by the house to see how the child was progressing. The family was very pleased with the follow up and openly expressed their gratitude.

Dramas are often used in community participation. They are one way to bridge language barriers as well as include participants who may be illiterate or have very limited reading and writing skills. Dramatization, for some, is also a less threatening way of conveying their concerns and comments. Participants are able to disassociate themselves from the characters they are playing and consequently are less inhibited by fears of censure and criticism. In the early months of the partnership, the working group members were shy and hesitant about participating in these activities. Gradually, however, they shed their apprehensions and now enjoy, lear,n and take part in the Centre's discovery-based activities with enthusiasm. Laughter, drama, songs, and dance, as well as thoughtful reflection and analysis characterize the monthly get-togethers.

**** Suggest some teaching tools, games or methods that can help to overcome language or literacy barriers?*** (see workbook)

Reflection

After the drama and a short break, the whole group engaged in reflection and analysis. One of the Centre trainers divided the participants into six groups. The Mozambican trainees and Canadian students each formed a group while the working group members made up the remaining four. Ideally each group would have included representatives from both student groups and the working group. However, due to language barriers it was decided that these separated group divisions were more likely to generate active group discussion.

Once the groups were formed, they each found a shady spot to sit and discuss what happened in the play, concentrating specifically on how the family and the health workers treated each other. Each

group was given a piece of flip chart paper with the following table and was asked to consider the messages portrayed by the drama.

What knowledge, skills and aspects of relationships and community did the health workers demonstrate?
What did the family from the community illustrate?

By reflecting on these questions they could complete the table.

	Health Workers	Community
Knowledge and Skills		
Relationship and Communication		

Small group work is a particularly effective way of building capacity and encouraging mutual learning and active participation. It encourages participants to recognize their own knowledge and provides opportunities for them to learn from each other. Small group work can help to empower the participants to take ownership over their own learning.

**** What are some additional benefits of small group work? Can you think of any disadvantages to working in small groups?***

After 20 minutes of discussion, the groups reconvened to share their analysis with the other participants. Both the health workers and the working group reacted positively to the drama. The working group members were pleased with how the nurses welcomed the patients. They commended the nurses on their attentiveness and their useful advice concerning the administration of the child's medication and methods of preventing malaria. The community also appreciated how the nurses applauded the family for the treatment they had provided their child at home and for bringing the child to the hospital so promptly. The follow-up visit by one of the nurses was particularly well received.

***** See work book question #4

Centre trainer, Florência, congratulated the groups on a job well done. She then reminded everyone that the real-life situation may be more complex but what is important is to talk about it together.

Questions to promote dialogue

To create an open dialogue on how the nurses and the community interacted, Florência once again split the participants into groups. That of working group members were asked to formulate questions for the nurse trainees while the nurse trainees were similarly asked to develop questions for working group. The Canadian students were asked to devise questions for both the working group and another for the nurses. All groups were then asked to prioritize their questions, selecting three to pose to the others. Before breaking off into their respective groups, Florência asked Geraldo, a working group member, to provide an example of a question that may be posed by the community. After a moment's thought, Geraldo stood and said the following:

> I am accompanying a sick community friend to the hospital and we wait patiently. Finally he is seen by a nurse who says to us that the problem is one that the doctor needs to see but the doctor

> isn't here. He then suggests that we come back tomorrow. Why isn't the doctor available and what are we to do when we have come so far?

After listening to Geraldo's comment, Florência asked the Mozambican nurses to similarly provide a question. One nurse stood and provided the following example.

> A child is sick with a fever and the family decides to get help from a traditional healer. Unfortunately the child doesn't improve and is taken to the hospital. By this time the child is so sick that the medication won't help and the child dies. Who is responsible? The family, the traditional healer, the hospital or the health care system?

The participants listened thoughtfully to each of these examples and then broke into their small groups to discuss and formulate their own questions. After 20 minutes the participants returned to the plenary to share their questions. Taking turns, each group displayed its flip chart paper and read aloud their questions.

Questions by the community included:

- Why do some people get to jump the queue to see a doctor when others have waited in line for hours?
- Why is the hospital pharmacy always running out of medication?
- Why is it that pregnant women are so often poorly treated in the maternity?
- When someone is sick and needs to go to the hospital, what can we do to help him/her before reaching the hospital?
- Why are some people with more money able to pay for better services?

Questions by the nurses included:

- Why do you wait so long to seek treatment from a hospital?
- Why do only women bring sick children to the hospital?
- How do you treat a child with diarrhea at home?
- How can we work better with traditional healers to treat patients faster and better?
- What can we do to help reduce sickness in your community?

Questions by the Canadian students:

To the nurses:

- When a sick person arrives at the hospital, do you ask about medications that have been taken, for instance, what was given by a traditional healer?

To the traditional healers, who are members of the working group in the community:

- Where and how did you learn about treating a sick person?

**** If given the opportunity, what questions would you like to pose to the community? How would answers to these questions help you to better respond to the needs of the people you serve?***

Due to time constraints, Florência asked the working groups to identify one question to give to the plenary for discussion and for the nurses to identify another. After a short debate, the working group

members settled on the question concerning the shortages of medication in the hospital pharmacy. Having identified the topic of discussion, Florência then asked the plenary for comments or responses.

One of the nurses stood and responded by stating that shortages of medication are very important issues for both health workers and the provincial health authority. He emphasized that all health workers try their best to make sure that there is enough medication for everyone. Unfortunately, sometimes, health authorities miscalculate the amounts of medicines to send to the districts. For instance, if there is an unpredicted outbreak of a disease, such as cholera, the demand for medication exceeds the regular monthly supply and the hospitals and health posts simply can't keep up. In these cases, patients may have to be referred to a private pharmacy to obtain their medication. Another nurse then interjected to assure the community that while shortages of medication do occur, they are doing everything they can to improve supplies.

The working group thanked the nurses for their responses and invited them to ask their question. The nurses chose to pose the question concerning working with traditional healers to better serve the community. This question provoked a great discussion about the role of traditional healers and why community members are reluctant to tell a nurse when they have seen a traditional healer. The community members explained that they are afraid that if they make this admission, the nurse will treat them differently. A traditional healer then commented that most healers recognize the importance of cooperating with other health workers. When a healer is unsuccessful in curing a sickness, they will most often encourage the patient to go to the hospital and will even send a note along stating what treatments have been given and what medications have been prescribed. He then suggested that the reverse should occur when a person leaves the hospital for their community.

**** What importance do you give to health workers working closely with traditional healers? Why?***

Following this discussion, Florência thanked all of the participants for their insights. Final words were expressed by several nurses who thanked the working group for allowing them to participate and for their honest and thought provoking comments. The session was formally closed at 2:30 pm with a hymn and a prayer.

***** See work book question #5

Once the session ended, the working group celebrated the productive day by singing and dancing. The Canadians were invited to take part and the festivities continued while a hearty lunch of corn meal porridge and goat meat was served. As people finished their lunch, the gathering place slowly began to empty out. Some people lingered for more singing and dancing and even some Xitsua lessons for the Canadian students. The Mozambican nurses returned to Massinga in one of the cars as they had to continue their classroom training the next day. The Centre staff and the Canadian students; however, stayed overnight with several host families in Tevele.

The overnight stay in the community is an important feature of the Centre's community participation program. It helps to build relationships between the different participants and provides an opportunity for the Centre team and trainee groups to witness, first hand, the realities of rural Mozambican life. Also, it demonstrates the Centre's appreciation of the significant and important role rural communities play in supporting the rest of the country. It is a demonstration of solidarity with those most in need of health services support. During their stay, guests are expected to help haul water and sleep with the families in their homes. In exchange for their hospitality, the Centre provides their hosts with food for supper and supplies for the overnight stay such as soap and candles. For Mozambican Centre trainees

now living in urban areas, it may be a struggle to realize the value of returning to this simple environment, sleeping on a grass mat, with no electricity and scarce water. For Canadian students, the time spent in Tevele is often the highlight of their Mozambican experience. A moonlit evening bath, in a small grass enclosure with a basin of hot water, and the generosity of people with so little is not easily forgotten.

4. Day Two: October 27th

The second day in Tevele started early. The trainers and the Canadian students woke up to the cock's crowing and quickly departed from their home stays in time to reach the gathering place to help prepare breakfast. By the time they arrived, the cooks had the fire ready. A couple of the Canadian students left again in the truck to haul water from the nearby river. By sharing in the work, the participants gain a greater understanding of each other's reality and reaffirm their mutual commitment to the partnership. Shared physical work also helps to balance the power between partners.

Following the same schedule as the day before, working members began arriving around 8am. Some busily began sweeping and tidying the area while others laid out mats and chatted. The tea and bread with jam were served at 9:30 am, as usual, and the session began on time at 10 am.

Again, members opened the session with singing and clapping, a roll-call of the members and finally a short hymn and prayer. It was raining quite heavily so the activities were moved inside the meeting house, a simple structure of local materials with mats on the ground for sitting. Outside, women with their babies and toddlers began arriving for the monthly maternal child health clinic that from Massinga. These mobile clinics provide rural women the opportunity to weigh and immunize their children and obtain both pre and post natal check-ups. Within a short time, hundreds of women were gathered and most of the Canadian nursing students stepped away from the working group to help weigh and immunize babies.

Choosing the sex of your baby

The first activity of the day was introduced by Fátima. She began by recollecting the events of last month's meeting when the working group and the Centre team tackled issues surrounding sexual activity as it relates to HIV/AIDS control. Many of the community members found the topic sensitive and were quite uncomfortable discussing it. Fátima acknowledged these feelings and apologized for the awkwardness felt by some as a result of the explicit language used to talk about condoms and the penis models that were used to demonstrate applying a condom. She then, with the help of Florência, quickly moved into the first activity

Florência created a scenario for the community. She asked the working group members to imagine that each of them, with their spouse, had to choose the sex of their next baby. Handing out small pieces of paper she asked each participant to indicate on the paper whether they would choose a boy or a girl; an "O" would signify a boy, while an "X" would represent a girl. With a marker, each member indicated down the sex they would prefer for their child. Florência collected the papers and asked the participants to turn to one another and explain why she or he had chosen that sex. After a short period of discussion, Florência randomly handed back the pieces of paper so each person could share the symbol on the paper without fear of personal censure. As the members read out the symbols on their random piece of paper, Florência tabulated the results on a piece of flip chart paper pinned on the wall of the grass hut. Of the participants, 35 had chosen a boy, while only nine had chosen a girl.

Once the results were clearly recorded on the flip chart, Florência asked the group to explain why they had chosen a particular sex.

Those that had selected a boy gave the following reasons:

- If the father dies, a boy is able to carry on the family name.
- A boy is able to study, obtain a good job, go to South Africa for work and thus help to improve the mother's life.
- If the father dies, a boy is able to take care of the family. A son has the liberty to take his mother into his own home, whereas a girl must obtain approval from her husband.
- A boy has the power to make a woman pregnant, and thereby contributes to procreation. This comment was countered by a woman who pointed out that procreation requires both sexes and that boys and girls both have important roles within a family.

Those who had selected a girl gave the following responses:

- A girl helps at home by working in the garden, doing the cleaning, washing and cooking and having children.
- A man commented that he had only boys. If he had a girl, he would be able to better distribute tasks within the family.
- One woman relayed how her son had left home to study and work in Maputo. He has since become busy with his own family and no longer has time for her. A girl would take care of her and would ask her husband to let her visit her mother.

Someone commented that since one can't really decided on the sex of their child, whoever is born needs to be taught to be a good and helpful person, and it is up to the parents to do that.

Gender and HIV/AIDS

After thanking the working group for their perceptive and informative remarks Fátima and Leah**,** a Canadian advisor with the Centre, took turns analyzing their comments. By critically examining the working group's responses to the activity, they illustrated how men still hold much of the social power in Mozambique. They then used this point to introduce a discussion on gender, power, and HIV/AIDS. Using the participants own revelations and thoughts is part of the discovery-based approach to learning that is a core component of the Centre's methodology for working *with* the community.

- Insert information box with definitions of sex and gender:

Sex refers to the biological differences between men and women that are genetically determined.

Gender is the composite of characteristics, roles, and behaviour patterns that differentiate women from men and are socially determined.

Sex is the product of nature while gender is the product of society (Commonwealth Secretariat, 1999)

- Insert tips for talking about sex, HIV/AIDS ex: word substitution?

(KARA OVER TO YOU FOR IDEAS, PLS)

Having refocused the discussion on gender and power, Fátima asked the working group whether any of them knew of Luisa Diogo. Only a few knew that she is Mozambique's Prime Minister. For the benefit of those unfamiliar with her, Fátima described her as a "wonderfully strong and capable person." She also identified two other female leaders who are more familiar to Tevele—the provincial Director of Education and the District Director of Health.

Fátima then opened a dialogue about how women fit into society's power structure. She spoke of how it is almost always the woman who brings the child to the hospital. However, if the child is very sick and needs to be transferred, the approval of the husband is necessary. By the time he can be found and the approval granted, the child's condition has often deteriorated significantly.

Fátima discussed the limits of a woman's sexual power using an example of a woman whose husband has returned from the mines in South Africa. This woman does not have the right to refuse sex with her husband, even if he is sick and she suspects that he may have contracted a disease from another woman while he was away. If the woman suggests using a condom, the man may accuse her of being unfaithful. Consequently, the woman has no control over her sexual health and can be exposed to any number of sexually transmitted diseases, including HIV/AIDS.

Fátima explained that it is these types of gender differences that need to be understood and addressed in order to effectively combat HIV/AIDS. Until women hold an equal position of power in their relationship it will be extremely difficult to educate or encourage condom use. Having provided the participants with a lot to think about, Fátima called for a short break after which the group would engage in an activity to help them further examine the relationship between gender, power, and HIV/AIDS.

- work book question #7

The Boats of Hope[*]

After the group reconvened, the session continued outside on mats as the sky had started to clear. As the members gathered around, Florência placed a piece of navy blue cloth with three boats stitched on it in the centre of the mats. She explained that the blue cloth represented water which could slowly rise over the years, putting everyone at risk. The danger posed by floods is all too familiar to most Mozambicans as the years 2000 and 2001 were marked by torrential flooding in many parts of the country. Florência then made the comparison to HIV/AIDS which, like the rising flood waters, increases over time without people fully realizing it. Each boat on the cloth signifies a different lifestyle choice: abstinence, fidelity and condom use. By maintaining one of these choices, a person can protect him or herself from the "AIDS flood." To emphasize the danger of being in the water unprotected, a laminated illustration of an alligator was placed in between the boats.

After explaining the significance of the cloth and the three boats, Florência distributed laminated cut-out characters to each participant. A wide selection of characters were handed out: some were women—one a mother with a baby strapped on her back, another was a fashionable teenager; there were elders; young people; and children; studious characters as well as some who looked like they frequented the "disco." Members were each given a character quite different from their own identities; for instance, an older woman was given an image of a young football player. Participants were asked

[*] adapted from the Fleet of Hope

to create a story for their character and decide which boat they would choose. The members laughed and joked as they each took their turn. Much discussion was generated as the group commented on each other's choices.

When all the characters were placed in the boats, Fátima explained that people may opt for a different boat as they mature or experience a lifestyle change. A young boy may choose abstinence, but as he grows older he may decide to move into the condom boat. A business man may choose fidelity when he is at home with his wife, but opt for abstinence or condom use when he travels. It is not important which boat you are in, as long as you are in one boat to remain safe. After contemplating Fátima's comments, some of the participants reconsidered their choice and placed their characters in a different boat, each explaining why they had changed their minds.

After the exercise was complete Fátima asked the working group: What can we do to help keep Tevele community members in one of these boats? What is the community's role in educating its people about the dangers of HIV/AIDS "flood"/pandemic? How can a community provide and support safe choices to keep its people safe?

Fátima's question produced an animated discussion. Comments were made concerning fidelity and the possibility of offending a couple in a committed relationship by telling them to use condoms. Other questions were raised relating to condoms, such as "At what age should people be taught about condom use?" Many of the questions had to be tabled till the next meeting as time had run out and there was still one important issue to discuss.

Similar to dramas, role playing activities such as the life boat game allow participants to examine their realities in a non-threatening way. HIV/AIDS is a sensitive topic which many communities have difficulty discussing openly. By framing the issues in a game and disassociating themselves from the characters, participants are able to explore subjects and ask questions they normally would be too uncomfortable examining. Simulation exercises like this one can be repeated a number of times with the same group allowing for different aspects of the topic to be explored.

Closure

After such a productive meeting, it was time to think ahead. Fátima reminded the group that this gathering place was still in need of new latrines. Everyone agreed that latrines were needed; however, given that the latrine would be part of the gathering place and designated for public use, who would prepare it: community members at large or the working group? with or without assistance from the Centre? An energetic debate unfolded and finally ended with the decision that members of the working group would prepare the latrines themselves. Their collective action would demonstrate their concern for hygiene and good public health and would model the type of responsibility and initiative needed for community health and well-being. It was decided that the latrines would be ready for next month's gathering.

Dates for the next meeting were set and sincere words of thanks were offered by the Canadian students to the working group. Two community members responded with best wishes for their upcoming final exams and for a happy graduation as this was the end of their studies. Another shouted out how wonderful it would be "if even one of you would please come back and work as a nurse here in Tevele." On this warm note of solidarity, the session ended accompanied by a hymn and a prayer and a hot meal shared in the company of new and old friends and partners. By 4:30 pm, dishes and pots were cleaned and the participants had dispersed for home. The gathering place was quiet.