Abstract

Understanding why, when, and with whom women engage in opportunities for HIV & AIDS education is critical in exploring the extent to which popular education strategies promote transformational learning among women in Malindi, Kenya. Three central questions animate this research: a) What do rural women who participate in HIV & AIDS popular education programs learn about HIV & AIDS, b) through what range of pedagogical practices and theories does their learning occur, and c) how does this learning contribute to transformative changes that improve women's health, at both individual (e.g., beliefs, behaviour) and communal levels (e.g., group actions)? Employing a qualitative research design, face-to-face interviews, and document analysis of secondary sources enabled a rich and in-depth exploration of specific learnings and actions among Kenyan women. Qualitative analysis of eight semi-structured interviews reveals three dimensions of transformative learning among adult women in Malindi, including a) striving towards openness, b) culture of support, and c) connected knowing. These inter-related themes outline the potential for Kenyan women's HIV & AIDS education to move beyond instrumental, and communicative, to more empowering transformative learning.
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Chapter 1: Introduction

Recent figures estimate that over 25 million people in Sub-Saharan Africa are living with HIV & AIDS (UNAIDS, 2008), of which over half are female (Barnett & Whiteside, 2006). In particular, adult women in East Africa tend to be disproportionately infected with HIV compared to adult men. This is most disproportionate in Kenya where adult women (8.7%) are almost twice as likely to be infected as adult men (4.6%), suggesting that risk of infection is gendered (UNAIDS, 2008). Women may have different prevention needs than men, thus requiring gender-specific HIV & AIDS prevention and education. However, prevention and intervention programs rarely consider the gendered nature of HIV & AIDS in their design and implementation despite gendered-disparities in Kenyan infection rates (Barnett & Whiteside, 2006; Morrell, Unterhalter, Moletsane, & Epstein, 2001; Muturi, 2005).

In Kenya the primary mode of HIV transmission is heterosexual intercourse. Prevalence trends showcasing the high infection rates among unmarried youth and married couples have caused AIDS education to become a moral issue. Efforts to modify sexual practices, in particular pre- and extra-marital sex, have made HIV & AIDS education a highly politicized sphere with international, non-governmental, and faith-based stakeholders throughout Kenya since the 1990's. Historically, these interventions are based on western understandings of individual health as cause-and-effect (Barnett & Whiteside, 2006). Recently, there has been a drift away from this limited biomedical approach and a move towards community-based strategies and techniques. Summarized as popular education, these initiatives are particularly relevant for rural communities and involve interactive workshops, theatre, peer-education, radio broadcasts, and songs, among other strategies (Campbell & MacPhail, 2002; Harvey, Stuart, & Tony, 2000; Vaughan, Rogers, Singhal, & Swalehe, 2000). Popular education strategies are particularly viable for adults who
have limited access to formal education programs delivered through schools. Additionally, popular education is essential for populations who may not be able to read and write, as many printed resources (e.g., pamphlets, billboards) are inaccessible to those who cannot decode them.

Harvey et al. (2000) and Vaughan et al. (2000) examined popular education and HIV prevention, offering valid insight into HIV & AIDS education in rural African contexts. However, both studies fail to provide a gender-based analysis of the findings despite reporting different learning contexts and outcomes for women and men. Although the call for HIV & AIDS prevention programs designed specifically for women is not new (Gollub, 1995; Heise & Elias, 1995), deep examination of women’s experiences of learning, whether instrumental, communicative, or transformative, as central to the development of HIV & AIDS education initiatives is largely unexplored (Muturi, 2005).

**Purpose**

The purpose of my study is to explore the role of popular education strategies in HIV & AIDS awareness and prevention among women in one rural community located in Coast province, Kenya. Through partnering with a local non-governmental organization (NGO), I inquire into rural Kenyan women’s experiences of community-based HIV & AIDS education and explore if and to what extent popular education programs promote transformative learning.

**Research Questions**

Three central questions animate my research:

- What do rural women who participate in HIV & AIDS popular education programs learn about HIV & AIDS?
- Through what range of pedagogical practices and theories does their learning occur?
How does this learning contribute to transformative changes that improve women's health, at both individual (e.g., beliefs, behaviour) and communal levels (e.g., group actions)?

By unpacking each research question below, I will sharply define the phenomena of rural women's HIV & AIDS education in Kenya and provide a rationale for this area of focus.

Research question one explores what rural women are learning about HIV & AIDS through popular education programs. The category of rural women is defined in part by Barnett and Whiteside's (2006, p. 238-239) story of a rural Kenyan household as people whose livelihoods depend primarily on personal labour and subsistence farming. I add that women may serve a rural community in other capacities outside the realm of agriculture (e.g., schoolteacher, midwife, shopkeeper), and are considered rural or semi-rural women for the purposes of this research. HIV & AIDS has a significant impact on rural communities, decreasing crop productivity, reducing the labour pool, and forcing family groups to exchange meager assets or withdraw children from school to purchase costly medications. Barnett and Whiteside (2006) explain how the impact of HIV & AIDS on rural populations has been "largely overlooked in the focus on prevention" (p. 240), providing the impetus for my focus on one rural community in Kenya. Exploring HIV & AIDS education can shed light on a community's response to the epidemic, identify specific areas of prevention for rural populations, and illustrate how women's lives are sites of agency.

The second research question inquires into the range of pedagogical practices and theories through which rural Kenyan women are learning. This question creates room for women to discuss how they prefer to learn, what pedagogical pathways are most effective, and what conditions create a safe learning environment. Within HIV & AIDS education there is often a gap between theory and practice. Morrell et al. (2001) illustrate the paradox within women's
education, noting how strategies fail to ask critical questions concerning gendered understandings of HIV, therefore perpetuating "gender-blind" prevention programs in Sub-Saharan Africa.

Research question two seeks to illuminate the extent to which rural women are involved in the development of well-intentioned education programs designed to harness female empowerment. Bloch, Beoku-Betts, and Tabachnick (1998) contest the underlying assumption that education is the "ultimate liberator of women in Africa" (p. xi). At least in the case of formal education, the authors note that HIV & AIDS education may regulate and disempower to the same degree it liberates and transforms. Alternative perspectives outside of the normative emphasis on the value and benefit of popular education for women may more accurately portray the reality and totality of HIV & AIDS education.

Research question three, regarding transformative changes at individual and communal levels, connects the previous two research questions, and constitutes the heart of the study. The foundational components of HIV & AIDS education are exposed as women articulate and give voice to stories of personal and collective transformation. This third research question also invites dialogue on agency and social action, highlighting women's interpretations of social practices or norms that limit their learning. Barnett and Whiteside (2006) assert that HIV & AIDS programs are only successful for participants when learners can openly engage in frank discussion without fear of repercussion. Echoing Freire's (1970) emphasis on societal transformation through participatory dialogue, I stress that relations of power among learners and educators may inhibit honest discussions of norms surrounding gender and sexuality among rural women.

Overall, the three research questions focus my efforts to gather rural Kenyan women's insights into processes of learning that create transformative change among adult learners. Their insights are invaluable in understanding how learning can engage the voices and participation of
women in health decisions that affect them. One of my aims in researching this topic is to provide alternative directions and possibilities for HIV & AIDS education programs to become more responsive to the learning needs of rural women in Kenya. As you will see, the findings from this study outline a framework that represents the learning experiences of rural adult women in Malindi, Kenya. This model may urge governments and NGOs to re-focus their HIV & AIDS awareness programs with particular consideration for women. Further, on, you will see how this study contributes to theory and practice in the fields of adult education, particularly transformative learning theory, community development, and HIV & AIDS education within Sub-Saharan Africa. Particularly, the findings of this research yield new cross-cultural implications for a growing body of adult education literature within the contexts of HIV & AIDS and transformative learning theory.

**Language and Representation**

It is essential that I position myself and my own biographies, place, and stories in relation to the research context. I am a White, western educated Canadian woman who was born and raised over six years in Sierra Leone. I completed my first year of undergraduate studies in Nairobi, the bustling metropolis capital of Kenya. Albeit limited, my first-hand experience of Kenyan life in rural and urban settings has provided me with some cross-cultural competencies and skills for living and researching in Kenya. These experiences form the basis for my current research interests and contributed to my understandings of the reality of HIV & AIDS in Kenya.

I am not Black or African, do not speak Kiswahili, and have a limited understanding of cultural nuances and practices enacted by rural Kenyan women. Yet I have elected to explore and articulate their experiences of HIV & AIDS education. Like Halperin (2005, p. xiv), who has documented Kenyan women's lives, I wonder whether I am the best person to engage such research. I admit that being born in Africa and having a deep love for the continent and its
peoples does not grant me the right to speak for or about "them." However, I also feel a deep moral and ethical responsibility to tell women's stories and document their tales of transformation. In choosing to research in Kenya, I acknowledge how the appropriation of data from Kenya to Canada may perpetuate asymmetrical relations of power and I commit to working towards methods and practices that counteract neo-colonial tendencies within research (Alcoff, 1991). While conveying the oppressive reality of HIV & AIDS, I also hope to portray moments of triumph and instances where women invoke their power and agency. It is my intention that this thesis articulates and engenders an authentic understanding of what it means to be a Kenyan learner and tries to accommodate the diverse range of educational experiences. Similarly, I wish to paint a portrait of adult education that is vibrant and impactful.

Words and language are extremely powerful in shaping and constructing our world (Freire, 1970). Explaining several key concepts used throughout this thesis will maximize clarity and understanding for readers (see Appendix A: List of Abbreviations and Acronyms). Human immunodeficiency virus (HIV) is the virus that causes acquired immune deficiency syndrome (AIDS). Some literature uses the term HIV/AIDS; I prefer to use an ampersand because HIV is not the same condition as AIDS. A person can live for years with HIV and not have AIDS; full-blown AIDS presents more robust challenges in the area of prevention and care. Throughout this thesis, my use of the phrases "the virus" and "the epidemic" are synonymous with HIV & AIDS. Unless necessary, I do not provide background information or definitions for clinical terms used by the participants in this study as the meaning of specific HIV & AIDS treatments or medications is often implied within the quote.

Much literature references the importance of risk and risk reduction behaviours in HIV & AIDS education. These concepts are rooted in epidemiology and are often misused in other disciplines. Barnett and Whiteside (2006) explain how concepts related to risk (risk environment,
high-risk behaviour, risk reduction) have become "connected to ideas and emotions such as those of blame and stigma" (p. 85) as certain social groups (e.g., commercial sex workers) are perceived to be a risk to the healthy rather than be at risk. Within this research context, I have elected to use terms related to vulnerability and seek to shift blame away from women as the primary source of HIV transmission. Practices such as abstinence from sexual intercourse are seen as protective rather than a strategy to reduce women's risk of infection. Boesten and Poku (2009) explain how concepts of vulnerability and protective practices recognize how "socioeconomic inequality and gender has particularly devastating effects" (p. 10) on women's health and HIV prevention. Focusing on protective practices within women's HIV prevention invites discussion of social constructions of gender and sexuality that may constrain women's decision-making powers and heighten their vulnerability to HIV infection.

Additionally, I refer to the cross-cultural nature of this research throughout the thesis. I use the term cross-cultural to signify that a foreign researcher is working and living in a country context that is not her own. I do not make any comparisons across cultures as the traditional definition of the term may suggest. In referring to authentic learning, I borrow from Cranton (2006) in viewing authenticity as central to processes of transformational learning. Supporting learners through relationships of trust is central to meaningful and authentic learning.

Finally, I use the term storying instead of storytelling to reduce the emphasis of telling and increase the value of hearing and listening to a story. Use of the term storying is prominent within several disciplines (e.g., counseling, literacy) but limited within the context of transformational learning and HIV & AIDS education. As a strategy to foster critical self-reflection among adults, Cranton (2006) writes about the value of autobiographies, pointing out how sharing one's life story orally invites others to "interpret and reconstruct each other's biographies" (p. 146). In this research study, storying encompasses an understanding of dialogue
where the story-teller and the story-listener are equally involved and active in a process of learning.

**Layout of the Thesis**

In its entirety, this thesis reports on the design and processes of a qualitative research study carried out as part of the requirements of the Masters of Education degree program at Queen's University. Chapter 2 reviews the extant literature in the areas of transformative learning theory, HIV & AIDS education, and rural research contexts in African countries. Chapter 3 argues for a qualitative research methodology and describes the various methods used to collect, manage, and analyze the data. Chapter 4 focuses on research context, describing Pwani's HIV & AIDS prevention programming and presenting a portrait of each interview participant. Chapter 5 reports the general findings and cross-cutting themes that emerged through the analysis of the qualitative data. Chapter 6 discusses the themes, linking the major findings of the research study to the extant literature. Chapter 7 offers a summary, concluding remarks, recommendations for HIV & AIDS education programming, and implications for further research. This thesis portrays the experiences of eight adult females learning about HIV & AIDS on the outskirts of a small town along Kenya's coast. I do not attempt to generalize or extend the findings to Kenyan women as a whole but seek to articulate and represent the educational journeys of eight women in the community of Malindi.
Chapter 2: Literature Review

This chapter presents a rationale for the study's focus on rural Kenyan women and situates transformative learning theory as an appropriate theoretical underpinning for exploring rural Kenyan women’s experiences of HIV & AIDS education. First, I map the HIV epidemic in Kenya and problematize cross-cultural research. An overview of transformative learning theory is followed by discussions on the centrality of support and dialogue in fostering transformational learning. Next, peer education is presented as a particularly effective pedagogy for HIV & AIDS prevention and education in resource-limited contexts. Finally, I conclude with a discussion of several related studies which provide insight into processes of education in rural Kenya.

Mapping the Epidemic in Kenya

I selected Kenya as the preferred location of the research site for several reasons. First, it is positioned geographically and economically as the hub of East Africa, with the main port in Mombasa serving as the origin of the trans-Africa highway. Pratt, Obeng-Quaidoo, Okigbo, and James (2000) explain how this location makes Kenya a “reservoir of, and a conduit for, the spread of HIV & AIDS” (p. 132). HIV & AIDS education is particularly prominent in Coast province, enabling me to select several potential research communities which would be suitable for exploring the social phenomena under study.

Second, Kenya remains a focal point for non-government organizations (NGOs), which have collectively created Kenya AIDS NGO Consortium (KANCO) and by 2000, had brought in over $90 million in HIV & AIDS program funding (K’Oyugi & Muita, 2002). This suggests that extensive HIV & AIDS education programming is not only underway, but that there is significant and long-term donor investment in fighting the epidemic within Kenya. Established NGOs, prevention strategies with successful histories, and participants with a range of educational
experiences enrich the context and invite a deep exploration of the possibilities of transformational learning in Kenya.

Third, there are significant differences between rates of infection in rural and urban areas in Kenya. Although prevalence is higher in urban centres, the vast majority of the Kenyan population lives in rural areas, therefore in total there are more rural women living with HIV & AIDS than urban women (K'Oyugi & Muita, 2002). As Stoskopf and Yang (2004) highlight, many rural women and men are migrating to urban areas for employment. Exploring what rural women understand about HIV & AIDS is essential in order to facilitate the development of women’s protective practices and relevant skills for prevention in a higher-risk urban environment.

**Problematising Cross-cultural Research**

As much as there is empirical justification and personal passion for researching in Kenya, I acknowledge that research across "other" cultures, geographies, languages, and histories may be problematic. Writing as a non-western feminist, Narayan (1989, p. 263) clearly explains how interest does not provide a warrant for "us" (e.g., western, northern, colonizers) to speak about "them" (e.g., other, southern, colonized). Taiwo (2003) laments how African feminists and scholars "labor under a burden imposed by the misrepresentation, falsehoods, and half-truths which characterizes much of Euro-American scholarship on Africa" (p. 45). Illustrating this, Oyewumi (2003) poignantly remarks that despite hundreds of years of global progress, "images of Africa (by the West and for the West) have hardly changed" (p. 40). Western scholarship continues to reiterate generalized descriptions, such as "traditional African women," and "rural Africa," as if women, education, and rural geographies across 53 countries are generic, mirror images of one another.
However, there is value in cross-cultural studies and much has been learned in researching transformative learning in a variety of cultural contexts within Africa. Easton, Monkman and Miles (2009) explored methods of transformative learning among rural Senegalese women explicitly stating that their purpose explores how "basic changes in outlook are understood in African cultures with histories and epistemologies that are quite different from the predominantly European American ones out of which most recent theories and methods of transformational learning have been developed" (p. 227). Further, Easton et al. (2009) describe the potential benefits of employing a western-based framework in a cross-cultural research context, seeking to "elucidate what cross-cultural study of transformational learning experiences may have to offer practitioners and theoreticians" (p. 228).

**Transformative Learning Theory**

A rich theoretical framework for informing this research is transformative learning theory. As a theory of adult education, learning is emphasized as a reflective process in which adults critically assess their taken-for-granted context and make decisions based on informed insight (Cranton, 2006; Mezirow, 1991, 2000). Critical self-reflection has the potential to lead adults beyond the initial *instrumental learning* stage as adults become aware of their own assumptions and create possibilities for transformation through questioning and negotiating their current context. Defined by Habermas (1984) (as cited in Mezirow 2000), instrumental learning is task-oriented or skills-based and includes learning new facts, learning to deduce cause-effect relationships, and how to share ideas and dialogue. The secondary domain is *communicative learning* and involves cultural decoding, in which the student or learner critically questions and negotiates normative, taken-for-granted values. In this regard, competency goes beyond being able to complete a given task and extends to the “ability of the learner to negotiate his or her own
purposes, values, feelings, and meanings rather than to simply act on those of others” (Mezirow, 2000, p. 10).

Rather than adopting the assumptions, emotions, and beliefs of others, Mezirow (2000) explains how a “perspective transformation” necessitates that an individual reconceptualize her understanding of herself and who she is in the world. Perspective transformation may be the result of a “disorienting dilemma,” such as a tragic or life-altering event, or may occur incrementally over a number of years. However, shifts in a person’s self-concept may lead to a person revising her beliefs and then changing her behaviour and lifestyle based on this new frame of reference. Illustrating this process of *transformative learning* is Mezirow’s (2000, p. 22) linear, though not necessarily step-wise, progression:

- Disorienting dilemma
- Self-examination
- Critical reflection of underlying assumptions
- Recognizing that feelings are shared with others
- Exploring options for new roles, behaviours, and relationships
- Planning a course of action
- Acquiring the new knowledge and skills needed to implement new plan
- Trying new roles
- Negotiating existing relationships or establishing new ones
- Building confidence
- Reintegration based on new life perspective

This progression highlights two central points: First, transformational learning focuses on the process of *how* adults learn rather than *what* they learn and thus is significantly different from other theories of adult learning (Baumgartner, 2001; Mezirow, 2000). Secondly, this progression
depicts Mezirow’s understanding of the process of transformative learning at the individual level. This progression also acts as a general framework for analysis when exploring the data for evidence of transformative learning in the lives of individual learners and a collective context. Kasl and Elias (2000) discuss the value of group learning, arguing that the "health and effectiveness of our organizations and communities depend on the capacities of small groups to be transformative learners" (p. 229). The markers of transformative learning within an individual can also describe group learning and transformation (Kasl & Elias, 2000). Easton et al. (2009) describe how most of the literature surrounding transformative learning emphasizes the "dynamics of individual change," further explaining that "personal transformation in an African setting [has] to be more than individual" (p. 235). Consequently, there are major implications for fostering transformative learning at individual and communal levels in Kenya, particularly when discussing highly sensitive topic like HIV & AIDS as "buy-in must be obtained from a critical mass of those concerned" (Easton et al., 2009, p. 236).

Similarly, Freire's (1970) now classic theory, *Pedagogy of the Oppressed*, outlines a framework in which the oppressed can only transform their worlds when they themselves challenge the system that creates and perpetuates their oppression. Although Freire's work is rooted in critical theory, it is comparable to transformational learning in that both are constructivist approaches to knowledge. However, while Freire's pedagogy is emancipatory in nature and rooted in liberation from oppression, Mezirow's theory is focused on the transformation of the individual, adult learner and remains the central theoretical lens for informing this research. Within the context of the AIDS epidemic in Sub-Saharan Africa, transformative learning theory has the potential to offer tremendous insights into the learning processes and experiences of women as a collective and as individual learners. Undoubtedly, HIV & AIDS brings a host of disorienting dilemmas to African women regardless of whether
they are personally infected. Stigma, reduced access to health services, high child mortality rates, grandmother-orphan care, and job absenteeism are just a few of the myriad of examples that may compound the HIV & AIDS crisis for women.

Evidence of transformative learning among rural Kenyan women may appear in a variety of beliefs, practices, teachings, and actions. At the individual level, the traditional example would be that a woman advocates condom use. However, exploring shifts among women's beliefs and attitudes towards their sexuality, health, and future, may yield surprising information concerning their self-concept and revised sense of purpose. Collectively, women may form advocacy groups or propose community hospices for HIV & AIDS related support. Additionally, through support group meetings women may benefit from synergistic group discussions and experience a “perspective transformation” through talking with others, discovering the value of shared experiences, and resolving alternative interpretations and points of view (Montell, 1999). It may be possible that the women in the host community express or understand the concept of transformative learning in their own way. In gaining an emic portrayal of the phenomena it will certainly be appropriate to explore what these concepts may be. Whether on individual or collective levels, the extent to which women’s frames of reference shift and evolve is irreversible (Baumgartner, 2001). Examining aspects of transformative learning among rural, Kenyan women has the potential to offer deep and informed insight into the challenges they face in moving through informative, towards more empowering, transformative life practices.

The Role of Support

Support for learners is regarded by several theorists as the most important element in facilitating the process of transformative learning. Whether support is an external factor (e.g., friends) or an integral component of authentic learning (e.g., social interaction), several studies conclude its assistive effect in promoting transformative learning among adults. In a qualitative
study focusing on meaning making among HIV positive adults, Baumgartner (2005) found social interaction to be an integral component of transformative learning, noting how it provided increased opportunity for reflective discourse. She reports how participants were supported by sharing with others in groups where they "recognized that they were not alone, where they could accept the disease, accept themselves with the disease, and become empowered" (p. 19).

Baumgartner (2005) also indicates how transformation on an individual level evolved into collective acts of transformation as participants rallied together to raise awareness about HIV and affect change within their communities. Mohammed and Thombre (2005) analyzed the content of internet-based stories for a transformation perspective, focusing on the increasing use of storytelling in health care as a therapeutic technique for people living with HIV & AIDS (PLWHA). The authors conclude that the majority of web-based stories contain transformation "markers" and that the web itself can be a useful support for learners to vent their emotions and interact as they locate and join internet-based support groups. The value and role of storytelling as a pedagogical tool for HIV & AIDS education may generate deeper understanding into the nature and process of transformational learning among rural Kenyan women.

Within a broad consensus on the value of social interaction, several theorists reference the role of friendship as being particularly valuable in supporting a process of transformative learning among adults. Clark (2005) (as cited in Cranton, 2006) specifically addresses states "transformative learning could not take place without friendship" (p. 43). Similarly, in a review of 45 unpublished studies exploring the dynamics of transformative learning, Taylor (2000) found relationships to be the most common theme. He describes how trust and friendships underscores participation in relational dialogue, without which "critical reflection would seem to be impotent and hollow, lacking the genuine discourse necessary for thoughtful and in-depth reflection" (p. 308).
As individuals with varying experiences, learning needs, and attitudes, adults may benefit from and be accommodated by varying forms of support. At times the process of learning can be tremendously risky, threatening, and tumultuous, particularly in circumstances where adults are affected by an incurable and life-long illness. Cranton (2006) openly recognizes that isolation and grief may colour the process of transformative learning. Critical self-reflection and the adoption of more inclusive meaning perspectives is certainly not an easy or always uplifting task. Within this context, Cranton (2006) devotes an entire chapter to supporting learners engaged in processes of critical reflection, emphasizing authenticity as "central to being supportive" (p. 161).

Others also offer insight into conditions of learning that are inherently supportive of the learners themselves and facilitate transformative experiences. Mezirow (2000) highlights the importance of equality as a condition for participation in discourse. Belenky and Stanton (2000) point out the asymmetrical character of power in human relationships and the danger in ignoring this asymmetry. Addressing the inequities in the research articulating men's moral development and ways of knowing, Belenky and Stanton (2000) report on women's unique ways of knowing. Connected knowing, one of several ways of knowing, mirrors Mezirow's (2000) depiction of discourse as a foundational process in which participants seek agreement, consensus, and mutual understanding. Support for learners is embedded within such processes of learning. Belenky and Stanton (2000) suggest "raising up" as a metaphor for connected knowing which involves leaders who are effective in "drawing out the potential" of learners, particularly of those whose voices are missing (p. 97).

Similarly, at the heart of Freire's (1970) liberation pedagogy is a relationship of shared power and mutual learning among educators and students. He specifically outlines the role of trust in fostering meaningful dialogue among oppressed peoples. As a condition supporting
transformative learning, empathetic, honourable, and honest communication is at the heart of a liberating praxis, enabling learners to "become jointly responsible for a process in which all grow" (p. 67). In developing critical consciousness, learners act out of and upon their revised understanding of the world and their place in it; critical consciousness is a force which may propel rural Kenyan women to engage their worlds and become actors within their environments.

The Centrality of Dialogue

Mezirow (2000) asserts that adult learners "have the will and readiness" to participate in discourse as well as "Feelings of trust, solidarity, security, and empathy" (p. 12). Discourse underlies the optimal approaches to adult education as "the process in which we have an active dialogue with others to better understand the meaning of an experience" (p. 14). At the heart of discourse is striving to be free from "distortions by power and influence" (Mezirow, 2000, p.14), highlighting a collaborative, democratic approach to education in which educators assume their role as learners. "Informed constructive discourse" evolves within the context of open-mindedness and "empathic listening," emphasizing the value of negotiation, consensus, and shared understanding (Mezirow, 2000, p. 12).

However, Mezirow's interpretation of transformative learning is among many as the empirical literature evolves and theorists continue to debate central tenets and conditions for adult learning. For example, Cranton (2006) points out the inherent problem within Mezirow's emphasis on discourse and rationality, questioning how the disempowered participate in dialogue if they are limited by social conditions which prevented the opportunity for the development of objective thinking skills. This is not to say that socially disenfranchised peoples are not capable of rationale or critical thought, however, learners may be unaware that they are "agents of power and have the capacity for subverting dominant power relations" (Cranton, 2006, p. 124). Mezirow (2000) contends that symptoms of oppression may limit critical reflection upon the
conditions of oppression: "Hunger, homeless, desperate, threatened, sick, or frightened adults are less likely to be able to participate effectively in discourse" (p. 16). Clearly, this may pose a problem to some rural Kenyan women who are presented with any of these disorienting conditions, especially within the context of the HIV epidemic. However, Cranton (2006) argues that all who are "ready and willing to be engaged" can still participate in dialogue despite their societal conditions (p. 125). Exploring how Kenyan women overcome constraints in their social context to participate in dialogue with peers may generate valuable insight into conditions of learning and processes of transformation among adult learners. The findings of this study may contest or validate Mezirow's emphasis on rationality, offering insight into the social conditions which constrain or nourish opportunities for transformative learning among adults in a cross-cultural research context.

A component of this study seeks to explore the pedagogical pathways imbedded within women's HIV & AIDS education in Kenya. Pedagogy includes the role of the learner, particularly her role and relationship to the educator. Reflecting Freire's (1970) analysis of liberation education, collaborative learning is grounded in horizontal relations of power between the teacher and student. At its core liberation education seeks "reconciliation" which is founded upon an egalitarian power relationship and a shared understanding among teachers and students that both parties educate and learn from others. In direct contrast, Freire (1970) offers an analysis of the banking method of education. Described as an historical form of "education," the banking method reduces the process of learning to "an act of depositing, in which the students are the depositories and the teacher is the depositor" (p. 58). Maintaining their power of authority, teachers bestow knowledge upon the "absolute ignorance" of the students in a one-directional, hierarchical chain of command; the distant relationship between teachers and students is vertical and fixed. Freire (1970) goes on to describe that the structure of societal oppression is mirrored
and perpetuated by banking education which is an "exercise of domination" intended to
dehumanize and indoctrinate students "to adapt to the world of oppression" (p. 65).

Within the context of popular education in Kenya, it will be of value to explore the
relationship between educators and learners to generate richer insight into processes of women's
learning. Who are considered learners, who do rural women regard as HIV & AIDS educators,
and what characterizes the relationship between them? How and to what extent is participation in
discourse negotiated? Whose interests do HIV & AIDS education programs represent? How is
education used to liberate and validate but also silence and further entrench oppression? While
this study may not directly ask all of these questions it embraces the interplay of language, power,
and education as discourse embedded within the phenomena being explored.

Peer Education and Transformative Learning

A relatively recent practice, peer education programs have been implemented in rural
communities throughout Kenya. Peer groups formed by gender and age cohorts become the
examined the effectiveness of a peer education program in a South African town, attempting to
explore the conditions for program success. The authors note how previous research in the area
of peer education tends to be quantitative in nature and describes "the extent to which
programmes result in changes in target individuals’ HIV-related knowledge, attitudes and
reported behaviours, with little systematic discussion of the processes whereby peer education has
its allegedly beneficial effects on health" (p. 332). For Campbell and MacPhail (2002),
qualitative interviews with learners and educators shed light on how health-related behaviours
reflect social constructions of identity rather than personal choices and rational decision-making.
Peer education can elicit impactful discussion on social identities, evolving women's
understandings on how asymmetrical gender relations, identities, and powers place their health at
risk (Campbell & MacPhail, 2002, p. 333). Within Kenya, peer-based discussion surrounding women's education on condoms may invite dialogue on sexual identity, construction, and behavioural possibilities for peer educators, providing an informed insight into women's processes of learning and understandings of the HIV & AIDS epidemic. However, as with Campbell and MacPhail's (2002) findings, peer education may perpetuate the banking form of education if peer educators are viewed as knowledgeable authorities and there is minimal group discussion and student-teacher learning. Overall, the evolution of a critical consciousness, in which learners come to understand the conditions perpetuating their disempowerment, may enhance women's individual and collective agency, propelling their transformative engagement as actors in the world (Freire, 1970).

Such revolutionary action requires a fundamental shift in how people understand the process of education and the roles of learners and educators. At the core of peer education pedagogy is the belief that any willing participant is an expert. In a qualitative study exploring transformative learning among Kenyan farmers, Duveskog and Friis-Hansen (2009) insist that the expert is the poor farmer. Rural women in Kenya have the most powerful and potent educational resource at their disposal: lived experience. Through storying their experiences of HIV infection, prevention, education, and care, women are involved in an interactive and reciprocal process of sharing and learning. In this context, women in Kenya who are affected by HIV have some knowledge, resources, and educational tools, which position them as educator-learners at the onset of their participation in a peer education program. Rather than being taught by a formal authority figure, each member is an expert; each member has a story to share that will educate others; each member can learn from her friends. Within peer education programs "oramedia" regains its primacy as a pedagogical practice among rural communities in Africa (Pratt et al., 2000).
Freire (1970) elucidates how the "teacher-student with students-teachers" (p. 67) relationship is the crux of education that liberates. Mezirow (1991, 2000) asserts the importance of teacher and student roles in fostering a transformative learning environment. Implanted within the very nature of peer education pedagogy is a similar relationship of shared knowledge and mutual learning. The setting in which peer education occurs reflects the day-to-day settings of the problems the learners are engaging in (Duveskog & Friis-Hansen, 2009). Within the context of an epidemic that has virtually afflicted all spheres of society and invaded all institutions and social centers, peer education for Kenyan women may be appropriate in a variety of locations. Hospitals, community centers, homes, and churches are all places where adult learning and education typically occurs. Peer education is an accessible, viable, and sustainable pedagogical pathway for participants with practical learning needs in terms of HIV & AIDS education, prevention, and care. In addition, I add that that the central avenues for learning, or pedagogical pathways, may also invite dialogue or further repress those who are traditionally socially silenced (Freire, 1970). How these elements constrain or compel women to engage in authentic learning processes is crucial to exploring how adult learners negotiate their self-identity and to what extent they engage in social practices, which position them, both individually and collectively, as empowered agents within their communities.

**Education and Rural Kenya**

Multitudes of education initiatives have been implemented throughout Kenya since the 1990s creating a plethora of research in the area of HIV & AIDS education, gender, and Sub-Saharan Africa. However, very few studies conducted in rural Kenya explore processes of education through qualitative interviews with several key informants. Studies are primarily quantitative and measure the factual knowledge, or perhaps instrumental learning, of an entire rural community (Harvey et al., 2000; Karama, Yamamoto, Shimada, Orago, & Moji, 2006;
Pattullo et al., 1994; Stoskopf & Yang, 2004) compared to deeper qualitative explorations of learning (Campbell & MacPhail, 2006; Duveskog & Friis-Hansen, 2009; Easton et al., 2009). The quantitative studies survey Kenyans’ attitudes and knowledge about HIV and are helpful in outlining areas where misconceptions prevail, but do not rigorously question why or how community members came to believe a specific erroneous fact. Deeper exploration of particular beliefs and practices may yield insight into cultural and social norms that impact learners’ acceptance and utilization of HIV & AIDS education. Duveskog and Friis-Hansen (2009) report on several research studies with rural farmers in East Africa, describing learning tools that "facilitate critical thinking and transformation of mind-sets among rural poor" (p. 240). Of significance in this study is the authors' simultaneous theoretical pairing of Mezirow's (2000) transformative learning theory and Freire's (1970) pedagogy of the oppressed. In discussing critical consciousness and practices of freedom, the authors outline a platform for disempowered, rural farmers to "deal critically and creatively with their reality and discover how to participate in the transformation of their world" (p. 241). Although the study presented in this thesis does not adopt an overt discussion of consciousness-raising with the interview participants, the approach exemplified by Duveskog and Friis-Hansen (2009) offers insight into the constructivist roots and emancipatory outcomes of transformative learning.

orientation over several years. Although this study does not permit extensive time in the field, participants who have been involved in HIV & AIDS education for years may indicate otherwise or reflect a similar finding. In yet another study, Baumgartner's (2001) research with PLWHA outlines six stages adults progress through in learning to live with HIV, beginning with the diagnosis (e.g., disorienting dilemma), and working through an emotional and catalytic experience (e.g., transformational learning) towards integration and disclosure. Her work may be essential in providing a practical model upon which to compare women's stages of learning and experiences of HIV & AIDS education. My research is distinct from these studies by focusing on HIV & AIDS education and prevention for rural women in a cross-cultural context; however, these insights are valuable lessons for exploring learning in rural Kenyan communities.

The literature suggests that transformative learning theory is an appropriate framework for exploring adult learners' experiences of HIV & AIDS popular education. Extending the framework to women in a rural, Kenyan context invites new insights and may break ground into processes and contexts of adult learning. As a theoretical lens, transformative learning enables deep inquiry into Kenyan women's experiences of community-based HIV & AIDS education; subsequently, inviting reflection on what women learn, how they learn, and to what extent HIV & AIDS education impacts their lives. While the literature indicates substantial quantitative inquiry into rural communities' knowledge of AIDS, this qualitative study invites an emic portrayal of the phenomena, providing renewed understandings of the epidemic that may augment or contest previous findings. Hinging on Mezirow’s (1991) explanation that all learning is change but not all change is transformational, exploring what types of learning (e.g., informative, communicative, or a combination) women experience during or after their participation in HIV & AIDS education programs is essential in understanding to what extent, if any, popular education practices promote transformational learning among women in Malindi, Kenya. In the next
chapter, I describe in detail the approach and methods used to realize the purpose of this study, outlining strategies to identify participants, collect, and analyze the field data.
Chapter 3: Method

In this chapter, I present my argument for a qualitative methodology as a rigorous approach for this cross-cultural study. The focus is on semi-structured individual interviews as a culturally responsive research technique allowing for constructivist, emic portrayals of the phenomena. I also address the difference between the original proposed methods and the actual methods used for data collection. Procedures involved in data collection will be discussed, including obtaining ethical clearance from the university ethics board as well as the Kenya Research Council, partnership with Pwani Christian Community Services (Pwani), host community selection, purposeful sampling, a description of the participants, the process of individual interviewing, and document collection. Additionally, I outline data management, coding and analysis, and the system for referencing sample quotes, and finally, address the limitations of the study.

Rationale for Approach and Method

Qualitative research strongly lends itself to this study: it allows the researcher to explore the phenomena in context and as McMillan and Schumacher (2006) explain, communicate insights from an emic perspective. As the purpose of this study centres on eliciting Kenyan women's understandings of HIV prevention, the naturalistic and interpretive approach of qualitative methodology validates the unique experiences of a small number of Kenyan women. Qualitative methods offer rich potential in describing women's processes of learning and depicting circumstances which may enhance or hinder their ability to engage in more meaningful, transformative learning experiences. Given the limits of a Master's thesis and the complex nature of HIV & AIDS in Kenya, qualitative interviewing is the most salient technique for carrying out a rigorous, interpretive cross-cultural study. Nested in the assumption that peoples' voices are
meaningful, the interview strategy is a flexible technique allowing women's voices to emerge and made explicit (Patton, 2002, p. 341). A semi-structured individual interview guide consisting of open-ended questions facilitates the emergence of varying ideas, offering a constructivist portrayal of the phenomena. Specifically, this enables flexible yet guided discussion within the bounds of the research questions. As research question one explores, asking women what they learn about HIV & AIDS in a confidential, individual interview positions participants as the experts and allows them to engage in dialogue and reflect upon their educational experiences in a manner that few other research methods allow. Such discussions also suggest areas in which women are not learning and better inform my understanding of women's HIV & AIDS education in Kenya. Research questions two and three are more complex. However, open-ended, individual interview questions enable confidential and credible discussions regarding the range of women's educational programs, practices, and pedagogies. The educational experiences of individual women are varied and dynamic; individual interviews allow each woman to articulate what has been most enabling for her to adopt protective practices and engage in a potentially transformative journey.

Qualitative interviewing is congruent with traditional African forms of oral communication, summarized by Pratt et al. (2000) as oramedia. The use of methods that are culturally appropriate is especially important as I am not a member of the participants' culture. Making the participants' voices explicit requires avenues of inquiry which consider the power-laden aspects of (cross-cultural) research. One on one interviews facilitate and reinforce a culturally sensitive research design and may position the researcher as subordinate to the participant, who is elevated to the role of expert. Discussed by Kamberelis and Dimitriadis (2005), working with rather than on the participants enhances the power of dialogue as a dynamic tool for critical inquiry into real problems.
My previous experience in Kenya and a variety of literature (Chilisa & Preece, 2005; Miller & Rubin, 2007; Muturi, 2005; Pratt et al., 2000) informed my understanding of communal tendencies within Kenyan cultures, and as such, I originally proposed to use focus groups as the primary method of inquiry. In my proposal, individual interviews were a secondary data collection method to enrich the contextual, negotiated conclusions generated from the focus group discussions. After I arrived in Kenya and established Malindi as the host community, I immediately began developing relationships with members in Living Positively, an HIV & AIDS education group. Upon consultation with the leaders of Living Positively, the first focus group interview was set for October 19, 2009. Preparing for four participants and one translator, I was shocked when 15 women showed up to the location, most of whom I had not discussed the research study with (Research Journal, p. 35-36). After explaining the purpose of the research and going through the letter of information and consent, the group of women unanimously declared that they preferred "one-on-one" interviews (Interview 2, p. 2). In a personal e-mail communication, I explore reasons for this unanticipated preference:

The women I am working with in the Malindi community are quite reluctant to be interviewed in focus groups, they much prefer 1:1 interviews - quite contrary to what I expected and wrote about in my proposal drafts. In 1:1 interviews, the women feel they can openly and freely express themselves to an outsider because I don't know their family members and won't 'spread secrets'. Women are quite reluctant to share their stories and discuss HIV with other Kenyan women, even if these other women are working within the area of HIV. There is the belief that even if someone is your friend, your personal information will be spread around and people will judge you. This certainly has implications for how women learn about HIV and the tremendous hurdles that women overcome in terms of moving towards transformative learning experiences. (November 4, 2009)

Although not articulated as such, the women's primary concerns centre upon privacy and confidentiality. Using one-on-one interviews protects the participants' privacy to a greater extent.
than focus groups where the identity and narrative of each woman would be known among focus group participants. Based on this conclusion and the women's preference, I opted to discard focus groups and use individual interviews as the primary strategy for data collection. The use of document collection remained as a secondary method to gather data and triangulate interview findings.

**Data Collection**

Before research began in Kenya, I obtained ethical clearance from Queen’s University Education Research Ethics Board and General Research Ethics Board (Appendix B). Researching a sensitive topic and working with potentially vulnerable groups required a number of protective practices. I provided a combined Letter of Information and Consent to prospective study participants, outlining additional consents for audio recording the interview and use of a pseudonym (Appendix C). It was clear that HIV status had no bearing in participant selection and that the interview was not a test about HIV & AIDS but an exploration of how women are and could be learning about HIV & AIDS. Anticipating the use of a translator, I developed a confidentiality agreement to ensure the privacy of the participants who opted for translation services. Although not a requirement of Queen's University ethics boards, I also sought research authorization from the National Council of Science and Technology of Kenya (Appendix D). This authorization requires all foreign researchers to partner with a Kenyan body. I was issued a formal letter of invitation and partnership from Pwani, a Kenyan non-government organization (NGO) (Appendix E).

**Partnership with Pwani**

A pivotal component of a rigorous cross-cultural study, I established a relationship of mutual learning with Pwani. Acting as a liaison between a foreign researcher and a local
community, partnering with a Kenyan NGO was essential in locating a suitable host community and building relationships in the field.

Pwani works in 86 communities throughout Coast Province, reaching people through comprehensive initiatives focusing on HIV & AIDS prevention, gender, and community health rehabilitation. With a central mission to empower Coastal people and communities living with AIDS, Pwani trains local people to educate their own communities and facilitates grass-roots prevention initiatives, both of which play a strategic role in enhancing the agency of women. For example, Church Health Days is a popular program that facilitates voluntary HIV testing and establishes support groups for women. Operating as peer education groups, women train other women to become educators within their own families and larger communities. Self-governing peer education groups represent an emerging sector of civil society with considerable influence on gender equality and women’s rights. Pwani's expertise in the area of HIV & AIDS education coupled with a successful history of women's programming positioned them as a highly suitable partner for the purposes of this research.

I was fortunate to meet with John Mangenge, Executive Director of Pwani, in person from May 9 - 12, 2009 in Edmonton, Alberta. Together we discussed the extent of our collaboration and Pwani's role: Facilitate entry into the host community, locate suitable accommodation, introduce local officials, provide contact information for crisis scenarios, and assist with the initial setup of the proposed study. In addition, my research study is closely aligned with several of Pwani's projects and responded to some of the organization's needs. For example, vibrant peer educator training has been implemented throughout Coast province over the past three years; however, Pwani was not aware of the extent to which women are actively engaged as peer educators once they complete the training program. Partnering with Pwani was mutually beneficial to both the researcher and the NGO; it facilitated an in-depth exploration of
several popular education strategies which impact women's learning and movement through informative, towards transformative engagement with their communities. While maintaining ethical standards of confidentiality, the initial findings were shared with Pwani staff for the purposes of collaboration and interim analysis. The knowledge gained in this study provided feedback on the value of peer education groups and will assist Pwani in developing community-based HIV & AIDS prevention programs and practices in the future.

**Host Community Selection**

I selected Malindi as the optimal site for fieldwork after visiting six communities throughout Coast province. McMillan and Schumacher (2006) highlight how field sites need to be "suitable for the research problems and feasible for the researcher's resources of time, mobility, and skills" (p. 342, italics in original). The following site selection criteria were negotiated to meet the purposes of this study within the constraints of my resources:

- High HIV & AIDS prevalence,
- history of HIV & AIDS education programming for women,
- existence of community-based initiatives (e.g., support groups, peer education programs)
- presence of local NGO,
- permission and cooperation of the community, and
- safety, access, and logistics (e.g., transportation, accommodation).

Being familiar with the statistical data of various districts in Coast province, including HIV & AIDS prevalence, Pwani suggested six communities. With the staff responsible for each site, I visited the communities of Lunga-Lunga, Kinongo, Watamu, Malindi, Kaloleni, and Mariakeni from September 22 - October 9, 2009 as illustrated in Figure 1:
At each meeting, I was introduced to community elders, religious leaders, and learners in HIV & AIDS education groups. Visits ranged from one to two days depending on the number of groups available to meet with me. Explaining the purpose of my research and who I wanted to discuss HIV & AIDS education with was a key component of the visits. I asked the following six questions at each site to generate a quick snapshot of the scope of popular education:

- Can you tell me a brief history of the group/program?
- Who can join the group? (Women, men, youth, mixed)
- What are some of the challenges the group has experienced?
- What are some of the achievements the group has experienced?
- Does the group have any future plans?
- When will the group meet next?
These questions generated significant discussion, regardless of gender or age. The group leader described their history while the members identified challenges and achievements in the areas of HIV & AIDS education and prevention. Representatives of each community were gracious and hospitable, often taking time off from their work and sharing precious resources to make sure I was comfortable. Table 1 outlines the range in size and gender composition among the six communities:

Table 1 - Overview of Community Visits

<table>
<thead>
<tr>
<th>Community</th>
<th>Group Type</th>
<th>Women</th>
<th>Men</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunga-Lunga 1</td>
<td>Living Positively</td>
<td>5</td>
<td>5</td>
<td>Has liquid soap as an income-generating activity</td>
</tr>
<tr>
<td>Lunga-Lunga 2</td>
<td>Being Faithful Club</td>
<td>20</td>
<td>4</td>
<td>Promotes awareness through role-playing and drama</td>
</tr>
<tr>
<td>Kinongo</td>
<td>Peer Educators - Youth</td>
<td>35</td>
<td>25</td>
<td>Vibrant group, mostly school-aged youth</td>
</tr>
<tr>
<td>Watamu</td>
<td>Peer Educators, Living Positively</td>
<td>10</td>
<td>2</td>
<td>Concerned for HIV &amp; AIDS education of young children</td>
</tr>
<tr>
<td>Malindi</td>
<td>Peer Educators, Living Positively</td>
<td>3</td>
<td>1</td>
<td>Operates a project for Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>Kaloleni</td>
<td>Peer Educators</td>
<td>1</td>
<td>5</td>
<td>Wants to show HIV &amp; AIDS educational videos</td>
</tr>
<tr>
<td>Mariakeni 1</td>
<td>Living Positively</td>
<td>20</td>
<td>2</td>
<td>Experiences stigma from the medical community</td>
</tr>
<tr>
<td>Mariakeni 2</td>
<td>Peer Educators</td>
<td>4</td>
<td>3</td>
<td>Advocates for parental involvement in child HIV education</td>
</tr>
</tbody>
</table>
The numbers in the columns entitled "Women" and "Men" represent the proportion of female and male participants who attended each community meeting. This portrays that with one exception, the number of women was always equal to or greater than the number of men who attended the community meeting. The "Miscellaneous" column notes issues that were particular to one group, representing how each community differently interprets and responds to the same HIV & AIDS education programs delivered by Pwani.

During our discussion I took brief notes and paid close attention to the number and role of women in each group and my perception of their willingness to discuss HIV & AIDS education with me. Using a basic rubric I ranked these factors, along with the site selection criteria, as minimal, adequate, or ideal to allow quick comparisons among the host communities. Figure 2, the rubric for the Malindi research site, exemplifies the value of this activity:

<table>
<thead>
<tr>
<th>One Evaluation Criteria</th>
<th>Melissa Spaling</th>
<th>Date: Sept 26/04</th>
<th>Site: Malindi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Duration (min. 2 yrs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women focused programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Translator readily available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation Nearby</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety &amp; Security</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health &amp; HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>social context (willing to talk about HIV/AIDS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>not in formal school system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>social positions - diverse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2 - Rubric for Malindi Site
After considering the rubrics and notes made during each visit as well as logistics, I selected Malindi as the optimal research site for exploring women's HIV & AIDS education. Through funding by Pwani and the courageous efforts of a local couple, one church in Malindi has developed and implemented four different HIV & AIDS education programs. For the purposes of the research, the most important program was the Living Positively group. Spearheaded by a passionate and educated woman, the group recruits women from the surrounding community to participate in HIV & AIDS programs and access HIV testing, treatment, and counseling. Unlike other peer education groups, the members of Living Positively had worked together to create an official constitution, vision, and purpose, demonstrating an organized and successful community-based education initiative. In addition, women in Malindi were the first to self-identify as HIV positive and discuss the importance of education as an avenue for stigma reduction and fostering hope (Research Journal, p. 16). Although HIV status was of no importance in identifying participants, the women's candor, optimism, and determination were inspiring and revealed a clear willingness to communicate about HIV. Demonstrating a vibrant history of women's enterprise in the area of community-based HIV & AIDS education, Malindi was the only community to meet all the criteria for inclusion.

Although Malindi is a bustling, beachfront tourist centre, the physical location of the church on the semi-rural outskirts of the town limits and the group's recruitment of women from outlying villages match the original research focus on rural women. Additionally, many of the single women in the support group frequently travel to their rural homes to collect produce for selling in Malindi, indicating that many of their livelihoods depend on subsistence farming. Initially, I proposed to live and research within the same community; however, suitable housing could not be found and I chose to live in the smaller town of Watamu. Located only thirty minutes south and easily accessible by public transport, living and researching in different communities was manageable for the remaining three months of fieldwork.
After selecting Malindi, I spent several days mapping the field. McMillan and Schumacher (2006) describe this as "acquiring data of the social, spatial, and temporal relationships in the site to gain a sense of the total context" (p. 343). Sketching hand-drawn maps of the area, noting public health offices to visit, and introducing myself to various local officials were important steps in becoming acquainted with the physical and political geography of Malindi. Initial exposure to the field allowed me to reorient specific research questions as needed. I was invited to become a formal member in Living Positively; regularly attending meetings enabled the women to get used to my presence. During these educational meetings I began to identify learning strategies used for adult HIV & AIDS education. Storytelling emerged as an important educational tool; listening to and sharing stories nurtured a relationship of respect and trust with the women in Living Positively.

**Sampling Strategies**

Purposeful sampling was employed as a strategy allowing the researcher to select "individuals likely to be knowledgeable and informative about the phenomenon of interest" (McMillan & Schumacher, 2006, p. 343). Based on the assumption that women in different age groups, with varying levels of education, biographies, and histories will experience and present different interpretations of learning, I combined purposeful sampling with maximum variation sampling. As McMillan and Schumacher (2006) explain, this enhances the trustworthiness and credibility of the study as discrepant or negative data is accounted for, and the findings more closely reveal the reality of women's HIV & AIDS education. To identify participants for an in-depth interview, the following attributes were upheld to obtain maximal variation:

- Member in community-based HIV & AIDS education program,
- length of time involved as a peer educator, counselor, or nurse,
- social position (e.g., school teacher, shop keeper),
- willingness and ability to communicate about HIV & AIDS,
After developing friendships with the leader (Belinda) and founder (Margaret) of Living Positively, I invited both to participate in an individual interview as each woman met the criteria for inclusion. Not all members of Living Positively met the criteria for an in-depth interview, thus comprehensive sampling was not a valid strategy for data collection.

With the exception of Carol who asked to be interviewed, most study participants were recruited using snowball sampling (Research Journal, p. 45). Women and Pwani staff referred people who met the interview criteria, and subsequently, these people suggested others. After being introduced to someone by a mutual friend, I would invite the referred person to share a light meal and talk about HIV & AIDS education in a relaxed setting. Pre-screening allowed me to explore the extent to which the person met the dimensions for obtaining maximal variation. Our informal discussion also helped to establish rapport and facilitated a more intimate, personal discussion of HIV & AIDS education. Snowball sampling was an effective sampling strategy; there was only one instance where I elected not to carry out a formal interview with a participant recruited through this strategy as she did not meet the interview criteria. Strongly resonant within a culture emphasizing relationships, snowball sampling also provided the appropriate liaisons for accessing several local health officials whom I otherwise would not have been able to contact.

Description of Participants

Through purposeful sampling eight semi-structured individual interviews were carried out with eight women. Although the level of English fluency varied among the participants, all the women were comfortable carrying out an interview in English and none elected to use a translator. The participants were given a copy of the Letter of Information and Consent as well as an in-depth oral explanation of the research study. With the exception of Carol, all the women, including those who were referred through snowball sampling, were invited to participate directly
by me. All eight women agreed to participate in an individual interview. None of the women opted for a pseudonym; however, I have elected to use them to ensure the participants' confidentiality and anonymity. Traditional Kenyan names are not used for pseudonyms as the women identified themselves by their English names; therefore, I selected English names as pseudonyms. I also changed the specific name of the support group and do not include the name of the church, which established Living Positively, in this thesis. Purposeful sampling allowed me to invite individuals who were "information rich because they are unusual or special in some way" (Patton, 2002, p. 231); thereby creating a diverse pool of eight female participants, each of whom represented different interpretations of popular education strategies. Ranging in age from 31 to 53 years, the participants were varied in educational background, marital status, number of children, and time involved in HIV & AIDS education. Table 2 encapsulates some of this basic demographic data:
Table 2 - Participant Demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Employment Status</th>
<th>Formal Education</th>
<th>Children (deceased)</th>
<th>Marital Status</th>
<th>Role in HIV Education</th>
<th>Time in HIV Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belinda</td>
<td>38</td>
<td>Volunteer Community Health Worker</td>
<td>Some High School</td>
<td>7</td>
<td>Single Mother, Widowed</td>
<td>Educator</td>
<td>10 years</td>
</tr>
<tr>
<td>Carol</td>
<td>?</td>
<td>Unemployed</td>
<td>Some High School</td>
<td>2 (1)</td>
<td>Single Mother, Divorced</td>
<td>Learner</td>
<td>6 months</td>
</tr>
<tr>
<td>Rehema</td>
<td>36</td>
<td>Sells handicrafts and produce to tourists</td>
<td>?</td>
<td>3</td>
<td>Single Mother, Widowed</td>
<td>Learner</td>
<td>6 months</td>
</tr>
<tr>
<td>Lucy</td>
<td>38</td>
<td>Volunteer Church Assistant</td>
<td>?</td>
<td>4</td>
<td>Single Mother, Separated</td>
<td>Learner</td>
<td>6 months</td>
</tr>
<tr>
<td>Margaret</td>
<td>40</td>
<td>Program Development at Church</td>
<td>University</td>
<td>4 (2)</td>
<td>Married</td>
<td>Development</td>
<td>3-4 years</td>
</tr>
<tr>
<td>Irene</td>
<td>35</td>
<td>Volunteer Community Health Worker</td>
<td>Some High School</td>
<td>5 (1)</td>
<td>Married</td>
<td>Learner</td>
<td>10 years</td>
</tr>
<tr>
<td>Naomi</td>
<td>53</td>
<td>Shop Owner, Volunteer Community Health Worker</td>
<td>Junior High</td>
<td>5</td>
<td>Single Mother, Separated</td>
<td>Learner</td>
<td>2-3 years</td>
</tr>
<tr>
<td>Pauline</td>
<td>31</td>
<td>Regional Coordinator, NGO</td>
<td>University</td>
<td>2</td>
<td>Married</td>
<td>Development</td>
<td>7-8 years</td>
</tr>
</tbody>
</table>
Pauline and Margaret achieved a post-secondary degree; other participants completed some high school while Naomi mentioned barely finishing Standard 8 (equivalent to Canadian Grade 8). Irene discussed early pregnancy as a reason for not completing further education. The participants were eager to share details about their family life, in particular their children. Altogether three women had lost children; Irene and Carol openly discussed losing a child to HIV while Irene and Rehema are both raising a child who is living with HIV. All eight participants referenced having a husband; currently, five of the women (Belinda, Carol, Rehema, Lucy, Naomi) are single mothers. Six women disclosed their HIV status without any questioning or prompting on my part. To their credit, none of the participants discussed the status of other women in Living Positively (Research Journal, p. 43).

While most of the women described their occupational status as unemployed, half of the participants work full time doing volunteer or unpaid work. For Belinda, Naomi, and Irene, volunteering comprises counseling and community health work, while Lucy voluntarily contributes to her community in other ways. Margaret and Pauline are employed full time, working for a church and Pwani, respectively. In HIV & AIDS education Margaret and Pauline have a program development role, Belinda considers herself an educator, and the other five participants are considered learners. The length of time involved in HIV education ranged substantially from a period of six months (Carol, Rehema, Lucy), several years (Naomi, Margaret) to more than eight years (Belinda, Irene, Pauline).

**Individual Interviews**

The data from this research are eight individual transcripts that arose from eight one-on-one interviews as well as a variety of documents collected in the field. All interviews were carried out in English, audio recorded with the participants' permission, and transcribed by the
researcher. I wrote brief notes during the interviews, describing body language and behaviour. Considering the cross-cultural context of this research, nonverbal communication may be just as important as verbal in assisting with the data analysis (McMillan & Schumacher, 2006). At the conclusion of each interview I reformulated research questions as necessary and noted the possibilities of transformative learning. The interview process consisted of demographic and semi-structured open-ended questions (Appendix F: Individual Interview Guide). McMillan and Schumacher (2006) note how topics are pre-determined in the semi-structured interview but the order in which they are discussed can vary. Due to idiomatic differences in spoken English, I adopted a Kenyan syntax and rhythm in my speech, using local examples in my questions to ensure the participants could understand me.

Mutual respect was essential in maintaining the confidence of the participants since I asked questions regarding sensitive and private topics. As a tactic for intercultural health communication, Muturi (2005) describes the importance of participatory development. Involving other stakeholders in the community development process was central to engaging the participation of women in reflective discussions of their own health. Arranged ahead of time, participants were referred to Pwani for free counseling and support services. I established a solid rapport with each woman before the interview took place to increase her comfort and reduce the potential stress of an interview.

Interviews occurred over a three-month period, beginning in October and concluding in December, 2009. While the specific location varied, six interviews took place in Malindi. Belinda wanted me to meet her children so we held the interview in her home. I arranged to meet Carol, Rehema, Lucy, and Margaret in a small, well-lit room at the church while Irene preferred to be interviewed at the Comprehensive Care Centre where she volunteers. I met Pauline at her
private office in Mombasa and Naomi chose to be interviewed outside Watamu in an open, public meeting space. Each participant was provided with a bag of maize meal, the staple food in Kenya, which cost several days wage in Kenyan Shillings but was approximately only $2 CDN. The interviews ranged substantially in length, the shortest being half an hour (Carol), the longest over 90 minutes (Belinda). Interviews frequently concluded with the women inviting me to come to their house or share a cup of chai tea together. I accept all the interviews at face value and believe that the participants had integrity and presented themselves openly to me.

**Document Collection**

Described by McMillan and Schumacher (2006) as a "noninteractive strategy for obtaining qualitative data" (p. 356), I collected official documents as sources of data which could augment, verify, or contest the interview findings. In the context of this research study, official documents are community-based HIV & AIDS training documents as well as NGO and government reports. Researching in a field setting with limited resources and frequent power outages required that most documents be collected in digital form (photograph). On several occasions photographing documents was not permitted and I made brief notes in my Research Journal. Initially I collected digital documents of the constitution written by the members of Living Positively, noting their purpose and learning objectives. In referring to strategies for artifact collection, McMillan and Schumacher (2006, p. 358) outline how participants may offer documents. The leader of Living Positively provided me with brochures and documents she uses in her work as a volunteer community health coordinator.

From the Pwani office in Mombasa I collected digital documents outlining funding partners and communication between project stakeholders. McMillan & Schumacher (2006, p. 357) describe how documents used internally and externally communicate the organization's
values, purpose, and functions. Internal and external documents from Pwani illuminate the
complex relationship between international donors, local NGOs, and programs delivered at the
grassroots levels (see Chapter 4). I was not permitted to copy donor reports as they contained
detailed personal and financial information. Similarly, the Deputy Public Health Officer for
Malindi District expressed reluctance in photographing health documents despite these reports
being available to the public. As a representative of Pwani I chose to respect these wishes and
did not obtain digital copies, although I did briefly analyze these documents and note my findings
(Research Journal, p. 62-63). Additionally, a partner of Pwani provided me with a lengthy
document outlining a model for the church's response to HIV & AIDS in Kenya.

Data Management and Analysis

McMillan and Schumacher's (2006) chapter on the process of qualitative data analysis
was helpful in maturing my understanding of several approaches and strategies for systematically
interpreting raw data. The use of interim analysis as an ongoing process facilitated tentative
interpretations in the field and was foundational in developing a rigorous, evidence-based
approach to exploring codes, categories, and themes. Additionally, a digital recording device,
word processing programs, and qualitative analysis software were invaluable in assisting with
data management, storage, and organization.

Recoding and Transcribing

I digitally recorded all eight individual interviews using a Panasonic RR-US750 for the
purposes of verbatim transcription and use of low-inference descriptions (McMillan &
Schumacher, 2006). Transcribing the audio files immediately after the interview sessions, I
incorporated notes made during the interview as footnotes in the transcripts. I added punctuation
where natural pauses and breaks seemed to occur within the rhythm of speech. Before I left
Kenya on December 18, 2009, all eight interviews were transcribed verbatim. Upon my return to Canada I developed a notation system to consistently describe meaningful pauses, background noises, and behaviours, and added this detail to the transcripts. Acknowledging the differences between Kenyan and Canadian forms of English, I constructed a short language guide to explain some of the nuances of Kenyan English. Together this notation system and language guide make up Appendix G: Transcription Key.

To uphold the voices of my participants I chose to maintain some common Swahili words, using *italics* with the English translation in ( ) parentheses. However, to enable the readers, who are likely not familiar with Kenyan English, to understand sample quotes, I use [ ] brackets to clarify meaning where necessary. Additionally, since Swahili does not use sex-differentiating pronouns and the participants freely interchanged "she" with "his" I altered any inconsistencies to enhance flow and clarity. Frequent murmurs during interviews (e.g., Mm-hmm, Uh-huh) were common and not meant as agreement but indicate that the speaker is being heard. I did not transcribe these sounds as they are not relevant to the research study.

**Interim Analysis**

McMillan and Schumacher (2006) explain how a qualitative research design emphasizes the importance of interim analysis as an "ongoing, cyclical process" (p. 364). Collecting and analyzing data simultaneously enabled me to make informed decisions regarding data collection as I became more cognizant of recurring trends and topics in the data. While maintaining ethical standards of confidentiality, initial findings were shared with two senior Pwani staff for the purpose of corroborating the data. This is prioritized by the National Council of Science and Technology, the body which grants research authorization to foreigners, in its requirements to partner and share findings with a local organization.
Reciprocity between the researcher and participants was also a key aspect of the research design in an attempt to limit the neo-colonial tendencies of cross-cultural research (Bloch & Vavrus, 1998; Oyewumi, 2003). However, member-checking with each individual was difficult. Initially I gave each participant a copy of our interview on CD, however, few had the resources required to listen privately. Six of the participants do not have e-mail and I did not have access to resources which would allow me to distribute print copies to each participant. Pwani recommended the creation of a community newsletter as a strategy to invite feedback from the participants on the recurring ideas within the data. While maintaining privacy I outlined initial findings and constructed a newsletter with the participants for distribution throughout their communities (see Appendix H: Community Newsletter Sample Page). Interim analysis required diligent, reflexive writing in a Research Journal. Examining my assumptions about the research process, participants, and context helped me to identify my own bias and perspective. To convey the voices of the participants in this thesis, it is essential that I continually examine whose voices emerge (McMillan & Schumacher, 2006).

**Document Analysis**

Each document was examined for its target audience, focus, author(s), partners or sponsors, and principal messages to explore "who uses it, how it is used, where it is used, and the purpose of its use" (McMillan & Schumacher, 2006, p. 358). Revealing gaps in the interview data, document analysis deepened my understanding of women's HIV & AIDS education in Malindi and lead to further inquiries that I explored during one-on-one interviews. For example, in exploring the monthly reports submitted by Pwani I noted how there were substantial differences in the proportion of rural and urban women who participate in peer education training programs. This prompted me to inquire about the differing barriers and possibilities for women's
education in rural or urban contexts during an interview with a senior Pwani staff member. Data from the documents also provided information about Malindi that could not accurately be gained through interviews, such as its history and population. Being unfamiliar with the field, these data generated a deeper understanding of the research context.

**Coding and Analysis Framework**

After verifying the interview transcripts for accuracy, I began to code the raw data using Nvivo, a software program for qualitative analysis. Nvivo was an essential tool in data management and organization and, after several on-line tutorials, was easy to use independently. In Nvivo, free codes are organized yet unrelated chunks of data while tree nodes are categories with sub-branching and related child nodes. This organizational function of Nvivo was helpful in comparing codes and the data coded to each category. Since the research study was conceptualized within a specific theoretical framework and not a grounded theory approach, I decided to use a semi-structured, rather than open, model for coding. I employed three coding systems separately and then wove them together to facilitate the emergence of pervasive themes.

Initially, codes were directly modelled on the questions asked in the semi-structured interviews. Using the interview questions as predetermined codes created a quick impression of the data as participants' responses to the same central topics were organized. For example, all participants were asked interview question five: "Who is the best person to educate Kenyan women?" Each woman's response was coded as "best person is a positive person." This code summarizes the interview question and indicates the unanimous response it generated. In other cases where responses were varied, I created a description of the code to explain the diversity of perspectives within it. For example, the description for the code "how women learn about HIV" reveals the diversity among responses: "Women learn about HIV through seminars, workshops,
storytelling, friends, support groups, and NGO programs." This coding framework provided broad insight into the multiple perspectives among Kenyan women's understandings of HIV & AIDS education; however, it did not capture all significant portions of the raw data.

The second level of coding and analysis created a portrait of each participant to communicate her unique story and process of learning. Maintaining the voices of the female participants is central to an emic understanding of the phenomena being explored. In this approach I worked through each interview transcript separately, using the code inVivo function to create a code using the exact words of a participant. For example, Carol was the only person who discussed how "AIDS is just another disease." While this conversation occurred tangentially and thus was not coded using the first coding framework, it provided alternative insight into Carol's radical perceptions of the HIV epidemic as a whole. In reading through Belinda's transcript, the phrase "I sacrifice myself" was coded as her discussion of sacrifice within education was unanticipated and I wanted to further explore this concept in relation to transformative learning. Focussing on the personal story of each woman painted a portrait of how she is unique but also what is held in common among the participants as a whole.

McMillan and Schumacher's (2006) recommendation to create a category as an "abstract entity that represents the meaning of similar topics" (p. 370, italics in original) prompted me to merge several free codes into larger tree nodes (categories). Comparing the tree nodes "Causes of HIV & AIDS" and "Challenges in HIV & AIDS Education" revealed many shared child nodes, such as "poverty" and "stigma." I merged both into an all-encompassing tree node, "Socio-political Context of HIV & AIDS in Malindi" which consists of various factors described by the participants. Along with this tree node, my other major categories were "Importance of Support," and "Descriptions of Learning as Relational."
In re-evaluating my original three research questions I realized that the codes and patterns derived from these two coding systems offered little insight into the third question's focus on how learning may contribute to transformative changes. I did not want to analyze the data set for each individual phase of transformative learning outlined by Mezirow (2000) as this process was too prescriptive and compartmentalized. Although this approach was originally proposed as a framework for analysis, field work made me cognizant of how cultural differences may be manifested differently in the adult learning process; therefore, what a western based theory describes as a point of learning may not appear as authentic in Kenyan learners. However, despite differences in the phases involved, adult learners engage in processes of transformative learning regardless of cultural context. I chose to focus the third system of analysis on identifying promising examples of transformational learning in its entirety.

Drawing on the analysis resulting from the previous two coding systems, this approach was the catalyst in materializing the three primary themes. In exploring possibilities of transformative learning I inadvertently teased out dimensions or conditions of learning which were congruent with the tentative categories and include role of support, connected knowing among women, and striving towards openness. Satisfied that these themes encapsulated the participants' learning, I followed McMillan and Schumacher's (2006) advice, pouring through the data set for "discrepant and negative evidence" (p. 374) that would refute any or all of the themes. Continually searching for evidence that contradicts the pattern of learning illuminated by the primary themes may reveal variations in learning which more aptly describe processes of women's education in Malindi.

This rigorous, tri-fold approach to data analysis resulted in codes, categories, and themes which detail and bound the processes of popular HIV & AIDS education and women's
learning in Malindi, Kenya. Occurring over six weeks, I met with my supervisor several times during the analysis process to chart my progress and bounce ideas back and forth. I also enlisted the support of an academic who researches in Kenya and is familiar with the theoretical framework to assist with gaining deeper understanding into the context of the research study.

**System for Quoting the Data**

Sample quotes from interviews and my Research Journal are used to support claims and arguments through this thesis. In a manner similar to citing literature, quotes from interviews are referenced using the following two identifiers: Participant's first name, page number of quote in the original transcript (p._). Pagination restarts for each interview transcript. The following excerpt from Chapter 4 illustrates the simplicity of this system:

> Through this approach the parents will be empowered to "take the full responsibilities of educating their own children at home" while the church simultaneously provides the children with a foundation of "the facts about HIV & AIDS and even …the challenges youths are facing." (Pauline, p. 12)

Likewise, at times I paraphrase writing from my Research Journal (see Appendix I: Sample Writing from Research Journal). These selections use the same two identifiers, namely Research Journal and page number (p. ).

**Limitations**

There are several limitations associated with this study that readers should take into consideration. Due to the highly personal nature of the data and complexity of a community, caution must be exercised in attempting to generalize findings from a small number of female participants to the community at large or beyond. Other women, in Malindi or elsewhere in Kenya, may not equally value or require support, openness, or learning from other women. Although this study broke ground in terms of exploring how women learn about HIV & AIDS,
the research questions did not go deep enough to dissect the specificities of the process of transformative HIV & AIDS education.

Threatening the internal consistency of the research design is the use of self-reported data. Although self-report is the most appropriate channel for exploring women’s learning, the findings are largely based on the women’s experiences as communicated to and interpreted by a foreign researcher, reflecting the constraints posed by differences in language and culture. The fact that I am a White Canadian woman affects the credibility of the interview guide and my representation of the experiences of Kenyan women, despite my best intentions and efforts to portray their voices. Had this study been carried out by a member of the women's culture, or had I been able to speak fluent Kiswahili, I would expect some differences in the findings. As a cultural broker and intermediary, Pwani's role was essential in minimizing the threat that these differences in biography and history pose to the collection and interpretation of the data. In addition, procuring the assistance of a researcher familiar with the field context was an important element in the design and orientation of a trustworthy cross-cultural study.

The next chapter presents the research context, outlining Pwani's role as an NGO involved in HIV & AIDS prevention, and framing each interview participant in more detail to create a portrait of each woman.
Chapter 4: Contexts and Portraits

This chapter is the first of two reporting on research findings. Chapter 4 contextualizes Pwani's role within the arena of international HIV & AIDS funding and presents a portrait of each interview participant. Participant portraits highlight what is most important to each woman and what is shared among the group of participants as a whole. The portraits also shed light on the daily realities of HIV & AIDS education for adult women in Malindi.

Pwani and International Funding

Situated the role of Pwani as a locally enacted yet foreign-funded organization illuminates how international donors influence the types of programming available for HIV & AIDS education. Pwani receives all of its funding for HIV & AIDS prevention from Family Health International (FHI), indicated in Figure 3 as one of six international members of a large-scale project known as APHIA II (AIDS, Population, and Health Integrated Assistance):
AIDS, tuberculosis, malaria, and maternal health. Subsequently, Pwani's goals for HIV & AIDS education are an amalgam of the Government of Kenya's Vision for 2030, Anglican Church of Kenya's objectives, and APHIA II Project foci. Text boxes in Figure 4 emphasize selected characteristics of Pwani's programming:

**Figure 4 - Pwani's HIV & AIDS Program Goals**

These goals demonstrate the value of partnership among international funding bodies (USAID), national organizations (ACK, APHIA II), and local community-based organizations (Pwani) as critical to the success of each stakeholder. The second last bullet in the document reinforces this in describing how Pwani staff refers orphans and vulnerable children (OVC) to Catholic Relief Services (CRS), an APHIA II consortium member. To target the varying challenges of HIV &
AIDS prevention within the country, APHIA II is sub-divided into regional areas of focus, each with unique goals and community partners. Subsequently, as a community partner, Pwani implements educational programs solely within Coast Province and is accountable only to APHIA II Coast.

Pauline, Regional HIV & AIDS Coordinator for Pwani, is responsible for implementing peer education programs throughout Coast Province. Originally training around 1,300 people since 2007, she explains how Pwani is currently working with only 570 peer educators due to high attrition (Pauline, p. 4). In terms of monitoring and evaluation, the transitional nature of youth who frequently relocate for higher education, marriage, and employment is disadvantageous. However, Pauline explained that the mobility of young people may also be an advantage in terms of facilitating peer education:

You know once you give somebody knowledge and uh, with the, the kind of interactive sessions they've been having, wherever they are they will always do peer education. Even if they are not under any other program, they will always initiate some health discussions about HIV & AIDS, about other issues affecting people's health around them and uh, hear what people say and give the facts to the people. So peer education is very addictive. So they'll never stop it! {Laughter} They are not monitored by any organization, but they are doing it. (p. 4)

Imparting basic counselling skills to youth enables them to be educational resources for whatever communities they join. Pauline describes why peer education is employed as the primary HIV & AIDS education tool within the APHIA II project:

Actually they started this with the youths because they thought, you know peer influence is so strong. So they thought when they equip this person, they equip them with the full information, so that when he is influencing his peers then he is influencing them ah, with the knowledge. Not just rumour mongering or just misinformation or misconcepts but with the right information. Yeah. That's how peer education started. (p. 3)
Due to its success, peer education programs have been up-scaled and transplanted among "the married men, married women, most at risk populations like commercial sex workers, like the men who have sex with men, the uniformed workers, even the informal sectors" (Pauline, p. 3). Through working with community members and religious leaders alongside peer educators, Pauline has gained practical insight into the process of peer education, eagerly concluding that the success of the program is "evidence-based" (p. 4).

As the peer education program is funded by APHIA II Coast through FHI, Pauline is responsible for reporting achievements and challenges within the program to FHI representatives. Figure 5 models the flow of communication between the program developers (APHIA II Coast, FHI), implementers (Pwani), and participants (peer educators in selected communities):

![Figure 5 - Communication Between Stakeholders](image)
At the community level effective, localized efforts such as Living Positively emerge from this multilateral, external process. Through partnering with Pwani, APHIA II Coast Project enables women to access medical services, support one another, and learn more about HIV & AIDS. By harnessing the community focus of the church large-scale development initiatives create impactful learning opportunities for PLWHA. However, working in predominantly resource-limited settings, Pwani is only able to carry out educational programs for which they receive external funding, despite interests, ability, and knowledge of other methods for HIV & AIDS education. These methods are discussed in detail by Pauline in Portrait 1. Coupled with the understanding that funding from APHIA II will be depleted in late 2010, significant efforts are devoted to obtaining additional funding from other external sources, thereby affecting Pwani's overall ability to mature as an autonomous organization. The dependence of small NGOs on foreign donors illustrates the role of power in the area of HIV prevention and may have considerable consequences for groups such as Living Positively which may no longer be able to support women when funding is exhausted.

Participant Portraits

Stories of each participant (total of eight) are presented below beginning with Pauline and following in interview order from first to last. Discussions centre upon what is unique to each participant within the context of HIV & AIDS education, creating a portrait of each woman. Memorable quotes from each interview frame the women's perspectives on learning and uphold the participants' voices, rather than my own.

Portrait 1: Pauline

In her third year as Coast Region HIV & AIDS Coordinator for Pwani, Pauline is remarkably knowledgeable, competent, and resourceful. Originally trained as a nurse, she left
bedside nursing in favour of working with the community. When I asked her to explain her most profound learning experiences, Pauline discussed the importance of mobilizing the churches in the fight against HIV & AIDS. She laments the church's "lack of information," explaining how "discrimination can even deny somebody access to the services and even to HIV care and testing and even management" (p. 8). Given her supervisory role in the development of HIV & AIDS programs, Pauline has several key recommendations which entwine the role of the church and educational interventions. Although programming is limited by funding received through organizations like USAID, Pauline described four primary features which should form the architecture of holistic HIV prevention, including empowering men, developing micro-finance initiatives, educating young children, and enhancing family dialogue.

Primarily, she emphasizes the need to empower women and men simultaneously, repeatedly stating that a focus only on women's education is not beneficial to women as men hold the decision-making powers. The following lengthy quote illustrates rigid gender roles and how these fuel the HIV epidemic in Kenya:

And if it's getting infected, she will just get infected that easy. You see? Because she is depending on this man for emotional support, for economic support, the financial support - who will pay her house rent, who will feed her children, who will pay her children's school fees if not this man? So, because of that dependency then it reduces some of her decision-making powers...And again, even if they are empowered, you see decision-making here in specific the sexual act. It's again the man who has the power to decide whether they're using protection or not. If this woman, well she's empowered, she knows her rights, she knows the basic information about HIV and AIDS, she even knows how to protect herself, but here again she is helpless. So that now we have started targeting males - men involvement in the prevention of HIV and AIDS and even in reproductive health and other health related issues. To see that we are now bringing men in being involved in supporting this because they are very important people, they're the decision makers of the homes, if he's not empowered, even if you
empower the woman - yes, you have done something - but, you need to put more effort now there. So if you target the woman, you target the man as well, then I think you can get the desired results that you want. (p. 9)

Pauline's discussion of how men's education may revolutionize women's ability to become actors and decision-makers within their households is of great importance for HIV education and prevention. Illustrating this potential is Pauline's example of extreme oppression some women face in accessing health services:

And another issue that I forgot to mention is the women access to health services. You see, maybe I'm in a relationship, it's violated, my husband is moving out with other women, I am infected, maybe I have an STI, him he'll go out and get treated, he'll get some injections, he'll get all the medications that he needs. Me here, I don't have access to the health facility as a woman, I even don't have the money to facilitate me getting the services. I even don't have the permission to go to the hospital. Look here, how helpless a woman is. (p. 11)

She then goes on to describe that along with targeting men, women need to be empowered financially. Impairing women's decision-making ability is their complete economic dependence on men; gaining a source of income may enhance their role and power as decision-makers:

By maybe starting the micro-finance, maybe imparting some business skills in them or maybe even taking them for vocational trainings to uplift their standards of living and even linking them with micro-finance institutions for loaning as groups and as individuals. I think this would help...You just empower them with knowledge, you empower them financially, and then yeah, you enhance their decision-making...So that if she's well, if she's empowered here, her decision-making is good but she's very dependant financially - she can't do anything - but she's empowered with knowledge, she's empowered well with - even her self-esteem is risen. And then she has other options to fend for her family and she'll not be able to accept some unacceptable things. Uh-uh [shaking head no]. Yeah, she'll stand on her grounds and fight for her rights and be free from HIV. (p. 11)
For women, HIV prevention is based on partial economic independence, HIV education, and an empowered and educated husband. This three-fold approach to HIV prevention in Kenya illuminates the primacy of gender inequality as a root cause of the epidemic. Pauline is outlining a strategy to combat patriarchy; a side result of which will be a reduced number of HIV infections, but ultimately a more equitable culture for both genders.

The third feature of Pauline's holistic approach is the education of young children. Targeting the youth with peer education programs has been effective but is also problematic, as illustrated in her description of the behaviour change process:

Cause you see behaviour change is a process and if you start targeting [Pauline] - I am a married woman, I am an adult, look at how old I am, look at my past, my knowledge, my attitude, my practices, depending on the experiences that I’ve passed through - for me behaviour change will not be as easy if you target the child who is upcoming. You give them that information that they require, give them the life skills, self-esteem, motivation, you give them the decision-making skills. Let them make informed decisions, knowing that ‘if I do this, this will happen, if I do this, this will be the result’ and I think that by doing so, I think we shall have responsible members of the community if we start targeting the children as young as they are. (p. 12)

Concern for children's education was echoed by others, including Lucy (Portrait 5), Carol (Portrait 3), and Rehema (Portrait 4) in their discussions of how their own children are learning about HIV in school. Pauline also discussed the significance of family dialogue in the education process of children and youth. She specifically mentioned how:

Research shows that these youth, especially the ones approaching puberty and in puberty would like so much to hear about the sensitive issues regarding their reproductive health, their relationships with the opposite sex, things to do with the changes in their body, they would like to hear these things from their own parents. (p. 12)
Traditionally, grandparents and elders provided sex education for young people. Urbanization, globalization, and the HIV & AIDS epidemic have eradicated this vital relationship in some contexts, creating a conundrum in which "most parents lack knowledge, they lack skills, they lack even the confidence of discussing such pertinent issues with their children" (Pauline, p. 12). To bridge this divide, Pauline believes it is essential that the church provide a safe and nurturing environment in which to build family dialogue skills. Through this approach parents will be empowered to "take the full responsibilities of educating their own children at home" while children are taught "the facts about HIV & AIDS" (Pauline, p. 12). While this study focuses specifically on the role of education in transforming the lives of women affected by HIV & AIDS, Pauline's all-encompassing approach embodies a variety of strategies which could positively impact the overall health and well-being of women throughout Kenya. Her insights into the role of men as a social group which can both constrain and compel women to enact social change is a central component of the analysis and has deeply informed my understanding of HIV & AIDS education within Coast Province.

**Portrait 2: Belinda**

When Belinda and I met for the first time in late September, 2009, I was immediately drawn to her bright smile and generosity of spirit. Widowed for over a decade, Belinda dedicates all her spare time as a volunteer community health worker while simultaneously caring and providing for seven children (four biological). Through her volunteer efforts she enables women, children, and men to gain access to HIV testing, treatment and counseling services. A central aspect of reducing the fear and stigma associated with being HIV positive, Belinda encourages PLWHA to "become open...join the support group...discuss [their] status and...become happy" (p.
Sharing and developing relationships with others who are positive is integral to the process of becoming open and free within a support group:

If you just stay alone in your house you will think that your problem is just your problem. It will make you become down. So I always tell people 'you have to come up, they have to come out. There are some people like you... If you are positive you will find someone who is positive like you...someone else will have the same problem, so you share'. (p. 10)

Originally the founder of a support group at the Malindi District Hospital, Belinda also helped to establish Living Positively. Through her recruitment and counseling efforts, membership grew from three to eighteen (17 females, 1 male) within a few months of starting. Belinda is currently the leader for Living Positively and has created a curriculum for the group, including "prevention of transmission, mother to child care, voluntary counselling and testing, anti-viral therapy, nutrition" (p. 3) as well as basic financial skills and stigma reduction. Attending educational workshops for over ten years, Belinda is well qualified to educate other women on a diverse range of issues associated with HIV prevention and care. She explains the shift which occurred within her own learning as a result of participating in workshops:

I didn’t know how to manage the illness, to cope with stigma. First, I didn’t know, but after going, now I know. Not everyone knows how to cope with stigma. Not everyone can accept you the way you are. Some are abusing you when they are passing. But you have to know how to - you have to accept yourself the way you are. (p. 6)

Belinda's belief in the value of becoming open and accepting oneself is central in her efforts to fostering community awareness about HIV & AIDS. Her activism is often met with harassment and scrutiny; however, she justifies her behaviour and continues to educate children about HIV prevention despite community disapproval:
They told me that I am living like a Western person! 'You are like a Western woman; African women do not something like this!' {Laughter} But me, I have to make [my children] free. If I am free with them they will tell me more about them and I will know how to save them if they are going the wrong way. (p. 19)

In describing how she sacrifices herself, Belinda illustrates the impact that her learning has had on how she sees the world. In particular, she articulates her right to be sexually active despite living with HIV:

Belinda: I sacrifice myself because some people don't like me...like where I was working. I was volunteering with [a church] but they came to know that I had a boyfriend, so they fired me! {Laughter}

MS: [somewhat incredulously] You were volunteering and they fired you because you have a boyfriend?

Belinda: Yes! I asked them 'how can I stay alone? Like she knows her status, he knows his status; we know how to take care of ourselves. Are we animals? We cannot stay alone'. (p. 14)

Belinda's description of having a boyfriend and staying alone is a discreet reference to the sexual rights of PLWHA. Within the context of discussing the church's stringent focus on abstinence, Belinda has now begun to assert her sexual rights as an educated woman who knows how to protect herself and her partner:

We need to be loved and she or he needs to be loved – what can you do? You can’t deny. Let’s say all of the knowledge you have about prevention, how you can prevent yourself from being infected. But the church always just says ‘don’t do this, don’t do this.’ - it can be difficult for us. (p. 14)

The rights of PLWHA to maintain healthy sexual relationships within or outside of marriage are vital to Belinda. In discussing the importance of addressing commercial sex work and poverty to combat HIV, she concludes with "But I would not suggest to people that they abstain - that one is cheating us" (p. 18). Advocacy for the sexual rights of PLWHA was unanticipated. Outside of
this interview, there was no discussion of what PLWHA can do to prevent transmission of the virus yet maintain a sexually active lifestyle. Essentially, Belinda outlines a strategy for HIV prevention that effectively recognizes the unique needs of women living with HIV & AIDS. Belinda's discussion of these ideas may indicate a process of transformation as she reconfigures who she is and negotiates what it means to live positively.

Belinda continues to work as a community health educator for little to no remuneration. When I asked her what motivates her to continue volunteering she explained, "I want to live a long life. You know I’m HIV positive, so if I want to live long I must learn more about HIV. Then I will live long and accept myself" (p. 6). The value of education and its connection to self-acceptance within the context of HIV is an over-arching theme within Belinda's discussion, illustrating a transformative process she may experience in moving through feelings of isolation, to becoming open and happy.

**Portrait 3: Carol**

One of the first women recruited to Living Positively, Carol was the only participant who asked to be interviewed. During the interview she was intent on obtaining information about post-secondary education in Canada for her daughter. While this may have spurred her to participate in an interview, I do not doubt the credibility of the data garnered from our discussion.

Carol is a single mother to one daughter, whose health, well-being, and education are her primary concern and motivation for learning more about HIV & AIDS:

> Every time I talk to her I say ‘you are the only daughter’. The second one is dead because she was HIV positive, she was 2 years old. In 2001 there was no drugs, my daughter died at 2 years, she was positive. And my husband divorced me. He said ‘to hell with you, you are positive’. (p. 5)
After the loss of her first child, Carol does everything she can to safeguard her daughter's health, going as far as not sharing personal effects, a prevention strategy taught to members of Living Positively. Exemplified by her ex-husband's actions in the previous quote, stigma is a prominent concern for Carol and surfaced multiple times throughout the interview. Primarily, Carol discussed stigma as a reason for joining Living Positively:

The time you know you are HIV positive some people...have a stigma. Even your friends they can discriminate you. So we decided, all positive living, we can stay together, we can discuss, we can exchange ideas, how you can live positively. (p. 4)

She goes on to explain how an all-positive support group protects the members from rumours being spread about them:

Some groups you can’t be free. Some people they collect things about people and then go to talk about those things somewhere outside there [gesturing away from the compound]. That’s why we meet with positives only, we mix the positive living with the outsiders – no! (p. 4)

Fear of slanderous gossip prevents many women in the community from participating in educational programs and receiving emotional and social support. The Living Positively group offers training in stigma reduction and status disclosure in an effort to combat this problem. Carol has learned how to reduce stigma in her community, explaining how "you have to talk to them about how to keep out the stigma, to wake up, to be open" (p. 7). As a cultural response, stigma is not wholly directed at a person's status, but at the immoral behaviours the person is assumed to have taken part in which acquired a positive status:

You know in Kenya people think those who have HIV are going with many men, anywhere, doing bad thing. That’s why people discriminate; they know you are doing bad things. But now, people have come to know you can get it from sharp objects, you can get it from blood, accidents, and whatever. But the time first
HIV was here, you can be dumped somewhere with a lot of dust.
(p. 10)

The fact that Carol associates "doing bad things" with "going with many men" suggests values and norms associated with female sexuality in Kenya. Carol does not reference sexual promiscuity in general but women going with many men who are the problem and the root cause of discrimination. Similar ideas are conveyed in almost all the interview data, reflecting a particular construction of women as the source of disease and vector of transmission. Carol also explained how men's behaviour facilitates the spread of HIV infection:

In Malindi, women are the high risk. They are many. By the way sometimes we are in the hospitals, you can look at the programs, you can get many women and only one man. Like men they are still hiding themselves. And still, men they are having some women outside there. One man can get even five women. So they are spreading the disease. (p. 6)

This statement, considering the previous quote's emphasis on women, is contradictory and illustrates an element of the tension within the data. Within most of the interviews and the data set as a whole there appear to be varying interpretations of the root causes of HIV and effective intervention strategies.

Outside of stigma, Carol adamantly and uniquely discussed how HIV is "just another disease" (p. 7). After explaining how HIV testing is stigmatized, Carol was quick to add:

Ok, but for now people are not worried about HIV - what it is. Everybody has HIV - so everybody is not worried…If you don’t have HIV, you have diabetes, you have pressure – so it’s better you have HIV. Some others have cancer, others have pressure. There are a lot of diseases. (p. 7)

This matter-of-fact explanation that HIV is as much a part of life as diabetes or cancer may reveal the degree to which Carol is embedded in a community of people learning to live positively. In saying that it is better to have HIV, she may be referring to the fact that medications for PLWHA
are free whereas treatments for other diseases are not. Later, I asked her if PLWHA would claim
to take cancer medications to hide their HIV status and she disagreed:

...But for now people are not getting AIDS, they are just living
with the virus. You can’t see somebody who is thick-thick
because of AIDS – No! By the time you know you are HIV
positive, you will take the drugs, take the steps and you will go
on with your life. (p. 8)

Carol's statement may reveal a shift in women's perceptions of HIV. Formerly, a positive HIV
status was regarded as a death sentence, now women recognize that they can "go on." This
perspective shift suggests that Carol has processed a deep shift in reconfiguring who she is as a
woman living with HIV, perhaps facilitating authentic HIV education for her daughter.

**Portrait 4: Rehema**

An unemployed mother of three children, Rehema is remarkably optimistic and brimming
with personality. Widowed for over four years, she is focused on providing her daughters with
appropriate sex education. As a relatively new, yet faithful, member to the Living Positively
group, Rehema talked about the supportive role Belinda (Portrait 2) and Margaret (Portrait 6)
played in encouraging her to be tested and access treatment. Throughout our discussion she was
very confident, inquisitive, and gestured fluidly with her hands to reinforce her points. Two
instances stand out clearly as areas where Rehema had incredible insight.

First, when I asked her what else could be done to prevent HIV in Malindi she described
a unique perspective on criminalizing intentional transmission. Rooted in the belief that
"sometimes the positive ones make the negatives to be positive and run away," Rehema believes
that this behaviour should "be a police case now" (p. 8). Her recommendations stem from
personal experiences of infidelity, behaviour familiar to women in this research study, and which
caused her to be infected with HIV: "It was like me, I was not aware. I loved [my boyfriend] but

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what happened” (p. 5). In describing her boyfriend's death, Rehema notes how the "doctors did not tell me the sickness" (p. 2). Considering such circumstances, Rehema's response is a justifiable suggestion for HIV prevention among Kenyan women:

You are negative, he’s positive. But you met. The negative one, she has to, or he, has to go back and speak to police. ‘I was ok but it came like this and he did not tell me. And I loved him, so what can I do now?” (p. 8)

If a person experiences stigma from her family, is abandoned by her partner, and ignored by the medical community, turning to the police for help if someone infected you is a logical path.

Secondly, Rehema described survival sex as a factor fostering the spread of HIV. Rather than labeling this type of transactional sex as prostitution, the term 'survival sex' implies how this behaviour is the only option for women to provide for themselves and their children:

In Malindi, you know here in Malindi {giggles}, the womens are the ones who struggle for their life and they are not – most of the women are single. That’s the problem. So there are those who go out at night…so they don’t care when they are drunk. And others they don’t care that ‘I will get a little thing but I will lose my life. Or I will get more problems.’ They speak like ‘I have got a client. Now I need, I need only breakfast at my house. I don’t want more’. The breakfast is dangerous. The breakfast will be poison to your family. Yes. Because maybe the man, he had other lady who is sick, now you have met together and are at the table and you say you are honeymooning or you have got - it’s your chance, but the chance…it will be danger, will be poison to you. (p. 9)

Rehema's description of breakfast being poison represents her complex understanding of survival sex and the ensuing results. The breakfast is not literally poisoned but the sexual act that bought the meal may be fatal for the woman. Although other participants discussed commercial sex work as a cause of HIV, few conveyed similar depth into the complexities of transactional sex.
Portrait 5: Lucy

Always wearing an orange headscarf and a green soccer jersey, Lucy is one of the newest members in Living Positively. A quiet participant during group discussions, I was surprised by her level of enthusiasm in meeting with me for an interview. Lucy eagerly discussed how she was continually ill for a long period; only through the persistence of friends did she gain the courage to seek an HIV test:

For those 2 years I had been sick on and off, on and off, on and off. I had never thought of going to the hospital and being tested. I thought it was just, just, it will just end. But it never… So it became so serious that I had to stay in the house, I had to close my business – I had a shop – I closed it. I had to stay in the house doing nothing cause I was – but there in the house I was all the time alone. My husband was not there – see I told you we separated so I was staying alone with the kids. My mind never told me, never educated me about going to the hospital and getting tested for this disease. I thought it was typhoid because I was being treated for typhoid. So it took time. Until [Margaret] noticed. My kids used to take lunch at her house… so she used to ask them ‘Where is your mother? Tell your mother to come here.’ And the kids used to say ‘Our mother is sick, she is in bed.’ So one day [Margaret and Pamela] came to my place, they saw me, they talked with me… we talked a lot so I had no fear. They escorted me; [Belinda] escorted me to the hospital. I went there and I was tested. (p. 6)

The supportive role that women play in helping other women is crucial in facilitating conditions for impactful and meaningful learning. Highlighted in this interview, psychological and emotional support is central in developing a trusting relationship between women. Belinda and Margaret not only encouraged Lucy to seek an HIV test, but also persistently counseled and supported her involvement in Living Positively:

[Margaret] approached me. You know they are the ones who helped me in the first place when I was, I was down. So they approached me, they told me the goodness of the group, so they told me we can organize, we can be together, we can get other
people of the same, the same – what can I say?...The same same needs and category as us. So I get interested.  (p. 3)

Now an eager member of the support group, Lucy is undergoing a transformative process in which she is nourishing friendships, becoming more social, improving her physical health, and volunteering daily. She explains how "the group leader she is trying to lift us. You know we never knew anything, like me I never knew anything. But [Belinda] is trying to educate us" (p. 6). Throughout her interview, a budding sense of hope is tangible as Lucy demonstrates how moving beyond barriers of fear and stigma has been an impactful learning experience. Although she was "fearing for the first time" (p. 10), Lucy now encourages other women in her community to join the group in the same manner that Belinda and Margaret befriended her:

Yeah, I have talked to some other women. I approached them. They are willing to come but yet, they have not yet come. I will still be talking to them, pushing them, and then I think they will come…I have to tell them my story first. (p. 12)

Through inviting a relationship of reciprocal dialogue and sharing, Lucy illustrates the educational power of storying. She is assured that her friends will respond to her invitation and join the group, overcoming their fears and learning to participate more fully in a positive life.

**Portrait 6: Margaret**

Founder of Living Positively at her church, Margaret is a vibrant and instrumental woman. Operating on a miniscule budget and with few resources, she also voluntarily facilitates a program for orphaned and vulnerable children, a marital counseling group, and a youth club. University educated as an Agriculturalist and working in the tourism industry for seven years, I was very interested in how Margaret became an HIV & AIDS education activist:

But after I got married…I stayed closely with [Belinda]. I had a business there, a small business, a *duka* - a kiosk - and she was our neighbour there. So I came to know her and I felt for her
when she was really bed-ridden and she had kids. So I started helping her and that is how I got the interest because after I started supporting her I saw what God needed. She was strong after getting the medicine, she was strong enough to be able to do her things and look after her kids well. I got interested, I got encouraged to see at least she has walked, she is doing things and she is happy. So I got interested in working closely with the people who are infected or affected by HIV. (p. 2-3)

Margaret's friendship with Belinda completely reoriented the focus of her life, culminating in her tireless efforts to extend the church as a place of "refuge" for the many PLWHA in her community who are "side-lined" (p. 12). Peer education programs were developed in direct response to accusations that congregations and clergy were propagating stigma and denying the possibility of HIV & AIDS in the church (Belinda, Pauline, Lucy). This church's role in delivering educational programs for couples, youth, children and PLWHA represents a four-tiered approach to confronting the HIV epidemic. Margaret has witnessed encouraging responses within her community to these programs, concluding that she is happy because "at least I know we are not encouraging the breeding ground for more HIV" (p. 12).

Despite these achievements, Margaret explains how several factors impede the success of the support group. Coming from circumstances where "nobody is trying to support them" and they are "condemning themselves" (p. 12), women in Malindi are reluctant to join support groups:

And others they don’t see the need because they don’t see what they get – after meeting what do they get materially? They see us as a waste of time, they don’t see the benefit. (p. 6-7)

Belinda, Naomi (Portrait 8), and Irene (Portrait 7) echo how a lack of material benefits is a barrier for participation in popular education programs. Material payout in exchange for attendance is reasonable: Walking to meetings in hot weather because you cannot afford local transport, with several young children, while you are sick and tired is surely exhausting. Promising to meet immediate needs by providing food or money may be sufficient motivation for women while
other non-material benefits, such as friendship, seem vacuous. For women who do make the effort to join Living Positively, Margaret is assured that there are worthwhile, immaterial benefits:

Ok, when we come together at least we are taught how to live positively, how to accept themselves even if they are sick and also they get new friends. You see when they come here we meet as a group and we establish friendships. And it’s very important, I see even me, I see they are close to me. When we meet here, as we continue meeting together they will become close and also I will become close to them so even amongst themselves they have new friends. People who are sharing with you a common problem. So it’s only that they don’t see but there's a very big benefit of coming together, at least they can encourage one another. Some of them have the disease for many years so they encourage the ones who are, at least, who got infected recently. So I see this is too their advantage when they meet. (p. 7)

Friendships, encouragement, and sharing a common problem are key benefits of joining a support group. The psychological, social, and emotional support women experience as members of Living Positively enable them to participate more fully as members of their communities, illustrated clearly by Margaret's description of a new group member:

She was very secretive, she was not able to be open, she was staying in the house – the whole day staying in, staying in the house. After she came to the group she is very open, she comes to help me there with the kids. She helps me washing the dishes. So I encourage her to come every day because sometimes she doesn’t have to be in the house. So when we are cooking with the kids at least we are able to, we can share what we have for the children. And also she has established a relationship with me, if she has a problem she can tell me because we are close. Before she never used to tell me but now as she has continued staying together, staying together, I have continued to encourage her in the group and she is now open. If she has any problem she can share with me freely. So I am happy about it. (p. 7)
Margaret goes on to describe that this transformation occurred over a few months, concluding with "Even the children they tell me their mom is happy" (p. 8). Her story is invigorating and testifies to the power of support in creating educational contexts that restore adult learners.

**Portrait 7: Irene**

Irene's life story is painful to tell but her desire to share this part of herself so others may learn to live positively is incredibly powerful. The quote below illustrates her movement through the lowest places in her journey and how she has become a resilient force of hope within her community:

> It’s sad; sometimes if I tell some people [my story] they started crying. I tell them don’t cry because that is where I come from. I know, I think I will make it. Ah there is a day I slept straight, I asked God, Can you tell me which time people are dying?... - I think if you get a pain then you die...And me I’m getting pain but I’m not dying. Let me close my eyes, if somebody closes his eyes he can die. I try even in my bed, I close my eyes I become straight like this, so I said I’m going like this, let me die now. {Laughter} Oh I’m dying now!...Yeah! I tried so much to die but I know God wants something inside me because I help so many people. I help so many, many people. If they come [to the hospital] and they don’t want to talk about HIV, they call me – [hospital staff] will get her phone and call me '[Irene] please, I want you to come to the hospital right now. Talk to this woman, talk to this man. Can you tell this woman your story because she has little children and she doesn’t want to take the drugs? Why don’t you talk?' (p. 9)

And further on, Irene describes how she volunteers herself because "I come from somewhere like there…So we are working in the grace of God but we are not working for the money...I didn't want to stay but God knows why He wants me to be here" (p. 19). Irene's story offers insight into the process of learning for women living with HIV & AIDS in Malindi. Specifically, her eloquent description that "what is killing people is how others talk about you" leads her to suggest to others that they "look for somebody you can open your heart to tell her that you are HIV
positive, don’t talk about your status with everyone” (p. 12). Irene's discussion of selective disclosure is a strategy the group has been taught as part of a healthy, positive life.

However, people can inadvertently disclose their status by virtue of group membership or by accessing treatment. In this way, men's fear of their status becoming known causes them to restrict women's involvement in educational support groups:

They fear their husbands because if that husbands hears 'Ai! You are going to the support group for people living with HIV! All of the people they will see you there. I don't want that!' So most of them they fear because the husband is the head of the house. If he says no, it's no, if he says yes, it's yes because he's the one who is feeding you. So you can't do what he doesn't want. (p. 16)

As part of her health work, Irene pays particular attention to "fearing husbands," trying to persuade them that the benefits of attending the support group outweigh the perceived stigma of belonging to one:

Now like me I have a benefit, so I can tell the husband, 'you know me, where I come from, I was sick, I was down, what I went to see in the support group is I want to know if there is somebody who is living with HIV like me. And I get that support for me and I get happy, so we are together. And the other thing you get some, a lot of knowledge and a lot of courage.' So if you tell the husband 'you can get drugs for free, we can help you, if you are sick we can look for a way to support you', those are the benefits. (p. 17)

Again, the role of storying and sharing one's experience educates others about living positively. Irene and other members of Living Positively are the foundation upon which effective popular education programs, such as peer education, can flourish.

**Portrait 8: Naomi**

Locally described as a "messiah," Naomi is passionate for raising community awareness of HIV & AIDS. Through disclosing her status "in the church and the funeral places" (p. 7)
Naomi hopes to enable her community to be more accepting of PLWHA. She describes how fear and stigma are obstacles:

Some of them they do run away from me. If they see me they say that 'Ah I have been seen by [Naomi]. This thing is going to be announced everywhere.' You see now? That is not what I mean. Me, even if I see you are coming from the VCT, I am told not to tell you, to talk about your status and tell someone. What I know, what I know on my behalf is about disclosure, my own disclosure and I do disclose everywhere. (p. 8-9)

When I asked her why she chooses to disclose her status in the first place, Naomi explained how she "felt very sorry to die earlier than the years [she] was given by God" (p. 11). Although she struggled initially with her diagnosis, she abruptly changed her mind and decided:

I can't die because of this little thing like this. To live positively only, it is very simple to me. I took it very simple though it took me time but I came to decide and I felt very free. Even now I'm free. Maybe if I couldn't be free you couldn't know me! (p. 11)

Naomi makes a valid point in stating that she would likely be unable to participate in an interview if she did not feel "free." Accepting oneself and being receptive to the idea of living positively may be both a cause and consequence of HIV & AIDS education. The first step in the process of living positively is HIV testing, the crux of the message she shares with her community:

And the thing I am telling them is this: 'Even if you see someone, you see a boy is very handsome or a girl is very beautiful and smart maybe but you haven't know her status, then you want to go with her, how do you go with her and haven't gone to the VCT together and known your status or her status? 'So that is dangerous to you now.' So I felt to tell them because they were just fearing…I just wanted to explain it to everyone so that everyone could find it very simple to her or to him. So [she or he] can come to the VCT and open her heart and just come and know his or her status so that [she or he] can proceed with the life. Yeah. So even if they throw [things at] me, they speak bad things, but I don't listen to them. (p. 6)
Naomi's indomitable efforts to educate her community despite stigma demonstrate the power of one woman to affect change. Overcoming circumstances that hinder the process of education requires a keen awareness of purpose and deeply rooted motivation:

Then I tell them, 'If there is money for me, if I'm given, I'll take, but if there is no money still I can do that job because even my sons and my grand-daughters will live in this world of HIV. How will I make it be a secret of my own and they, who will tell them? Heh? Who will control them if I myself am shy of that? Who will control the life of them?' Yeah, that is how I took it and I am just like that and I told them - 'there is no one who will stop me speaking' {Laughter}. (p. 7)

Naomi's resilient attitude has contributed to positive changes within her community, helping "many people who were bed-ridden [so] now they are walking on their own feet" (p. 16). Although she has some employment from a hardware shop, Naomi's dream is to own a small office space where she can continue to do community counseling more effectively and with appropriate resources. A lack of finances however, will not dissuade Naomi as she explains, "a day will not pass without me speaking about HIV & AIDS" (p. 7).

The next chapter reports the general findings and cross-cutting themes which emerged through the data analysis process.
Chapter 5: General Findings and Cross-Cutting Themes

This chapter presents the major findings and primary themes that have emerged from the data. Within the findings, I address the HIV & AIDS curriculum, report participants' knowledge of HIV & AIDS, outline participants' descriptions of how women learn about HIV & AIDS, and finally, speak to specific challenges within HIV & AIDS education. Following, I outline the three primary themes, which include striving towards openness, culture of support, and connected knowing. I also include a brief rationale and model for presenting the themes as inter-dependent dimensions of transformational learning for women in Malindi, Kenya.

General Findings

This section will craft the findings which emerged from the analysis of the eight interview transcripts and documents collected in the field. Organized into four sections, I first address the overt curriculum in HIV & AIDS education, paying particular attention to documents gathered from Pwani and Living Positively. Second, a summary of the participants' knowledge of HIV & AIDS is reported. Third, I outline descriptions of how the participants think women in Malindi best learn about HIV & AIDS. Fourth, I speak to specific challenges in women's HIV & AIDS education, giving particular consideration to sociopolitical factors that hinder processes of transformative learning.

HIV & AIDS Curriculum

Aside from educating women through Living Positively, Pwani encourages churches to offer other programs as well. True Love Waits focuses solely on premarital abstinence while True Love Stays targets the already married, offering counseling to promote marital fidelity. Additionally, a scholarship program for orphans and vulnerable children (OVC) ensures that
school-aged youth receive a daily meal, clothing, school supplies, and at least a primary education. To deliver these programs churches receive funding from Pwani; however, monies received are often insufficient in meeting community demand. As the sole staff member in charge of implementing all four programs at her local church, Margaret explains that "sometimes it's very tough, it can be taxing" (p. 5) as there are few resources and personnel to accommodate the needs of her communities. However, she continues to operate these programs, seeking out the support of others in identifying and recruiting families to participate in church-based educational endeavors:

So in the long run through [Belinda] she helped me to identify other needy kids, those kids whose parents are sick. You see how she visits in the homes; she knows this is a particular home where they really need. So through her she helped me get the kids...Then we started cooking with them and I got the burden more because I came to know how they stay even in their homes. So I had to relate with the kids to make sure that I could get through to the parents. See when the kids they know that '[Margaret] is there, she is helping us' the [parents] also gets the interest. (p. 3)

Later, Margaret explains how Belinda helps OVC access health services, assisting young children in learning how to live positively and prevent HIV. At the policy level, creating educational clubs for the major social groups in Malindi (children, unmarried youth, married couples, and PLWHA) enables all household members to seek programs that accommodate their unique learning needs. A document detailing Pwani's vision for HIV & AIDS education validates Pauline's description of programs being grounded in this holistic family approach. Figure 6 indicates how topics such as poverty eradication, gender-based violence, and micro-finance are incorporated into HIV & AIDS curriculum, reflecting a complex understanding of the social causes and impacts of the HIV epidemic in Kenya:
Margaret affirms the effectiveness of this holistic curriculum by describing how the success of *True Love Stays* and the OVC program are inter-related:

> But when we do the program we have seen [parents] come together and live together as a couple and in that we see the children, at least they are also happy for that kind of relationship. Because when the families are not together the children are also affected. So when I see the couples are living together, they are happy with one another - that one also encourages me because at least I know we are not encouraging the breeding ground for more HIV.  

(p. 12)

At their root, the HIV & AIDS education programs employ the tremendously popular ABC strategy for HIV prevention: Abstain, Be faithful, Condom. Where pre-marital abstinence is encouraged in *True Love Waits*, faithfulness is the dominant behaviour promoted in *True Love Stays*; when abstinence or faithfulness is not possible, condom use is encouraged as a last resort.

Christian communities throughout Kenya are vehemently divided on the topic of condoms. At a peer educator session led by Pwani staff, I witnessed a heated and passionate debate concerning the promotion of condoms as an HIV prevention tool (Research Journal, p. 2). In conclusion, the group decided that promoting condom use among youth may be seen as encouraging premarital sex, and is therefore not congruent with Christian beliefs regarding sexuality. However, the members in the training session did feel that they could refer youth to other institutions, such as secular NGOs or medical clinics, to obtain information about
It is important to note that although Pwani chooses not to advocate condom use as an organization, employees may have alternative personal viewpoints. A senior staff member at Pwani and a devout Christian, Pauline referenced the importance of condom use in all types of relationships to curb the spread of HIV.

The values of abstinence and faithfulness are emphasized during weekly meetings held by the Living Positively members. As strategies to prevent HIV, participants echoed the value of abstaining from premarital sex and being faithful while in a relationship. When I asked Carol what she thinks is most important for Kenyan women to learn about HIV she said, "just to abstain" (p. 4). Lucy discussed fidelity as a strategy for HIV prevention, noting how "everybody should learn to be faithful" (p. 7). Similarly, in her public health talks, Naomi pairs youth abstinence and marital faithfulness as the two central strategies for preventing HIV (p. 13). Veiled in a discussion of polygamy, Irene illustrates how marital fidelity may be rooted in communication skills: "First of all [women] have to talk with their husbands because for husbands to learn it is very hard… [Wives] better be taught first…how to talk in the house" (p. 15). These comments represent Irene's concerns about husbands "looking for another woman" and that deflecting infidelity in marriage is the responsibility of wives (p. 15). Margaret echoes this sentiment in explaining how "the wife might be untidy or rude," causing the husband "to go out," but also that a lack of contentment at home may prod women to be unfaithful and "look for other ways to get some extra coins" (p. 11-12). In stark contrast to this emphasis on marital fidelity and abstinence, Belinda repeatedly remarked throughout her interview that she "would not suggest to people that they abstain. That one is cheating us" (p. 18).

As leader of Living Positively, Belinda's attitude is remarkably less conservative than the church that hosts the educational seminars. Reflecting her 10 years of HIV & AIDS education,
Belinda teaches the group members about prophylactics, talking openly about having "lovers" even though the church encourages PLWHA to be celibate. For Belinda, condom use is the most essential strategy to protecting one's health, even within marriage:

The most important thing for Kenyan women to know is that...If you don’t want the virus to multiply themselves in your body, you have to use protection. I do adherence counselling for those who are taking the drugs - I always tell them, my women colleagues, 'we want to talk like women'. I say 'I know you love your husband, but I know you love your kids'...So husband and kids which is which? If you don’t want the virus to multiply in your body you have to use protection. If you want to live a long life and take care of your kids you have to use protection. If you do sex without protection the virus will be multiplying in the body because the husband maybe has the virus and you, you will get it. (p. 12)

Belinda's openness on the subject of condoms is a personal choice; in the documents collected from Living Positively there is no reference to prophylactics in the curriculum outline. In this context, Belinda's discussion of sensitive topics demonstrates an act of agency as she evaluates sources of information, perhaps negotiating the authority of each source. Five participants, all educated through the leadership of Belinda, discussed the importance of condom use. In recounting a conversation she had with her daughters, Rehema explains how "condom is another thing to prevent with disease, with pregnancy, so it’s very important" (p. 6). If she were the President of Kenya, Lucy would prevent HIV in her country by initiating a program in which people "would be educated on condoms, on how to abstain" (p. 11). Providing options may be important in enabling women to adopt a variety of protective practices which improve the management of their own health.

**Knowledge of HIV & AIDS**

I report the participants' explanations of what it means to live positively, focussing on the possibilities for safer sex and pregnancies despite living with HIV. Exploring responses to a
thought-provoking interview question reveals contrasting understandings of HIV among the participants.

Of most importance for women in Malindi who are living with HIV is education on how they can negotiate sexually active, safe relationships and manage healthier pregnancies. Children are of great importance to the participants and an HIV positive diagnosis will not prevent women from becoming pregnant, despite increased risks for the mother and child. I directly asked four participants: "If someone is living with HIV should they try to have a child or more children?" All four responded with yes, with one explaining how being "Positive does not mean destruction of your fertility" (Naomi, p. 18). Rehema illuminates the value of having a child by describing that if you "take care during pregnancy and go to the clinic…it can be beautiful life for your kid. It won’t be positive like you. But if you are worried then you will be staying for all times alone" (p. 9). Through sharing a story, Rehema highlights the consequences of not "taking care" during pregnancy:

I heard my cousin…was the first to the community to be positive…after she gave birth the daughter started to be weak. Later on, she went to another doctor - [My cousin] is positive, her husband should be positive, the daughter is positive, and no other means for the daughter to survive…And also - impossible for her to give birth again. If she likes her life, it is better for her to stay with the one kid and take care. (p. 8)

In contrast, Naomi illustrates the possibilities for multiple healthy pregnancies, suggesting the importance of family planning in women's health:

You can give birth but you've got to take care for that child so you shouldn't reinfect [your partner] or the child...In fact since I came to know this I had my sister - Since she knew her status she has given birth to four…They are safe yeah because she took care…But what I told her now…is to go to Family Planning. To tell her to take Family Planning or to tell her to come to - what
do we say about this? TBL, it's sort of a, to cut, so that she couldn't give birth anymore. (p. 18)

From a counseling perspective, Belinda outlines the advantages and risks of pregnancy for her female clients, so they can choose "between what is good and what is the risk" (p. 13). As counselors in medical clinics, Belinda, Naomi, and Irene routinely outline favorable conditions for a healthy pregnancy and "safe" newborn, encouraging women to maintain a nutritious diet, adhere to a specific ARV drug regimen, reach a minimum CD4 cell count, and receive Nevirapine injections to prevent transmission of the virus to the infant during pregnancy. Pauline and Rehema also discussed the importance of bottle-feeding as a strategy to prevent mother to child transmission. During home visits, Belinda coaxes HIV positive mothers to abandon nursing and access free family planning services (Research Journal, p. 37).

While these conditions target the behaviours of women and prevent the transmission of HIV during pregnancy, a question remains regarding the use of condoms: How can a woman prevent (re)infection with her partner and become pregnant when condoms are contraceptives? Pregnancy necessitates that a woman become vulnerable to HIV (re)infection as there is not, at the time of writing, a single method publicly available which would inhibit transmission of the virus but permit conception. The ABC model for HIV prevention falls drastically short of the reproductive rights and needs of women. As part of the Living Positively curriculum Belinda teaches women who wish to remarry to:

'Look for someone like you, who is on ARVs like you, who is positive like you, he will understand you so much and then he will not stress you. Maybe he will even remind you, go and take your ARVs, it is the time for taking the drugs.' And we know we don’t have sex without [protection], we won’t do it without because of this virus. I always teach them like that. (p. 15)
As a newcomer to Living Positively, Belinda's advice is echoed in Rehema's description of how she encourages her female friends living with HIV to seek out a partner and have a child:

If one needs a child and she is positive, [to me] it’s better to look a man who is positive. And she will get one, because there are many now. You can get through speaking, be open. Be faithful. 'You love me, or I love you, but my dear, I’m positive'. It will be one way to take care of your health and it will be one way to take care of the baby. So it's better that partners are positive. (p. 9)

Rehema illustrates how a shared understanding of specific health needs forms the basis of an open and honest relationship. An activist for positive women's sexual rights, being with someone who is HIV positive and on ARVs is not enough for Belinda. Throughout our interview, she discussed the importance of love as an essential "part of life [and] part of psycho-social support" (p. 15). Ultimately, Belinda encourages women living with HIV & AIDS to exercise their "right to have a boyfriend" (p. 14), resisting the church's stringent emphasis on celibacy for anyone living with HIV: "I asked [the church] 'how can I stay alone? Like she knows her status, he knows his status, we know how to take care of ourselves. Are we animals?' We cannot stay alone" (p. 14). Negotiating a place for sexuality redefines possibilities for women in Malindi learning to live positively. Creating space for dialogue on how women can participate safely in a sexually active relationship is restorative to the humanity and dignity of PLWHA. Encouraging women to find partners who are "HIV positive, on ARVs and love you so much" (p. 20) reflects learning which is beyond communicative and may evidence part of Belinda's transformative journey. In moving through being lonely and out of self-condemnation she now allows herself to be in a loving, sexual relationship she believes "the Bible would even accept" (p. 15).

Although six of the eight women interviewed belong to the same HIV education program, they present varied understandings of the HIV epidemic. Differences were most prominent when participants reflected upon the following question: "Let's pretend you are the President of Kenya -
this means you have a lot of money, power, and influence. What would you do to prevent HIV for people in Kenya?" While initial responses were "just educate some people" (Lucy, p. 10), subsequent probing revealed different perceptions of why HIV spreads with such rapacity. Lucy explained how education is essential because "There are some people who have no idea. The others are still in darkness. They are saying [HIV] is not there so they need to be educated" (p. 11). Similarly, Rehema's story exemplifying how HIV spreads in villages is grounded in her assertion that "they have no knowledge"; consequently, she asks:

Will the disease stop or will it continue? [In the villages] there they get baby, the mama maybe she doesn’t know about a clinic, she make the *nyonyo* (breast milk) to the baby. After all, the baby becomes sick, sick, sick, sick. Later when she goes to the hospital, ‘Ah I’m sorry, where were you?! That is last moment, your kid is living positively now.’ So [she] will be wondering ‘Where did I get the disease?’ … [She] will not accept… [she] will get a boyfriend, infect the boyfriend. With me, I think, the disease will not end. I think like that. (p. 8)

From a different standpoint, Irene explains that people need to be educated specifically on the importance of HIV testing even when they feel healthy:

HIV can live in your body for even 10 years without knowing that you are sick. And that is the time you are giving it to this one, to the other one, it’s like this. So [everyone] better be tested - all then know the status so [they] don't go here and here and spread [their] HIV. (p. 18)

In contrast, Margaret, Lucy, and Carol attribute ignorance and apathy as a cause of HIV, suggesting perhaps that measures beyond education are needed to curb the epidemic. Margaret explained how people know "that through sexual intercourse people can get infected but they still move around without any protection...Still all of them they are ignorant about it" (p. 6). Lucy also ascribes "don't care peoples" as responsible for fuelling the epidemic, explaining how some people continue to go the "wrong way" because "They don’t care about the others...[they're] not
caring of [the] family" (p. 11). Finally, and perhaps most disheartening is Carol's outlook that "everybody has HIV - so everybody is not worried" (p. 7). Carol's explanation that "If you don’t have HIV, you have diabetes, you have [high blood] pressure, have cancer" (p. 7) may reveal a growing attitude that HIV is just another disease.

Learning About HIV & AIDS

The participants in this research study largely agree on how women learn best about HIV & AIDS. Primarily, participants spoke about the value of learning with other women, particularly those who are living with HIV & AIDS, within the format of a workshop or seminar. When I asked Carol how women learn about HIV she said they should "go for the seminars…where you can talk about what is HIV" (p. 6). As a popular education strategy for adult learning, seminars enable women with minimal formal schooling to be educated on the practical aspects of HIV prevention and care. Belinda has participated in workshops for over a decade, learning basic health practices such as personal hygiene and water sanitation as well as more complicated intervention strategies such as drug adherence, psychotherapy, and stigma reduction. In acquiring technical knowledge, adults learn skills that enable them to better manage their own health but also improve the health of others. Irene describes how she applies her workshop training to help others who are living with HIV & AIDS:

I learned more which is helping me now and helping other people. And I learn how I can talk to somebody [who is] HIV positive and [does not] want to disclose. And if I came to you and you are telling me, ‘Ah I just have a headache. This headache is disturbing me, what and what. I have tuberculosis.’ - Then I know how to approach you, then you come out and tell me anyway - because many people they know [their status], but they don’t want to disclose and they don’t want to go to the hospital. (p. 11)
Belinda describes how participating in seminars facilitates emotional and psychological growth, helping her to:

Manage the illness, to cope with stigma. First, I didn’t know, but after going, now I know. Not everyone knows how to cope with stigma. Not everyone can accept you the way you are. Some are abusing you when they are passing. But you have to accept yourself the way you are. (p. 6)

She concludes that physical and emotional health cannot be separated and are equally important (p. 6). Carol reiterates the emotional value of workshop education and training by describing that "you feel you are not the only one who is HIV positive" (p. 5).

In the Living Positively group, Belinda, Irene, Lucy, Carol, and Naomi had all participated in one or more HIV & AIDS seminars. Rather than all Living Positively members attending the same workshop, Lucy explained how the members of the group nominate one woman to attend so she can learn and "educate the rest" (p. 10). While some of the women are new recruits to Living Positively and have limited experience with popular education, Belinda's decade of involvement offers insight into the structure of workshops, providing a glimpse into the target audiences, teacher roles, and pedagogies employed in peer-based HIV & AIDS education.

As a generalization, Belinda states that there are "So many more women" (p. 7) participating in HIV & AIDS education workshops. This may reflect the nature of HIV & AIDS education in urban areas as Pauline points out how "In the urban [areas] it's vice versa - The ladies are more than the men" (p. 7). Carol also describes that although many women participate in a hospital-based education program, men's participation remains low because "they are still hiding themselves" (p. 6). Belinda was the only participant to describe the teachers and learning activities involved in an HIV & AIDS seminar. In her most recent workshop differences in
gender and race among the three teachers were irrelevant as the instructors were "teaching together" (p. 7).

Belinda illustrates how dialogue is a valuable pedagogical tool for community-based HIV & AIDS education: "The teachers asked questions and they picked community health workers to teach us how to provide for those people who are living with HIV and AIDS" (p. 7). Similarly, Carol explained how she was taught to "wake up" and talk to her community about HIV & AIDS "so they don't have stigma [or] discriminate" (p. 7). During our interview, Belinda sang in Kiswahili, explaining how songs and poetry are used "for outreach when we teach people and sensitize people about positive living" (p. 9). Oral communication strategies are important facets of popular education as they are memorable and effective in relaying the basics of HIV prevention and care for learners with limited formal schooling or high illiteracy rates.

Learning from peers is an essential component of HIV & AIDS education in Living Positively. Each meeting began with the women sharing a brief story of who she is, often disclosing her status and sharing concerns with the group. Similarly, each participant told her life story to me before or during our one-on-one interview. Lucy explains how members in Living Positively learn from one another "Because you are meeting with different people, you are talking, everyone is talking her own views, her ideas, so it is enlightening everybody" (p. 10). As the church coordinator for Living Positively, Margaret has several years of expertise working with a variety of learners in the area of HIV & AIDS. She describes how one woman in particular used to be quite secretive and quiet, but now "as she has continued [coming to Living Positively]...she is now open. If she has any problem she can share with me freely" (p. 7). Sharing stories facilitates dialogue where each learner is able to contribute her experiences to the group and learn from the stories told by other women.
Challenges to HIV & AIDS Education

Challenges to women's learning are numerous. Each participant discussed barriers she had personally experienced and reflected upon social conditions that hinder learning for women in general. The most substantial challenges to women's HIV & AIDS education in Malindi include stigma, churches, and gender inequality, which may increase women's vulnerability to HIV infection and decrease their access to health services. Additionally, systemic factors such as poverty, educational infrastructure, and persistent belief in witchcraft inhibit AIDS education and fuel the spread of HIV.

All eight participants spoke about rampant stigma and its enduring, negative effects. Rehema illustrates how stigma effectively severed her relationship with her family group:

To my community the stigma was - you can find some sitting together as a group…when you pass by, after a little minutes you will hear them laughing hahaha! So if you hear a laughing like that you will turn back and look. They all hide themselves…first time, second time, third time; you will feel guilty of staying. Sometimes they can maybe cook the meal, but the plate - you have your own plate, they will share together, but you will be away… [They say] 'you will eat here [gesturing away] and stay alone because we are afraid you will infect us even'…Yeah, I left my community because of the stigma. (p. 7)

Rehema's quote reveals the impact of stigma, shedding light on the importance of belonging and the burden of community exclusion. Carol also discussed how stigma could be "physical" among family members (p. 7), while Naomi has things thrown at her by people when she is giving public health talks (p. 6). The internalization of stigma threatens the psychological and emotional health of many people living with HIV. Irene poetically describes that "what is killing people is how others talk about you:"

You hear your neighbour say ‘Oh, our neighbour is HIV positive.’ You will feel bad, eh? You will feel like how did she
Carol, Rehema, and Lucy spoke about "being down" and "staying alone" for years as a consequence of slanderous gossip. Carol illustrates that professional people are not immune from stigma by describing how pastors and teachers "cannot stand somewhere and say 'I'm HIV positive'... no they have stigma" (p. 10). However, participating in popular education programs helps to reduce self-condemnation and stigma: "Before attending the support group many people have a depression, hopelessness, but in the support group they disappear because [PLWHA] find people like [them]" (Belinda, p. 18). In an oppressive environment, where accepting one's positive HIV status is against cultural norms, living positively requires learners to overcome hurdles that impede their re-integration into society as a whole and dignified person.

Several participants were forthright in discussing oppressive practices of the church. As an institution, the church long denied the existence of HIV, ostracizing members of the congregation believed to be HIV positive. Although this thesis emphasizes the leadership of one church's holistic response to the epidemic it is important to voice disparaging practices of other churches which undermine community-based HIV & AIDS education. Descriptions of church prejudice in this section do not refer to one church or denomination but reflect women's experiences of institutionalized oppression in general.

During her interview Pauline discussed the church's attitude towards HIV & AIDS:

In fact our main mandate in this program is to mobilize the churches in the prevention of HIV and AIDS. I'm learning that there's still stigma, a lot of it in the church. Although it has come down to some degree because initially when we started it was
not easy at all. We could be chased out of the churches. It is true it was that difficult! And they would always say 'HIV is outside there, not in the church, because in the church it's holy people.' But we see that discrimination and lack of knowledge can even put people at risk…even deny somebody access to the services and even to HIV care and testing and even management. (p. 8)

If being "chased out" exemplifies the church's response towards HIV education, the consequences for congregational members living with HIV are likely more severe. As a volunteer educator in several faith-based organizations, Belinda has witnessed and personally experienced multiple acts of oppression by the church. The following example illustrates the horrific effects of dogmatic proselytizing:

Belinda: We have some churches [where] someone is saying, 'I am saved, I am saved, I am healed, I can’t take the drugs again.' And then a short period later, they go and die.

MS: Do they think that because they are a Christian they don’t need ARVs?

Belinda: Yes, they say 'You are healed, go and take that drug to the toilet! Go and drop them there!' …So we always keep on telling them that God is here, God is everywhere and God is the one who brings these drugs for us to use! So you have to use the drugs…We just leave them…I feel very sorry for them but what can we do? You have already [taught] them…But if someone denies that you just leave them. (p. 8)

Historically, Christian churches preach abstinence before marriage and faithfulness to one's marital partner as Biblically based guidelines for sexuality. Within the context of the epidemic, these teachings have solidified as prevention strategies, enforced especially among PLWHA. Consider the challenges Belinda experiences as a woman living with HIV:

So that is a challenge for those people living with HIV and AIDS in the church. Because they don’t want you to have a boyfriend, they say you are positive, why don’t you abstain? But you know if you are still young you can’t. Maybe you are like me, 38 years
old, my husband dies 10 years back. And I agreed maybe to stay alone for 8 years but then you meet someone positive saying 'Belinda, I love you'. We need to be loved...You can’t deny. Let’s say all of the knowledge you have about prevention, how you can prevent yourself from being infected. But the church always just says ‘don’t do this, don’t do this.’ It can be difficult for us. (p. 14)

Belinda explains later that she was fired from volunteering when church staff discovered she had a boyfriend. However, she displays considerable audacity in defending the sexual rights of PLWHA and her need to be in a loving relationship:

But I just try to tell [the church] that we are human beings and that we have our rights. Even if the husband dies 10 years back, you have stayed alone for a long time looking after the children but someone will come into your life who is positive, who is on ARVs...And he will ask you...I want to stay with you, be friends with you, to share with you.' You can’t ignore him! I think even the Bible would even accept that. (p. 15)

Pauline describes how the church needs to become more responsible in implementing holistic education programs which target family needs. Educating children about HIV & AIDS, offering counselling programs for couples and imparting communication skills for people in all types of relationships will enable the church to bolster rather than erode the health of its communities. Lucy also views the church as a potentially viable educational institution in recommending that men be educated "through the church" on abstinence (p. 8). However, further training is required among pastors and clergy in this area as one participant balked at Lucy's suggestion, stating that "the church is not well informed in that subject" (Margaret, p. 9).

Besides stigma and the church, the participants also routinely discussed men and gender inequality as a challenge affecting women's access to health services and popular HIV education programs. Participants noted how men "remain hidden," with Irene elaborating on how husbands learn their HIV status:
[Men] don’t want to appear for many things...if you try to tell him you better go to the clinic, better check your status, he will say 'No. If you go to clinic and you have already known your status I will know mine. So you just go, you just continue and take your drugs. Me, I’m a man, I’m ok.' (p. 2)

As community counselors, both Irene and Belinda describe how men often prevent women from seeking medical services because of the pervasive stigma associated with even accessing clinics. Described by Irene, fear of disapproving husbands is a substantial barrier for women's participation in HIV & AIDS education programs:

What's the problem is that they fear about their husbands because if that husbands hears 'Ai! You are going to the support group for people living with HIV. All of the people they will see you there. I don't want that.' So most of them they fear because the husband is the head of the house; if he says no, it's no, if he says yes, it's yes because he's the one who is feeding you. So you can't do what he doesn't want. (p. 16)

As part of their volunteer community health work, Belinda and Irene visit women in their homes, coaxing husbands to allow their wives to become members in Living Positively:

They come and ask you 'What am I going to tell my husband? Because I've tried to tell my husband but he doesn't want me to be here so what am I going to do?' Then what we normally do sometimes, we go with that woman to her house and talk to the husband and tell the husband the benefit of the group. (Irene, p. 17)

Overall, men's behaviour, combined with women's minimal decision-making powers, perpetuates circumstances "In Malindi [where] women are the high risk" (Carol, p. 6). These quotes illustrate how women need to enlist the support of other people who may act on their behalf in circumstances where they have little decision-making power.

Pauline discussed at length how women's economic dependence on men, limited formal schooling, and social constructions of gender create socio-political circumstances in which
women have little decision-making power. Within the context of HIV prevention and education, this is particularly disastrous for women who understand how to protect themselves from infection but are helpless when it comes to acting upon their rights within asymmetrical relations of power:

And again, this issue of gender-based violence - you see women are being oppressed. Maybe you are in a married relationship with a man. Maybe at some point you feel like no, what this man is doing is not right, so ah, do away with! Maybe you want to go and sleep in the children's bedroom, but you see there is rape in the marital bed. And so some will be raped by their own husbands and for that matter if you have an infected husband and you start avoiding him, he will just rape you. Yes. (p. 9)

This harsh reality centers Pauline's recommendations that HIV & AIDS programs focus on educating men. She explains that exclusive education of females will not benefit women nearly to the same extent as when men are involved "in the prevention of HIV and AIDS and even in reproductive health and other health related issues" (p. 9). Lucy also describes how boys need to be educated from a young age "on how they can abstain" as women "are suffering a lot cause the man he goes out, he comes back, he's not well" (p. 8). Targeting women and men simultaneously may enhance communication skills among couples, equipping them with tools to address their shared health concerns. As part of a holistic approach, communication skills may enable families and communities to address practices that are particularly problematic within the context of HIV & AIDS:

But this boy here, who is growing up to be a man, was left free...when they go in their family they are told 'What kind of a boy are you? You, but you have not made any girl pregnant. You have not done this [mimicking sexual intercourse with her hands] to any girl! Are you really normal?' Look now - they are encouraging them to do some, to actually engage in sexual activities... But it is true. So that when he does it 'Yes, yes, this one is a real man!' Melisa, but it is true, in African tradition. The
more women you have, you are a real man. These are some of the things that maybe will have to be addressed for us to be successful. (Pauline, p. 14)

However, Belinda describes how resolute efforts to educate men about HIV & AIDS prevention are often met with resistance and scepticism:

It is very challenging because the men don’t like to learn from [women]. So some are very challenged because [the men] don’t accept. We teach the women, they know how to use a condom, but the husband says no. Woman can’t do anything if the husband just denies. (p. 9)

The church's role in community education may be elevated given such trying circumstances: If men will not listen to their wives, engage in counseling sessions with community health workers, are not being educated by the public school system and are subject to cultural messages emphasizing early sexual promiscuity, there remain few institutions other than the church with the wide-reaching capacity required to educate millions of men.

Several participants also presented sociopolitical factors contributing to the spread of HIV and inhibiting educational initiatives. Poverty is a substantial concern for women as it drives them to engage in survival sex and acts as a barrier to women's participation in educational groups. Margaret and Pauline outlined how women may be infected when they are forced to engage in commercial sex work to provide for their children, prompting them to discuss how more efforts to combat HIV & AIDS should be directed towards causes of disease, such as poverty. Irene highlights the effects of poverty within the context of commercial sex work:

Because HIV sometimes is spreading like this - if I'm a woman, like me, I don't have something to eat but now you look I'm [beautiful]. I can go out if I don't have something to eat and get a man. But here in Kenya a man tells you 'If you want me to fuck you with a condom I give you 500 and if it's without a condom I give you 2,000.' So what can somebody do, which one will you choose? (p. 17)
A lack of material benefits also prevents women from becoming involved in HIV & AIDS education programs. Naomi explains how people are reluctant to "disclose" their status publicly when they are "not given anything" (p. 20). Belinda's poignant account summarizes the tremendous burden of poverty and its impact on a woman's ability to engage as a successful and knowledgeable learner:

When you are going through learning you are positive...how to learn how to manage this illness...they think 'Are you going to give me some things?' Because some are in poverty they say, 'If you are going to give me something I'll accept. But if not, I'll just go away.' So it's difficult. Because we teach them and they have the knowledge but she can't apply it. Maybe she will use herself and sell her body to get something for the baby or for herself to eat. So how can you help such a person? It is very difficult. (p. 13)

Related to and affecting poverty is educational infrastructure. Margaret was the only participant to discuss HIV & AIDS education in the public school system, stating that HIV education is not part of the national curriculum. Although candid messages advocating for condom use and testing are disseminated through national radio and television broadcasts, millions of Kenyans do not have access to such media and may remain uninformed. Margaret made an excellent point when she stressed that:

Teachers also need to be taught. I don’t think there is a program for them to be taught. They wanted to put it in the curriculum but I don’t know how far that one has gone. But I feel it should be in the curriculum so that it is taught as a subject. So that the teachers can know and when they know at least they will be able to help the students. (p. 10)

Teacher education is essential to ensuring appropriate delivery and discussion of highly sensitive issues with young children. Margaret explains that mandating HIV education in schools by trained and sensitized teachers will "safeguard" Kenya students against HIV infection (p. 11).
Finally, two participants discussed witchcraft as a cultural belief and practice obscuring people's understandings of HIV and adoption of protective practices. Margaret reported the impact of witchcraft in Malindi, explaining how "some people believe…[HIV] is not a sickness, they are bewitched. And in such a case they don’t go to the hospital, they don’t seek medical attention" (p. 6). Irene recounted how her family tried to cure her unknown illness by bringing "some witch craft [which] is going to help" (p. 6). Diagnosed over a decade ago, Irene sold household goods to purchase numerous "drugs," recounting how frequently her husband succumbed to the promise of yet another traditional "cure" for HIV:

Please don’t buy another one. I will not take this one. And stop going to the hospital and asking for HIV cure because there is no drug for HIV cure. People are cheating us here. You have already lost 50,000, you have already lost 40,000, you lost 20…Even me I don’t have anything in this house. You just stop. It’s the fridge you sell, it’s the gas you sell, it’s the water you sell! So please, this cheaper one is not drug. So please stop it!...He told me 'No! You don’t know the drugs, this is the drug which is going to help you.' I said, 'No, I don’t want.' (p. 8)

Later, she casually reflects on the industry of AIDS, noting how "people in Kenya make a lot of money because of HIV" (p. 8).

**Cross-Cutting Themes**

Three primary themes have emerged from the data analysis process, recurring throughout the findings and participant portraits. The themes articulate three dimensions of learning which foster transformative education for women in Malindi. Described in the participants' own words, using stories and examples from the data set, the themes are fleshed out in this section. First, I outline the concept of striving towards openness, which emphasizes self acceptance, individual readiness, and the importance of becoming open as a foundation for fostering critical reflection and ultimately, transformative HIV & AIDS education. Second, a
culture of support is comprised of supportive institutions and people; the most important support for women in Malindi is friends. Third, connected knowing represents how women learn best from other women through storying and reflects how transformative HIV education is rooted in empathy. Fourth, I situate the three themes inter-dependently, illustrating how they may evolve concurrently and underlie transformative learning for the female participants in this study.

**Striving Towards Openness**

Self-acceptance, particularly accepting one's positive HIV status, is vital in enabling an adult to learn about the possibilities of living a balanced, joyful, and purposeful life. Belinda described how participating in seminars facilitated self-acceptance:

> First, I didn’t know, but after going, now I know. Not everyone knows how to cope with stigma. Not everyone can accept you the way you are. Some are abusing you when they are passing. But you have to accept yourself the way you are. (p. 6)

However, self-acceptance is not an easy process for most women, particularly within a sociopolitical context that can delegitimize and discriminate against PLWHA. A positive diagnosis is certainly a disorienting dilemma and may be associated with a range of emotions. Lucy described how she felt "shocked" and was worried when she first heard she was positive because she was living alone with school-aged children (p. 6). Naomi initially struggled with how to live with HIV, openly talking about how "it brought me some stresses and it was disturbing my mind" (p. 5). When Rehema learned her status, she was anxious about the health of her three young daughters; thinking "they will all be positive" (p. 4), she sent them to be tested with another family member. Irene's struggles with suicide and despair are perhaps the most extreme, providing a glimpse into her self-concept at the time of her diagnosis:

> I saw on television somebody who is in Uganda and who has HIV. Ai! I see the guy and wow, this is how people with HIV
look? They have no hair, somebody is massaging with the gloves, you can’t talk. So I [thought of] that picture that I saw on the television, 'Wow, this is how I’m going to be!’ Ah, never, it’s paining me if I try to [picture myself]… So the doctor came with my husband and he told me 'Madam don’t cry…if you cry you will die very soon and you have children. So you better be encouraged, don’t do something like that.' (p. 4)

Additionally, Belinda discussed how many women "have a depression, hopelessness" (p. 18) before they attend support group meetings. Margaret similarly revealed how PLWHA struggle to accept their status because "they are really judgmental…like they are condemning themselves" for their illness (p. 12). Joining Living Positively is often a catalyst for women, enabling them to be uplifted and learn "how to accept themselves even if they are sick" (Margaret, p. 7). Through popular education strategies women learn that other ways of living and engaging with their world are possible.

However, a woman engages in a process of authentic learning only when she feels ready to do so. Individual readiness is a relatively straightforward concept; it is crucial to meaningful and impactful HIV & AIDS education among women in Malindi. Simply being aware of counseling, medical centers, and educational programs does not mean a woman will seek out these services; she must be willing and ready to learn about HIV & AIDS. Lucy describes how a woman "has to decide" for herself that she is ready to join Living Positively and that in "talking to them, pushing them," (p. 12) women in the community will feel encouraged to learn about HIV prevention and care. Rehema's daughter initially refused to be tested for HIV because she was "afraid," only after participating in a health program did her daughter feel ready, and consequently, she "volunteered herself" (p. 4). By providing women with more information they may become ready to participate in discussions on HIV and learn how to manage their own health. Naomi reports that she simply "came to decide" that she would not "die because of this
little thing" (p. 11). She goes on to say that if she had not accepted herself and was not ready to live positively she could not "speak these things" about HIV in an interview (p. 11). Similarly, Margaret explains how women will not join Living Positively when "they are still separated" and "don't even know that they are sick" (p. 6).

Becoming free is an important element for women striving towards openness. Where readiness and self-acceptance enable women to seek educational services initially, becoming free represents a perspective shift that may be prompted by continual learning. For example, women learn how to become free with their status, selectively disclosing to appropriate listeners rather than opting for secrecy. Carol explained how she was taught to "wake up," and teaches people in the community to "be open" about HIV & AIDS "so they don't have stigma [or] discriminate" (p. 7). Through learning how to "become open" in a support group setting, Belinda ensures that people will "live a longer, happier life" (p. 11). Naomi explains how she "felt very free" (p. 11) when she decided to be open with her status and accept the possibility of living with HIV. Such liberating experiences are contagious and may inspire others to reflect upon their assumptions and recognize that they too can participate in transformative processes of learning. Lucy describes how Margaret's friendship and Belinda's openness reduced her self-condemnation and encouraged her to become a member in Living Positively even though she was afraid (p. 9). In contrast, not feeling open may be grounds for alternative action. Rehema left her family home when she felt that her daughter was "not free" and that it was better to return to Malindi where she "will be more comfortable" (p. 7).

Striving towards openness may be a life-long endeavour for adult learners in Malindi. Belinda has attended HIV & AIDS education workshops for over a decade and is a tireless activist in raising women's awareness not only of HIV prevention strategies but of their sexual
rights as PLWHA. Irene also illustrates the impact of her learning among people who are living with HIV. As a counsellor in the local AIDS care centre, Irene's volunteer work as a PLWHA testifies to openness, freedom, and joy that an HIV negative person cannot express or share:

Then the hospital they started calling me, 'Please can you go and tell other peoples your life history…please tell people where you came from so they can wake up.' So I started working and telling people where I came from, my status – the way I tell you now. Then they get some people, those who don’t want to take the drugs, they call me again and tell me, ‘I want you to go to training, to adherence, and you can tell people how these drugs are working because you in yourself you know the way this drug is working because it’s working for you…So you better go and start telling people.’ (p. 9)

**Culture of Support**

As a social enterprise, learning requires several levels of social support in addition to a learner's individual readiness. For women in Malindi, sources of support are primarily people-oriented (e.g., family, friends, pastor) or institutional (places of worship, medical facilities, NGOs). Not all types of support are helpful to all women learning about HIV & AIDS; part of the learning process is negotiating a sense of place within a culture of support. Irene, Margaret, and Pauline have supportive husbands while Carol's husband divorced her because of her status (p. 5). Rehema's extended family was particularly exclusive in their treatment of her, forcing her to eat alone because they were "afraid you will infect us even" (p. 7). In contrast, Naomi's five sons are close to her, one even accompanied her to our interview, praising his mother's hard work and activism (p. 16). Rehema thinks that being able to prosecute those who knowingly infect others would be an assistive policy and practice for women (p. 8). However, Lucy scoffed at this idea, noting how "It’s good but you know the cases are so many of the same kind. So every woman will be going there, every woman will be going {Laughter}" (p. 9).
All participants agree that educational programs support learners by developing networks and friendships among women. In my Research Journal, I documented the following:

One of the ideas I am grasping at it is how learning and adult education are centered upon RELATIONSHIPS…So many of the participants have testified to the importance of friendship - repeatedly being visited and encouraged by friends, nurses or other women enabled them to seek treatment and live positively. (p. 57)

Lucy explains how she learns by "meeting with different people - you are talking, everyone is talking her own views, her ideas, so it is enlightening everybody" (p. 10). When seeking medical services, Naomi goes with friends she has made in support groups (p. 2). Rehema decided to join Living Positively because she thought:

Its better I go to speak or be supported with another people. After all, when [Belinda] told me it’s a support group of a church I really enjoyed. I said ‘Well, I’ll tell you when I will be starting to come.’ Later on, she also came again and they were continuing. She came to me again and speak to me, ‘[Rehema], don’t be alone. You will be thinking a lot and it’s still early for you. Come and share a little with your friends.’ And I say ‘Ah! [Belinda] I will come!’ (p. 3)

Friendship is an important facilitator in recruiting members of the community to join HIV & AIDS education programs. Belinda, Margaret, and Lucy described how building friendships with women living with HIV can be a lengthy process, requiring patience and persistence. In particular, Belinda explains how "You have to do one to one counseling first, and then after that someone will change slowly, slowly. You can’t expect someone to change just by speaking to her today and then they change today" (p. 16). Belinda goes on, outlining how relationships are at the base of her volunteer work with PLWHA: "You will try to make friends, to befriend, to befriend. And at long last she or he will accept" (p. 16).
Within the context of a community where social relations are tightly interlocked, women's behaviour can serve as a model for other learners: "You can’t change your behaviour with no friends. You can’t by yourself. You must have a friend who changes her behaviour before you" (Belinda, p. 16). Friends enable adult learners to recognize that feelings are shared and that they are experiencing similar dilemmas. As a member of Living Positively, Carol feels that she is "not the only one who is HIV positive" (p. 5). She explains the group's decision to "meet with positives only" as it offers a measure of protection to the group members who are worried about slanderous gossip: "How can you spread [rumours if] you are HIV and I'm HIV?! You can’t talk anything" (p. 4)! Irene illustrates the interplay between institutional and personal sources of support in describing her early experiences with medical treatment at a Malindi clinic:

That is a place where I met my friend [Belinda]. Because all of us, we are sick, we are there like this, we are waiting for the doctor to come. I looked at [Belinda] and I thought 'Hey, even this woman looks like HIV positive.' And I looked at another guy there and thought 'Hey' and we started to make friends. Because if you come, we are coming together. So I go to that doctor and he told me -he’s a very good doctor -…He used to encourage us, if you sit with that doctor he is telling you so many things like ‘You are going to stay, you are not going to die, you better be ok, what and what’, he’s telling you so many things. (p. 7)

In negotiating a culture of support, learners must identify who will be a friend and what will be a source of support as they engage in a process that has the potential to be emotionally taxing. When women are affirmed by a resilient culture of support they can continually strive to be open, perhaps experiencing transformative learning to a greater degree when they are part of a synergistic collective than as an isolated individual.

**Connected Knowing**

The participants presented HIV & AIDS education as an experience in which women highly value learning from PLWHA, particularly women, within the format of a seminar. All
eight participants were asked the question: "Who is the best person to educate Kenyan women about HIV & AIDS?" Seven participants reported that a person living with HIV is the best to educate others. Pamela went into detail, explaining why she is a capable educator:

When it comes especially to beginning to sensitize the people about HIV and AIDS, I have the experience. Life experience. So maybe I can talk to them and I know how I can win over my colleagues. {Laughter} And teach them how to manage this illness. But in some cases we find that it is very challenging with someone who is not positive. If someone is not positive they can tell 'this one is talking about those things but they don’t know the heat of it'. (p. 11)

Carol reiterated, "you can’t be negative and teaching - do you know what is HIV positive? You don’t know anything. You have to know what is that virus is in your body" (p. 10). Naomi went further explaining that it is "wrong" for people who are HIV negative to educate others (p. 17). Three participants with a leadership role in this study (Pamela, Margaret, Irene) specified how it is best for women to learn from other positive women:

I think it would be good and well acceptable for women to hear from their fellow women. You see, if we empower this woman, she has more influence to her fellow women and that peer influence will be much, they'll be more willing to listen to this woman than listen to the doctor. Yes, the pastor is very influential but again, the pastor alone cannot. (Pauline, p. 12)

However, Rehema provides a dissenting viewpoint in asserting that "everyone" should educate and that delivering training "to the pastors, to the school, to doctors" (p. 11) will have a greater affect in preventing new infections.

The data suggests that authentic learning occurs through connected knowing, or a practice of empathic dialogue. Seeking to understand the other person's point of view and experiences is the root of connected knowing; dialogue is the primary pedagogical tool for establishing consensus and promoting authentic learning. Margaret explains how the members in
Living Positively "become close" because they can all relate to, share, and understand "a common problem" (p. 7). Belinda illustrates how empathy and connected knowing is the root of women's HIV & AIDS education:

> I always encourage people to join to reduce stigma. You know even if you just stay alone in your house you will think that your problem is just your problem. It will make you become down. So I always tell people 'You have to come up, they have to come out. There are some people like you. If you have a problem you will find some people in the support group who have the same problem as you. If you are positive you will find someone who is positive like you. You don’t have food, you don’t have whatever, someone else will have the same problem, so you share.' And life goes on. (p. 10)

Women discover common problems by sharing their stories and learning from the stories of others. Storying, as a process of empathic dialogue, builds trust and rapport among women, facilitating instrumental, communicative, and transformative learning as new skills may be taught, ideas exchanged and negated, and subjective identities reflected upon and reoriented.

The primacy of storying as an educational tool is embodied in Belinda's simple description of how she learns from and with other community health workers in Coast province: "We are just exchanging. I tell her my story, she tells me her story" (p. 16). In cultivating learning networks, peer educators see what others "are doing, what things they like, what things they don't like" (Belinda, p. 8), illuminating a collective, active and responsive process of HIV & AIDS education among women.

Similarly, Pauline animates the practice of peer education by labeling it "addictive."

Beyond a pedagogical pathway for HIV & AIDS education, storying is essential in developing relationships of trust and respect among Living Positively members. Each meeting began with every member sharing a brief story; similarly, each participant integrated her life story as part of the whole interview experience. Illustrating how she invites women to join Living Positively,
Lucy remarks that she has "to tell them my story first" (p. 12). Finally, Irene is consulted by staff at the Malindi hospital to share her story of despair, recognition, and renewal so newly diagnosed patients "can wake up," accept their status, and embrace a positive life. Storying is particularly powerful as women of all education levels, classes, ethnicities, and backgrounds can participate as they already have knowledge and resources to contribute.

**Dimensions of Transformative Learning**

Woven together, the themes of striving towards openness, culture of support, and connected knowing represent dimensions that promote transformative learning experiences for adult female participants in Malindi, Kenya. The data suggests that transformative learning is a cyclical, dynamic, and on-going process at individual and communal levels. Often, an individual's personal restoration inspires the transformation of others, such as Pamela's years of activism and continued support for PLWHA in her community. Naomi's transition from "craziness" to a fiercely independent leader exemplifies how transformative learning can embody a psychological, emotional, and physical restoration that appears to be irrevocable. The data suggests that women who participate in HIV & AIDS education may experience a major, life-altering change that is liberating as they embrace who they are, regain hope, and renew their life's purpose (Research Journal, p. 42). Figure 7 models the inter-related dimensions of transformative learning for women in Malindi:
Figure 7 - Dimensions of Transformative Learning

The circular arrow in the middle of the diagram illustrates how the potential for transformative learning is at its peak when all three dimensions of learning are present. A learner's culture of support rests upon her readiness to engage in an educational program, which is likely composed of many other women, nourishing storying and generating a process of connected knowing. Margaret describes how one member in Living Positively has undergone a profound transformation in learning to share with others, develop trust, gain confidence, contribute to her community, and participate socially:

She was very secretive, she was not able to be open, she was staying in the house - the whole day staying in the house. After she came to the group she is very open, she comes to help me there with the kids… I encourage her to come every day because sometimes she doesn’t have to be in the house… And also she has established a relationship with me, if she has a problem she can tell me. Because we are close. Before she never used to tell me but now as she has continued staying together, I have continued to encourage her in the group and she is now open. If she has any problem she can share with me freely. So I am happy about it.

MS: That's a big change.
Margaret: A very big change. Even me I know that she has really changed. She is one of the most recent who has accepted herself so that we are [here] for a lifetime.

MS: And how long has she been coming to this group for?

Margaret: She has been coming – at least this is the second month. And she is doing well.

MS: And all those changes within a short time, maybe only 5, 6 weeks.

Margaret: Yeah it’s within a short time. She has really changed, even socially she can talk – she used to just keep quiet… Even the children they tell me their mom is happy because she used to stay indoors the whole day. And there would be no food and that’s not good for the kids…but now since the mother came out now at least she can tell me. And those kids used to come and tell me the mother is sick but they didn’t have money to buy medicine. You see they didn't know what the mother is suffering from – it’s headaches. But now she is improving. (p. 7-8)

In summary, the three dimensions of transformative learning are mutually augmentative: Readiness to engage in learning, access to connected ways of knowing, and negotiating a culture of support creates an interface for impactful learning. Within this nexus, a learner is most able to learn about HIV & AIDS, creating opportunities to deeply reflect upon her beliefs, negotiate who she is within the context of living positively, and craft avenues for social change within her community. It is most likely that the dimensions of learning develop simultaneously and interdependently, however this may not always be the case. To a degree, all three aspects must be situated within an educational environment to facilitate a meaningful experience for adults learning about HIV & AIDS.

The following chapter discusses the findings and primary themes in relation to the extant literature, connecting this study to a large body of research in the areas of emancipatory pedagogy, transformative learning theory, and restorative frameworks for education.
Chapter 6: Discussion

This chapter is broken down into three sections that connect the findings to the extant literature and research questions that animate this study. Again, the research questions are:

- What do rural women who participate in HIV & AIDS popular education programs learn about HIV & AIDS?
- Through what range of pedagogical practices and theories does their learning occur?
- How does this learning contribute to transformative changes that improve women's health, at both individual (e.g., beliefs, behaviour) and communal levels (e.g., group actions)?

Section one, "Tension and Possibilities," creates space for topics that are problematic or absent among the data and literature, framing a discussion that informs the first research question. Section two, "Pedagogical Pathways and Practices," summarizes and presents a visual image for each primary theme before connecting each theme to the literature. Section three, "Communal and Individual Transformation," combines all three themes as inter-dependant dimensions of transformational HIV & AIDS education in personal and collective spheres.

Tensions and Possibilities

This section invites discussion on tacit assumptions within HIV & AIDS education that are not voiced or represented in the data set but which still impact learning. By drawing attention to tension within the data, I discuss how HIV & AIDS education should be more responsive to gender-differentiated needs and consider sociological constructions of disease as approaches that promote meaningful and potentially transformational learning.
Despite participants' understandings that women's empowerment is heavily dependent on the education of men, the data suggests that popular education initiatives in Malindi maintain "gender-blindness" (Morrell et al., 2001, p. 90). Participants discussed how women tend to be more responsive and involved in HIV & AIDS education, yet no initiatives are evident in Malindi that accommodate only women's HIV prevention and care needs. Similarly, popular education programs implemented by partner churches and Pwani, in accordance with APHIA II, do not accommodate gender-based understandings of the HIV epidemic despite widely-accepted literature outlining differences in vulnerability to and impact of HIV among genders (Aluku, 2008; Barnett & Whiteside, 2006; Morrell et al., 2001; UNAIDS, 2008).

Much of the data emphasizes how women's understandings of HIV should inform women's educational programs and how increased male involvement in the area of reproductive health education could bolster women's learning. The data suggests that learners would value strategies and policies that explicitly acknowledge, respond to, and target specific constraints, problems, and possibilities within gendered understandings of the epidemic. Within the context of transformative education and rural West Africa, Easton et al. (2009) realized that men's involvement was "vitally instrumental" (p. 236) to the success of an educational program within a community. Participants repeatedly spoke about the significance of men's behaviour in affecting women's learning, indicating that perhaps women and men in Malindi would be more responsive to HIV & AIDS education if initiatives addressed men's concerns of stigma, testing, and treatment. The number of women enrolled may also increase and their learning may move beyond communicative, towards transformative experiences if more men in Malindi were involved in HIV & AIDS education.
The constitution of Living Positively outlines membership criteria based on HIV status as a measure of protection from slanderous gossip. Similarly, creating educational programs for female and male learners exclusively could facilitate safer learning environments in which adults can engage more fully in various processes of learning. Barnett and Whiteside (2006) assert that HIV & AIDS education is successful only when learners can openly engage in frank discussion without fear of repercussion. I do not advocate for complete segregation of women and men in HIV & AIDS education, but holistic HIV prevention should be sensitive to learning as a gendered process. Cranton (2006) and Mezirow (2000) both describe a safe environment as a condition for learning. As the data in this study indicates, women and men are not equal in Malindi; gender inequality may undermine women's ability to have "[a]n equal opportunity to participate in the various roles of discourse" (Mezirow, 2000, p. 13). If learners are disadvantaged and marginalized at the onset of their involvement with the program, as well as by its structure, how can HIV & AIDS education lead to empowerment? Morrell et al. (2001) argue that AIDS education messages are "mediated by context, personal histories, and discourses of sexuality, masculinity, and femininity" (p. 91). The authors outline how HIV & AIDS intervention programs are blind to the gendered process of education and often "miss their target" (p. 90). Women's understandings of how women learn about HIV, as presented in this study, could partially rectify the gender-blind character of popular HIV & AIDS education strategies in Malindi.

The ABC approach to HIV prevention is particularly problematic for women in reflecting a myopic biomedical understanding of disease that emphasizes cause-and-effect relationships between individual behaviour and health. Such discourse creates a false dichotomy among "the sick" and "the healthy," which in the context of HIV & AIDS is socially reconstructed as "the
bad" and "the good" (Francis, 2008; Morrison & Guruge, 1997). The healthy develop notions of entitlement while the socially disenfranchised sick group is stigmatized based on known or assumed HIV status. Participants spoke about HIV status and stigma, explaining how PLWHA are assumed to be sexually immoral or bad people. In emphasizing individual behaviours, the ABC approach signifies instrumental learning at best and may undermine the potential for transformative HIV & AIDS education among women in Malindi. Campbell and MacPhail (2002) attribute biomedical constructions of health and HIV prevention as a reason for ineffective peer education programs among South African youth. Additionally, Heise and Elias (1996) explain the inherent dangers within the ABC approach as women may have the "mistaken impression that if they remain monogamous, they will be safe from HIV" (p. 933).

Participants in this study have a keen understanding and awareness of condom use, often speaking to the importance of condoms in marriage. However, knowledge does not always translate into action; although "people have the knowledge, they may not have the incentive or the power to change their behaviour" (Barnett & Whiteside, 2006, p. 46). Promoting condom use without discussion of gender roles and sexuality disregards asymmetrical constructions of power between women and men. Rural women in Kenya rarely have the power to negotiate condom use with their partner and, paradoxically, may now have less control over their sexual health than before the advent of condoms in their communities (Gollub, 1995; Heise & Elias, 1995; Morrell et al., 2001; Muturi, 2005). Additionally, condom use may be deterred by their contraceptive function. In cultures that highly value fertility, condoms are problematic for women who are trying to conceive but also protect their health. Preston-Whyte (1999, as cited in Barnett and Whiteside, 2006) describes how a woman's decision about personal infection is bisected by social identity timelines (p. 24). Participants frequently referenced the importance of having children,
regardless of a woman's HIV status. For women throughout Kenya, condom use is substantially more complex than a matter of personal infection, although the ABC approach operates within this assumption. Despite being profoundly ineffective as a tool for enhancing rural women’s health, condom use is one of the three main modes of HIV & AIDS prevention still advocated throughout Kenya and much of Sub-Saharan Africa (Barnett and Whiteside, 2006; Gollub, 1995; Heise & Elias, 1995; UNAIDS, 2008).

The ABC campaign is ineffective in propagating reflective, critical discussion and may be deleterious to the health of women and communities at large. Without frank and open discussion of social sexual health, women and men in Malindi cannot be expected to change their behaviour even if there is a scientifically informed link between the ABC practices and HIV prevention. Especially within the context of childbearing, ABC strategies are irrelevant and appear to negate the sexual rights of PLWHA. Minimal efforts address this problem in Malindi, further marginalizing PLWHA and increasing their vulnerability to re-infection and other diseases. Communicative learning, or cultural decoding, within the context of HIV & AIDS education requires that adult learners critically question and negotiate normative, taken-for-granted values (Mezirow, 2000). To some extent, the members of Living Positively engage in communicative learning. Participants discussed the impact of gender roles on women's access to AIDS education. Several question traditional authorities, such as the church, and its prescriptive messages of celibacy. However, the data also suggests that some participants view gender roles as static and power as prescribed rather than socially constructed and capable of transformation. Learning that goes beyond instrumental may generate shifts in such perspectives, inviting possibilities for women's lives to become sites of agency and transformational, social change.
Pedagogical Pathways and Practices

Women discussed the importance of striving towards openness, negotiating a culture of support and connected knowing as pedagogical pathways and practices that foster transformational HIV & AIDS education in Malindi, Kenya.

Striving Towards Openness

The concept of striving towards openness describes an intrinsic readiness for learning, which is the foundational component of HIV & AIDS education in resource-limited settings. An adult learner must be open to engaging herself in an educational journey, whether that journey includes attending a peer education session, counseling, or testing for HIV. The participants spoke about the importance of self-acceptance and becoming free as attitudes that enable a woman to join educational groups and foster an internal striving towards openness. These attitudes and behaviours are inter-related, for example, learning more about HIV & AIDS may reduce self-condemnation and teach a woman how to disclose her status selectively, facilitating an internal liberation and reducing stigma within her family. Self-acceptance, becoming free, and learning more about HIV are inter-linked, each phase influencing the progression of a learner's desire to be open and free. In turn, striving towards openness manifests itself further in continual, life-long investment in HIV & AIDS education. Figure 8 may be helpful in depicting striving towards openness as a dimension of adult learning:
Figure 8 - Striving Towards Openness

Individual readiness is crucial for adult learners to be able to engage in a meaningful and authentic process of education, especially when stigma and other social factors may hinder their initial access and prolonged involvement in HIV & AIDS programs. Mezirow (2000) explains that learners must "have the will and readiness to seek understanding" (p. 12). The role of readiness is central to adult learning, an educational process Cranton (2006) characterizes as voluntary: "Individuals choose to become involved in either informal or formal learning activities" (p. 2). The findings in this study confirm Cranton's (2006) interpretation of adult education and transformative learning as processes requiring learners to participate out of their own volition. For women in Malindi, readiness underlies participation in Living Positively. Participants decided for themselves when they were ready to learn about HIV prevention and
care. Often feeling timid the first time they attended an educational workshop, participants gained confidence through continual participation, ultimately becoming registered members in the program. Choosing to be involved in an adult learning program can be taxing emotionally, physically, and socially considering the oppressive contexts in which many Kenyan women live (Halperin, 2005). Cranton (2006) explains how the oppressed may not be able to fully participate in the process of transformative learning as choices may not be evident or accessible to them, but how "unbearable social conditions can also provoke transformative learning" (p. 60).

Oppressive social conditions may more prominently situate the roles of readiness and self-acceptance in HIV & AIDS education as learners are cognizant of their difficult circumstances yet make an active choice to accept a life with HIV. Participants discussed stigma extensively, highlighting how a learner's biggest challenge is learning to accept her positive status in the midst of a stigmatizing community. Self-condemnation exemplifies the effects of internalizing stigma and prevents women from joining support groups. Baumgartner (2001) considers self-acceptance to be an integral component of learning to live with HIV. Similarly, research in Thailand confirms that living positively entails coming to terms with a positive status (Duongsaa, 2008, p. 172). Self-acceptance represents a shift not only in how a woman views herself but also in her perception of the world and her place within it, ultimately leading to external action (Cranton, 2006, p. 171).

Selectively disclosing one's status represents action for some participants. Participants share their status with people they believe will not discriminate against them. Six participants disclosed their HIV positive status freely to me without prompting on my part. Learning how to disclose enables learners to become free and is an integral aspect of counseling for PLWHA in Malindi. Duongsaa (2008) echoes the importance of selective disclosure for people learning to
live positively in Thailand. Disclosing one's status permits liberation from the bonds of stigma and self-condemnation.

Within a framework of emancipatory education, striving towards openness is similar in tone and parallel in purpose to Freire's (1970) critical consciousness. A hallmark of a pedagogy that transforms, Freire (1970) argues how learners themselves need to be convicted "of the necessity for struggle" (p. 54). In a study exploring participatory peer education programs among South African youth, Campbell and MacPhail (2002) outline how the development of a critical consciousness among peers facilitates "a sense of personal and collective confidence in their ability to safeguard their sexual health" (p. 333). Participants referenced increased confidence, enhanced self-esteem and psychological growth as benefits of peer-based HIV & AIDS education programs. Striving towards openness may be a force which propels, invoking learners collectively and individually to fulfill their humanist vocation as actors within their world (Freire, 1970).

**Culture of Support**

Participants described various supports they experience which enable them to continue in their educational journeys despite challenges that hinder their learning. Categorized as institutional or personal, a range of supports may be drawn upon to create a culture of support that is unique for each learner. Institutional supports for women in Malindi include medical centres, places of worship, NGO programs, and civil society groups, among others. Personal supports include individuals who encourage and sustain adult learners. Who or what is helpful for learners varies among women; however, the data suggests that friendship is the most important in enabling women to change their behaviour and live positively. Conversely, the absence of people or institutions may greatly confound the learning process, thwarting HIV & AIDS education for
some adults. Communities or families that undermine or oppose HIV & AIDS education may disable women from attending popular education programs despite their readiness and desire to do so.

A culture of support enables women to negotiate their identity and reconfigure their sense of self as they draw upon people and institutions that will assist them in meeting their financial, psychological, spiritual, or medical needs. With the appropriate supports, women in Malindi are encouraged to explore new roles and options, particularly within the context of living positively, and to assess their environments for appropriate courses of action. Figure 9 visualizes the components of a culture of support:

![Figure 9 - Culture of Support](image)

Participants discussed the importance of friends as role models for adopting protective practices, facilitators of self-acceptance, and supports in accessing medical treatment or services. Additionally, participants encourage women in the communities surrounding Malindi to
participate in educational workshops by establishing friendships with them. The data repeatedly indicates that one of the benefits of peer education is the development of friendships and networks among women as they learn problems are shared. Cranton (2006) references the work of Clark (2005) who "goes so far to as to say that transformative learning could not take place without friendship" (p. 43). Of similar earnest, Taylor (2000) found relationships to be the most common theme in a review of 45 unpublished studies examining transformational learning theory. He describes how trust and friendships underscore participation in relational dialogue, without which "critical reflection would seem to be impotent and hollow, lacking the genuine discourse necessary for thoughtful and in-depth reflection" (p. 308). Cranton (2006) notes how learning can be emotionally difficult, isolated, or psychologically threatening for some learners. Similarly, the participants explained how they progressed through periods of hopelessness and depression through the persistent care of friends. One participant expressed sacrifice in HIV & AIDS education; she forfeits jobs in order to educate her friends about positive women's sexual and reproductive rights.

Church education programs, NGO initiatives, and free public clinics for PLWHA are important sites of social interaction and enable learners to craft a culture of support. Baumgartner (2002) found social interaction to be a "key component in the transformational learning process" (p. 14) among HIV positive adults in North America. In follow-up study, social interaction is again found to provide increased opportunity for reflective discourse and enable learners to "[recognize] that they were not alone, where they could accept the disease, accept themselves with the disease, and become empowered" (Baumgartner, 2005, p. 19).
**Connected Knowing**

Connected knowing describes a way of knowing that is rooted in empathic storying. In the context of HIV & AIDS education in Malindi, the data suggests that women want to learn from other women, in particular from those who are living positively, in a seminar or support group setting. Seeking to understand other points of view is the root of connected knowing; dialogue is the primary pathway for establishing consensus and promoting authentic learning. Connected knowing reveals how knowledge, skills, and practices pertaining to HIV prevention and care are disseminated through peer education, valuing women's lived experiences of HIV & AIDS as the educational resources used to teach others. Effective strategies for HIV & AIDS education are rooted in empathic dialogue, building trust and rapport among women and facilitating instrumental, communicative, and transformative learning as new skills are taught, ideas exchanged, and subjective identities reflected upon and reoriented.

Storying is a process of reciprocal education in which the story-teller and story-listener are equally and actively involved. Adult learners may need coaxing when it comes to sharing their stories and may actively listen to other women before they are confident to voice their own experiences of HIV & AIDS. Using stories to communicate examples, practices, and skills enables participants to learn about private and sensitive topics. Educators in support groups would tell stories to convey their particular messages; participants often shared stories to demonstrate their learning and their concerns, rather than referring to concepts directly. Storying is particularly relevant for rural Kenyan women who may have limited formal schooling experiences and higher illiteracy rates, and are therefore unable to decode printed educational materials. Figure 10 models the theme of connected knowing:
Storying can foster psychological learning and emotional healing. In recounting how she initially felt horrified at the prospect of joining Living Positively, one participant generated shrieks of laughter as women realized they shared similar feelings but had previously been too shy to voice their fears. Mohammed and Thombre (2005) note how stories "transport" people into another person's world, generating deeper understanding of what it means to live positively. In learning how others too feel hopeless or worried participants are uplifted in recognizing that they are not the only ones learning to live with HIV. Easton et al. (2009) present "storytelling" as central to a pedagogy of respect where, in educating community members, people share what they have learned and done, creating space for learners to "tell their own stories and make their own decisions" (p. 232). Similarly, Taylor (2000) discusses the interplay between emotional growth and critical reflection, noting how "The outcome of affective learning resulted in a greater sense of self-confidence and self-worth" (p. 305).

Connected knowing as a pedagogical pathway mirrors Mezirow's (2000) description of discourse as a foundational process in which participants seek agreement, consensus, and mutual understanding. Support for a learner is embedded within, not added onto, processes of connected knowing. Effective educators are central in "drawing out the potential" of learners, particularly of
those whose voices are missing (Belenky & Stanton, 2000, p. 97). Similarly, honourable and empathic communication is at the heart of a liberating praxis, enabling learners to "become jointly responsible for a process in which all grow" (Freire, 1970, p. 67). In connected knowing, participants evolve into educator-learners as they recognize how each woman can engage in democratic dialogue, simultaneously educating and learning from others.

Duveskog and Friis-Hansen (2009) report how any participant in a peer education program centered upon dialogue can be an expert. Inter-group exchange facilitates and reinforces oramedia as traditional patterns of oral communication and consensus in Africa (Pratt et al., 2000). It is not surprising that Chilisa and Preece (2005, p. 31) recommend "storytelling" as one of three culturally responsive techniques for facilitating adult education in African cultural contexts. In upholding democratic and community-centred ways of knowing, language and dialogue are dynamic tools for critical inquiry into and with real-world problems (Kamberelis & Dimitriadis, 2005). For example, discussions surrounding condom use created space for dialogue on the social construction of gender and sexuality. Such frank conversation builds understanding of how women's possibilities for behaviour change are limited by the social contexts in which discourse of health and disease are situated. Understanding the social, political, and economic conditions perpetuating disempowerment enhances learners' agency on individual and collective levels, as they are "extended less and less in supplication, so that more and more they become human hands which work, and working, transform the world" (Freire, 1970, p. 29).

**Communal and Individual Transformation**

There are many indications and examples of women's experiences in Living Positively that suggest that popular education strategies promote learning processes which can lead to transformational HIV & AIDS education. Participants described learning that went beyond
adopts skills to negotiating meaning and processing profound shifts in perspective. Women who have participated in HIV & AIDS education for many years demonstrate a radically altered worldview compared to their reported self-concepts and perspectives at the time of a positive diagnosis. This research does not attempt to apply Mezirow's (2000, p. 22) specific phases of transformative learning but seeks to elicit greater understanding of the potential for popular education to promote transformational experiences for women in Malindi. Consequently, "[i]t is more difficult to identify just what measures and methods are most directly transformative in a program that has been shaped by participants and events as much as it has shaped them" (Easton et al., 2009, p. 234).

However, at the heart of this study I outline three inter-related and inter-dependent dimensions that underlie the participants' experiences of transformative HIV & AIDS education. Illustrated in Figure 11, women are striving towards openness and learning through a process of connected knowing that emphasizes a culture of support:

![Figure 11 - Dimensions of Transformative Learning](image)

Through peer education and other popular education programs, women benefit from synergistic group discussions and may experience a perspective transformation through talking with others,
discovering the value of shared experiences, and resolving alternative points of view (Montell, 1999). Participants actively identified social, emotional, and developmental changes not only within themselves but also among other learners. Women were active in forming support groups at local hospitals and influential in the start-up of care centers for PLWHA. Participants challenge uncritically assimilated assumptions (Mezirow, 2000), choosing to embrace their status and break traditions in order to educate others about HIV prevention and care. Despite abuse and stigma, several participants volunteer their expertise and care as community health workers, translating what they have learned about individual prevention into communal health practices.

Within a framework of health and disease, the data suggests that transformative learning experiences appear to be particularly restorative for adult learners living with HIV & AIDS. Participants described their journeys as moving beyond despair and hopelessness and gaining a renewed sense of purpose for their lives. Before joining Living Positively, several participants had given up their careers and adapted to a reclusive life. Peer-based HIV & AIDS education restored these women to their full humanity and dignity, providing them with a wider learning network, increased social support, and liberation from self-condemnation. Mezirow (1991) writes how one of the most important areas of adult learning is freedom from habitual perspectives and assumptions. The participants discussed how self-concepts, perceptions of life, and behaviours were altered due to their participation in popular education programs. Women have learned to live with HIV, selectively disclose their status, adopt safer sexual practices, and manage healthier pregnancies and families. In contrast, women who do not participate in popular HIV & AIDS education programs likely do not accept their status and may engage in practices that maintain their vulnerability. Additionally, participants volunteer as counselors, encouraging other women to seek testing through storying their personal journeys of transformation and restoration.
Baumgartner's (2005) research on the stability of transformed meaning perspectives concludes that perspective shifts remain stable over time. The data suggests further empirical support for this finding, suggesting that transformational learning is a life-long process. Several participants' practices, behaviours, past histories, and future stories are woven around a continually redefined sense of self. Those who experience a perspective shift appear to be transforming in a recursive, spiraling process of reflection and action. Baumgartner (2001) highlights that the extent to which frames of reference evolve is irreversible regardless if the shift occurs individually or collectively. In working through a process of hopeful reflection, Kenyan women have the potential to emerge from positions of silence as actors who can invoke their power and create vibrant, responsive communities (Freire, 1970, p. 33).

While much literature emphasizes individual transformation, the participants' actions illustrate how transformational learning in African cultural contexts is beyond individual and may advance transformative action within communities at large. In a study on transformative learning in rural West Africa, Easton et al. (2009) present similar conclusions, describing how:

Major personal decisions or changes in African cultures are also collective matters, having implications and entailing long-standing practices at the family and community levels as well, even - and perhaps particularly - when the substance of the change is itself highly innovative. (p. 235)

After becoming involved in peer education women use their training and expertise to educate others. Groups of trained, educated women often accompany one another to hospital appointments or become active volunteers in medical clinics, church-based HIV & AIDS education programs, or community centers. As a group, Living Positively established a curriculum, outlining a range of topics they wished to learn more about and devising guidelines
for appropriate conduct during educational workshops. Additionally, the group members operate a scholarship program and petition for funding from their local public health office.

Kasl and Elias (2000) write about the concept of a "group mind," arguing that individual learning theory can be applied to group learning. The authors argue that both individuals and groups learn through critical reflection and both experience transformational learning as an "expansion of consciousness" (Cranton, 2006, p.48). Does the Living Positively group "create knowledge for itself" or are the group's efforts primarily evidence of the women's commitment to social change (Cranton, 2006, p. 46-47)? The research questions do not explore the specificity and development of group learning, yet the data suggests that at some point, "Transformations propagate once a tipping point…has been reached" (Easton et al., 2009, p. 236). In Malindi, learning may begin with individual readiness but through popular education, women develop friendships with other learners and realize that HIV & AIDS education may enhance their quality of life. Consequently, children are taught how to prevent HIV and husbands are counseled and coaxed to participate as well. Processes of learning are rarely restricted to an individual adult but appear to have some "ripple effects"; whether these ripples propagate transformative learning in others requires further inquiry.

The next chapter concludes the thesis, offering a brief summary of the study and outlining several recommendations for practice and implications for future research.
Chapter 7: Conclusions

This chapter begins with summarizing the research study presented in this thesis. Following, I present several conclusions, organized in response to the three primary research questions. Next, I offer several practical recommendations for informing future HIV & AIDS education frameworks for women in Kenya. Then, I outline implications for further research, focusing on questions raised in this study and areas where follow-up could contribute to understandings of transformative HIV & AIDS education. Finally, I speak to my own transformative experience and the learning journey I embarked on, which originated in and evolved from the moment I considered graduate school and conceptualized this study.

Summary

This study explored women's experiences of HIV & AIDS education and inquired into the types of learning (e.g., instrumental, communicative, transformative, or a combination) promoted by HIV & AIDS education programs. Using a qualitative research design and purposeful sampling strategies, I interviewed eight women in Malindi, Kenya over a period of four months. Documents collected in the field substantiate findings and insights garnered from the interview data set. The primary themes that emerged through a rigorous data analysis process include striving towards openness which emphasizes the importance of individual readiness; negotiating a culture of support which accentuates the role of friendship; and connected knowing which underscores the centrality of storying as reciprocal, empathic dialogue. Evolving in unity, these themes form the basis of a learning environment that has the potential to foster transformative learning experiences for women attending HIV & AIDS education programs in Malindi. The findings in this study contribute to the literature on cross-cultural inquiries into
transformative learning theory, offering insight into the potential applications of the theory to
disciplines outside of adult education. Additionally, it is my hope that the findings are used to
inform frameworks for future HIV & AIDS education, ultimately improving Kenyan women's
management of their own health.

Conclusions

Based on the analysis of the documents collected in the field and findings from the
interview data, the following conclusions to the research questions were reached:

Research question one: What are rural women learning about HIV & AIDS through
popular education initiatives? The emphasis within HIV & AIDS education in Malindi is on
acquiring technical knowledge. For women in Malindi, HIV & AIDS education primarily reflects
the mandated and now institutionalized ABC approach to prevention. Indicative of instrumental
learning, the participants referenced the importance of abstinence, being faithful, and condom
use, promoting these as strategies for HIV prevention among their children and friends. Women
learn a great deal about living positively, specifically the value of eating nutritious meals and
adhering to a prescribed drug regimen. Instrumental learning at times can foster communicative
or transformative learning. One participant engaged in an analysis of social constructions of
gender as factors that fuel the spread of HIV, and questioned harmful cultural practices.
Similarly, another voiced the dilemmas inherent in the sexual and reproductive rights of women
living with HIV & AIDS. Critically examining the intention behind educational messages, she
demonstrates resistance to traditional authority, enacting social change within her community.

Research question two: Through what range of pedagogical practices and theories does
women's learning occur? Essentially, women in Malindi are learning through a process of peer
education, which involves groups of trained women targeting their peers with messages aimed to
unveil social norms and influence positive behaviour change. Peer education occurs in a workshop format where women acquire knowledge and skills pertaining to the practical elements of HIV prevention and care. Additionally, peer education is successful in long-term support group settings with an established curriculum and regulated membership. The roles of learners and educators and their incumbent relations of power were not clearly specified or directly discussed. As a pedagogical pathway facilitating the potential for transformative education, striving towards openness is the foundational dimension of learning among women and emphasizes individual readiness, self-acceptance, and selective disclosure. As learning about HIV & AIDS can be emotionally taxing, learners need to be supported by individuals, programs, and systems that are responsive to their diverse needs. In negotiating a culture of support, friendship was stressed as the most important in enabling learners. Finally, connected knowing is the third pedagogical pathway, highlighting the importance of storying as a learning process involving reciprocal, empathic dialogue among women in Malindi.

Research question three: How does this learning contribute to transformative changes at individual (e.g., beliefs, behaviour) and communal levels (e.g., community actions) that improve women's health? The participants described profound changes they experienced themselves or witnessed in others as an outcome of their involvement in an educational seminar or support group for PLWHA. These include newly acquired technical skills, such as dietary requirements for PLWHA, and enhanced communicative knowledge, such as becoming open, sharing stories, and engaging in a process of participatory dialogue. Group discussion on women at risk prompted several participants to appeal to the need for men's education, explicitly stating that unlearned partners constrain women's ability to apply new knowledge, despite their desire to do so. Several activists apply their knowledge of human rights to HIV & AIDS education programs,
and enable numerous women to conceive and raise a child with the least risk possible. Similarly, a local church leader has established several programs targeting populations that are most vulnerable to HIV infection. Collectively, all members of Living Positively contribute to church-based education days, recruitment efforts, and assisting other PLWHA in accessing health services. There is a strong indication that several participants are beyond instrumental and communicative learning domains, and moving towards transformative practices that enable them to better manage their own health and become agents of change within their communities.

**Recommendations for Practice**

The participants proposed several suggestions in the areas of prevention, church-based education, and gender. Considering their perspectives, several recommendations incorporate the findings of this research study into practical applications for informing HIV & AIDS education frameworks in the future.

First, it is appalling that HIV & AIDS education occurs *after* infection or in adulthood when the majority of Kenyan women have likely been sexually active. Based on the research process as a whole, my primary recommendation is for the development of a national reproductive health curriculum, with emphasis on HIV & AIDS, to be implemented throughout the elementary public school system. NGOs could form part of the scaffolding that would uphold and evaluate the curriculum, facilitating receptiveness among parents and opposing communities. Discussed by a participant, extensive teacher training would be required in order to prepare educators and provide them with the tools and resources necessary to promote conversations about sensitive topics. HIV & AIDS knowledge could form a component of high school matriculation exams. Since the Kenyan government made elementary school free for all children
in 2003, a national curriculum is the most effective strategy to safeguarding the health of future generations.

Significant efforts need to address the theoretical underpinnings for holistic HIV & AIDS education described by several participants and fleshed out in this thesis. Programs and NGOs targeting specific populations do assist in meeting the unique needs of various social groups but are also divisive in isolating learners from the socio-political contexts in which their education must have meaning and relevance. Focusing on holistic education and prevention could have far-reaching, positive effects in engaging not only individuals, but also both genders and ultimately, family groups, and communities. Holistic education must be integrated into community development programs as the fight against HIV is founded upon efforts to eradicate gender inequality, socio-political illiteracy, and other forms of oppression. This study illuminates how women's education is influenced and disrupted by social constructions of gender and sexuality, even in well-intentioned and theoretically sound HIV & AIDS education programs that aspire towards and prize female empowerment.

The dimensions of transformative learning in this study represent the unique learning conditions for the participants and are not meant as a generalization upon which women's HIV & AIDS education should be modeled. However, in outlining the educational successes of a small group of women, I recommend that at their core HIV & AIDS prevention programs facilitate connections between learners. Friends become primary sources of support for women learning to live positively. Educators must value discourse, in particular empathic dialogue and storying, as avenues inviting critical self-reflection and discussion of social norms that constrain women's utilization of protective practices. Discourse and critical reflection are pivotal to transformational learning, facilitating the evolution of adult learners' frames of reference. Storying is appropriate
for cultures valuing oral histories and is accessible to all women regardless of their formal education as all people have stories to share and can learn from the experiences of others.

Finally, this study provides concrete examples of the dearth of literature and educational programming for the specific prevention needs and sexual and reproductive rights of PLWHA. Policies must be developed and implemented which go beyond stigmatized recommendations that PLWHA permanently abstain. Programs advocating for positive living must invest in education on safer sex among HIV-positive and discordant couples. It is critical that religious institutions become community-based, education centers as many people have limited access to HIV & AIDS information beyond the church. I consider it a privilege that I was able to witness and participate in such discussions during my fieldwork in Malindi. Additionally, the reproductive rights of women living with HIV must be addressed on international levels; it is indefensibly unjust and morally reprehensible that at the point of writing, a woman in Kenya must become vulnerable to HIV infection in order to conceive. While microbicides may prove somewhat of a remedy in this area, it is my sincerest hope that such interventions will be widely dispersed and not met with the same international gridlock which stalled the delivery of ARVs to Sub-Saharan Africa. Theorists and practitioners must continue to examine how HIV & AIDS education in Africa represents and serves the interests of western discourse and actors, further entrenching the subordination of others for western purposes and profits.

**Implications for Research**

This thesis has created space for further research and dialogue, raising more questions and areas for consideration than it offers responses and insight.

The educational group Living Positively is now well into its second year of existence. It would be interesting to explore the group's educational endeavors and to track the learning curve,
psychological growth, and evolution of protective practices adopted among original members. Future research with this group could also explore if a perspective transformation has indeed occurred and if such shifts and reorientation are permanent and acted upon within the constraints posed by oppressive sociopolitical factors. Additional research needs to explore the longevity of such programs, in particular if groups are sustainable and continue to meet despite reduced funding, monitoring, and leadership of a local church. The research questions did not permit an exploration of the development of group learning and consciousness within Living Positively, although such study would certainly have important implications for the literature on transformational group education.

The concept of individual readiness needs further thought, discussion, and research as a foundation upon which women's transformative HIV & AIDS education is based. It could be valuable to explore how readiness may be varied or consistent across attributes such as gender, age, or formal education. Documenting the educational 'spin-offs' of seminars could contribute to deeper understandings of the outcomes of peer education. All the participants discussed how they applied what they have learned to the education of their young children, particularly emphasizing health promotion for girls. Further research needs to delve into this phenomenon and explore communicative learning strategies used by mothers. An invitation to explore qualitative accounts from PLWHA could portray women's experiences of what it means to live with HIV, including processes of disclosure, risk navigation in reproductive health management, and protective strategies used among HIV concordant couples. These phenomena heavily impact the health of women and communities but go beyond typical HIV prevention and care.

This study provides empirical insight into the applicability of transformative learning theory to cross-cultural contexts, in particular to material-limited settings where asymmetrical
relations of power restrict access to educational programs and can overwhelm the learning process. The findings of this study may contest an assumption that adult learners need foundational cognitive skills to engage in the process of transformational learning. Given the appropriate support and dimensions for learning, all adults have the potential to shift their perspectives and negotiate their identities, regardless of their formal schooling or lack thereof. In addition, non-western research contexts have much to offer to practitioners and theorists in the area of adult education. While the specific phases of transformational learning (Mezirow, 2000) may be culturally bound, this study illuminated how processes of transformational learning are applicable, valuable, and authentic in describing the educational journeys of several Kenyan women. Exploring phenomena in varying cultural contexts assists in developing inclusive frameworks that more accurately and richly depict humanity's experiences rather than the evolution of learning in western-based contexts alone.

**The Researcher's Transformative Journey**

*Karibu sana!* With these Kiswahili words I was welcomed to Kenya and embarked on one of the most profound journeys of my adult life. In personal, academic, relational, and emotional spheres, I did not anticipate the impact that four months in Malindi could have on my life outside of being a graduate student. I reflect on my journey; what I experienced, tasted, witnessed, voiced, and listened to as a woman living and working in a bustling Kenyan town.

Stationed on Kenya's coast, I frequently sought the beach for the refreshment that only cool, salty ocean air can bring. The process of transformative learning at times is comparable to walking down a hot, sandy beach. When grains of sand and bits of shell in my shoes and in between my toes became unbearably aggravating, I could not keep going until I stopped to examine the problem. I have come to understand that processes of research occur on a global
stage, not in isolation, and that there are unexpected and unintended consequences for all actors in such a production, including the audience. Despite all my preparation, background reading, and previous experience in Kenya, at an early stage in the data collection I experienced multiple disorienting dilemmas. These culminated in the realization that despite my best academic efforts to minimize risk, it was incredibly difficult to maintain the pretence of neutrality; by virtue of travelling to Kenya and simply having the privilege to research I was perpetuating the very social injustices and inequities I sought to address. This truth was impossible to ignore and once learned, was permanently impressed upon me. The idea that research, which has learning and the construction of knowledge at its root, can cause harm is something I had never previously been confronted with; subsequently, much of my reflection centers upon learning to unlearn.

As a White, western-educated researcher working with women whose languages, cultures, geographies, and biographies are not my own, I was able to witness an experience through the eyes of others and offer it as a testimony to the power of transformative learning. At times however, my nuanced interpretations of the eight participants depicted in this thesis may propagate "African otherness" (Bloch & Vavrus, 1998). I do not deny the reality of rural Kenyan women's experiences with poverty, illiteracy, disempowerment, and gender inequality; however, I do not seek to portray this as their only reality. If this thesis offers insight to alternative ways of living and being among Kenyan women and acts as a portal through which the vivid, dynamic, rich character of their lives becomes evident, I will have completed one of many tasks.

I continue to question who benefits most from this study, for whom it provided the most leverage, and whose voices are excluded from this work. In portraying Kenyan women's education, learning, agency, and resistance, it is important for me to examine how I construct, advocate for, and interpret educational processes that may regulate, disempower, liberate, and
transform. I consider it a remarkable privilege and honour that I was invited into the lives of women who owed me nothing yet shared everything. It is my deepest wish that the women in Malindi hear their voices and see themselves in this work. Through their most sincere generosity of spirit, Kenyan women harnessed our collective synergy, acting out of and through ubuntu, the African ethic of interaction, in which a person is only a person because of other people.
References


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Appendix A

List of Abbreviations and Acronyms

ACK - Anglican Church of Kenya
AIDS - Acquired Immune Deficiency Syndrome
APHIA II - AIDS, Population and Health Integrated Assistance
ARV – Anti Retroviral Therapy
CIDA - Canadian International Development Agency
CLUSA - Cooperative League of the USA
CRS - Catholic Relief Services
FBO - Faith-Based Organization
FHI - Family Health International
HIV - Human Immunodeficiency Virus
JHPIEGO - a Johns Hopkins University affiliate (not an acronym)
NGO - Non-governmental organization
NOPE - National Organization of Peer Educators
OVC – Orphans and Vulnerable Children
RH/FP - Reproductive Health/Family Planning
PLWHA – People/Person Living With HIV & AIDS
PMCT - Prevention of Mother to Child Transmission
PSS – Psycho Social Support
Pwani - Pwani Christian Community Services
UNAIDS - Joint United Nations program on HIV and AIDS
USAID - United States Agency for International Development
Appendix B
Queen's University Ethics Approval

August 4, 2009

Ms. Melisa Spaling
#3—74 Patrick Street
Kingston, ON K7K 3P1

GREB Ref #: GEDUC-449-09
Title: “Learning as Transformation: Empowering Women Affected by HIV/AIDS in Kenya”

Dear Ms. Spaling:

The General Research Ethics Board (GREB), by means of a delegated board review, has cleared your proposal entitled “Exact Title on Application” for ethical compliance with the Tri-Council Guidelines (TCPS) and Queen’s ethics policies. In accordance with the Tri-Council Guidelines (article D.1.6) and Senate Terms of Reference (article G), your project has been cleared for one year. At the end of each year, the GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your unit REB, of any adverse event(s) that occur during this one year period (details available on webpage www.queensu.ca/vpr/greb/addforms.htm#Adverse). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that any adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes in study procedures or implementations of new aspects into the study procedures on the Ethics Change Form that can be found at http://www.queensu.ca/vpr/greb/addforms.htm#Change. These changes must be sent to Linda Frid at the Office of Research Services or FRIDL@queensu.ca prior to implementation. Ms. Frid will forward your request for protocol changes to the appropriate GREB reviewers and/or the GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours sincerely,

Joan Stevenson, PhD
Professor and Chair
General Research Ethics Board

c.c. Dr. Sheryl Bond, Supervisor
Dr. Malcolm Welch, Chair, E-REB
E-REB: c/o Graduate Studies & Bureau of Research, Attn: Celina Freitas
Appendix C

Letter of Information and Consent: Individual Interview

September, 2009

How do Kenyan Women Learn about HIV & AIDS?

Dear: First Name, Last Name

My name is Melisa Spaling and I am a graduate student at Queen’s University, Ontario, Canada. I am conducting a research study with Pwani Christian Community Services (Pwani). This research study is funded by the Canadian International Development Agency (CIDA). I am writing to tell you about my research and to invite you to participate.

I am doing this research to better understand how rural Kenyan women learn about HIV & AIDS in your community. As part of the research, I will be doing interviews with women from the community, with Pwani staff members, and local health officials. These interviews will occur after September 10, 2009 and before December 17, 2009.

You are invited to take part in one 45-minute individual interview with me. The individual interview will be at a time and place that works for you, such as the community centre or Pwani offices. A translator will be at the interview if you choose to do the interview in Kiswahili. If you allow me to, I will audio record the interview. Also, I will make brief handwritten notes. The taped interviews will be translated into English, if necessary, and I will type them out.

If you agree to do an individual interview, I will ask you several questions and we will have a conversation about HIV & AIDS education. The interview is not a test; I am not trying to find out how much you or other people know about HIV & AIDS. I will ask you questions about your age, job, and involvement in developing HIV & AIDS education programs. There are no right or wrong answers; we will have a private discussion about how you think women in the community learn about HIV. Agreeing to participate in this study means that you understand what the individual interview is about.

Any discussion about HIV & AIDS might be hard for you to talk about. I will give you the names of support people from the community after the interview if you want to talk to someone after our session. You may contact Pwani at 254-041-2315577, which offers free counseling services, support groups for women and men, and recommendations for alternative support services with other community-based organizations.

What I learn from the interviews may help your community and Pwani understand how women learn about HIV & AIDS. I will share what I learn with the community through a newsletter but will use fake names and will not release any details which could identify you.
Taking part in this research is your choice and you may withdraw at any time. You do not have to take part in an interview and you do not have to answer questions which make you feel uncomfortable. If you choose to stop participating in the study you may talk to the translator, or you may call John Mangenge, Executive Director of Pwani, at 254-041-2315577. You may also email me at melisa.spaling@queensu.ca If you withdraw you may request part of all of your information to be removed from the research study. Withdrawing from the study will not harm your relationship with Pwani. Agreeing to take part in this study means you understand how taking part is your choice and that you may withdraw at any time.

I will take steps to protect your identity and privacy. Audio records will be stored in secure files on my password-protected personal computer. The computer will be stored in a locked case in my home, only the researcher has a key to unlock the case. All paper records will be stored under lock and key in my home. Only me and my supervisor will have access to the information. If someone’s identity is figured out, the participant will be told and I will remove her information from the study if requested. The translator will sign a privacy agreement. Privacy will be maintained to the extent possible.

What I learn from this research may be used in reports or seminars. In all publications I will use a fake name to protect your identity. If other researchers wish to do a follow-up study, your identity will never be revealed. After this research is over, I may save the audio files and my notes for use in the future but will continue to store the information safely and protect your privacy. After 5 years, all information will be destroyed. Agreeing to take part in this study means you understand how I intend to keep your identity private.

Questions relating to this research study are welcome. You may contact John Mangenge, Executive Director of Pwani, at 254-041-2315577. Mr. Mangenge may help you get in touch with me in Kenya and also knows how to contact me once I return to Canada. You may also contact me, Melisa Spaling, by email (melisa.spaling@queensu.ca) or my supervisor, Dr. Sheryl Bond (slb2@queensu.ca).

Sincerely, Melisa Spaling

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By giving oral consent to Melisa Spaling, the researcher, I agree that I discussed the statements contained in this letter of information for individual interview, had the opportunity to talk about my concerns and questions, and fully understand what it means to take part in this study. I also agree that I received a copy of this letter for my personal records.

Oral Consent Given: Y  N  Audio File Number, Time: _______________________

Date: ___________________  Researcher’s Signature: _________________________

By initialing below, the researcher confirms that the participant has given oral consent for

_____ Permission for the researcher to use an audio recorder
Appendix D

Research Authorization, Kenya

[Image of the document]

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ‘Learning as Transformation: Empowering Women affected by HIV/AIDS in Kenya’

I am pleased to inform you that you have been authorized to undertake your research in Kwale and Kilifi Districts for a period ending 31st December 2009.

You are advised to report to the District Commissioners and the District Education Officers Kwale and Kilifi Districts before embarking on your research project.

Upon completion of your research project, you are expected to submit two copies of your research report/thesis to our office.

[Signature]

PROF. SHAUKAT A. ABDULRAZAK Ph.D, MBS
SECRETARY

Copy to:
The District Commissioner
Kwale District
Kilifi District

The District Education Officer
Kwale District
Kilifi District

The Medical Officer of Health
Kwale District
Kilifi District
Appendix E
Letter of Invitation from Pwani Christian Community Services

PWANI (COAST) CHRISTIAN COMMUNITY SERVICES
(A.C.K. DIOCESES OF MOMBASA AND TAITA TAVETA)

P.O. Box 80072
Mombasa – Kenya
Tel: 041-2315577
E-mail info@ackpcwscs.or.ke
Date: ....................

The research Melisa Spaling wishes to undertake in our communities very much welcome and will be of great benefit to us as an organization as it will bring to the wider public the best practices and the successes achieved in the fight against HIV and AIDS as will be evidenced in her documented findings. The shared findings will also help the community members appreciate their efforts and further reduce the stigma in the community. On the part of the student, Melisa Spaling will have a very hospitable, ready and supportive population to work in. Since we work in the most rural communities in the coast province, she will be at liberty to choose from either North Coast – Kilifi and Malindi up to Lamu or South Coast – Kwale to Lunga Lunga. As an Organisation we are committed to ensure that her stay in the communities is enjoyable, comfortable and safe. Our field staff will always be available to give her all the necessary support she will require. They will ensure that they have introduced her to the village elders, local administration and the Church. Apart from these, she will be also be introduced to other stakeholders we work with in the field especially the Ministry of Health she will therefore be integrated into the HIV and AIDS work in the community. ACK Pwani CCS has in the past hosted other research students in our Food Security and Environmental projects thus able to give good support and good evaluation report of the student’s performance in the field and community.

Thank you.

Sincerely,

John Mngenge
EXECUTIVE DIRECTOR
Appendix F

Individual Interview Guide

The interview questions for research study: “Learning as transformation: Empowering women affected by HIV & AIDS in Kenya” will focus upon relevant demographics as well as the following ten major open-ended questions:

Demographics:
- a) Name (pseudonym)
- b) Interview number
- c) Date
- d) Place
- e) Marital status
- f) Number of children
- g) Age
- h) Occupation
- i) Education
- j) Time in district

1) How long have you been attending HIV & AIDS programs in Malindi? Can you explain why you wanted to attend the program? What was happening in your life at that time?

2) Please describe one or more of these programs. Who was the teacher? How many people participated - were they women, men, youth, a combination? How did you learn about HIV & AIDS?

3) What did you learn from these programs that you did not know or understand before?

4) What would you say is the most important thing you learned in these programs? Do you think or act differently now? For example, do you help other people, like your family, children, or friends learn about HIV & AIDS? How do you help them learn?

5) How else do you learn about HIV & AIDS? How do you think other rural women learn about HIV & AIDS? How and where are you able to obtain information on HIV & AIDS?

6) Why do you think some rural women do not participate in HIV & AIDS education programs? What prevents them from attending?

7) If you were the President of Kenya, what would you do to prevent HIV in your country?

8) Who do you feel is the best person to educate rural Kenyan women on how to prevent HIV & AIDS?

9) Is there anything else that you would like to talk about?

10) For program developers: How has your involvement in these programs helped your own learning and awareness about HIV?
Appendix G

Transcription Key

Notations used in verbatim transcription:
MS: Melisa Spaling/Interviewer (other initials are of the interviewee)
--- A long pause (4 seconds or more)
*Italics* Swahili phrases/words
( ) Translation of *Swahili words/phrase*
{ } Describes background noises, sounds that are not translatable
{ } in between speakers demonstrates a shared sound, e.g. laughter
{ } in the speech of one speaker demonstrates sound from only one person
  e.g., participant smacking the table
[ ] Describes things being pointed to or clarifies the meaning or reference in a sentence
13:24 Time in bold indicates the approximate duration of the interview

Additional transcription notes:
- Where a sentence ends with no punctuation or indications of a break/pause, this indicates that the person speaking was interrupted.
- Some words in Kenyan English do not have the same literal meaning as in Canadian English. For example, the ambiguous phrase "to play" refers to sexual intercourse. I clarified where necessary using [] brackets, however, the meaning of original phrases is often quite clear.
- Swahili does not use sex-differentiating pronouns. Some of the participants freely interchanged "she" with "his," I altered any inconsistencies to maintain flow and clarity for the readers.
- Common Swahili words or phrases have not been removed from the transcript but are *italicized* (with the English translation following in brackets).

**Language Guide:**
*Asante* – Thank you
*Jambo* – Hello
*Karibu* – Welcome
*Mzungu* – Foreigner
*Sowa sowa* – OK
*Karibu sana* - Welcome
Appendix H

Community Newsletter Sample Page

Tumaini: Learning and Hope

Pwani CCS, KAG Church Living Positively Group, and Melisa Spaling

“Becoming free”

Living with HIV & AIDS is not easy. A mzungu came from Canada to speak with women who are learning about HIV & AIDS. Here are interesting things we learned by sharing stories together:

- You can have a family if you are living with HIV—Come and learn how to have a healthy baby!
- If you accept yourself with HIV you can have a beautiful life!

Together we can become open and learn how to live with HIV and be happy!

Some adult learners invited Melisa to participate in an HIV & AIDS seminar at KAG church! If you are living with HIV or would like to learn more about HIV please join the group! Karibuni sana!

November, 2009

- Living Positively was started only a few years ago yet it has 18 members!
- Balinda, has attended 10 workshops focused on HIV/AIDS prevention and awareness. One day she may be the one leading a workshop for others!
- There is 1 brave man in the group, the 17 other members are women!
- The group hopes to begin an income generation project, such as making liquid soap or starting a poultry farm.
Appendix I

Sample Writing from Research Journal

Lunga Lunga - Tuesday, Sept. 22, 2009

Prayers

Psalm 20:3 - No one who trusts in the Lord will be put to shame.

- Attendees: Pastor Zephaniah (women) - Secretary (one)
- Sebastian (women) - Jackson (Community Health Worker)
- Chairman (men)

Ndera Post-test Group: Have been tested, positive

- Group started October, 2007
- Initially awareness group made from peer educators
- Group is registered with social services on May 30, 2008

Objectives of Group:
1. Fight against the spread of HIV/AIDS through awareness
2. Improve the livelihood of the people living with HIV/AIDS
3. Fight against stigma and discrimination
4. Form a family with affected individuals who can be free to talk and help each other

- Have an awareness campaign - Activities: soap-making
- Income-generation to pay for transportation and fees to access clinics
- Farming project

Challenges:
- Unwillingness to disclose HIV status, difficult task for people
- Food shortage, information dissemination among members (drought)
- Lack of information on HIV/AIDS has contributed to people not disclosing their status
- Market has other liquid soap distributors
- Communication issues

Future Plans:
- Variety of soaps (ed powder, tablet) to bring to market
- Requires training
- Will reduce lethargy among the group
- Office to organize and operate from
- Welcome new members

- Group meets 2x per month.
  1st & 3rd week of the month.
  Thursdays @ 9:00 A.M.
- Other meetings as needed.

Compulsory attendance for members.