

Sisterhood for Change Project

Evaluation



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Acronyms

SFC – Sisterhood for Change (Project)

KMET – Kisumu Medical and Educational Trust

HIV/AIDS – Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

SSA – Sub-Saharan Africa

AJWS – American Jewish World Service

RH – Reproductive Health

FPM – Family Planning Methods

PLWA – People Living with AIDS

Depo – Depo Provera Shot

STI – Sexually Transmitted Infection (formerly STD – Sexually Transmitted Disease)

CSW – Commercial Sex Worker(s)

VCT – Voluntary Counseling and Testing

CHW – Community Health Worker(s)

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Summary of Project Purpose

The Kisumu Medical and Educational Trust (KMET) has created a peer-to-peer outreach project, Sisterhood for Change (SFC), which has been created to train girls and young women on reproductive health issues and thus become community peer educators. This program is now in its third cycle of students and currently has two groups of young women (age 12-24) who have been through life skills training and learned to be reproductive health peer educators; they have also gained vocational training in order to give them alternatives to commercial sex work or reliance on males for money. The purpose of this evaluation was to assess the pilot project by interviewing and observing the first 25 women to be involved in the project, interviewing their relatives, interviewing staff members close to the project, and assessing the participants' impact in their communities. By using multiple research methods (i.e., interviewing, focus group meetings, participant observation, and surveying) and multiple sources of information, triangulation was achieved to gain a larger view of the successes and challenges in the pilot year of the SFC Project.

Research Objective and Questions

The evaluation objectives were designed to capture indicators of the three objectives of the SFC Project as identified in their original grant proposal for funding:

- increase access and utilization of quality Sexual & Reproductive Health (S&RH) services by adolescent girls by 20% by the end of 2007
- increase access to information on S&RH including gender-sensitive issues among adolescent girls in Kisumu District
- enhance adolescent girls' participation, involvement & empowerment at all levels of S&RH programme implementation and management by the end of 2007

As such, the main evaluation objectives are 1) to determine if access and utilization of quality Sexual and Reproductive Health services increased by adolescent girls by at least 20% in 2007; 2) to determine the extent to which the Sisterhood for Change Project has fostered behavioral change in both its participants and targeted communities through the dissemination of information; and 3) to identify strategies that will lead to the sustainability of the project.

1.) To determine if access and utilization of quality Sexual and Reproductive Health services increased by adolescent girls by at least 20% in 2007

- What programs and services are being offered through KMET **and** being promoted by the SFC Project?
- With what frequency are these programs utilized and/or accessed by members of the three target areas of the Kisumu District?
- Has the use of reproductive health services increased among adolescent females in the three target areas of the Kisumu District since the inception of the SFC Project?

2.) To determine the extent to which the Sisterhood for Change Project has fostered behavioral change in both its participants and targeted communities through the dissemination of information

- Has the Sisterhood for Change Project met the goals of empowerment for the 25 adolescent commercial sex workers it was initiated to accomplish?
- Are the SFC participants practicing safer sex techniques which they did not engage in prior to becoming part of the SFC Project?
- Are the participants of the SFC Project still engaging in commercial sex work as a form of income generation?
- Are the participants utilizing the vocational skills they received training in? How are these skills being utilized?
- How has the SFC Project affected the reproductive health practices of other adolescents of the Kisumu District?
- Has the awareness of gender-based violence increased in the three target areas of the Kisumu District? If so, in what ways?

3.) To identify strategies that will lead to the sustainability of the project.

- How have the participants of the SFC Project continued to teach their communities reproductive health education? And, with what frequency?
- How has the SFC Project affected the reproductive health practices of other adolescents in the three target areas of the Kisumu District?

- What are the Income Generating Activities that have been initiated by the participants? How successful have these initiatives been?
- Are young women being recruited for future SFC training?
- Do young women express desire to be a part of the SFC Project and what are their motivations for participating?

Assumptions

Assumptions made are:

- All participants – SFC Project participants, their parents/guardians, and community members – were honest in their answers to their fullest ability.
- Research methodology was appropriate and accurate for the intended purpose based on pre-field research.

Definitions of Terms

Commercial Sex Worker – any person who engages in any sexual act(s) in exchange for money, goods, or services.

Parent/Guardian – a person who has primary decision-making in, is the primary support for, and/or has custody of an adolescent.

Empowerment – the basis of “empowerment” by the researcher’s standards is the understanding that each person has a right to autonomy and gainful employment that does not demean or jeopardize the health of people. Furthermore, it is the acknowledgement that each individual has the right to make decisions for his/her life and body that are based on correct information and personal beliefs.

Access to Information – the ability to gain information about subjects (especially those that are taboo) in a manner which is truthful, unbiased, and nonjudgmental.

Safer Sex Techniques – correct and consistent condom-use at the time of any sexual act (be it vaginal, anal, or oral); finding alternatives to intercourse (open-mouth kissing only, mutual masturbation, “outer-course,” heavy petting, or encounters that do not include touching); or monogamy (having only one lifetime sexual partner or being tested between monogamous sexual partners).

Unwanted Pregnancies – any pregnancy that has not been planned and which the pregnant mother is unhappy about (based on self-reporting).

Gender-based Violence – “encompasses (but is not limited to): physical, sexual, and psychological violence occurring in the family and in the community, including battering, sexual abuse of children, dowry-related violence, marital rape; female genital mutilation and other traditional practices harmful to women; non-spousal violence; violence related to exploitation, sexual harassment, and intimidation at work and in educational institutions; forced pregnancy, forced abortion, and forced sterilization; trafficking in women and forced prostitution; and violence perpetrated or condoned by the state.” (UNFPA)

Sexual Transmitted Infections (STI) – any bacteria or virus that can be spread by skin-to-skin contact or an exchange of bodily fluids (typically blood, semen, or vaginal fluids) which is usually passed through sexual intercourse, anal, or oral sex.

HIV/AIDS – human immunodeficiency virus/acquired immune deficiency syndrome; a person is initially infected with HIV and can eventually die from an AIDS-related illness.

Methodology

Stage One – Participant Observation

Upon arrival in Kenya, the first week was spent learning the culture of both the country and of KMET. This was accomplished through time spent with the employees of the clinic and through meeting community members, some of whom included the SFC participants. Furthermore, the community was observed through participating in a daily-life routine - such as shopping at the market and living with a host family.

During this time, two research assistants (RAs) were chosen from five possible applicants to assist in the interviewing process and to help the researcher with observations in the homesteads of those people interviewed. One was chosen based on her history of doing qualitative research while the other was chosen due to her advanced level in University. Both had the project explained to them, were given a two-day basic training of qualitative methods of research, and helped to refine the questions which were asked in the interviews for cultural appropriateness and relevance. They also were given a day to go through the questions together and clarify all questions in Kiswahili and Dholuo in order to ensure there would not be meaning lost in translation, were it needed.

Stage Two – Data Collection

This was a non-experimental, outcome evaluation.

- Interviews were conducted with 17 participants of the pilot year of the Sisterhood for Change Project who had recently completed their attachment¹ and who were actively involved in the project by awaiting graduation. These interviews were semi-structured, open-ended interviews which were conducted in a location chosen by the interviewee – typically their home but twice in their place of employment. At least one research assistant who spoke both Kiswahili and Dholuo in addition to English accompanied the researcher in order to translate for those participants who felt more comfortable in one of these two languages. In addition, the research assistant enlightened the researcher on cultural taboos/norms that may have been missed due to cultural differences between the researcher and the participants. See Appendix A for question guide.

Note: Interview questions were written with the idea that the majority of participants were minors and/or former commercial sex workers and questions were designed to help protect their emotional well-being, thus did not delve too deeply into their sexual histories. While this was found to be unnecessary due to all respondents being 18 or older, findings suggest this line of questioning was more culturally appropriate due to a limited time to establish a deeply trusting relationship.

- Interviews were conducted with one or two of the parents/guardians/siblings of 10 of the participants; twice, both the husband and wife were interviewed while all other interviews were conducted with only one relative. While the goal was to survey one parent/guardian for each of the participants, this goal was not met. These interviews were semi-structured, open-ended interviews which were conducted in a location chosen by the interviewee, which was their home in each case. At least one research assistant who

¹ An attachment in Kenya is the equivalent to an internship in the U.S.: on-the-job training with no or little payment.

spoke both Kiswahili and Dholuo in addition to English accompanied the researcher in order to translate for those parents/guardians/siblings who felt more comfortable in one of these two languages. In addition, the research assistant enlightened the researcher on cultural taboos/norms that may have been missed due to cultural differences between the researcher and the parents/guardians/siblings. See Appendix B for question guide.

- A two-hour focus group was held with Community Health Workers (CHW) in order to capture their opinions of the SFC Project. Twelve participants were chosen and invited through a letter by the CHW coordinator; they received “attendance credit” for a required micro-finance loan weekly meeting by coming to the focus group. The focus group was held with nine people who were chosen because they had actively helped recruit members of the SFC pilot year and they were privy to the activities of the SFC Project. This discussion was conducted by the research assistants and overseen by the researcher. See Appendix C for question guide.

- The six staff members who were involved in the creation of and/or the implementation of the SFC Project were interviewed about the project. In addition, the three main tutors of the different vocational sectors were interviewed with the same questions. These semi-structured, open-ended interviews were held in the offices of KMET or at the Nyamasaria building which houses the SFC Project at a time convenient for each staff member/tutor. See Appendix D for question guide.

- Interviews and focus groups were audio recorded (with each participant’s permission) and transcribed within a week of the interview/focus group. Transcription of interviews which were conducted mostly in Dholuo were transcribed by the research assistant who helped to conduct the interview, translating from Dholuo into English as needed. After transcription was completed of interviews, each document was transferred to Atlas.ti for analysis. The transcription of the focus group was hand-coded.

- A questionnaire was administered to members of the community who were audience members in the SFC outreach program. Thirty-six people at four open-air market centers, one school, and two private homes in which outreach programs were carried out were questioned. The questions were short with a 5-point Likert scale including words and pictures to help the less-literate community members (see Appendix E); furthermore, research assistants inquired as to whether the participant wanted to read the form or have it read to them and in which language. All 10 questionnaires that were administered at the school were disqualified from this analysis as they were answered by minors who did not qualify for the study. Answers to the questionnaires were analyzed using Excel.

- Triangulation came through the cross-checking of opinions and feelings of those who are directly and indirectly impacted by the SFC Project. Through information from those who benefited from the project (the participants and their family members), the creators of the project (the staff members, the participants, and the focus group members), and the observations of the research team (both the researcher and the research assistants), it is hoped that the full impact of the SFC Project on those closest to it was

captured. Furthermore, the information gathered from the community questionnaires supports the information obtained through interviews and the focus group concerning issues outside of reproductive health which need to be addressed in order to further support the youth of Kisumu.

Stage Three – Data Analysis

Analysis of overarching themes and answers to the research questions was done using open-coding and the qualitative analysis software package Atlas.ti to support coding. To accomplish this, interview transcriptions were entered into Atlas.ti, enabling the user to identify emergent themes through classifying excerpts from multiple interviews.

Analysis of quantitative data (the questionnaires) was accomplished through running statistics in Microsoft Excel.

Context of Research

It is estimated that 38.6 million people worldwide were living with HIV in 2005 – half of them women. An estimated 4.1 million became newly infected with HIV and an estimated 2.8 million lost their lives to AIDS. The pandemic remains the worst in Sub-Saharan Africa (SSA), home to over 64 percent (24.5 million) of the global population currently estimated to be living with the virus. During the course of the 1980s and 1990s, HIV/AIDS was recognized on a world-wide level as a “key crisis in international health” (Parker 2000). The World Health Organization (WHO) began the interventions that have taken place in the world through the Global Programme on AIDS (GPA – est. 1987), which encouraged a trickle-down approach to the pandemic that is sweeping the globe. This approach included encouraging countries to create National AIDS Programmes (NAPs) through WHO financial support and coordinating efforts at the local level (Parker 2000).

While these efforts have helped raise awareness of how HIV is spread and what the definition of AIDS is, this does little to stem the spread of the disease due to the developmental processes and power dynamics which counteract these efforts. Parker (2000) notes: “Vulnerability to HIV and AIDS has increasingly come to be understood as fundamentally linked to questions of social and economic inequality and injustice.” He goes on to suggest that this is not solely on the part of the global structures and processes, but is also influenced by gender and sexual relations, both of which he calls “structures of oppression.”

Today’s youth generation is the largest in history: nearly half of the global population is less than 25 years old (UNFPA, 2003 cited by UNAIDS in 2004). Sadly it is this group that is affected most by the HIV/AIDS scourge. Statistics indicate that HIV/AIDS places a particularly high burden on youth, specifically those in sub-Saharan Africa (SSA). Young people between the ages 15 and 24 are both the most threatened – globally accounting for half of all new cases of HIV – and the greatest hope for turning the tide against AIDS (UNAIDS, 2004). According to the same report, at the end of 2003, almost two-thirds (65% of all youth) of all young people living with HIV were in SSA – approximately 6.2 million people, 75% of whom are female.

Schoepf (2003) opens her chapter by acknowledging that it is fashionable – and fitting – to cite Michel Foucault when addressing the relationship between knowledge, power, and gender. According to her, “knowledge of AIDS in Africa is about power” at multiple levels of the power dynamics: between the people and the government, laypeople and physicians, young people and their elders, and between women and men. This power dynamic – especially between older men and younger women – has fostered gender inequalities which have been central to the epidemic spread of HIV. As will be discussed, women are afforded less formal education which leads to a heavy reliance on men for financial support. As younger women often fall victim to this need after having received very little education – especially reproductive health education – they must trust the information they are given from the men they must rely on. Susser and Stein’s (2003) research, which supports Schoepf’s, found that communities where women felt empowered through their reproductive health knowledge had a lower HIV rate. It was

found in one community with a low HIV prevalence that women were treated as equals to their male counterparts and that men respected when woman ask their partners to use condoms. This type of power balance of the sexes, if encouraged throughout Africa through reproductive health education, could help stem the pandemic of HIV.

The agenda for young people thus needs to be mobilized by incorporating the 2001 UN Declaration of Commitment on HIV/AIDS in concrete actions. These actions include:

- **Creating a supportive environment** so young people can obtain HIV and reproductive health (RH) information, education and services.
- **Reaching those who influence young people.**
- **Placing young people at the centre of the response.**
- **Mobilizing an educational system** to become a vehicle for a comprehensive prevention and care program for school-age youth.
- **Mainstreaming HIV prevention and AIDS care for young people into other sectors** which can be used to provide information and services.
- **Addressing gender inequalities** by improving young girls' opportunities to obtain education and skills training, by protecting their rights, and by boosting their income-earning prospects.
- **Opening dialogue on sensitive issues.** Adults and young people need to work together on adolescent sexuality, sexual health education, sexual violence and abuse, gender roles and traditional practices.

All of these, if done within a rights-based approach, will contribute greatly in stemming the spread of AIDS. According to the UN Office of the High Commissioner for Human Rights (2002), a rights-based approach “is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights.” This type of approach includes elements such as: express linkage to rights (on a national level), accountability (with emphasis on the part of governments), empowerment (at the ground level), participation (on the community and programmatic levels), and non-discrimination and attention to vulnerable groups (at the local level). Through involving the community and the voice of the participants of the project, the aim of the Sisterhood for Change Project is to incorporate the later three elements of this type of approach.

The Kisumu Medical and Educational Trust (KMET) began with the aim of “breaking the silence” surrounding high maternal mortality due to unsafe abortions through training and creating networks of health providers. With time, KMET expanded its mission to cater for people living with HIV/AIDS (PLHA) through home based care (HBC) which has grown to include a nutrition component to cater for patient's nutritional needs in order to help with medication compliance.² KMET's other projects include: revolving loans with the community health workers (CHW), a family-friendly clinic in Nyamasaria, and a safe motherhood initiative which incorporates the different aspects of KMET.

² This is achieved in two ways: 1) PLHA are able to take their medications without getting sick to their stomachs because they have food to cushion the medications, and 2) patients will not sell their medications in order to buy food because they have their nutritional needs met.

KMET is an indigenous community-based organization founded in 1995 with a mission to promote development in underserved communities through innovative health and education programs. It has its headquarters in Kisumu, Nyanza Province with a satellite office in Mombasa (Coast Province) and Embu (Eastern Province). The organization is managed through a Board of Trustees and supported by global partners such as Planned Parenthood Federation of America-International (PPFA-International), Planned Parenthood Federation of Bucks County and American Jewish World Service. KMET initiated the Sisterhood for Change (SFC) pilot girls-only project in October 2006 with an aim to recruit 30 girls aged 12 to 24 years from the three main slum areas of Kisumu, namely Nyamasaria, Nyalenda and Manyatta.

In implementation of its projects, KMET has a progressive 5-step model, which forms an integral part of the RH programming. The first step, identification of systemic gaps in RH services, was the rationale behind initiation of the SFC program after a gap was realized due to adolescents missing out on RH education. A baseline survey³ revealed a high number of teenage pregnancies and subsequent unsafe abortions, school dropout cases, engagement in commercial sex work and an increase in HIV/AIDS among youth, especially the girls of Kisumu.

- ❖ The **goal of the SFC Project** is to contribute towards the reduction of teenage pregnancy, unsafe abortion and HIV/AIDS prevalence.
- ❖ SFC's **vision** is to have a community where teenage girls are safe, know their rights, are able and willing to access youth-friendly services, and are able to air out their views freely.
- ❖ SFC has a **mission** of empowering girls through educating and advocating for behavior change and equipping them with reproductive health knowledge, vocational training, and life skills.

It has been found that most young people in Kenya become sexually active in their teens, many before their 15th birthday; however, many more girls than boys are debuting early into sex (Longfield et.al, 2004). One qualitative research study found that parents report children in slum areas and broken homes debuting with sex as young as 8-10 years of age (Amuyunzu-Nyamongo, 1999). In a report written by Bruce and Chong for the Population Council in 2003, of Kisumu adolescents, 25% of sexually active young boys and 33% of young girls reported not using a condom during their first and subsequent sexual encounters. This, coupled with their biological vulnerability, puts girls at higher risk of contracting HIV through heterosexual intercourse, which almost exclusively accounts for the growing number of young women infected with HIV (Longfield et al, 2004, Glenn et al, 2001). In SSA, socio-economic factors exacerbate girls' vulnerability in reproductive health due not only to a lack of access to education but also their dependency on men and their money (Plan, 2007).

³ This survey did not include questions regarding access to and utilization of Sexual and Reproductive Health services. Furthermore, this survey data was not presented to the researcher for use during the SFC Project Evaluation.

To this extent, one “structure of oppression” can be seen in the power dynamics between men and women worldwide with women being subjugated to a lack of: education, autonomy from men (be it a father, husband, or other financial provider), and access to reproductive health care and/or education. Throughout the literature, women report that to ask their partners to wear condoms admits a lack of trust or is an admittance of being infected, either with HIV or another sexually transmitted infection (STI) (Voeten, 2007; Akwara et. al, 2003; UNAIDS, 2006; Voeten et. al, 2001; Amuyunzu-Nyamongo, 1999). Both scenarios can have devastating effects on a woman: a man may choose to harm her or he may simply discontinue the relationship with her, which may be a loss of financial support for the woman. This is not to say that women who are losing money are commercial sex workers; many partnerships are established on the premise that women provide sexual encounters and companionship while men contribute to the payment of bills, children’s school fees, or other financial needs. It is noted (UNAIDS, 2006) that the secondary school drop-out rate is higher for females than for males in large urban areas of Kenya. This initially is caused by females being called on by the family to do chores and take care of the home; it then quickly leads to limited access to skilled, higher-paying jobs. As this can happen by the time a young woman is in her late teens to early twenties, she may have found limited opportunity to financial support outside of sexual relationships (Plan, 2007).

Throughout the literature from both academia and research by human rights organizations, it is found that discrimination against girls and young women remains deeply entrenched and widely tolerated throughout the world. Gender-power imbalances, patterns of sexual networking and age-mixing are important factors that tip the balance further against girls. Typically, girls in cross-generational relationships have limited power to resist pressures to agree to unsafe sexual practices. Poverty has been cited as one reason: poverty for women is more intractable than for men since women are not offered the same socio-economic and political opportunities as men and they lag behind on virtually every indicator of social and economic status (Beaglehole & Bonita, 1997). However, other factors forcing girls into early sexual debut include coerced sexual relationships, gender imbalances and lack of information on reproductive health (RH) topics (Bruce, 2004).

This leads to a comparison of the differences in sexual relations between women who self-report as commercial sex workers (CSW, also seen in the literature as female sex workers or FSW) and their sexual partners (Voeten, 2007; Akwara et. al, 2003; Voeten et. al, 2001). Of the different relationships, a CSW may have a husband, boyfriend(s), regular partner(s), regular client(s), and clients – each granted a progressively lower level of intimacy and/or rights over the woman. However, through documented research (Voeten, 2007; Akwara et. al, 2003; Voeten et. al, 2001), it has been observed that the only partner frequently required to wear a condom when having sex with a CSW is a “client,” which may be defined in general by CSW as a man who is a first-time client or is so irregularly seen that he cannot be considered “regular.”

While the majority of CSW report using condoms with their “clients,” this is not consistent because they do not always have condom-negotiating power. Other partners

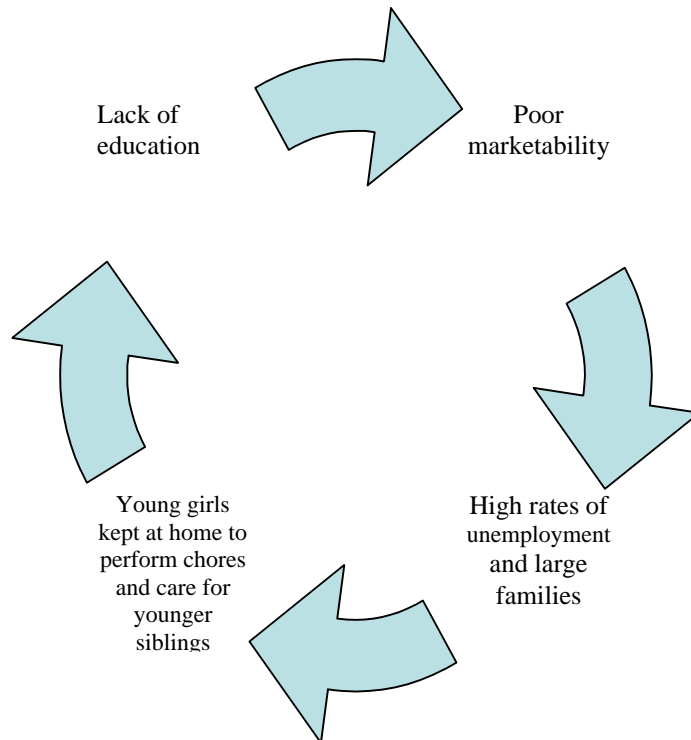
that CSW have do not wear condoms consistently because they are reported to be “trusted” with CSW believing that these men wear condoms with all of their other sexual partners. Conversely, one research project (Voeten et. al, 2001) found that men in Kisumu who frequent CSW have an average of 6.2 sexual partners at any given time (including wives [Polygyny is practiced in Kenya], girlfriends, extramarital partners, and steady or one-time CSW) with 22% of married men having at least two sexual partners outside of their marriage. Being married and visiting multiple CSW was significantly linked with low levels of condom use with a reported 13% of condom usage “sometimes” and 31% using condoms “rarely” or “never”. When seen as the larger picture of the situation, this means that condoms are rarely used because it is expected that everyone is using condoms with their *other* partners. This contributes to the high numbers of HIV/AIDS, other sexually transmitted infections (STIs), and unwanted pregnancies.

Kenya’s population is almost 38 million people with a 2.758% population growth rate; however, the CIA World Factsheet notes that the high rate of AIDS (estimated to be 1,300,000 people at the end of 2005) has an adverse effect on multiple determinants of health throughout the country. This includes: a lowered life expectancy, higher infant mortality rate, high death rate, low population growth rate, and an unequal distribution of the population by age and sex. In fact, the average age in Kenya is 18.6 years old with 42.2% of the population in the age range of 0-14 years old (CIA – The World Factbook). The ramifications of these two facts could be extrapolated to mean that the majority of the children in Kenya are being raised by people who are not much older than themselves – in short, children are raising children.

Furthermore, it is estimated that about 75% of the AIDS cases in Kenya happen in the age group of 20-45 years old, peaking for women at 25-29 years old and for men at 30-34 years old (Akwara et. al, 2003). As the 20-45 year old age group typically constitutes the majority of the work-force in any country, these high infection rates lead to a lowered production rate for the country which in turn leads to a low gross domestic product (GDP) (Parker, 2000). While political corruption and scandals, draughts/erratic rains, political infighting, and violence have all contributed to the economic crisis Kenya now faces, the loss of such a dramatic portion of the workforce (estimated at 6.7% of the adult population) to either illness or death only adds to their current state of 50% of the population living below the poverty line (CIA).

Compounding the problem, Bedi et al (2004) states that the unemployment rate of Kenya rose from 6.5% to 18% between 1989 and 1997. The university-educated population was the least affected; however, those with some education matched the unemployment rates of people with no education. While primary school enrollment has increased through the government’s initiative to make primary schooling free (UNAIDS, 2006), there remains a high dropout rate for girls due to pregnancy or a lack of money for school uniforms and supplies. Multiple international human rights organizations - including Amnesty International (2008), Plan (2007), and UNAIDS (2006) (which includes agencies such as UNFPA, UNDP, UNICEF, and WHO) – have conducted research in developing nations and find a female’s education is not valued as much as a male’s education. In addition, females will be kept at home to perform chores or help with younger siblings instead of

having the chance to go to school. This perpetuates the cycle evident in the following figure:



According to McCulloch and Ota (2002), one of the largest portions of Kenya's GDP comes from their exports of horticulture to the European Union; as such, this is one of the largest employment opportunities for low-skilled, female workers in the country through gathering and packing jobs. They go on to state, however, that this work is seasonal or short-term and that the provinces of Kenya which are arid and semi-arid (including Nyanza) do not benefit from this industry though they have the highest poverty rates in the country. A lesser known detriment to employment for low-skilled workers was given attention by Kirigia et al (2006); they have found that the "brain drain" of Kenya (a practice of highly educated professionals moving to industrialized countries for higher wages) results in less employment opportunities in fields such as housekeeping, child care, and gardening.

Kisumu is the third largest city in Kenya with a population estimated at 380,000 residents (Voeten et. al, 2001) and has the highest rate of HIV infection in the country at 15% (Voeten, 2007; Kenyan Ministry of Health⁴, 2008). Girls between 15 and 24 are 2-3 times more likely to get infected with HIV than their male counterparts in Kisumu

⁴ 2007 HIV prevalence rates were released by the Ministry of Health through the media during the researcher's time in Kenya; the report was relayed to the public via the nightly news cast and the newspaper.

(Akwaru et. al, 2003; UNAIDS, 2006; Amuyunzu-Nyamongo, 1999); this is due to both the physical susceptibility of a young woman's body and to the lack of socio-economical bargaining power when it comes to condom negotiations (Akwaru et. al, 2003; UNAIDS, 2006). With this knowledge, the estimation by UNAIDS that half of all new HIV infections occur in 15-24 year olds implies a heavy burden on the young women of Kisumu. They estimate from antenatal testing that in the Nyanza Province (where Kisumu is located), 3% of 15-19 year old women and 9% of 20-24 year old women are HIV positive (UNAIDS, 2006).

Outside of HIV infection, another economical danger that young women face is the burden of becoming a mother, especially when young and single. According to the UNAIDS (2006) report, 27% of 19-year-old women in Nyanza are either pregnant or a mother. Furthermore, Mitchell et al (2006) state that only 11% of the 42.1% of 15-19 year olds who are sexually active reported using modern contraception. Though abortion is illegal in Kenya, there are an estimated 252,000 abortions a year for 15-19 year olds (Kiragu et al, 1998); this accounts for 16.5% of all abortions in Kisumu (Oindo, 2002). The UNAIDS report states that 1 in 10 women who obtain an abortion in Kenya will die of complications from the illegal procedure; this is significantly in contrast to the United States where giving birth is more dangerous than having a legal abortion (Planned Parenthood).

There is documented evidence that more than 90% of the adult Sub-Saharan African population know how HIV is spread and understand what precautions are needed to hamper the pandemic (Amuyunzu-Nyamongo, 1999). However, as has been discussed, condom-use is still very low among people with multiple sex partners; various reasons have been found for this fact and efforts are being made to reverse the thought-patterns which put people at risk. Some reasons have been: "we all have to die of something", "my partners use condoms with everyone but me", "I must be immune if I haven't gotten sick yet". Furthermore, while adults have this knowledge, the fact remains that young people feel as though they have no one they can trust to talk with and they feel as though they receive contradictory messages about HIV and its transmission (Amuyunzu-Nyamongo, 1999). A large factor in this is that many adults are unwilling to talk with teenagers about sex or foster an atmosphere of trust which allows for two-way communication about such taboo subjects.

Though there has been no time for peer-reviewed journals to document the backlash of post-election violence of this year (2008), reports from news media in Kenya have documented the problems arising from over 1,000 deaths and roughly 250,000 people being displaced from their homes. The western part of the country, including Kisumu, experienced the majority of violence which destroyed homes, schools, and places of employment and forced nearly a quarter million people to live in camps created for Internally Displaced Persons (IDP). One article coming from Eldoret, Kenya documented an alarming rise in teenage prostitution due to the loss of parental income, the necessity to drop out of school, and the harsh living situations in IDP camps. The Associated Press stated that medical experts fear an increase in young prostitutes which could undermine Kenya's recent gains in HIV reduction.

Due to the taboos of discussing sex – either educationally or with a focus on personal habits - with people of all ages in many of the Kenyan cultures, research on this subject is difficult to do in a quantitative manner. It has been found more effective to take a qualitative approach to reproductive health research through participant observation, interviews, and surveys that are done face-to-face. Power has observed that having the rapport-building time creates a situation for people to speak more openly about subjects which typically are not discussed (Power, 2002). On a larger scale of use of qualitative methods, Molyneux (2008) references the American Anthropological Association stating:

“... in the social sciences there is generally greater awareness of and attention to changing and conflicting interpersonal relationships, and greater concern with justice and the political implications of the research endeavor.” (pp. 691)

Through the literature, it has been suggested that effective methods of teaching people the importance of condom usage and female empowerment have the potential to stem the AIDS pandemic which has stunted many non-industrialized countries. However, it is still to-be-determined what “effective methods” may be and where the gaps of knowledge still exist. As such, research on existing programs aimed to disseminate information – especially to teenagers and young adults - is vital to the fight against the spread of HIV.

Findings

Note: Throughout the following sections, names of interviewees are used to identify the speaker. The names used are nicknames chosen by each participant; when nicknames of interviewees are the same as those of SFC participants, relatives, or staff members, it is purely by coincidence.

1.) The first research goal was to determine if access and utilization of quality sexual and reproductive health (S&RH) services increased by adolescent girls by at least 20% in 2007. This SFC Project objective was meant to be accomplished through use of the Youth Friendly Clinic which is operated by the coordination staff members of the project.

As the Youth Friendly Clinic (YFC) was opened during 2007, this objective was impossible to determine as a success versus a missed goal on the basis that any clients to the YFC represented an increase. Upon enquiring after records for the YFC clinic in order to determine services being used by youth, the researcher was informed that patient files (which numbered in the hundreds) are kept by hand instead of in the computer and there is no data being collected from these files through logs, statistics, or other means. As such, the researcher would need to physically go through the hundreds of patient files from both the KMET clinic and the YFC, a task that would be too great and would violate the HIPPA laws of the United States due to the researcher's access to patient names. Due to this, determining use of the Youth Friendly Clinic was impossible. Moreover, there may be overlap in the amount of clients coming into the KMET clinic which then are sent to the YFC, again complicating the ability to determine if this goal has been met.

Any additional activities, programs, or services that are offered by KMET which youth may have an opportunity to be a part of were not identified outside of SFC. While KMET has multiple programs, only one participant - whose parent is a community health worker (CHW) taking part in home-based care - identified that SFC participants would be able to participate in KMET's home-based care project.

However, all of the participants spoke of the community outreach talks they had been a part of during their time in the project. These outreaches were typically carried out every Friday afternoon and would consist of the young women entering a community market or other highly populated area, staging a fight between two of the participants in order to draw a crowd, then speaking with the crowd about a reproductive health topic. These topics included HIV/AIDS/STI reduction, condom-usage, family planning methods, or simply answering questions the crowd posed to them. Outreaches, which are a scheduled and programmed part of SFC, were the only activities outside of vocational training which were mentioned as part of SFC or KMET by both participants and staff members.

SFC participants' response to youth in Kisumu accessing S&RH services:

Due to the cost and the location of the clinic, the majority of the participants stated that their friends do not use the Youth Friendly Clinic (YFC) in Nyamasaria. Over half of the women stated that they and their friends go to either the hospital or to other youth clinics which do not charge for services or medications. Three respondents stated that the clinic

was too far for people to travel, especially when they would have to pay once there on top of paying for the transportation.

“(Friends go) mostly to (another youth clinic) because in KMET, usually they are charging and most of the girls around here don’t have money. But in (another youth clinic), they offer their services for free. In KMET, they were offering family planning services to us free but now they are being asked for some fee. But most of the girls will now go to (another youth clinic) because you can get everything there for free: family planning, testing, drugs - everything.” Sweetie

One participant, Conslete, talked at length about the YFC citing multiple problems which keep youth both in and outside of the SFC Project from using the services provided there. The YFC’s location in the middle of the SFC classrooms and the fact that the teachers use it as their office offer little privacy; potential patients do not feel comfortable with this situation. Furthermore, she stated that multiple members of the SFC staff can be seen during clinic hours talking openly about people (“gossiping”), both participants in the project and the YFC patients. Finally, she spoke of the resource center lacking resources (such as literature about safe sex, STIs, HIV/AIDS, or sexuality) and being used for purposes other than a “youth friendly” resource center (i.e., eating room, office, and daycare room).

Ex.: This sign was posted on the Resource Center throughout the three months of research; the “childrens” it refers to are the children of SFC participants, making the center unavailable to youth who may come to the Youth Friendly Clinic for treatment or information:



During the focus group session, community health workers (CHW) were asked whether they felt as though the SFC participants were going to the health clinics in order to fulfill their reproductive health (RH) needs. In addition, they were asked whether the

participants had any influence on the use of the clinic by community members. This influence, they were reminded, could be either positive or negative.

The two men of the focus group were the only ones to answer this question and both answered negatively in regards to the YFC or the KMET clinic. One man stated that young women may be going for testing, counseling and treatment, but they are doing it at other clinics which are closer to where they are located; he went on to state that the KMET clinic “should put in more effort” in order to get more patients there. The second man claimed to have referred young people to the KMET clinics, but they may be disappointed in the amount of birth control methods that are available at the clinic as he has had problems procuring medications from the clinic to distribute in the community (he is a community-based distributor, which allows him to dispense medications in his community instead of clients going to the clinic or pharmacy).

2.) The second research objective was to determine the extent to which the Sisterhood for Change Project has fostered behavioral change in both its participants and targeted communities through the dissemination of information

- One determinant which can indicate whether SFC has accomplished this goal is understanding whether the Sisterhood for Change Project met the goals of empowerment for the 25 adolescent commercial sex workers it was initiated to accomplish.

The term *empowerment* is a difficult variable to operationalize due to the ambiguity of what this means; it is complicated because social-demographic factors such as nationality, age, educational attainment, sex, and economic standing can skew the meaning. As such, this variable was defined by those people who determined it as a goal (the KMET staff) and the target group (SFC participants).

Personal Empowerment:

Eight out of 17 (47%) of the participant interviewees mentioned personal empowerment as a benefit to being in the SFC Project at some point during their interview:

“Nowadays, I am very much empowered and I cannot just be treated that way.” Abiero

“I know my rights as a lady.” Achieng

“I have learned about my rights, learned to be confident about myself and I can decide on what I want and what I don’t want.” Atieno

“Some men, they are difficult, they want it unprotected - so unless you convince him, it is very difficult. So, in the peer education training, they told us that we should not accept, we should not allow them to sleep with us unless it is protected.” Becky

“Because I really know it works, I really know that there is HIV - it’s real, I really know that there are other things out there. So, no one can convince me not to use that condom... I’m changed!” Conslete

“Earlier on, I would just get into relationships blindly and this cost me because the man lied. But now it’s hard for someone to lie to me.” Josephine

“I can now have sex but its protected sex. Then I know my rights, I know about myself and can stand up for myself now.” Ogapa

Four staff members stated that empowerment was essential to these young women in order for them to begin a healthier life-style. For them, empowerment was the ability for these women to make their reproductive health choices and have the ability to talk with either their parents or their partners about these choices. One staff member explained that empowerment comes from or is established by the ability to talk openly with community members and government officials concerning RH issues.

One male focus group member talked of the need to integrate males slowly into the SFC Project because it would actually help empower the female participants by letting them “*know the enemy*” through a knowledge transfer during reproductive health training. As several of the SFC participants expressed their lack of desire to date or have a partner due to their mistrust and anger at men, it is the researcher’s contention that they remain disempowered. Through the definitions given by the staff members, an inherent aspect of empowerment is the ability to make decisions from an informed perspective based on personal desires instead of financial necessity. When decisions are made based on negative feelings such as fear, anger, and mistrust, it disenfranchises the decision-maker by taking away one possible option to the decision and perpetuates the negative stereotype placed on males. As such, this creates a cycle of misunderstanding between the sexes and does not lead to constructive solutions which may be found by working together.

Teaching Empowerment to Others:

Roughly 18% of the quotes from participants surrounding empowerment dealt with the SFC women teaching empowerment to other women and trying to help them understand when their rights have been violated. One particular interviewee, Conslete, spoke of being able to help young girls and married women in her area when they have been raped. She spoke of being more comfortable in making sure men who rape women are taken care of through the justice system and making sure that the women get the help they need after such an experience.⁵

⁵ Conslete (6% of the study population) was the only participant to mention that a woman *can* be raped by her husband; as she stated that she had learned this through SFC, the actual rape statistics may be much higher than the reported amounts due to women believing that any sex between spouses cannot be considered rape.

Confidence:

Of the participants, 53% mentioned confidence as part of the empowerment they were able to attain during their time with the SFC Project, typically speaking of the ability to stand before people and talk. Two women mentioned specifically that they would not have been able to even have the conversations with the interviewer and her assistant had it not been for the SFC Project because they were previously so shy and afraid to talk in front of strangers.

Three staff members spoke specifically about the changes they had seen in the SFC participants through their ability to do community outreach when they had once been very shy. One staff member, Grace, stated that the women had not been able to talk with anyone when the project first began and “now, they can talk, sing, act drama, they can feel confident” when they are around most people.

Throughout the interviewing process, the researcher and research assistants discussed the behaviors of the SFC participants during their interviews as part of the debriefing after each interview. While many of the women expressed themselves with a high level of confidence, at least four (24%) of the participants came across in their interviews as timid, reserved, or shy, especially when discussing reproductive health matters and the challenges of the SFC Project. One of the first interviewees informally informed a research assistant three weeks after her interview that she wished she had shared more but had felt nervous as to the amount of information the researchers would share with the KMET staff. These behaviors would indicate a lower amount of empowerment than what the interview data says.

HIV Status:

During the interviews, two women stated that they were HIV positive while two women - whose intakes stated that they are HIV positive - did not comment on their HIV status; in fact, they both stated that they would go for Voluntary Counseling and Testing (VCT) with a new partner before having sex with him in order to determine his status and *not* get infected by him. When the two who were open during their interview about being HIV+ were asked if they spoke openly at SFC, they both said that they were made to feel bad by the staff of the SFC Project about being HIV+ when their status had been shared with the other women in the project without their permission.

“There was one other girl who was also HIV+ and she stopped coming because of the way the people were talking about her. In fact, one day during lunch, she just sat and cried instead of eating because she knew how the people were about her. And after that, all people knows about her and after that she stopped coming...” Kajia

In contrast to this statement, one staff member reported that the women who were HIV+ were now sharing their HIV status with community members and employers in order to teach and reduce the stigma toward the disease. As the one she spoke of most works in the food industry and openly declared her HIV status during her interview, it is assumed that she has been honest with her employer. However, she represents a quarter of the

known HIV+ population of SFC participants and may not be indicative of what is happening across the board.

Self Reliance:

One staff member stated that there was a part of “empowerment” which she felt was “not so good” as in still lacking for the participants: the fact that SFC participants were still looking to the SFC Project for financial support. She felt as though their lack of ownership in their vocational training and ability to find employment lead them to remain reliant on an outside source. Though it is healthier for this reliance to be placed on KMET as opposed to men, it is still a detriment to the participants to not be self-sustaining.

In contrast, another staff member felt as though the vocational training was the key to self reliance:

“We are giving them training in a vocation like catering, hairdressing, tailoring; after the training, they are getting something they can do for their life. After getting something they can do for themselves, then they don’t have to depend on anyone and they are able to get money for themselves.” Kilo

A defining quote of “empowerment” came from one staff member who felt as though this goal was being met because she had just talked with two participants about their recent employment:

“...money is power and means that you are not relying on someone else. Because if it comes from a man, then there are strings attached and that is sex and that is sex that maybe you can’t negotiate to use a condom. But when you have your own money, then the relationships you have, if the man refuses to wear a condom, then fine, then be done with it because I have my own money. That employment part of it is the answer.” Yagot

One SFC participant, who is now employed due to her training through SFC, supported this statement through one of her own:

“Last year, 2005, 2006, I have a boyfriend and he was the one to help me buy some products. But now I can buy them myself and can depend on myself...The past boyfriend was after sex - he would sleep with me and give me some money. Or, if (he) had a gift, he would request for sex, then he would give it. Or, if not, he would go with it.” Lynn

From the researcher’s point of view, the women have begun their path to empowerment but have not fully achieved it. It was encouraging to have three of the women state that before entering SFC, they would not have felt comfortable to sit with the researcher and research assistants talking about themselves or subjects of a sexual nature. After their year learning information and going on outreaches, they feel more confident in

themselves and feel as though they should be talking with people about sexual education. In addition, statements such as Lynn's (above) prove that the women who were able to be employed have gained an amazing ability to rely on themselves and to feel confident in their ability to choose men based on what they want. Unfortunately, only five of the women were employed and able to make statements such as Lynn's.

Though they have the ability to gain employment, the majority of the women do not feel as though they have enough knowledge about their vocation to be gainfully employed – which has been proven by the bulk of the women remaining unemployed. Whether this is due to an actual lack of knowledge or due to a lack of confidence which leads the women to not be aggressive in their search for a job, the end result is still that the majority of the women are not able to be self-reliant. As evidenced by Lynn's statement, reliance on families, men, or KMET makes the women feel less empowered because they still do not have the ability to take care of themselves and their children without help.

Furthermore, as stated before, it is the belief of the researcher that women are more empowered when they are able to make decisions regarding their sexuality based on their wants, desires, and passions as opposed to making decisions based on fear, anger, or necessity. As of the interview time, over a third of the respondents stated that they did not want anything to do with men such as dating or having sex due to their past experience with men hurting them (physically and emotionally), leaving them pregnant or with a small child, or giving them a STI (including HIV). While the women know how to protect themselves from what men can pass to them sexually (which is a necessary skill in Kenya), most did not express to the researcher that they have the ability to choose a man who would help to keep her emotionally safe. However, it must be realized that the researcher may have a different standard for "empowerment" and the fact that the majority of the participants stated they feel empowered is a better indicator to such a subjective determinant.

- Another indicator as to whether the SFC Project has fostered behavior change is to understand if the SFC participants are practicing safer sex techniques which they did not engage in prior to becoming part of the SFC Project. In the United States, it is typically understood that "safer sex techniques" encompass both the reduction of sexually transmitted infection (STI) transmission and having the ability to practice family planning. However, due to the high rates of STI transmission – especially the HIV rate – and the high incidence of teen pregnancy in this setting, reproductive health education has been separated into two categories: safe sex techniques and family planning methods (FPM). As such, each participant was asked about her knowledge and use of both.

Knowledge of Safe Sex Techniques:

All 17 participants talked of condoms being the safest form of sex in terms of protection from STIs, though only six (35%) of them mentioned condoms as a form of safe sex *and* a form of family planning. Seven (41%) mentioned abstinence as the only way to ensure no infections and two of those seven indicated that being faithful in a committed relationship is the most reliable form of safe sex.

Three participants answered that they have not been to the clinic for a check-up, one (Josephine) claiming that she feels “okay” so doesn’t “see the need of going there.” Of the six that claimed they do go to the clinic, four (67%) stated they go to the VCT clinic for STI testing and treatment (when necessary), which is different than a clinic for obtaining a FPM or receiving a Pap smear.

Use of Condoms:

All 17 of the interviewees stated that they know the benefits of wearing condoms now and the majority of them stated that if a man refused to wear a condom, they feel empowered enough to not have sex with him.

Responses to the question “What if he refuses to wear a condom?”:

“I just leave! I leave him and go away!” Atieno

“I’ll try for my level-best to convince him to use a condom; if he refuses, I tell him that it is not a must that he have sex with me. Then, just get out from him.” Christine

“I tell him that we have to change the subject; let’s just forget about this sex thing. Let’s just forget about it because I know that if he doesn’t do it, he will die.” Conslete

“...before we do it, we must first agree on what method, and if I tell him I want him to put on a condom and he refuses, I let him go, and I leave and it’s over.” Dudu

“You know for now you can go for an HIV test but I can’t really trust my boyfriend because you cannot trust him fully: he was alone, I was alone. He might tell me he didn’t sleep with anyone but I can’t tell, so he has to use a condom... maybe he is cheating me that he loves me when I am with him, but he can’t force me to sleep with him without a condom, I have a choice, I leave.” Stella

“In the past, I could just go with the sex without knowing if there were STIs there - I didn’t even know how to use a condom. But, in the SFC, I was taught how to use a condom; I was taught how to talk - to be assertive and tell a man to use a condom and show him how to put it on.” Sweetie

As this research was done in a short amount of time with a research team who were not well-known to the informants, it is difficult to fully determine if this goal was met. The participants each spoke of their knowledge about condoms and have stated that they know not to have sex without condoms. However, when the women were asked about their use of family planning methods or safer sex techniques, a typical answer began with “I know that I must use...” instead of firmly stating a technique or method that is consistently used. As they were being asked a personal question by a woman they had

not met before and they knew what the “correct” answer is to a question about condom usage, it is difficult to determine whether they are truly using abstinence or condoms without fail.

Knowledge of Family Planning Methods

When asked to name different forms of family planning methods (FPM), 11 (65%) could recall three forms or more while six of the 17 (35%) could not name more than two forms; four of those six knew only using condoms. Four mentioned that they realized they were leaving some methods out when trying to name them, though they were not able to recall what they were. Of those who named at least one FPM outside of condoms, the Depo Provera shot was the most commonly known method. Seven of the women (41%) specifically stated that their RH knowledge has been increased by their training in the SFC Project.

Use of Family Planning Methods

- None: Of the six participants who directly stated they are not currently using a hormonal FPM, two did not offer a reason for not using them at this time, one HIV+ participant stated that she is trying for another child, one stated that she is practicing abstinence and would use condoms were she to have sex again, one mentioned that she uses the emergency contraceptive (EC) “sometimes”, and three mentioned using condoms due to the side effects caused (primarily) by the Depo shot. However, of these three, two had made their decisions based on personal experience while the other made her decision based on what she had heard.

“I just don’t like them - their side effects. Lots of girls are using contraceptives, like the (injection) for 3 months - I’m told that if I use this, maybe I will bleed like hell, maybe I won’t see my monthly, there are cramps... I don’t like this! Or, that it will interfere with my fertility. I just don’t like the blood flow.” Sweetie

- Depo: Five stated that they are now using the Depo shot for family planning while three mention using it in the past. Of those three, one is currently trying to have another child and the other two had adverse side-effects to the injection.

- Condoms: While all 17 women interviewed mentioned knowing that condoms are one of the methods to use in order to avoid STIs, only 5 (29.4%) stated that they use them as their form of birth control, one of whom mentioned using them in conjunction with Depo.

Staff Knowledge of Participants’ Use of Safe Sex & Family Planning Methods:

Three staff members, one from the KMET office and two in the SFC Project office, spoke of the use of safer sex techniques by the participants. The one in the KMET office, Yagot, stated that she believed 70% of the participants were using family planning and she believed only one of them was pregnant in the duration of the SFC Project’s year. She stated that this girl had been pregnant at the start of the project, though, and was able to return once she had given birth. (The researcher interviewed one SFC dropout who

stated that she had been pregnant at the beginning of the project, had dropped out due to difficulty with traveling the distance to the SFC office, and had not been able to return to the project.)

One staff member in the SFC office, Dani, stated that she believed six of the participants had gotten pregnant during the first year of SFC, though a few of them had obtained safe abortions and one had given birth. Regarding STI transmission, the staff member Hair from the SFC office stated that there were “a few” of the participants who had been infected with treatable infections and had received treatment at the YFC. She stated that one of the girls, when found infected, had claimed the condom broke and was given another demonstration after she and her partner were treated.

Current Partners of Participants:

Nine of the 17 respondents (53%) stated that they will go for voluntary testing and counseling (VCT) before having sex with a new partner now that they have completed the SFC training. Six mentioned that they do not now have a partner nor do they wish for that in the future. All stated that this is different than what they have done in the past with two of the women alluding to the idea that they previously had sex for money. Overall, the participants stated that they take more time getting to know their partners and make sure that he is someone they feel is a suitable partner:

“I can say I choose those who know women’s rights, faithful, and who is financially stable.” Atieno

“You know, if I were to learn of what I have learnt at KMET long time before, I wouldn’t have even had a baby at an early age. I am more keen on choosing a partner, more comfortable on even sharing with him on what I want and how I want it done.” Ogapa

Though many of the women were elusive about whether or not they are currently using a family planning method or condoms consistently, two staff members confirmed that some of the women in the SFC got pregnant or infected with a STI during their year with the project. However, all of the women knew of options to unprotected sex – even if they solely know of condoms and abstinence – and expressed the desire to practice this protected sex when faced with the opportunity to have sex. However, as evidenced by one interviewee being pregnant at the time of her interview by choice and another trying to become pregnant, it is clear that there are life circumstances which determine whether the women will apply their knowledge or not.

- As it was believed that the majority of the participants were at one time practicing commercial sex work, one goal of the evaluation was to determine whether the participants of the SFC Project are still engaging in commercial sex work as a form of income generation.

Two of the 17 participants (12%) interviewed stated that they had practiced commercial sex work (CSW) before coming into the SFC Project while three others alluded to this.

There were four women who said outright that this was never a way in which they made money, though many women would not understand the question when it was phrased “sex for money” and only understood this question when the word “prostitution” was used. Unfortunately, this did not encompass the extent of “sex for money” as many women will have one or more partners because of a male’s ability to provide money or goods; however, this is perceived as a “boyfriend” and not commercial sex work. Of those who stated they were previously CSW, all claimed that the training they received from KMET has helped them to no longer feel comfortable with this practice.

As stated in the “Limitations”, it was suggested by those SFC participants who were interviewed and helping to find other participants for interviews that those who were unable to be located may still be practicing CSW and thus have apprehensions toward being interviewed. The intake profiles of three of the women who were not interviewed and were known to be living in Kisumu stated that they had been CSW before entering the SFC Project, which would give credence to this suggestion.

- As the largest portion of the SFC Project year was spent in vocational training and on attachment, a determinant to the success of the project is whether the participants are utilizing the vocational skills they received training in and how are these skills being utilized.

Each of the participant interviewees was asked whether she was able to use her vocational training and where the money for daily living came from in order to establish if they had gained enough education through the SFC Project in their chosen field. Nine participants (53%) stated that they are making at least some of their spending money by doing jobs which they were trained for in the SFC Project, though most of them stated that they could only get small jobs occasionally. Only two of them were able to make enough money for their families to rely solely on their salaries, one of whom was working with the SFC Project. Nine of the 17 participants (53%) still rely on a relative (typically at least one parent) in one form or another to pay for the majority of their living costs; one of the nine had lost both of her parents but was still living in the house they had built before their deaths and thus had no rent to pay. Four of the participants stated that they are making money by doing jobs outside of the profession they were trained for at SFC, including one woman who worked in outreach for another RH organization and another woman who was working in as a teacher in a primary school. The majority of those who are not employed full-time stated that they could not get a job due to not having their certificates from SFC, which they hoped would change after their graduation (held at the end of data collection).

Three women from the catering class, two women from the hairdressing class, and three women from the tailoring class stated that they had not learned enough to be employed or to feel confident working. The most common complaint about the catering class was that there were too many theoretical hours and not enough practical hours learning how to cook. For hairdressing, there was not enough equipment and the women only learned how to plait without learning the machines or enough about chemicals to be hired into a salon. And, in the tailoring class, there was not enough time to move past the basic skills

so the participants felt as though they were only able to make school uniforms which, again, is not enough knowledge to be hired in a tailoring shop.

One participant, Achieng', mentioned that there are multiple vocational training schools which are working with the same three vocations as the SFC Project, flooding the market and making it hard for people to find work once they are finished with their training. She also mentioned that she had believed SFC would be training women in other skills, such as computer skills, a training which did not happen.

As for the relatives' perspective on employment, seven (58%) stated that their charge was not yet working though this had been the main goal of the project (as they saw it), five of whom directly stated that this was due to the participants not receiving their certificates from SFC. Two of those seven frankly stated that the lack of having a certificate was making their charges "lose hope" that they would be able to find jobs.

"...they should only give them certificates... This is not good because what I want is to see my daughter employed or with something stable that she can do. Some see them idle without a job and they are like 'what are you doing here?'" Bill

As shown through less than half of the participants having gainful employment and the majority of the women feeling as though they did not learn enough in the vocational training, it has been determined that this goal needs to be focused on with a determination toward improvement. See "Recommendations" for steps to how this may be accomplished.

- As the goals of the SFC Project included an outreach aspect, this research wanted to answer the question "How has the SFC Project affected the reproductive health practices of other adolescents of the Kisumu District?" This question was determined by the answers from questions about the participants' friends and peers, namely whether their friends are using family planning methods and whether the participant is taking her peers to the clinic for birth control or STI testing.

Friends' FPM

Of the seven participants who stated that their friends are using some form of FPM, four stated that usually women use the Depo shot ("the injection") as their preferred method (it is long-lasting and leaves no evidence of being used), with two mentioning that some women use oral contraceptive pills ("The Pill"). Two stated that their friends do not go to the clinic either because they fear finding out that they are "positive" (referring to HIV) or that they have believed the myths which state that FPM will make a woman infertile when she is older. One participant said that all of her friends work with reproductive health organizations and so are going to the clinic.

Go to the Clinic with Friends

According to the interviews, 14 of the 17 participants (82%) declare that they have taken at least one friend to a clinic for reproductive health matters; one stated that she has taken

at least four of her friends because she has been able to see the positive alternatives to the life she has had:

“I got pregnant at 16 years old, so if I see some girl who can (do the same thing), I am trying to stop it. Like, I found another girl there and she was not having anywhere to live. So, I talked to her and took her to the hospital and told her not to get pregnant because she was looking for a husband. I told her that she needed to find a family to stay with because she was searching for a housemate; so, now, I know she is safe.” Kajia

Two of the respondents stated that they only encourage their friends to go (they do not accompany them to the clinic) because, usually, women don't feel comfortable with someone else being a part of this type of exam (i.e. hearing the medical background, knowing that a friend is getting a Pap smear, etc.). One participant stated that no one has come to her for this type of advice.

This question has a subjective answer in that a researcher not familiar with the area the participants are from will not be able to determine the amount of impact they have had on their friends and peers. Based on the answers to these questions, the first year participants of the SFC Project have influenced a small circle of people close to them with the potential to effect more. Furthermore, the longer the project continues and the more women who are taught by SFC return to their communities, the potential for a deep impact grows.

- Finally, whether the awareness of gender-based violence increased in the three target areas of the Kisumu District and in what ways was addressed to gain an understanding into the holism of the reproductive health training and the amount of community outreach the participants were doing.

This question was addressed in two ways: asking the participants about “other trainings” they received through SFC (outside of the RH education and the vocational training) and through asking the community health workers in the focus group what they felt was the impact of the SFC Project in the community. Only one participant spoke of her knowledge of gender-based violence, which was stated previously concerning her understanding of rape and her knowledge of how to help a woman who has been raped. The focus group answered with a resounding “no” to whether or not the SFC participants were helping to teach about this and women's rights in the community (see below).

3.) The final evaluation goal was to identify strategies which will lead to the sustainability of the project. As “sustainability” takes many forms, this evaluation goal does not solely focus on the financial sustainability and the ability of the SFC Project to continue, but rather incorporates the project's ability to continue educating the communities and bringing more participants to the project.

- The first focus is on the ability of the project to promote community awareness and to endorse outreach to those people outside of SFC. As such, questions were asked

of participants to determine how they continued to teach their communities reproductive health education and with what frequency.

Thirteen of the participants (76%) stated that they are still teaching people in their community about S&RH, FP, and unsafe abortion. There were four who stated they hold specific classes in their homes or at church for groups of people on a consistent basis, one who stated that she talks with women while she is plaiting (braiding) their hair, and others spoke of talking to their friends or community members when they see someone has a problem or as part of their informal conversations. Two stated that they do not talk to people at all because no one comes to them for information or because they are not well-received when speaking of such topics.

“No, (I don’t teach)... Because most of them are unreceptive, they just don’t want to hear anything on reproductive health, they think we are lying. We even used to find hard time during the outreach program.”
Atieno

Four of the 17 participants (24%) stated that they had a desire for the outreaches to continue but had not received the (mostly financial) support they needed to do so.

- It was also important to determine how the SFC Project affected the reproductive health practices of other adolescents in the three target areas of the Kisumu District. This question was best answered by the members of the focus group due to their accessibility to the community. They were asked what differences they believed the women of the SFC Project had made in the community at-large through three questions:

Have the participants changed the RH knowledge in the communities?

The first two answers to this question rapidly came from the only two men in the focus group: “the answer is yes” and “no, they have not done anything” and the two remained on opposite sides of the answer throughout. Three women answered the question as well, usually supporting the negative answer to the question by stating that more could have been done in the communities that were closer to home.

“...they go for outreaches up in (communities outside of Kisumu) – how are you going up there yet your house is falling?!”

One woman expressed her negative feelings about the need for second group being trained to pay tuition for the SFC Project. She felt as though this fee set the priority for these women on their vocational training as opposed to the reproductive health training and the community outreach aspects of the project:

“...because they paid money, their direction was direct to the classes. I think that is the problem: it’s very impossible for them to have time to do many outreach just because they have paid.”

Were participants teaching in the community about women's rights?

The first answer to this question was from one of the women: “No. Those ones, they don’t know their rights.” One of the men supported this answer by stating that he didn’t think the women had been taught in this subject but both agreed that they had not heard the SFC women speak on this topic; only these two people answered the question. However, a second man brought up another organization which goes into the communities and teaches both women’s and men’s rights.

Did the SFC Participants have an influence in the community?

One woman answered this question alone, stating that the first group of SFC participants had a positive influence on the community enough to get other women to join the group during the second year. However, she felt as though the second group was not doing anything to influence the community because they are not seen.

Again, as an outside researcher, this question is hard to determine; because the researcher was not familiar with the situation before the SFC Project began, it is hard to determine what changes they have brought about. It is to be noted that while in the community surveying people, many community members could remember the SFC participants by their bright orange t-shirts and stated that they thought these girls knew what they were talking about. Typically, community members could recall that the SFC women were teaching about sex, though none could recall anything particular they learned specifically from the SFC Project.

- Financial sustainability for the participants and the ability for them to get away from reliance on other people (especially men) was a main focus of the SFC Project. Because of this, the income generating activities (IGA) that have been initiated by the participants and how successful these initiatives have been was a determining factor into the success of the SFC Project. However, this was found to be a “Challenge” to the SFC Project and will be discussed in further detail under that heading.

- In order to know that the SFC Project will continue, it is important to know whether young women are being recruited for future SFC training.

The majority of participant interviewees stated that they are not helping to recruit new members to the SFC Project because they were made to feel as though they were not allowed to by the staff of the project. They were asked to hand out fliers about the project for the recruitment of the second year, but they were told by one staff member that the SFC staff would be choosing the next group in order to recruit young women who were easier to work with. When asked if they would encourage women who came to them with questions about the project, the participants stated that, yes, they would encourage it, though potential participants would be referred to the SFC staff in order to determine eligibility. (For further details, see the “Challenges” section.)

All of the relatives stated they will and do encourage other young women to join the SFC Project, though one stated he is not encouraging women at this time:

“For me, I don’t because as at now she’s not yet employed, no certificates. But once she’ll get a certificate and a job I will because I’ll be directing people at the right place with a vision and a goal.” Bill

While this one sentiment was felt by a couple of the relatives, it is obvious that they support the project and will continue to gear young women toward the SFC. Some of the reasons given by relatives for encouraging others to get involved:

“So that they may also get the training that can help them control their lives and for their progress.” Chak

“...some of them in community are just doing nothing and, if you are idle, they just stick here. You may be tempted to join another people and that will just get you in trouble, like early marriage, early pregnancy, like that.” Makam

“... there are many diseases; they’ll get to learn more about the diseases and how to protect themselves from them, and will be able to know how to live safely in the community.” Maureen

“..as we walk around I have come across girls who are the sole caregivers of their mothers so we always try to encourage them and empower them so that they don’t get lured into prostitution because of money problems.” Mary

- Finally, as an extension to the question of sustainability through more young women joining the SFC, the research team hoped to learn whether young women in the community express desire to be a part of the SFC Project and what are their motivations for participating. It was hoped that this question would be answered through the community questionnaires more thoroughly; unfortunately, this was not the case as the questionnaires were not equipped to tackle this question and the majority of respondents were men. However, one parent – Metro - stated that there are “girls fighting to get into SFC,” yet this was the only comment made to this effect.

The SFC participants were asked what KMET and SFC could do to motivate more women to get involved with the project. Overwhelmingly, the answers were about the need for public involvement through outreaches with a loud speaker, a mobile testing center, media advertisements, and more educational fliers in the communities that have the SFC information on them. The other theme that was found is the need for free services: if the SFC Project and the YFC offer services for free, vulnerable women with few financial options will come to them.

Additional Findings

As this was an evaluation of the SFC Project as a whole, there are additional questions that were asked of each of the interview groups concerning the benefits and challenges to the SFC Project in order to help the project improve for future participants.

Benefits

All individual interviewees were asked what they believed were the benefits of the SFC Project in general; this included benefits to the participants and to the community as a whole. Due to the nature of the interview questions, many of the benefits were able to be found in the answers to the specific research questions and can be read in more detail in the previous section. However, the following benefits were those that were stated directly to the interview question: “*What are the benefits of the SFC Project?*”

Vocational Training:

Eleven of the participants (65%) were enthusiastic about the knowledge they had attained through SFC: three specifically talked about the reproductive health training they received, three specifically mentioned the vocational training, while the remaining five mentioned “training” or “knowledge” in a general reference.

“...there are many benefits, like when we are learning about reproductive health and the vocational trainings. When (a woman) has these, she won’t mess the way she will mess if she doesn’t have even one knowledge.”
Sweetie

Of the three who spoke about the vocational training directly when asked of the benefits of the project, two participants mentioned the jobs they are currently working in. Half of the relatives stated that the biggest benefit of the SFC Project was the vocational training their charge had received and the fact that they are now able to be employed.

“I didn’t pay for anything in terms of fees yet my child learnt and she’s now employed. Thank you!” Florence

Focus group participants were not asked for the specific benefits of the project, but were instead asked to speak on the changes they had noticed in the SFC participants since beginning the project. They mentioned SFC participants working now that they had completed their training with one woman stating that she had seen one of the participants working for KMET.

Reproductive Health Knowledge and Outreaches/Community Education:

Four participants (24%) mentioned outreach training as a benefit to both themselves (through confidence-building) and others (through the dissemination of information). While it was intended that the reproductive health knowledge should be shared with the community as a whole at the outreach level, two mothers stated that their charge was also teaching younger sisters and the mothers about safe sex. Four of the 12 (33%) relatives stated that the RH training their charge received benefited the respondent, the participant, and the community.

“The change I have seen is on how they were being taught... she is able to teach people about sex just like the way they were being taught; she can explain to people about reproductive health.” Ann

The focus group recognized the SFC girls’ knowledge in RH education and commended those who have left CSW due to their training in the SFC Project. Four people stated that these girls were doing good things in their communities because they are teaching their peers, sisters, and others RH education in order for more people to be protected against infections and unintended pregnancies. One woman was impressed enough with the SFC participants’ knowledge to voice that the SFC participants should be doing these trainings *“at a high rate so that others can get the information.”*

Nearly 38% of the comments made by staff regarding the strengths of the project referenced the two main aspects of the SFC Project, reproductive health education and vocational training. Of the RH knowledge that was disseminated in the project, the participants’ ability to teach others, knowledge of how to protect themselves against STIs and unwanted pregnancies, and access to safe abortions during their time with SFC were specifically mentioned. Furthermore, one female staff member spoke about how the SFC women were able to be in an environment where there were no males around, thus increasing their ability to speak openly and learn about RH issues because the conversations were not being dominated by males and they did not have to feel shy about their questions/opinions.

Attitude:

Of the 16 participants who mentioned at least one benefit of the project, three (19%) mentioned that they have improved their live-styles in that they are now practicing better habits or have discontinued their associations with a “bad crowd”. One respondent stated that she agreed with the level of discipline used on three participants who were suspended during the project:

“According to me, I feel like it was fair because there are some girls who lack discipline and they need to be done that way.” Christine

When asked about the changes they had seen in their charges, relatives responded with benefits which were unintentional as per the initial goals of the project but highly appreciated. Half of the 12 relatives spoke of positive comments their charge has made about the SFC Project and the positive lifestyle changes the project has made in their charge’s life.

“She has told us that she is very much happy to be there and that she is hoping that they continue teaching others in what she has learned... it’s like she almost lives there now!” Rock

Eight of the relatives (67%) stated they have seen their charge at home more often instead of “roaming” and they have become more helpful around the house. Phrases such as

“respectful”, “more disciplined”, “available”, and “busy with work instead of being idle” were repeated by these eight people. Three relatives (25%) gave examples of a personality improvement in their charges, such as being easier to talk with or being the peace-keeper in the house.

“Since she started with the project, they (the participant and her sisters) can just do what they need to with no problems. I wake up in the morning and there is no fighting, they are just going on with their activities. And whenever quarrels are there - because they are normal with human beings - when they happen in this house, she (the participant) steps in and just talks them out.” Makam

A quarter of the comments made by staff members in regard to the strengths of the SFC Project referenced the project’s ability to empower the participants and, as one male stated, the staff as well. This was in part due to the nature of the project design and the fact that both groups of people had a voice in the establishment and implementation of the SFC Project.

Aspects Specific to the SFC Project:

Two participants mentioned that they were still receiving treatment from the Youth Friendly Clinic (YFC) and that they felt as though they and their child had benefited from the medicines they were able to receive. One participant stated that SFC had benefited her by making her realize the need to seek medical attention when she felt as though she may have a STI. Though she uses the provincial hospital instead of the YFC because of the cost, she is still thankful to have the knowledge of how to protect herself.

“You know, earlier on I couldn’t go for HIV test because I thought if found positive I just get stressed up and even commit suicide, but since I was trained and educated on how to, I have courage and I always go for test. Also, I could get discharge [sic] with funny smell and assume to be normal, but now at least I know if I do I guess it might be an STI so I rush to Russia (provincial hospital) and am treated...” Stella

Three of the staff members mentioned that the food participants receive is a benefit for the women and their children due to a reduction in malnutrition in the children and an increase in concentration for the women while they are in class.⁶ One staff member brought up other benefits to the SFC Project: the fact that the SFC participants can bring their children, having the YFC on-site for participants to use, and that sustainability is being fostered by having sponsors from the community for the women of SFC.

Of the staff comments made about the benefits of the SFC Project, 18% were in reference to the community involvement and their visibility in the community. The different ways which SFC touches the community included: outreach and education to peers, the fact

⁶ It is to be noted that the availability of food was never fully understood by the researcher. Both staff members and participants would state that breakfast and lunch are served to participants and their children; however, both participants and their relatives spoke about the participants going hungry all day.

that this is a “grassroots” project, and that the community is involved in the project through the advisory committee made up multiple key-players in the community. One female staff member spoke about the community that is created by the SFC participants:

“...they create a unit; even out(side) of the project, you find them together. Maybe they are a total orphan and now they have a family.” Yagot

Challenges

While this section appears to be lengthier than the “Benefits” section, it is important – as with all evaluations – to bear human nature in mind. Through the researcher’s experience as a counselor, it has been observed that people have a tendency to note the negative aspects of a situation easier than they do the positive aspects. Furthermore, because the participants of this particular evaluation knew the information was going toward improving a project which they are highly supportive of, it can be assumed that they were focusing on the aspects of the project which need help in order to make it the best it can be. It is important to note that one participant stated that she “*didn’t see any gaps*” in the project at all while five other participants stated three or less details which needed to be addressed in order to improve the SFC Project.

In-House Problems:

Of the challenges stated by the participants and staff members, 44% were in reference to in-house issues which could be addressed by the SFC staff in a fairly timely manner.

- Food: Four participants mentioned the food during the project: there were problems with the taste, the amount, the fact that it was oftentimes not appropriate for the children of the participants, and the fact that it was not served on a consistent basis for this group (the first group to complete the SFC trainings).
- Resource Center: Two participants noted that the “resource center” was not what it should be due to a lack of resource materials, posters, and use of the T.V./VCR which was meant to show educational programming. However, the lack of use of the resource center for its intended purpose was also blamed on the fact that this room is used as a day-care center for the participants’ children and the room where most people in the program eat when food was available. Multiple staff members mentioned that this gap should be addressed once the new KMET building is completed, giving more room to the SFC Project and the development which comes from the SFC.
- Certificates in a Timely Manner: Of the 12 unemployed participant interviewees, 10 stated that when they had looked for work they were not able to be employed due to the lack of a completion certificate from KMET. They stated that they had completed the SFC Project vocational training and the certificate had been promised to them for the preceding 1-3 months. Many participants expressed feelings of frustration toward KMET for the delay in receiving their certificates as they felt that KMET must know how this would damage their ability to become employed.

As stated before, seven of the relatives (58%) stated that their charge was not yet working though this had been the main goal of the project (as they saw it), five of whom directly

stated that this was due to the participants not receiving their certificates from SFC. (see page 30 for details)

- Inappropriate Behavior of Staff: Ten participants (59%) talked of:
 - o the coordinating staff or the teachers being verbally abusive or disclosing personal information to others involved in SFC,
 - o feeling as though promises made by KMET were not kept,
 - o feeling as though members of the teaching staff were not putting forth a full effort in their teaching,
 - o and the harsh manner of disciplining participants in the project.

There were two stories of participants' HIV positive status being told to people in the project by SFC staff members in order for the participants to "protect" themselves from these women; three interviewees talked of a particular staff member disclosing a participant's recent abortion in front of them in a manner meant to berate the woman who had the procedure done; and twenty-one percent of the overall "challenges" for participants directly dealt with feeling abused by the way the participants were talked to by staff members or comments made by the staff members which revealed to the participants that staff members "looked down" on the participants.

Three of the participants stated that the tutoring staff is called into meetings with the SFC staff too often, leaving the students to remain in the classroom reading instead of actively being taught. And, three of the participants spoke of students being suspended from the project for weeks at a time; one participant complained that the students were not given a chance to tell their side of the story nor were the other participants allowed to speak on her behalf. This respondent spoke passionately about her desire for participants to be allowed a more active role in the disciplinary actions toward fellow SFC members.

Four staff members (44%) and three participants (18%) stated that a counselor should be hired either full-time or be available to the participants a few times a week in order to handle some of the problems which arise with the participants. Furthermore, it was stated by three staff members that the current coordination team was not sufficient, stating that the coordinators are too young and ill-equipped to manage problems which arise in the course of the year participants are in the SFC training.⁷ It was suggested that not only should a counselor be on-hand in order to talk with participants who are experiencing trauma, but that this person should train the staff members on how to handle such situations themselves. One staff member, Kilo, was aware that many of the staff members are willing to offer advice to the participants but lacked the counseling skills of simply listening without advising.

As will be discussed in detail in the following section ("Financial Support"), the "promises" which were not kept by the KMET and SFC staffs may be explained by the recruitment process and the breakdown in communication as to what the participants

⁷ Note: Since the end date of data collection, one member of the coordinating team resigned and was replaced with someone who was hoped to possess the skills staff members and participants were suggesting for this position though she is not a counselor.

could expect out of the SFC Project. However, it is mentioned in this section as many of the participant/relative interviewees and multiple members of the focus group felt as though promises has been broken and expressed resentful feelings toward KMET. Furthermore, three staff members mentioned that the participants had expected more out of KMET than was feasible for the organization and their financial standing.

Financial Support

- Direct financial help during the project: Over a third (35%) of the participants mentioned that they felt as though they had been promised financial help from KMET in order to pay for transportation, both to and from the training facility (the KMET clinic) and in order to pay for their outreach transportation. While one person mentioned that there had been a KMET vehicle sent to their area of town to pick-up participants in the morning, this assistance had been terminated by the KMET director fairly early into the project and there had been no transportation assistance after that time, financial or through the use of the KMET vehicle. Furthermore, it was noted that KMET vehicles sporadically took the participants on outreaches, though this had decreased as time passed. And, finally, the participants stated that they had been told they would each be given Ksh100 (roughly US\$1.50) on the Fridays when they went on outreaches to help pay for transportation; the four participants who mentioned this stated they were only paid “a few” times before those payments stopped.

When asked about challenges, 44% of comments from family members had to do with money: relatives felt that since the project was aimed at vulnerable, no-to-low income women, it was the responsibility of SFC to cater for transportation, food, and medical treatment while participants were in the program.

“They told our girls that they were to transport them from their various homes to school but they didn’t. She had to walk long distances to SFC... There was no food also and without money I could not give her any food to carry so she could go hungry the whole day.” Maureen

Furthermore, it was stated by one relative that the families were asked to provide a large amount of money to pay for outings the participants were to go on while in the project.

“They were supposed to be taken for outings like going to Nairobi and the KMET people asked for money from them. And to me that wasn’t good because they welcomed them as children who are unfortunate financially and they are the ones who selected them for the project; why couldn’t they just take them there for them to learn without paying and let them go out with others? They asked for Ksh1000 (about US\$15) from each of them and I told her that I could not raise (it) and if people were going she would have to remain. And they did not go because no one was able to raise the money.” Agnes

- Equipment: One participant mentioned that KMET had:

“promised to cater for totally everything in terms of equipment - shampoos, conditioners, etc. But it never happened because when we went there we were to provide for everything, buy our own shampoos, conditioners and any money that came from the project went to the staff, we never benefited. And if you had no money and no resources, like shampoos, you would only sit and watch until the rest finished.” Ogapa

- Secondary School Education: Five of the 17 participants (29%) stated that KMET had promised to pay for the completion of secondary school for those participants who had dropped out, though this had not happened and there had been no talk of it happening. One participant, Conslete, was asked directly if this had actually been promised to the participants, or if it was an idea that had been talked about; she responded that she did not *“know that it was actually promised, but it was a suggestion we gave them.”* Nonetheless, this was felt as a challenge for almost a third of the women interviewed to gaining employment after completion of the SFC Project.

Two staff members, one male from the KMET office and one female from the SFC office, stated that the SFC participants did not fully understand what the project would be able to provide for them. The participants had stated that those who had not finished secondary school would be taken back, which was echoed by these staff members; however, it was felt by these staff members as though this was never a promise by the KMET staff. Furthermore, these staff members stated that the participants felt as though KMET would help in employing them after the project was finished, either by finding them a job or by providing micro-financing loans in order for the participants to start a small business. This, both of the staff members felt, was a promise made to the young women and not followed through with.

- Youth Friendly Clinic Cost: Though it has been mentioned previously in this paper, it is worth reiterating the fact that, as a Youth Friendly Clinic, the clinic is not being well-utilized due to the payment requirement for services and goods. As there are multiple facilities (clinics and hospitals) throughout Kisumu which offer services, medications, and birth control options at no cost, young people with little or no access to money will choose these options. Furthermore, the fact that there is only one YFC which is a long distance from their area, the participants are not willing to pay for transportation in addition to paying for services.

Recruitment of Subsequent Groups

Six women (35%) stated that they felt as though the SFC Project charging tuition for subsequent participants of the project goes against the premise of SFC being for *vulnerable* women.

“I’m only suggesting that if SFC is for vulnerable girls, then let it be for vulnerable girls. SFC was not supposed to be a program to strain girls, it was supposed to help vulnerable girls. So, if they start asking for a small

contribution, then it is like they are looking for girls who are capable and they are leaving the vulnerable girls in the community. Why don't they look for those girls who are not capable - and those who can pay, why don't they go to institutions where they pay and then (SFC) help those who can't?" Conslete

The focus group and three of the relatives (25%) also voiced a deep concern that women have been asked to pay to be trained at SFC now, which is not in tune with the target group being total orphans who cannot afford vocational training somewhere else (though it was mentioned by one man that SFC was cheaper than other places in town). Two women in the focus group shared stories of young ladies they knew wanting to be a part of SFC and either marrying in order to have money to pay for it or dropping out due to lack of funds. Moreover, two SFC staff members were disappointed in the lack of recruitment done with commercial sex workers (CSW) for the second and third groups stating that it is a gap because SFC was missing its target population.

Seven participants directly stated or mentioned that they were specifically told not to help in recruitment of the next group of SFC participants. One participant mentioned that they had been given fliers to pass out but were instructed to direct interested women to the staff members of SFC. As the staff members' mistreatment of the participants has been discussed, the interaction between the staff and participants flowed into this aspect of the project through this description from Conslete:

"C: She said that she didn't want to hear anything from us because - it was during the recruitment of the new girls - we saw that it would be better if the recruitment was from us because we are in the community and we can take the girls. I don't know what came up, but they were saying that at KMET, they pay. So, the other group that is there, they pay; so, a vulnerable girl cannot pay. And then [she - the assistant coordinator] also say that they don't want any girl from us - they want to recruit.

CT: And, how did she... was she nice saying, "No, it's O.K., we can do it..." or was she mean...?

C: No, she said it - it was like we were stubborn to her, we were just a hell to her and she thought that we would only bring girls to disturb her. So, she wanted to go into the community and pick the girls by herself."

One lady in the focus group asked why KMET was no longer involving the community health workers (CHW) in the recruitment of the new girls; she went on to state that she felt SFC was not taking the girls recommended by the CHW due to wanting women who could pay for the program.

Recruitment should be, according to almost 25% of interviewees, spread more throughout the three slum areas due to the high percentage of participants coming from one of the three areas, a few coming from the second, and none from the third.

Due to the previously stated misunderstandings (see “Financial Support”) that the women in the project had about what SFC would be able to provide for them, it was found that recruitment was not sufficient. It was expressed by both participants and staff members that the information given out during recruitment should be accurate and provide a clear indication as to what exactly the women can expect out of the SFC Project

Limitations to Training

- Vocational Training: Of all 38 interviews, 32% of respondents (including two of the three vocation tutors) stated that the vocational training was either “not enough,” “too short,” or it was “too theoretical.” Six participants stated that they did not feel as though they knew what they were doing once they began working at their attachment. Two of the female relatives have sent their charges for further training; one stated that the amount of theory used in training versus practical learning was not sufficient for this population of women:

“I think catering should be more of practicals than theory... Most of the girls are (school) dropouts so some don’t even know or understand by reading alone. I think they should be given lots of practicals to help them.” Florence

One participant, Susan, and her tutor noted that the facilities for the training were inadequate due to the training space and the fact that there was only one dryer:

“...they should also improve the facilities for the vocational trainings - like last year, we only had one dryer. So, we could waste a lot of time waiting for one person to finish. So, I think they could improve on that.” Susan

Another participant, Atieno, stated that the participants had been told there would be more training, such as computer training, that was not followed-up on. While she was the only participant to mention this, it is a valid point. One of the participants stated that the job market in Kisumu is flooded with the three vocations which are being taught at the SFC Project, making job attainment after training extremely difficult.

Two staff members mentioned that many of the participants were still without jobs, though one of them put the responsibility on the participants by claiming that they were not “aggressive” enough in finding a job after training. One tutor noted that the participants were at different learning levels, making the lesson plans difficult to standardize. And, finally, one tutor stated that if SFC were to be recognized in the community and prove the validity of the vocational training, the participants needed their completion certificates in order to obtain work.

- Reproductive Health Training: Two staff members talked about some of the participants becoming pregnant unintentionally even after the RH training; a female SFC staff member stated:

“I feel that after RH training, they should be using family planning and condoms to not get pregnant.” Dani

- Logistics: Almost all of the staff members and roughly a third of the participants interviewed mentioned that the space of the SFC Project training area was too small for the amount of participants they now have and this lack of space hinders the project’s ability to expand. Three staff members mentioned that a PA system, voice recorder, and video equipment were needed in order to retain the girls’ stories and to make a larger impact while in community on outreaches.⁸

Follow Through

- Micro-Finance Loans: Another challenge to the participants’ ability to begin working after completing the program was the fact that many had counted on receiving a micro-financing loan from KMET but did not receive this. As they had “*targeted*” (had been counting on) this money, at least three (18%) mentioned the lack of this financial backing as another unfulfilled promise by KMET. None of the participants stated receiving finance lessons from KMET, though it was understood to be a part of the SFC Project.

Three staff members (33%) stated that the SFC participants were not granted micro-finance loans through KMET due to a lack of trust in the participants by the KMET staff member in charge of the rotating loan system. It was stated by two staff interviewees that the rotating loan officer did not trust that the participants would stay in Kisumu and use the money appropriately or manage the money properly were he to give them loans. A female staff member from KMET stated that it was “thought that all of the girls would get jobs when they were finished” and so finance training was “not something (KMET) took into consideration” when planning the project (though it was understood by the researcher that this was part of the original plan for the SFC Project due to what was conveyed during initial discussions of the project).

- Income Generating Activities during the SFC Project: Three of the participants talked extensively while three others mentioned (35% all together) that there was money made through income generating activities (IGA) during the course of the SFC Project. The women stated that this money was promised to them during their time in the SFC Project then was later promised to be given to them at their graduation ceremony. However, each woman who mentioned this money had not received it at the end of the data collection period. During their interviews, all of them made a comment which alluded to their belief that they would not see this money due to a lack of proper accounting on both the part of those who earned the money and the SFC staff.

- Employment Opportunities: One participant, Abiero, stated that she was upset about the job opportunities in SFC going to people outside of the project after the participants had been trained for such positions and were still in need of work. Due to

⁸ At the end of data collection, a PA system had been bought by KMET, though was not at the SFC building for use. Furthermore, all of the staff members are hopeful in the future of the SFC Project due to the newest KMET building, which – at the time of writing - is in the process of being built.

one participant being employed by SFC and another working for a different sector of KMET, this statement is not entirely true. However, the concern of this woman was supported by the members of the focus group due to a lack of employment for CHW and SFC participants within the project in positions such as tutoring.

- Follow-Through of Outreaches: Over half of the participants expressed disappointment that they were no longer going on outreaches which stopped due to financial reasons.

“...we were to go out on outreaches. But, when it stopped, it is like we are keeping the information to ourselves - we want to go out and share this knowledge with other women.” Sweetie

A question which was asked of each research participant was “*What challenges – either here in Kisumu or throughout Kenya – do young people face?*” This question was asked in order to understand what challenges KMET and the SFC Project will encounter throughout the project and which foci they need to have in order to increase their ability to help the young women of the SFC Project. In addition, the answers to this question can guide and shape further projects by KMET and other agencies which KMET works in conjunction with.

Challenges Young People Face

Poverty and a Lack of Jobs:

Poverty and the inability for adolescents to find jobs were the most mentioned problem for young people in all interviews, the focus group, and through the surveys (though this was not the largest challenge identified in the surveys). It was noted by the SFC participants, relatives, the focus group, and staff members that this challenge leads to women marrying for money when they are young, both forced marriages and by choice. It was also found that poverty leads to commercial sex work which then leads to a higher chance of infections (primarily HIV infection) and unplanned pregnancies. The staff members and focus group spoke about their feelings of lack of support from the Kenyan government to encourage jobs for young people; this is both due to a lack of creation of new jobs and to the nepotism in the workforce. Finally, one person in the focus group talked of how a lack of money can lead males to steal in order to impress ladies with goods or, in cases where men are frustrated by their lack of money leading to the inability to get girlfriends, men turn to rape in order to have sex.

Reproductive Health (RH) Education:

Education and the taboo that surrounds talking about sexual topics were mentioned by all research groups as a challenge to young people. It was interesting to note that two SFC participant and three relative respondents were not necessarily talking of only the reproductive health knowledge for young people but that the ignorance on part of older adults hurts young girls too, usually through rape:

“Some people, especially men, go for very young girls as young as 12 years of age and choose to sleep with them. They have a mentality that

young girls are HIV negative and therefore safe. Some don't use condoms because of this on these girls.” Stella

The focus group spoke on the fact that many teenagers do not feel comfortable talking with their parents while both the parents and the focus group spoke about the fact that parents do not feel comfortable talking to their children about sexual issues. One parent mentioned that in the schools, teachers do not feel comfortable teaching RH education and that students of the opposite sex from the teacher do not feel comfortable discussing such topics in front of the teacher. It was further noted that teenagers do not feel comfortable talking about sexual issues in front of people of anyone of the opposite sex, especially their peers. The community surveys showed that “pressure for sex” was rated the highest challenge for young people by 70% of the respondents choosing it; this coupled with a lack of education leads to serious problems with young people.

Dropping out of school:

All participant groups stated that there is a high rate of school dropouts in Kenya, usually due to poverty and a lack of money for school fees or, as one male staff member mentioned, as a result of parents not valuing education (“especially for girls”). Dropping out of school leads to the inability to find a job and a lack of empowerment, according to half of the staff members, thus leading to activities which are harmful (i.e., prostitution, alcohol/drug use or abuse, etc.).

Diseases and infections:

Roughly 20% of all respondents stated that diseases and infections were a challenge to young people in varying ways: either fear keeps them from getting tested, infection occurring in young people, or young people being challenged by losing one or both of their parents to death from disease. HIV was the only infection that was specifically stated, though SFC participants and two of the relatives talked of other diseases, mostly those can go left untreated and “hurt her chances for having a baby.”

Alcohol and Drug Abuse:

Drug or alcohol abuse was cited as a major challenge for young people with 18% of SFC participants, half of the parents, and 63% of the survey responses dealing with one or both of these issues, though alcohol was mentioned more often. *Bhang* (a drug similar to crack-cocaine) and *changa'a* (a local brew which is exceedingly high in alcohol content and similar to “moonshine”) were the main substances mentioned by respondents which they feel are being abused by adolescents due to their accessibility and the relative inexpensiveness of both. One SFC participant and one relative each stated that alcohol/drug use combined with a lack of RH education places adolescents at a higher risk for STIs, including HIV.

“Some young people take too much alcohol so when they are in bedrooms they don't even remember to put on or ignore using condoms.” Stella

“Drug abuse and ignorance: you know if both children in a relationship are drunk, they end up sleeping together without protection because no

one is so keen to use protection. Some don't listen to advice and it's due to this that they mess. It affects both girls and boys, so it becomes a chain of problems..." Florence

Lack of "voice":

Through examples of problems adolescents face when standing up for themselves, three of the 17 participants (18%) spoke of youth having no voice with most adults, either their parents, teachers, or employers. The findings from the community questionnaire did not support this as only one respondent stated that youth have no voice on all accounts, though the possibility that this question was not fully understood is high. Though three people stated that youth do not have a voice in the school system, this could have been a skewed answer due to protesting that was occurring in the school system at the time research was being conducted. Almost a third of the adults interviewed stated that teens do not feel as though they can talk with adults openly, though this typically was focused on reproductive health issues.

Attitude of Youth:

Half of the relatives interviewed spoke of either the attitudes of young people or the lack of skills that parents have to raise children. Of the young people, "laziness" and "rudeness" were some of the attitudes which lead adolescents into "bad habits" such as not finding a job or having sex at a young age because they are acting as though they are adults. As for parenting skills, Florence stated:

"It begins with us: if you send your child to buy cigarettes or alcohol, I think the child will be eager to test it out because he'll know "there must be something good". This is irresponsibility that the parents have. They'll (the kids) have to practice it out and check what is good in the bottles that makes the parent enjoy the beer. It starts here then ends up in other forms of drugs, the other problems like fornication, rape and irresponsible behavior flow."

Peer Influence/Lack of Parental Influence:

Seven of the relatives (58%) stated that peer influences can lead to early sex, prostitution, early marriage, or "walking a lot" (being promiscuous), which would lead to the idea that peer influence leads to many of the other challenges. Furthermore, influence from men can lead young women to forego their dreams for the sake of their families:

"...maybe a young woman may desire to do something substantial in the future but then she goes ahead and gets a male partner who convinces her such that she can't do anything but only thinks about their relationship and at the end you find that someone is affected and maybe gets impregnated, STIs, and such things." Chak

The focus group discussed that youth are lacking proper role modeling. Four members of the focus group voiced a concern that if only women were trained in RH and empowerment, nothing would change because men are the people who typically hurt

women in this area. One man stated “*most of the young people have the potential but have nobody around to boost their self-esteem*” through lack of education and outreach.

One lady talked about how a lack of money leads parents (especially single mothers) to be away from the home frequently looking for work or food, leaving children unsupervised for long periods of time. This leads many children to “*grow with his or her own lifestyle not knowing what is good or bad.*” One man brought up that - quite often - there is no parent at home due to death from AIDS, leaving children and adolescents to raise their younger siblings, typically forcing them to drop out of school.

Recommendations

As can be surmised through the findings section, students found immense benefits in the reproductive health education they received in the SFC Project while relatives consider it a joy that the women in their lives now have the opportunity to gain employment.

However, there are some gaps in the project which can be filled in order to help the SFC fulfill their mission of assisting such a vulnerable population to become strong and empowered women. Some issues that have been identified in this evaluation have begun the process of change while others were verbally discussed with staff members at the end of the research time. While there were gaps acknowledged, one major strength of KMET is their willingness to have the project evaluated in order to improve it because, as one staff member stated:

“I think that because this was the pilot project, we are learning in the process. This is a project that we have no references for; this is the only project in this area that is specifically for girls only, so this is a very new approach.” Yagot

1. As discussed with KMET staff, the participants had a difficult time getting to the SFC building on time usually because they lacked the funds to take public transportation and circumstances kept them from being able to walk the long distance from their homes. It was found that, in the beginning of the project, KMET had sent one of the organization's vehicles to the areas of town where the women live and was made to wait for hours for the participants; after a short time, this practice was terminated leaving the women to walk. It is suggested to re-establish the practice of picking participants up and begin part of their professional training with an understanding of the importance of timeliness. Firmly stating that the vehicle can take them only if they are on time sets expectations of punctuality and establishes boundaries which are vital to a young person entering the job market.
2. A number of the women stated that they did not like the food which was served then were made to feel bad by staff members if they did not want to eat. Allowing the participants to help in the planning of weekly menus can help by granting ownership of what is being served and knowledge of what to expect. This could be accomplished in groups of five women each planning four weeks' worth of meals at the beginning of the project; this should not happen in one day, but over the course of several days in order to allow for a non-stressful, team-building activity. In order to increase their budget-making skills and begin financial management training, each group would be given a budget for the four weeks they are planning, to be spent either in equal parts or with some weeks receiving more money than others.
3. The vocational training requires more time, as evidenced by remarks from two of the tutors and multiple participants in the project. Though the SFC Project was established with the timeframe of one year's training in order to facilitate the participants entering the workforce as quickly as possible, the lack of training does more damage to their marketability than an additional 3-6 months of training would. If there are participants who cannot be unemployed for that amount of time, SFC can offer different levels of certificates (beginner, intermediate, and expert) which can be achieved for each level of skill competency they have been able to obtain. This type

of system would necessitate a flexibility to allow women to return to the project if they find they do not have the qualifications to be hired after leaving SFC.

4. Training in micro-finance loans should be carried out by the KMET loan manager throughout the year that the participants are with SFC in order to form a relationship between him and each participant. This may reduce the lack of trust he feels toward the women and it may increase the respect the participants feel toward KMET. This relationship would increase the probability of the participants being responsible with the money they receive as a loan from KMET. Furthermore, the relationship could give the loan officer a chance to understand what each woman was hoping to do with the money; if a community health worker is already using the loan for a purpose one of the participants would fit well with, then a partnership could be established. This would reduce the amount of money a participant could receive alone (helping to ease the doubt of the loan officer) and would grant both parties the opportunity to learn from and with someone outside of their generation.
5. Reproductive health education and vocational training should offer more explanation in Dholuo. The findings suggest that knowledge of family planning methods had low retention; as many of the interviews were conducted in Dholuo due to the participants' comfort in this language, retention may be higher in the language they understand the most. This would also increase their ability to conduct outreach more efficiently as their training would be in the language which they most often find themselves teaching.
6. Staff members should receive training from a qualified specialist in the field of adult education in order to increase their ability to efficiently work with late-life learners. Though participants of the project may be teenagers (which most were actually in their 20s), their lived experiences of having children, losing parents, and otherwise having the need to be more self-reliant have made them closer to that of a grown adult. Furthermore, SFC staff members should receive training from a counselor who is experienced in working with former commercial sex workers. Though their lives have been hard, as people they are soft and prone to having their feelings hurt by the adults who are leading them, which was a complaint made by the majority of the participants. And, finally, staff members should be encouraged to hold one another accountable for negative comments made to the participants and should be granted a forum in which to safely address any trespasses.
7. Schedule weekly SFC staff meetings during the Friday afternoon outreach time period in order to avoid lost class time. If there are issues which arise during the week, staff members who are not teaching should try to work out the problem before asking the tutors to become involved. Overall, as often as possible, there should be a promotion of active teaching from the tutors (meaning that the tutors are teaching instead of asking the students to read) in case there are literacy and comprehension difficulties on the part of the student.
8. As a group, a schedule of outreach areas should be made every two months for the next eight weeks and a vehicle should be reserved for every Friday afternoon to transport the participants to outreach areas. If there is not a need for the vehicle, then a call should be placed into KMET by the Thursday before.
9. Foster the creation of monthly meetings between all women who have been part the SFC Project, both formerly and presently, within their different areas in order for the

women to support, retrain, and share with one another. These can be deemed “Sisterhood Parties,” “Sorority Parties,” or some other name that re-enforces the mission of the SFC Project. These gatherings would be for only the participants and, just as a support group would, will entail: sharing of stories to allow for support from “sisters” and promote accountability, games to reinforce RH knowledge, and outreach at the end to continue the transfer of knowledge.

10. Due to the need for financial sustainability of the project, the initial demographic of the most vulnerable population has limited access to the SFC. Through comments made by one staff member and research into the backgrounds of the second group of participants, it was found that commercial sex workers were not included in this group and many of the women did not fit the criteria of “vulnerable” set for the SFC Project as understood by the researcher. It is recommended that recruitment practices be revised and that former SFC participants be the largest part of the recruitment process. Sponsorship should be sought out through faith-based organizations, private hospitals, and the Ministry of Health in order to establish consistent financial backing for the project. Furthermore, there needs to be a collaborative relationship between KMET and other organizations in the community, such as Tuungane, who know of more funding sources and can assist in some teaching aspects of the project.
11. The market in Kisumu has been flooded with the three vocational trainings which are offered through SFC. One focus group member stated that women can be taught in vocations typically dominated by men, such as mechanics and welding. Expanding – or even changing – the vocational training topics can gain higher marketability for the young women; furthermore, computer training is essential to many markets and can help the women with their ability to access jobs and correct information.
12. The KMET and the YF clinics are encouraged to promote the use of patient logs in order to maintain service and demographic information; this will help in charting successes and gaps in services rendered by understanding what the needs of the community are. Additionally, data from the charts can be used as support information when seeking funding sources and planning for the growth of the clinics. Please see Appendix F for a sample demographic chart.
13. Finally, many staff members and quite a few of the participants stated that there is a desire to see the project expand and have the ability to take on more students. It is encouraging that there are plans for a larger building to be built in order to house KMET and the SFC Project, making this desire a possibility soon. However, one of the largest complaints the focus group and a few of the staff members expressed was the lack of male inclusion in the project. One focus group member stated that if even five of the students were males, they could 1) take the information back to more males and 2) help the women participants learn how to interact with men.

Deliverables

The *form* deliverables were presented as a final report to KMET, which may be used for internal growth of the SFC Project and/or could be used as a funding source document. In addition, a teleconference presentation for the agency will be held in order to present findings and recommendations for the future. In order to enable any stakeholders interested in the presentation the chance to be a part of the presentation, the PowerPoint presentation will be sent to the agency prior to the teleconference. Furthermore, the transfer of skills to research assistants is a source of capital.

The *content* deliverables include, but are not limited to: 1) the understanding of the effectiveness of the Sisterhood for Change Project on the first cohort of young women and 2) an evaluation of the strengths and weaknesses of the project as it was administered during its first year.

Limitations

The limitations of the study include, but are not limited to:

- The specified population is a group of young women who volunteered to be part of the SFC Project and who were motivated and able to continue being part of the group process over the course of a year or more. This evaluation is specifically addressing these women and this project and is not intended to generalize to the country's culture as a whole.
- The parent/guardian who was chosen to be interviewed was determined by what is culturally relevant and appropriate. Due to cultural norms, two interviews were conducted with a husband and wife together instead of a one-to-one interview; in both cases, the husband spoke significantly more than the wife.
- As the interviews were conducted face-to-face with the participants and then with their parents/guardians, there is the possibility that the interviewees may not have been honest due to embarrassment, shame, fear, mistrust, misunderstandings in communication, or other reasons. Furthermore, there may be a pride in the program and/or a desire for it to continue which may have prompted some interviewees to be less honest about the successes and/or gaps in the program.
- Of the 22 young women who attended the first SFC graduation ceremony, 17 interviews were conducted; the initial list of potential interviewees contained 28 young women. One person on the list was not interviewed because she dropped out of the program, it was known that four were no longer in Kisumu (one due to pregnancy), and the other six were described by interviewees as "difficult" to find and speak with. It is believed that some of these women may still be practicing commercial sex work and were purposely avoiding being interviewed, meaning that this at-risk group is not documented in this evaluation.
- The focus group members were chosen from the group of CHW who are involved in KMET's revolving loan program and were not randomly selected.
- The results of the research cannot be generalized to all at-risk youth or to programs which are similar in nature outside of Kisumu, Kenya.
- Survey findings possibly yielded biased information due to the majority of respondents giving only positive feedback to all of the questions. It is unclear as to whether these were their true feelings about the SFC Project or if, culturally, people are agreeable to strangers with questionnaires.
- There was a language barrier as Swahili is one of the official languages of Kenya along with English. Furthermore, there is a third language that is widely spoken in Nyanza Province (Dholuo) which some interviewees (including focus group participants) felt more comfortable speaking in. Two trained research assistants translated when needed in both verbal communications and transcribing (please see "Methodology" section for details); however, there could have been linguistic subtleties lost in translation.

Personal Reflections

My journey to Kenya began nine months before I boarded a plane through my initial contact to KMET. For three months, there was a dialogue via e-mail filled with confusion as to how I could benefit the organization and fulfill my practicum needs; it seemed as though I could not express the necessity for KMET to tell me their needs instead of them asking me what I would like to do for them. While I sent them my CV and explained the multiple ways in which I could be utilized, they continuously asked that I design my own project to conduct with them. At the end of these three months, tragedy struck Kisumu, and so much of Kenya, in the form of riots and violence prompted by citizens' anger toward the government in their handling of the presidential elections. At this point, three months of uncertainty and disappointment ensued as I searched for other options to my practicum.

Finally, on April 2, I received an e-mail from the student volunteer coordinator stating that all was well again in both Kisumu and KMET resulting in a resurgence of desire for volunteers to come to Kenya. And, after so many months of confusion, they had pinpointed a way in which my skills could be put to best use: an evaluation of the pilot year of their peer-to-peer educational project, the Sisterhood for Change (SFC). At this point, two months of proposal-writing, planning, and IRB approval-seeking commenced. One of the biggest challenges of this time was being approved by two separate IRBs, both of which required approval on the part of a Kenyan entity to ensure my research was culturally and ethically acceptable in a setting outside of the United States. Thankfully, KMET had the ability to grant approval through their governmentally-approved ethics review board.

During the proposal-writing stage, I had stated an assumption I had was my ability to quickly and easily adapt to an African setting due to the time I had spent in an African-based, formerly colonized country (my three years as a Peace Corps Volunteer in Jamaica). I found this to be true upon my arrival in Kenya: the infrastructure of the government and school systems, the living and working conditions, the animals roaming about, the terrible roads, and the friendly, welcoming citizens of the country were all very similar to what I had known in Jamaica. My first week in the office was spent solidifying my interview questions, familiarizing myself with the KMET and SFC staffs, and choosing research assistants (RA) which would be appropriate for this type of project. Within one week and one day, these tasks were accomplished, the RAs were trained in interviewing and qualitative research skills, and we had an interview appointment with our gate-keeper into the community of SFC participants.

My RAs would prove invaluable to me as they not only made respondents feel more at ease and gave them reassurance to speak openly, but they also worked as translators for both language and cultural nuances. Though I had apprehension about them conducting interviews due to their lack of experience, they were able to shape questions in a manner which was more accessible and better understood by the respondents when I hit a roadblock in how to express myself more clearly. Furthermore, they were able to convey the meanings behind small details of respondents' homes; for example, the fact that one SFC participant had peanut butter and facial cream in her home built of mud suggested

that her family had once had money and had lost it, presumably due to the death of the father. They were also able to highlight behaviors (especially those of the young women) which would be acceptable in American culture but were not in the Kenyan context. These women became my teachers, my informants, my company, and my friends. Due to what I was able to learn from them and the fact that I was able to teach them research methods they otherwise would not have learned, I sincerely hope other researchers know the importance of involving community members in the implementation of research projects.

Of the 38 interviews conducted, only the nine staff members' were conducted outside of one of three slum areas in which the SFC Project works. The areas were characterized by: a dense population; multiple animal species freely roaming through; children who were dirty, giggling, and happily playing with their friends; houses made of mud and cow dung in multiple stages of completion; women selling produce and cooked foods by the side of the road; the road being more a earthen footpath with large divots; streams of water filled with sewage, soap, and scum; red clay which produced a dust that stuck in your nose and made a foot-washing imperative as soon as you reached home; tin roofs with satellite dishes atop them; and people – everywhere there were people greeting the nice young lady and her *Mzungu* (white lady) friend. Getting to know these areas was the defining difference between visiting Kenya and living there.

Working with the KMET staff was rewarding in that they were supportive and appreciative of my evaluation of the SFC Project; furthermore, they were willing to grant me the autonomy needed to remain objective. This was shown through their willingness to explain the culture of Kenya and the various ways in which culture hinders access to reproductive health knowledge with their focal point being the need for the SFC Project. However, none of the staff members asked who I was interviewing nor did they ask what was specifically being said in the interviews. Each staff member's insight was an essential part of my participant-observation for both Kenya and the SFC Project. During the interview sessions with the nine staff members, I felt as though each of them wanted the SFC Project to succeed and thus most were willing to be honest and frank with their answers about the gaps in the project.

However, working for KMET also proved one of the most challenging aspects of this research, which was a sentiment shared by the other American student volunteers working with the organization throughout the research time. Though KMET was informed prior to my arrival that a host family was essential to the participant-observation facet of the research, they made little attempt to find a host family for me. Prior to my arrival and at a point when there was a need for me to move out of my first host family's house, KMET staff tried to steer me toward living in the student housing they have near to the office. This living situation lowered the amount of community interaction, did not offer a typical Kenyan family living situation, and was three times more expensive than living with a host family.

Due to a personal conflict that emerged as a result of my decision to take a trip during my time there, it is recommended to future volunteers with KMET to decide travel plans

before arriving in Kenya and to state them as soon as the plans are clear. The conflict was compounded by my request for information which KMET staff felt was outside of my needs in order to fulfill my evaluation. Unfortunately, there was tension due to each of us crossing symbolic boundaries; though these missteps were addressed at the end of my research time with KMET, it feels as though there was damage done to the relationship. In this way, I feel as though three months may not have been enough time to fully understand the cultural differences if only isolated to the Kenyan work environment. This is not to say that I left Kenya or KMET on bad terms; I simply feel as though there exist nuances I did not have time to master.

My host family stay was worked out by using my network and relying on the friend who had informed me about KMET due to her time working with them. She was able to find a host family who could take me in on the day of my arrival, easing my anxiety of coming to a new place and giving me immediate access to a warm and welcoming environment. Through the different members of this family, I was able to learn a vast amount about Kenya living and about the town I was living in. I was able to learn to cook Kenyan food in the manner most common to Kenya by sitting in the kitchen and talking with my “mom” about her role of a married mother who works to sustain her family. My “father” taught me about Kenyan politics, the history of tribalism, and the characteristics of the tribes of Kenya. My “sister” was able to share the life of my counterpart in the Kenyan setting: a 30-year-old, unmarried woman who is working on a degree at the University. My two-year-old “nephew” was able to teach me beginner Swahili as only a two-year-old can: through the game of “point and name”. My “brother” took me through Kisumu and explained how a young, unmarried male raised by a strong woman - but with a strong father present – approaches relationships. Unfortunately, he also taught me the consequences of the high unemployment rate among young adults when he stole from me. Though this was a negative aspect of my time with this family and, ultimately, resulted in my leaving this family for another one, it was a positive learning experience in hindsight.

My second host family granted me the opportunity to see a different side of Kenya through both the people I lived with and the surrounding area I moved to. My shift in location took me out of an area which was considered a slum by some into an area of town with large houses and families who own cars. My time with this family forced me to see a prejudice I had held since my time as a Peace Corps Volunteer toward people with an economical advantage in predominantly economically disadvantaged areas. As these types of prejudices can impede on objective anthropological study, the necessity to recognize and combat them is imperative. Through the donations my new “father” made, the rural area in which he grew up now has a school running from pre-school to eighth grade, an opportunity which did not exist until he was able to make money and put it to good use.

Throughout my tenure as a Masters’ degree student, I have combined culture and public health through classes, papers, and my way of viewing the world. This experience has only solidified this dual paradigm as the reproductive health problems Kenyans are facing do not start or stop solely with education nor is this the only public health issue which

they face as a nation. I chose this project specifically because of the nature of KMET and my desire to work at an international level teaching sexual education and supporting outreach techniques at the ground level in order to dampen the affects of poverty. I am encouraged by the enthusiasm everyone I interviewed and worked with has to see this project excel.

While I believed that finishing my time in Kenya would begin the easy part of the practicum process, this has proven to be the hardest part. Because the amount of information that I not only had to analyze but also internalize and process has been so emotionally charged, it proved to be a barrier in my ability to tackle the task at-hand. I realize, though, that this emotional charge is something I cherish in order for me to always remember who it is I am working for and how it is that I can be thankful for the privileges I enjoy in life... including the ability to continue this type of work.

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Appendix A

Interview Questions for SFC Project Participants

1. What is your preferred nickname and your age?
2. How did you hear about the Project and what made you want to participate in the SFC Project?
3. Tell me about what have you learned through the SFC Project?
4. What changes have occurred in your life this past year?
5. What vocational training did you receive through the SFC Project?
6. How are you using that vocational training?
7. Where does the money you need to pay for food and rent and clothes come from now? How does each bill get paid for?
8. Is this easier or harder than being sexual with men for money?
9. How do you choose your sexual partners now, if you have any?
10. Is this different from how you would choose partners in the past? How?
11. Do you feel more comfortable telling your partner(s) to use condoms? Why or why not?
12. What do you do now if your partner does not want to wear a condom?
13. What are some of the safe sex practices you learned about in the SFC Project? Do you use the practices you learned? How (or why not)?
14. Do you go to the clinic for check-ups and to get birth control? If so, what services do you use? If not, why not?
15. Do you think your friends are going to the clinic for check-ups, testing, or birth control? Why or why not?
16. Do you take your friends to the clinic if they ask you questions or ask you to go with them? Why or why not?
17. Are you educating your community about reproductive health? If so, how and how often? If not, why not?
18. Have people you've taught in the community asked you questions about getting tested or getting birth control? Did they go to the clinic or say that that they would after you gave them information (that you know of)?
19. Are there other things that you learned in the SFC Project you have used to help your community? If so, what are they? (If need prompting, empowerment, gender-based violence, some of the goals of SFC)
20. What are the problems that young people have that keep them from having safe sex?
21. Are you encouraging other young women to get involved with the SFC Project? Why or why not? Are there any gaps or problems you saw in the SFC Project? If yes, what were they?
22. What are the biggest challenges that young people face today?
23. In your opinion, what will motivate other young women to participate in the SFC Project?

Appendix B

Interview Questions for Parent/Guardian of SFC Project Participants

1. What is your preferred nickname?
2. What do you know about the SFC project?
3. Did you encourage your daughter to become involved with the SFC Project? If so, why? If not, why not?
4. What are the differences you have noticed in your daughter since she started with the SFC Project?
5. What information has she been able to share with you since getting involved with the SFC Project?
6. What are your thoughts about the SFC Project? What are the good parts? What are the negative parts?
7. What do you understand about “safe sex”?
8. What do you tell your friends about your daughter teaching people about safe sex?
9. What are the biggest challenges that young people face today?
10. What do you see as (your daughter’s) biggest challenge to living the lessons she has learned through the SFC Project?
11. What are the problems that young people face regarding their reproductive health?
12. Are you encouraging other young women to get involved with the SFC Project? Why or why not?

Appendix C

Focus Group Questions

1. What are the biggest challenges that young people face today?
2. What is the biggest challenge for young people to get sexual health information?
3. What do you all know about the SFC project?
4. Have you seen changes in the young women who have been a part of the SFC Project? If so, what are they? What is still needed?
5. Have you have seen changes in the young people in your community since the SFC Project began? If so, what are they? What is still needed?
6. Why do women turn to commercial sex work here?
7. Have the participants of the SFC Project changed the level of knowledge of sexual health in your community? If so, are they making it better or worse?
8. Have the young women in the SFC Project have been able to teach the community about the rights of women? If so, how?
9. Are young people using the clinic for sexually transmitted disease testing and birth control? Have the participants in the SFC Project had any influence (either good or bad) in the use of the clinic?
10. Are the young people in the community talking about safe sex?
11. How do you feel the SFC Project could help more people?
12. What would the ideal organization do to improve the situation for young women?

Appendix D

Staff Questions

1. What is your preferred nickname?
2. What do you understand KMET's goals of the SFC Project to be?
3. Do you feel as though the goals of KMET were met during the first year?
4. What were your personal goals in becoming involved with the SFC Project?
5. Do you feel as though your personal goals were met during the first year?
6. Have you seen changes take place in the participants through their year being involved with the SFC Project? (Not necessarily each individual girl, but overall.)
If yes, how have they changed?
7. Are there strengths in the SFC Project? If so, what are they?
8. Are there weaknesses in the SFC Project? If so, what are they?
9. What are the biggest challenges that young people face today?
10. How do you feel the SFC Project could help more young people?
11. Do you feel as though the SFC Project has contributed to KMET's overall goal?
How or why not?
12. What would the ideal organization do to improve the situation for young women?

Appendix E

SFC Project Questionnaire

Questionnaire # _____






Taken at (circle one): Market Private Home School Location: _____

My name is _____ (first names only and don't ask them for their name). I am a volunteer at the Kisumu Medical and Educational Trust (KMET). I will ask you some questions about your thoughts on the Sisterhood for Change Project, who are the women you saw do skits and songs and talk about reproductive health last year. We want you to only think about the women from last year, not any you might have seen this year. The information collected from this survey will be used in making the SFC Project better. Your responses are confidential and I will not ask you any personal information such as your name, your specific area, or anything. Your opinions will be given only to KMET and will be treated in a way that no one can be individually identified.






Age: _____

Sex (circle one): Male Female






I enjoyed their performance. (Don't ask at private homes)

 strongly agree  agree  no opinion  disagree  strongly disagree






I learned something new.

 strongly agree  agree  no opinion  disagree  strongly disagree






I felt they were knowledgeable about reproductive health.

 strongly agree  agree  no opinion  disagree  strongly disagree






I felt they were easy to talk to.

 strongly agree  agree  no opinion  disagree  strongly disagree

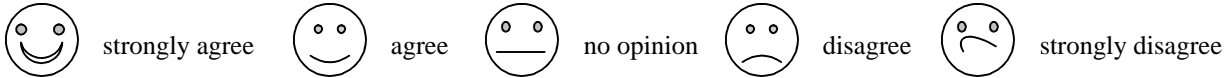
They explain issues about reproductive health clearly.

 strongly agree  agree  no opinion  disagree  strongly disagree

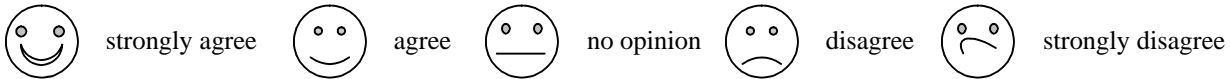
I trust what they told me to be true.

 strongly agree  agree  no opinion  disagree  strongly disagree

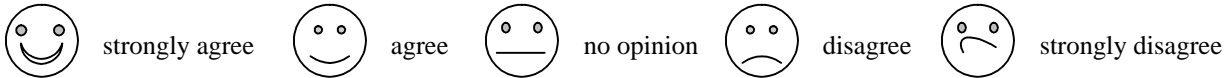
I feel it is important that young people receive reproductive health education.



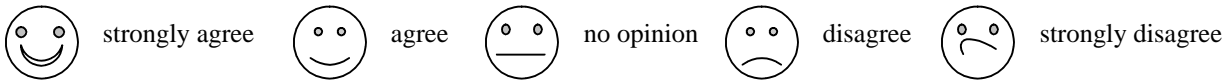
I like groups that teach reproductive health education through skits and songs.



Teenagers and adults should know about condoms to protect themselves from HIV/AIDS.



Teenagers and adults should know about contraceptives (family planning) to protect themselves from unwanted pregnancies.



Some challenges faced by youth in Kenya today are (circle as many as apply):

- a) There are not enough jobs
- b) Dropping out of school
- c) Pressure for sex
- d) Alcohol abuse
- e) Substance abuse(drugs other than alcohol)
- f) Having no “voice”
 - a. Voice in the family
 - b. Voice in the school system
 - c. Voice in the community
 - d. Voice in politics
- g) Can’t talk with their parents about what they want
- h) Violence in the home
- i) Violence in the community
- j) Other: _____

What are your suggestions to face these challenges? (multiple answers allowed)

Appendix F

(this is an Excel spreadsheet which I can't get to transfer over well – please see other attachment)