

PERFORMANCE FOR ETHNOGRAPHY, DIALOGUE, AND INTERVENTION: USING
ACTIVATING THEATRE TO EXPLORE THE REPRODUCTIVE HEALTH ISSUES
FACING KENYAN ADOLESCENT GIRLS

by

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This thesis explores the utility of using performance, specifically activating theatre, both as a reproductive health intervention and as an ethnographic tool for exploring the reproductive health worldview of 17 adolescent girls, all peer counselors at a state-run all-girl boarding school in Rift Valley Province, Kenya. The study is grounded theoretically in the traditions of action research, critical ethnography, performance theory, and dialogic expression. I facilitated a week-long activating theatre workshop that included warm-ups, bridge work, improvisation, and activating material. The workshop, which was video recorded, was analyzed alongside a reflective journal and audio recorded semi-structured interviews and a post-workshop focus group for core themes and categories using grounded theory. My analysis shows that the use of activating theatre is an effective tool for understanding the reproductive health perceptions of adolescent girls, for encouraging them to openly discuss their reproductive health issues, for increasing their sense of agency, for improving their decision-making skills, and for helping them critically assess the social and historical roots of reproductive health issues. The project web site which includes workshop video clips is at <http://purityjerop.wix.com/kapkenda-performance>.

Keywords: activating theatre, action research, adolescent reproductive health in the developing world, critical ethnography, dialogic theory, Michael Rohd, reproductive health interventions, performance theory, communicative openness and sexuality

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Master of Arts in Communication

by

Purity J. Kimaiyo

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CHAPTER 1

INTRODUCTION: A PERFORMANCE-BASED APPROACH TO THE REPRODUCTIVE CRISIS FACING ADOLESCENT KENYAN GIRLS

The reproductive health challenges facing adolescents, particularly adolescent girls, in the developing world are enormous. Growing up in Kenya I witnessed firsthand friends and family members whose lives had been irrevocably changed because of one reproductive health crisis or another. Early sexual debut, unplanned pregnancy, early marriage, dangerous illegal abortion, risky childbirth, transmittable sexual disease, teen motherhood, female genital mutilation, and more, are all problems associated with adolescent reproductive health. For my part I was fortunate that my mother, a nurse with experience educating teens on reproductive health, was knowledgeable and had no reservations about discussing sexuality. Across the developing world social and cultural forces related to reproductive health militate against the life chances of adolescent girls. They have poor access to basic reproductive health services and contraceptives (Gennari, 2013; “WHO, Reproductive health,” n.d.; WHO, 2011, 2012). They are subjected to conservative social norms that prevent an open and realistic approach to human sexuality. They are so poor they turn to transactional sex, often with older men, to meet basic needs or for school funds (Jones & Norton, 2007). They are confronted with profoundly unequal gender relations they are in no position to challenge (Moore, Awusabo-Asare, Madise, John-Langba, & Kumi-Kyereme, 2007). They face powerful cultural traditions that maintain practices such as female genital mutilation (UNFPA & UNICEF, 2013). On top of that, a regime of silence too often surrounds any healthy discussion of sexuality and reproductive health issues (Anasi & Nwalo,

2012; Bammeke, 2011; Isikwenu, Omokiti, & Nurudeen, 2011). These issues are especially troubling in sub-Saharan Africa, including my home country, Kenya.

Global concern over reproductive health, especially the reproductive health of youth in the developing countries, was addressed at the 1994 Cairo Plan of Action where the 4th International Conference on Population and Development called for aggressive and holistic action on sexual and reproductive health issues, including family planning and maternal health, reproductive health and rights, and women's empowerment and gender equality (*Report of the International Conference on Population and Development*, 1994; WHO, 2008). These concerns were followed up with the "Barcelona Youth Force" at the 2001 International AIDS Conference in Spain, which foregrounded the HIV/AIDS crisis facing youth (Lk, 2002).

The Millennium Development Goals (MDG) outlined in 2010 by the United Nations pay special attention to issues related to reproductive health. Goal 3 calls for the promotion of gender equality and empowering women. Goal 4 calls for a reduction in child mortality. Goal 5 calls for improved maternal health. And goal 6 calls for the reduction of HIV/AIDS. Importantly, success on these goals would have, one could argue, a positive impact on other MDGs, such as the reduction of extreme poverty and hunger (Goal 1) and achieving universal primary education (Goal 2) (United Nations, 2010).

Over the past few decades, largely in response to the spread of HIV/AIDS, there has been a substantial effort across the developing world to develop reproductive health education programs and interventions. Thankfully, there is evidence that these education programs and interventions have had some success improving knowledge and changing intended behavior (Hindin & Fatusi, 2009; Kalembo, Zgambo, & Yukai, 2013a; Speizer, Magnani, & Colvin, 2003; Speizer, Tamashe, & Tegang, 2001). For example, adolescent girls in Kenya generally now

know more about how HIV is transmitted than in the past. They now *intend* to delay sexual debut and *intend* to use contraception. But education programs have not been especially effective in changing *behavioral* outcomes, such as raising the age of sexual debut, increasing condom use, improving efficacy in sexual negotiation, or reducing number of sexual partners (Sunmola et al., 2004; Hindin & Fatusi, 2009; Jones & Norton, 2007; Kinaro, 2013; Njogu & Martin, 2006). This issue gets to the core of my proposed research: “Information is not enough. It is useless without the power to act” (Rohd, 1998, p. xvii).

Repeated policy positions from Kenyan ministries have recognized this issue and, if nothing else, at least pay lip service to the empowerment of adolescent girls. The *Reproductive Health Communication Strategy Implementation Guide* sets as a target the “increased ability to negotiate sexual behavior” (Ministry of Public Health and Sanitation, 2010, p. 17). The Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015 seeks an outcome of “Empowered young people able to develop, adopt and sustain healthy attitudes and behaviors towards reproductive health and development” (Ministry of Education & Ministry of Planning and National Development, 2005, p. x).

While adolescent girls in the developing world have little power, or agency as it is called in the social science literature, when confronted with larger social and cultural forces, they face another, more immediate personal challenge. Acting responsibly is no simple task for any adolescent. In a fascinating National Public Radio discussion, Daniel Siegal, an interpersonal neurobiologist and the author of *Brainstorm: The Power and Purpose of the Teenage Brain* (2013), argues that the adolescent brain is actively remodeling itself in its transition from dependence to independence. But to break free and navigate the world on one’s own means taking risks. This leads to what Siegal calls hyper-rational thinking, thinking that de-emphasizes

the consequences of risky behavior. There is plenty of action, but too often it is risky action. The brain's reward system is altering as dopamine levels drop.

... and this leads to boredom, restlessness, 'like, I need to do something. I need to do something.' Rewarding experiences are novel – risky ones – for the adolescent. Trying out new things. Pushing the limits. Going into the unfamiliar. The upside is that this is how the adolescent moves on in life, leaves the protective sphere. Social engagements change: They try to connect with their peers more than their parents. The downside is the risky behaviors" (Siegal, 2014).

Valerie Reyna and Frank Farley examine this adolescent risk-taking in detail and conclude that adolescents actually are quite competent at estimating risks, but that "perceived benefits may drive adolescents' reactive behaviors and behavioral intentions, thereby accounting for risk-taking behaviors" (Reyna & Farley, 2006, p. 29).

So how can we support adolescents and help them minimize risk at a time in their lives when they are first experiencing sexual feelings that can make them feel out of control? Siegal, echoing the quote above from Rohd, suggests that just providing information about risk and lecturing adolescents about what not to do is not the answer. We must help them "... get in touch with what's positive in their own values. We must get beneath the circuitry of hyper-rational thinking to what your heart is telling you [and] develop the capacity to cultivate an internal compass" (Siegal, 2014).

My research was conducted at Kapkenda Girls High School, an all-girls public boarding school I attended from 2001 to 2005. I worked with a group of 17 peer counselors, aged 14-18, who had been elected by students as their representatives. Thirteen of these peer counselors participated in a workshop followed by a focus group and four non-workshop participants were interviewed for about 30-40 minutes each. From my experience as a peer counselor myself, these are the student leaders that other students would confide in if they are having troubles with their studies or personal lives. Kapkenda is located in countryside about 50 miles from my

hometown of Eldoret in Kenya's Rift Valley Province. As an action research study, my project has the dual goals of intervention and research.

Project Goals

The first goal is one of intervention, to help the girls understand the gap discussed above between what they know and how they behave, with regard to reproductive health. This intervention side of the project links up with Paulo Freire's (Freire, 1974, 1997) "Pedagogy of the Oppressed" and its recent applications to health literacy (Estacio, 2013; Wallerstein & Bernstein, 1988). This intervention will use activating theatre in an effort to empower the girls, to improve their decision-making skills, to help them critically assess the social and historical roots of reproductive health issues, and to increase their sense of agency in relation to disempowering social and cultural forces.

The second goal is to provide an ethnographic understanding of the reproductive health challenges Kenyan adolescent girls face. I worked as a participant-observer at Kapkenda Girls High School facilitating five two-hour-long workshops inspired by the work of Michael Rohd (1998). The workshop included warm-up activities (energy and focus work), bridge work (a sort of warm up to more challenging improvisational activities), improvisation, and activating material. The entire workshop was video recorded and this material has been analyzed alongside semi-structured 30-40 minute interviews, a post-intervention focus group, and a reflective journal. Video clips of the workshop can be seen at the project web site:

purityjerop.wix.com/kapkenda-performance. My method analysis of this data is inspired by grounded theory, a method of data analysis designed to help the researcher systematically and transparently identify categories and themes (Birks & Mills, 2010; Corbin & Strauss, 2007; Glaser, 1992). The goal of ethnographic description in this study is to provide reproductive

health educators and other intervention designers a window into the way Kenyan adolescent girls are thinking and perceiving reproductive health issues.

The drama-based intervention component is grounded in the traditions of action research (Brydon-Miller, Greenwood, & Maguire, 2003; Stringer, 1999), critical ethnography (Conquergood, 1991, 1992; Madison, 2012), performance theory (Carlson, 2004; Schechner & Brady, 2013; Turner, 1988), and Mikhail Bakhtin's theory of dialogics (Bachtin & Holquist, 2011; Morson & Emerson, 1990). Reason and Bradbury (2001) define action research as:

a participatory, democratic process concerned with developing practical knowing in pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities (p. 1).

The inspiration behind action research is the idea that theory should not just inform practice, as more traditional researchers would have it, but that theory should be generated *through* practice. Beyond that there is the idea, first inspired by Kurt Lewin (Lewin, 1946; Lewin & Cartwright, 1964), that research should be undertaken collaboratively, alongside stakeholders with a consciousness raising and liberating intent. These concerns overlap with the method called critical ethnography, which Soyini Madison (2012) defines as “a meeting of multiple sides in an encounter with and among others, one in which there is negotiation and dialogue toward substantial and viable meanings that make a difference in others’ worlds (p. 10).

A Performance Approach

This project is also grounded in performance theory. Unlike traditional sociological theory, performance theorists, with their roots in speech communication, symbolic and interpretative anthropology, place performative cultural processes in the foreground and take them to be as intelligible and real as any underlying explanatory principles (Turner, 1982; Turner, 1988).

Performance theory stresses the dynamic connection between performative behaviors and their specific social and historical circumstances. Performance scholars argue that understanding a social group requires that one understand the meaning of that social group's performances and the social work these performances accomplish (Carlson, 2004; Schechner & Brady, 2013).

Schechner and Brady (2013) argue that performances are, at one and the same time, a reflection of social life as it has already been constituted (Schechner calls these performances "restorations") *and* creative actions that provide opportunities to reflect upon and creatively respond to the way social life has already been constituted. For instance, a group of Kenyan adolescent girls having a lively discussion – a performance – about whether or not they should, or whether or not they will, “do it” with their boyfriends out of love, or with older men in exchange for school fees, are both restoring society and culture as it exists at a specific historical moment (with its economic and gender inequality, tribal and religious values, etc.) *and* they are thinking through, and creatively responding to, this set of circumstances.

The Russian philosopher Mikhail Bakhtin arrives at a similar destination working from within the rhetorical tradition. Social life – with its socio-structural hierarchies, its norms and values – is built up over time from our small everyday interactions, such as our conversations and our informal and formal meetings. While our everyday interactions embody and reflect larger social and historical forces, the social order is never closed and static. It remains open and free. It is constantly redefined. Stephen Littlejohn and Karen Foss (2011) summarize Bakhtin's point this way:

By this he means that the possibilities in any dialogic situation are enormous and unending. Each participant in dialogue is open to the possibilities that may be suggested by the other; each is enriched by the dialogue; and each is a co-creator of the future that is being created in the interaction – a future that is constantly changing as the interaction changes (p. 240).

In other words, while performances reveal social structures and social norms, they are also open, negotiable, and dialogic opportunities to reflect on, explore, and respond to one's lived world. Michael Rohd (1998) provides an excellent set of activating tools for creating performances that explore reproductive health issues. Rohd's approach is described in his book *Theatre for Community, Conflict & Dialogue – The Hope is Vital Training Manual*. Among others, including Viola Spolin's (Spolin, 1986; Spolin, Sills, & Sills, 1999) work in improvisational theatre and by Robert Alexander's (1983) work with the Living Stage Theatre, Rohd's work is inspired by the Brazilian Augusto Boal's "Theatre of the Oppressed" (Boal, 1979, 2002; Schaedler, 2010). The driving philosophy behind these artists/educators is that individuals can rehearse taking action, that the act of creating is both an act of self-affirmation and social change, and that you can use drama techniques and exercises to open up liberating possibilities.

Boal created the "Theatre of the Oppressed" in the 1950s to help address Brazil's social and political problems. He introduced techniques like Image Theatre, a technique in which participants sculpt each other's faces and bodies. These frozen tableaux can represent opinions, feelings, moments of oppression, or even moments of liberation. This is a technique for "making thought visible" (Boal, 1979, p. 137). It functions as a powerful tool to create dialogue and critical reflection. Another technique, Forum Theatre, is a problem-solving technique that dramatizes an unsatisfactory or oppressive past, present or future situation. In Forum Theatre a dramatic situation can be frozen by an outsider to the scene (Boal called them *spec-actors*) who "changes the dramatic action, tries out solutions, discusses plans for change – in short trains him[her]self for real action" (Boal & Epstein, 1990, p. 282). Other Boal techniques include Cops in the Head, a technique for exploring internal voices and oppressions, and Rainbow of Desire, a technique for exploring one's fears and desires.

Rohd's (1998) "Hope is Vital" project picks up where Boal leaves off. He aims to create safe spaces for promoting dialogue and exploring choices and their consequences, to provide opportunities to enhance decision-making skills and practice for real life by participating in fictional worlds, and to provide opportunities for youth to "critically and viscerally analyze life situations" and become "the protagonist in one's own life" (p. xviii). In short, Rohd aims to help adolescents explore the interactions that shape their lives. He wraps up his preface with this citation from Boal's discussion of improvisational theatre: "It is a lab for problem solving, for seeking options, and for practicing solutions" (p. xix).

Rohd's activating theatre proceeds in stages. He begins with simple warm-ups that build trust, energy and focus. He then moves on to bridge work that starts theatricalizing the space by introducing characters and their relationships. It is here that core issues of concern to the adolescent girls can be identified and their perceptions explored. Bridge work, he writes, "quietly begins to address subjects of interest and concern to the participants" (p. 50). He then moves on to improv where the adolescents begin creating pretend encounters and scenes together. In the final stage, activating scenes – or compressed scenarios – are developed to relate directly to the lives of the adolescents. These scenarios are not message scenes. They do not instruct what to do. Instead, the question – what can be done? – is explored when a facilitator freezes scenes, turns to the girls and prompts them to step up and explore alternatives to the ongoing action. These scenes are realistic because they "create a need to struggle with possibilities" (p. 102).

In other words, by mobilizing a group "to explore a social problem compressed into a specific, fictional interaction that is culled from the collective consciousness of the participants" (Rohd, 1998, p. 71), activating theatre may help adolescent girls, as Seigal (2014) put it, "cultivate an internal compass."

The second component of this study, that of providing reproductive health educators and intervention designers a window into the perceptions and worldview of Kenyan adolescent girls, is inspired by Dwight Conquergood's position that the ethnographer's search for understanding "begins with cultural performance" (Conquergood, 1992b, p. 259). Conquergood cites the anthropologist Johannes Fabian to make his point: "No one, not even the native, has information that can simply be called up and expressed in discursive statements. This sort of knowledge can be ... made present ... only through action, enactment, or performance" (Fabian, 2002, p. 6). Consequently, the ethnographer is "but a provider of occasions" (Conquergood, 1992b, p. 85) who "does not call the tune but plays along" (p. 19).

By documenting, analyzing and interpreting the girls' activating theatre performances, I hope to provide what Clifford Geertz (1973) called a "thick description" of Kenyan adolescent girls' thinking and understanding of reproductive health issues, including sexual debut, contraceptive use, abortion, early parenthood, and the risks of sexually transmitted disease. For instance: How do adolescent girls fictionalize a scene that explores male pressure to have sex without a condom? How do they fictionalize a discussion about sexual risks with their friends or their parents? How do they represent a discussion of "do's" and "don'ts" with their elders? What exactly is said when two adolescent girls fictionalize a discussion about their relationship with boys? How is it said? How are their bodies used to portray the scene? Likewise what happens in a fictionalized scenario in which one adolescent brags to another that she is sexually active? Or in a fictionalized scene in which an adolescent despairs that she is pregnant and seeking an abortion?

Alongside performance theorists, I hope that I have been able to take us deeper than what can be learned from the survey instruments so often relied upon in the field of health

communication. I hope to have achieved emic understandings, ones that “describe thoughts and actions primarily in terms of the actors’ self-understanding – terms that are often culturally and historically bound” (Morris, Leung, Ames, & Lickel, 1999, p. 782). This effort draws on Kenneth Pike’s distinction between etic and emic understandings (Harris, 1976). Pike considers etic understandings “outsider observations,” observations that straightforwardly describe behaviors. Emic researchers, on the other hand “assume that a culture is best understood as an interconnected whole or system, whereas etic researchers are more likely to isolate particular components of a culture and state hypotheses about their distinct antecedents and consequences” (p. 782). This type of description of adolescent girls’ world view, I argue, can augment the design of future educational programs and reproductive health interventions.

Literature Review

The United Nations and the World Health Organization have amassed startling facts about the state of adolescent reproductive health in the developing world. About 11% of all births worldwide are to adolescent girls. About 95% of all adolescent births occur in developing countries, where an estimated 16 million 15-19 year olds give birth annually. Up to two million of these adolescent girls will be younger than 15 years old. Adolescent pregnancy in the developing world leads to dangerous illegal abortions, risky deliveries, infant and maternal mortality, and a host of other negative socio-economic outcomes. Each day in developing countries about 20,000 girls under 18 years of age give birth. Adolescent birth rates are especially high for girls from poor families living in rural areas and girls with little or no education. In 2010 15-24 year olds accounted for 42% of new HIV infections worldwide. Young women have HIV infection rates double that of young men. (Gennari, 2013; United Nations, 2010; WHO, 2012).

Sub-Saharan Africa and Kenya. These issues are especially acute in sub-Saharan Africa where about 50% of babies born to all adolescents worldwide are born (WHO, 2008). Up to four million young people are living with HIV in sub-Saharan Africa, where about 75% of all young people in the world living with HIV reside. Young women in sub-Saharan Africa aged 15-24 account for 31% of new infections worldwide (Bearinger, Sieving, Ferguson, & Sharma, 2007; UNAIDS, 2013). Over 75% of all new HIV infections occur in sub-Saharan Africa among girls between the ages of 15-24 (Global Health Council, 2007).

Kenya has a population of just over 43 million. Kenya's population rate grows about 3% per annum. Its population is 78% rural and 60% of its households engage in farm work. It ranks 177th in per capita gross national income (out of 193 countries), and about 47% of all Kenyans live below the national poverty line. Forty percent of Kenyan's live on less than US \$2 per day. Kenya's poor are very poor; its rich are very comfortable. The poorest 20% of Kenyans capture less than 5% of the national wealth, while the richest top 20% of Kenyans capture 53% of the national wealth. Thirty percent of children under the age of five are categorized as stunted (low height-for-age), 6% as wasted (low weight-for-height), and 20% as underweight (low weight-for-age) (KNBS, 2010). Kenya's literacy rates – at 90% for males and 83% for females – are considerably higher than for sub-Saharan Africa generally. Primary school completion rates are high (80%) because primary school is free, but only 49% of adolescents attend secondary school where a school fee is required (KNBS, 2010; World Bank, 2010).

Kenya faces many of same “pyramid shaped” population pressures faced by much of the developing world. That is to say, there are a lot of children and adolescents in Kenya. About 42% of Kenya's population is under 15 years old. About 63% of the country's population is below 25 years old, and 32% of its population is between the ages of 10-24. About 41% of all

reproductive-aged women (15-49) are below 25 years old (Kenya National Bureau of Statistics & ICF Marco, 2009; Kenya National Bureau of Statistics (KNBS), 2010).

While age of sexual debut is increasing in Kenya and across sub-Saharan Africa, Kenya's National AIDS Control Council provides these facts: 48% of women between the ages of 15-49 still reported that they were sexually active before they reached 18. The figure for men: 55%. One in nine women reported that they had sex before the age of 15; of these 22% reported that their first sexual intercourse was coerced. Women who reported that they had sexual debut before the age of 16 were twice as likely to be HIV positive. Adolescent girls aged 15-19 are four times as likely to be HIV positive as boys (2.7% vs. 0.7%) (National AIDS Control Council, 2012). Unwanted pregnancy, which often leads to illegal and unsafe abortion, is prevalent among Kenyan adolescents. An estimated 13,000 Kenyan adolescent girls drop out of school each year as a result of pregnancy. Of the estimated 320,000 abortions each year in Kenya, 48% occurred in young women aged 14-24 and 45% of these abortions were unsafe, a grave situation for adolescent girls because they often postpone their decision to abort (Kenya Human Rights Commission, 2010).

Research, Education and Interventions

Research has clearly identified the most important risk and protective factors for adolescent sexual and reproductive health in developing countries. Researchers (Mmari & Sabherwal, 2013) reviewing 244 published journal articles between 1990 and 2010, over half of which were focused on interventions in sub-Sahara, identified studies by these outcomes: sexual initiation, number of sexual partners, condom use, contraceptive use, pregnancy and early childbearing, HIV and STIs, and sexual coercion. They identified factors by ecological level,

such as individual, peer/partner, family, school, and community. The authors identify nine cross-cutting risk and protective factors related to more than one outcome.

Key risk factors for sex and reproductive health outcomes included: married, older, employed, alcohol use, having forced sex with first sexual partner, urban residence, and orphan status. Others included: leaving school early, attending discos, viewing X-rated material, less family stability, sexually active friends, lack of peer and family support for condom use, cost or availability barriers for condoms, partner with lower education, early sexual debut, low future aspirations, smoking, a young sister with a child or pregnant friend. Key protective factors included: educational years and attainment, ability to discuss sex and reproductive issues with one's current or last partner, positive attitudes about using condoms, fear of acquiring HIV and STIs, permanent partner, knowledge of contraception, and desire for fewer children.

Intervention evaluations typically assess the following outcomes for reproductive health education interventions: knowledge of HIV transmission, perceived risks of contracting HIV/AIDS, self-efficacy to negotiate condom use, abstinence from sexual relations, reduction in high-risk behavior (such as unprotected sex with multiple partners), early marriage, condom and contraceptive use, and testing for sexually transmitted infections. It is encouraging to know that there is considerable evidence that adolescent reproductive health education and interventions in developing countries, including sub-Saharan Africa and Kenya, that are based in schools, communities, clinics and workplaces are having some impact on adolescent reproductive health, especially on reproductive health *information* and *intention* outcomes (Agbemenu & Schlenk, 2011; Bearinger et al., 2007; Hindin & Fatusi, 2009; Isikwenu et al., 2011; Kalembo, Zgambo, & Yukai, 2013b; Speizer et al., 2003).

Less optimistic is Bearinger et al.'s (2007) conclusion that effective sex education programs typically reduce adolescent risk-taking behavior by just a third or less. This is a common theme in the literature (Adegbeniga M Sunmola, 2004; Jones & Norton, 2007; Kinaro, 2013; Kwigizile et al., 2013; Njogu & Martin, 2006). After reviewing 41 school, media, community, work and clinic-based interventions in developing countries, Bearinger et al. (2007) conclude:

Less positive is that behavioral impact was not found in a sizeable proportion of the interventions reviewed, interventions that target multiple behavioral outcomes more often than not failed to achieve such impact ... and the evidence supporting the efficacy of youth-friendly health services and youth center interventions, which are currently quite popular in developing country settings, is thin to non-existent. (p. 345)

It would appear evident that the information alone approach to the adolescent reproductive health crisis needs to be reevaluated and augmented with an active learning approach that more actively engages adolescents in exploring reproductive health issues.

Kirby, Laris, & Rolleri (2007) offer a useful summary of 17 characteristics of effective curriculum-based reproductive health education programs. These effective characteristics are organized into three categories: the process of developing the curriculum, the contents of the curriculum itself, and the implementation of the curriculum. While there is no mention of drama or activating theatre approaches, successful activities and teaching methods are described as ones that "create a safe social environment for youth," ones that include "multiple activities," ones that employed "methods that actively involved the participants, that helped participants personalize the information," and ones that employed "multiple activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age, and sexual experience" (p. 213). The activating theatre proposed here may serve as an important step toward bridging the gap between information/intention and behavior.

Drama-based Interventions

There are few drama-based adolescent reproductive health interventions in the literature, especially in sub-Saharan Africa. This is dismaying because drama-based approaches can be meaningful communication resources in resource-poor settings where they can provide unique opportunities for involving community members, especially if they integrate local oral and performance traditions (Mitchell, Nakamanya, Kamali, & Whitworth, 2001). Drama has proven to be an effective tool to change knowledge about and attitudes toward HIV, as well as getting youth involved as change agents (Harvey, Stuart, & Swan, 2000; Kamo, Carlson, Brennan, & Earls, 2008; Mabala & Allen, 2002).

Dwight Conquergood (1988) describes the effectiveness of a drama production, the Rabies Parade done at a Hmong refugee camp in Thailand to address sanitation problems. “Dogs came pouring in – on rope leashes, in two-wheel pushcarts, and carried in their owners’ arms. We could not vaccinate them fast enough” (p. 184) writes Conquergood about the startling outcome after performances by Hmong youth.

One study (Middelkoop, Myer, Smit, & Wood, 2006) provides a typical example of a drama-based intervention. The goal of this intervention was to promote voluntary counseling and HIV testing, as well as to address popular misconceptions about HIV/AIDS. This 2003 intervention was conducted in a South African township about five miles outside Cape Town. The intervention used *intsomi*, a Xhosa storytelling tradition that uses mythical characters to pass down traditional knowledge and values. Topics for scenes were identified through consultations with community members. For a month, youth received acting lessons from professionals, plus a reproductive health information session on HIV/AIDS topics including testing, HIV transmission, and treatment and prevention methods. Ten sketches were developed by a diverse

team that included educators, health professionals, and a dramatist. Eighty performances were given over the year to audiences that varied from 20-300 at a variety of sites including bus stops, churches, shops, and clinics. Voluntary counseling and HIV testing self-referrals jumped 172% in the small community, far outstripping any changes in control communities. The authors write that drama provides “simple, unambiguous messages [that] may be the most appropriate way to address misconceptions ... [and that] can be easily adapted to a variety of settings (p. 526). In addition to increased counseling and HIV testing self-referrals, Rumsey et al. (2004) found improved knowledge levels in a Malawi intervention that employed youth in drama-based interventions.

Another drama-based intervention, the Young Citizens Program, in Moshi, an urban municipality in Tanzania, described itself as based on theories of human capability, communicative action, and social learning. It aimed to deploy drama while at the same time promoting youth citizenship and health agency. The health promotion intervention describes itself as “a fully scripted yet highly participatory curriculum for young adolescents facilitated by young adults” (Kamo et al., 2008, p. 201). College and secondary school graduates facilitated the training of youth, aged 10-14. The program had four modules. Five sessions were used to form group identity and introduce concepts of deliberation and critical thinking. Four sessions were used to build techniques in “shared social action to build HIV/AIDS competence in their communities” (p. 204). Here the teens learned leadership skills alongside mapping, observation, and interview techniques. Five weeks were spent studying the biological, behavioral, and social aspects of HIV transmission. The microbiology of HIV transmission was taught “by personifying the roles of HIV and specialized cells of the immune system interacting within the human body” (p. 202). In the last module the 15 groups performed both “macroworld” and microbiology skits

to the community twice a week for 14 weeks. The macroworld skits were developed by the adolescents to present real-life scenarios of youth at risk and to encourage voluntary testing. The microbiology skits dramatized the scientific principles behind HIV transmission, explained testing and treatment, and engaged community members in dialogue and discussion. The researchers concluded that “young adolescents can effectively open public channels of communication with adults and increase their sensitivity toward the impact of the HIV/AIDS pandemic on children, particularly on issues of stigma and disclosure of HIV status” but that “witnessing the dramas did not change adults’ information or knowledge about certain aspects of HIV/AIDS” (p. 203). They attribute this to channel issues, especially the limited ability to project the performances to large crowds.

Limitations of Standardized Questionnaires

Surprisingly few studies were found that attempt to describe and understand adolescent concerns, attitudes and perceptions using methods apart from the standardized questionnaire. Standardized questionnaires (or standardized interviews) have certain strengths – many questions can be asked on a given topic and a large population can be sampled and quantitatively described – but they do have their weaknesses.

Surveys – especially surveys about sensitive issues such as sexuality (or bigotry and racism, for example) – are prone to participants lying (or what is technically called the social desirability bias). Adolescent males, for example, might tend to over-report, while adolescent females might tend to under-report, number of sexual partners. Wellings et al. (2006) write that this bias accounts for the “striking differences between men and women in sexual activity” (p. 1706). After reporting that young Tanzanian women systemically underreported birth control use, pregnancy and abortion rates in survey interviews, Bleek (1987) writes that “embarrassing

questions in a survey produce unreliable answers” (p. 319). This lying, the author maintains, is revealing and provides something to learn from because it works as a “code to preserve one’s own and other people’s self-respect” and offers “their only escape from embarrassment” (p. 319).

Baxter and Babbie (2004) proffer this list of concerns: Surveys can “only collect self-reports of recalled past action or of prospective or hypothetical action” (p. 199). Survey data are subject to artificiality, a “shortcoming that is especially salient in the realm of actions and behaviors” (p. 199). Surveys are inflexible and can’t be modified as new information comes in from field observations. Their findings “often represent the least common denominator in assessing people’s attitudes, orientations, circumstances, and experiences” (p. 199). Additionally, survey researchers are “bound to ask the same questions of all respondents and having to impute the same intent to all respondents giving a particular response” (p. 199). Perhaps the greatest weakness of survey-based information gathering mentioned by Baxter and Babbie is that surveys fail to comprehend the context of social life: “The survey researcher rarely develops the feel for the total life situation in which respondents are thinking and acting ...” (p. 199). Performance, I argue, can overcome the shortcomings of standardized questionnaires for information gathering.

Moving Beyond the Standardized Questionnaire. Surprisingly little research has been done that moves beyond standardized survey questionnaires to understand the thinking and perceptions of African adolescents on matters of reproductive health. (Undie, Crichton, & Zulu (2007) explored how 14-19 year old Malawian youth conceptualized sex and sexual relations by analyzing personal narratives collected in 11 focus groups that asked the adolescents to describe their behaviors, attitudes, and motivations to reduce unplanned pregnancies and avoid HIV/AIDS. The authors, drawing upon Lakoff and Johnson (1980), specifically argue that the

sex-related metaphors, or conceptualizations, that are revealed in adolescent speech can be used to inform sex education. For instance, the frequent metaphorical reference to women's genitalia as "doors," the authors say, conceptualizes women as "passive receivers in the sexual process, whose only role is to be entered into and exited from" (p. 227).

Crichton et al. (2012) examined the quality of mother-daughter communication in informal settlements in Nairobi in 14 focus groups with 12-17 year old girls, teachers, and mothers with teenage daughters. Few of the girls or mothers described frequent and effective communication with their mothers about sexual matters, though they did express the desire for better communication. For example, one mother said:

My daughter started and just came and told me that 'mum I want pads.' And I bought and gave her without telling her anything ... I told my sister to tell her how to put them on. We fear talking about sexuality with our children and feel it is shameful but it is a habit that should be stopped because ... they will grow up knowing the wrong kinds of things. (p.24)

The study provides numerous transcriptions of talk about communication taboos, embarrassment, and mothers' uncertainty when communicating about sexuality.

Surprisingly I found just one ethnography related to sexuality and reproductive health in Africa (Plummer, Wamoyi, Nyalali, & Mshana, 2008). Plummer and colleagues examined 15-27 year olds' attitudes and beliefs about abortion using male-female participant observation teams of east African graduate students and secondary school graduates. Participant observation was combined with focus groups to show that adolescent sexual activity, which can limit a young woman's ability to find a husband and can reduce the dowry given by the groom's family, is stigmatized and punished. As a consequence young women carefully conceal their sexual relationships and seek abortions if they become pregnant, despite the fact that they themselves view abortion as dangerous and unacceptable. The "wrongness" of abortion, however, has less to

do with the Western idea of “taking a life,” than with the idea that men and their clans are entitled to their potential offspring. The ethnography provides heartbreaking accounts of young schoolgirls attempting to abort using the detergent “Blue,” chloroquine, or other traditional approaches, and then, failing to abort subsequently dropping out of school.

Method

My research method was guided by the interpretive paradigm, an approach that typically turns to qualitative approaches for data collection. Its operating assumption is that humans are creative and purposive, that human action is meaning-making action. I did not enter the research field seeking causal explanations, nor did I begin with a hypothesis to confirm or disconfirm the relationship between specific variables. I did not work deductively, operating with a theory or a hypothesis to confirm or disconfirm. Instead I worked inductively moving from one specific qualitative observation to another to get a sense of the whole and to infer general patterns. Leslie Baxter and Earl Babbie (2004) put it like this: “...qualitative studies generally work with more general research questions than those found in quantitative studies, along the lines of ‘what is going on here?’” (p. 25). What I have aimed to accomplish in this project has been to embrace the subjective world of these adolescent girls. I have tried to see the world through their eyes and have attempted to provide what Clifford Geertz (1973) called a “thick description” of reproductive health issues they face, of the web of meanings surrounding reproductive health. While I collected qualitative data from semi-structured interviews, from the discussion following a reproductive health information session, from a focus group, and from a personal journal, the unique contribution of this study was to collect data from a performance, or activating theatre, workshop. The performance workshop with its actions and enactments, I argue, has unparalleled access to the girls’ subjective worlds, beyond what could be, as Fabian has put it “simply called

up and expressed in discursive statements (2006, p. 6). This data was systematically reviewed using methods inspired by grounded theory (Birks & Mills, 2010; Corbin & Strauss, 2007; Glaser, 1992), a coding and categorization approach that helps the researcher discover core issues, categories and themes.

Semi-structured Qualitative Interviews

I recruited four peer counselors who were unable to participate in the workshop for semi-structured interviews. The interviews functioned to establish a baseline about what and how adolescent girls are thinking about reproductive health issues. Because the interviews were conducted toward the end of the workshop, I was able to explore, and often confirm, issues that had come up during the workshop. While I prepared basic questions about sexuality and reproductive health, the semi-structured interview approach was especially useful because it allowed me to probe issues that had come up during the workshop, and it provided substantial freedom for me to adjust to the flow of the conversation and explore reproductive health issues of special interest to the girls. These interviews were audio recorded and systematically reviewed to discover core issues, categories and themes. (*Appendix C: Interview Protocol*)

Reproductive Health Information Session

Midway through the project we held a short information session on reproductive health. The information session provided basic statistical data about reproductive health and adolescents in the developing world and Kenya. The statistics were taken from the *World Health Organization* (2011), *Adolescent and Youth Sexual and Reproductive Health – Taking Stock in Kenya* (2011) and *Adolescent Reproductive and Development Policy – Plan of Action 2005-2015* (2005). In the information session simple facts were provided: that 13,000 Kenyan adolescent girls drop out of school each year as a result of pregnancy; 48% of Kenya's 320,000 abortions are had by young

women aged 14-24; and that 42% of 15-19 year-old Kenyan girls have had sexual intercourse. This was followed by an open conversation in which I explored their reaction to the information provided. The session was not designed to set an agenda or moralize with a list of do's and don'ts; it was designed to get some basic reproductive health facts and issues on the table and to get the girls' reactions and response to these facts. This open conversation was recorded and systematically reviewed to discover core issues, categories and themes.

Activating Theatre

The activating theatre I employed followed Michael Rohd's (1998) *Hope is Vital Training Manual* step-by-step. We held five two-hour activating theatre sessions with 13 adolescent peer counselors over the course of a week in May, 2014. Rohd's activating approach works in the following stages:

Warm ups. The purpose of warm-up activities is to build energy, focus and trust: "to get people playing together in a safe space, to energize that space, and to create a sense of comfort in the collective doing of specific and structured activities" (p. 4). (*Appendix D: Activating Theatre, Sample Warm-ups*)

Bridge activities. Warm-ups are followed by bridge work that begins to theatricalize the space. Bridge activities "use image work, improvisation, and discussion to create pretend worlds, explore group perceptions, and start to identify core issues for dialogue" (p. 49). (*Appendix E: Activating Theatre, Sample Bridge Work*)

Improvisation. Bridge activities are followed by improvisation activities that are designed to lay the foundation for the more complex activating scenes to come. (*Appendix F: Activating Theatre, Sample Improvisation*)

Activating material and facilitation. Lastly, there is activating material and facilitation. In the activating scenes the girls posed questions and explored choices and options in situations with believable characters and relationships. Often these situations presented a conflict of some type. The activating material was drawn from questions and issues uncovered in the reproductive health information session, bridge and improv activities. The activating material was structured, but not scripted. Scenes were, for example, set up as follows: A girl's friend brags about losing her virginity and teases her friend for being reluctant to try it. A teen tries to get specific information from her mother about a sexual issue, but she only gets a sermon of "don'ts" in response. A girl agrees asks her reluctant boyfriend to get tested for HIV because she had heard rumors that his former girlfriend has AIDS. A pregnant girl's older sister tells their parents that her younger sister is pregnant and tries to convince them not to banish her younger sister from the house. (*Appendix G: Activating Theatre, Small Groups Activating Material*)

The idea was not to teach the girls about the right or wrong way to handle things, but to provide them the opportunity to explore the issue from the perspective of the characters they develop and inhabit. Issues and decisions made by the characters were then explored during facilitation, a process in which I froze the scene, turned to the workshop members, and posed questions such as "Why do you think the mother would agree with the father that the daughter should get circumcised?" or "What else might the girl do in this situation?" Workshop participants with - suggestions would then replace characters in the scene and play it out once again. The scenes were sometimes redirected with a circumstance change or a gender flip. This facilitation created a dialogue for exploring a scene. Rohd (1998) states it like this: "This then allows you to investigate the reality, the wisdom, and the potential of those choices within real-

life circumstances, and to actively analyze strategies and possibilities with everyone in the room through the replacement process” (p. 103).

I gradually moved the workshop toward more and more challenging activities. The first day, for instance, included introductions, ground rules, and several energy/focus and trust warm-ups. On the second day, after a circle group to process the first day with a ground rules refresher, we introduced bridge activities. On days three through five I progressively introduced more bridge and improvisation activities and activating scenes with facilitation. (*Appendix H: Workshop Overview*). All activities were video recorded and systematically reviewed to discover core issues, categories and themes. Video clips of the workshop activities can be seen at the project web site: purityjerop.wix.com/kapkenda-performance.

Focus Group

After a day’s break to allow the workshop experience to sink in, I held a 90-minute focus group with the participants. According to Richard Krueger and Mary Anne Casey (2009) a focus group – a guided discussion organized around predetermined and sequenced open-ended questions – is an effective data collection procedure both before and after interventions. Krueger and Casey maintain that focus groups are effective for providing information about why people think or feel the way they do because they encourage openness about attitudes and perceptions of all types without judgment.

I designed open-ended discussion questions both to discuss reproductive health issues one last time *and* to elicit participants’ thoughts about the activating theatre project itself. Did they find it a useful tool for exploring and discussing reproductive health?

I followed established procedures for conducting a focus group, suggested by Krueger and Casey (2009). I provided an overview of the topic, established ground rules, began each area

of interest with open-ended questions, provided sufficient time for participants to reflect, and followed their answers with probes. I designed the open-ended questions systematically to achieve clarity and precision and I tried to memorize the questioning route. This was not about me or my opinions, so I remained non-judgmental and provided supportive comments to promote openness. As best as I could, I tried to listen effectively and probe responses intelligently.

The carefully targeted questions with probes enhanced, I believe, the project's validity. The findings of focus groups has high face validity because the setting is a relatively real-life, non-experimental, one that can capture the dynamics of group interaction (Baxter & Babbie, 2004).

The focus group was video recorded and systematically reviewed to discover core issues, categories and themes. (*Appendix I: Focus Group*)

Reflexive Journal

Each day I wrote a reflexive record of the field research process. Reflexive journals can serve as important documents in the analysis stage, one that can be analyzed alongside the interviews, the workshop, and the focus group. Reflexive journals can provide what Lincoln and Guba (1985) call an "audit trail" of the research process, a trail that will enhance the confirmability and credibility of one's research. In the journal I recorded what was done, when it was done and why it was done. I used the journal as tool for critically reflecting upon the way the girls were responding to the workshop activities. I recorded seemingly unimportant things that, in the final analysis, may have been significant after all. It provided an opportunity for me to document significant moments or turning points. Importantly, the journal helped me reflect on my role in the project. According to Mruck and Breuer (2003), reflexive journals provide an

opportunity for researchers to explore “their presuppositions, choices, experiences, and actions during the research process” (p. 3).

Analysis. The project provided a diverse body of material to analyze. I had interviews, a short reproductive health information session, a focus group, a journal, and, most importantly, the performance workshop – all to examine side-by-side and to interpret. The interviews were audio recorded; the reproductive health information session and entire performance workshop were video recorded. Using methods suggested by grounded theory, and always recognizing my subjective role as an interpreter, I worked inductively trying to tease out core issues, categories and themes – all in an effort to capture how these particular Kenyan adolescent girls in the year 2014 interpret and understand the reproductive health issues they confront. My analysis aims to provide “textualizations” (or interpretations) from the body of work I collected. Sillars and Gronbeck (2001) say this about this process of textualization: “The difficult-but-crucial point to understand about textualizations is that they are constructions made from the work yet, in an important sense, are grounded in that work” (p. 26). I have tried to draw reasonable and insightful conclusions from the layers of data I collected. As suggested by grounded theory, I generated assets in the field with long discussions with my crew and in a reflexive journal. During analysis I labelled important words or expressions used by the participants, what grounded theorists call *in vivo* codes, and I compared incidents, issues, categories and themes that emerged from each layer of the project, something that grounded theorists call “constant comparative analysis.” The systematic review was conducted until what grounded theorists describe as a “full theoretical saturation” was achieved (Birks & Mills, 2010, p. 12). This approach should provide a credibility that meets the basic criteria of research. I hope my interpretations “ring true” (Baxter & Babbie, 2004, p. 298) and point back to my data. Lastly, I

hope my interpretations are transferable and thus useful for individuals and organizations designing similar or related reproductive health interventions. That is to say, I hope my interpretations “provide sufficient details so that a reader can make the decision about whether to apply the findings elsewhere to a different context or group” (Baxter & Babbie, 2004, p. 298).

Assumptions and Limitations

As a research approach this project suffers from the assumptions and limitations that confront all qualitative research (Phiri, n.d.). It lacks the order and clarity of beginning with a theory combined with a hypothesis and then reducing measurable data to numerical indices. It does not identify variables and measure their causal relationships, nor does it make predictions based on those measurements. I have not attempted to discover the objective reality of facts as seen by an aloof and uninvolved observer. Grounded theory begins with data, data specific to one location, in my case the adolescent girls at Kapkenda High School. I asked a question that many would argue is too big to answer: What and how are these adolescent girls thinking about the reproductive health issues they are beginning to face? Many argue that questions like this are just too big, too fuzzy. They argue that the social world needs to be explored as if it were the natural world; they argue that seeking an insider’s point of view is a pointless exercise; they argue that the interpretation of the meaning of cultural performances has no role in social science; they say a clear picture only emerges when you strip down and isolate complex interwoven variables. But I would argue, alongside many others working in the social sciences, that this is a one-sided position, and that the richness, complexity and meaningfulness of human experience requires that we attempt to understand the way that meaning and shared social understandings function in society.

I also faced challenges as a researcher working in the field. Action research, an effort to “bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people” (Reason & Bradbury, 2001, p. 1) and critical ethnography, a method in which the researcher is “but a provider of occasions” (Conquergood, 1992, p. 85), provided a very specific challenge: my personal and empathetic involvement as a researcher. I wasn’t simply collecting data; I sometimes became an involved mentor. Traditional positivistic research has little room for the subjectivity of the researcher and it only rarely accepts an approach that would bring together participatory engagement and action (social change) with research. Beyond that there was the practical limitation that orchestrating the activating theatre is an exhausting activity, and I may have missed key moments simply because I was too busy facilitating. Fortunately, I worked with two videographers, one of whom has had considerable research experience.

A serious shortcoming of this research *as an intervention* is that it acted only at the individual and peer group level. The ecological and social and behavior change communication (SBCC) model provided by Kenya’s Ministry of Public Health and Sanitation (2010) shows that that adolescent sexual and reproductive health must be understood contextually. Individuals, with their information, knowledge, motivation, attitudes, beliefs, and agency, and as the carriers of gender and sociocultural norms, are subject to powerful economic and sociocultural forces. The SBCC ecological model conceptualizes adolescents as being at the center of a set of concentric rings that includes their family, their community and its services (or lack of services). They are also at the center of a larger national environment, with its budget, one that adolescents can lay little claim to, and its policies – policies that, for instance, lead to unsafe abortions by outlawing them almost entirely. Socioeconomic circumstances drive girls to engage in

transactional sex for school fees. Conservative and religious norms stigmatize open discussion of sexuality, access to condoms and contraception. These norms stigmatize open communication with parents and even teachers, many of whom are uncomfortable and unwilling to provide reproductive health information. While this intervention does create possibilities for adolescent girls to explore options and the decisions and issues they face by “working as a lab for problem solving” (Rohd, 1998, p. xix), it does not act directly on the broader reproductive health context itself (by, for instance, promoting school policies giving support to pregnant teens). But I would argue that this intervention might help empower teens in the short term by helping them make more responsible choices and, as women over the long term, by empowering them to actively create a more compassionate and supportive reproductive health context.

Significance

To my knowledge this project is unique in its effort to employ activating theatre to explore the reproductive health issues facing adolescent females in Africa.

I hope this study contributes to the theoretical literature on performance theory, action research, and critical ethnography. More importantly, I hope I have provided a model for future interventions, a model that can help adolescent girls gain control over the reproductive health decisions they face now and into the future. I hope to have helped them, as Siegal stated in an interview, find their “internal compass” (Siegal, 2014). Beyond this, the project suggests a means to promote agency, with empowering girls to question – to challenge, if needed – the social and cultural norms and silence that too often surround reproductive health issues. This project suggests an alternative approach to adolescent reproductive health interventions in the developing world.

Importantly, the recorded activating material produced texts that can be examined to provide a window into the worldview of Kenyan adolescent girls and how they understand and interpret the host of reproductive issues they face. The recorded texts provide an entry into the adolescent girls' understanding of the interactions that make up their lives, with a special focus on sexual and reproductive issues. The analysis of these texts should help educators and program designers develop content and strategies for adolescent reproductive health interventions.

But my intention here goes beyond this. I hope to have contributed to a particular dialogical approach to thinking about health interventions and research "Theatre," Rohd writes, "allows us to converse with our souls, to passionately pursue and discover ways of living with ourselves and others. We have no better way to work together, to learn about each other, to heal and grow" (1998, p. 140).

CHAPTER 2

THE ACTIVATING THEATER WORKSHOP AT KAPKENDA GIRLS HIGH SCHOOL

Setting

I decided to conduct my workshop at Kapkenda Girls High School, the school I attended and where I had been a peer counselor from 2001 to 2005. Kenya uses the 8-4-4 educational system (eight years primary, four years secondary, and four years university). Kenya has three types of secondary schools: national, provincial, district, and private. A majority of Kenya's secondary schools are all-girl or all-boy boarding schools, a system derived from the British colonial education system. The secondary system is structured by forms one through four, similar to the American system of freshmen, sophomores, juniors and seniors. Students typically arrive at age 13 and finish at age 17.

Kapkenda is a large provincial-ranked school in Rift Valley Province with about 700 students and 40 staff, teachers and administrators. About 90% of Kapkenda students come from within the surrounding rural Keiyo County, with a small percentage coming from outside provinces and from Eldoret County. The majority of students are members of my tribe, the Kalenjin. Students, teachers, staff and administrators all live at the school. Kapkenda is located about 50 miles from Eldoret in the countryside on hills overlooking the beautiful Rift Valley. Eldoret is one of the fastest growing cities in Kenya. With its population of about 300,000, it is now Kenya's fourth largest city.

The system for getting into secondary school from primary is as follows. During the last year of primary school students will apply to three national, two provincial and two district schools. After taking the Kenya Certificate of Primary Education exam – something that would in the United States would be considered a “high stakes” exam – students receive invitation letters based on their test scores, nothing else. Students aim to get into the higher-ranked national schools, despite the fact that they will often board very far away from their family.

From personal experience the transition from home life to boarding school is an extremely difficult time for 13-year-olds. I was not surprised to hear the girls at Kapkenda talk about the same issues I faced: I missed my family, my neighborhood friends, my home cooked meals, my hot showers. It's cold and foggy in the hills above the Rift Valley. We used buckets and cold water to splash on ourselves for bathing. Breakfast was tea and bread; lunch was corn and beans; dinner was ugali (mashed corn) and cabbage. Little had changed since I was a student at Kapkenda. There was a new dining hall (which also housed the peer counselors' office) and a shiny new bus with the school motto on the back. Buildings had been painted to make the school

look nicer. But one thing that stood out was how crowded and jammed the classrooms had grown. Average class sizes had grown to 50-60, up from about 30-40 when I was a student.

I was a peer counselor through all four forms and was happy to see the peer counselor system was still active and important to Kapkenda. The peer counselor system is a feature of many Kenyan secondary schools. Kapkenda's four forms have a total of 24 peer counselors. Peer counselors are elected by their fellow students; they are the ones that students turn to with their problems. For instance, peer counselors will often mediate between students having problems with their teachers. They also hold forums on a variety of issues facing Kenyan society and Kenyan women.

Kapkenda's infrastructure includes a field for volleyball and soccer, four classroom buildings (which contain 13 classrooms), a dining hall (the one place where students can view a small TV hoisted up in the corner), a small library, a (very dated) computer classroom (which is where I conducted the workshop), a science lab building, a farm (with several acres, a handful of cows, and a garden where students studying agriculture grow corn, potatoes, cabbage, carrots, kale and spinach), a laundry area (where students wash their clothes by hand each weekend), eight students dormitories (where students are grouped into forms one through four), staff, teacher and administrator housing (a combination of small houses and an apartment complex), and a few minor structures, including the chaplain's office and the nurse's office. School grounds are surrounded with wood fencing.



Figure 1.1. Kapkenda Girls High School entrance with its mission statement: “Providing quality Education, to mould and Nurture young Talents, grow to Fullness, for quality life to enable Girls meet the challenges of life.”



Figure 1.2. School grounds: The main walkway at Kapkenda Girls High School. Classrooms are on the left and the assembly area is to the right. The walkway leads to the cafeteria, the science lab, the laundry, and eight dormitories.

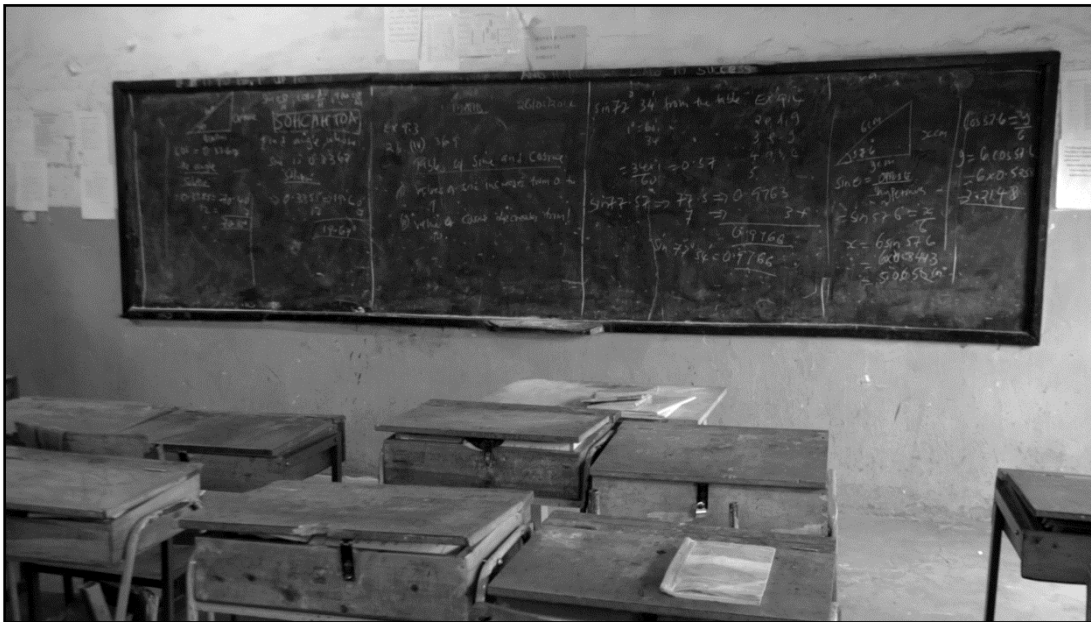


Figure 1.3. A typical classroom at Kapkenda Girls High School. Most classrooms hold about 50 students.



Figure 1.4. A warm-up activity, Trust Falls, at the beginning of a workshop.



Figure 1.5. Reviewing plans for an Activating Scene in the Small Groups activity.



Figure 1.6. The peer counselors gather outside the computer lab where the workshop was held.

The Crew

Bruce dePyssler

Bruce is a family friend and mass communication professor at N.C. Central University. He travelled to Kenya with my family two years ago for a month, so he knew what he was getting into. I am a member of his documentary team, the Bull City Doc Squad, and have worked on two short documentaries with him about Durham's African-American community. Bruce shot the workshops and provided valuable feedback before, during, and after the workshops.

Judy Chemutai

I recruited Judy, my next door neighbor and childhood friend, as an assistant to help with audio recording. Judy just graduated from Catholic University in Eldoret studying finance and had not yet found a job. Bruce and I gave her a crash course in audio/video and she took to it quickly. Her responsibilities included setting up and breaking down lights and equipment at each workshop. During the workshop itself she handled the boom mic while Bruce handled the camera.

Day One: Our First Meeting

It was Monday, May 19. Today would be the first day we set foot at Kapkenda Girls High School. My goal was to meet with participants and Mrs. Carol Chang'ach, the adviser to the school's 24 peer counselors. Carol worked closely with me via email and telephone to help organize the project with the school and peer counselors. I was eager to meet her and thank her for her help. It had been nine years since I graduated from Kapkenda. My father, who had agreed to drive us each day to the school and back, announced that the car was ready for the hour long ride to Kapkenda. It was 2 p.m., and we were ready to begin our journey. Bruce had all his video equipment ready to go and tested. My friend Judy arrived to help load the equipment. I felt reassured having them on board as a second set of eyes, but still I was anxious and could feel my stomach churning as I flashed back to my high school days and thought about the workshop ahead.

We were up and running. All my hard work would soon be put to the test. I felt an overwhelming sense of déjà vu as I gazed out of the window as we left Eldoret and headed down Kaptagat Highway, a two-lane tarmac road. Calling it a highway, by American standards, would

clearly be an exaggeration, especially since there's a speed bump every few hundred yards. Bruce shot B-roll from the car on Kaptagat Highway. Judy and my dad caught up on local neighborhood gossip. I found myself reflecting back on the matatu – or taxi van – rides I would make between my home and Kapkenda three times a year. It was still mostly farm country – maize, wheat and potatoes. We still had to swerve around motorcyclists and bicyclists transporting grain, potatoes, milk cans, furniture, and more. We had to stop every now and then for cows or sheep to cross the highway. We passed the same buildings I saw as a high school girl, but now there were more settlements and small shops on the highway.

After about 45 minutes we approached the turn off from Kaptagat Highway, and I saw the sign: Kapkenda Girls High, P.O Box 5, Chepkorio. Turning off the tarmac unto Chepkorio Road, a murrum (dirt) road, I noticed all the trash alongside the road. Perhaps I had been desensitized to all this trash as a child, or perhaps it just stood out more now since I had been living in the United States where there are laws against littering.

It was market day in the small business district where Kaptagat Highway meets Chepkorio Road. My dad playfully fussed at a matatu driver who was blocking the road and in no hurry to move on. The villagers were selling corn, kale, potatoes, onions, tomatoes, milk, and peas. Some men were auctioning off cows. They crowded the car excited to see Bruce, a mzungu (or a white man) with a camera. I know what they were thinking: Here's someone with lots of cash. We passed a few more buildings and I noticed a small, familiar building next to a meat shop. It had been my mother's medical clinic for six years. We drove about 20 minutes down Chepkorio Road slowly. Nice to see it was as bumpy as ever. I thanked my lucky stars it wasn't raining, knowing that there was no way to navigate Chepkorio road once it started raining. We crossed a familiar wooden bridge, climbed a steep hill. As we climbed the temperature dropped

quickly. I could now feel my Kapkenda school days deep in my bones, recalling all the time I spent there cold, missing my family, and tired of bland food. I also recalled some of my life's greatest moments, especially the days I was elected by students as a peer counselor and later as the head girl, or student president. Kapkenda sits proudly atop the hill. Surprise, surprise, the walls were still white, the roofs red.

We pulled up to the gate. I noticed two new images – drawings of keys about six feet across – at the entrance, one declaring Kapkenda's vision, the other the school's mission. The school's motto was written into the circular head of each key. It was a motto I knew well. It's on the school buses and the side of the computer lab: "Bidii huleta ushindi" (Hard work brings success). In the stem of the key holding the vision it read (exactly): "Providing quality Education, to mould and Nurture young Talents, grow to Fullness, for quality life to enable Girls meet the challenges of life." In the stem of the key holding the mission it read (exactly): To provide quality Education to produce a wholistic Girl child.

I smiled inside at the way these ambitious declarations were worded. But wasn't I there too, after all, "to enable Girls meet the challenges of life"?

No one was at the gate to open it, so I jumped out of the car, opened the gate. My dad pulled in, veered left, and parked. As we unloaded our equipment, a watchman approached us asking who we were and what we were doing. We explained and signed in. My father, who grew up on a nearby farm, would leave us each day to chat with old friends near my grandfather's farm. Judy, Bruce and I said goodbye to my father, unloaded the video equipment, and marched to the main office to find Carol.

It was wonderful seeing familiar faces. I saw my former math teacher, Mr. Asava. The man used to make us sleep, drink and eat math. I saw my hilarious geography teacher, Mr.

Bwaleh. And I saw my favorite, Mr. Tomno, my always smiling biology teacher. They were so warm and full of questions about my research. Carol wasn't at school that day, which led to some confusion. But she had arranged for another teacher to gather the peer counselors for our first informal meeting. We found the teacher, who then found Rachel, a student captain and peer counselor, who then spent about 45 minutes tracking down 20 peer counselors. Already behind schedule ... a typical Kenyan experience. I took it in stride. We didn't have a lot planned for day one.

We walked down to the school's new dining hall where Nelilus told us to meet up. The room was a huge open area. It was noisy. It would never work for the workshop itself. We chose a corner of the room away from the noise and the girls trickled in one by one. Bruce thought it best not to pull out a lot of equipment on our first meeting, so he simply held one camera unobtrusively. We re-arranged a few benches to form a U-shape for our discussion. Once every one was seated, I introduced myself first and explained to the girls why I was there and what my research was about. Bruce and Judy introduced themselves. Then I welcomed the peer counselors and asked them to briefly introduce themselves. It was then that I found out that the Form Four students would be tied up with exams during the week. This turned out for the best because it brought the workshop group down from 20 to a more manageable 13. I asked the Form Four students if they would agree to be interviewed after their exams. They agreed.

I then explained my project in some detail and went over the IRBs line by line. Similar to their parents, when given the opportunity to ask detailed questions about the workshop, they weren't very inquisitive. This didn't surprise me. I had instant credibility as a former student and as someone who is studying in the United States. "Why," they might have asked themselves, "would I question or have doubts about her project? She's been studying in America for

goodness sake!” On top of that, in Kenyan society girls are not socialized to assert themselves and question someone who is older and more educated. Because of this reluctance to ask questions I pushed a little harder and asked some leading questions like “Are you wondering what you should do if you’re unhappy with something that happens in the workshop?” But in truth, there were few critical questions, mostly questions about when and where we would be meeting and for how long.

Before ending this first meeting, and just to have a little fun, we played an ice breaker, Two Truths and a Lie, an activity I learned as a graduate assistant in Dr. Thomson’s Honors seminar class “Puppet Shows that Make a Difference.” The girls took to the game, but they did not exactly let their imaginations run wild. They made us take easy self-evident guesses like what form they were in, their hometown, the number of brothers or sisters they had, and their ages. Interestingly, three participants picked up on my research discussion and told truths or lies related to reproductive health. One participant told a truth that her mother had had her uterus removed; one participant told the lie that she had a boyfriend (an easy lie to guess); and one participant told an easy-to-guess lie that she had had an abortion. Reflecting back, I may have been reluctant at their age to raise these issues, especially the truth of the hysterectomy, in the presence of strangers and a camera. Other lies included owning a business, being an only child, having been born in India, having been involved in a car accident, and studying in form three. Truths included being the first born in the family, loving to eat, having been raised by a single mother, having a brother, loving to dance and enjoying going to church.

After the game, I thanked the girls, and we concluded our short session. We agreed to meet the next day at 4:10 p.m. in our assigned space, the computer lab. While we were rearranging the benches, one of the girls said the head cook wanted to meet with me in the

kitchen. I knew her from my days at Kapkenda. We embraced each other and she offered us tea in the peer counselors' office upstairs in the dining hall. She also updated me with her son's progress in high school. She then asked if I could help pay his school fees. I wasn't surprised by this request. I was coming from America after all. Surely I was now loaded with cash. I promised her I would help her out before the end of the workshop. As we were having our tea two participants dropped by to chat, Leah and Mary. These two would become two of the workshop stars.

I was happy with how the first day went. It was a great relief just to see that the participants had arrived and that they seemed excited about the workshop. As we walked to the car, we got a lot of attention from students looking out from their classroom windows, especially Bruce, the mzungu. As we took off in my dad's car, rain clouds were moving in. I felt elated that things had started off so well.

Day Two: Workshop One

Today was the first workshop. No problems on the drive to Kapkenda. We arrived early, because this would be our first time to set up the equipment and lights. One of the peer counselors, Mary, had the key to the computer lab, which had been assigned to us for the project. It was the first time we saw the lab, and it seemed workable. There were not enough chairs to form a group circle, so we shifted some benches around in a 90 degree angle.

Bruce and Judy went to work. I began reviewing, once again, my plans for the day. Bruce commented on the room's "art work." There was the tattered leftover of an inspirational note saying "Have you wasted a minute today?" I recalled that my computer lab teacher had pasted these up when I was a student. And there was the photo of a plump, smiling, paternal looking man – "His Excellency" – Hon. Mwai Kibaki, President and Commander-in-Chief of the Armed

Forces of the Republic of Kenya. I told Bruce it was our former Kenyan president. Bruce joked that it would look terrific in the background while the girls were discussing reproductive health. Bruce and I had discussed the issue of trying to get the participants habituated to the cameras, and we decided to adjust the day's plans by adding a component in which the participants would each stand before the camera and formally introduce themselves. I decided we would do this after the warm-ups so the participants would be loosened up.

So now the plan was as follows: create and hand out name tags, explain the workshop, introduce ground rules and the importance of making the workshop a safe and trusting space. The day's activities included two silent warm-ups designed to build energy and focus, Cover the Space and Blind Handshake, on-camera introductions, and Storytelling, an activity designed to introduce the concept of stories and build trust within the group. Finally, we would have a short information session on reproductive health issues facing Kenyan adolescent girls.

As the participants entered the room they sat quietly, scarcely talking among themselves. Traditional Kenyan schoolgirl behavior, I thought to myself. Monica eyed the cameras somewhat suspiciously. They're so quiet!

This was typical Kenyan schoolgirl reticence. My greatest fears were being realized. Will these participants come alive? For one of the few times in the workshop, I spoke in Swahili trying to put them at ease: Leo tujaribu kabisa kuoongea kwasauti kubwa. Sauti sauti kubwa kama ya kuchunga ng'ombe. Hakuna mtu amewai kuchunga ng'ombe? Mimi peke yangu? Nyinyi ni watoto wa town. (Today let's try and speak loudly. Loud! Loud! As if you're rounding up cattle. Hasn't anyone rounded up cattle? Just me? So you all grew up in the town?) The girls laughed at this.

Perhaps a note on language use at Kapkenda is needed here. Instruction at the school is in English apart from Swahili language courses. Even among themselves students at Kapkenda are not allowed to speak their ethnic languages, such as Kalenjin or Luhya. Outside of class students will typically speak Swahili with each other.

I began to explain our first activity, a warm-up called Cover the Space. In this activity a big rectangle is set up in the room using four chairs. I explained that everyone would start walking, with no talking or contact, and that everyone must keep moving. “Be aware of your body. Be aware of the space,” I explained. “And always try to cover the space. Make sure that there are no open spaces.”

When we started, the participants seemed to understand the plan, but when we began, they just moved into the area and stood still. I shouted “move, move,” and they began to move. After a couple of minutes I shouted “freeze,” heard a few giggles, and pointed out the empty spaces. I explained “cover the space.” They got it. I then did variations on the activity and had the girls form groups of three and restarted the activity. Reviewing the tape I see that almost all the girls have broad smiles on their faces throughout. The activity lasted about seven minutes.

I then had the participants form pairs and introduced our next warm-up, Blind Handshake. I explained that this too was a silent activity. I told them they would shake hands, freeze, and hold their position. When I said “go,” they would hold their hands in place and back up until I said “freeze.” Then they would try to find their partner’s hand. We repeated the activity four times.

Reviewing the tape (and this is hilarious), I saw that some of the participants didn’t at first understand that they were supposed to let go of each other’s hands, so they were pulling at each other. Since I participated in the activity, I didn’t notice this. But Bruce did and alerted me.

Lucy arrived, and this gave me the opportunity to explain the activity once again from the beginning. We then did the activity three more times. There were lots of giggles and smiles at the conclusion of each activity. It was fun to see how tickled the girls were by the activity, but I began to realize that more experience providing activity instructions would be helpful. The activity lasted about eight minutes.

We moved back to the benches. Interestingly, at this time most of the girls grabbed their notebooks and pens as if it was time for me to begin the lecture, now that the fun and games were done! Ah yes, the Kenyan education system strikes again! The students were back into their proper schoolgirl mode. They were very quiet and waiting for me to make my next move.

Next I explained how we would handle the introductions: Name, form (class), age, parents' occupation, fears, hopes and dreams.

The participants did their introductions somewhat formally. It was as if they were introducing themselves as candidates for student council. Importantly, they seemed relaxed and didn't show any fear of the camera. Not a single one froze up with stage fright. Everyone clapped after each presentation. Based on what they shared, I now introduce you to each of the participants, so that you can get to know them.

Workshop Participants. Note: The names provided are pseudonyms.

Mary: Form Three. She is 15 years old. Her father manages a dairy plant and her mother is a supervisor at Kenya Cooperative Creameries in Eldoret. Her biggest fear is not being able to go to the university. She dreams of studying in America or abroad.

Elizabeth: Form Three. Her mother is a farmer. She doesn't have a father. Her biggest fear is not realizing her dream of becoming a doctor. She hopes to help her mother and others in need. (Age not provided.)

Lucy: Form Three. Her father works in the Kenya Revenue Authority, and her mother is a teacher. Her biggest fear is dying. She wants to be a role model in the society and in the world. (Age not provided.)

Monica: Form Three. She is 17 years old. Her father is a teacher and her mother a farmer. Her biggest fear is not achieving her goals in life. She wants to become, as she put it, an international beautician.

Diana: Form Two. Both her parents are teachers. Her biggest fear is that she wouldn't complete high school. She hopes to be a news anchor or a gospel artist. (Age not provided.)

Charity: Form Three. Her father is a farmer, her mother a teacher. Her biggest fear is dying after completing university. She hopes to be a role model among students. (Age not provided.)

Rita: Form Two. She is 15 years old. Her father is a forest officer; her mother is a teacher. Her biggest fear is getting pregnant while in school. She wants to be a lawyer and promote peace in the country.

Ann: Form Two. She is 15 years old. Her father is a doctor, and her mother has a business. Her biggest fear is not getting the grades that will allow her to pursue medicine at university. She hopes to build a two story house for her parents.

Doris: Form Two. She is 15 years old. Her father is a doctor, her mother a business woman. Her biggest fear is not getting the grades to go to university and hopes to be a doctor.

Ruth: Form Two. She is 15 years old. Her mother is a farmer. She does not have a father. Her biggest fear is to have dreams shattered when she is close to achieving her goals. She wants to become a neurosurgeon.

Jane: Form Two. Her mother is an agricultural engineer. She does not have a father. Her biggest fear is to get AIDS. She wants to become a lecturer. (Age not provided.)

Leah: Form Two. She is 15 years old. Her father is a manager at Sunripe, an agricultural seed company. Her mother is an auditor at Fuga King, an animal feed company. Her biggest fear is dying after Form Four. She wants to be the best pilot in the world.

A few things stand out from the introductions. Their parents are mostly professionals, often teachers, excluding Ruth and Monica whose mothers are both farmers. Three do not have fathers, Elizabeth, Ruth and Jane. Almost all have set very ambitious goals. Sometimes their biggest fear is not reaching their goals by, for example, dying or not getting grades that would get them into university. Many of the girls, quite touchingly, said they aspired to “be role models in society” or to help their parents. As Ann put it “I want to build a storied house for my parents.” Most significantly for my research, two participants, Jane and Rita, see a reproductive health issue – HIV/AIDS or pregnancy – as their biggest fear.

After the introductions we moved on to the final activity of the day: Storytelling. We formed a U-shape with the benches, which gave us a nice intimate feeling. I first introduced the concept of stories and their importance in human societies. Then I discussed what makes for good stories and wondered aloud why humans like to tell stories so much. I explained that stories are about events, relationships between people, and circumstances. I stressed that good stories need details.

I then instructed them to each tell a story to a partner. I told them they could pick any story, but I suggested some topics such as their happiest or most memorable moments, their biggest challenges, or their best gift. I explained how I might make a story out of one of my happy days, the day I was picked Kapkenda student president.

I then told them a brief story about coming to the United States as the biggest challenge I’ve ever faced. I talked about how shy I was when I first arrived and how hard it was to

understand the people in North Carolina and how often people didn't understand what I was saying and how often people asked me to repeat myself. I talked about how difficult it was to leave my friends in Kenya and how bad things seemed. I said I was sad and lonely and didn't know what the future would bring. But I tried and persisted and now it doesn't seem as bad as before. Life gets better, I said. I concluded my story stressing how I am no longer shy or afraid to speak up. Reflecting back on my story now I realize that it was not so much a story with a beginning, middle and end as a pep talk and an effort to open up to them. Reviewing video footage I now see that I often I slipped into this mentoring and empowering role.

The participants formed pairs, and I told them they had 4-5 minutes each to tell their stories. I told them that if they finished early, they needed to go back and fill in details about their stories. The participants went right to work during the breakout. The room buzzed as each girl told her story, usually in Swahili. Bruce roamed the room with a handheld camera and Judy with the boom mic. The girls seemed at ease with the presence of this equipment.

After 10 minutes or so we returned to the bench and I asked each girl to briefly summarize her partner's story. The stories included a litany of the difficulties of life in Kenya: a cousin who drowned, an alcoholic uncle on a murderous rampage, breaking free of a kidnapping attempt by some men, the difficult and confusing first days at Kapkenda (several participants told this story), a misunderstanding that having O-positive blood type meant that you were HIV positive, a stubborn suicidal brother who wanted to kill the storyteller's mother, hearing the terrible news that a father had died, a severe whipping that led the storyteller to doubt that the punisher could be her real mother, a rebellious sister that was raped and taken to the hospital after drinking poison, and a happy trip to Mombasa. I didn't push the participants to go into detail about their stories. We all clapped at the conclusion.

I then handed out a reproductive health quiz about adolescent reproductive health in Kenya and the developing world. The idea was to have a short information session to get some key facts on the table. I used data provided by the World Health Organization. I asked the girls to look it over together and prompted them to suggest answers to the questions. (*Appendix J: Reproductive Health Information Session*)

Asked what the term “reproductive health” means, the girls hit upon most of the major issues: birth control, pregnancy, STDs, HIV/AIDS, abortion, and FGM. The first answer given for “top fear expressed by girls your age” was “pregnancy,” followed by “dropping out of school,” “HIV/AIDS,” “cervical cancer,” and “rape.”

Asked to guess what percentage of 15-19 year old girls in Kenya they thought had had sexual intercourse the answers were higher than I would have expected. They guessed 80%, 50% and 60%. The correct answer: 42%.

Asked how many adolescent Kenyan girls out of 1,000 have had babies, the first answer given was 60. The second answer was 100, very close to the correct answer of 103.

Asked what percentage of all births were from adolescent girls across the developing world, the participants answered 50%, 75% and 80%. The correct answer: 95%. I asked if this was surprising and they all exclaimed “No!” Reflecting back this would have been a good moment to probe about why this didn’t surprise them.

Asked to guess how many girls in the developing world under 18 years of age have babies each day, the girls gave wildly variant answers of 800,000 and 6,000. The correct answer: 20,000.

Asked what percentage of 15-24 year olds accounted for new HIV infections worldwide, nobody seemed to have an exact percentage, although the general consensus was that it was a high percentage. The correct answer: 42%.

Asked whether boys or girls were more likely to get HIV, the girls chorused “both.” They seemed surprised that girls were in fact more vulnerable to catching HIV than boys.

Asked what percentage of Kenyan adolescent girls have comprehensive knowledge about HIV, the participants overestimated the knowledge Kenyan girls their age have about HIV. Their response was 85%. In fact, the correct answer is 41%.

Because we were running out of time I quickly summarized some of the statistics from the information session. I mentioned that the two biggest influences on an adolescent girl’s decision to have or refrain from sexual activity are religiosity and parental influence. I gave them the startling statistic that 13,000 Kenyan adolescent girls drop out of school each year because of unplanned pregnancy and that there are a total of 320,000 abortions in Kenya each year. I told them that 45% of those abortions were unsafe. I told them to take their handouts and share any reflections they had during tomorrow’s workshop.

It was a good day. Yes, the girls were a little stiff. This didn’t surprise me. But the warm-ups seemed effective. I loved the way the participants kicked it into gear during the storytelling activity. I did realize that it was more difficult than I expected explaining the details of the activities. Bruce and Judy managed to keep their video and audio recording from interfering, and the girls seemed to forget about the cameras once the action began.

As we packed up, Rachel – a peer counselor who had missed the workshop – arrived with tea and bread. A few of the girls asked if we needed some help packing everything up. This would become a routine with several of the “standout” participants. It soon became clear that

these girls cherished this opportunity to hang around Judy and Bruce, the mzungu they clearly thought was hilarious. They riddled me with questions about my life, about life in America, and about how I managed to get to America. On the drive home I thought back on some of the stories shared by my new friends – kidnapping, rape, suicidal siblings, alcoholic relatives, parental beating, the death of a parent, and just one single happy story, the trip to Mombasa. I've been fortunate, I thought to myself. I've got stories about a tragic alcoholic relative and those harsh first days at boarding school away from my family (which the participants and I have in common), but no kidnappings, rapes, suicidal siblings, parental beatings or deaths.

Day Three: Workshop Two

We got to Kapkenda early, and the computer lab was already open. It was nice to be able to set up the lights and equipment without rushing. Judy was clearly mastering the equipment set-up, making Bruce's life a lot easier. First I made the "I agree," "I don't agree," and "I am unsure" signs for one of the day's activities. Then I reviewed my plans for the day while we waited for participants to arrive. I had five activities planned for the day: a review of the previous day's reproductive health information session, two warm-ups and two bridge activities. The warm-ups included a trust activity called Trust Falls and an energy activity called Circle Dash. The bridge activities were Environment and Values Clarification. I was both excited and nervous about the group's first effort at doing bridge activities. These, according to Michael Rohd, build on the energy and trust developed in the warm ups to "theatricalize the space" and "focus on the imagination and issues" (Rohd, 1998, p.49). Now we are really going to see what these Kapkenda girls can do, I thought to myself.

Most of the participants arrived from their classes on time. They usually entered alone or in pairs. Bruce and I would greet them, sometimes guessing their names correctly, sometimes

not. Judy, the silent member of the crew, would simply wave. I directed them to their name tags on the table. As usual they would sit quietly while Bruce and I engaged them in small talk. Lucy did not arrive so we had 11 participants for the workshop.

Just as we were ready to start, the school bell started ringing continuously. From my days at Kapkenda, I knew that this calls an assembly. The girls rushed out, but they had no idea what the assembly was for. Was it an emergency, I wondered? Another thought crossed my mind: The crew and I just might be expected to introduce (and explain) ourselves to the entire student body. False alarm. The Red Cross had arrived and was requesting blood donations. The payoff: we got some good video of the entire student body at the outdoor assembly. The girls soon returned and we started our workshop.

I explained that our first activity would be Trust Falls. I asked the girls to pair up. I explained that one girl, the one in front, will be trusting that the girl behind her will catch her as she falls backward. We would begin with short falls and then increase the length of the falls a few inches each round. I decided to play with the girls, with Leah as the one who would catch me. When we began the game I immediately heard the girls giggling. “Are your eyes closed?” I asked. Then I said “ready,” and we started our first falls. It’s funny to say, but upon reviewing the tape, I now realize that I could scarcely be categorized as a trusting soul. For some reason I couldn’t trust my partner. I felt vulnerable when my eyes were closed, like a little girl scared in the dark. I felt like a hypocrite asking the girls to trust their partners when I hardly had the courage to do the same. It’s clear from reviewing the video that Ruth and I were tied as the biggest cowards. We switched partners and repeated the activity.

The activity, which lasted about seven minutes, was a riot. I think we were all surprised at how difficult it was to trust our partner to catch us. Now that I reflect on the activity I think we

should have worked on this these trust falls more. I could have taken the opportunity to discuss the need for trust in the workshop. And this would also have been a golden opportunity to get the form two and form three girls to mix it up. I was beginning to notice that the participants were tending to group themselves by their forms.

Our next activity was Circle Dash. I told the girls that this was a silent game. I explained that we needed to form a circle and have one person volunteer to be in the middle. People forming the circle would silently signal with someone else their intent to switch places. They should use a non-verbal signal, such as a wink or a shrug, to communicate. No talking, I insisted. I explained that the person in the middle of the circle would try to grab an open spot during the switch, and that several pairs could switch simultaneously. Then I explained that they needed to go around, not plow through, each other.

I played the game with the participants, starting as the person in the middle of the circle. The participants took their time deliberating their first moves. Mary initiated the first switch with Rachel. Reflecting back, this was no surprise. Mary would often be the participant to rise to the occasion. I was flat footed during that switch. But when Monica made a switch without communicating with Elizabeth I grabbed a slot in the circle. Sometimes up to ten seconds would pass before a switch was initiated. The participants took this whole business seriously, but whenever a switch was initiated several of the participants would giggle aloud. The activity lasted about six minutes.

Once everyone had settled back on the bench, I asked my participants to reflect back on the previous day and think about the information I had provided about adolescents and reproductive health. I asked them what they thought was interesting or surprising. After a brief

silence I asked them what they thought about the material on early sexual debut of Kenyan adolescent girls. After a long pause Rachel gave a long answer, saying:

I think it is because of the peer pressure. Most likely when the youth are at the age of 16 that is the time whereby they start realizing that they are grown-ups. And the pressure that they get from their friends makes them to engage in sex because I think now days most of the youth believe if you are engaging in sexual activities when you are still young it means umechanuka (you are hip/modernized).

Mary responded by saying that perhaps the girls wanted to experiment because they have heard about it. Rachel added that technology gives access to pornography and that may be a contributing factor. Leah added that children who are molested may not see the use of staying virgins as they grow older. Rachel said that the environment, such as the countryside where people drink a lot, can be a problem.

“Anything else surprising?” I asked. Elizabeth said she was surprised to learn that young women are more susceptible to catching HIV than young men. She explained that she thought that men and women had the same chances. Leah said she was surprised that the percentage of girls with comprehensive knowledge of HIV/AIDS was just 41%.

I asked the girls what they thought about the fact that the average marriage age in Kenya was 19, just two or three years older than them. Rachel said it was not good, because at 18 or 19 girls have just finished high school. They don't have jobs yet, she explained, “and you go there ... and your life is going to be miserable.” I ask if 19 is too young for a girl to be a bride and everyone answers in a unified voice “Yes.” The girls agree that 25 or 26 years is an ideal age for marriage. Mary explains that at that age you have finished your education, and it's time to get involved. Thirty-seven is evidently way too old for marriage in the minds of these girls, because

when a participant suggests *that*, the room erupted in laughter. Mary explained that if you extend marriage past age 30 it might be hard to find a spouse. My sense of this exchange was that the participants were puzzled by the idea of not getting married sometime in the early-to-mid 20s, and that the idea of marrying after one hits her 30s seemed foreign to them. Not surprising, I guess. At their age, that was my plan too!

Charity said she was surprised that so many girls her age dropped out of school because of pregnancy. I asked the participants what they thought about the fact that there are about 320,000 abortions annually in Kenya and 48% of these occurred in young women. There was a long pause. No one answered. I piped in “Can you imagine?” Elizabeth did a “tsk tsk” and shook her head. Leah said that many young girls begin sexual activities and are not prepared for the consequences:

For example, I get pregnant and I’m afraid I don’t know what will happen to me. I don’t know how I am going to take care of the baby and how my parents are going to treat me. So I see abortion as the best choice. Yeah.

As we wrap up the discussion, Bruce wonders aloud if abortion is legal in Kenya. Several girls say it’s not, and they explain that the only exception is when the mother’s life is at risk. Bruce asks the girls whether or not they feel they should be able to get an abortion if they were raped. Only Leah answers, saying that abortion “is not the best choice. Just hang in there and have the kid and then after that you can give the baby away or something.” None of the others disagrees with Leah’s opinion. I then move the discussion away from the moral question of abortion itself and ask the girls about the types of unsafe abortions they’ve heard of. Several types are suggested by the participants, such as mixing Omo detergent and Panadol pills.

Next I asked the participants what advice they would give, as peer counselors, to someone their age who is choosing to be sexually active. Rachel said “the best thing to do is to

tell her the consequences of having sex at the early age, and if she's not going to change – as far as school – to tell Madam, our Patron, that she can know how to guide her.”

At the conclusion of this session, my mentoring kicked in and I pointed out that some girls their age will still, after all, remain sexually active. “What advice do you have for them?” I asked. “What could they do, at least to protect themselves?” Monica said “contraceptives.” I asked “And what else?” She said: “condoms.”

With the discussion of reproductive health facts finished, we then moved on Environment, a bridge activity. In this silent activity, I explained, a volunteer begins doing an activity and makes that activity as real as possible. As other participants figure out her activity they join in doing any activity that might take place in that same setting. By doing this, I explained, they would be creating the space using their bodies and gestures. After I said “let's start,” it took a full two minutes before Mary – thank God for Mary! – jumped into action. She walked into the center of the space, giggled briefly, and lit up an imaginary cigarette and started smoking it. Nightclub? Bruce seemed to think so. He set down his camera, moved into the space and started drinking and dancing. I joined in, dancing up a storm. Bruce went back to his camera leaving me and Mary center stage for what seemed an eternity. No one joined. I ended the scene.

“Who wants to start a scene?” I asked. Diana walked center stage, knelt down, and thrust her arms into the air. She was obviously in church worshipping. Off and running! Soon Rachel joined by standing and swaying her arms towards the sky. Monica joined with an imaginary Bible. Mary and Leah then joined in prayer. Charity joined with praise and worship motions. I was relieved that everyone got so active creating this environment. Were they spurred into action by their humiliating nightclub performance, or were they simply more comfortable creating a church environment? I wonder.

I started our last Environment by milking a cow. Charity joined to herd animals. Rachel began smashing maize. Jane plowed soil. Her beaming smile (on the video) as she wraps up her plowing duties is to die for. Not as many had joined creating the environments as I hoped, but I feared worse.

Next I introduced three, still silent, reproductive health variations on Environment. I formed pairs and provided issues for them to enact. In the first we had best friends, one informing the other that she is pregnant. In another, one best friend is disclosing to the other that she is going to have an abortion. In the third, a boy is telling a girl he wants to end their relationship because the girl doesn't want to be sexually active. While volunteers for each variation weren't exactly easy to come by, the participants managed to stay silently focused on their performances, and the performances were, in large part, convincing.

Our last activity of the day, Values Clarification, may have been the most surprising to someone raised in Europe or the United States, or someone, a Kenyan like me, who has seen the world from the perspective of living in the United States for a few years. In this activity, I explained to the participants, that I would read a statement and they would decide how they feel about that statement and then move to one of the stations in the room labelled "I agree," "I don't agree," or "I am unsure. I explained to the participants that they would be asked to explain their decisions and that they could move to different stations if someone's explanation changed their thinking.

My first statement was: "Girls should remain virgins until they are married off." All 11 of the day's participants – without a moment's hesitation – headed to the "I agree" station. Rachel provided this explanation: "It will make her to be respected by her husband. He will see her as a lady of substance." I asked if men really care that much. "Yes," most of the participants replied.

Then I asked if men really could tell if a woman was a virgin. Again “yes” from the group. “How?” I asked. Diana and Rita gave peculiar answers. Diana said men could tell by “how you dress yourself.” “By the look on your face,” replied Rita. “Oh!” I answered, “Just by looking at you!” Rachel got a bit more specific, explaining that “I once heard that at first your vagina has not been disturbed” and that “you might bleed the first time with your husband.”

My second statement was: “I am worried that I, or someone I love, will get AIDS.” This time the entire group headed to the “I am unsure” station. After I restated the question Rachel and Mary alone moved to the “I agree” station. The remainder moved to the “I am unsure” station. “For example,” explained Rachel, “if my mum gets AIDS and dies I would be the one to suffer. There would be nobody to fill that gap.” Mary said that “if anyone around here maybe gets AIDS, and they are still young, their lives would be cut short.” The participants at the “I am unsure” station seemed confused about the question. I asked them to tell me by a show of hands if they were worried if an uncle or a brother might get AIDS. All of the girls raised their hands. After I pushed the “I am unsure” group for their thinking, Leah explained that antiviral drugs can now keep people alive for a long time.

My third statement was: “It is ok to kiss and caress a boy if you really love him, even if you’re not married.” Amidst a wave of giggles, the girls at the “I am unsure” station, along with Mary and Rachel from the “I agree” station, marched quickly to the “I don’t agree” station. Unanimous! No kissing or caressing before marriage. “So we are all saving our kisses until the pronouncement ‘you may now kiss the bride?’” I asked. Bruce couldn’t hold back on this finding. “Aw c’mon,” he exclaimed. The girls broke out in loud laughter with Mary performing one of her signature laughs, swaying back and bending her knees low to the ground.

My fourth statement was: “Parents and their children should talk about sex in depth.” All 11 marched in unison to the “I agree” station. With this agreement firmly established, I then asked how many, by a show of hands, have actually talked about sex with their parents. All hands went up. This was a hopeful finding, but later probes in the workshop would show that these “talks” were rather superficial and one-sided warnings. Leah explained that her mother told her it was not wrong to have boys as friends, but:

I should not go to the extent of having sex with that boy, because right now I am still young and not ready for the consequences ... and I’m not going to feel so good about myself because right now I know it’s wrong.

“Are these conversations mostly with your mums or your dads?” I asked. All hands went up for moms, two for dads. “Why do you think your dads don’t talk to you about this?” I asked.

Elizabeth struggled to get this reply out: “It’s a woman’s thing. The woman should talk to the girl, not the father, to talk to the girl.” “So hiyo nimambo ya wanawake.” I add. (So it’s women’s business.) Rachel explains that the Kenyan tradition is for fathers to talk to their sons about circumcision and for mothers to talk to their daughters about FGM.

Out of the blue Leah provided this reflection on the heartbreak that can come with becoming sexually active at a young age:

I was reading that every time you have sex with someone ... it’s not only body-to-body, but it’s like I’m giving part of myself to that someone. ... For me ... for us ... to be able to break up it would be so hard. So I guess being advised not to engage in sexual activities would save us from a lot of heartache.

Rachel picked up on this theme saying that she was told that young people who become sexually active run the risk of getting this disease called “sexteria.” The girl faints, Rachel said, “and the only way she will wake up is if a boy touches her.” Mary added that young girls that get sexually

involved will feel a lot of guilt when, for instance, they are in health class while the teacher is talking about reproductive health.

My fifth statement was “A student your age should be able to stay in school even if she’s pregnant.” For once, there was a significant split in opinions. Six of the participants agreed; three disagreed; and two were unsure. Disagreeing, Elizabeth said that “the other students will say ‘Who told you to do that?’ and you will feel low. She will be disturbed and won’t even be studying.” Charity said that the girl will be sick and won’t be able to concentrate. Ann and Doris were unsure. Ann said that the girl needs to go home where she can get a proper diet, and Doris said that the girl “may feel like the other students don’t like her.”

Interestingly three of the participants who were emerging as participant stand-outs – Rachel, Leah and Mary – agreed with the statement. Both Rachel and Leah raised their hands simultaneously to explain their positions. It’s a “major setback,” explained Leah, “but one should stay in school.” Rita explained that the girl “will be facing many challenges, being sick all the time and being looked down upon by the other students.” In Rita’s view, with help from the school nurse, a pregnant girl can continue to study. “You see,” said Mary, “when you are in school you can get advice from the teachers ... and students will be there for you.” But if you go home “you may feel that there is no more life for you. You may decide to commit suicide. At least at school you’ll know that life continues after your education.” On top of that, she explained, other girls can learn from your situation. Despite these strong arguments from Leah, Rita and Mary, none of other girls reconsidered their stances.

My sixth statement was “It’s ok for a woman to love a woman or a man to love a man.” The “I disagree” station suddenly became crowded, as it was occupied by all 11 participants. This did not surprise me. “God created a male for a female and a female for a male,” explained

Leah, adding that “it’s not the law of God.” After I asked “other than religion” do you have any reasons for disagreeing? Mary explained that same sex relationships can lead to diseases. “They won’t be able to get children,” added Monica.

“How many want children?” I asked. All hands went up. “How many want 10 children?” I asked. Laughter all around. “Five?” No hands. “Four?” No hands. “Three?” Four hands go up. “Two?” The remaining seven hands go up.

My final statement was “Someday I expect to have a fulfilling sexual relationship with another person.” I say “everyone is giggling” as they all move at once to the “I agree” station. “Good luck finding the right man,” joked Bruce. Giggles all around. Monica boldly moves to the “I am unsure” station as everyone’s heads turn in surprise. “I might die,” she says. “We’ll pray you don’t,” I say. “What do you think that means” I ask the group, “having a fulfilling sexual relationship?” Rita elicits what may have been the loudest laugh of the entire workshop when she says: “A sexual relationship whereby you are not afraid of ... yea it’s good.” After everyone stops laughing, the next few responses shift away from the issue of sexual pleasure. Leah says it’s about “trust”; Charity says “it will be forever ... until you die or he dies.” Elizabeth says “it’s a relationship where love exists ... and also somebody you can really talk to.” Ruth struggles to say the following: “it’s a sexual relationship where you have children and live with your husband.”

The session today was exhausting but rewarding. I had so many activities lined up, and I was glad that the participants kept up with me. Values Clarification really helped me understand what the participants were thinking on some key reproductive health issues. It also provided some areas to explore in the remaining workshops. Mary, Rachel and Leah stuck around and chatted with us while we broke down the equipment. Bruce asked the girls if they knew that in

some states in America it was becoming legal for gays to marry. “Yes,” they nodded. I knew what they were thinking: “No way that’ll ever happen here.” I told them that in the United States you actually get to know some gay men and women because many of them are not ashamed and hiding away in the closet. They looked puzzled at that. Once you know them, I said, it’s just not a big deal. I was not trying to change their beliefs, nor was Bruce. That, I knew, wasn’t going to happen. I knew that the very idea must have seemed alien to them. This seemed to put them in a tricky position. They clearly liked, respected, and admired me. Here was a woman who came back from an American university to conduct research at Kapkenda, someone who, unlike their Kenyan teachers, was probing *them* for their thoughts and attitudes about reproductive health. And now she’s got this strange idea that homosexuality just isn’t a big deal!

Carol, the peer counseling adviser, joined us after the workshop. As usual, we chatted a few minutes in the peer counselors’ office over tea and bread, but a rain storm was moving in, so we cut it short. As we headed to the car to load our gear, thunder screamed across the sky and lightning flashed. We got to dad and the car just before the rain. Carol would ride to Eldoret with us so she could look after her ailing husband at their home. She and my dad chatted about their families as we headed down the highway in the dark. My thoughts were stuck on the “ok to be gay” question in the Values Clarification activity and our discussion during the breakdown. I realized how my attitudes about homosexuality had changed since arriving in the United States. How else had they changed? I wondered.

A loud “pop” interrupted my thoughts. My dad had been nursing an old tire along for days now and it finally caught up with us. He safely got our station wagon to the side of the road. It was pitch dark and drizzling. All my Kenyans were already at home and the road was deserted. Dad and Bruce got the tire changed by the light of our mobile phones. Back in the station wagon,

we were ready to roll. But now the battery – something else my dad had been nursing along – was out cold. A lone matatu was heading towards us from Eldoret. Probably their last run of the day. They stopped and came to the rescue by pulling their battery and using a crowbar to jump the charge. Bruce said something along the lines of “First car stopped to help. That’s not the sort of help you’d expect along I-40.” Dad and one of our saviors were excited when they realized they had been in the same village primary school. The rest of the drive was uneventful. We dropped Carol in town and headed home. It had been a long and hectic, but rewarding, day.

Day Four: Workshop Three

Before leaving the house I reviewed the day’s activities with Judy and Bruce. I had the sense that we were all getting more and more comfortable with what we were doing and I was feeling a growing sense of mastery over the process. Bruce was unhappy about the video lighting set-up on the previous days so he went over a new plan with Judy. We got to Kapkenda on schedule. But today the computer lab, our workshop space, was locked. We sat on the verandah waiting for Mary to arrive with the key. The 4 o’clock bell rang. I could see the students in their classes stripping off their uniforms down to their T-shirts and shorts. I recalled this routine at Kapkenda: an hour run, a quick (and very cold) shower, ugali and cabbage for dinner, prep time (or study hall) for two hours, and then group discussion time to review our studies for another hour.

As the girls streamed to the field, we were the usual sensation thanks to Bruce the mzungu and our video equipment. The girls giggled as they walked past us. They whispered to each other casting quick glances in our direction. Bruce, a typical outgoing American, would loudly say “hi there,” and they would giggle louder and pick up their pace. Soon Mary arrived with the computer lab key. Her class ran overtime. She joined Judy and Bruce to help set up the

equipment. Diana arrived and joined them. It was wonderful to see how the girls joined in, especially since Diana had said she hoped to become a news anchor. Bruce and Judy seemed to enjoy instructing these budding videographers. After 15 minutes we were assembled. Today I planned to repeat three warm-ups we had previously done: Trust Falls, Circle Dash and Cover the Space. I also planned to introduce two new warm-ups: Zip Zap Zop and Find Your Mother Like a Little Penguin. The day would conclude with Monologue Work, a bridge activity.

As we waited for Lucy and Elizabeth, I played a handclapping game in which everyone repeated the name of the person next to them. Once Elizabeth and Lucy arrived we had our 13 participants assembled. We got to work with the Trust Falls. Upon reviewing the video I can see that everyone was a little more trusting that they would be caught by their partner. Even me! Once again giggles filled the room. Next we played Circle Dash. I quickly repeated the game's guidelines. This time the participants were more creative with their "switch" signals and more adept at switching. The girls giggled, clearly enjoying the game. Each time a participant was trapped in the middle, she smiled sheepishly as if asking herself "Now how did that happen?"

Next we played Cover the Space. I reminded the girls that it was a silent game and that they should all strive to get their bodies involved while trying to cover the space. The girls went into action. Today I didn't have to point out the uncovered space. They understood the activity.

It was now time to introduce Find Your Mother Like a Little Penguin, a game adapted by Michal Rohd from Augusto Boal. Judy and I had talked this over the previous night and decided that the participants would be lost if asked to figure out penguin sounds so we decided to rename the game Find Your Mother Like a Little Chick. I formed the participants into pairs. One member of the pair would be mothers and the other would be the children blindly searching for their mothers who would be making chick sounds. I stressed that the mother would have to

create unique sounds because everyone in the room would be hunting at the same time with their eyes closed. I told them to try to memorize their mother's sound. It was a hilarious scene as the teams quietly practiced their sounds. Then I told everyone to close their eyes and "mix up" in the room. "Eyes closed and using your little chick sound, find your mother. When you find your mother hold her hand. After a few minutes I'll call out 'open your eyes' and we'll see who has found their mother." I joined the game playing Monica's mother. When Monica found me I shouted "freeze." Most of the chicks had located their mothers by that time.

Upon reviewing the video, I see the girls laughing and even opening their eyes as they tried to find each other. It was hard for the chicks to concentrate and keep silent. We switched and the children became the mothers and the mothers became the children. The mothers practiced their chick sounds and I repeated the guidelines for the game. We mixed up then I asked the girls to close their eyes and "find their mothers like a penguin, er, I mean chick," I said. The new mothers began making chick sounds and their children tried to locate them. After a few minutes I called "freeze" and the participants opened their eyes. The girls burst out laughing because some of them had ended up with the wrong mother.

Reflecting back on this activity – which I wouldn't say came off exactly as I had hoped – I see a number of shortcomings emerging, some small and some more significant that I will discuss in the analysis chapter. It takes practice, quite a bit of practice, to describe, explain and organize activities effectively, especially challenging activities like this one. A workshop facilitator needs hands-on experience to discover the kinds of things that participants won't quite understand about an activity, the kinds of things that need to be emphasized while explaining the activity. Another shortcoming was that the workshop facilitator also has to learn from experience

how to best conduct a quick debrief after each activity, something that I surely could have done better.

After Finding Your Mother Like a Chick we returned to the bench for the next activity, Monologue Work using base questions. This would be our third effort at a bridge activity. I explained to the girls the concept of on-the-spot improvisation or “improv.” I explained, “Improv is basically imagining a situation and trying to solve a problem you have at hand and trying to solve that situation with your imagination.” I told them we were trying to develop our imaginations so we could build larger scenes later in the workshop. I told the girls that this activity required that they use their imaginations to develop characters. “Do we know what the word monologue means?” I asked. Lucy answered that it is “this conversation that we are speaking to our self.”

I then introduced three base questions for discussion. These base questions, I explained, would be used for their monologues. My first base question: Why do some girls your age choose to drink and use drugs? Lucy took the first stab saying “peer pressure.” Rachel said “stress.” Charity explained that if their parents took drugs, “the children were likely to emulate them.” Ann said that some girls are “idle, maybe they left school or dropped out.” Rachel explained that even high school girls still in school can use drugs. To enter some groups, she explained, there is an initiation that requires the members “to have sex with seven members from that group” and you must use alcohol and bang and rob people. I was surprised to discover that gangbanging culture had apparently filtered its way down to some high schools.

The second base question was: “Why do you think girls your age might choose to have sex with an older man?” “Because of money,” answered Elizabeth. “Some of the girls are left as orphans ... and they have to cater to their siblings,” explained Leah. Mary added that “some

girls, they have low self-esteem and they don't see themselves as worthy or valued or even beautiful, but when old men come they sweet talk them and they fall into their traps. So they see old men as the ones who value them.”

My third base question was: “Why do you think some teens get pregnant even though they didn't even want to become sexually active ... and these are really good girls the ones who respect their parents and go to church?” “Some are forced,” said Monica. “Most of the girls that are quiet, that go to church, and people usually view them as good girls ... they don't see the need of talking to them. So at the end of it all, they find that they don't know how to use contraceptives, and so they end up getting pregnant,” said Leah. “I can say,” added Mary, “maybe these girls are few so they feel quite isolated from the rest. They are considered like Holy Joes, so those are the ones who don't engage in such things. They want to prove the others wrong so they engage in such.”

After the discussion of the base questions, I sorted the 13 participants into three sections. The members of each section would each create a scene based on our discussion of one of the base questions. For example, I explained that each member of the first section would create a scene about the choice to use drugs based on one of the explanations – peer pressure, stress, parental example, initiation/group membership – provided during our discussion. Elizabeth chose to do a monologue about peer pressure. Ruth selected stress. Leah selected initiation. And so on. I then repeated the process with group two about the base question of sex with older men and repeated the process with group three about the base question of good girls getting pregnant.

I explained that they should tell a story – a monologue – related to the base question and explanation provided by the participants. I asked them to create a fictional character with details, like a name and a family, and a point of view, one that's not necessarily their own. I gave them

10 minutes alone to process their monologues. A few of the participants didn't quite get the plan and they began to form into pairs or groups. I explained that they weren't doing this in groups, but they were creating a character by themselves. A few of the participants got up to get their school notebooks, evidently to jot down notes about their fictional characters. Only upon reviewing the video did I realize that I didn't let the participants know in advance that the audience to their monologues would be able to question their characters about their decisions and the consequences of their decisions.

Leah began with story that lasted about three minutes. She played Becky, a teenager who joined a clique because she was seeking attention from her busy parents who favor her older brother. The members of the clique were up to no good – drinking, using drugs, sexually active, and being anti-social. After Becky's principal reported her behavior to her parents it was "like 'yes' I finally got their attention." In the end she realized that her parents really loved her, but they were too busy struggling to earn a living to provide for her needs. She turned to outside help, went to rehab and received counseling. Reviewing the video I am surprised at how the audience members are sitting on the edges of their chairs wrapped up in the story. Mary asked how long she abused drugs and how long her rehab lasted. Becky explained that she had several relapses. Monica wanted to know which drugs Becky used. When Becky answered "cocaine," Monica gasped. Then everyone laughed. I asked if she had ever been hospitalized. "I fainted once," said Becky, "and had some stuff coming out of my mouth. My parents were very disappointed in me." The questions lasted about two minutes.

Next Elizabeth played 17-year-old Nancy, a girl who gives in to peer pressure. Elizabeth was nervous and initially had a difficult time getting started. She explained that she was from a rich family like her new friends. Her friends looked down on the other lower class students, and

she joined them. “I had to follow the group,” she explained. Her friends were more accustomed to drugs and partying. “I was not up to their standards. I always felt intimidated with them. They would say test it. It is not going to harm you. I gave in. But I found it hard to cope with that life.” I asked if she enjoyed getting high. “No,” she said. Lucy asked Nancy if she regretted using drugs. “Yes,” she said. “How has this affected you?” asked Leah. Nancy said she dropped out of school and may not be able to get back in. “I saw this may be the end of my life,” said Nancy. She now realized that she had “just wasted her time.” “Now I have to convince my parents that I have to change.”

I reminded the participants to fill in details, to describe how things happened, and to explore the consequences of their decisions. Mary offered to provide the next monologue as 15-year-old Moreen, a teenager from Kibera, Nairobi’s largest slum. Her mother, the family breadwinner, fell from a storied building, was paralyzed on her left side, and couldn’t work. Her father became depressed and began drinking. “And life was just changing. We became poorer and poorer,” she explained. “There were no school funds for my brother and me,” she said. “We slept hungry.” One day she was walking around Kibera looking for food and there was this older guy. “He came with a Range Rover, a fancy one. And I was like, eh, this is something good.” He “opened his wallet” for me. I told him my story. I was so grateful. I told him “I’ll do anything you want.” But the condition was that I have sex with him at his place each time I met with him. He paid our school fees. “I didn’t have a choice,” she said, continuing:

I could not consider the life again of living in the slums ... of not being able to move forward. Even though I used a contraceptive, I got pregnant after a year, but he denied being the father and he sent me away. Now the condition was worse. I am pregnant and I am getting his baby. And there’s no money. And there’s no one to protect me. Or to protect my family. I regret ever having made that decision. And that’s my story.

After a moment's silence, I heard Bruce whisper "wow." Mary's four minute monologue was gripping. Her tone of voice matched the reality she described. When she described meeting the man with the Range Rover, her eyes lit up and her voice was upbeat, as if her problems in life were solved. At the end of the tale her voice softened with despair and regret. Her audience was captivated throughout. Leah asked if Moreen couldn't get help from other family members. "My uncle had to help his own family," explained Moreen. Her father was always drunk and too proud to seek help. Jaqueline wanted to know if her father knew about the relationship. "He didn't care," replied Moreen. "His life was just involved in drinking." Leah wanted to know how she treated the baby now. "I do love the baby now. ... the fault is not in the baby." "Were you ever afraid of HIV?" I asked. "I wasn't informed about such," answered Moreen.

Next up was Charity, playing Christine. She described herself as a Christian from Nairobi. While at a Christian rally at another church a male friend from her church said to her "Let's try this sex. That we hear other people say 'Let's do sex'." I said: "What shall people do if they hear I did sex with him?" But he said "Nobody will suspect us, because we are on the praise and worship team." Christine said she went along because he was convincing and was her friend. She said they had sex during church services behind one of the buildings. (Here the audience laughs). After this they went to back to church. Back at home "I was just disturbed ... I was not that normal. I was thinking rhetorical questions that I could not answer myself," said Christine. Her mother suspected something, saying "You don't look like the Christine that I know." I said it was nothing, but after two weeks she once again said "Just tell me the truth." When Christine told her mother she had sex with the boy "she was really disturbed." "Is this really the girl that I know, or another girl?" her mother asked. Her mother took her to the hospital, and she found out that she was pregnant. The church members wouldn't allow her back in the church. After a year

and she had the baby, she returned to the church and confessed. “They prayed for us,” said Christine. “Since I came from a Christian family, they had to forgive me. We were prayed to at the church and allowed to come back to the church. And that is the end of my story.”

Lucy immediately asked “Who takes care of the baby now?” Christine explained that she stayed out of school for a year during form two, but that her mother takes care of her baby now and she is back in school. Lucy followed up, asking “Do you think this action that you took with the boy will affect your future marriage. Do you have plans to marry this boy you had sex with?” Christine said she wouldn’t. “Since he convinced me to do sex with him, it’s like he didn’t love me. Not that true love.” Leah wondered about the availability of counseling services at the church and then wondered “Why did the church chase you away? It didn’t seem to be the right thing to do.” Christine explained that she didn’t accept it herself that she had sex with the boy. “So it was like I was cheating to them but they really knew it,” explained Christine. “So they stopped me because I was a great sinner and taking myself to be in the praise and worship.” Leah persisted, saying “But a sin is a sin and there’s no difference between you and a person who steals one shilling, so why did your church chase you out? Were the preachings that you were getting maybe ... I don’t know.” After a long pause there was a nervous giggle in the audience. Christine struggled to answer and then fell back on the fact that she had failed to confess in the first place. Lucy asked if Christine’s past relationship with the boy will affect his future relationship with other girls. Christine really thinks this one over. She smiles broadly. Thinks it over some more. I jump in asking: “He’s the father of your child. How do you think the other girls look at him?” Christine said that the girls will not trust all the boys at the church after this.

Unfortunately we didn’t have time for all the participants to do their monologues. But I was excited about the monologues that were presented. Now in the final edits of this draft I am

still struck by how deeply the participants embraced their roles not only as storytellers, but also as interrogators seeking to understand the issues the storytellers had presented. I decided to end things with a quick session of Zip Zap Zop. But there clearly wasn't much energy left to be found, even for Zip Zap Zop. I thanked the girls for their hard day's work. As we were breaking down, Mary and Rachel came back with tea and bread. Mary had an old tattered Kapkenda newsletter. "Do you remember this?" she asked. Goodness! It was a picture of me in the opinions column promoting school spirit and urging my fellow students to study hard. "Where did you get that?" I asked Mary. She said she saw it in the school library and recognized my picture. Judy and Bruce cracked up when they read my line "Wow! We're Kapkenda girls! We can succeed if we work hard every day!"

We had a smooth ride back to the house. I couldn't get my mind off the Monologue Work session. The girls really went deep. I was happy with how they were able to build their characters and how they made their stories seem real. It was wonderful seeing everyone so riveted during the stories. Bruce said he had some great reaction shots of the audience listening to the monologues. I was very grateful for my star participants Mary, Leah and Elizabeth. These girls were always quick to volunteer no matter the challenge. They did a great job, seldom falling out of character. I realized that I needed more practice at efficiently providing activity descriptions and guidelines. I sometimes would forget to give an important detail, and it would throw the participants off. I was upbeat and feeling that the participants were really starting to use the workshop, as Michael Rohd put it "to explore the interactions that make up their lives" (p. xix). And they were having fun while doing it!

Day Five: Workshop Four

We started workshop four on schedule. Everyone was present, excluding our standouts Rachel, Mary, Diana, and Lucy who were away at a school awards ceremony. The day's plan was to briefly discuss the reproductive health facts I had provided during the information session, to introduce a new warm up called Machine, and to have the girls perform two improvisational activities, Relationship Wheel and Line Improv. I opened with the reproductive health information session discussion to help generate themes for the Line Improv.

I was a bit nervous, especially since four key participants were not on hand. Warm-ups and trust activities, though sometimes difficult to explain clearly, don't call for a lot of nerve and imagination. Even if things didn't go exactly as planned, warm-ups and trust activities were always fun and generated a lively atmosphere and a sense of group unity. And even if the participants were swimming in unknown waters with these activities, they weren't exactly putting themselves on the line. But with improvisational activities the waters are more perilous. On-the-spot creativity isn't just challenging, it can be scary as well. But I now knew the participants well. They knew and trusted us. They were now indifferent to the lights and cameras. We all had the sense we were on a mission of some sort. Still having Rachel, Mary, Diana and Lucy around would have been reassuring. Judy and Bruce had things up and rolling. I took a deep breath and began workshop four.

In the information session discussion I went right to a critical issue. "About 40% of girls your age have had sex, despite curriculum- and religious-based promotion of abstinence. And these are good girls, just like you," I said. "When they hear about sex, they hear 'abstinence' and little else. So why do you think this number is high?" Ten seconds pass and not a peep. I rephrase the question. "What do people talk about when they talk about sex?" Leah finally raises

her hand, a formality that's hard for Kenyan schoolgirls to let go. The media does in fact promote condom use instead of abstinence only, she says. "And do you think people know how to use contraceptives?" I ask Leah. On video review I see Ruth cast a delightful half smile toward Leah as if asking "Uh oh. Let's see you answer that one."

All the participants agree that none of their parents had discussed contraceptive use with them. "What's the message they convey?" I ask. In unison all the participants say "abstinence." Leah nods her head in agreement. "But people are still having sex," I say, "as much as they say 'don't have sex.'" "Should the message change?" I ask. Elizabeth says that, sure people should talk about contraceptives, "the effects, that you cannot be 100% sure." I pop into my mentor mode to give a quick mini-lesson on the proper way to use a condom. "What would be the proper way to use a condom?" Dead silence. Ann and Charity stare into the void using their body language as if to say "don't look at me." I recall the advertisement that ran in the early 2000s for Trust Condoms. "Trust Condoms, kila mtu na yake" (which translates as "Trust Condoms, everyone should have theirs"). "Who can tell me the proper way to use a condom?" I repeat. And repeat again. No one says that they've seen demonstrations on condom use. The participants listen attentively as I provide some specifics about condom use. The participants mention other types of contraception they've heard about: the coil, pills, and injections. They don't mention female condoms, rings, patches, implants, Plan B, diaphragms, sterilization, or vasectomies. Reflecting back upon this discussion, I'm thinking that workshops with specifics on contraception methods are needed, or, at a minimum that performance workshop coordinators be prepared to provide detailed on-the-spot reproductive health information.

Next I introduced Machine, a silent warm-up conceived by Voila Spolin. In this activity the participants form a circle. One establishes a clear rhythmic motion using her entire body. One

by one the participants add a new rhythmic motion to add to the initial rhythm. This forms the “machine” of movement, I explained. I decided to start the machine. The first time around everyone basically imitated my movement. The second time around the participants were a little more creative, finding my rhythm while not imitating my movement. I called “freeze.” Next, I explained, we’ll each add a different sound to our movement. Monica started our machine with a silent dance-like move. Charity struggled to find a different movement. When it was my turn to join the machine I added the sound “oh lo lo, oh lo lo.” Rita, next in line, was stumped. “Let’s try this again,” I said. Bruce suggested that everyone just do the same sound. Leah started the machine with a unique shuffling movement with her feet. The sound of her shoes set the rhythm nicely. Elizabeth joined. I then added sound to the machine: “whop whop whop.” Rita added her rhythm and a “whop whop whop” sound. Monica added a distinctive arm movement. And so it went. “We got it,” I said when the machine came full circle.

The next activity, Relationship Wheel, would be our very first improvisational activity. It is a Michael Rohd original. I asked the girls to select a partner and then form a circle. I told them I would call out a relationship and an activity, such as two friends washing dishes or a mother and her daughter farming. I explained that the pairs would begin silently in an activity. After a minute or so I would call out “speech.” Then they would add talk to their activity. “Be sure to listen to each other. Have a conversation,” I said. Their conversation could be about anything so long as it related to sexuality and reproductive health. They would continue until I yelled “freeze.” When finished, I explained, we would rotate partners and do a different activity with a new relationship.

I set up the first round as two friends silently washing their clothes. After a few moments I yelled “speech.” The conversations between the pairs began immediately and the room was

filled with hushed conversations. I formed a pair with Leah. Judy and Bruce floated around the room. Judy moved in closely with her boom mic to catch fragments of conversation scattered throughout the roomful of clothes washers. Here are some of the conversation fragments: Charity's character – "a guy who told me he loved me and wants to go out"; Monica's character – "maybe I will do an abortion ... I don't know how I can control my feelings now"; Ruth's character – "I don't think that's a good idea"; Leah's character – "the pamphlet we (peer counselors) have is about rape"; Doris's character – "one boy approached me but I just ran away." The conversations were non-stop. After about three minutes I yelled "freeze" and asked each group to summarize their topic.

Leah and I talked about contraceptives. Jane and Jaqueline's characters talked about "a relationship that is not correct ... to have maybe a lover at this age." Rita and Ann's characters talked about Rita's boyfriend "who told me if I don't engage in sex with him he will leave me." Ruth's character "encouraged" Monica's character not to get involved with a boy "because you might get pregnant." Charity and Doris's characters talked about a guy who proposed to Jaqueline's character that they be lovers. Doris's character said "it is still early to get in a relationship with him."

Upon reviewing the video, it's exciting to see how deeply everyone was involved with each other. The physical action of washing dishes seemed to liberate the participants to talk freely. I now wished Judy and Bruce had set up remote mics on a few of the pairs so I could review the specifics of the conversations.

The next round was to be a conversation between a mother and a daughter farming in the fields. I paired with Charity. Again Judy and Bruce roamed the room with the camera and a boom mic. Some fragments of conversation included: Monica's character – "Do you know

Kibet? I have fallen in love with him.” “It is not good,” replies her partner Doris’s character. Ann’s character – “They want me to carry out activities like discos and taking drugs and alcohol.” I yelled “freeze” and asked for quick summaries. Jaqueline said her partner’s character – yours truly – advised her it might be best to delay a relationship. Leah’s character was telling her mom about “this guy I really liked and we kissed and I was afraid that it would go to some extent, a more risky extent. And she told me not to engage in some stuff.” Elizabeth’s character was telling her mom about her friends who are encouraging her to use drugs. Ruth’s character advised her daughter not to spend time with a friend who was pressuring her to try sex. “I advised her that she should not accompany her anymore,” said Ruth’s character. Monica’s character told her mother she was pregnant and wanted an abortion. “She encouraged me not to do so. That I should just keep the baby,” said Monica’s character. I asked her partner Doris how she felt to discover that her daughter was pregnant. “I told her that she should not abort. It was just by a mistake. She should keep the baby.”

The next round was to be a conversation between a boyfriend and a girlfriend having tea and mandazi, a pastry similar to a doughnut. We began silently. Monica’s character, a sweet boyfriend, held up some mandazi to my mouth. Jane’s character placed her hand gently on Elizabeth’s shoulder. Fragments of sound: Ruth’s male character (mixing English and Swahili) “Ile story ya jana nilikushow, about sex ... you promised me” (which translates as “About that story yesterday, about having sex ... you promised me”). Elizabeth pleads: “No, no. Why can’t you wait until I’ve finished school?” Leah’s character: “I told you to use contraceptives. You can’t blame it on me.” I yelled “freeze.”

My character, a boy, was trying to make arrangements for a sexual tryst. Monica said it would be difficult because her sister would be accompanying her when they “fetch firewood.”

Jane's character, a boy, told Charity's character "I'll be taking her for dating tomorrow. And she accepted." Ann's character, a boy, was denying responsibility for his partner's pregnancy "because maybe she has other boyfriends, secret ones." Ruth's character was telling his girlfriend "she promised to have sex. She refused." Doris's character was trying to talk her girlfriend out of getting an abortion: "I told her to stay with the baby, until the time of giving birth."

Next we moved on to Line Improv. I explained that the participants would form pairs facing each other from about ten paces apart. I would provide a relationship, a circumstance, and an intention for their characters to play out. I explained that they would be responsible for building detailed real-life stories on the spot. I emphasized that, as always, they needed to stay in it, to stay in their characters, to find truth and emotion. I gave the participants a minute for them to think over their characters.

In the first Line Improv, I played a mother. My partner, Doris, played my daughter. She is worried that she may be pregnant. She tells me her period is late. She does not want my character to tell her father. Doris gave a flat and unimaginative performance. She might as well have been reading tax forms. "My menstrual flow has stopped for two months," she said with an out-of-character half smile. She always seemed uncomfortable, always kept her performances brief. Naturally shy? I wonder. Or was this a subject she just couldn't feel relaxed discussing? I told her she would have to tell her father. "But me, I also fear to tell my father," she said with a grin. She then added that she didn't know who the father of the baby was "because ... I had so many boyfriends." I am acting like a horrified mother might, but she just can't get in character. I would love to be able to review how everyone else was reacting to Doris's unrealistic performance, but it's not on video. I clearly should have asked some questions after this

performance: Was it realistic? Did she stay in it? Is this how a young girl would report her pregnancy to her mother?

The next Line Improv was played by Elizabeth and Rita, two sisters. Elizabeth played the older sister, Rita a younger sister who wants to get sexually active. Rita's character wants Elizabeth's character to buy condoms for her. The older sister refuses. She tells her younger sister she is too young. "Condoms are not that protective. You are my sister. I have the responsibility to watch over you," she said. "I am not telling you to advise me about it," says the younger sister. "Having sex means that you are digital. Since you are still analog, you may buy for me those condoms and I continue with my business." "You are still young," repeats the older sister. "I am young but digitalized. What about you? You are stupid." A much better performance. The performers stayed in the scene. The references to "digital" vs. "analog" are exactly the kind of thing you might hear a young Kenyan adolescent telling an older one while the older sister is trying to keep her on the straight and narrow.

In the next Line Improv I set a scenario in which one friend would be pressuring the other to get sexually active. When I asked "Who will play the sexually active friend?" there was a pause and then laughter. "Ok, ok," I said, "it's just imagination." After that was settled Leah agreed to play the sexually active friend; Jane would be the other friend. "Hi Becky. How are you?" opened Leah. "How's Collo that boyfriend of yours?" Jane's character says she's solo, has no boyfriend. "Eh, you are almost 17. You're going to be a grandmother soon," says Leah's character. "You'll be married soon. It's the only way to know if he's good in bed or not." Leah plays off Jane's comments wonderfully. "You don't have to be a Holy Joe, you know. You have to explore life. You know that motto YOLO? You only live once." Jane's character says she's

“born again” and that she was “brought up in the church.” Leah’s character retorts “so was Beyoncé. Her father was a pastor.”

The next Line Improv is a boyfriend, played by Monica, and a girlfriend, played by Ruth. I set the scene up as follows: They are sexually active. Monica’s character has heard a rumor that her boyfriend’s former girlfriend has tested positive for HIV. She wants to get tested together. He’s doesn’t. Ruth begins: “I’m scared. I’ve heard something that’s not pleasing. I heard that your ex, Charity, has HIV.” Monica, playing Nixon, counters in a not uncommon aggressive Kenyan male fashion: “You girls like believing in rumors. Who told you?” Ruth’s character repeats that she wants Nixon to get tested. “Me having HIV?” counters Nixon with a dismissive wave of the hand as if the notion was too ridiculous to contemplate. “I’m sorry. I can’t go. I can’t go ... You are so stupid. I don’t love you anymore. Psheeeew!”

The final Line Improv was played by Charity and Ann. Ann played a boy who wants his pregnant girlfriend to get an abortion. Jaqueline begins: “Hi Tony. I have a story to tell you. Should I tell you? Should I tell you really? Will you not react that much? You know what Tony? I am just even afraid of telling you this. I’m pregnant. I’m pregnant.” Charity utters these last four words with a tone of complete grief. Ann’s character says she must abort “because at this moment I am not financially stable and I can’t be able to raise your child.” He continues: “My parents are very strict and they might even kill me.” But Charity is afraid. “Abortion is very dangerous,” she says. “I may die.” Ann’s character is cold-hearted. “No problem,” she says. The participants watching the line improv giggle slightly at this uncaring (and unrealistic) reaction. “This means you don’t love me. You used to tell me that you loved me.” Ann’s character is cruel. With half a smile she says “Who told you to believe my words?” Charity reacts with these words: “I will never trust a man again. If you can do that to me.” Charity, who stayed in

character beautifully, faced an interesting dilemma: Her improv partner didn't stay in character, wasn't imaginative, and was not particularly realistic.

We concluded the day with our usual rituals. We had tea and biscuits while we broke down our equipment. Elizabeth, Leah, and Jane stayed to chat about Kapkenda life. I asked about the changes that had occurred since my days. As we discussed this, Bruce began asking question after question about their classes and teachers, their living arrangements, the food, and more. He pushed them on the whole idea of leaving home to go to an all-girls boarding school. Wouldn't they prefer to be in a mixed (or co-ed) school? Wouldn't they prefer not to wear uniforms? Wouldn't they prefer to be in a school near their families? His questions seemed to puzzle the girls. I suppose an American teen in Greenville would be as puzzled by the sudden proposition that it was time to purchase a uniform for her boarding school in Asheville. And that once the school session begins she would visit home a mere three times a year.

On the drive home I reflected on the day's activities. Yes, we were getting through the activities successfully, but I felt I wasn't getting the participants to explore issues as deeply as I wished. This is an issue I will explore further in the final analysis. As I write up this section I found myself taking side notes to the effect that I should have pushed for more feedback. I should have asked questions such as: Did the characters stay in it? Did they make it real and important? Did they build the story together? What might the characters have done differently? And so on. Live and learn, I guess.

Day Six: Workshop Five

It was raining, but we managed to get up Kaptagat Road to Kapkenda before the road dissolved into mud. Everyone, excluding Rachel, made it to the final workshop. I was already sad thinking that we would only see everyone once more after today, at the concluding focus

group. Now that we had attempted bridge and improv activities, we would try our hand at creating activating scenes. Rohd calls this activity Small Groups and describes it as “compressed scenarios that relate specifically – either realistically or metaphorically – to the lives of the participants in the room” (Rohd, 1998, p. 98). The facilitator can freeze these scenarios, pose probing questions, and get an audience member to jump into the scene as a character replacement to explore choices and options.

I decided to let the participants select their favorite warm-ups. They selected Zip, Zap, Zop and Circle Dash. The warm ups got us into a fun mood quickly. We then returned to a bridge activity, one we had done on day three, Values Clarification. I wanted to introduce a few new statements to the activity today.

All the participants moved to the “I Agree” station after the first statement – “It’s ok for girls your age to hold hands with a boyfriend” – but none, at first, admitted to having ever done so. After I asked “How many have held hands with a friend?” – implying that I meant a male friend, not necessarily a lover – Rita started to raise her hand, but then paused. Evidently she wasn’t interested in sticking her neck out alone on this issue. But when she saw Monica confidently raise her hand she completed the action. They are the only two of the group who admitted to having held hands with a male friend. When I asked again if anyone has ever held hands with a boyfriend there were still no hands. But after I said “I have,” Monica, often the bold outlier of the group, raised hers.

All participants moved to the “I Disagree” station with the next statement that “FGM is an important tradition and should be allowed.” The reasons provide against FGM included: bleeding, disease, and childbirth complications. I was not surprised that not a single participant mentioned the likelihood that FGM is likely to diminish sexual pleasure.

My next statement was “It is ok to get a divorce from a man who is physically abusive.” Elizabeth was the only participant to stand clearly in front of the “I don’t agree” station. The rest agreed with the statement. Elizabeth disagreed saying you shouldn’t divorce because “it is not allowed” and “it is a sin.” But because the stations were close together, I was confused about Doris. Here is an interesting example of Kenyan schoolgirl submissiveness to authority. First she told me that she agrees with the statement. But it didn’t sink in. I then asked her why she *doesn’t* agree that it’s ok to divorce a physically abusive husband. Rather than correcting my confusion and stating flatly that she does in fact agree, she said this: “If you have fell in love with him it is difficult to divorce him.”

Monica agreed that you should leave “because he might go to the extent of killing you.” Mary argued that it is only a sin if you divorce and then remarry. “You should separate and be on your own before you get hurt ... and end up dying,” she said. I then probed for suggestions about what a woman might do if she is being physically abused. Lucy suggested that the woman should explain to him that what he is doing is “against her will,” and if he continues she should leave him.

Then I changed the issue from physical to mental abuse. “What if he is mentally abusive to you? He’s not beating you, but he’s messing with your mind. He is messing with your self-esteem.” First Lucy, then Leah, and then Monica, moved to the “I Am Unsure” station. “It depends on the relationship you have and if you really love him. And maybe if that’s his character, there’s no way that you can divorce him,” says Lucy. “Maybe you made him angry,” says Monica. “Maybe I’ve gotten older and stopped maybe taking care of myself, and I’ve stopped doing all the things I used to do when I was younger. Maybe he tells me that because I’ve stopped doing those things,” says Leah.

Rita, on the other hand, argues for divorcing a psychologically abusive husband. “If he is abusing you mentally, that means that he doesn’t have interest in you. It means that he has found other women. So he sees you as ugly and useless.” Mary backs her up with these words: “Why spend the rest of your life with someone who doesn’t even care? ... You may even end up losing your mind.”

Since Mary and Lucy were back with the group today, I wanted to see what they could do with Line Improv, the activity we did on the previous day, but with a new circumstance. I set up the scene as one between a mother and daughter. The daughter wants to get an abortion, but the mother wants her to keep the child for reasons of Diana. Lucy selected to play the daughter, Mary the mother. Lucy’s character began solemnly: “Mom I have something to tell you. Mom do you remember when you allowed me to go out with Mark?” “In December?” asks the mother. “Yes I remember.” “There is something that went on,” said the daughter. “Uh huh, I am listening,” said the mother. “I find it hard to explain to you but since you are my mother I am going to tell you,” said the daughter. The mother replies, “You can tell me anything my dear.” “I am pregnant,” says the daughter. The mother, looking stunned, asks “Are you serious? Are you sure? Did I hear you right? What did you say? 100 percent sure? But how? What happened?” The daughter says she is three months pregnant. “And Mark is the father?” “What were you thinking?” asks the mother. “I was just experimenting,” answers the daughter. “Experimenting?” asks the exasperated mother. “You should have known better. I have taught you everything about the Bible. You are not supposed to mess around when you are still young.” Mary’s character concluded the Line Improv explaining that she would take care of the child and transfer Lucy’s character to another school to save her from humiliation. “But just don’t. Please don’t abort the baby. Ok, my dear?” As expected Mary and Lucy’s Line Improv was performed beautifully.

“You did a wonderful job. Your imagination ran deep,” I said as we transitioned to the next and final activity, Small Groups.

We then arranged the room so that there would be performance and audience areas for the activity. I explained that the participants would break down into groups of three for 10 minutes to plan a scene to present to the audience. I explained that the Small Groups scenes would last about four or five minutes and could be about any issue related to reproductive health, I briefly reviewed some of the issues that had come up during the workshop and said they could work with these or any other issues they wanted to explore. I explained the distinction between a protagonist and an antagonist – the idea that someone, the protagonist, is trying to accomplish something, while the antagonist is frustrating the goal of the protagonist. I suggested that each group deal somehow with the issue of “disclosure,” a term I defined and explained. I gave a few examples: someone disclosing that they are HIV positive, someone disclosing that they are sexually active, someone disclosing she is pregnant. I told them not to plan specific lines or write an exact script, but rather to plan a general outline of the situation and identify who would be playing each character in that situation. I reminded them to make it real, something that could happen in real life, to provide details, and to put emotion into the scene. What we wanted, I explained, was “something that will draw everyone in so that we’d say ‘whaaaat?’”

A delightful hushed buzz filled the room as soon as everyone went into their breakouts and planned their scenes. Judy and Bruce handed small voice recorders to each group so that I could later study their planning sessions. In all, there were three groups of three and one group of two, Mary and Diana. After five minutes I went to each group to hear about their plans and offered a few reminders, suggestions, and words of encouragement. Two groups selected FGM

as their topic, one group selected alcohol and drug use, and the last group chose to do a scene about rape.

Monica, playing a mother, Lucy, playing a father, opened the first scenario. They are discussing the upcoming circumcision of their daughter, played by Leah (who is not in the space yet). The father reminded the mother that “tomorrow is a very important occasion in our community.” The mother agreed. The father asks if their daughter is prepared. “I’ve not told her anything, so she doesn’t run away,” said the mother. “I do not want any shame on this house,” said the father. The daughter is now in the space and overhears the conversation. She asks “What is this I hear about being circumcised?” The mother moves toward the daughter and misleads her saying that she is “just going somewhere.” The daughter sees through this ruse and the mother then admits that, yes, she will be circumcised tomorrow and that she “should not shame the father.” The mother tries to reassure the daughter saying “Even I had it. Look at me. I am still young.” The daughter cries “You can’t do this to me.” The father reenters the scene asking, “What’s this I am hearing?” As the daughter holds her ground, the father asserts his power saying “So long as you live in my home, my dear, you are going to be circumcised.” The father says she will bring a “curse” and “death” to the family. “I may die,” says the daughter. “Your mother never died,” says the father. The father asks his daughter to explain her refusal. “Because I have many dreams,” says the daughter. The father says her mother had dreams too. “And has she even accomplished one?” ask the daughter. The father replies “Yes, having married me.” Here the audience laughs noticeably.

At this point I freeze this excellent performance and ask, “Does anyone have questions for our characters?” Rita wants the father to explain why FGM is so important to him. “She’ll become a real woman. And let me tell you, a woman who has been circumcised will never be

unfaithful to her husband,” he explains. I then ask if someone would be willing play a mother making different choices, one that doesn’t support her husband. Elizabeth fills in for Monica, the mother, at this point. They pick up with the new mother responding to the father’s insistence that the daughter be circumcised. “No,” she states firmly, “our daughter will never be circumcised.” The daughter positions herself behind her mother, as if using her mother’s body as a shield, and they both stare assertively at the father. “So both of you are turning against me in my house?” demands the father. The mother and daughter lean forward together and, in a firm and loud chorus, shout “yes,” a terrific moment of female opposition to male dominance. “I am the man of this house and nobody goes against me,” he says. The mother, now very emotional, holds her ground. “I know the consequences, and I will never let my daughter to be circumcised.” The mother outlines health issues she and her sister faced from FGM. The father makes a final appeal to his honor in the community. I freeze the scene.

Next up were three girlfriends played Ruth, Rita, and Ann. Ruth plays Lisa, an adolescent girl being challenged by her friends Lynn, played by Rita, and Claire, played by Ann. Claire is drinking and Lynn is smoking. They are acting stoned and drunk. “Have you gone crazy,” asks Lisa. “It’s for pleasure,” says Lynn. “That’s not nice,” says Lisa, warning her friends about the effects of using drugs. “When you are drinking alcohol you will be enjoying your life,” says Lynn. “The stress will be relieved.” Lisa warns her friends again about negative effects saying “You have red lips” – a remark that calls to mind sickness and the likelihood of having AIDS. I freeze the scene and suggest a gender flip: “What if Claire and Lynn were boys?” I ask. “Do you want to try it?”

This time Rita and Ann, playing the boys, get up into Lisa’s face. Ann aggressively holds her joint up to Lisa’s face. Unlike the girls in the earlier scene who rhetorically tried to change

Lisa's mind, the boys are aggressive and in her face. "I can't," pleads Lisa. "I'll beat you thoroughly," says Rita. I freeze the scene and ask the audience for questions or comments. "Why are you forcing her?" asks Lucy. "Because we want her to be in our group," answers Rita. "Which group?" demands Lucy. "The group of abusing drugs," answers Rita. Ann covers her face with her hand. She can't hold back her smile on that peculiar answer. I suggest "digital group" and she says "yea, the modern group." Rita may have stumbled finding a group name, but she does get to a key issue facing adolescent girls – peer pressure and the need to feel that one fits in.

Next up was Doris, playing a father, Jane, playing a mother, and Elizabeth, playing a daughter. The daughter has just been raped taking a shortcut home from buying sugar at a nearby shop. Once again Elizabeth is placed in a difficult situation. Her performance is stellar, but her partners produce flat, unrealistic, and uninspired performances. The daughter enters the scene limping silently. She is devastated. "Where is the sugar?" the father asks. "Or have you eaten the money?" The daughter says "Something has happened. I am even ashamed to tell you ... I was raped." The mother and father remain seated. "By who?" asks the father. "I don't know," replies the daughter. "What were you doing on the way?" asks the father. The mother, still seated, has yet to say a word. The daughter then asks: "Why are you asking such a stupid question?" It is as if she's asking *both* the actors and the characters this question. As the daughter provides some details about the location of the rape, the parents are still seated, unmoved by the girl's plight. I call out "freeze." "Is this realistic? Are they being real? I think the dad and the mom might be smiling. Is it real?" I ask. I suggest that they take another go at the scene. Elizabeth once again is in top form performing the rape victim. The mother and father take to their feet, but keep their distance and aloofness from their daughter. Once again, even after their daughter expresses

suicidal intentions, the mother asks, rather passively, who the rapist was. Once again the daughter says that's a stupid question. We are clearly going nowhere. After a minute or two I again call "freeze." I ask for questions. After a short silence Bruce says "I am curious. If you were raped ... think about what your father and mother would do." There is a sense in the room that Doris and Jane didn't step up to the challenge. I ask for a supportive round of applause to help them save face.

I then suggest a replacement with a new mother and father. Lucy would play the father; Leah the mother. The father is wondering aloud where their daughter is. "It's taking too long," he says. The daughter then enters the room, same as before. The mother immediately notices that something is terribly wrong as soon as the daughter cries, "Mum." "Why are you crying? What is the problem my daughter?" She asks as she approaches her tenderly. The mother is physically and emotionally supportive. She wraps one arm around her daughter, holds her arm with the other. "What is it?" asks the father in a stern tone. "I am ashamed of telling you," says the daughter. "What is it?" whispers the mother. "I ... I was ... I was raped," cries out the daughter. The mother jolts back in horror. The father shouts "Raped!" He demands to know who the culprit is. Then he's on a tirade about his honor. He turns to the audience: "These people don't know me. I am a man. How can they do such things to my daughter? The whole community will suffer." He then commands the mother to take the daughter to the hospital. She insists that he accompany them. I say "freeze." This time there was no need to solicit a face-saving round of applause.

Then I asked for a replacement for the mother. Monica jumped at the opportunity. She clearly had something in mind. Again the mother and father begin the scene wondering why their daughter is late. As soon as the daughter arrives, and before she utters a word, the mother

realizes that something terrible is up. She approaches her daughter warmly. “What is wrong? Say it! Please tell me.” The daughter replies: “I regret this ... I was raped.” Monica, playing the mother, explodes into the most dramatic scene of the entire workshop. She turns away. She raises her hands to her head, slaps her hands to her knees in horror. “Uuwee! Kigeme! Heh! HEH! HEH! RAPED! Uuuhuuuu ... Who did that? Kigeme.” (Kigeme in her tribal language, Kalenjin, translates as “We are dead.”) While shouting these words, Monica rapidly paces back and forth between her husband and daughter. She rapidly slaps her hands, moves them to her hips, then thrusts them into the air as she stabs her knee into the air. “SHE IS RAPED,” exclaims the mother looking at her husband and placing her hand on his shoulder. “Woouoooo!” she shouts as she crouches down. “Are you sure your daughter is raped?” asks the father. “Can’t you see this blood here?” asks the mother getting close and pointing to her daughter’s legs. Once again she cries out “Woouoooo!” “My daughter ...” she says tenderly. I say “freeze.” Everyone immediately breaks into laughter at the dramatics. Elizabeth, the daughter, slaps her hand to her forehead cracking up as she exits the performance area. Monica thrusts her head back in laughter. Despite everyone’s laughter after the scene, this is exactly how a horrified Kenyan mother might react. I take a moment to discuss how parents might immediately react to a daughter’s report of being raped. I slip into my mentoring mode and tell the girls it’s important for a rape victim to go to a hospital immediately.

Only two participants, Mary and Diana, were in the final scenario, a second one about FGM. In this scenario a father, played by Mary, tells his daughter it is time for her to “transform into a big girl.” The father pressures his daughter with an appeal to the customs of their tribe, the Masaai. She resists and threatens to run away. The scene plays out very similar to the FGM

scenario above with Monica, Lucy and Leah, so I need not provide a detailed summary here. But the participants do improvise the situation nicely. Soon I say “freeze.”

I suggest a substitution. “What if someone plays her best friend and she’s trying to convince the daughter that FGM is a good thing?” I ask. Diana’s character begins the replacement scene expecting support from her best friend: “I was told that I will be circumcised tomorrow, but I cannot allow it.” Lucy’s character surprises her with this line: “My friend that is a very sweeeeet...” Diana’s character cuts her off: “No, no, no. Even you are supporting.” Lucy’s character plays down the danger and pain, saying “this is the only way to become a woman.” Diana’s character appeals to what she’s been taught in school about the dangers of FGM. “All those teachers,” warns Lucy’s character, “are big liars.” “Let me tell you,” she continues, “education was brought by the white man. Don’t you see we are black? We are supposed to keep the customs of our land.” She continues arguing that FGM will show support for her community. She says she’ll be on hand for support. I call out “freeze” and say “good job.” Everyone claps.

It’s been an extremely long day. Everyone is clearly worn out, so I keep my final comments short. As the participants settle back to the bench I say “Gosh. We’ve done so much. You guys have taught me so much. You taught me things I didn’t know. I hope you’ve learned things you didn’t know before.” I ask them to process the workshop and tell them that we’ll be meeting in two days to have our group discussion, a focus group about all that we’ve done.

After Judy, Bruce, and I have all the equipment packed up, Mary, Leah and Lucy escort us to a nearby classroom. The students there, it seems, were dying to meet us and ask questions. The classroom was packed with about 50 students. The scene was electric. I introduced myself. Told them I too was a Kapkenda girl and was doing research for a thesis. After each bit of

information I provided the class they would shout “WOW!” in unison. Judy told them where she went to high school and said she had just finished college. “WOW!” they replied. Bruce was next up. They could barely hold it together. He said he was a professor. “WOW!” He said he had done anthropology in India. “WOW!” He asked them if they knew what anthropology was. He explained it a bit. He said that he and I had worked on two documentaries together. WOW! WOW! WOW! The scene, which repeated itself in two more classrooms, was both heartwarming and hilarious. Bruce jokingly recalled the newsletter that Mary had brought to us a couple days earlier. He pointed out that I too had used the word “wow” in the column I wrote as a student. He suggested that I was most likely the source of this peculiar tradition. Kaptagat Road was still muddy, but made it to the highway. We were in good spirits and had a fun ride home joking about the classroom scenes and telling my father every detail we could remember about the scenarios the Kapkenda girls had produced.

CHAPTER 3

FINDINGS, RECOMMENDATIONS AND REFLECTIONS

In this concluding chapter I will first provide a brief description of the schoolgirls at Kapkenda, including those who participated in the workshop and those I interviewed. Following that I will provide a short discussion of how they say they get their reproductive health information and their attitudes on a variety of reproductive health issues, including contraception, virginity, abstinence, sexual debut, abortion, homosexuality, female genital mutilation, and lastly, the nature of men, women, and love. I will then outline some of the shortcomings and lessons learned from the project, provide a few suggestions, and conclude with a few personal reflections.

Kapkenda Girls, Who Are They?

Most of the girls in the workshop and interviews are members of my tribe, the Kalenjin, but one was Kikuyu. Most are from the small towns or the countryside, but a few are from larger cities such as Eldoret and Nakuru. Their parents hold a variety of occupations: several are teachers, others included farmers, factory managers, doctors, business men and women, and government employees. All the girls in the workshop as well as those interviewed said they are Christians, not surprising since about 78% of Kenyans are Christian (45% Christian-Protestant, 33% Catholic, 10% Muslim, 10% Indigenous Religions, 2% Other) (Religion, Republic of Kenya, n.d.). All said they were regular church goers, and many said that gospel was their favorite music genre. One workshop participant even said she aspired to be a gospel singer. I will explore this in depth below, but now it should be pointed out that religion, and the concept of sin, often provided the rationale for their stance on a number of issues – such as abortion, virginity, and homosexuality – related to reproductive health. It is safe to say that Christianity, specifically

a Kenyan synthesis of African traditional culture and the European Anglican Christianity first brought to Kenya in the mid-19th century by the German missionaries Johann Ludwig Krapf and Johannes Rebmann, is the driving force behind the worldview of the Kapkenda schoolgirls who participated in the workshop.

Both the girls in the interviews and the workshop participants were school peer counselors. Most of them expressed ambitious career goals. On a few occasions they stated that they feared that a reproductive health issue, especially pregnancy, but also HIV/AIDS, would prevent them from achieving their goals in life. Future careers most often mentioned included doctors, lawyers, and university lecturers. Also mentioned were airline pilot, surveyor, and news anchor. I was approached numerous times with questions about how they could get to the United States to study at a university. Just one girl aspired to what would be considered a working class career as a beautician. They all planned to marry in their mid-20s and almost all planned to have two children. They all thought that having a traditionally larger family of, say, four was laughable.

What stands out is how sweet and polite the schoolgirls were. This didn't surprise me, but it was something that the project videographer Bruce, an American, often commented upon. He couldn't resist comparing their behavior to what one might expect from American teens. When asked about their aspirations beyond their careers, the girls had answers like "to be role models" or "to help their parents financially" or "to build a house for their parents." It was never about taking, always about giving. When the girls came to each workshop they sat on the benches quietly, scarcely talking amongst themselves. They were what you would describe as "well-mannered." Even several days into the workshop I noticed that even the most self-assured

participants would still raise their hands to answer my questions, despite the fact that I had often told them they could speak up without doing so.

But there is a flip side of this politeness. I'm not sure how to label this. Perhaps it's reticence. Perhaps it's restraint. Perhaps it's inhibition. But I often felt the need to get them to open up. In any case the Kapkenda schoolgirls, especially those from the countryside, were very shy. They showed no inclination to assert themselves or challenge authority. On numerous occasions it was a challenge to get the girls to volunteer for activities or to offer up their opinions on sensitive issues. On one telling occasion a participant even let me, because I was confused, misrepresent her position on whether or not it is ok to divorce an abusive husband.

A final thing must be said: These girls face many life challenges. When I suggested for ideas the Storytelling activity, I suggested their happiest or most memorable moments, their biggest challenges, or their best gift. But in the end only one happy story was told. The remaining stories were of kidnapping, rape, suicidal siblings, alcoholic relatives, parental beatings and the death of a parent.

And What Do They Think about Reproductive Health Issues?

Reproductive Health Information and Awareness

Combined, the interviews, workshop and focus group provided a general sense of how the Kapkenda girls get their reproductive health information. In the focus group I asked when they first received information about sexuality and reproductive health. One girl said "primary," another "second or third grade," and another "fourth grade." Another said "TV." One interviewee said the following: "I learnt a lot from school. For more information you just Google or you refer to magazines." Another mentioned guidance and counselling sessions in primary

school and a Christian course text in form four. One interviewee summarized the multiplicity of sources nicely saying this:

For me, maybe listening to radio mostly. Even watching TV sometimes. Reading the Young Nation magazine. Even from my friends in class when they are in group discussions. Sometimes you know you just sit in a place and listen to people talking. Like sometimes in class people form a group where they are just discussing about sex. You hear a little about that, but myself, I haven't maybe indulged with them or really talked to them. But I do listen to them talking about sex. I think I can get more information through the media mostly. Um ... my dad, no, but my mum maybe just a bit.

On numerous occasions, in the interviews, the workshop, and the focus group, I had the sense that the Kapkenda girls were not especially comfortable talking about sexuality in any detail. One interviewee said it clearly: "Girls are reluctant to talk about these issues." But a telling moment in the workshop was when I slipped into my mentor mode and questioned the girls about the proper way to use a condom. I was met with stone silence. In my journal I wrote that two participants stared into the void using their body language as if to say "don't look at me."

There was general agreement amongst the girls that parents should communicate more often and more specifically about reproductive health issues. In the Values and Clarification activity the entire group agreed that parents and their children should talk about sex in depth. Clearly this isn't happening. One interviewee said this of her reproductive health communication with her mother and father: "Sometimes when she counsels us at home she tells us to be careful. 'Don't break your virginity.' Just something of the sort. My dad won't talk about it because maybe it is something in the culture ..." In one workshop discussion I asked the participants about how they planned to communicate with their children in the future. One participant said this:

Ok for me it would be a lot of difference from how my parents talk to me about reproductive health ... I'll also urge them to be free with me so if anything happens I'll be able to help them, and they'll be able to share their problem with me.

Another said that all her parents say is “Don’t engage in sexual activities ... they don’t give me any details. So what I’ll make sure is that I talk to them in details.”

A few final points on the girls’ reproductive health awareness are worth noting. How did the girls fare in their thinking about reproductive health issues compared to World Health Organization statistics (WHO, 2010)? While the girls in the workshop generally overestimated the number of Kenyan girls their age who have had sexual intercourse, they underestimated the number of girls their age who have given birth. They also overestimated the general knowledge that Kenyan girls their age have of HIV/AIDS. One of the things several of them reported as the most surprising facts that I provided in the reproductive health information session was that girls are more vulnerable to catching HIV than boys.

Contraception

All the workshop participants agreed that none of their parents had discussed the specifics of contraceptive use with them. “What’s the message they convey?” I asked. In unison all the participants say “abstinence.” “Very few understand [how to use a condom] because like now days parents have really failed,” said one workshop participant. She continues:

It’s very hard for the parents to explain to the children about these issues. The only way the student can get to know about it is maybe in the school or in a workshop like this. It’s very hard for the teenagers of this age to know about using contraceptives.

I found it troubling that there was so little understanding of condom use, given that the major reproductive health issues facing Kenyan adolescent teens are pregnancy and HIV. While most of the girls appeared to have sound information about HIV and its transmission, information provided primarily through school curricula, few had specific knowledge about how to use a condom. “I have seen an illustration of how to use a condom but I was too young, I can’t

remember,” said one interviewee. Another said she had seen them advertised, but “I have not seen the proper way to put a condom on.” Information about other types of contraception beyond condoms was limited. For instance, when I asked the girls if they knew about the morning after pill less than half raised their hands. One participant put it this way: “The thing that we know is just the condoms because we see it on TV and people talk about it mostly, but the other pills, no.”

Virginity, Abstinence and Sexual Debut

Abstinence is reinforced by Christianity and the ideal of virginity. “As for me and religion ... the only thing I’m told is don’t do it. It’s a sin,” said one focus group participant. One interviewee put it this way: “As you read the Bible, it guides, it usually says that your body is the temple of God, that you should abstain from sex till marriage.” “Virginity is something you should treasure,” said another. Another said this:

What I understand about sex is that it is not something bad but it has a right time. You know, everything has the right time. Like in your youth stage, of course, you should not maybe do sex or what. It is for the people who are married.

And yet another said this:

Virginity should be highly valued. It is respectable before God and the community. The moment they discover you are a virgin you will earn respect. Young ladies should be encouraged to remain virgins because if you share stories with other girls they will tell you that men are beasts simply because they engaged in those relations when they were still young and they get hurt. If you remain a virgin you won’t be hurt.

In the Values and Clarification activity there were several statements that shed light on this perspective on virginity: All 11 of the day’s participants – without a moment’s hesitation – headed to the “I agree” station when I read the statement that “Girls should remain virgins until they are married off.” “It will make her to be respected by her husband. He will see her as a lady

of substance,” explained one participant. They also all disagreed with the statement that “It is ok to kiss and caress a boy if you really love him, even if you’re not married.”

In one activity, Line Improv, workshop participants even seemed uneasy and reluctant to *play* the role of a sexually active teen. Some of the workshop participants even believed that a girl who has lost her virginity can be spotted “by the look on your face” and by “how you dress yourself.”

One issue I often tried to understand throughout the project was the gap between this stress on abstinence/virginity and sexual debut. Early sexual debut, or the loss of one’s prized virginity, was most often understood as a result of peer pressure, the desire to be modern, the desire to be grown up, male pressure, poverty (leading to transactional sex with older men), and rape. The tragedy of rape – the loss of a girl’s virginity along with her potential marriageability – was captured powerfully in several performances, especially the “kigeme” (we are dead) Small Groups performance discussed in detail in Chapter Two.

But peer pressure was viewed as the most common reason for early sexual debut. “Everybody does it,” said a focus group participant. “So no matter how religious you are there is a part of you that starts thinking ‘it’s ok because everybody does it.’” In a discussion following the reproductive health information session, one participant summarized how peer pressure and the desire to be modern – or “digital” as it was sometimes put – merge:

I think it is because of the peer pressure. Most likely when the youth are at the age of 16 that is the time whereby they start realizing that they are grown-ups. And the pressure that they get from their friends makes them to engage in sex because I think now days most of the youth believe if you are engaging in sexual activities when you are still young it means umechanuka (you are hip/modernized).

A nice example of this peer pressure in operation was provided in a Line Improv activity when one character, pressuring her friend, said the following:

Eh, you are almost 17. You're going to be a grandmother soon. You'll be married soon. It's the only way to know if he's good in bed or not. You don't have to be a Holy Joe, you know. You have to explore life. You know that motto YOLO? You only live once.

But great dangers lurk behind sexual debut according to the girls. Throughout the workshop and interviews sexual debut and a resulting pregnancy were seen, not just as leading to heartbreak, stigma, and low self-esteem, but as something that would put their education in peril and prevent them from achieving their life goals. One interviewee put it simply: "If I got pregnant now I would not achieve my goals." Another elaborated:

First I will have low self-esteem; I won't be able to go back to my normal life of speaking and being social. It will affect my studies because I won't be able to go back to school. Also I will feel rejected because maybe the neighbors at home will just be saying, 'look at that girl what she has done.' I will be depressed. I have a friend at home who got pregnant when she was in form two. And from then on, she hasn't continued with her education. She is just staying at home suffering because her own parents deserted her. So she is just there living with her poor kid. There is no money. So for me I see that life has changed for that girl.

Clearly then the girls are fully aware of the risks of early sexual debut, especially the risk of pregnancy, and they often express the intention to delay sexual debut, but intentions are one thing, and behaviors another. Statistics tell us that 48% of Kenyan women between the ages of 15-49 years old report that they were sexually active before age 18 (National AIDS Control Council, 2012).

Abortion

There was universal agreement among the Kapkenda girls that abortion, which was consistently framed in religious terminology as a sin, is an unacceptable choice for a pregnant woman. The most commonly supported exception was for the mother's health. A few girls expanded this exception to include rape and incest, but most did not. "Abortion is bad," said one interviewee. "It should be illegal. It is ok when the mother is in danger or in case of rape or incest." One

workshop participant made no allowances for abortion saying, “You just bear that pregnancy. Give birth to the child because you are breaking the laws of God if you don’t.”

Another workshop participant put it this way:

For me am totally against it because it’s like you are destroying what God created and also against the commandment that you shouldn’t commit murder. You will also be depressed looking back as a failure. There should be exceptions maybe when the person is experiencing some difficulty and maybe the mother has some infection. If she was raped I don’t think she will have to abort. Maybe she just stays with the pregnancy until she delivers successfully.

One workshop participant, in response to a question about abortion in the case of rape, said that abortion still was “not the best choice,” adding that the girl should “just hang in there and have the kid and then after that you can give the baby away or something.”

Still that very same workshop participant was fully aware, and even sympathetic to, the reasons a girl her age might select to abort saying this:

For example, I get pregnant and I’m afraid I don’t know what will happen to me. I don’t know how I am going to take care of the baby and how my parents are going to treat me. So I see abortion as the best choice. Yeah.

This participant offers up the dilemma a pregnant adolescent girl faces. On the one hand an abortion is a sin, tantamount to murder, but on the other hand, a secretive and risky illegal abortion is a perfectly reasonable and rational choice because she can then avoid social and parental rejection and will not have to face the hardships of raising a child.

Homosexuality

The girls took a unanimous stand against homosexuality. As with abortion, their thinking was framed as matter of religion. In the Values and Clarification activity their response to the statement “It is ok for a woman to love a woman or a man to love a man” was to quickly march to the “I disagree” station. “God created a male for a female and a female for a male,” explained one workshop participant, adding that “It’s not the law of God.” One interviewee put the issue

this way: “On gay marriage ... It is forbidden by God because how can a woman and a woman conceive a child? Only marriage between man and woman is allowed in the Bible.” In a discussion after one workshop Bruce and I told them how attitudes in the United States were changing. The very idea that a society might reverse its norms and laws about the acceptability of homosexuality seemed to puzzle the girls. What a strange and mysterious land the United States must be! Kenyans would never change their attitudes about homosexuality. I suspect that it would have shocked them if I informed them that my attitudes already had.

Female Genital Mutilation

There was universal opposition to the practice of FGM both in the interviews and in the workshop. “On FGM I have a negative attitude,” said one interviewee. “FGM should be discouraged because it has many side effects,” said another. “The government should arrest those people,” said another. This attitude was supported in the workshops. One of the most powerful performances in the Small Groups activity was by a daughter resisting the demands of her mother and father that she get cut. The performance became even more powerful during a character replacement when the mother joined the daughter to resist the father’s claims that custom and honor demand that she get cut. The health dangers of FGM were often stated but, interestingly, the interviewees and workshop participants never mentioned the disturbing outcome that FGM is likely to reduce sexual pleasure.

Men, Women and Love

Men, and less often women, were not always described as the best of souls. “Nowadays you find a woman is the sole bread winner of the family, but men they are drunks,” said one interviewee, adding that girls are getting ahead with their education, but boys are becoming an endangered species. Interviewees across the board described women as “more hardworking,” “more caring,”

and “more God fearing.” “I think women are more responsible and men are usually the ones who don’t care,” said one interviewee. “Women have more challenges,” said another, adding that “most people don’t respect them because they think they are weak.” “Society favors men more than women,” said one interviewee. Another added that men often get paid more because they are seen as having “more energy.” Girls who have lost their virginity at a young age will tell you that “men are beasts,” said another. “For men, love without sex goes nowhere,” said another.

But it’s even worse than that. In the focus group after workshop three, participants took dead aim at the way men don’t respect love. “I think men, their thought of love and sex is different because they just see love and sex as to just have fun,” said one focus group participant, adding that “they don’t respect love; the man wants to use you and dump you.”

“Many boys just try to be friends with you so that they can have sex ... they just want to satisfy themselves but they don’t really love you,” said one workshop participant. “Most girls may be in love with a man but in real sense that man may not love the girl. Maybe he will just be using that girl yet the girl believes that the man is truly loving her,” said another. And another:

The men don’t think the same as we ladies think about sex and love. Some say that if you have a boyfriend or a guy and he doesn’t have mpango wa kando (a girl on the side) he’s not a real man. So for them they think opposite as we think.

And men all seem to demand more children, “It’s like a woman says we should stop ... but you see, men still want to have more. They say we need more children.” Interviewees said that men expect “respect,” “humility,” and “sexual satisfaction.” Often “women have to prove they love their men,” said one interviewee. In workshop performances boys and men were often portrayed as aggressive, even mean. In one Small Groups performance several boys threatened to beat up a girl if she didn’t drink and smoke a joint with them. In another Small Groups performance we saw how domineering husbands can be. In that performance about FGM the performer playing

the father had little trouble conjuring up his aggressive demands that his daughter get cut as expected by “the customs of our land.” “I am the man of this house and nobody goes against me,” shouted the father at his wife and daughter.

In a Line Improv activity a performer easily imagined an adolescent boy’s aggressive response to a request they he get tested for HIV. “Me having HIV?” said the boy dismissively. “You are so stupid. I don’t love you anymore. Psheeeew!” In another Line Improv an adolescent boy displayed a stunning cold-heartedness while pressuring his girlfriend to abort. When she said she could die from an illegal abortion, he said “no problem,” and added that she shouldn’t ever have believed his expressions of love in the first place.

But women, too, were not always described as saintly. Their biggest fault: they can be gold diggers who only seek out men with money. “Most women nowadays are extravagant,” said one interviewee. “They like to exploit men. They want a luxurious life. They want to be bought clothes and to be taken for outings and to very expensive hotels. They pursue the rich men because they want those riches and money.”

One interviewee, thankfully, moved beyond the war of the sexes and saw that there “may be” deeply shared mutual needs between men and women. She said this: “What both men and women need is, maybe, sexual satisfaction, love, companionship and wanting a child.”

The Workshop and Lessons Learned

In the focus group at the conclusion of the performance workshop we discussed the participants’ thoughts and feelings about the workshop and the reproductive health issues we explored. First I asked them what their friends had asked them about the workshop. “The first day I was asked and I said we were playing something like a game,” said one respondent. Everyone got a laugh out of that. She continued: “They say ‘Just a game? It’s boring; it’s

useless.’ And then I tell them I see it as interesting to me.” Another said “I was asked by my classmates and told them we are kind of filming, the topic was reproductive health, and we are getting deep into it. And they said they want to be a peer counselor because they thought this was fun.”

It was clear from the focus group discussion that the warm-up activities (Energy, Focus and Trust Work) achieved what they were intended to accomplish. It was a good sign that the participants were able to recall each activity by name. When I asked them why they thought we did these seemingly “childish” games they said “to refresh ourselves,” “to break the monotony of just talking,” “to cheer people up,” and “to get creativity.”

I was pleased with their extended discussion to this focus group question: “Now that you’ve done this workshop what do you think about the idea of using characters and scenes as a way of exploring reproductive health issues?” I was specifically interested in their thoughts about the Improvisation and Activating Material, such as Relationship Wheel, Line Improv, Monologue Work, and Small Groups. “It helps when we use the scenes. It brings it to a real life situation. Somebody imagines ‘really if I was in that foot I’ll do this.’ So again it helps,” said one girl. “I think the scenes are really helpful because, ok, the reproductive health issues really affect the young people ... the scenes will really help them. They’ll see it as something fun. It’s not boring like reading a book,” said another to everyone’s laughter. “It’s great,” said another,

because ... activities like performance, acting ... makes you see what happens. It might be difficult to say some things ... but through the performance you can bring it out. It can be seen clearly. So it helps a lot.

“These scenes are really working,” said another girl, adding that:

Most of us are used to talks. You are just told if you do this, this will happen. But now having seen it yourself, if you are able to draw the conclusion yourself, it’s like if you put yourself in that situation you’ll be moved by that scene.

This girl said that motivational speakers are “just boring” and “you’re not listening” to them, but with these performances you’re “putting yourself in that scene. I think it’s more educating.”

The girls, and importantly the extremely shy ones, said the workshop activities increased their “creativity,” “confidence,” and “courage.” “It fired my imagination,” said one. “It built my creativity, like the way we were told to create some scenes,” said another. “For me, I’ve gotten my confidence. I’ve never presented like this before an audience,” said another. “I’ve gained a lot of confidence because I’ve never acted in front of a crowd,” said another, adding that “When I’m told to act or do something I shiver and tremble so when I came I was shy, but this time I’ve gained courage. I’ve actually discovered that I can actually do something in front of others.” Another said “This has built my courage because sometimes when I’m told to talk in front of people sometimes I cannot.” Importantly, the courage expressed wasn’t just the courage to perform before an audience; it was also the courage to openly discuss reproductive health issues: “Now I’m able to talk about reproductive health. I have that courage because before this I thought ‘how can I talk like that?’ Now I see the importance of talking freely about reproductive health,” said one girl.

Several also said that the Values Clarification, Monologue Work, Line Improv, Monologues, and Small Groups activities would help them solve future problems and help them be better peer counselors. “I think it can help me because when I have problems later in life I will be able to solve them,” said one, adding that:

It’s very hard to be free with people. It’s very hard to explain situations and, being a peer counselor, I find it hard to tell the other students in class about reproductive health or such things. After this workshop I’ll be able to speak to them about it more. Also this will really help me in the future. When I have my own children and I’ll be able to speak to them in a much better way.

Another described the performance activities “as challenging because you have to think critically about the character and the actions. Because, you see, you are supposed to bring that character into a real life situation and make it believable.” Another said the activities “made us recall the things maybe that you’d gone through or seen. Then you just put it out, dramatize it. It was quite interesting.”

As I write this I am almost surprised at how the participants are almost restating some of the key ideas behind performance theory. In their own words they summarize Schechner and Brady’s (2013) position that performances are both restorations, or a reflection of social life as it has already been constituted *and* creative actions that provide opportunities to reflect upon and creatively respond to social life as it already exists. In their own words they provide an account of the improv-as-education/intervention tradition expressed in the work of Augusto Boal (1979, 2002), Viola Spolin (Spolin, 1986; Spolin et al., 1999), Robert Alexander (1983) and Michael Rohd (1998).

Importantly, on the rare occasion performance can even take participants to a place where they explore the limitations of the way their religious worldview frames their understanding of reproductive health issues like sexual debut and virginity. For instance, in one Line Improv activity when an adolescent girl is telling her mother she is pregnant and wants an abortion, the character exclaims “You’ve shown me about the Bible, but not the outside world.” In the focus group one girl put this issue more explicitly:

I’m told I should not have sex before marriage, but if I fall into that trap, the Bible does not tell me how a condom works. Most of the religious people they don’t have much information about using a condom and all; that’s mostly why they get abortions and they get pregnant.

With these remarks the workshop participant has gone out on a limb to explore the way her religious-based abstinence-only approach interferes with an open and realistic approach to

sexuality and reproductive health. And the chances are great that many of these girls will “fall into that trap.” Indeed, the majority of my close girlfriends were sexually active before they were 18 years old and before they married.

All in all I felt that the workshop was successful in achieving its goals. The warm ups did in fact generate trust, energy, and focus. The bridge work, improvisation, and activating material did provide a safe means for the participants to examine and explore the reproductive health problems they and other girls their age may face. These activities helped them explore options and reflect on the shortcomings of their worldview. The participants did, it seems, see performance as an act of self-affirmation able to open up new ways of understanding the world. This entire discussion returns us to the Augusto Boal quote that Michael Rohd (1998) cites at the conclusion of his Preface:

Theatre is a language through which human beings can engage in active dialogue on what is important to them. It allows individuals to create a safe space that they may inhabit in groups and use to explore the interactions which make up their lives. It is a lab for problem solving, for seeking options, and for practicing solutions (p. xix).

The participants not only said the workshop built their confidence and courage, they also said it was fun. Some video footage sticks in my mind, such as the shots of them loosening up and simply having fun, or the shots of audience members rapt in attention as their fellow peer counselors performed. In the focus group discussion there was clearly evidence that the workshop had put a dent in the “conspiracy of silence” surrounding sex and reproductive health issues. A statement like this one, which I cited earlier, is certainly encouraging: “Now I’m able to talk about reproductive health. I have that courage because before this I thought ‘how can I talk like that?’ Now I see the importance of talking freely about reproductive health.”

I would certainly highly recommend using performance as reproductive health intervention, but this is not to say that all went perfectly. Doing activating theatre is difficult. It is

labor and time intensive. It requires a facilitator with experience, something I had little of. Upon reviewing my journal and video footage, it's clear that I could have done better. I felt that I met many of Rohd's criteria for a good facilitator: I was enthusiastic; I created energy; I was a caring listener; I was nonjudgmental; and I was aware of the dynamics of the room (Rohd, 1998). But sometimes I explained activities inadequately and this sometimes led to some initial confusion. Sometimes I missed golden opportunities to probe and deepen discussions. Sometimes I failed to help them explore situations in new ways. Sometimes I could have organized the space a little more effectively. There are many little things I would now do differently. For example, the focus group got off to a terribly slow start. Next time I would even begin the focus group itself with energy and focus activities.

As I reviewed the video footage I was sometimes scolding myself for not probing issues more often and more deeply. Looking back, I wish I had reinforced Rohd's feedback questions more effectively, asking them if they stayed in it, if they played every moment truthfully, if they made strong choices, and if they made the stakes high. Only experience on the part of a facilitator will solve these shortcomings. And I certainly feel that when I do this again I will be much better at it. A suggestion for similar interventions would be that facilitators get first-hand experience working alongside someone with facilitation experience.

Importantly, at the end of the workshop Judy, Bruce and I all concluded that I should have trimmed back on warm ups and gotten to more of the improv and activating material. Even one of the more observant participants made this observation. In the focus group I asked "What should we have done more of?" Her answer, without any hesitation: "The creation of scenes and acting them out."

It is also important that facilitators be trained to provide specific, accurate information on reproductive health issues because these issues will arise, even if they are not planned as part of the workshop. During my reproductive health information session, in which I provided reproductive health statistics, and elsewhere in the workshop, questions often came up that needed to be answered accurately. How exactly is a condom applied? How is herpes spread? What are the symptoms of chlamydia? Do certain contraceptives damage fertility? What's the best emergency contraceptive? Once participants are encouraged to open up about reproductive health issues, questions like these are likely to tumble out. Facilitators need to be ready for them.

Final Reflections

As I compose my final thoughts I cannot help but reflect on the Kapkenda girls and where they may be headed in life. What reproductive health crisis will some of them soon be facing? Soon some may find themselves standing before a pharmacist purchasing a morning after pill. Soon some may be praying for their period to arrive. Soon some may be terrified that, after a night of unprotected sex, they may have contracted HIV. Some, to salvage their "honor," may soon be marrying a man who isn't gentle, one they can't trust, or one who doesn't love them. Soon some may be dragged into poverty struggling to raise a child while still children themselves.

The Kapkenda girls are where I was just 10 years ago. I too would remain a virgin until I married sometime around the age of 25 years old (or so I thought). I too would never engage in risky sex (or so I thought). I too would not caress a man until we were pronounced husband and wife (or so I thought). As with the Kapkenda girls Christianity is, and remains, central to my identity and worldview. But the fact is that I and most of my friends "fell into that trap." Some had a child out of wedlock while still teenagers. Others took chances with unprotected sex.

Others had risky illegal abortions. The fact is that tens of thousands of adolescent girls, and hundreds of thousands of African adolescent girls, and only God only knows how many adolescent girls across the developing world, will also “fall into that trap.” An open and realistic approach to sexuality and reproductive health is in order. The silence surrounding our sexual lives must end.

As I write these final reflections some of the ideas that most inspired me come to mind: the idea of increasing adolescent girls’ “ability to negotiate sexual behavior” (Ministry of Public Health and Sanitation, 2010, p. 17); the idea of helping adolescent girls develop “the capacity to cultivate an internal compass” (Seigal, 2014); the idea of helping adolescent girls become “the protagonist” in their lives; the idea of empowering “young people able to develop, adopt and sustain healthy attitudes and behaviors towards reproductive health and development” (Ministry of Education & Ministry of Planning and National Development, 2005, p. x). Michael Rohd’s activating theatre, itself the product of decades of reflection of the role of performance in human life by practitioners and theorists, offers a powerful tool for adding subjective agency and behavioral change to information and intention.

I conclude with a recommendation: A Kenya-based NGO- or government-funded center using an activating theatre approach to promote adolescent reproductive health. This center would train and support workshop facilitators able to fan out across the country and conduct workshops similar to the one examined in this study. If successful, this trial center could serve as model for other countries in the developing world as they struggle to address their own adolescent reproductive health crises.

The problems faced by humankind in the 21st century are daunting. The list of the complexly interconnected problems we face is long: human population pressure; environmental

devastation of land, water and air; extreme poverty and the unequal distribution of wealth; gender inequities; the abuse of human rights based on every social division imaginable (gender, race, religion, generation, and sexual orientation); a global economic system that fails to serve human ends; failing and corrupt national governments; religious, racial and ethnic conflict. The adolescent reproductive health crisis in its many forms – early sexual debut, teen pregnancy and motherhood, unsafe abortion – is, I would argue, one of our foundational problems, one that spreads its devastation across all aspects of social life in the developing world.

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APPENDIX A



EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building · Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office ~~252-744-2914~~ · Fax ~~252-744-2284~~ · www.ecu.edu/irb

Notification of Initial Approval: Expedited

From: Social/Behavioral IRB
To: [Purity Kimaiyo](#)
CC: [Deborah Thomson](#)
Date: 5/12/2014
Re: [UMCIRB 14-000616](#)
Performance for ethnography, dialogue, and intervention

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 5/12/2014 to 5/11/2015. The research study is eligible for review under expedited category #6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Name	Description
Interview questions	Interview/Focus Group Scripts/Questions
Proposal Application	Study Protocol or Grant
USE_Assent-Template-12-17-years-of-age 03.12.2012.doc	Consent Forms

USE_Informed-Consent-Template-No-More-Than-Minimal-Risk-03-28-2013.doc
Consent Forms

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

East Carolina U IRB #1 (Biomedical) IORG0000418
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

APPENDIX B

INFORMED CONSENT AND ASSENT FORMS

East Carolina University



Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: Performance for ethnography, dialogue, and intervention: Using activating theatre to explore the reproductive health issues facing Kenyan adolescent girls.

Principal Investigator: Purity Kimaiyo

Institution/Department or Division: East Carolina University

Address: 102 Joyner East, Greenville, NC 27858

Telephone #: 9195194140

Study Sponsor/Funding Source: ECU School of Communication

My name is Purity Kimaiyo. I was a student at Kapkenda High School from 2001-2005. And like your daughter I too was a peer counselor. After graduating from Kapkenda I attended United States International University in Nairobi and then, after my mother took a nursing job in the United States, I finished college in North Carolina with a degree in journalism. I am currently working on a master's degree at East Carolina University in a field called health communication. This research is being done to fulfill my credits. For two years I have been studying issues such the age at which teenagers become sexually active and teen pregnancy in Kenya.

I am very interested in understanding how girls your daughter's age think about reproductive health issues and in finding creative ways to help teenage girls make better decisions about these potentially life changing issues. That is the purpose of this workshop. The title of this project is "Performance for ethnography, dialogue, and intervention: Using activating theatre to explore the reproductive health issues facing Kenyan adolescent girls." This document, which is required by my university, is my official request to have your permission (or informed consent) to allow your daughter to participate in this workshop.

My hope is that the workshop will be a great experience for you daughter and that it will address a very important topic that affects all teenage girls, sooner or later. In the workshop the girls will be creating stories and short improvised scenes about the issues girls their age may face. These workshops will be

audio and/or video recorded for two reasons: I will need to review the workshop closely as I write my thesis and it is important that I share this preventative education approach with others attempting to address issues such as teen pregnancy.

The workshop will take place for about two hours a day for one week in May. I am hoping that all the Kapkenda peer counselors will be able to participate.

Why is this research being done?

I am doing this research to explore the way that a form of theatre, or the acting out of imaginary scenes created by students, can be used as a form of preventive education, one that will help teenage girls discuss and think about reproductive health issues, such as their relationships with boys and the pressure they may experience to become sexually active.

Why is my daughter being invited to take part in this research?

Your daughter has been invited to participate in this project because I feel that she can make an important contribution to the way preventive reproductive health education programs are designed. I want to work with the peer counselors as a group to see if the theatrical approach I will be using can help girls improve their decision making over the difficult issues they may soon face in regards to their reproductive health.

Are there reasons my daughter should not take part in this research?

The only reason your daughter will be excluded from this research and workshop is if either she or you decides not to participate.

What other choices do I have if I do not take part in this research?

Your child can choose not to participate. There is no penalty if your daughter decides to withdraw from the workshop while it is underway or if you want her to withdraw. She will not be criticized at all and your/her decision will be supported. Your daughter will simply return to her regularly scheduled activities at the school.

Where is the research going to take place and how long will it last?

The research procedures will be conducted at Kapkenda girls high school and I have arranged with school administrators for the workshop to take place during the afternoons after classes for one week in early May.

What will my child be asked to do?

Your daughter is being asked to participate in 5 two-hour workshops in which she and about 20 other Kapkenda students will be asked to discuss reproductive health issues, such as their perceptions about the behavior of boys, their knowledge of contraceptives, teen pregnancy, and the consequences of teen pregnancy. These discussions will be the basis for creating short skits in which the girls will explore the kinds of issues they may face and the decisions they will make. Your child will NOT be asked to reveal or discuss anything at all about her own personal experiences. The improvised theatrical scenes the girls create will be based only on imaginary situations the girls create.

These discussions and skits will be recorded in audio and video. I will use these recordings to better understand how adolescent Kenyan girls perceive and understand issues related to reproductive health. These recordings will also be edited to make a video about our workshop. If anything is ever recorded

that your daughter wants to keep private and does not want incorporated into the workshop video I will ensure that it is not incorporated into the workshop video. These audio/video recordings will become a permanent record of this research.

Your daughter will also participate in a 90 minute group discussion – called a focus group – about her experiences with the workshop. Here we will ask very general questions such as “What did you think about using scenarios to explore reproductive health issues?” “Do you think other girls your age will be more likely to delay sexual debut after participating in a workshop like this?” “Sometimes boys pressure girls to have sex. Do you think a workshop like this will help girls your age make better choices?” Your daughter may also be interviewed individually for about 45 minutes before the workshop begins. Here we will be asking questions such as “What do you think men are looking for when they are seeking someone to marry?” and “Where would you say you’ve found out most what you know about sexuality and reproductive health?”

What possible harms or discomforts might my daughter experience if she participates in the research?

Your daughter may experience some embarrassment such as “stage fright” when participating in the improvised theatrical scenes, but I take special measures, using warm up exercises, to create a safe, relaxed, and trusting atmosphere in the workshop. Your child may also be grappling with some difficult personal issues related to themes we explore in the workshop. If your daughter wants to talk to me confidentially about these issues I will ensure that she does not introduce these issues into the workshop. I will encourage her to speak to you about her issues and I will follow up with her to see if she has spoken with you.

What are the possible benefits my daughter may experience from taking part in this research?

The workshop will be fun! But even more importantly, your daughter may come away with a set of tools for making better decisions about her future. She will know that by participating in this research she is playing an important role helping girls her age make better reproductive health decisions. Additionally, your daughter will be able to refer to her participation in this workshop in her college or university applications.

Will my daughter be paid for taking part in this research?

No, your daughter will not receive payment. Your daughter will receive a certificate of completion and your family will be provided complementary DVD of the workshop video after it is edited.

What will it cost me to take part in this research?

It will not cost you any money to be part of the research.

Who will know that my daughter took part in this research and learn personal information about her?

In addition to me and my professor, a number of people will have access to the things we learn about you in the workshop. I may also hire someone to assist with Swahili to English translation and I may have someone assist with editing the video. When I publish my results for others interested in this research I will assign pseudonyms (fake names) for all the workshop participants. We will not be reporting to your

parents or teachers anything that occurs in the workshop, but they will be able to view the workshop video at a later date. If anything is ever recorded that you want to keep private and do not want incorporated into the workshop video just let me know and I will ensure that it is not incorporated into the workshop video. The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your child's welfare during this research, and other ECU staff who oversee this research.

How will you keep the information you collect about me secure? How long will you keep it?

The data will be stored in my personal laptop while in Kenya. To protect and preserve the data I will make periodic trips to an Internet Cafe to upload the data to Piratedrive, and then erase it from my laptop. Once I return from Kenya in July 2014, I store the consent forms and other materials in Joyner East room 103 B in a lockable drawer. Audio and video recordings will become a permanent record of the research and may be used for teaching, academic presentations and documentation of the workshop. The last names of your daughter will never be used in any of this material.

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping. You will not lose any benefits that you should normally receive.

Who should I contact if I have questions?

The people conducting this study will be available to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator at 919-519-4140 (days, between Monday through Sunday).

If you have questions about your rights as someone taking part in research, you may call the Office of Research Integrity & Compliance (ORIC) at phone number +1 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may call the Director of the ORIC, at +1 252-744-1971

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

Parent or Guardian Name (PRINT)

Signature

Date

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

Person Obtaining Consent (PRINT)	Signature	Date
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[Optional]

<i>Principal Investigator (PRINT)</i> <i>(If other than person obtaining informed consent)</i>	<i>Signature</i>	<i>Date</i>
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IRB Study #UMCIRB 14-000616

Title of Study: Performance for ethnography, dialogue, and intervention: Using activating theatre to explore the reproductive health issues facing Kenyan adolescent girls.

Person in charge of study: Purity Kimaiyo

Where they work: East Carolina University

Study contact phone number: 9195194140

Study contact E-mail Address: kimaiyop13@students.ecu.com

My name is Purity Kimaiyo. I was a student at Kapkenda High School from 2001-2005. And like you I too was a peer counselor. After graduating from Kapkenda I attended United States International University in Nairobi and then, after my mother took a nursing job in the United States, I finished college in North Carolina with a degree in journalism. I am currently working on a master's degree at East Carolina University in a field called health communication. This research is being done to fulfill my credits. For two years I have been studying issues such as the age at which teenagers become sexually active and teen pregnancy in Kenya.

I am very interested in understanding how girls your age think about reproductive health issues and in finding creative ways to help teenage girls make better decisions about these potentially life changing issues. That is the purpose of this workshop. The title of this project is "Performance for ethnography, dialogue, and intervention: Using activating theatre to explore the reproductive health issues facing Kenyan adolescent girls." This document, which is required by my university, is my official request to have your permission (or informed consent) to allow you to participate in this workshop.

My hope is that the workshop will be a great experience for you and that it will address a very important topic that affects all teenage girls, sooner or later. In the workshop you will be creating stories and short improvised scenes about the issues girls your age may face. These workshops will be audio and/or video recorded for two reasons: I will need to review the workshop closely as I write my thesis and it is important that I share this preventative education approach with others attempting to address issues such as teen pregnancy.

Your parent(s) needs to give permission for you to be in this research. You do not have to be in this research if you don't want to, even if your parent(s) has already given permission. You may stop being in the study at any time. If you decide to stop, no one will be angry or upset with you.

The workshop will take place for about two hours a day for one week in May. I am hoping that you will be able to participate.

Why are you doing this research study?

I am doing this research to explore the way that a form of theatre, or the acting out of imaginary scenes created by students, can be used as a form of preventive education, one that will help teenage girls discuss and think about reproductive health issues, such as their relationships with boys and the pressure they may experience to become sexually active.

Why am I being asked to be in this research study?

You are invited to participate in this project because I feel that you can make an important contribution to the way preventive reproductive health education programs are designed. I want to work with the peer counselors as a group to see if the theatrical approach I will be using can help girls improve their decision making over the difficult issues they may soon face in regards to their reproductive health.

How many people will take part in this study?

If you decide to be in this research, you will be one of about 20 other Kapkenda students taking part in it.

What will happen during this study?

You will be asked to discuss reproductive health issues, such as their perceptions about the behavior of boys, their knowledge of contraceptives, teen pregnancy, and the consequences of teen pregnancy. These discussions will be the basis for creating short skits in which the girls will explore the kinds of issues they may face and the decisions they will make. You will NOT be asked to reveal or discuss anything at all about your own personal experiences. The improvised theatrical scenes you create will be based only imaginary situations the girls create.

Our discussions and skits will be recorded in audio and video. I will use these recordings to better understand how you understand issues related to reproductive health. These recordings will also be edited to make a video about our workshop. After the first few hours you will probably not even notice the recordings, but if you are very uneasy about being recorded it would be best if you choose not to participate in the workshop.

Check the line that best matches your choice:

_____ OK to record me during the study

_____ Not OK to record me during the study

This study will take place at Kapkenda High School and will last 2-3 hours per day for 5 days.

Who will be told the things we learn about you in this study?

In addition to me and my professor, a number of people will have access to the things we learn about you in the workshop. I may also hire someone to assist with Swahili to English translation and I may have someone assist with editing the video. When I publish my results for others interested in this research I will assign pseudonyms (fake names) for all the workshop participants. Your last names will never be used in any of the material produced from this workshop, including the workshop video. We will not be reporting to your parents or teachers anything that occurs in the workshop, but they will be able to view the workshop video at a later date. If anything is ever recorded that you want to keep private and do not want incorporated into the workshop video just let me know and I will ensure that it is not incorporated into the workshop video.

What are the good things that might happen?

The workshop will be fun! But even more importantly, you may come away with a set of tools for making better decisions about your future. You will know that by participating in this research you are playing an important role helping girls your age make better reproductive health decisions. Additionally, you will be able to refer to your participation in this workshop for college or university applications.

What are the bad things that might happen?

You may experience some embarrassment such as “stage fright” when participating in the improvised theatrical scenes, but I take special measures, using warm up exercises, to create a safe, relaxed, and trusting atmosphere in the workshop. You may also be grappling with some difficult personal issues related to themes we explore in the workshop. Things may also happen that I, the researchers, do not know about now. You should also report any discomforts to your parents and to me. If you want to talk to me confidentially about these issues I will ensure that you do not introduce these issues into the workshop.

What if you or your parents don't want you to be in this study?

You can choose not to participate. But if you do have any questions or concerns I would love to have the opportunity to discuss the workshop with you in more detail. If you decide not participate, you will not be singled out because of this decision. You will continue with your regularly scheduled activities at Kapkenda.

Will you get any money or gifts for being in this research study?

You will not receive any money or gifts for being in this research study. You will receive a certificate of completion and your family will be provided complementary DVD of the workshop documentary after it is edited.

Who should you ask if you have any questions?

If you have questions about the research, you should ask the people listed on the first page of this form. If you have other questions about your rights while you are in this research study you may call the Institutional Review Board at 252-744-2914.

If you decide to take part in this research, you should sign your name below. It means that you agree to take part in this research study.

Sign your name here if you want to be in the study

Date

Print your name here if you want to be in the study

Signature of Person Obtaining Assent

Date

Printed Name of Person Obtaining Assent

APPENDIX C

INTERVIEW PROTOCOL

Introductory comments

Hello, thanks for meeting with me. I appreciate your taking the time to talk with me. My name is Purity Kimaiyo. What's your name?

First let me tell you a little bit about me. I was a student and a peer counselor here at Kapkenda HS from 2001-2005. Five years ago I left Eldoret to study journalism at a university in the United States, and now I'm studying health communication for my master's degree. For this degree I'm required to conduct research of a topic that's important to me.

Let me tell you a bit about my project: I'm interested in finding out about how girls your age think about reproductive health issues. So when we're talking there's no right or wrong answers – I simply want to understand your thoughts and feelings about issues like sexuality, birth control, family planning, early pregnancy, STDs. As you may know many young Kenyan girls catch STDs or get pregnant and this can make their life very difficult. In fact, one of the things that I'm interested in know is how it's sometimes difficult to openly discuss these issues.

It's important that you be as open as possible and do know that I'm not going to judge you at all about anything you tell me. For instance, when I was a student your age I would have been reluctant to tell someone like me that I had a boyfriend. Don't worry about those things.

My goal in conducting these one-on-one interviews with you and other students your age is to better understand what your thoughts are about reproductive health, a term I use to include

anything related to sexuality, birth control, family planning, early pregnancy, STDs, and other such issues.

One thing I want to assure you is that this interview is confidential. Your identity and all information you give me is strictly confidential. I will not report your name to anyone. I will not attach your name to anything I write, but will make up a name to attach to any comments you provide. In fact, we'll make up a name for you shortly.

Tape recording

It's important that I focus on our discussion, so I'll ask your permission to tape record this discussion. No one except me, my research assistant, and my professor will listen to these tapes.

Is that okay with you?

Turn on recorder now!

Interview overview

Before we get started: Do you have any questions or concerns about the project, or about what I've told you so far?

(Respond to interviewees questions/concerns)

A quick overview of what we'll be doing. Let's plan on the interview lasting about 45 minutes, more or less.

First I'm going to ask you some questions about your life in general, basically to find out a little about you. Then we'll talk about issues such as your plans for marriage and children, what you think about the differences between men and women, what you know about family planning, HIV and STDs. We will also explore your ideas about dating, virginity, early marriage, abortion

and who you discuss these issues with. We'll also explore what you think about the way that Kenyan society handles issues of sexuality and reproductive health.

Probe reminders:

Can you give me an example of that?

Can you tell me a little bit more about what you mean?

Anything you can add to that?

How would you relate to that personally?

Please explain what you mean? I'm not sure I follow you ...

How important is that to you?

Interview begins:

Theme: Sociodemographic

So tell me about yourself and your family. Age, family occupation, religion, siblings (older/younger), location, tribe, parents' education.

Theme: Life aspirations, hopes and fears

Tell me about your plans for the future, career, family, etc.

Theme: Media use/exposure

Tell me about the TV/radio programs and music you like and what you like to do on the Internet.

What do you think about the way they talk about sex? An examples you can think of? When you've watched Western TV/films/music videos/magazines, what do you think about the way they portray women and men? About the way they show sexual issues? Any examples?

Theme: Religion

How important is religion to? Do you think your religious (or non-religious) beliefs have influenced your ideas and attitudes about sexuality?

Theme: Marriage and preference for children

Tell me what you think about getting married, when, what type of guy, how many children, etc.

Theme: Gender

What do you think the main differences between men and women? How are they alike? What do you think women expect from a relationship? What about men?

Theme: Love

What does it mean to love someone? How is love expressed? How would a man best express his love toward you?

Theme: Marriageability issues.

What do you think men are looking for when they are seeking someone to marry? Good looks? Someone with a good sense of humor? Income earning potential? Education level? God-fearing? Kind? Good heart? Humble?

What about women? Good looks? Someone with a good sense of humor? Income earning potential? Education level? God-fearing? Kind? Good heart? Humble?

Theme: Knowledge about human reproduction. Where from?

Where would you say you've found out most what you know about sexuality and reproductive health?

Can you recall any discussions you've had with your mother or father about sex and reproductive health? What about discussions you've had with other family members, such as brothers or sisters? What about discussions with your friends?

Theme: Family planning methods

Tell me what you know about family planning methods?

Theme: Purpose of sex

What would you say are the main reasons for having sex? Why is sex important? (Reproduction? Pleasure? Bonding?)

Theme: Abortion

What are your feelings about abortion? Do you think it should be illegal? Do you think there should be exceptions, such as in cases of a women's health, rape or incest?

Theme: HIV/STD-related knowledge and attitudes

Tell me what you know about how HIV is transmitted. What about other STDs? How are they transmitted?

Theme: Attitudes about dating, virginity, premarital sex, pregnancy/sex, FGM.

What would you say to a friend (or a 16-year-old) who told you she's (dating, thinking about getting sexually involved, pregnant, etc.)

Theme: Consequences of early pregnancy/marriage

Do know any girls your age who have gotten pregnant or married at a young age. How do you think your life might change if you were to get pregnant at this point in your life?

Theme: Conspiracy of silence

We're going to wrap up soon, but first can you tell me about how you felt when I was asking you to talk about some of these reproductive health issues? Do you think girls your age are reluctant to talk about these things? If so, why?

Theme: Kenyan social norms on sexuality and reproductive health

Some people say that the way we think about sexuality and reproductive health is based on the way our society teaches us and talks about these things. If you had to give a grade to Kenyan society for the way it teaches us about sexuality and reproductive health, what grade would you give it? Why? Explain?

Wrap up: Are there any issues you would like to discuss that we didn't talk about?

APPENDIX D

ACTIVATING THEATRE, SAMPLE WARM-UPS

Sample Energy and Focus Warm-up.

Circle Dash. Original Source: Unknown (5-10 minutes). This is a silent game and a good one for the researcher to play along with. Girls form a circle around one person. Two girls silently signal each other and attempt to switch places before the girl in the middle can get to an open spot.

They must go around, not through the girl in the center. Whoever doesn't make it to a spot now takes the middle position. The person left takes the spot in the middle. More than one pair can switch at once. The game, by its very nature, promotes participation and energy, but at a level decided by the participant. A key lesson here is that the researcher will not referee or make an official call. The girls learn that they must work out any disputes among themselves.

Sample Trust Warm-up.

Trust Falls. Original Source: Unknown (5-10 minutes). Girls pair up and one partner puts her feet together, closes her eyes and holds her body stiff. The other girl puts her hands on the partner's shoulder and says "ready" and she falls backward to be supported by her partner. They do these several times each time the supporting partner moves back in small increments. The girls do this until either of them feels that it is enough then they switch roles and begin again. Once they are done, they sit down facing each other. This activity is about setting boundaries and pushing oneself to participate. Rohd typically follows this activity with Storytelling.

Sample Trust Warm-up.

Storytelling. Original Source: Rohd. (10-20 minutes). This is good activity to use after physical partner activities. Girls sit opposite each other. Facilitator introduces the concept of story and storytelling: What is a story? What role do stories play in human life? What are story beginnings, middles and ends? The girls get from 3-5 minutes to tell a story to their partner about a topic that the researcher provides. Encourage them to provide details to their story and to find a story that means something to them, but one that they are at ease telling and sharing, not some deep dark personal secret. Topics might include: trust, feat, love, an apology, a challenge. The story is just between the two partners and will not be shared with the group. Possibly discuss the topic with them beforehand. They switch only when the facilitator announces. If a girl finishes early have her start over and fill in some details (weather, clothes, etc.). This activity is an important step in group building and going deeper by bringing together topics, stories, story structures, memory and imagination. Later these stories can be more directly tied to themes of the research.

APPENDIX E

ACTIVATING THEATRE, SAMPLE BRIDGE WORK

Values Clarification. Original Source: Advocates for Youth (20-45 min.): Statements are generated from prior discussions and interviews. Statements are read aloud, for example: “I think it is ok for people my age to have sexual intercourse if they really love each other” or “I think a schoolgirl my age should not be able to attend school if she gets pregnant.” Girls move to locations marked “agree,” “disagree,” and “unsure.” Starting with the largest group, I ask members each group to share their thoughts about their decision. This is not a debate! No one can respond to another’s opinion, only to the statement itself. Not everyone has to speak. If girls revise their decision they can move to another group. Let the smallest group finish last. Each group may generate an overarching statement or two that explains their position. These can be used to develop activating scenes later. My assistant or I may participate or respond to their questions.

Monologue Work. Original Source: Rohd (15-20 min.): Discuss several base ideas related to the workshop and assemble the reasons and explanations they provide. For example, one base idea might explore this question: “Why do some girls your age get sexually involved with older men?” List the reasons participants generate in the discussion. Poverty, flattered by attention, etc. After the discussion give the participants ten minutes alone to generate a story based on one of the reasons provided. They think about this person, create a character and a story about the choices they made, a story that includes the person’s life history, details and background. After they have thought about this character they sit in a chair and tell the story from this characters point of view. After they tell their story the audience questions them about their lives, decisions, and choices.

APPENDIX F

ACTIVATING THEATRE, SAMPLE IMPROVISATION WORK

Rohd stresses that these activities need to be followed up with four feedback questions: Did you stay in it? Did you make it important to you? Did you make strong choices and build the story together? What could have been done differently to make the stakes higher? “Pure improv,” writes Rohd, “involves living in a pretend world, in a given circumstance, from a character’s point of view, and playing every moment truthfully and imaginatively” (Rohd, 1998, p. 74).

Relationship Wheel. Original Source: Rohd (20-30 minutes): Pairs of girls form a circle around the facilitator, one as “A,” is on the inner edge of the circle, the other as “B” is on the outer edge. The facilitator calls out a relationship (ex-lovers, siblings, best friends, etc.) and an activity (shopping, cooking, exercising, etc.). They can’t talk about who is which character. They just begin activity silently. After a couple minutes the facilitator says “speech.” After a couple minutes the facilitator says “Freeze. A’s shift one partner to the right, silently.” With switch made facilitator declares a different relationship and activity and then “Go, silently.” They begin activity silently. After a couple minutes the facilitator says “speech.” And so on. Process the activity with the feedback questions. Explore challenges doing activity. Did they find characters? Did scenes have conflict, or not? This activity is a primer for Russel’s Soup, a modified version of the Relationship Wheel. In this activity one character adds a strong intention to a longer scene.

Line Improvs. Original Source: Living Stage (20-30 minutes): Two lines of girls are facing each other about 10 paces apart with a partner opposite to work with. In this activity a relationship, general circumstance and intention are provided by the facilitator, but the details (of the character and circumstance) are left to the girls to fill in. Possibilities are drawn from earlier

group discussions and bridge activities. For example, relationship is girlfriend/boyfriend; circumstance is that the girl has heard that the boyfriend's ex is HIV positive. She wants to him to go with her to get tested. Some decisions about details can be made in the minute or so before the activity begins, others must be made during the interaction. Challenge girls to take on characters different from themselves and what they know, not just another version of themselves. When you say "go" one girl crosses to the other. After 5-10 minutes freeze the action and discuss the feedback questions. Rotate the line so that each person has a new partner. Begin again.

APPENDIX G

ACTIVATING THEATRE, SMALL GROUPS ACTIVATING MATERIAL

Michael Rohd offers several options for conducting Activating Material: Monologues, Sculpting, Machine and Small Groups – all of which build upon prior bridge and improvisation activities performed in the workshop. I decided to go with Small Groups. The idea behind this was to have participants create activating scenes centered on reproductive health issues that might relate specifically to their lives. I explained to the participants that they would break down into groups of three for 10 minutes to plan a scene to present to the audience. I explained that the Small Groups scenes would last about four or five minutes and could be about any reproductive health issue raised in the earlier sessions. I briefly reviewed some of these reproductive health issues that had come up during the workshop.

According to Rohd activating scenes are neither role plays nor message scenes. They are compressed scenarios that relate directly to the issues they face in their lives. He provides a valuable checklist for activating scenes: the scenes should be realistic and believable; they should be structured, but not scripted; they should revolve around a moment of decision; there should be a location, clear relationships, intentions, conflict, and circumstances. Someone – the protagonist – should be trying to get something they want. For instance, an adolescent girl might be trying to get her boyfriend to get tested for HIV or a daughter might be trying to convince her mother to allow her to have an abortion. The idea was to get the audience participants to look at these issues from the perspective of the characters involved in the scene. At critical moments I would freeze the scene and explore the situation with them. This is what Rohd calls “facilitation” – deepening the discussion and getting audience members to share observations and consider

new angles and options. How else might the girl deal with a boyfriend so reluctant to get tested? What should she do if he continues to refuse? Why do you think an adolescent boy might be so reluctant to get tested? And so on. After this exploration, I suggested that audience members replace one or another of the characters to handle the situation differently. Rohd puts it this way:

...the activating scene, rather than soothe the audience with a satisfying resolution, demands the audience's help in figuring out WHAT TO DO! Because the power of theatre has involved them emotionally in the situation, they care about the outcome and they are left with a need to struggle with possibilities (1998, p. 102).

APPENDIX H

WORKSHOP OVERVIEW

Session One

- Introductions, circle discussion, and ground rules
- Cover the space (energy/focus warm up)
- Blind handshake (energy/focus warm up)
- Storytelling (trust work warm up)
- Circle and debrief

Session Two

- Circle time to review previous session
- Trust falls (trust warm up)
- Circle dash (energy/focus warm up)
- Reproductive health crash course
- Environment (bridge work)
- Values clarification (bridge work)

Session Three

- Circle time to review previous session
- Trust falls (trust work warm up)
- Cover the space energy/focus warm up)
- Find your mother like a penguin (trust work warm up)
- Monologue work (bridge work)
- Zip zap zop (energy/focus warm up)

Session Four

- Circle time to review previous session
- Reproductive health crash course discussion
- Machine (bridge work)
- Relationship wheel (improvisation)
- Line improv (improvisation)

Session Five

- Circle time to review previous session
- Zip zap zop (energy/focus warm up)
- Circle dash (energy/focus warm up)
- Values clarification (bridge work)
- Activating material/Scenarios (activating material)

Session Six

- Focus group with workshop participant

APPENDIX I
FOCUS GROUP

Note: The design of this focus group was influenced and shaped by the issues that came up during the project.

- We spent a few days performing scenes about the kinds of issues girls like you are beginning to face. What do you think were the most important issues we touched upon?
- What do you think were the most difficult issues to think about and to perform?
- We raised a lot of issues about relationships and love and sexuality while doing our scenes. What are your feelings about these issues now?
- Do you all remember the scene when Nancy and Grace had the discussion about Nancy's boyfriend and she said he was telling her if she really loved him she would agree to sleep with him? Can we talk about that scene for a while? *(Several questions like this, probably.)*
- Do you recall the scene when Nancy told Grace that she had an abortion a few years back but she was pregnant again? Let's talk about that scene for a while.
- What was going through your minds when you watched the scene where Nancy woke up crying because she was naked and realized that she might have been raped the previous night since she was dead drunk? How did this scene make you feel?
- Which of the scenes that we created did you think were the most life-like? Why?
- Can you share your feelings about everything that we've been doing last week? Be honest. Don't worry about hurting my feelings. I need to know exactly how you felt about things when we were doing them and now that we're finished.

Sample probes.

- Could you explain that a little more? I'm not sure I understand.
- Can you give me an example of what you mean?
- Tell us more.
- What makes you feel that way?
- Please describe what you mean.
- Can you tie your point to anything that we did during our activating material?
- How does what you just said relate to what Nancy just said?

APPENDIX J

REPRODUCTIVE INFORMATION SESSION

When I say “reproductive health” what kinds of things do you think I am talking about?

What do you think are the top “fears” expressed by young people your age? (Unemployment, unintended pregnancy, HIV/AIDS)?

What percentage of 15-19 year old girls in Kenya do you think have had sexual intercourse? (42%)

Out of 1,000 15-19 year olds, about how many do you think have had a baby? (103)

Of all the births by adolescent girls across the world, what percentage of these births do you think are from adolescent girls in the developing world? (95%)

About how many girls under 18 years old do you think have a baby in the developing world each day? (20,000)

What percentage of 15-24 year olds accounted for new HIV infections worldwide? (42%)

True or False: Young women are less likely to get HIV infection than young men (F – HIV infection rates are 4x for girls in Kenya)

What’s the population of Kenya? (43+ million)

What percentage of the Kenyan population is under 25 years old? (63%)

What is the average age in Kenya when girls get married? (19)

What are the two biggest influences that affect a girl’s decision to get or refrain from sexual activity? (religiosity and parents’ attitude)

About how many Kenyan adolescent girls drop out of school each year as a result of pregnancy? (13,000)

Each year there are about 320,000 abortions in Kenya. What percentage of these do you think occurred in young women aged 14-24? (48%)

About what percentage of abortions for young women aged 14-24 years old in Kenya are unsafe? (45%)

What percentage of Kenyan adolescent girls have comprehensive knowledge of HIV? (41%)

Reproductive Information Session Sources

- WHO. (2011). WPRO | Fact sheet on adolescent health. Retrieved January 7, 2014, from http://www.wpro.who.int/mediacentre/factsheets/docs/fs_201202_adolescent_health/en/index.html
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