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"A LIFE THAT YOU WOULDN'T HAVE IMAGINED": QUALITATIVE EVALUATION OF AN HIV-LIVELIHOOD-EMPOWERMENT INTERVENTION FOR SINGLE MOTHERS IN KENYA

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ABSTRACT

Women bear the overwhelming global burden of HIV/AIDS, particularly in low- and middle-income countries (LMIC) where they experience significant social and economic disadvantages. Integrated HIV and livelihood programs (IHLP) simultaneously targeting health promotion and income generation are increasingly being explored as a potential public health best practice for addressing HIV/AIDS in low resource settings, yet evidence remains limited. Moreover, little is known about the participant experience or programs' broader effects on women's quality of life. This study examined the impact of an IHLP in Kenya utilizing qualitative interviews to explore participants' lived experiences. Four themes and ten sub-themes emerged depicting the most salient program outcomes for women: (1) Wellbeing (Physical Health; Emotional Wellness; Spiritual Wellness), (2) Economic Security (Livelihood Skills; Assets & Resources), (3) Empowerment (Empowered Women; Empowered Mothers), and (4) Social Inclusion (Diminished Stigma; Social Support; Social Influence). Overall, results revealed dramatic transformations for many participants—from severe illness, financial instability, and social exclusion to healthy, empowered entrepreneurs considered valued family and community members. While longitudinal evaluation of program effects is needed, these qualitative findings suggest that IHLPs may meaningfully enhance the physical, emotional, economic, and social wellbeing of single mothers facing dual challenges of HIV/AIDS and extreme poverty.

KEYWORDS: HIV/AIDS, poverty, livelihoods, women's health, evaluation

1. INTRODUCTION

With more than 1.7 million new infections still occurring annually, HIV/AIDS remains a global public health crisis [1-2]. Sub-Saharan Africa (SSA) has been among the hardest hit areas, and HIV infection rates in Kenya continue to rank among the highest in the region [1, 3]. Similar to other SSA countries, women in Kenya remain disproportionately burdened by HIV/AIDS, accounting for over 60% of new infections [4].

Poverty is closely linked to HIV/AIDS, particularly for women in low- and middle-income countries (LMIC). Poverty increases women's risk for contracting HIV, exacerbates disease impact, and hinders treatment and adherence [5-6]. Consequently, intervention researchers have increasingly focused on gender inequities and poverty as key structural factors which shape HIV risk and treatment outcomes for women in these low resource contexts [7-9].

1.1 Gender and HIV/AIDS in LMIC

Disproportionate rates of HIV/AIDS among women in LMIC are well documented [10-11], and gender inequality has been described as the primary underlying determinant of HIV/AIDS in SSA [12-13]. The unequal rights, opportunities, legal protections, and access to resources afforded to women heightens their vulnerability to HIV [12] and hinders their participation in HIV prevention and education programs. Gendered barriers to accessing treatment and care include health illiteracy, lack of transportation, lack of bodily autonomy, and economic constraints [14-15].

The persistent stigma of HIV/AIDS in sub-Saharan Africa [16] can be especially detrimental for women in LMIC [17], leading to social exclusion, isolation, and loss of spousal, familial, and social supports [18-20]. Moreover, the well-documented neglect, abuse, and violence that women living with HIV/AIDS experience at the hands of spouses, family members, neighbors, and health care providers create additional barriers to wellbeing [15, 17].

1.2 Poverty and HIV

For women in LMIC, poverty heightens risk through a series of structural disadvantages—including lack of education, literacy, income generating skills, employment opportunities, and property ownership [18, 21]. These economic vulnerabilities have been linked with increased survival-based risk taking, inability to negotiate safer behaviors [22] and poorer living conditions that undermine health [18].

Poverty also creates significant barriers to HIV testing and treatment, increasing the likelihood of HIV-related morbidity and mortality [1]. Poverty-related factors, including food insecurity, lack of transportation, unemployment, and poor social support, represent key barriers to adherence for women living with HIV/AIDS [23-24]. Moreover, individuals living in poverty who are focused on the prevailing struggles of daily survival for themselves, and their families are ill positioned to be able to take seriously their HIV infection and take action today to prevent future health consequences [25-26].

Even as poverty increases risk of infection and creates barriers to testing and treatment, HIV/AIDS can push non-poor households into poverty and worsen pre-existing poverty [25, 27]. The relatively common practice of women abandoned by husbands and extended families when their HIV status is revealed [18] further compounds this impact, leaving women to provide for children while living with HIV/AIDS. Female headed households affected by HIV face numerous challenges, including

inability to earn an income/diminished employment opportunity [18], diversion of financial resources to HIV care/healthcare [18], increased food insecurity [28] which have long-term consequences for the household [26].

It is now understood that to curb the HIV epidemic in low resource contexts, the economic vulnerabilities that increase women's HIV risk and exacerbate the impact of HIV/AIDS must be addressed alongside target health outcomes. Consequently, researchers have increasingly focused on the structural factors, such as poverty and gender inequities, that shape HIV risk and create barriers to care for women in low- and middle-income countries [7-9].

Integrated HIV and livelihood programs (IHLPs) [29] which focus simultaneously on health promotion and income generation are increasingly being explored as a public health best practice in these low-resource contexts. Yet, evidence on IHLP and other interventions linking HIV and economic strengthening is limited [30-31], and significant gaps exist in our understanding of women's experiences in such programs and their broader impact on quality of life. This pilot study examined the impact of a faith based IHLP serving single mothers in extreme poverty living with HIV/AIDS in Kenya to help address this knowledge gap.

2. MATERIALS AND METHODS

2.1 Study Design

Qualitative data were collected during phase one of a two-phase mixed method pilot evaluation study. Individual interviews and follow-up focus group discussions were conducted with program participants to explore women's lived experiences before, during, and after completing the IHLP. Narratives were intended to both illuminate program impacts and inform development of evaluation instruments to be used in the subsequent quantitative study phase. A participatory research approach was used, involving both program participants and staff as collaborators throughout the study [32]. This paper reports qualitative results related to program outcomes that participants identified as most meaningful to their lives.

2.2 Program and Participants

The Women's Equality Empowerment Project (WEEP) is a faith-based initiative to empower mothers living with HIV/AIDS who have been widowed or abandoned by their husbands or partners and have a high level of economic vulnerability. Operating through seven community centers located in both urban informal settlements and rural villages throughout Kenya, the program aims to improve mothers' health, reduce household economic instability, and improve wellbeing.

WEEP participants progress in cohorts through three consecutive program phases, each approximately six months in duration. In the Stabilization Phase, the program provides assistance with food and nutrition, HIV medications, housing, and other basic needs. The primary goal is to

ISSN 2581-5148

Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

help these single mothers, who may range from moderately to gravely ill at enrollment, to begin to manage their HIV/AIDS and other health conditions, achieve food security for themselves and their children, and regain physical health to support participation in program activities at the local WEEP center. The second phase, Skills Development, offers participants a series of group and individual trainings to build literacy and numeracy, increase health literacy, and develop income-generating skills such as sewing or soap making. Vocational skills training is tailored for the context of each WEEP center (e.g., urban centers focus trainings on creation of marketable products relevant to the informal settlements where they are located, while rural centers where plots of land are available may focus more on basic farming and animal husbandry skills). Finally, in the Sustainability Phase women learn financial and entrepreneurial skills such as saving, budgeting, creating a business plan, and how to form a microlending group. These activities complement each participant's newly developed income-generating skills with training designed to help them launch a microbusiness, accrue household assets, and begin building toward her family's future economic security.

To participate in the program, women must be (1) single mothers diagnosed with HIV or AIDS, (2) caring for biological children under age 18 in their home, and (3) living in extreme poverty (<$1.90 USD equivalent/day). Approximately 110 participants were enrolled in the program at the time of data qualitative collection.

2.3 Sampling and Recruitment

A purposive sample was drawn from current program participants and recent graduates from three locations. Respondents were selected through a collective decision-making process: each center coordinator explained the interview purpose and process, and mothers determined collectively which of the current participants and recent graduates from their center would be interviewed. Women were asked to consider including participants who would offer different perspectives and experiences (i.e., newer participants as well as recent graduates, older and younger women, mothers with fewer children and those with many), but the final list of names and interview scheduling was solely determined by participants at each site. Center coordinators confirmed each nominated woman's interest in being interviewed before creating an interview day schedule which was passed on to the researcher. This process resulted in 7-12 respondents interviewed from each site.

2.4 Data Collection Procedures

Informed consent was obtained from all respondents using consent forms written in both English and Kiswahili. Interviews were conducted onsite at each center by the author with assistance from local interpreters, depending on respondents' primary language (most preferred to speak in Kiswahili; a minority spoke in English or one of several local languages). Interviews were conducted in the most private space available at each center (i.e., a small office at the urban locations and a multi-use structure at the rural site).

The qualitative interview protocol included three sets of questions focusing on (1) participants' lives prior to program enrollment, (2) how HIV/AIDS had impacted their experiences as women and mothers, and (3) how their lives had changed since participating in the IHLP. The latter question, which is the focus of this paper, aimed to explore the perceived impact of participation in the intervention and thus identify participant-framed program outcomes (other qualitative findings are reported elsewhere; see: [26]).

Interviews were digitally recorded and transcribed verbatim; those conducted in Kiswahili or local dialects were translated to English by the same person who had interpreted during the corresponding interview. Women received a handheld dry-erase board and set of dry-erase markers for their participation. Protocols were approved by the author's university Institutional Review Board and the Kenyan community partner's Board of Directors.

2.5 Data Analysis

Exploratory analysis was conducted to examine emerging themes related to program impact. The first iteration of the coding process involved a reading of the narratives to identify elements describing women's life experiences before versus during or following program participation. This included open coding to identify relevant segments and open up the inquiry [33] followed by a second round of coding to group and collapse initial codes into categories. Overarching themes and sub-themes were identified based on these codes. An inductive approach was applied using the overarching objectives drawn from the participatory evaluation study as the initial guiding principles [34]. Preliminary analysis was conducted by a primary coder (author) who then met with two secondary coders (both from the collaboration team in Kenya) who had each reviewed and coded a sub-sample of eight transcripts. Coders discussed and reconciled coding schemes to create a collectively agreed upon framework of categories and sub-categories.

Several strategies, including prolonged engagement, reflexivity, member checking, and parallel coding [35-36], were used to enhance the trustworthiness of findings. Following preliminary analysis of all transcripts, the author convened two focus group discussions with a large subset of the interview sample. Initial themes and categories were presented to each group of participants to obtain feedback on the analysis, interpretations, and thematic descriptions. To further enhance the credibility of the interpretations, programmatic stakeholders including center coordinators and staff members from the sponsoring organization were provided an opportunity to comment on the main findings through focus group sessions and one-on-one communication. Additionally, the primary coder (author; U.S. citizen) and secondary coders (interpreter and program staff; Kenyan citizens) discussed and critically reflected on the ways in which their interactions with these data were shaped by their respective life experiences.

International Journal of Education and Social Science Research

ISSN 2581-5148

Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

3. RESULTS

Participants (n=27) ranged in age from 20-48 years, and all were single mothers caring for between 1-6 children each. The sample was a mixed geographically, including urban women residing in two informal settlements in Nairobi and rural women from five villages in one upcountry area. The majority of respondents were current participants in the final stage of the program, while a small number were participants who had graduated within the previous three months.

Four themes and 10 sub-themes emerged from women's narratives regarding program impact: (1) Wellbeing (Physical health; Emotional wellness; Spiritual wellness), (2) Economic Security (Livelihood skills; Assets & Resources), (3) Empowerment (Empowered women, Empowered mothers), and (4) Social Inclusion (Diminished stigma; Social support, Social influence). Table 1 presents these themes and sub-themes alongside the in vivo codes from member checking focus group discussions. Women's names have been replaced with pseudonyms in the illustrative quotations below.

Table 1. Participant-Identified Outcomes: Themes, sub-themes, and in vivo focus group codes

Sub-Themes	Categories	In Vivo Codes from Focus Group	Illustrative Quote
THEME 1: WELLBEING			
1a. Physical Health	Eating Well	*"I am strong"* *"learned to eat a balanced diet"*	*Here we are taught, there are sometimes seminars where we are taught on how to eat. And also, we were being taught how to cook, even if let's say you get that flour, but you don't have cooking oil, you buy vegetables… green, and if it's firewood you'd get it outside, you cook your vegetables well and eat your ugali, and I started feeling like I was getting better even if I was still living in the slum."*
	Medication Adherent	*"consistent with medication"*	*"You know, these drugs […] are not a cure, but they're good if you continue to take them and follow the doctor's instructions because you're able to get your strength back. And you'll be able to do your work normally like everyone else if only you follow the doctor's instructions."*
1b. Emotional Wellness	Reduced Stress	*"happier than before"* *"happy"* *"no stress"*	*"I started eating well I became stronger and now I'm feeling good and I'm working well. I know that once I leave [program] I will have a good life. […] When I was coming here, I didn't have many thoughts [stress] and wasn't depressed because when I go back home, I would cook and eat. Now, I feel very good and now I live without being*

International Journal of Education and Social Science Research

ISSN 2581-5148

Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

			depressed because at the end of the month I get money to buy food and to pay my rent."
	Self-acceptance	*"confident"* *"lost the shame of HIV"*	*"Now I don't have any fear because I am a person who accepted herself, and I say I can even stand and go on TV and I tell people 'accept it, if you're found to be HIV positive accept yourself and most important take your medication the way the doctor advises.' […] what I tell women […] is accept yourself, even if your husband refuses to accept you, accept yourself and continue with your treatment and you'll live to help your children."*
	Hope for future	*"hopeful about the future and living"* *"have hope, great hope"*	*"Before I came to [program] I had lost hope completely because I didn't see that, like I'd reached where I've reached now in my life. And by now I am happy because even my children, I just used to think they'd be street boys, and I didn't think they'd go to school. Even me, I didn't think I'd be able to learn anything or get a course because my father refused to take me to school when it was time, my age, it was time for me to go to school. I'm really happy about what I'm learning and the course I'm doing."*
1c. Spiritual Wellness	Spiritual Strength	*"strong in spirit"* *"consistent in my faith"*	*"That life…that was very bad life that I would not even want again. Now when I got into WEEP, my life did an immediate turn, because at that time I was not saved, now I'm saved."*
	Spirit of Love and Forgiveness for Others	*"spirit of forgiveness"*	*"So many things I was carrying, like you see the burdens you are carrying. If they were beating my kids, they were refusing to give them food, those things will kill you very fast. But if you know God and get your mind being…lift by God, you'll be able to live. And you'll be able to forgive. By knowing God, I know how many times […] you're supposed to forgive. Because you're forgiven also, and yet you've not forgiven for the times you're supposed to forgive. You'll be able to forgive."*
THEME 2: ECONOMIC SECURITY			
2a. Livelihood Skills	Income-generating	*"sewing" "soap making" "bead work" "skills for our future"*	*"When I got sick […] I couldn't work anymore. Now what I have found that will help me, I have learnt how to sew clothes and then these beads...I can make them. Now what*

			has made me most happy is that sewing and making beads I can do it while seated…making clothes as well."
	Savings & Money management	*"knows how to budget"* *"can save money"* *"knows how to save"*	*"Any amount of money that we get, we make sure there is some that we put aside for saving. And then that way we will be women of development. And so, we started saving every, every Tuesday we used to put in 100 shillings. And then we found that in December, each person was getting 3,000 shillings. We were so happy, we saw that we really can."*
	Entrepreneurial	*"can run a business"* *"does her own business"*	*"I now don't need to depend on anybody to get for some help, it is only the skills that I got here that I use…to, to get my income, yea. And even when we graduated […] just a way they taught us business skills, we went through the recording bookkeeping of them so that they give us some money so we start our business and to continue well."*
2b. Assets & Resources	Housing security	*"live in my own house"* *"can pay rent"* *"own home"*	*"I see that I've learnt so much, things like sewing I didn't even know how to sew using the machine. Now I even realize that within the plot where I live people respect me because even the landlord cannot lock me out because my rent is paid for, even food."*
	Stable income	*"has income"* *"working for myself"*	*"When I graduated, I didn't go back to sitting in the house, I continued with the business skills we were taught of making clothes because I have a sewing machine […] so I had to continue with the sewing skills and sell the clothes and continue with my life. Continue paying the rent, continue paying school fees for my children, and continue getting full day to day."*
	Access to capital	*"participates in a microfinance group"* *"economically empowered"*	*"Everyone will be borrowing to go and do their business and you pay back the money. […] once we started borrowing small amounts and giving it back, we realised it is of benefit to us and now we can borrow even a lot more money as we pay it back and we are able to continue with our business. And right now, there is no one who has graduated who does not own her business and it's because of that money."*
THEME 3: EMPOWERMENT			

International Journal of Education and Social Science Research

ISSN 2581-5148

Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

3a. Empowered Women	Independence	*"lives without depending on others"* *"can stand on my own"*	*"I was not respected before. Because earlier, they [family] were the ones contributing money for me to eat, and now they see that I cater for myself. I use my own money from my pocket, I don't borrow from them anymore. And now they see me as very healthy, they see I will continue to live, I will not die. They even wonder where I went for such luck."*
	Personal agency	*"lives changed for the better"* *"started with nothing and has climbed up"* *"thought process has changed"*	*"When [program] goes away [after graduation], what are we going to do? Will we really go back to the life, the difficult life that we had? And here were these people that tried to bring us up. We have to stand on our own feet, so that when we get out of [program], its, it's evident that all we needed was a boost, a support, so that we can push ourselves forward."*
3b. Empowered Mothers	Provides for children	*"can feed children"* *"provides for family consistently"* *"role model for children"*	*"Our children don't blame us, your child can't blame you for anything, because they see we are strong, we are able to give them food, they don't see that we are sleeping, that we are sick. And so even when a child hears that the mother is [HIV] positive, they don't realize it, they don't, they can't see it because they see that the mother is able to do everything, and we see that [program] has helped us, it has really helped us."*
	Manages household	*"keeps a household"* *"cleanliness of house matters"*	*"As I see myself as a mother, I see myself doing the work that a husband and wife would do."*
	Children are educated	*"educated children"* *"can pay school fees"*	*After being in [program] now, I manage to pay school fees for them, and they continue with their education […] I have been able to educate my children. Now two of them are in high school […] they are doing well. And through the skills, I am paying school fees for them by myself."*
THEME 4: SOCIAL INCLUSION			
4a. Stigma	HIV stigma has diminished	*"stigma is gone"* *"others know you're good and*	*"What I do, it's like I forgot about it, because I survived, I don't see a difference between me and the next person.*

International Journal of Education and Social Science Research

ISSN 2581-5148

Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

		no longer having problems [of HIV]"	*Because sometimes I see that other person has even more problems, I help that person. So, the stigma, it ended."*
4b. Social Support	Peer support (WEEP)	*"center has been a home"* *"we come together"* *"share our problems"*	*"[At the center] I found women, big, big women, healthy they were like the way I am now…big women…they were happy, they didn't have stress. […] What made me happy, you're really welcomed here. Firstly, like I've not been greeted by anyone, even being hugged, but here we come, we greet each other, women hug you, there are talks at the support groups, everyone shares their own story. We are taught about how to take medicine, we are taught that if you don't love yourself there is no one else who will love you."*
	Family/ Community acceptance	*"my family accepts me now"* *"people in the community treat me better"*	*"It has really changed, now they [family] come and visit me. They sometimes even ask for support from me. It's a change. Even the neighbors that used to stigmatize me, they changed their attitude. Now we are friends, we live happily. They, most of the time, they come to ask for advice from me. Before they would not come near me, no one would like to associate with me, talk to me, even [talk to] my children."*
4c. Social Influence	Community role model	*"has become the light of the community"* *"a woman is seen that she makes an effort"*	*"Yes, very much I'm a role model. Even if you…if you go to the community, you may see, maybe we'll not walk a long distance before you will see or hear somebody talking to me, asking me 'How is you today?' Others normally […] call me a doctor because through the support I have given to them most of them have come up. […] Mostly in Kibera, most saw where I was and when they see it I am role model. They can say that if Rachael made it and she was just alone very sick, people are waiting for her to die, but now she is strong, she has done many things so we can make it."*
	Educates others about HIV	*"better able to talk to others"* *"trained as peer educators to go out and educate other women"*	*"My family has realized that I'm somebody. And it make me sad because I went and I talked to my brother and I said, 'Brother, I know you are not wrong, I know you did that because of lack of education, but now I've been educated and I educate other people in the community.' […] and I've seen my brother really being strong and when someone is sick [he] would stand with that person and say, 'You know when my sister was sick, we didn't have the time, the time to*

			take care of her, and when she came back, she taught us a lot of things.' And now they have learned."
	Helps others	*"able to help others financially or otherwise"*	*'I have become strong, and I said I will help others who were down like me so that they become like I am now. Even there is another lady at my place now, she had developed may pimples and boils, and her people hated and disowned her. I went and took her, and took her to hospital, I counselled her, now even when you look at her you can't believe it. She comes to my place, we sew together and I give her casual work, and we live like sisters"*

3.1 Theme 1: Wellbeing

Participants described three primary aspects of wellbeing that were improved through their participation in the IHLP. Physical health transformations were profound, particularly for women who had entered the program when seriously ill or bedridden due to HIV/AIDS. During the initial program stage participants gained weight and the strength needed to attend program activities each week. As Naleke (age 43, mother of 3) noted:

> *Even now I feel that I have a big difference because my body…even I was being carried this way and that way when [I couldn't walk] but now I feel I can stand on my own…even when I left [the hospital] the first time I was carried like a baby on my neighbor's back. Now, even now the neighbor sees me and gets shocked at how good I am looking […] now I'm heavy and healthy and I can do any business whatever it is.*

Progressing through program stages, physical health continued to improve with women reporting better dietary habits, increased knowledge of nutrition needed to stay healthy and maintain strict adherence to ARV regimens, and a healthy appearance that was noticed by others.

Emotional health gains paralleled these physical changes, with greater happiness and reduced stress as key changes emerging from the narratives. Respondents overwhelmingly reported that they had gained self-confidence and "lost the shame" of their HIV status—in fact, some proclaimed that the stigma of HIV was completely gone. Importantly, participants described the program as helping them gain (or regain) hope for the future. Women shared that for the first time since learning of their HIV status, they believed themselves capable of pursuing a better life for themselves and their children. As Violet (age 27, mother of 2) put it, describing her first day at the WEEP center:

International Journal of Education and Social Science Research

ISSN 2581-5148

Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

> *We were really wondering because how [will we be] able to do it. Because when we look at ourselves there is nothing that we knew, because even holding something to start sewing was difficult. Eh, so […] we had a formal meeting. So, women [program graduates] started introducing themselves, that 'I come from this place I make uniforms,' 'I come from this place, I make nets.' Now that's when we believed, we realized that we also can do that.*

Participants identified spiritual wellness as another important facet of wellbeing that was enhanced through participation in the IHLP. Women shared that they had gained spiritual strength and became more consistent in their faith, finding fellowship and spiritual support in their cohort of women at the center. For some, this growing faith was the critical element in their return to health. Participants described a spirit of love and forgiveness for others that developed during their time in WEEP that impacted their relationships with others outside the program. As Agnes, age 48 and mother of three, shared: "The advice I'd like to give [to other women living with HIV/AIDS] is that they keep faith in everything that they do because it is God who is able to do everything here on earth. However much you may be disrespected by others, even by your clan, never lose hope because there is a way God can used to help you and make you well and healthy. For example, as I was, so they shouldn't think that being HIV positive is the end of life….no it's nothing like that."

3.2 Theme 2: Economic Security

Through participation in the IHLP, mothers first learned basic income-generating skills such as soap making, sewing, and bead work. More advanced skills followed, tailored for the local context, including training in farming and animal husbandry in rural areas and cake baking and malaria prevention bed net production in urban areas. Women expressed great pride in these skills, and for most this marked the first time in their lives that they could earn an income to support their families. Gladys (age 32, mother of 2) explained:

> *It's not like how I was earlier, I have known that I am the mother, and my children rely on me, I have known how to sew clothes, how to make mats, how to sew laptop bags and some other sort of bags…I have become knowledgeable, even if I have not formally schooled, even English. I've learnt my English here, it's not that good but I've learnt some here, and I'm very happy. And now I'm proud, I'm a woman who is knowledgeable.*

The financial training and entrepreneurial skills they obtained from the program, along with seed funds provided to launch each cohort's microlending group upon conclusion of the program, provided the foundation needed to launch and maintain a successful business. Fatima (age 40, mother of 4) summarized, "The business has really helped me and makes me happy because now [we] don't sleep hungry, my child goes to school, you know here we even buy [clean] water. Earlier I used to lack water

International Journal of Education and Social Science Research

ISSN 2581-5148

Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

because I couldn't afford even two shillings to afford water, but now I have water because I can afford it."

Participants also obtained assets and resources through the program that were pivotal in the move to financial stability. Women described how they had received rent assistance during the initial stabilization stage and later were able to pay rent on their own or purchase their own house and land elsewhere. In addition to the pride of earning a stable income, women shared how they had built savings and used their microlending group to obtain capital to expand or improve their entrepreneurial ventures. Summarizing her path to economic security, a recent graduate (Silvia, age 33, mother of 2) noted:

> *I said, 'this money, if we borrow and we return it will help us.' I went and bought those panties, I bought vikoi, I started hawking them in the village, people would buy them from me, I get money—I get some for saving, I get some even for buying more stock….[the program] had built a one room house for each of us, I added another three rooms to it and I rented them out for one thousand [shillings] each as I have even put electricity. Now, I feel I continued well. Now, this year I have decided that even I can leave this slum.*

3.3 Theme 3: Empowerment

Women articulated two interrelated types of empowerment that they had gained through the IHLP: empowerment as women and empowerment as mothers. Being an empowered woman was described as internal to women: being knowledgeable, having self-worth, and able to stand on one's own without dependence on others. A sense of personal agency was at the core of women's empowerment stories, which described gaining confidence in their ability to exercise that personal agency in the future with other emerging challenges they may face. As Lucy (age 45, mother of 6), a recent graduate of the program, expressed, "I have been helped by the WEEP class, I was being bought for food, I was having my rent paid for me. Now there is no one who is paying for me, there is no one who is buying me food. I was lifted and then I lifted myself."

Women also emerged from the program as empowered mothers, which they described in terms of what they could provide for their children. Describing her experience of empowered motherhood, a recent graduate (Silvia, age 33, mother of 2 kids) expressed, "A woman should be strong and be willing to work for herself with her own hands, because, like us, our husbands left us. Now we are taking our children to school, and they are eating, and they are dressing well without relying on a man coming from there to bring food to put on the table." Women's narratives noted the importance of being able to manage their household, meaning that the home—whether rented or owned, in the slum or elsewhere—was safe, clean, organized, and a source of pride for the women. Participants shared that they could now be a positive role model for their children, especially daughters, demonstrating how a mother can be strong and persevere through dire circumstances and eventually thrive. Finally,

empowered mothers were those who were able to send their children to school—to pay for the school fees and uniforms required for their children to be educated. Participants, most of whom had very little to no formal education themselves, expressed great happiness about now having educated children with a hope of attending secondary school and even university. Gladys (age 32, mother of 2) explained, "You know the joy of a mother when you see that your children are going to school well, they are getting food, because my house is paid for."

3.4 Theme 4: Social Inclusion

All the women interviewed had experienced profound social rejection and isolation due to their HIV/AIDS status, including beatings by husbands and siblings, exile from the family homestead, and avoidance and ridicule by friends and neighbors. Participants described the profound emotional pain of social exclusion, which also extended to their children, knowing family and friends alike had written them off after learning of their HIV status as if their death was a foregone conclusion. Because of this, women described their newfound social connectedness after IHLP participation as one of the most meaningful program outcomes.

Mothers perceived a strong connection between their experience with HIV/AIDS stigma, which decreased as they progressed through the IHLP, and the social connections and support, which increased gradually over time. Participants spoke of accepting their HIV status and thus shedding their own internalized stigma through their involvement in the IHLP, with several noting that accepting themselves was the first step toward reducing the stigma they felt from others. Irine (age 42, mother of 3) explained, "the stigma now is no longer, I'm free […] It was hard because the stigma was there because I was fearing the surrounding [people] to not know of my status. But now I'm disclosed […], so long as I take my drugs there's nothing that can affect me in any way." The stigma experienced from others was perceived as diminishing after family and community members saw them not only surviving but now thriving d: due to the program, which changed others' perceptions of what it meant to be living with HIV/AIDS. Eunice (age 40, mother of 3) explained: "There's a song that used to sing that […] all those who have been HIV positive are going to die. It is really stigmatizing but I kept on encouraging myself. But for now, I thank God, I am out of stigma. If any of you stigmatize me, I feel very comfortable I even tell people, 'No, that is of no use to me because I am comfortable with myself, and the truth is I have HIV.'" A sentiment expressed by numerous participants, women noted that family members and neighbors used to look at them and only see HIV, but after participating in the IHLP these community members viewed them as 'businesswomen.' Joyce (age 36, mother of 2) noted, "I see that I no longer have that stigma. Even around the plot where I live, we stay with women who are not sick, and I even explain to them that I'm sick and the way I am, and we continue to share with them quite well."

Women's narratives highlighted how participation in the IHLP helped them to gain new forms of social support as well as regain supports they had lost when their HIV status became known. The comradery and acceptance they discovered with fellow IHLP participants was profound. Naleke (age 43, mother

International Journal of Education and Social Science Research

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Vol. 5, Issue.5, Sep-Oct 2022, p no. 302-326

of 3) shared, "when I was sick, I thought I was the only one, and when I came here, I found [HIV-positive] women like me. I've seen others, now they are healthy, so I said even me, I'd be like them!" Women described the center as "a home," noting how IHLP participants came together to share their experiences, confide about their struggles, and bolster self-acceptance and help others disclose who hadn't done so previously. As Purity (age 35, mother of 3) summarized:

> *"[At] lunchtime we'll have our own, uh, time […] come with a story or her story, the other one, the other one, there you get close. 'Cause everybody's sharing, like we are sharing and laughing, this time is not even crying. I used to cry, I used to cry, I used to cry. And if someone got some… troubles, then even you do, you feel courage, yeah, so you will become even like so sure without even knowing the [feeling of release] will just come by itself because uh everybody's talking, everybody's smiling, so that thing will just come[…] you'll be able to learn like with your friends, like with the other women, even if the other women are learning from you, still you be able to learn from them and be able now to start your life and know that I have to live."*

When individuals who had previously rejected these women observed their improved physical and mental health, they understood that these mothers were doing well and were not suffering from poor health any longer. As Joyce (age 36, mother of 2) articulated:

> *They [family] have changed their mentality towards me because I, uh, I think when I told them they just thought that I was just going to die. But now we've changed their mentality because even I speak to my father on the phone, and he even tells me if I feel strong enough I can go and visit and see how they're doing. There is even a sister of mine who is a teacher. She had completely refused to have anything to do with me, she had refused to come to my place but nowadays she even calls me and says, and tells me: when, when my children close school, they can go and stay with her and visit her.*

Importantly, women also gained social influence in their communities that they attributed to their program participation. Participants described how community members, family, and neighbors began to treat them with respect after seeing them making an effort to improve their lives week by week. Some participants reflected on how they were now referred to as role models or "a light" by those who noticed their improved household status. Participants shared how they used the knowledge and confidence gained from the IHLP to educate others about HIV prevention, testing, and treatment. Benter (age 45, mother of 4), a recent graduate, noted, "I became strong, I even teach. Everywhere we go, we teach people, and they go for testing if they find that they have a problem like mine I speak to them until they start taking their medication well." Jackline (age 32, mother of 2) explained how these advocacy efforts also helped to reduce the stigma women faced:

International Journal of Education and Social Science Research

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> *I used to go to the church and because I was very sick, I was very thin, and had rashes all over my body. Even the church members stigmatized me. But, eh, after joining here I had to go and teach them and tell them I'm HIV positive and HIV is real and anyone can get it, HIV. And now they change their attitude. By that time many were dying, so they used to believe they were, they had been bewitched, but through talking to them they changed. Now, most of them have gone to be tested and they are now on their medication.*

After being helped by the IHLP, many women felt a duty to help other women in need whether financially, with advice, food, or support. Violet (age 27, mother of 2), a recent graduate shared:

> *Most people when they go for tests and they find that they're positive, they come to me in my house. They come and tell me that, uh, 'You, you're the person we can talk to. We used to think since you got tested, we used to think you'd die, and now when I got tested, you're the first person I thought of, the first person I thought to come to. Because all those years we thought you'd die, you're still here. And nowadays you don't even look like you have HIV […] There's even one who came to me and told me, 'Please forgive me, there was a day we were doing casual labor with others, and we spent that whole afternoon talking about you and asking each other where did you get it from, are you going to die?' […] And I helped her, I took her to hospital, I helped her start off, now she is a very strong woman. And now we both continue well.*

Summarizing the impact of her social influence, Joan (age 47, mother of 4) noted: "Now I'm a lady who is respected in the village. Even when I had, was still here, I was still walking in the village explaining to women it's important to know about one's HIV status. If I find there's one who is HIV positive, I take it upon myself to transfer her to go to a clinic, and I feel I have helped many." Ultimately, women attributed their participation in the WEEP program as fostering both their desire to help and their ability to do so with greater resources.

4. DISCUSSION

The themes and sub-themes emerging from women's narratives illuminate program outcomes most salient to participants and suggest that the impact of this faith-based IHLP was multi-faceted. Collectively, these themes illustrate pathways toward resilience and growth for single mothers living with HIV/AIDS in extreme poverty and their personal transformations from "barely surviving" to thriving.

Initially, women gained strength, learned to eat with nutrition in mind, and maintained focus on medication adherence, improving their physical health. These gains are notable given that poor health has been linked with lower ARV adherence [18, 37], and reduced quality of life [38-39] among women living with HIV/AIDS in Sub-Saharan Africa.

Consistent with previous research by Amuyunzu-Nyamongo and colleagues [18], mothers identified their inability to provide for their children prior to enrollment as a significant stressor which exacerbated their already poor physical and mental health. Indeed, high rates of stress and depression are well documented among this population [40-41], and both have been linked with mortality among people living with HIV/AIDS [42]. Moreover, study findings support the link between income-generating skills and improved emotional wellbeing for women in high HIV risk contexts [43]. Having a hopeful future outlook may be a critical component of positive mental health for women living with HIV/AIDS [44-46]. For many mothers in this study, the ability to provide for their children was the first step toward reimagining a positive future and living with hope.

Acceptance of one's HIV status emerged as a fundamental component of emotional wellbeing in this study, consistent with previous research [47] in which Zambian women described the need to accept that HIV would be a permanent part of their lives while believing they could still lead a normal life with a sense of purpose. Given that stigma remains a persistent challenge for HIV-positive people in sub-Saharan Africa [16, 41, 48] and internalized stigma may be the most resistant to change [46], IHLP may offer a promising stigma reduction intervention approach meriting further examination.

IHLP participants increased spiritual strength also enhanced their wellbeing and was described as a source of hope for the household. Similarly, women living with HIV/AIDS in Grandmason's [47] study attributed much of their mental and emotional strength to continue living with HIV to prayer, support groups, and their faith. While it has been acknowledged that faith-based organizations can play an important role in the fight against HIV/AIDS in sub-Saharan Africa [49-51] research is needed to explore IHLP implemented in faith-based contexts.

Consistent with previous research on livelihood interventions with women in LMIC [52], IHLP participants in this study were able to gain the skills to earn an income, pay off debts (e.g., past due rent), purchase assets (e.g., beds, transportation), and build economic security for the household. In previous studies, increased economic opportunities and assets were associated with reduced HIV risk taking [53-54] and greater HIV medication adherence [21]. Underscoring this economic impact, research findings from Coˆte d'Ivoire [44] indicate that access to loans and basic financial management training may be more critical for PLHA because their access to economic resources within traditional social networks is often limited by HIV stigma. As women's economic stability is impacted by both their vulnerability to HIV and their ability to mitigate the consequences of HIV/AIDS, future research is needed to examine the target economic impacts of IHLP as well as their capacity for scale-up.

Taken together, participant narratives illustrated a process of change that supports previous conceptualizations of empowerment as the power to have or make choices where such choices were previously denied to them [55]. Participants described newfound abilities to exercise this power both in the context of gender (i.e., being a woman) and in the context of caregiving (i.e., being a mother).

Ruger [56] identified empowerment as a missing component in most HIV prevention and treatment interventions, suggesting that eradicating HIV/AIDS "requires improving the conditions under which people are free to choose safer life strategies and conditions for themselves and future generations." Previous research [57] found that participation in a combined microfinance and health intervention resulted in greater empowerment, autonomy in decision making and financial confidence for women living with HIV/AIDS (WLHA). Moreover, the livelihood component of the IHLP addressed structural factors influencing empowerment as mothers—such as ability to pay children's school fees and move the family to a safer home—which, in turn may strengthen child-caregiver relationships and enhance family wellbeing [58]. Researchers have acknowledged that HIV interventions for women must take into account the participant's family systems and parenting roles, particularly in single mother-headed households [26, 59-60]. Intervention strategies addressing the intersection between HIV and motherhood can not only improve sexual and reproductive health, but also broader economic wellbeing of families impacted by HIV/AIDS.

Consistent with research from Uganda [5], IHLP participants experienced freedom from HIV stigma in their social environment which coincided with increased (or regained) inclusion in social spaces. Women first began to rebuild social support networks with the other HIV-positive women through their shared participation in the IHLP, similar to previous research describing a sense of belonging, emotional support, confidence building, and validation of their experiences from the group which was critical to their improved wellbeing [44, 47]. This increased social belonging can improve HIV medication adherence, functioning, and quality of life [61] as well as help women regain access resources, information, and opportunities critical for household socioeconomic wellbeing [26, 62]. After friends and family observed participants' improved health and wellbeing, many regained the social supports that are critical to the survival of WLHA in sub-Saharan African [19, 63].

In terms of social influence, women described a shift in social position from the margins of community life to that of a role model or "light" to others. Participants attributed this improved social status both to their survival despite community expectations of mortality and their efforts over many months to improve their lives which community members had observed. This supports previous research finding that PLHA were initially perceived by their communities as "unproductive" and a drain on family resources but were later viewed as living, contributing community members after they had participated in a livelihood intervention [46]. Similarly, research from Coˆ te d'Ivoire [44] found that community perceptions of PLHA changed from "the living dead" to contributing members of society after participating in IGAs. Participants in the current study emphasized that their improved physical and economic wellbeing led to increased respect from others, which ultimately helped friends and family members to "see past" their HIV status. This increased social capital and connectedness may support other protective factors to improve life for WLHA, including HIV medication adherence and life satisfaction [61]. If so, this underscores the potential of IHLP as a useful public health strategy in low-resource contexts.

Finally, acceptance of their HIV status and knowledge gained about HIV transmission and treatment had prepared participants to educate others. As women became more empowered and confident in their skills, they began informal outreach to—and advocacy for—community members living with HIV/AIDS. Some participants even sought out training in peer education to serve their communities in a more formal health educator capacity. These findings support previous research suggesting that advocacy and education efforts by PLWHA can help to correct misinformation about HIV [64], improve family planning outcomes [65], and help communities to reconceptualize HIV/AIDS from an individual hardship to engage informal networks of care and support [66].

A study in Zambia [47] found that WLHA derived a sense of purpose from contributing in some way to the wellbeing of others. Women engaged in and offered help to those suffering from HIV, and these efforts helped them to "stay with HIV" or find purpose and meaning in life despite their HIV status. Participants in the current study reflected on their efforts to seek out and offer help to women rumored to be ill and isolated in their homes after completing the IHLP. Once their own economic situation had improved, women began to share food and other resources with neighbors in need and eventually some even provided loans to neighbors who needed help or wished to launch a business of their own.

Despite these encouraging findings, several study limitations should be acknowledged. First, as the study utilized a cross sectional design with participants retrospectively reflecting on program experiences, the causal relationship between participation IHLP and improved outcomes can only be inferred. Second, because an interpreter assisted in some interviews, the possibility of mistranslation or for intended meanings of words or phrases to be lost or misconstrued cannot be ruled out. However, local translators were selected by program staff based on familiarity with the program and strong language skills in Kiswahili and local language(s) to minimize this likelihood. Third, while the goal of qualitative research is not to produce generalizable findings, it is important to note that narratives reflected the experiences of participants of a single IHLP in Kenya. The participatory recruitment approach did yield a sample that was diverse with regard to geography, age, number of children, and time in program, however, suggesting that findings reflect the lived experience of HIV-positive single mothers with varying degrees of health and self-sufficiency and may offer important insights to inform exploration of such programs in similar low-resource contexts.

5. CONCLUSION

Overall, study participants unequivocally credited the 18-month faith-based IHLP for their improved health and wellbeing, economic security, and social (re)inclusion. While small in scale, this study offers qualitative evidence to support the use of integrated HIV and livelihood programs as a promising strategy for addressing the interconnected challenges of HIV/AIDS and poverty among women in Kenya and similar low-resource contexts. Research is needed to rigorously examine the health, economic, and social impacts of IHLPs using experimental designs as well as to explore the specific influence of faith-based programming on these interventions. Moreover, study findings support the

call by Harrison and colleagues [30] to make integrating economic strengthening with HIV prevention targeted to women most impacted by HIV/AIDS a top research and policy priority.

This study utilized participatory methods and qualitative interviews to center the voices of intervention participants. As such, findings offer a unique vantage point into the perceived impact of IHLP participation through the lens of HIV-positive single mothers' lived experiences. Jackline, age 32 and mother of two, shared:

> *I used to think, yea, I just thought "I will die" so my worry was now "How will I leave my children?" Because now I am still alive but even my sisters cannot take care of them, we are just in the house alone sleeping hungry and they are just around. So that was my worry. But after recovering I saw that now I can manage, so I still have a life to live and take care of my children and that could not be possible if I could not have joined WEEP. […] I sometimes can sit down and say "Yea, I have really come from far and I am very grateful."*

Beyond these important program outcomes, however, participation in the IHLP also had a broader positive impact on the ways that single mothers viewed their own lives and futures. As Violet (age 27, mother of two), a recent graduate of the program, explained:

> *My life right now is very nice, let me tell you that this WEEP project, it makes women start thinking very well about their lives. Because you'll find that there are women who are even yearning, longing to join the class, they're wondering, "What goes on there?" [By participating], you're given a life that you wouldn't have imagined you would have.*

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