Determinants of risky sexual behaviors of Kenyan immigrant men in the US and during visits in Kenya

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The Van Houten library has removed some of the personal information and all signatures from the approval page and biographical sketches of theses and dissertations in order to protect the identity of NJIT graduates and faculty.
Kenyan immigrant men originate from sub-Saharan Africa with the highest HIV prevalence in the world. The study hypotheses were: 1) Attitude towards condom use differs between Kenya and the US, 2) Condom use behavior with primary sex partners differ between Kenya and the US, 3) Condom use behavior with casual sex partners differ between Kenya and the US, 4) Sexual behaviors with casual partners differ between Kenya and the US, 5) Age affects risky sexual behaviors in the US, 6) Age affects risky sexual behaviors during visits in Kenya, 7) Income affects risky sexual behaviors in the US, 8) Income affects risky sexual behaviors during visits in Kenya, 9) Education affects risky sexual behaviors in the US, 10) Education affects risky sexual behaviors during visits in Kenya.

The qualitative research questions were: 1) What are the social factors that promote risky sexual behaviors for HIV/AIDS among Kenyan males?, 2) What cultural values, beliefs and practices support risky sexual behaviors among Kenyan males?, 3) How do changes in the social and cultural contexts of Kenyan male immigrants affect their thoughts and behaviors about HIV/AIDS risk?, 4) What are the effects of urbanization and migration in risky sexual behaviors of Kenyan males?, and 5) What are the factors that create variability in sexual behaviors of Kenyan male immigrants?.

The study was guided by Cultural Materialism (CM) model which posits that human behaviors are conditioned by practical conditions of daily life. For the quantitative data
collection, a demographic survey and one instrument, the Sexual Risk Cognitions Questionnaire (SRCQ) were administered twice to elicit differences in attitudes and use of condoms and sexual behaviors in the US and during visits in Kenya. The qualitative component consisted of individual interviews to determine the influence of sociocultural changes associated with migration and urbanization in sexual behaviors.

Purposive sampling was used to obtain the quantitative sample of 89 Kenyan males to obtain adequate effect size who met the following criteria: a) between 18 and 65 years, b) self-identify as first generation Kenyan immigrant living in the US, c) have visited Kenya at least once within the last 2 years, and d) able to read and write in English. The qualitative sample of 20 participants was drawn from those who completed the quantitative survey.

The study revealed existence of push and pull factors related to risky sexual attitudes and behaviors. Demographic factors as age, income and education had a significant influence on risky sexual behaviors. Older age, higher income and education were push factors for change in decreasing casual partners and increasing condom use. The US value of gender equality, self-reliance and freedom in sexual expression countered indigenous values and practices supporting risky sexual behaviors. Access to economic opportunities, quality health services, technology and information created the possibility of a positive future that motivated participants to be healthy and engaged in responsible sex practices. Changes in human thoughts and behaviors (superstructural) are conditioned by related changes in the infrastructure and social, structural contexts of people’s lives. The findings suggest use of initiatives that that include “social capital” in facilitating change towards health protective behaviors for immigrant populations.
DETERMINANTS OF RISKY SEXUAL BEHAVIORS OF KENYAN IMMIGRANT MEN IN THE US AND DURING VISITS IN KENYA

by

Japheth K. Kaluyu

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Presentations


This is dedicated to my friends and family who supported me throughout this entire process.
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CHAPTER 1

RESEARCH PROBLEM

1.1 Background

Acquired Immune Deficiency Syndrome (AIDS) is a health state caused by the Human Immune Deficiency Virus (HIV) that is known to weaken the body’s immune system thus making the body vulnerable to secondary or opportunistic infections and eventually causes death (Sabatier, 1987). Components of the body’s immune system, such as T-lymphocytes normally direct the immune system’s ‘killer cells’ to act selectively against these opportunistic infections. The sophistication of HIV is such that T-lymphocytes are rendered useless against any foreign invader causing the body to become vulnerable to a mirage of infections (Sabatier, 1987). With symptomatology occurring late in the illness, the healthy appearance of most people with HIV is deceptive, allowing for easier transmission of the virus to others (CDC, 2009) leap & Foreman, 2001- Men HIV and AIDS in Kenya- George Gathenya, Fri Asanga Bridget Sleap, Martin Foreman- look for better citation). While there is no known cure for HIV/AIDS, many people live for a long time with the syndrome versus the active disease (Sabatier, 1987).

With more than 40 million people infected, HIV is perceived to be the biggest threat to public health in the world today (Brown, Sebego, Seboni, Ntsayagae, Keitshokile & Mogobe, 2006). Of the 40 million infected in 2005, 60% were from Sub-Saharan Africa (SSA) with 44% of the cases documented from Botswana among individuals 25 years and older (Gobopamang, 2003). Among the 50 top ranking countries affected by HIV, 38 (76%) were from Africa with 34 (68%) from SSA (UNAIDS, 2005).
The endemic nature of HIV/AIDS in SSA remains a major issue. Due to the prolific nature of HIV/AIDS, its impact is felt in the social capital, population structure and economic outlook of the world (Piot, Bartos, Ghys, Walker & Schwartlander, 2001). In the Ivory Coast, the absentee rate of teachers secondary to HIV is 40% and there are increasing numbers of children missing school to care for sick parents or assume new roles as orphans (Fassa, Kangah, Quattara, Cisse, Kadio & Coulibaly, 1998). The magnitude of the HIV pandemic demands nothing less than a sustained method of combat. As the world continues to evolve into a global village where human migration takes place, the effect and vulnerability of one area will eventually affect other areas of the world.

Among East African countries, Kenya is the most affected by HIV/AIDS (AMREF, 2007). In 2003, 7% or 2.45 million Kenyan adults were infected with HIV/AIDS, of which 1.5 million have died. There was higher prevalence rate among men in the urban areas (Kenya Ministry of Health-Division of Reproductive Health, 2007). In 2006, Kenya was ranked 17th in the world with people living with HIV/AIDS and 4th in HIV/AIDS deaths (UNAIDS, 2006). HIV has reduced the life expectancy of adult Kenyans to 48 years primarily due to lack of ability to afford the costly antiretroviral drug therapy (Office of the United States Global AIDS Coordinator, 2004).

In many SSA countries, HIV prevention and care is poorly funded. In Kenya, a heavy burden is placed on affected families. A person with HIV spends seven times more ($60.84) than the average Kenyan for healthcare. Kenyan households carry 44% of the expenditure burden as opposed to Zambia with a prevalence rate of 9% and an expenditure rate of only 30% (National Health Accounts County Brief, 2005). Despite
large national expenditures, HIV/AIDS rates continue to rise. Some authors have attributed this to misappropriation of funds by authorities or poor utilization of effective prevention (Mwamburi, Wilson & Machalad, 2002).

In relatively advanced African countries like South Africa, Kenya, and Uganda where improved life expectancy, reduced corruption and 4-6 times better per capita spending on HIV are present, the epidemic appears not to have matured or peaked as prevalence rates continue to rise at least twice that of other SSA countries (Mwamburi, Wilson & Machalad, 2002). Economic stability and bigger healthcare expenditures in these countries do not translate to a reduction in HIV prevalence. As a result of a 15 year decline in human development indices, countries like Kenya are not expected to meet its Human Development Goals (HDG) of reducing poverty, gender inequality, and HIV prevalence, and improving maternal health and environmental stewardship by 2015.

For many poor people worldwide, migration to escape poverty and disease is a way of life. Migration and globalization have exacerbated the process, magnitude and mode of HIV spread (Department for International Development, 2007). Migration is perceived as one of the pathways through which HIV/AIDS and other sexually transmitted diseases are proliferated (Poudel, Jimba, Ovumura, Joshi & Wakain, 2004). A link between migration and high-risk sexual behaviors has been established. Men and women contract HIV through unprotected sex while they are away from home and transmit this to their wives, husbands or regular partners when they return back home (Pison, Guenno, Lagarde, Enel & Seck, 1993). There are no available data that show how frequent immigrants are likely to visit their homeland. It is fair to assume that many
immigrants live dual lives. They will miss their families back home and as long as they can afford, they will make the visit.

Chirwa (1997) reported that in Malawi, migrants tend to have unprotected sex with multiple partners. It has also been recorded that migrants tend to have infrequent use of condoms in both their host and home countries (Poudel, et al., 2004) and have notable deficits in knowledge of HIV and sexually transmitted diseases (STI). Once immigrants return home even for brief visits, they are attractive to local women because of their improved financial status, thus making them and their partners on either side of the globe vulnerable to HIV.

Due to male dominance in SSA, men are more likely than females to migrate to other countries and escape poverty (Langen, 2005). There is good reason to believe that male out-migration from cities with high HIV prevalence could contribute to the spread of HIV in the host countries (Pradesh, Verma, Saggurit, Das, Rama Rao & Jain, 2007). HIV vulnerability of migrants should definitely be studied in their cultural context to understand the sociocultural dynamics involved in spreading the disease globally. A good example of such population would be Kenyans who represent a large group in the U.S.

The presence of Kenyans in the United States (U.S.) dates back three hundred years ago when earliest migrants were slaves. Slavery was outlawed in 1808 (Rudolph, 2007). Voluntary immigration followed thereafter. The population of Kenya more than doubled between 1980 and 1990. In 2000, the US Bureau of Census recorded a total of 40,680 Kenyans in the U.S. The factors that encourage migration to the U.S. include good education and high paying jobs. The push factors for emigration from Kenya
include food insecurity, endemic poverty, low economic growth, arid and semi-arid land (80% of land mass) and the HIV/AIDS epidemic.

There is also a notable overrepresentation of Kenyans who come to the US to seek higher education (Okoth, 2003). According to Okoth (2003), among immigrants from 52 independent states in Africa, Kenyans have the highest proportion of college students in the U.S. Between 2001-2002, 47% (17,097) of the total 37,724 African students in the U.S. universities were from Kenya. There are 47,000 Kenyans in the U.S. out of the estimated 881,300 African immigrants in the U.S. (Okoth, 2003). In contrast, of the 874 million people in Africa, Kenyans comprise 32 million compared to Nigeria (137 million), Egypt (76 million), Ethiopia (68 million) and Congo (56 million). Families who are left behind are content with occasional visits from migrant relatives and maintain family relationships across continents.

In the U.S., most Kenyan immigrants settle in urban areas where they can benefit from cheap and convenient transportation systems, available jobs and affordable housing. Many Africans tend to blend with the African American population to avoid being singled out or profiled. Many immigrants arrived with plans to go back home but only 2% have returned after receiving their education. The rest chose to stay to avoid the economic instability in Kenya and maintain a stable economic position to help their families back home (Rudolph, 2007). The main destinations are the New York-New Jersey-Pennsylvania corridor and Washington DC.

Since most Kenyans come to the US as students, they tend to be well-educated and attain financial security in a relatively short time (Okoth, 2003). The acculturation process in the U.S. comes easy for Kenyans as both countries share English as the official
language (Rudolph, 2007). Many Kenyans have worked hard and acquired political clout for themselves or through their children. For example, the son of a Kenyan born economist, Mr. Barack Obama is a US Senator from the state of Illinois (Kaba, 2006) who has ran and the 2008 presidential elections to become the first Black president in the US history. Positive relations between Kenya and the US have provided an environment conducive for Kenyans to study in America.

Most Kenyan immigrants who managed to escape direct or potential poverty are often from well-to-do families who can at least raise the airfare to come to the U.S. and dwell in US cities where higher prevalence of HIV is present. Along the main destinations; Washington DC, and the Maryland-West Virginia corridor also rank second in the U.S. for Black male HIV prevalence (CDC, 2006). Sharing the same racial characteristics as American Blacks, Kenyans blend very easily with this population group which also suffers from high HIV prevalence. HIV/AIDS is the fourth leading cause of death among Blacks ages 25-44 years. Although Blacks represent only 13% of the U.S. population, they accounted for more than 50% of the new HIV/AIDS infections in 35 states with long-term, confidential name-based HIV reporting prevalence between the years 2001-2004. In 2004, the Centers for Disease Control (CDC) reported the risk factors associated with HIV/AIDS prevalence in Black Americans were low knowledge of sexual risks with multiple partners, unprotected sex, bisexuality and drug use (CDC, 2006). The same risk factors have been identified in Kenya.

Heterosexual transmission is responsible for 80% of HIV infections in poverty stricken African nations and only 15% of infections are transmitted from mothers-to-children (Lamptey, 2002). The entangled web of similar sexual-risk practices associated
with Kenyan immigrants can potentially exacerbate the prevalence rate of HIV/AIDS among all Blacks in the destination cities. It would be a mistake however, to assume that the elevated HIV/AIDS prevalence rise from the same pattern of sexually risky behaviors. African HIV infection is mostly from heterosexual contacts while Black American infections are mostly from homosexual contact and among drug addicts (CDC, 2006).

A study completed by Tharao, Calzavara and Myers (2000) shows that East African immigrants to Canada did not change their sexual-risk behaviors after migration. The authors suggested the need to investigate sexually risky behaviors and mode of transmission in the Kenyan context. The Canadian study unfortunately aggregated all East African cultures and failed to acknowledge the over forty different cultures in Kenya alone and the diverse groups in other African countries. It is imperative to investigate each country and recognize its cultural composition as well as the factors leading to sexual risk taking behaviors.

Worldwide, sex is the main mode of HIV transmission (Xu, Zhang, Anderson, Xu & Chu, 2000). A pregnant mother can also transmit HIV to the baby in the womb, during birth, and during breast-feeding (Doherty, McCoy & Donohue, 2005). In fewer countries, there are cases of transmission through males having sex with other males (MSM) (Halikitis, Zade, Shrem & Marmor, 2004). However, transmission through drug injection is growing rapidly (Brooks, Adams, Balka, Whiteman, Zhang & Sugarman, 2004). In some African countries like Kenya, the transmission is also possible through circumcision and other cultural practices (UNAIDS, 2007). During circumcision ceremonies, the traditional doctor uses the same knife for all the young men and women
during the same circumcision session thus increasing the potential of HIV transmission. There is no requirement for HIV testing or assessment of sexual behavior to participate in these ceremonies.

The country of origin and ethnicity are not risk factors for contracting HIV by themselves however, people from certain countries and ethnicities are situated in social, economic, political conditions and cultural contexts that promote the risks of HIV infection and spread of the disease (CDC, 2006). The sociocultural context of the host country as the US with availability of jobs and adequate healthcare services along with freedom of association attracts foreigners to emigrate from countries like Kenya (Poudel, Jimba, Okumura, Joshi & Wakai, 2004).

Many countries in Africa including Kenya are considered low-income-food-deficit countries with very low GDP and per capita income (UNDP, 2004) which are partly attributed to the existence of arid and semi-arid lands in many of these countries. The unemployment rate in many African countries is as high as 40% and the agricultural contribution to the national GDP is low (UNDP, 2007). The conditions that pose human survival risks include lack of food, endemic poverty, low economic growth, arid and semi-arid lands, and public health dangers of infection and spread of HIV/AIDS.

Like most other immigrants and minorities in the U.S., Kenyan immigrants settle in urban and inner city areas because of transportation convenience and job availability. In urban and inner city areas of the U.S., ethnic minorities and immigrant workers are recognized as important target groups for HIV/AIDS education and prevention programs to meet the goals of Healthy People 2010 (CDC, 2006). Existing research shows that there is an association between unprotected sex and homosexual men of lower
socioeconomic class and higher prevalence of HIV (Morrison, 2001). Consequently, less educated people may have less understanding of HIV and its prevention, and may choose less condom usage and multiple sex partners (Poudel, et al., 2004).

Immigrants are diverse in age, migration patterns, education level, socioeconomic status, and cultural background. As a consequence, they vary in behaviors that are known to cause and transmit HIV. After they are settled in the U.S., many immigrants frequently visit their country of origin and engage in sexual activities which places them at increased risk for HIV infection, as are their partners with whom they have unprotected sex after their return to the U.S.

Several factors have been attributed to the rapid spread of the disease in Africa including cultural beliefs, attitudes, lack of condom use, multiple sex partners, and to some extent violence (Bauni, 2000). Many Africans have chosen to immigrate to western countries particularly the U.S. to escape those conditions and they arrive with attitudes and beliefs known to cause a robust increase of HIV/AIDS. The literature indicates that the prevalence of HIV infection in the U.S. among foreign-born Blacks is more than double the rate for native U.S. Blacks (Kent, 2005).

A central question remains, what are the social determinants of behaviors that facilitate the spread of HIV/AIDS among Kenyan immigrant men in the U.S. and during their visits to Kenya? The answers to this question can inform HIV/AIDS prevention beneficial to Kenyans and other immigrant groups. Culturally competent interventions can be adopted to deliver appropriate health services and counseling to various immigrant groups. Reducing the spread of HIV/AIDS among Kenyan immigrants will contribute
towards achieving the goals of Healthy People 2010 in reducing and eliminating health disparities in the Black population.

1.2 Need for the Study

Kenyan immigrant men originate from a country where there is a high prevalence rate of HIV/AIDS (Mwamburi, Wilson & Machalad, 2002). Kenyan cultural beliefs promote behaviors that are in conflict with HIV/AIDS prevention and are associated with higher facilitation of the spread of the disease. In 2002, the prevalence of HIV among women between 15-49 years of age was 8.7%, compared to 4.6% among men in the same age group. HIV prevalence for men aged 44-49 alone was 9%.

The Kenyan male immigrants come to the US with their indigenous cultural beliefs and sexual practices. Experiencing the new found freedom of a democratic society, they are likely to continue these behaviors in the U.S. more freely. It is imperative to understand the determinants of high-risk sexual behaviors of these immigrants in order to design health interventions that address the cultural context of their lives. During visits to Kenya, these men have increased risk of HIV infection as are their partners with whom they are likely to have unprotected sex after their return to the U.S.

The existing literature has generally concentrated on racial health disparities where all Blacks in the U.S. are aggregated. There is no existing study that examines the contribution to the HIV/AIDS epidemic by Blacks from Africa separately from American Blacks. The Centers for Disease Control combines health data for all Blacks regardless of origin. Black groups are not homogenous in social and cultural characteristics. This study
will attempt to describe behaviors specific to HIV/AIDS risk in one group of African male immigrants, the Kenyans. The study findings will shed light on social and cultural-specific attributes of Kenyan males that can inform culturally competent HIV/AIDS prevention and control, and help address the goals of Healthy People 2010.

1.3 Purpose of the Study

The study will examine social determinants of risky sexual behaviors of Kenyan male immigrants in the US and during visits to Kenya that contribute to the spread of HIV/AIDS. Specifically, the study aims to answer five quantitative hypotheses and five qualitative research questions.

1.4 Quantitative Research Hypotheses:

1. Attitude towards condom use differs between Kenya and the US.
2. Condom use behavior with primary sex partners differ between Kenya and the US.
3. Condom use behavior with casual sex partners differ between Kenya and the US.
4. Sexual behaviors with casual partners differ between Kenya and the US.
5. Age affects risky sexual behaviors in the US.
6. Age affects risky sexual behaviors during visits in Kenya.
7. Income affects risky sexual behaviors in the US.
9. Education affects risky sexual behaviors in the US.
1.5 Qualitative Research Questions:

1. What are the social factors that promote risky sexual behaviors for HIV/AIDS among Kenyan males?

2. What cultural values, beliefs and practices support risky sexual behaviors among Kenyan males?

3. How do changes in the social and cultural contexts of Kenyan male immigrants affect their thoughts and behaviors about HIV/AIDS risk?

4. What are the effects of urbanization and migration in risky sexual behaviors of Kenyan males?

5. What are the factors that create variability in sexual behaviors of Kenyan male immigrants?
CHAPTER 2
REVIEW OF THE LITERATURE

2.1 Overview of Kenya

Kenya lies on the equator in East Africa bordering the Indian Ocean, between Somalia and Tanzania (CIA World Fact Book, 2007). The physical land area is 582,650 square kilometers covering an area slightly more than the state of Nevada. Kenya’s arable land is only 8.01 % and is plagued by recurrent droughts and floods. There is low life expectancy with high infant mortality of 57.44 deaths/1000 life births. There is increased mortality from HIV/AIDS with a 6.7% prevalence rate. It has a total population of 36,913,721. English and Swahili are the two official languages. In general, the population 15 years and over can read and write (CIA World Fact Book, 2007).

2.2 Kenyan Economy

The country is considered a low-income-food-deficit country with gross domestic product (GDP) per capita income of $460 (UNDP, 2004). The unemployment rate is 40% and agricultural contribution to the national GDP is 19%. Kenya ranks 152nd among the 177 countries with “low human development” (UNAIDS, 2004). Over 80% of its landmass consists of arid and semi-arid lands. In 2000, the U.N. estimated that 3.3 million Kenyans were at risk of starvation due to prolonged drought that affected all of East Africa. Human survival risks include food deprivation, poverty, low economic growth, arid and semiarid land, and the scourge of HIV/AIDS. Kenya is ranked as one of the most economically corrupt countries in the world (World Bank, 2006).
2.3 Kenyan People

Although the Kenyan race is black there are many inhabitants who come from other African countries such as Asia, Europe, and the Middle East. As the country had not faced major civil instability, it is home to many refugees and a chosen location for international events and agencies. It is the hub of the U.N. operations in East and Central Africa. There are about 40 indigenous cultures and ethnic groups that comprise Kenya. The major ethnic groups include: Kikuyu (22%), Luyia (14%), Luo (14%), Kalenjin (11%), Kamba (11%), Kisii (6%), and Meru (5%) (Kenya National Bureau of Statistics, 2000). These groups have distinct cultural beliefs and practices. In various communities, men decide on issues like land division, capital distribution, and technological practices. As a result, men are more educated than women, and hold more economic and political power. Since Kenyan men have more economic leverage, they also get the first chance to migrate to other countries like the U.S. in search of a better life and provide economic help for their families who are left behind.

2.4 HIV/AIDS Epidemic in Kenya

According to the UNAIDS (2006), among the top 50 countries most affected by HIV, Kenya ranks 17th. Even though the number of people living with HIV/AIDS dropped 50% in Kenya between 2003 and 2004 from 2,500,000 to 1,200,000, the number has remained steady from 2004 to present. Kenya dropped from 8th position to its current 17th position. The death rate decreased from 190,000 to 150,000 and has remained steady as well. Kenya now ranks 6th place from 4th place in HIV/AIDS death and 8th for people...
living with HIV/AIDS in the world. These figures are not encouraging at all and show the continuing seriousness of the epidemic in Kenya.

Unlike Western countries, heterosexual contact is the main route of HIV transmission in SSA (Barin, M'Boup, Denis, Kanki, Allan, Lee & Essex, 1985: Biggar, 1986). The UNAIDS Report on the Global HIV/AIDS Epidemic (2000) documented that by the end of 1999 over 10 percent of the populations in 16 SSA countries between 15 to 49 years of age were affected. The rate of infections among adults ranged from a low of 4.16% in Gabon, to 35.8% in Botswana (Drimie, 2002). In the late 1990s, the rate soared from 20 to 30 percent of adults in Zambia, who were predicted to die within ten years (Webb, 1997).

HIV/AIDS is quickly and deeply ravaging the basis of the socioeconomic structure in West and Central Africa (ICASA AF-AIDS. (2003). In all affected regions in SSA, HIV predominates in urban areas, at an urban-rural ratio of approximately 3.6:1. The rural epidemic is considered to be about seven years behind urban areas (Webb, 1997). This epidemiologic phenomenon is associated with the concentration of high risk behaviors in urban localities linked to prostitution and multi-partner behavior. Cities and large towns are often the first entry point of the virus into a country, leading to the spread down the urban hierarchy based on population and economic opportunities. Although there are regional variations in the pattern of HIV spread related to degree of urbanization and proximity to major road networks, the infection moves primarily south from the central African AIDS belt of Uganda, Kenya, Rwanda, Burundi and Tanzania towards and through southern Africa (Caldwell and Caldwell, 1993).
2.5 Gender Inequalities and HIV

Cultures in Africa play an extensive influence in creating gender roles and their assignments. Conversely, gender plays a role in the spread of HIV yet, is poorly understood in Africa. Gender refers to roles and expectations demanded of either men or women. The construction of masculinity and men’s dominance heavily influence the spread and mode of HIV infections (Agardh, et. al., 2007).

Gender inequality exists in SSA and is a recognized facilitator of HIV transmission (Adedigba, et al., 2005; Langen, 2005). As men occupy a dominant role in Kenyan societies, they have better access to jobs making them relatively more economically stable than females. Lack of economic stability renders women vulnerable to prostitution or being forced into sex by men. Men have more opportunities to have multiple partners because they are usually the main decision makers in all aspects of life including sexual engagements (Dodoo & Ampofo, 2001).

The single most important thing in African marriage is having children. In an African home, children are viewed as a source of pride. Parents view children particularly boys as a source of physical and economic security particularly in old age. Girls are viewed as a source of dowry for marriage. Women are not only expected to have children, but having a son is given greater significance in order to continue the family name. After marriage, women belong to their husbands but a husband always remains within the tribe of his parents. Women who cannot bear children or produce a son may have consequences such as their husbands may engage in polygamous relationships or abandon them (Wanjohi, 1999).
Some Kenyan cultures encourage men to have multiple partners or wives, and older men to have sexual relationships with younger women. Hence, forced sex and rapes are common. Kenyan men are seldom criticized for having multiple sex partners and are even encouraged to have multiple sexual encounters. Twenty-seven percent of Kenyan men are reported to have multiple sex partners compared to only 4% women (Dodoo & Ampofo, 2001). Sex education is never taken seriously and discussions about sex are considered taboo. Therefore, many young people end up venturing into the world of sex "blindly." A study found out that 39% of men with multiple sex partners never used condoms consistently (Ferguson, et al., 2004) leaving men and their partners at varied levels of risk.

Even though women may prefer to discuss sex with men in Kenya, they are afraid to demand this of their partners for fear of being abandoned or physically violated through rape or violence. Many women also believe that it is acceptable for men to use violence and to have many sexual partners (Susser & Stein, 2000). With no strict laws against domestic violence in Kenya, a married woman has no recourse if her husband or male partner demands unprotected sex. Some married women and sexual partners who put up a physical fight to defend themselves often lose and suffer physical abuse. Young women who are married to older men often find themselves lacking the sophistication and maturity to negotiate safe sex no matter how vulnerable they feel (Longfield, Glick, Waithaka & Berman, 2003; Mulindi, Osono, Gatel & Kenya, 1998). Women-initiated prevention such as using a female condom may not be deemed culturally acceptable by their male partners. Since men control most of the political and government agencies, women’s voices are never heard (Susser & Stein, 2000).
Spousal and sex-partner communication could be a key in preventing HIV/AIDS spread in Kenya. There is evidence that in areas where spousal communication is encouraged, contraceptive use has improved (Feyisetan, 2000). Religion further restricts sexual expression and negotiation skills (Trinitapoli & Regnerus, 2006). Church ministers forbid mentioning about condoms because of their belief that it promotes promiscuity. Churches instruct women to be submissive to their husbands, further disabling women’s confidence to face men in discussing safe sex preferences. Hiding behind religion often misleads many African men to assume that religious women are safer sexually, something African women may exploit in exchange of economic support (Trinitapoli & Regnerus, 2006).

Arranged marriages of young brides to older men for economic reasons intensifies existing gender inequalities as young brides lack the negotiation skills for safe sex with older males (Walsh 2005). The average difference in non-marital partnerships is 5.5 years and 47% of men’s female partners are adolescents. Fourteen percent of those involved in such partnerships have over 10 year age difference. High levels of “Sugar Daddy” relationships while associated with economic security also aggravates gender power imbalance and lack of safe sex negotiation power by women. In Africa, women’s rights to property are unequal to those of men, a situation that unfairly leaves women financially vulnerable should they lose their spouses. The ability for most women to acquire property is dependent on their relationship with men such as their fathers or male relatives (Langen, 2005; Walsh, 2005). Many women lose their property upon widowhood and resort to paid sex to survive. The communities and the government do not have a good support network that can help widows and orphans inherit property.
(Walsh, 2005). The situation is even worse for children of widows because they often do not get what they had and are predisposed to live a life in poverty, which leads to risky behaviors such as prostitution (Walsh, 2005; Okofor & Obi, 2005). Soon as their husbands or father die, many women are often subjected to widow cleansing (Langen, 2005; Walsh, 2005). Widow cleansing stems from the cultural belief that the widow would need to be cleansed of her dead husband’s spirits through a ritual that subjects the widow to public sexual intercourse with an outcast who does not use condoms nor tested for HIV (Walsh, 2005).

Many women suffer physical, emotional, and financial abuses, and are powerless in demanding use of condoms with their sexual partners. Many women have come to believe that such acts of violence are normal (Walsh, 2005). Gender inequalities and women’s economic disadvantage and lack of voice have a large impact on the spread of HIV among African women (Global Health Council News, 2004). The biological nature of women’s reproductive system further renders them more vulnerable to HIV infection during sexual encounters.

2.6 Homosexuality in Kenya

There are a few reported cases of MSM in Kenya, partly because homosexuality is illegal. Any existence of MSM presents stigmatization which further limits any free discussion with health officials because of fear of being exposed to the legal system. A study done in Kenya (UNAIDS, 2004) revealed that 22% of men reported being bisexual and 30% could not remember the number of sexual partners in the previous three years. Because MSM is illegal, these men are likely to fall victims to physical abuse because of
their marginal status. Victims of sexual abuse and assault are also known to have higher chance of being infected with HIV because they lack sexual negotiation power (Meel, 2005).

In order to design an effective HIV/AIDS prevention program, it is important to acknowledge the existence of MSM in Kenya and understand behaviors of these men. In the absence of guaranteed safety for these men, the careful choice of a partner may be the only way to reduce the risk of HIV infection. Research has shown that among MSM, those who have greater relationship needs such as support are likely to choose a steady partner as opposed to casual sex partners (Craft, et al., 2005).

2.7 Cultural Beliefs and Practices Relevant to HIV
Most men in Kenya use visual indicators to determine the health status of their sexual partners. According to the 2003 Kenya Demographic Survey, only 14% of men and 23% of women aged 15-49 years had been tested for HIV/AIDS (Kahan & Weiss, 2006). The causes of the epidemic are often referred to as a curse or a moral punishment for transgression of taboos by the individual or ancestor. It is also referred to as a “White man’s” disease that creates genocide in Africa or a “plague” that means death to the affected person (Erwin & Peters, 1999). It is also believed that HIV/AIDS is transmitted by sharing food or any contact with the person or by trapped semen inside the condom. People infected by HIV/AIDS believe that it is a culture-bound illness that can be treated by folk healers (Erwin & Peters, 1999). The sick are stigmatized and stigmatization is found to be stronger among younger and less educated persons (Adedigba, et al., 2005).
2.8 Kenyan Healthcare System and HIV

There is a wide gap between known HIV prevention and control, and actual preventive practices in the community. This gap exists because of cultural taboos and lack of governmental commitment supporting HIV prevention which results in ineffective transmission of information. Since many people do not know that condoms come in different sizes and textures, its use has been associated with ruptures, frustration and possibly HIV infection (Global Health Council News, 2004). Although healthcare workers may be prescribing appropriate HIV prevention the population requires far more detailed information that may be uncomfortable for healthcare educators to discuss, or demonstrate.

Often healthcare workers themselves are poorly trained and poorly compensated. A recent study showed that only 33% of Zambian healthcare workers’ partners had been tested and 60% believed that condoms were ineffective in preventing HIV (Karusa, Ngulube, Nyumbu, Njobvo, Erens & Mwaba, 2007). It is doubtful that unsatisfied, poorly educated and meagerly compensated healthcare workers can sufficiently support HIV/AIDS prevention in SSA. Ethical training and ongoing education are needed in Africa for healthcare workers in order to maintain a positive attitude towards HIV-positive patients and not to view them with stigma (Adediga, et al., 2005).

Efforts asserted by the African governments and throughout the world to combat the HIV/AIDS epidemic mostly rely on the Abstinence, Be faithful, and Condomize (ABC) paradigm (Airhihenbuwa & DeWitt-Webster, 2004). Unfortunately, this paradigm is individualistic and assumes that all individuals will respond in the same way. The
social, economic and political environments that surround the individual are not the same, consequently, each outcome will be individualized.

The burden of care is overwhelming the SSA healthcare systems where 42.6% of patients admitted in the medical and pediatric wards are HIV-positive (Govender, Rochat, Ritcher & Rollins, 2006; Doherty, McCoy & Donohue, 2005). Poverty is a huge barrier to self-care among HIV-positive patients and their families. In many cases, breastfeeding HIV-positive mothers are given free baby formula to refrain from breastfeeding. However, they use the formula to feed their other hungry children at home and let their babies continue breastfeeding.

Although the introduction of Voluntary Counseling and Testing had become an important tool in HIV prevention in Africa (Mola, Mercer, Asghar, Ginbel-Sherr, Micek & Gloyd, 2006), there is limited means of transportation provided for patients to be followed up in the clinics. Because of poverty, holistic and family-focused approaches to HIV prevention and care may be the only way to effectively contain the HIV epidemic (Adediga, et al., 2005).

South Africa has recognized the power men hold locally and capitalized on men to use their power to turn the tables on the HIV epidemic. A case study done in 2005 identified adverse health seeking behaviors regarding HIV/AIDS by men in Voluntary Counseling and Testing (VCT) clinics, as well as their general behaviors in seeking medical services (Anglewicz & Kohler, 2005). Rather than viewing men as inhibitors to HIV prevention efforts, they partnered men with other men to use their peer power in combating the disease and domestic violence. This group known as” Men As Partners” (MAP) promotes positive health seeking behaviors. Inculcating accountability in men,
this program has resulted in increased sexual responsibility among South Africans (UNAIDS, 2005).

2.9 Background of the Immigration Process

A large number of Kenyan Immigrants come to the US as students. The process of application to be accepted to enter the US can be quite lengthy. According to the Department of Homeland Security (DHS) (2009), all the international students must have immigration Form I-20 generated by the American university that intends to accept them. Each prospective student need to have passed the Test of English as a Foreign Language (TOFL), Graduate Management Admission Test (GMAT), and Scholastic Aptitude Test (SAT) or Graduate Record Examinations (GRE) as required by the American University during the application for admission. Each accepted applicant must present their Form I-20 to the American Embassy in their country in order to be considered for student Visa. Interviews are generally contacted for all students between the ages 14 and 79 by the consular officer. During the interview, the student must show prove of immunization, medical report regarding infectious diseases that include HIV and Sexually Transmitted Diseases (STDs). Evidence of financial support during the course of study in the US must also be provided to the embassy. Should they fail their medical exams, no visa would be issued until they have undergone treatment.

Once the students arrive in the US, they must remain in good standing to maintain their student visa status. They must attend school continuously until they complete their degree unless they are permitted to skip a semester by the international student office in their particular college or university. They could be allowed to travel back and forth to
their home country. Once a student is in the US, they are allowed to petition for change of status through the DHS. This could be through marriage, business, or investments. In order for a Kenyan immigrant living in the US to possess the ability travel back and forth between Kenya and the US, their immigration status must be in order otherwise they risk being denied a return visa to the US once they leave the country.

Since all students must submit their medical reports to the US consular office in their home country, it can be reasonably assumed that they come to the US with a negative HIV status. Voluntary HIV testing is encouraged by their local colleges once they begin their education but it is not mandatory. Once they choose to change their status to a permanent resident, they must once again submit their medical reports that include HIV status to the DHS. After the change of their status, only voluntary HIV testing is encourage by the school, State Department of Health, or local charitable organizations.

### 2.10 Kenyans Immigrant Population in the U.S

The foreign-born population grew by 43 percent between 1990 and 2000 to a total of 28,379,000. Approximately 33.5 million foreign-born people (FBP) live in the U.S. representing 11.7 % of the U.S. population (U.S. Bureau of Census, 2003). One out of every ten Americans is a foreign immigrant. The highest rate of immigrant influx is recorded in California followed by New York, Texas, Florida and Illinois. In 2000 the top cities with 100,000 or more population with the highest number of foreign born were New York City (2,871,000), Los Angeles (1,513,000), Chicago (629,000), Houston (516,000) and San Jose (330,000). In 2002, the top five counties with the highest
percentage of foreign born were Miami and Dade, Florida (51%), Queens, New York (47%), Hudson County, New Jersey (39%), Kings County, New York (38%), and San Francisco, California (37%). Recent arrivals have higher mobility than those that arrived prior to 1980 as they tend to be younger. More than 40% of FBPs live in a central city compared to only 25% of the native population.

Approximately 15 percent of New Jersey’s residents are foreign born (U.S. Census Bureau, 2000). In the state, the total number of foreign-born persons increased 25 percent from 967,000 in 1990 to 1,208,000 in 2000. Only four other states – California, New York, Florida and Texas had more foreign-born persons than New Jersey. Together with Illinois, these six states have the largest immigrant population accounting for approximately 70% of the nation’s total foreign-born population. By including the native population with mixed parentage (one parent is an immigrant) and foreign parentage (both parents are foreign-born), New Jersey’s total foreign stock was 2,360,000 in 2000. In other words, foreign immigrants and their children accounted for approximately 30 percent of New Jersey’s total residents as of 2000.

The U.S. government itself facilitates the immigration process through various methods that include college enrollment and visa lottery programs. College enrollment is by far the most common for Kenyans.

### 2.11 Immigrant Settlement and Acculturation in the US

Unlike the spatial patterns in the urban-suburban settlements among the US residents, immigrant communities are found in various city locations depending on where their receiving friends or relatives live. Immigrants come from relatively smaller cities and
villages in their home countries to a more urban America. Many immigrants use communication connections with friends and relatives who are already in the US to help find a final destination once they arrive (Kaplan, Wheeler & Holloway, 2004; Pandit & Holloway, 2005). These friends and relatives help them understand the American culture and how to survive in it. Simple matters like understanding the American currency and linguistic expressions can be challenging to a newly arrived immigrant. Newcomers gain both physical and emotional support from this network of fellow immigrants. It is therefore expected that their settlement patterns will vary from those of native-born Americans. Immigrants from the same geographical areas in the home country can generally be found in the same cities in the US. For example, the early Italian settlements in Middletown, Connecticut were from Syracuse province in a city called Melilli in Sicily; in midtown Manhattan, New York, the Italians were from a small city of Ainisi in Sicily while the Italians from the City of Avigliano settled in East Harlem, New York (Thompson, 1980).

There is no universal acculturation pattern among immigrants in the US. The assimilation and acculturation process depends on the country of origin and how the individual immigrant is received by the destination country (Portes & Rumbaut, 2001, 2006). Factors that facilitate the degree to which the immigrant acculturates include the education, income, generation of both the immigrant and the receiving relatives, and the type of friends and associates in the US. Through selective acculturation, immigrants choose what and when to assimilate further which makes the process more segmented and rather complex. Fix, Zimmermann & Passel (2001) found that neighborhoods can also affect school attendance behaviors of immigrant children. Even within the same poor
neighborhoods, the immigrant children are 19 percent likely to skip school vs. 15 percent among the children of native families. Various studies have attempted to explain the adaptation process of immigrants in the US society. According to Thompson’s (1980) model, immigrant colonies developed around the cities where first generation immigrants settled. As immigrants disperse in search of new opportunities, new colonies and continuous settlements develop between these colonies eventually forming a cohesive community.

Gordon’s (1964) model of acculturation describes the steps that immigrants undergo before they begin to gradually assimilate. Gordon points out that the first step is to adapt in both outlook (Clothing, appearance) and linguistics (language). The next step is to culturally adopt and believe in American ways gradually replacing their indigenous culture. Gordon’s model does not account for variability in immigrants’ motivation for assimilation. Fuchs’ (1990) model explains acculturation and adaptation as a voluntary process that is supported by immigration laws. However, immigrants can choose to become US citizens while privately maintaining ties and cultural practices of their country of origin.

Ogbu (1991) identified economic motivation as central to acculturation and assimilation. Immigrants are willing to sacrifice and work hard in order to afford basic needs and continue to improve their quality of life. Among immigrant communities, acculturation and assimilation are viewed as survival tools and in essence, there is a sense of urgency to adapt. Unfortunately, the model assumes that all immigrants are economically driven and motivated by their need to improve their financial status.
While these models do not fully explain immigrant acculturation and assimilation, there is great benefit in understanding the process through these various perspectives.

### 2.12 Kenyan Immigrants in the Northeast

The US Census Bureau (2006) reported 43,939 Kenyans in all fifty states including the District of Columbia and Puerto Rico. An estimated 18% of the entire Kenyan immigrant population in the US resides along the highly urban northeastern states (New York, New Jersey, Pennsylvania, Maryland, District of Columbia, and Virginia) within less than 300 mile stretch. Although variations exist in their demographic background, high educational attainment is a universal characteristic of Kenyan immigrants. Figure 2.1 shows the level of education in Kenyan immigrants in the Northeastern states. Maryland has the most Kenyan immigrants (1,119) with bachelor’s degree and Pennsylvania has the greatest numbers with the most doctoral degrees (108). New Jersey has the most numbers who completed high school and some college education (1,299) and highest numbers of Kenyan school enrollment in all levels and across all the ages.
Figure 2.1 Educational attainment of Kenyan immigrants in the US in 2006

As shown in Figure 2.2, majority of Kenyans earn an annual income of $40,000. Comparing individual incomes across the states, more Kenyans in Maryland and New Jersey earn higher incomes. It should be noted that the income distribution does not parallel the high educational attainment of this group.

Source: US Census Bureau 2006; http://www.census.gov/acs/www/Products/PUMS/C2SS/CodeList/2006/PlaceBirth.htm
Figure 2.2 Personal income of Kenyan immigrants in the US in 2006

As shown in figure 2.3, there were 25,108 Kenyan immigrant households in the US states including Puerto Rico and the District of Columbia in 2006. In the northeast, more Kenyan immigrant households were found in the state of New Jersey (1,881), followed by Maryland (1775) and Pennsylvania (679). New Jersey and Maryland had the most households earning less than $30,000 and the most number of Kenyan individuals Kenyans earning between $40,000 and $60,000. Pennsylvania had only six hundred and seventy nine households with annual incomes between $80,000 - $116,000 dollars a year. There are more households (178) in Pennsylvania with annual income over $116,000 in
2006. This reflects the greater concentration of Kenyans with doctoral degrees in the state.

Figure 2.3 Kenyan household income in the US in 2006

There are no recorded Kenyan residents in the District of Columbia despite the presence of the Kenyan Embassy. However, there are Kenyan-owned businesses, clubs, and restaurants catering mainly to Kenyan immigrants. Kenyan international students attend numerous universities in Washington, DC but live in other states. Sixty-one percent of adult Kenyans in Maryland are highly educated and most likely reside in the suburbs, commuting to work in Washington, DC and eating in local Kenyan restaurants (Speights, 2008).
Age and gender data on Kenyans in the northeast are not available in the US Census Bureau’s Public Use Microdata (2006). However, the US Census (2000) reported that there were 40,680 Kenyan immigrants in the US 55% of whom were men. 87% of Kenyans in 2000 were between the ages of 15 to 64 with median age of 32 years. 52 percent had bachelor’s degrees. Understanding the demographic characteristics of Kenyan immigrants in the targeted area for this study will help identify differential experiences of individuals and groups with acculturation and migration. Such variability will lend to a better understanding of similarities and differences in their experiences post migration.

2.13 HIV/AIDS Among Foreign-Born People in the U.S

The proportion of new HIV diagnosis among foreign-born Blacks increased from 3.5% to 7.5% and rates among African-Americans in the U.S. remained stable at 11-12%. In Kings County, Washington, new HIV diagnoses is more than twice among foreign-born Blacks (1.7%) than native-born Blacks (0.6%) (Kent, 2005). This number could be higher as many immigrants do not always have access to healthcare and many are illegal residents. Migration is a critical factor in high-risk sexual behaviors which vary by gender and residence (Brockerhoff & Biddlecom, 1999). Male and female migrants in both rural and urban areas are more likely to engage in high-risk sexual behaviors than non-immigrants. Understanding the dominant role and circulatory pattern of movement of migrants between cities and countries as the driving force behind their high-risk sexual behaviors could have a beneficial impact on HIV prevention (Brockerhoff & Biddlecom, 1999). Urban settings are contexts through which high-risk behaviors are practiced which
can provide understanding of the interaction between behavior and the environment. Individual and group behaviors, the social environment, and existing social opportunities and behavioral constraints contribute in shaping behaviors of immigrants in the U.S. (Finley, 1982).

2.14 Urbanization Effects on Immigrants

Many African immigrants originate from countries where cultural beliefs and attitudes are known to facilitate the spread of HIV/AIDS. These behaviors include multiple sex partners and unprotected sex. Permission by elders and extended families is required for marriage and unsanctioned sexual encounters are mostly practiced in secrecy. By contrast, the American culture provides freedom of expression, sexual preferences and association. Occupational productivity and individual economic success are valued in the US which may require long hours of work and travel away from home. The different social and cultural milieu creates detachment from traditional norms and immigrants tend to assimilate the new sense of self-centeredness and concentrate on roles that represent their competitive advantage (Durkheim, 1951).

The democratic freedoms and isolation from extended families predispose deviations from traditional values that in some ways promoted protective health behaviors such as being accountable to one’s parents for good sexual behaviors. Indeed, Putnam (2000) has found from his interviews of over 500,000 urban residents that they have become increasingly disconnected from their friends and family. Many immigrants face isolation, economic hardships and loneliness in the new country and without support from their families, they may turn to casual, unprotected sex for comfort. A study in
Ghana showed that 75% of migrant workers had sex in their first month of arrival and 66% never used condoms (Osho & Olayinka, 1999).

The possibility of intentional high-risk sexual behaviors in the U.S. is conditioned by the immigrants’ perception that medical advances and good health care in the west are adequate protection from the deadly consequences of HIV infection. Such perception is used by men who have sex with other men (MSM) as a pretext to engage in unprotected anal receptive intercourse (Halkitis, Zade, Shrem & Marmor, 2004). The low prevalence of HIV/AIDS in the U.S. at 0.6% compared to Kenya’s 6.7% creates a false belief that there is less likelihood to contract HIV in the US (UNAIDS, 2007).

Having multiple-sex partners is often considered a positive status for men in Africa. Male immigrants, who want to reestablish this status, will most likely engage in high-risk sexual behaviors (Morojele, Brook & Kacieng’s, 2006). The illicit drug use which is prevalent in the U.S. has been recorded as a predictor of risky sexual behaviors and can also influence sexually risky behaviors among immigrants (Brook, Adams, Balka, Whiteman, Zhang & Sugarman, 2004).

### 2.15 US Healthcare System

It would be a mistake to merely concentrate on vulnerable populations’ high-risk sexual practices without looking into the health practitioners’ contributions to health disparities in the US. Doctors have a big influence on who gets what medicine, which may contribute to developing drug resistant strains. Those who are deemed by doctors as non-compliant and a threat to the HIV virus regimen because of their chaotic lives may not receive all the necessary drugs (Browning, 1998). Minorities and black mothers are too
busy battling socioeconomic challenges to focus on adhering to expensive drug regimen. Healthcare decisions by professionals are predicated on prejudices rather than patients’ needs.

In most African nations where the cost of a blood test is more than the per capita expenditure on health, more advanced HIV regimens become insignificant and patients turn to their own time-proven treatment techniques such as complementary therapy and consulting folk healers. Scientists and western medical personnel tend to discount the Haitian explanation and perspectives on HIV/AIDS in the context of their culture. U.S. scientists have tendencies of discounting the African culture as ‘Mambo-Jambo’ (meaningless talk) while in the context of the Africans it has real meaning. Africans are not being heard in their context and the more sophisticated western scientists want things their way, so they do miss the point (Browning, 1998).

According to Boykin (2006) Black people in the U.S. have been trained to internalize and repeat the same prejudices used against them by the white community. Few opportunistic blacks are willing to tell White America exactly what they want to hear about them. White America is all too willing to promote and publicize controversial black figures that are severely misinformed about black issues. America has struggled to explain heterosexual AIDS cases and far fewer people were willing to talk about the impact of HIV/AIDS on gay and bisexual blacks. By the end of 1990s, over 30,000 Blacks had died from HIV and only a small percentage had reported that it was acquired through heterosexual transmission. Black voices have not been heard on the severity of the epidemic in their communities which has contributed to the high percentage of HIV/AIDS among them.
Because homosexuality is illegal in Kenya, immigrants are freer to engage in homosexuality in the US where sexual orientation is not questioned. Since they live in cities where more blacks live, their counterparts in sex are likely to be black gays, thus increasing the likelihood of contracting HIV/AIDS. Most gay men who have sex with both men and women do not identify as gay which is referred to as the ‘down-low’ phenomenon in black men. They often put their women sexual partners at risk (Boykin, 2006).

‘Sex tourism’ is also a hidden problem where foreigners from more affluent countries go to foreign lands for sex (Clarke, 2007). Browning (1998) describes “Western sex tourism” as foreigners trying to satisfy their sex fantasies in other countries. Clarke describes how older white women from England visit Kenya in search of young boys who like older girls and shun condoms as being too business-like for their exotic fantasies.

2.16 Social and Cultural Epidemiology and HIV/AIDS

Epidemiology is one particular system of approach to disease and relies on specific protocols and procedures. It tends to be disease-based and assumes that the causes of diseases can be directly identified and therefore treated. Consequently, it relies on measurements that would eventually indicate the extent of the disease and how to treat it. A major component that is not well addressed in epidemiology is the cultural influence on the people’s daily lives. People from various cultures and backgrounds approach and perceive disease in different ways and there is not possibly one defined way of approaching disease across culture. Therefore, it would be a mistake to apply one
theoretical model to all HIV prevention effort, rather it requires finding more appropriate models that fit specific societies and cultures (Trostle, 2005).

The challenge in HIV/AIDS is incorporating the environment in human activities to understand the patterns of disease in the past, present, or in potential future trends (Krieger, 2001). The fallacy of epidemiology itself is its main argument that exposure leads to infection, yet not all exposed people get infected. A different approach to disease in complex societies in Africa would be using the *emic* focus on local concepts of illness and contexts in which they occur rather than on the disease alone. This approach addresses the environment under which the HIV/AIDS is interpreted within the culture of the people themselves. The role of social and cultural context in disease does not only include political and economic factors but also gender inequality, cultural beliefs, and practices. This approach provides the bridge between the biomedical disease-focus and the cultural approach in the context of the local ways of life of the people affected.

Durkeim (1951) has explained how individual pathology results from social facts and dynamics. Carpiano (2006) has identified that the common thread to social epidemiology is ‘social capital’ which represents the reciprocal size of networks that an individual has and the type possessed by those with whom he or she is related. Rational social epidemiology calls for a holistic approach to all factors of our society including political, social, economic, biological, and even the neighborhood setting (Gee & Payne, 2007).

The study of HIV/AIDS phenomena calls for both quantitative and qualitative approaches particularly in SSA countries that comprise many tribes practicing different cultures within a country (Weiss, 2001). There is need to strengthen social supports rather
than traditionally focusing on the causation model of epidemiology. This is fitting in a study that considers a reconstruction of high risk sexual behaviors of immigrants and using possible approaches to behavioral modifications in different social contexts. Accurate targeting is necessary to combat the HIV epidemic and direct us towards managing HIV/AIDS for both immigrants in the U.S. and back in Kenya during their visits (Berkman, Glass, Brissette & Seeman, 2000).

In summary, existing scientific investigations and analysis have concentrated on sexually risky behaviors among Blacks in either the U.S. or in Africa separately (Ferguson, Pere, Morris, Ngugi & Moses, 2004; Karama, Yamatoto, Shimada, Orago & Moji, 2006). No study has addressed the determinants of risky sexual behaviors among immigrants of a specific African country separating the varied nature of cultures within the same country. The fact that migrants could make a decision to travel by themselves to unknown destinations and tackle unknown survival challenges could be perceived by itself as bold, risk-taking attitude and the potential risk for HIV/AIDS cannot be ignored either. Also, the fact that gender power imbalance in Africa gives men more opportunity to travel outside the country and back to Kenya makes Kenyan males good subjects for study (Walsh, 2005).

Development of culturally sensitive interventions to assist immigrants in combating the HIV/AIDS will require a good understanding of this population in the context of how they learn risk-taking behaviors. This study will be conducted in urban areas where Kenyan immigrants tend to inhabit making urban and fitting the Urban Studies Health discipline.
Harris’ (1979) Cultural Materialism (CM) is the chosen framework for this study which posits that socio-cultural adaptation is achieved through the interaction between the people and their environment. Human social life is viewed as a response to the practical problems encountered in daily life. CM postulates that the organizational aspects of politics and economy of a society (social structure) and its ideological and symbolic aspects (superstructure) are conditioned by a combination of variables related to the biological needs of society including production and reproduction (infrastructure) (Harris, 1996).

The CM paradigm stresses the empirical study of socio-cultural systems within a materialist framework of infrastructure, structure, and superstructure systems. Infrastructure consists of the etic (observable) behavioral modes of production and reproduction as determined by ecological, environmental, and demographic variables. Structure is characterized by the domestic order of economy and politics that include kinship and division of labor (Harris, 1996). Superstructure is the symbolic or ideological codes of social order and covers the wider political and social organization (Earl, 1997). In the Harris (1996) paradigm, the interrelationship between the three CM systems is unidirectional. He surmises that changes in Infrastructure will automatically trigger changes in the Structure, which in turn triggers changes in the Superstructure. Figure 3.1 shows Harris’ CM showing infrastructural determinism and unidirectional change.
In contrast to Harris' view of infrastructural determinism of human life and behaviors, this study is built on the premise that changes in any of the components of the sociocultural system affects the other components. Unlike Harris' position in the supremacy of the etic over emic, this study proposes that by examining the relationship between the emic (insiders' worldview) and etic (observable behaviors of subjects) will yield a comprehensive understanding of the phenomenon. This is especially significant in understanding risk-taking behaviors and protective behaviors relevant to HIV/AIDS. The emic approach allows the researcher to understand health behaviors within the social and cultural context of participants. The etic approach enables the researcher to empirically observe cultural behaviors in specific contexts.
Figure 3.2 below shows the conceptual relationship between superstructure, structure and infrastructure. Human behaviors are not only influenced by the social conditions and their situated environment but also conditioned by thoughts and ideologies. Thoughts and behaviors are intimately linked and conditioned by the social, cultural and environmental contexts. Conversely, infrastructural changes require consequent changes in the superstructure and social structure for humans to survive.

![Diagram of CM systems](image)

**Figure 3.2** Interaction of the CM systems

### 3.1 Challenges of CM Model

This study recognizes the need for a bifocal approach where both quantitative and qualitative research methods are employed in studying human behaviors. Unlike Harris’ supposition that etic or observable behaviors are the only units of empirical measurement,
this study proposes a strong linkage between thoughts, values and beliefs (emic) on behaviors. Studying both the emic (implicit framework) and observable behaviors yields a fuller understanding of the phenomenon of sexual behavior. As shown in figure 3.3, within the sociocultural context, not all the emic thoughts could be reduced to etic observations. On the other hand, not all etic observations reflect emic thoughts.

**Figure 3.3** Emic and etic interaction within sociocultural context

The three components of the CM components will need to be compared and contrasted in order to understand how changes in sociocultural contexts affect sexual behaviors and attitudes between Kenya and the United States. A comparative understanding of the superstructure, structure and infrastructure of these two societies provides the framework for studying the phenomenon of interest in different sociocultural contexts. The contrast allows for discovering changes in participants’ emic perspective and etic behaviors conditioned by their life pre and post migration. Emic and etic changes
will be analyzed as influenced by migration from the third world rural and less urbanized environment to one that is highly urban, high tech and modern. Hence this study used mixed research methods. The quantitative research component analyzed the condom attitude and sexual behaviors (etic) in the US and during visits in Kenya. The qualitative research component used in-depth interviews to further understand the reasons and thoughts (emic) behind risky sexual behaviors and attitudes.

3.2 Kenya and the US Sociocultural Contexts within the CM Model

There are notable differences in the sociocultural contexts between Kenya and the US within the three components of the CM model. The immigrants originated from Kenya whose culture, values and beliefs are different from those in the US. Upon migration, they were faced with a challenge of learning new beliefs and values that would enable them negotiate life in the new world.

In the Kenyan context, the infrastructure is marked by prevalent poverty and a large gap between the rich and the poor. Unemployment is high with limited opportunities for upward economic mobility. As a result, there is outward migration to escape poverty. Kenya has a predominately subsistence economy, low technology and less efficient transportation and communication systems. The region is marked by more rural and arid regions.

High HIV prevalence in Kenya remains a major obstacle in development. The social organization (structure) is influenced by the indigenous practice of polygamy, tribal kinship and unequal opportunities for men and women. The quality of healthcare services and access to these services are marginal. Kenyans use a combination of
professional and folk healers to deal with illness. Educational opportunities are limited causing many Kenyans to seek education outside the country. The symbolic ideals of Kenyan traditions (superstructure) include emphasis on gender-specific behaviors (patriarchy, masculinity, virility, female subservience to male authority) and kin loyalties to tribal healers. Expressions of sexuality are “taboo” and the HIV infected are subjected to stigma due to religious and superstitious beliefs regarding the cause of the illness. Homosexuality is illegal in Kenya. Relationships matter more over materialistic pursuits and communities rely on their kin for care and support.

In contrast, the US society is marked with higher productivity and standard of living, large middle class, better job opportunities and greater chances for upward economic mobility. In the US, people are free to migrate anywhere to seek better economic opportunities. Most areas are urbanized and supported by advanced technology and communication systems. Compared to Kenya, there is better quality of healthcare services and access to quality care. Americans have longer survival rate, lower infant mortality and better management of HIV/AIDS. While the US has professional-dominated healthcare system, its costs is much higher than other countries in the world.

In contrast to Kenya, the US embraces monogamous relationships and more equitable distribution of opportunities to men and women. The nuclear family orientation emphasizes individual self-reliance and achievement as opposed to Kenya’s tribal family. The individual effort determines success in the US and there is greater access to educational opportunities than in Kenya. The US political system offers freedom of speech, religion, association, and separation of religion and government.
The value system in the US (superstructure) embraces gender equality, respect for
different sexual practices as homosexuality, and open expressions of sexuality. Self-care,
self-responsibility, and economic success are valued over relationships. There are
scientific explanations (epidemiology) of disease in the US and HIV is perceived as
preventable.
CHAPTER 4

METHODOLOGY

The study aimed to examine social and cultural determinants of risky sexual behaviors of Kenyan male immigrants in the US and during visits to Kenya that contribute to the spread of HIV/AIDS. The study had ten quantitative research questions and five qualitative research hypotheses.

4.1 Quantitative Research Hypotheses

1. Participants’ attitudes towards condom use differ when they visit Kenya and while in the US.
2. Condom use behaviors with primary sex partners differ during visits in Kenya and in the US.
3. Condom use behaviors with casual sex partners differ during visits in Kenya and in the US.
4. Sexual behaviors with casual partners differ during visits in Kenya and in the US.
5. Age affects risky sexual behaviors in the US.
6. Age affects risky sexual behaviors during visits in Kenya.
7. Income affects risky sexual behaviors in the US.
9. Education affects risky sexual behaviors in the US.
4.2 Qualitative Research Questions

1. What are the social factors that promote risky sexual behaviors for HIV/AIDS among Kenyan males?

2. What cultural values, beliefs and practices support risky sexual behaviors among Kenyan males?

3. How does the social context affect Kenyan male immigrants’ sexual attitudes and behaviors?

4. What are the effects of urbanization and migration in risky sexual behaviors of Kenyan males?

5. What are the factors that create variability in sexual behaviors of Kenyan male immigrants?

4.3 Operational Definitions

The following are the operational definitions of terms referenced in the study.

- Risky sexual behaviors are defined as unprotected sex and having casual sex partners in the U.S. and during visits in Kenya. Information will be obtained from the demographic survey and interview.

- Kenyan men are residents of the US and between 18-65 years of age who self-identify as immigrants from Kenya and who visited Kenya within the last five years.

- Primary sex partner refers to subject’s spouse or regular partner who can be male or female with whom he had vaginal intercourse.

- Casual sex partner refers to sex partner other than one’s spouse or regular partner.

- Casual sex behavior is having more than one sexual partner -Information will be elicited through the demographic survey and interview.

- Sociocultural context refers to the infrastructure, social structure and superstructure of the society elicited by interview and demographic survey.

- Unprotected sex refers to the failure to use condoms at all times when having vaginal sexual intercourse. Information will be elicited through the demographic survey.
Attitudes toward condom use will be measured by the scores on the instrument, The Sexual Risk Cognition Questionnaire (Shah, Thorton, & Burgess, 1997).

Condom use behavior refers to the choice to use condom during vaginal sex.

The study utilized a combined approach of quantitative and qualitative methods.

A combined method allowed for studying the complexity of sexual behaviors embedded within the sociocultural contexts of Kenya and the US. Such behaviors are intimately linked with emic values and beliefs which are observable in etic behaviors of the target population of Kenyan males. While quantitative method is appropriate in measuring phenomena that are by their nature defined as behaviors and practices such as the number of times one uses a condom during sexual intercourse, the subtleties of why males engaged in casual sex partners and avoid using condoms despite the threat of HIV/AIDS can only be appreciated by understanding the integrative aspects of Kenyan culture in their thoughts and behaviors as they move from one context to another.

Although Harris' (1979) assumption emphasized that etic behaviors would generally represent observable and measurable aspects of cultural values and beliefs, this study is built upon the premise that emic and etic components are intricately linked and mutually embedded in each other. Hence, each one needs to be explicated to get a comprehensive understanding of how the concepts relate with each other.

The study used Cultural Materialism (CM) as the framework for examining human behaviors as conditioned by the infrastructural, structural and superstructural conditions of human existence (Harris, 1996). The limitation of reducing emic thoughts to observable measurements only strengthens the argument for a qualitative component to support and extend the empirical measurements. The distinct purpose of this study is to explicate how sexual behaviors are influenced by changes in the sociocultural context as
evident in behaviors as engaging in multiple sex partners and using condoms. Sociocultural changes such as shifts from the third world to developed societal contexts, rural to urban settings, particularistic to impersonal networks, gender inequality to egalitarian roles, and well-defined to more liberal sexual affiliations and practices are examples of the myriad and complex influences on human behaviors which can not be reduced to a single quantifiable phenomenon.

4.4 Research Design

4.4.1 Quantitative Method

Cross-sectional survey was used for the quantitative study design. A demographic form and one instrument, Sexual Risk Cognitions Questionnaire (SRCQ) were utilized for the data collection. The demographic survey consisted of a total of 33 questions: 15 items (Appendix A) elicited participants’ demographic characteristics, marital status, and age of initial sexual experience, nine items (Appendix B) elicited comparative information on participants’ sexual behaviors in the US, and nine questions (Appendix C) elicited information about sexual behaviors while visiting in Kenya.

The instrument was chosen based on the similarity between this study and the original study for which the instrument was developed. The SRCQ was developed by Shah, et al (1997) to measure attitudes towards condom use among individuals engaged in unsafe penetrative sex with casual or primary partner. The SRCQ does not limit condom use attitude when having sex with women only. Rather, these were worded to include either men (MSM) or women (MSW). The instrument is publicly available at the
Center for HIV Prevention and Treatment Services (CHIPTS) website (http://chipts.ucla.edu/assessment).

The instrument was administered twice to the participants to obtain comparative scores on their condom use and attitudes as residents in the US and as visitors in Kenya. There are a total of 22 questions in the SRCQ generating reasons for not using condoms. Participants were asked to indicate their agreement or disagreement with each statement about why condom was not used during sexual intercourse. A 5-point Likert scale ranging from never to very frequently was used to indicate each response. Higher scores mean more negative attitudes toward condom use. The instrument took between 15-20 minutes to complete.

To ensure validity, the instrument was chosen based on the similarity of the study that developed the instrument. The SRCQ’s discriminant validity scores show lack of high correlation with scales of other theoretical concepts (F= 9.2; df = 2; p <0.001). The internal consistency reliability of the instrument is reported in two studies was Chronbach’s alpha score of 0.91(Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Shah, et al, 1997). In Garofalo. et al’s study, the SRCQ was used to describe the real life challenges and HIV-risk behaviors in communities of color.

For this study, the Cronbach’s alpha for the SRCQ was 0.77 for Kenya and 0.78 for the US. A score of alpha value 0.70 was considered as acceptable reliability. (Martin & Altman, 1997; Gliner & Morgan, 2000). Therefore the scores generated from this study are reliable.
4.4.2 Qualitative Method

The qualitative research design seeks to understand thoughts and behaviors of participants within a contextualized setting. Hence, interviews were carried out while the researcher interacted with participants in their natural environment. The interviews were conducted in a conversational format using an interview guide (Appendix D) that allowed flexibility in the flow of conversation giving control to participants. The quality of the data depended on how the data were gathered and the steps taken to ensure validity (Lincoln, 1995).

Using a qualitative research method allowed the collection of thick data and enhanced the interpretation of the data within the context in which they were gathered. The qualitative component in this study elicited information regarding values, beliefs and practices of engaging in multiple sex partners, and how these are affected by changes in the sociocultural contexts as well as perceived changes in HIV/AIDS vulnerability influenced by sociocultural change. It should be noted that there is no instrument that measures appropriately the relationship between values, beliefs and practices of using casual sex partners in different sociocultural contexts.

4.4.3 Sample

The study has a cross-sectional design using a convenience sample of participants drawn from Kenyan social settings by snowball technique. The quantitative sample comprised of 89 Kenyan immigrant men who met the following inclusion criteria: a) between 18 and 65 years, b) self-identify as first generation Kenyan immigrant living in the US, c) have
visited Kenya at least once in the previous 2 years, d) able to read and write in English and e) willing to sign a consent to participate in the study.

There is only one existing study that provides the mean and the standard deviation on the SRCQ. According to Cohen (1992) at least two sample means and standard deviations each from similar studies that used SRCQ is necessary to calculate the effect size and sample size for the paired t-tests for power analyses. An alternative method using the difference rule \((n-v \geq 50)\) being the sample size, and \(v\) the total number of variables measured) developed by Harris (1985) was used to calculate the sample size for the study. In this study, the total number of variables is 34, which include the 33 demographic variables and one condom use variable. The sample size meets the criterion of exceeding the number of variables by at least 30 \((n = 50 + 34 = 84)\) as recommended by Knapp and Campbell-Heider (1989). 89 participants were recruited for this study. A power of .80 with an alpha of .05 was achieved using this sample size.

The qualitative sample consisted of 20 participants who had completed the quantitative component and indicated willingness to be interviewed. Participants for the study were drawn from Kenyan communities in Maryland, Virginia, Washington, DC, Pennsylvania, New York and New Jersey. These locations were chosen as they are favored destinations of first generation Kenyan immigrants (US Census Bureau, 2000). The social settings included social gatherings and bars/restaurants. As the researcher is also Kenyan, he had access to the different Kenyan communities in the eastern corridor of the US. Initial contacts were done through friends, relatives and acquaintances who were also asked to recommend other potential participants.
4.4.4 Quantitative Data Collection

All quantitative data were collected in the US. Using the SRCQ instrument, each data collection session comprised of an individual or a small group of participants gathered in a reserved private room in a Kenyan restaurant or network meetings at designated times. Written permission from various meeting locations was obtained prior to beginning the interviews. The researcher explained the study purpose and protocol before obtaining the participants’ consent. Participants were informed of the incentive for participation. Each one received a one dollar state lottery ticket after completing the surveys. All surveys were individually coded (First initial, last initial, month of birth and a participant number sequentially) before being handed out to participants to assure confidentiality. The researcher was present to administer the surveys and answer any questions.

Two forms of the surveys were administered. Form A (Appendix B) consisted of questions pertinent to the US context while Form B (Appendix C) questions relevant to the Kenyan context. Participants were be given specific instructions before they proceeded from Form A to Form B. Participants completed each form within 15-20 minutes.

4.4.5 Qualitative Data Collection

Out of the 89 surveys collected for quantitative research, 20 participants were solicited representing each of these six states (NY, NJ, PA, MD, DC & VA) for qualitative interviews. Face-to-face individual interviews took place in a private area at a time and place convenient for the participant. All interviews were conducted in the US.

Due to the sensitivity of sexual topics and the cultural “taboos” associated with sex in Kenyan society, the participants were reluctant to have their responses audiotaped.
The researcher documented as closely as possible their verbatim responses. Using an interview guide the researcher conducted individual face-to-face interviews in English. Each interview took approximately 40-60 minutes.

Participants were allowed to stop, leave, and discontinue the interview at any time and were assured that neither they nor their families would be jeopardized if they withdraw or decline to participate. Interviews were done by the researcher.

4.4.6 Validity and Reliability

According to Guba & Lincoln (1981), all research must have “truth value”, “applicability,”, “consistency,”, and “neutrality,”. The “truth value” which is synonymous to validity is used to establish confidence in the findings of an inquiry given a particular context. In this study, the “truth value” was achieved through thick descriptions of the sexual behaviors by participants. A trusting relationship was developed by allowing participants to control the conversations to prevent premature foreclosure of the interviews. This approach ensured collection of thick data. After approximately 13 interviews, similar patterns of responses were noted indicating data saturation.

“Consistency” is used to show that the same research method can be followed and achieve similar results given similar respondents. “Consistency” in this study was achieved through maintenance of paper trail of the data and the rationales used so that other researchers can have opportunity to review the data and use the same logic to arrive at the reported conclusion. Data were analyzed separately by the researcher and his mentor with expertise in qualitative research and together to promote inters-rater reliability. Additionally, findings from both quantitative and qualitative methods were
used to answer the research questions. Consistency and truthfulness were crosschecked through triangulation and extensive consultations and feedback from a qualitative research expert. Multiple methods of data collection (survey, interviews) were used to reduce the possibility of chance in the data analysis. The findings were shared with a small number of participants to further enhance truthfulness and credibility. They agreed with the research findings. “Applicability” which establishes the extent in which the results of a research study can be applied to a different research study in a different context. In this study, “applicability” was achieved by extensive descriptions of the demographic characteristics of the sample, documentation of participants’ responses and situating the findings within the existing literature.

“Neutrality” was achieved in this study by keeping a journal to record his own self reflections and participants’ non-verbal expressions and behaviors. This was done so that the researcher maintained neutrality during the interview to prevent any communication of bias that may influence participants’ responses.

4.5 Data Analysis

4.5.1 Quantitative Data Analysis

Data from the demographic survey and instrument were analyzed using SPSS version 16 for descriptive and inferential analysis. The independent variables were the US and Kenya groups; level of age, income and education. The independent variables were the US and Kenya groups. Condom use attitude data was collected using SRCQ and was treated as interval measurement. Paired t-tests were used to compare mean scores in the SRCQ to determine differences in attitude towards condom use during visits in Kenya.
and while in the US. McNemar tests were used to determine differences in condom use behavior with primary and casual sex partners in Kenya and the US. Condom use behavior was measured at ordinal level. Sign tests were used to determine differences in sexual behavior with casual partner in Kenya and the US. Sexual behavior was measured at nominal level. Sign tests were used for ordinal variables and McNemar test was used for categorical variables (Huck & Cormier, 1966). Student t-tests and Chi-square were used to determine relationships and association between demographic factors and dependent variables. To control for Type 1 error, significance was set at 0.05 levels, two-tailed.

4.5.2 Qualitative Data Analysis

Using content analysis, categories or themes were inductively derived from the data. Variations were described and accounted for. This process included identifying and coding the data units of meaning, categorizing each coded unit of meaning, and identifying patterns or themes (Lincoln & Guba, 1985). All segments for sub-themes were analyzed to form emerging themes. All categories were reviewed for illogical overlap and abstracted for data reduction. The same content analysis method was conducted to answer the specific aim and research questions. Explanations were then offered to tie the analysis to the conceptual framework.

Content analysis examined transcripts of participants’ conversational responses to identify the main themes. It offered more possibility for triangulation of data through coding and clustered categorization. Coding these ideas and themes allowed for triangulation between qualitative and quantitative findings (Webber, 1990). Content analysis provided an in depth look at the comparisons of participants’ thoughts and
linguistic expressions. Repetitious expressions were used to form categories of examination related to the research questions and the conceptual framework (Carley, 1990).

4.5.3 Triangulation

Mixed method designs include triangulation which focuses on mixing quantitative and qualitative research data to yield better understanding of the questions and hypotheses in question (Creswell & Plano-Clark, 2006). Once the data are collected and analyzed in both methods, triangulation could be used to support or confirm results of each method. The choice of the triangulation method depends on the purpose and the design of the study. Other factors that help determine the type of triangulations include whether the data are collected simultaneously or sequentially, which data have priority, and the reasons for triangulation (Morgan, 1998). Since the data collected in both methods were not over time, confirmatory triangulation was not possible. The triangulation model for this study is the convergence model. Convergence Triangulation model compares the results of both qualitative and quantitative data and interprets the comparisons (Creswell & Plano-Clark, 2006).

The justification for using mixed methods in this study was the lack of available instruments for measuring attitudes towards condom use and multiple sex partners. The qualitative data augmented the quantitative findings by generating participants’ perceptions and descriptions of their experiences and beliefs. Triangulation sought support from both qualitative and quantitative findings to answer the research questions and hypotheses (Dreher & Hayes 1993; Miller 1997). Discordant findings were used to seek further clarification and reasoning behind the discrepancies.
4.5.4 Ethical Considerations

Approval was obtained from the Institutional Review Board (IRB) of the University of Medicine and Dentistry of New Jersey prior to any data collection. A written consent was obtained from each participant after explanation of the study, its protocols and the nature of participation required. Participants were informed of the incentive for participation – one dollar state lottery ticket to be given after they complete and submit the surveys. The consent specified the audiotape and notes options for individual interviews. Participants were informed that their participation was voluntary and they could withdraw anytime without penalty.

All surveys were coded in lieu of participants' names. Interviews were personally arranged, conducted, and notes taken by the researcher. All completed surveys were placed in an envelope that was sealed and transported by the researcher in a locked box. Findings were reported as aggregates and themes without identifying individual participants in reporting and disseminating the study.

All the data was kept at the Research Advisor’s Office at The University of medicine and Dentistry of New Jersey, 65 Bergen Street, Bergen Building, GA45, Newark NJ in a locked cabinet accessed only by the researcher and the advisor. The office was kept closed when no one is present. All research data will be stored for six years after the study is completed. Participants were informed that the completed study will be published in the form of a dissertation with a copy filed at the University of Medicine and Dentistry of New Jersey Urban Health joint program’s Coordinator’s office.
CHAPTER 5
QUANTITATIVE RESEARCH FINDINGS

5.1 Demographics

This chapter reports the quantitative results of the study. 89 Kenyan immigrant men participated in the study. Participants were between 20-57 years of age with a mean age of 34.41 (N = 89; M = 34.31; SD = 9.45). They have resided in the US between 1-30 years with a mean length of residence of 8.5 years.

Table 5.1 Demographic Characteristics of the Study Sample

<table>
<thead>
<tr>
<th>Total participants</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tribes:</strong></td>
<td></td>
</tr>
<tr>
<td>Kalenjin</td>
<td>7</td>
</tr>
<tr>
<td>Kamba</td>
<td>34</td>
</tr>
<tr>
<td>Kikuyu</td>
<td>27</td>
</tr>
<tr>
<td>Kisii</td>
<td>4</td>
</tr>
<tr>
<td>Luo</td>
<td>9</td>
</tr>
<tr>
<td>Luyia</td>
<td>6</td>
</tr>
<tr>
<td>Masai</td>
<td>1</td>
</tr>
<tr>
<td>Mtiku</td>
<td>1</td>
</tr>
<tr>
<td><strong>Religious Affiliation</strong></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>20</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
</tr>
<tr>
<td>Protestant</td>
<td>68</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>89</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>30</td>
</tr>
<tr>
<td>College</td>
<td>39</td>
</tr>
<tr>
<td>Graduate</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Total participants</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;20 000</td>
<td>14</td>
</tr>
<tr>
<td>21 000- 30 000</td>
<td>14</td>
</tr>
<tr>
<td>31 000- 40 000</td>
<td>11</td>
</tr>
<tr>
<td>41 000- 50 000</td>
<td>14</td>
</tr>
<tr>
<td>51 000- 60 000</td>
<td>16</td>
</tr>
<tr>
<td>&gt;61 000</td>
<td>20</td>
</tr>
<tr>
<td><strong>Health Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Insured</td>
<td>56</td>
</tr>
<tr>
<td>Uninsured</td>
<td>33</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
</tr>
<tr>
<td>Married</td>
<td>51</td>
</tr>
<tr>
<td>Single</td>
<td>33</td>
</tr>
<tr>
<td><strong>Number of visits to Kenya</strong></td>
<td></td>
</tr>
<tr>
<td>1 time</td>
<td>69</td>
</tr>
<tr>
<td>2 times</td>
<td>19</td>
</tr>
<tr>
<td>3 times</td>
<td>1</td>
</tr>
<tr>
<td><strong>Sex Partners</strong></td>
<td></td>
</tr>
<tr>
<td>Have primary partner in US</td>
<td>89</td>
</tr>
<tr>
<td>Have casual partner in the US</td>
<td>22</td>
</tr>
<tr>
<td>Had primary partner in Kenya during visits</td>
<td>68</td>
</tr>
<tr>
<td>Had casual partner in the Kenya during visits</td>
<td>18</td>
</tr>
<tr>
<td><strong>HIV Seminar Before Migration</strong></td>
<td></td>
</tr>
<tr>
<td>Attended</td>
<td>50</td>
</tr>
<tr>
<td>Did not attend</td>
<td>39</td>
</tr>
<tr>
<td><strong>HIV Seminar After Migration</strong></td>
<td></td>
</tr>
<tr>
<td>Attended</td>
<td>65</td>
</tr>
<tr>
<td>Did not attend</td>
<td>24</td>
</tr>
<tr>
<td><strong>Blood Test Before Migration</strong></td>
<td></td>
</tr>
<tr>
<td>Had blood test</td>
<td>81</td>
</tr>
<tr>
<td>Did not have blood test</td>
<td>8</td>
</tr>
<tr>
<td><strong>Blood Test after Migration</strong></td>
<td></td>
</tr>
<tr>
<td>Had blood test</td>
<td>75</td>
</tr>
<tr>
<td>Did not have blood test</td>
<td>14</td>
</tr>
<tr>
<td><strong>Age of First Sex</strong></td>
<td></td>
</tr>
<tr>
<td>13 Years</td>
<td>3</td>
</tr>
<tr>
<td>14 Years</td>
<td>27</td>
</tr>
<tr>
<td>15 Years</td>
<td>20</td>
</tr>
<tr>
<td>16 Years</td>
<td>19</td>
</tr>
<tr>
<td>17 Years</td>
<td>10</td>
</tr>
<tr>
<td>18 Years</td>
<td>8</td>
</tr>
<tr>
<td>19 Years</td>
<td>1</td>
</tr>
</tbody>
</table>
### Table 5.1

<table>
<thead>
<tr>
<th></th>
<th>Total participants</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anal Sex with Primary Partner in the US</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some times</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>Never</td>
<td>87</td>
<td>97.8</td>
</tr>
<tr>
<td><strong>Condom Used in Sex with Casual Partner in the US</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the times</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Most of the time</td>
<td>12</td>
<td>13.5</td>
</tr>
<tr>
<td>Some times</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Not had sex</td>
<td>67</td>
<td>75.3</td>
</tr>
</tbody>
</table>

Table 5.1 summarizes the demographic characteristics of the study sample.

Majority of participants were from the Kamba (38%) and Kikuyu (30%) tribes. 76% were Protestants. Majorities were college (44%) and high school graduates (34%).

Participants’ annual income ranged between less than $20,000 to over $61,000 with 41% earning at least $50,000. 63% had health insurance. 57% were married, 37 % single, and 6% divorced. 78% visited Kenya once after migration to the US.

All of the participants reported having a primary sex partner in the US and 76% were accompanied by their primary partners during visits in Kenya. 23% reported having casual sex partners in the US vs. 20% during visits in Kenya. 56% attended a seminar regarding HIV prior to migration to the US while 73% attended HIV preventive seminars after they migrated to the US. 91 % had HIV blood test before migrating to the US compared to 84% post migration. It should be noted that HIV negative status is a requirement for US immigration.

Most participants had their first sexual intercourse at 14 years of age (30%), followed by 15 years at 23% and 16 years at 21%. Only 2% reported having anal sex with primary partners in the US and 15% reported using condoms during anal sex with a primary partner all the time, 98% had never engaged in anal sex with a primary partner.
75% did not report having vaginal sex with a casual partner in the US and only 14% used condoms all the time during vaginal sex with their casual partners. 23% did not report having oral sex with their primary partners in the US and only 1% reported using condoms all the time.

5.2 Condom Attitude in Kenya and the US

The research hypothesis (H1) assumed that condom use attitude differed in Kenya and in the US. The SRCQ instrument was used to collect data on condom use attitudes of participants in the US and during visits in Kenya. Paired t-test for repeated measures of dependent samples was used to compare the mean scores. As shown in Table 5.2, the mean and standard deviation of the SRCQ in the US (M = 67.32, SD = 7.80) and in Kenya (M = 7.02, SD = 7.02) demonstrated that there was no significant difference in condom use attitudes of participants in the US and Kenya (t [67] = 0.08, p = 0.45). Hypothesis 1 was therefore not supported by the findings.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>Std. Deviation</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>67</td>
<td>67.32</td>
<td>7.80</td>
<td>0.08</td>
<td>0.45</td>
</tr>
<tr>
<td>Kenya</td>
<td>67</td>
<td>67.91</td>
<td>7.02</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.3 Condom Use Behavior with Primary Partner

Hypothesis H2 assumed that vaginal condom use behavior with primary sex partner differed in Kenya and in the US. The independent variables were the contexts of Kenya
and the US. The dependent variable was condom use behavior with primary sex partner measured at the ordinal level. Sign test was used to examine the hypothesis. As reported in Table 5.3, there were no significant differences in condom use behavior \( (p = 8.50) \) in Kenya and the US. Therefore H2 was not supported by the findings.

**Table 5.3** Comparison of condom use behavior with primary partner in the US and Kenya

<table>
<thead>
<tr>
<th>Condom use with primary partner-US</th>
<th>Most of times</th>
<th>Sometimes</th>
<th>Never</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use with primary partner- Kenya</td>
<td>All the time</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Most of times</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Some times</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>7</td>
<td>6</td>
<td>35</td>
</tr>
</tbody>
</table>

### 5.4 Condom Use Behavior with Casual Partner

Hypothesis H3 assumed that condom use behavior with casual sex partner differed in Kenya and in the US. The independent variables were the contexts of Kenya and the US. The dependent variable was condom use behavior with casual sex partner measured at the ordinal level. There were only data reported on two categories, “all the time” and “most of time,” for the variables of unprotected sex (condom use with casual partner) the McNemar’s chi-square test was used to examine this hypothesis.

As shown in Table 5.4, there were significant differences in vaginal condom use behavior with casual partners in Kenya and in the US \( (p =0.04) \). Most participants used
condoms all the time or most of the time with casual sex partners in Kenya. H3 was supported by the findings with regard to condom use with casual partner.

**Table 5.4 Comparison of condom use behavior with casual partner in the US and Kenya**

<table>
<thead>
<tr>
<th>Condom behavior with casual partner- Kenya</th>
<th>All the time</th>
<th>Most of the time</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>All the time</td>
<td>2</td>
<td>9</td>
<td>0.04*</td>
</tr>
<tr>
<td>Most of times</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05

**5.5 Sexual Behavior With Casual Partners**

Research hypothesis H4 assumed that there was a difference in participants’ sexual behaviors of multiple sex partnership in the US and during visits in Kenya. The independent variables were the contexts of Kenya and the US. The dependent variable was sexual behavior of multiple sex partnerships measured at the nominal level.

McNemar's chi-square test was used to examine this hypothesis. As shown in Table 5.5, there are no significant differences in sexual behaviors of multiple sex partnerships during visits in Kenya and in the US ($p = 0.61$). Therefore, the hypothesis was not supported by the findings.
Table 5.5 Comparison of casual sex behavior in the US and Kenya

<table>
<thead>
<tr>
<th>Casual sex behavior in the US</th>
<th>All the time</th>
<th>Most of the time</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casual sex behavior-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>44</td>
<td>0.61</td>
</tr>
</tbody>
</table>

5.6 Age Comparison with Risky Sexual Behaviors in the US

Hypothesis H5 assumed that age affects risky sexual behaviors in the US. Risky sexual behaviors refers to having casual partner which was measured at nominal scale and unprotected sex with casual partner which was measured at ordinal scale. However, there were only data reported on two categories “all the time” and “most of the time” for the variable of unprotected sex (condom use with casual partner). Age was measured by ratio scale so student t-tests were used to examine the associational relationships between the independent variable of age and the dependent variables of risky sexual behaviors in the US. As shown in table 5.6 Age made a significant difference in having casual sex partners in the US ($p<.001$). Younger participants tended to have more casual partners in the US compared to older participants. The hypothesis was supported.

5.7 Age Comparison with Risky Sexual Behaviors in Kenya During Visits

Hypothesis H6 assumed that age affect risky sexual behaviors during visits in Kenya. Age was measured by ratio scale so student t-tests were used to examine the associational relationships between the independent variable of age and the dependent variables of risky sexual behaviors in the US. As shown in table 5.6 There was significant difference
in age and having casual partner in Kenya \((p=.003)\). Condom use with casual partners during visits in Kenya made a significant difference \((p =0.004)\). Younger participants tended to have more casual partners in Kenya compared to older participants. The hypothesis was supported. Older participants used condoms for intercourse more consistently than younger participants when engaging in intercourse with casual partners in Kenya. The hypothesis was supported.

### Table 5.6 Student t-test statistics for age and risky sexual behaviors

<table>
<thead>
<tr>
<th>Risky Behavior</th>
<th>N</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>t</th>
<th>df</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US Casual Partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>28.5</td>
<td>6.41</td>
<td>4.30</td>
<td>53.63</td>
<td>(p=.001^*)</td>
</tr>
<tr>
<td>No</td>
<td>67</td>
<td>36.2</td>
<td>9.54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use behavior with casual partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the time</td>
<td>5</td>
<td>31.40</td>
<td>5.90</td>
<td>1.22</td>
<td>7.11</td>
<td>.26</td>
</tr>
<tr>
<td>Most of the time</td>
<td>17</td>
<td>27.65</td>
<td>6.47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Kenya Casual Partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>28.78</td>
<td>6.21</td>
<td>3.16</td>
<td>46.55</td>
<td>(0.003^*)</td>
</tr>
<tr>
<td>No</td>
<td>53</td>
<td>35.04</td>
<td>9.72</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use behavior with casual partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the time</td>
<td>16</td>
<td>29.38</td>
<td>6.34</td>
<td>3.39</td>
<td>15.00</td>
<td>(0.004^*)</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
<td>24.00</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^*p < 0.05\)

### 5.8 Income Comparison with Risky Sexual Behaviors in the US

Hypothesis H7 assumed that income affects risky sexual behaviors in the US. Income variable was measured at nominal scale, therefore Pearson’s Chi-square tests were used
to determine associational relationships between the independent variable of income and the dependent variables of risky sexual behaviors in the US. As shown in table 5.7, there was a significant difference between income and having a casual partner in the US ($X^2 = 8.72, p = 0.003$). Higher income participants tended to have fewer casual partners than those with lower income in the US. Participants with lesser incomes used more condoms during vaginal intercourse with casual partners in the US. Both findings implied that those with lower incomes tended to have more casual sex partners and also used condoms when having vaginal sex with these partners in the US. Hypothesis was supported.

### 5.9 Income Comparison with Risky Sexual Behaviors During Visits in Kenya

Hypothesis H8 assumed that income affects risky sexual behaviors during visits in Kenya. Income variable was measured at nominal scale, therefore Pearson’s Chi-square tests were used to determine associational relationships between the independent variable of income and the dependent variables of risky sexual behaviors in Kenya. As shown in table 5.7, no significant findings found between income and having casual partners in Kenya. The hypothesis was not supported.
Table 5.7 Chi-Square statistics on income and risky sexual behaviors

<table>
<thead>
<tr>
<th>Risky Behavior</th>
<th>Income</th>
<th></th>
<th></th>
<th>Chi-Square (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;50 000</td>
<td>&gt;50 001</td>
<td>(p)</td>
<td></td>
</tr>
<tr>
<td><strong>US</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>3</td>
<td>8.72</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>33</td>
<td>(0.003)*</td>
<td></td>
</tr>
<tr>
<td>Vaginal sex condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the time</td>
<td>3</td>
<td>2</td>
<td>3.82</td>
<td></td>
</tr>
<tr>
<td>Most of the time</td>
<td>16</td>
<td>1</td>
<td>(0.051)</td>
<td></td>
</tr>
<tr>
<td><strong>Kenya</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>4</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>29</td>
<td>24</td>
<td>(0.08)</td>
<td></td>
</tr>
<tr>
<td>Vaginal sex condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the time</td>
<td>12</td>
<td>4</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
<td>0</td>
<td>(0.42)</td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05

5.10 Education Comparison with Risky Sexual Behaviors in the US

Hypothesis H9 assumes that education affect risky sexual behaviors in the US. Education variables were measured at nominal scale therefore Pearson’s Chi-square tests were used to determine associational relationships between the independent variable of education and the dependent variables of risky sexual behaviors in the US. As shown in table 5.8 there were no significant findings found between the level of education and other risky sexual behaviors such as having casual partner in the US and condom use behaviors. The hypothesis was not supported.
5.11 Education Comparison with Risky Sexual Behaviors During Visits in Kenya

Hypothesis H10 assumed that education affects risky sexual behaviors in Kenya.

Education variable was measured at nominal scale; Pearson’s Chi-square tests were used to determine associational relationships between the independent variable of education and the dependent variables of risky sexual behaviors in Kenya. As shown in table 5.8 there was a significant association between education level and condom use with casual partners in Kenya ($\chi^2 = 6.25, p = 0.04$). More educated participants reported fewer casual partners in Kenya. The hypothesis was supported.

Table 5.8 Chi-Square statistics on education and risky sexual behaviors

<table>
<thead>
<tr>
<th>Risky Behavior</th>
<th>Education</th>
<th></th>
<th></th>
<th></th>
<th>Chi-Square (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>Casual sex Partner</td>
<td>Yes</td>
<td>10</td>
<td>10</td>
<td>3.54</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>20</td>
<td>29</td>
<td>(0.17)</td>
</tr>
<tr>
<td></td>
<td>Condom use with</td>
<td>All the time</td>
<td>2</td>
<td>2</td>
<td>0.93</td>
</tr>
<tr>
<td></td>
<td>casual partner</td>
<td>Most of time</td>
<td>8</td>
<td>8</td>
<td>(0.63)</td>
</tr>
<tr>
<td>Kenya</td>
<td>Casual partner</td>
<td>Yes</td>
<td>11</td>
<td>4</td>
<td>6.25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>15</td>
<td>23</td>
<td>(0.04)</td>
</tr>
<tr>
<td></td>
<td>Casual Vaginal sex</td>
<td>All the time</td>
<td>9</td>
<td>4</td>
<td>1.32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Most of time</td>
<td>2</td>
<td>0</td>
<td>(0.49)</td>
</tr>
</tbody>
</table>

* $p < 0.05$
In summary, there were no significant differences in condom use attitude between Kenya and the US. Participants felt the same way regarding the use of condoms whether they were in the US or during visits in Kenya. In the case of condom use behavior with primary partners, there were no significant differences between the US and Kenya during visits. However, there was significant difference found in condom use behavior with casual partners in Kenya. No significant difference was found in risky sexual behavior with casual partner between Kenya and the US. Participants had casual partners in both the US and Kenya during visits. As to the association between demographic variables and the risky sexual behavior such as having casual sex partners and inconsistent condom use, age and income were significant factors for risky sexual behavior in the US. Younger and lower income participants tended to have more casual partners in the US. Age and education were significant factors in risky sexual behaviors in Kenya. Younger and less educated participants had more casual partners in Kenya. Also younger people tended to have more unprotected sex compared with older participants.
CHAPTER 6
QUALITATIVE RESEARCH FINDINGS

The qualitative findings are organized in overarching themes with supporting subthemes and sample responses by participants. Participants are identified by numeric codes.

6.1 Social and Cultural Factors Supporting Risky Sexual Behaviors

6.1.1 Loneliness, Isolation and Vulnerability Associated with Migration to the US

Seventeen participants reported loneliness due to separation from their relatives back in Kenya. Separation from kin intensified their feelings of vulnerability and fear of being alone during times of illness. Kinship ties that have provided them a sense of security is absent while they are in a foreign land and unfamiliar with the new culture. Participants recognized the contrasting social life between Kenyan and US cultures. As a collective society, Kenyan culture emphasizes communal support and involvement, mutual trust and reciprocity. By contrast, the US culture emphasizes individualism and self-reliance. P14 stated:

*Life in Kenya is based on a community where everybody watches over each other. The community also watches over everybody’s children and will report a child’s bad behavior to the parents. In the US, people stay away from each other and especially children.*

Participants observed that in the US, relationships tend to be impersonal and legal statutes are enforced more fully than in Kenya. P8 noted, *One can’t even give a neighbor’s kid candy because they can easily be sued.*
Participants lamented over the vast geographical divide between Kenya and the US. All participants entered the US on student visas hence visits to Kenya were limited because the costs were unaffordable for students without fulltime legal employment. The physical distance and lack of means to visit Kenya more frequently intensified their feelings of isolation and loneliness. According to P5:

*The US is too far from home and you do not get to enjoy your hard earned material wealth with your relatives. A round trip air ticket cost between a thousand dollars and sixteen hundred dollars depending on the airline, season, and the time it is booked. Basically you are stuck in the US if you can’t afford it.*

In times of desperation, P10 stated:

*I am thinking of forgetting school and working ten jobs to get lots of money and ask the immigration to deport my ass. When you go home you find that you have missed a lot and before you know, you are in plane back to the US. With $100000 in Kenya you can live like a king and at least you can see them every day.*

For all participants, migration to the US represented the very first time they had been separated from their families and the security of a tight network of family and friends in Kenya which they described as highly cohesive where everyone in one’s village looked after each other. Their feelings of vulnerability were intensified by the fact that they came on student visas which were temporary in nature and prevented them from taking legal full time employment. Participants took steps to convert their status from students to permanent residents, a process that took years. As they had to get employment in order to support themselves in the US they had this constant fear of being arrested for violating the conditions of their student visa. Unfamiliar with the social norms and laws of the new society, they feared being picked up by the police and incarcerated much like the dreaded police abuses in Kenya. Incarceration can totally isolate them from relatives in distant Kenya. P3 related:
You always have a creeping stress of missing your family back at home. It is one thing if you were used to traveling and leaving your family for months. You prepare to come to America and one day you leave your family for many years for the first time. If Immigration is slow in getting you a green card then you start living in America indefinitely without knowing when you will ever see your family again.

Married informants with spouses in the US share the same feelings of vulnerability. They fear catastrophic events such as death of a loved one in the US or other difficulties they have to deal with alone without the support of their extended family. Unlike their kinship organization back in Kenya, the nuclear family orientation emphasizing individualism and self-reliance embraced by the American culture intensifies their lonely and solitary existence.

Participants admitted taking steps to mitigate these feelings of isolation, loneliness and vulnerability. According to P4, *It's easy to get married or get any girlfriend just to have someone to share your personal life with.* Some participants acknowledged that they married for practical, business reasons of financial security and to have someone to live with. Marriages were based on need rather than love or attraction and once their needs were met, they ended up looking for more fulfilling relationships from other women including other sex partners. Participants admitted that that they are too busy working, leaving very limited time with their spouses. Work has preoccupied their time which influenced their choices of mates. They shied away from women who were "hard to get" and settled with those who were willing to get married. P 7 stated:

*We have become like Americans, we don't take marriage very seriously. Basically we get married here to get company and have someone to help in paying bills and take you to hospital if you get sick. You may end up loving this person and if not, you end up cheating a lot.*
6.1.2 Continued Reinforcement of Traditional Kenyan Culturally Patterned Attitudes and Behaviors

Participants longed to maintain their associations with other Kenyan families and men.

Initial relocation and adjustment of participants in the US were generally facilitated by other Kenyans. P6 described the experience of a typical Kenyan student:

*He came to Uppsala College in New Jersey. He lived with his cousin's family for a year, saved some money, bought a car, and moved in with a roommate (another Kenya) in West Orange.*

Participants regularly visited social clubs and restaurants frequented by other Kenyans.

This pattern of social engagement is typical of Kenyan men back in their homeland. P7 described, *In Kenya men go out together and women stay at home. Even at home during family visits, men socialize separately from women unlike America.*

Some participants admitted treating their Kenyan wives in the US much like they did in Kenya. They tended to socialize separately with other Kenyan men without their wives and girlfriends. Sometimes they encouraged their wives to associate with other women as well. On one hand, they noted that American men and women go out together and tended to do everything together. Despite resistance to the American way of life, they reported that the American way of life is the environment they live in and they constantly find themselves learning to fit in. P11 reported:

*Once you get married to an American woman, your life is over. Even when you go to grocery store, they are always calling you on the cell phone to know why you are taking too long.*

Some of them saw the advantage of continuing the Kenyan tradition of gender-separated social interactions. This was exemplified by P17.

*I think there are advantages for men to socialize by themselves once in a while. You may be having family problems and they help you to get over it. These are*
the traditions of Africa. We have to use our tradition in dealing with our Kenyan problems.

Participants also observed that Kenyan wives support continuing this tradition and teach other Kenyan women to accept this tradition in order to keep their husbands. P19 stated:

I have been together with this lady for a long time. When we go to Kenya, she teaches other women in church how to treat and respect their men and keep a steady relationship.

Majority of participants reported the main difference in the treatment of women by men in Kenya and the US. Kenyan men view themselves as superior to women reinforcing the need to separate from them in social gatherings. According to P1,

In Kenya, men are more dominant and women are submissive and socialize separately in the kitchen. That's the expectation. Masculine women are not accepted because they don't look sexy.

P1 further stated that in Kenya, women are not allowed to question their husbands' whereabouts because it is assumed that that they were with other men in clubs and restaurants. As stated by P1, A good Kenyan woman does not question the husband on anything. Few participants like P16, admitted living the Kenyan tradition with regard to sexual activities:

I don't care whether you are married or not, many Kenyans keep Kenyan girlfriends in different cities and states. I earn good money and I can keep a girlfriend in Philadelphia which is only two hours away. I could take her to movies and be at home for dinner. I just need to pretend to be stressed and tired when I come home and my woman will sympathize with me instead.

Only P4 admitted his belief that women who are churchgoers are HIV free. He selects potential sex partners from religious organizations and churches in the US and during visits in Kenya:

I get clean girls (free from HIV) through referrals from church. You can't trust City girls you will "exit" fast (Kenyans use the word exit in streets to mean die).
6.1.3 Changed Social Status of The US Immigrants During Visits in Kenya

All participants reported that their economic status changed when they came to America. They are able to work and improve their own lives as well as those of their families back in Kenya. Because of rampant poverty in Kenya and in Africa, participants are regarded as rich by their friends and families. This new economic status makes them attractive to Kenyan women. According to P4:

*In Kenya you can have as many women as you wish by a flash of a dollar. Its normal in Kenya for people both married and unmarried to have multiple sex partners. If you are from The US, every girl and even married people want you.*

Like some participants P4 indicated preference for married women as sex partners during their visits.

*In fact you feel much safer with a married woman in Kenya because you know that they don’t run around. You can practically have sex with any one you want as long as you have the dollars.*

6.2 Social and Cultural Factors Favoring Changes in Sexual Attitudes and Behaviors

6.2.1 Egalitarian Ideal of America

Participants unanimously recognized the egalitarian ideal of the American society. This ideal was especially noted in rights, roles and expectations of men and women. Gender equality was found threatening by some participants. P1 noted,

*Here in the US, they turn the tables on you. Women rule in this country and you don’t just leave the house. You do what they say. They can even wake up one day and tell you to leave the house and you must leave or you get arrested.*

P9 added,

*In the US, women are always up in your business and you have no chance to do “men talk.” Men talk freely about sex and business but you can’t do that with*
Some participants perceived women as having more power than men. According to the participants, men who disrespect and cheat on their wives are regarded as “dogs” in the US. P2 stated,

*Here in the US women have more power than in Kenya. Here they tell you what to do and the government listens to them more than they listen to men.*

Gender equality is evident in the roles performed by men and women in the US. Unlike in Kenya where women are expected to serve their husbands, American men are more involved with domestic affairs including childcare and cooking for their wives and children. Participants indicated that the expanded role of males in the US, leave them less time for extramarital affairs. P17 noted,

*When you are in Kenya, men are not supposed to get into the kitchen. Its women's job and they will disrespect you if you start getting in and out of the kitchen. Men sit in the living rooms or in the bars while women stay at home to cook and gossip. In the US, couples cook together, share domestic duties, and go out together everywhere.*

Participants noted that in Kenya, men make decisions on every aspect of family life including sexual matters. Women are subordinate to men and not allowed to question a man’s decision or authority. Women perceived to misbehave are physically disciplined by their husbands by slapping or beating them. Participants narrated that in Kenya, husbands often come home drunk and end up having forced sex on their partners with consequent unplanned pregnancy. While Kenyan authorities ignore domestic violence, participants believe that American authorities protect women’s rights. P14 reported:

*Women in Kenya don’t even control their own bodies. Husbands have express permission to have sex with their wives any time. The women submit to anything for fear of being beaten. The Kenyan government makes it worse because when*
the woman takes her husband to court, the first question from the judge is, “what did you do to him?” In the US, such men would be first arrested, jailed and the government will ask questions later. The women can talk to men about how they feel without fear, but sometimes they insult you for nothing.

Women’s rights are protected and practiced in the US. As P 16 noted,

_In the US, you touch any woman without her permission you will have yourself to blame. The courts will throw your ass in jail. Here women decide how many kids they want not the man. Here you are also respected more in the society if you treat women well._

All participants reported having a different outlook towards women post immigration.

Living in a different social milieu has promoted changes in the way they treat women not only in the US but also during visits in Kenya. P13 reported:

_I have learned to respect women both here and Kenya. I can never disrespect women again. It is basic, why would you beat someone else and what are you trying to prove. The women love you more when you respect them and take care of them. Of course you have women who cannot be satisfied, are trouble and so are men._

6.2.2 Changes in Cultural Norms About Sex and Sexuality

The more liberal attitudes towards sex and sexuality in American culture was found liberating by participants. In contrast to Kenya’s cultural taboo on open discussions and expressions of sex and sexuality, the American society has given them freedom of sexual expression, and to learn about sex and sexual options. They were enabled to talk, ask and learn about sex and how to maximize their sexual satisfaction. These are reflected in P5’s statements:

_In the US you can do whatever the heck you want without the fear of your parents or village shame. You can go out with anyone, young or old without fear of criticism. You can even kiss and hold hands in public._
I could express myself about anything without fear of the government or neighbors. I could also express myself to girls by wearing tank tops to show my muscles unlike Kenya. I could also talk about sex freely and even seduce girls by explicitly telling them what I am going to do to them. I believe that no one cares what I do and that gives me freedom to venture into more sexual fantasies without cultural restrictions of Kenya. I could even curse using sexual acts like Americans “shit”, “fuck”, and “screw you,” things I couldn’t do or say in Kenya.

Here in the US, they are always talking about sex. You even learn to make love in ways you never knew. You also learn that you can even discuss how you are going to do the sex before you start. It’s amazing.

The American cultural and social context has influenced participants’ attitudes towards homosexuality which is not accepted in Kenya. P18 stated, Gay people whether they are sick or not, they don’t bother anyone and it’s their way of life. So I have come to reluctantly accept them. Things that helped me change included lots of information on TV and brochures, schools, and anonymous telephone lines. P12 added,

I think the homosexuals are harmless and do not bother anyone. I have come to accept them. You find them everywhere even in US congress, lawyers and teachers. Homosexuality must be real or must mean something in real life. I never see gay people when I visit back in Kenya, so I never have a chance to react to them in any way. But also I fear that they may mistake me for being gay by trying to express that it’s okay to be tolerant.

Tolerance of homosexuality did not mean that participants accepted the practice. None of them reported having engaged in sex with other men or anal sex in Kenya or the US. P14 stated:

I believe sex must be between men and women. It’s nonsense to be gay-, it’s American. Two women or men don’t have the correct facilities naturally to have sex with each other. In Kenya you can never be respected if you are gay. Gay people are associated with people from Mombasa city in Kenya” (Mombasa is a city off the Indian coast in an internationally heavy commercial coastline).
All participants viewed the US government as being fair by giving its citizens freedom of speech, association and residence. P1 noted, *Freedom of speech is real in America as long as you don’t touch anyone.* P7 added,

> People in the US, speak and express themselves freely even when they are angry at each other. They can fight with words but they do not physically fight like in Kenya. Basically you can tell anyone what you have in mind without fear of physical aggression. One can get arrested if he physically fought with anyone. There are many other freedoms in the US like moving from one state to another. If you use the system well in the US, it will work for you. In Kenya you are always watching for anyone watching you. Its messed up.

Participants recognized their freedom to make choices that directly affected their lives.

Unlike Kenya, freedom of movement to pursue one’s success and happiness is allowed by the US government. P1 narrated:

> I came to Wisconsin to attend college. I then moved to Florida before finally settling in New Jersey. I needed to go to a cheaper college and was referred to the Florida University (FSU) by other Kenyans. I was also given a name of Kenyan guy who attended FSU. After I moved to Florida, even though the college was cheap, I quickly learned that there were no good paying jobs that would support the college fees. I then moved to NJ to find a better job and finish school. I settled in Haledon City in Northern NJ near other Kenyans. I think trying to do things on your own is stressful. I feel secure knowing other Kenyans in each city who knew how to navigate through the system and I did not have to worry about making mistakes.

### 6.2.3 Enhanced Capacity for a Better Future in the US

All twenty participants agreed that the US has brought them economic stability and greater potential for a secure future. Economic stability has allowed them to go to school, drive a better car, buy a house and support other family members back in Kenya. They recognized that jobs are available in America if one is willing to work. Each one recounted their work experiences and the many jobs they held over the years. They were motivated to work hard and succeed economically in order to meet the expectations and
demands of their families in Kenya. Economic success in the US is an expectation they must live up to. Participants narrated with pride stories of long work hours working several jobs held at the same time and the long travel from one job to another. P4 stated:

*I have a very good job making six figures. I started as “cold calling” clerk in the brokerage firm, and advanced quickly by taking the licensing exams. But boy, they make you earn the money with your sweat and blood.*

Despite the stress associated with this work history, participants were determined to move up in their career by working hard to get promoted. Unlike Kenya, they were convinced that the US is a land of equal opportunity that rewards hard work. While they saw potential for a good future, some participants noted the stress of meeting the continuous burden of family expectations. According to P13,

*People here reward and respect you for hard work. On the other hand, Kenyans think that you should have expensive material wealth in both back home and the US. They want your money too. They forget you have bills, residence to maintain and even family to support in the US. The tragedy is that many Kenyans start living beyond their means.*

All the participants indicated that having a good paying job allowed them to live independently. Before reaching economic stability, they were forced to live in areas not because of choice but because of availability of jobs and sharing small spaces with other roommates to pay the rent. Good income translates to buying a home, owning a car and the means to visit Kenya. Although participants share the American value of a strong work ethic as the pathway to success and secure future, they lamented the loss of meaningful and satisfying social relationships of Kenyan society. These are reflected by the following statements:

*There is too much work and no play. But work is good, it means money. You can afford to buy a house, a good car, and afford to pay your school fees. Unfortunately people here are always working day and night.*
P8

_Life here is too fast, it's always work, work, and work. In Kenya, its 8-5 and then people go out and the city kind of closes except the restaurants and the movies._

### 6.2.4 Enhanced Quality of Life Associated with Urbanization and Modernization

Migrating to a high-tech, urbanized environment in the US was identified by participants to have contributed to their quality of life. Wide availability of the internet and telecommunication in schools, libraries and other public places enhanced their capacity to connect with friends, look for jobs, and obtain educational programs online. P18 stated:

_Everything in America is technologically synchronized and one can obtain information about anything from computers or just calling the appropriate office to speak to a live attendant or automated information system. You can even work from home if you wanted. There is even online dating and you can find a girl in Kenya before you visit._

Sending money to their loved ones regularly has been made easier by automated banks, credit cards, and electronic transfers. Online banking, telephone banking and direct deposits allowed them to utilize their time more wisely and productively. All participants admired the great efficiency in transportation within and between US cities. The combination of owning a car, good roads and better income permitted them to travel long distances faster and work more than one job at a time.

PI commented that the _US is a city everywhere_. Eighteen participants associated urbanized settings or cities with availability of jobs. In contrast to rural areas, they experienced less discrimination from getting jobs and promotions in cities where impersonal, business like relations prevail. Urbanization and modernization supported participants’ capacity for independence and self-reliance. American cities have the
infrastructural and social structural supports that foster the shift from their traditional community and family reliance to self-reliance. P3 stated:

*Life here is so fast and if you don't keep up with what's going on you will be left behind. There are so many things happening at the same time. The government is very strict, the city cleaning rules must be followed and people are so busy attending to their own lives. There are people from every country and you can't follow their advice because they think differently. Basically you are on your own and must be alert.*

6.2.5 Improved Access to Quality Care Promotes Health Achievement and Continued Economic Productivity

All the participants had a high regard for the US healthcare system. They believed they can access medical services any time through the emergency room. Access to quality healthcare services was seen by participants to mean less illness, better treatment and more opportunity to succeed economically and academically. This was particularly evident in their changed outlook about HIV as a treatable condition giving the affected longer life with quality. Although trying to be cynical, P4 presented the contrasting prognosis for the HIV infected in the US:

*These days if you get HIV, you just run to the HIV clinic and live forever like Magic Johnson. The HIV drugs are free and you can live in HIV shelters where you eat and sleep for free.*

6.2.6 Access to Information Promoted Changes in Beliefs and Attitudes Towards HIV

Majority of participants admitted that fear of HIV prompts them to stick with one partner. They noted that they have gained better knowledge of how HIV is transmitted and its treatment through the internet, brochures, seminars, posters in buses and telephone information. They learned that HIV is not just transmitted through heterosexual contacts but also by contaminated equipment used in barber shops and dental offices. It should be
noted that no participant identified IV drug abuse as mode of transmission of the disease.

P9 reported:

*HIV is scary and dangerous. You catch it, you die. Before I came to the US I would never go near anyone suspected of having HIV. In the US, you learn that you can only get it if you practice careless sex. They tell you everything about how it is transmitted and I now know that you can hang out with HIV positive people and never worry about getting infected.*

Majority of participants were agreeable to HIV/AIDS testing and many of them reported had been tested at least once before migrating to the US. P4 stated, *given the high HIV/AIDS prevalence in Kenya, testing is the only sure way to ensure that a girl is free from HIV infection.*

6.3 Individual and Group Differences in Behaviors and Attitudes Towards Risky Sexual Behaviors

6.3.1 Variability in Level of Acculturation to the American Culture

All participants acknowledged the importance of friends, relatives and other Kenyans in adapting to the new environment upon migration. This was reflected by P15:

*Once you come here, you can't function without someone showing you how things work. Everything is different, toilets, light switches are opposite the one we have in Kenya, and some of us grew up in upcountry we couldn't start a range stove. Kenyans are smart, all they need is a crash course and that's it. The catch is that you have to behave like them till you are independent. That's hard.*

Participants not only depended on other Kenyans but availed of other resources available to them. P8 stated,

*On top of other Kenyans helping you to adapt in the US, there is plenty of information on the internet to further help you. Plus I made effort to adapt. Some Kenyans take too long to adapt because they are trying to live like Kenyans here. They don't even clear their accents.*
All participants reported to have gone through noticeable cultural and social transformation since they came to the US. Some were able to adapt successfully but they felt that they could not maintain the transformation when they were around other Kenyan groups. P10 stated:

*When you go to Kenyan meetings like funerals, they expect you to automatically behave traditionally and express yourself like we are back in Kenya. If you seem to be Americanized, they criticize you as if you are going crazy.*

Some individuals in the Kenyan community were regarded as powerful patriarchs that can wield influence on behalf of others in times of need. To gain their favor, one has to behave traditionally and maintain cultural traditions. P14 related,

*If you mess with the influential guys, they will not call fundraising meetings for you in case you get sick or lose your parents back home. In other words, you must stay versed with Kenyan traditions or get someone to speak on your behalf.*

Participants reported that in networking meetings or in bars and restaurants with other Kenyans, the expectation is for one to behave like a traditional Kenyan ranging from one’s attitude to personal hygiene. Group sanctioned behaviors are powerful. P20 stated:

*We have many types of people here. K’s (a community leader) group, they are younger and educated. They have changed towards American way but M’s group, these are old, married and they expect you to be traditional. You just have to know “what time it is” (meaning you need to know where and who you are with).*

### 6.3.2 Differential Effects of Marital and Travel Partners

Most married participants travelled to Kenya with their primary sexual partners. They tended to remain faithful to their primary sexual partners while in Kenya. Only two participants were married to American born wives. They reported a distinct variation in interaction with their American wives as opposed to participants with Kenyan-born wives. These participants described their American wives as controlling and were
watchful of their behaviors. P20 stated, *My wife is an American and they don’t like men cheating. They will smell your underwear to see if you slept with someone else.*

P6 who has a Kenyan sex-partner added,

*Amercian women are trouble. They are loud and they know that you can hit them back. They can throw you out of the house and mess your record with domestic violence charges. That is not the Kenyan tradition and Kenyan women will never do such a thing to you.*

### 6.3.3 Differential Expectations of Sexual Behaviors of Married, Single and Divorced Participants

Both married and unmarried participants agreed that single and divorced people should enjoy the freedom of dating as many people as possible until they get married. They expressed greater concerns regarding child support payments than contracting HIV or other sexually transmitted diseases. P1 noted,

*When you are single or divorced, you should try as many women as possible after all you don’t belong to any one just don’t get by your girl. All you need to make sure is that you use condom with “manyangas” (young, attractive Kenyan women) otherwise you are going to get someone pregnant. In Kenya you must always use condom if you want to live but the American girls will try to get pregnant to keep you. The last thing you want to be paying is child support.*

P3 stated:

*When you are single, all you need is to call your buddies in Kenya before you travel and they will have clean “manyangas” ready for you” when you arrive. Kenyans will do anything to hang out with you when you are from the US.*

Married men reported less multiple sexual partners and more commitment to their wives and found having multiple sex partners an expensive practice. P13 who is married stated:

*I am now married, I “zero graze” (keep one woman) I am now a one woman man. It’s too expensive and worrisome to date outside besides that’s a young man’s game. I am a little too old for this. I did my time and they are just doing their time before they get married and stay home.*
In summary, three major themes emerge from the qualitative research. First, there were social and cultural factors that promoted maintenance of sexual risky behaviors congruent with traditional Kenyan male practices. These included loneliness, isolation and vulnerability resulting from migration to the US. The Kenyan men sought to mitigate loneliness and isolation by seeking company from other Kenyan or sexually intimate partners. No time was spared to understand the sex partners thus increasing the chances of associating with sexually risky partners. The Kenyans who sought company of other Kenyans in social networks became part of continued reinforcement of Kenyan traditional ideals that prevented faster acculturation process. Better economic prospects and stability gave Kenyan immigrant men a more desirable social status during visits in Kenya. They were more attractive to local Kenyan women and more desirable for company with other traditional Kenyan men who use women as “currency” for economic favors.

On the other hand, there were also evidence of social and cultural factors that favored changes in participants’ sexual attitudes and behaviors. The egalitarian ideal and legal protection of women’s rights in the US prompted a change in participants’ attitudes and practices toward women particularly American women. Some participants admitted having more respect for women even during their visits in Kenya. Because of freedom sexual expressions in the US, participants learned more about alternative sexual orientations and ways to maximize their sexual satisfaction. They were more tolerant of homosexuality in others but not among themselves.

Second, the prospect for a better economic future in the US and the ability to improve the lives of their loved ones in Kenya was an impetus for participants to take
care of themselves through responsible sexual behaviors. Better quality of life associated with urbanization, modernization and technology enhanced acculturation of participants to the US society. Availability of economic and educational opportunities and changed their outlook towards HIV and homosexuality. Perceived quality of care and access to quality of care in the US, gave participants more hope for a long, healthy and economically productive life.

Third, there were evidences of individual and group differences in behaviors and attitudes towards risky sexual behaviors. Older, higher income and more educated participants were less likely to engage in risky sexual behaviors than younger, less educated participants with lower income. Acculturative differences were also noted among participants. Participants married to American women appeared to have been more acculturated. Participants expressed greater approval of risky sexual behaviors of single and divorced males than those who were married.
CHAPTER 7
CONCLUSION

The study was guided by the assumptions of CM which posit that behavior changes are conditioned by the practical realities of life. Changes in these realities of life bring a consequent change in human behaviors. In addition to the CM model which focuses on observable behaviors, the study recognized the importance of emic thoughts in analyzing culturally based studies. Hence both quantitative and qualitative research methods were applied.

Both qualitative and quantitative findings provided evidence that participants tended to use condoms during vaginal intercourse with casual partners. In the quantitative findings condoms were minimally used when having sex with one’s primary partner. The qualitative research supported such findings through the participants’ responses that they considered their primary partners as trustworthy and not likely to “fool around” with other men. Married women and church members were preferred as they were assumed to be “clean” and were expected to be promiscuous.

The quantitative research further revealed that participants used condoms more when having casual sex in Kenya than in the US. The risk of contracting HIV was viewed to be greater in Kenya than in the US. Participants understood the risk of “dying” if they contract HIV especially in a country where the prevalence is so high. By contrast, the qualitative research uncovered that even though the level of condom use with casual partners in the US was the same as in Kenya, they were utilized for different reasons in either country. The Kenyan immigrant men feared HIV infection in Kenya but needed to
avoid unwanted pregnancies that would result to child support payments in the US.

Demographic factors of age, education and income were significant influences in risky sexual attitudes and behaviors. Compared to younger participants, the older group was less likely to have casual sex partners in both Kenya and the US. In contrast to the younger group, they consistently used condoms during vaginal intercourse with casual partners in Kenya. Interview findings revealed consistent expectation of single and divorced males to have multiple sex partners. Married men were expected to be more faithful to their primary sex partners. Although participants in the quantitative portion of the study were not asked how they migrated to the US, all 20 participants in the qualitative study indicated they entered the US on a student visa and applied for immigration right after completing high school in Kenya. It is logical to assume that older participants were more likely to have longer residence in the US, be married, more educated and earning higher income than their younger counterparts.

Bicultural perspectives among participants on homosexuality (MSM), HIV and gender roles were revealed through the in-depth interviews. Exposure to the US sociocultural context has influenced their outlook towards these phenomena. Biculturalism generally assumes that acculturation to the new culture and to the culture of origin is independent and individuals may be acculturated to only one, neither, or both cultures, resulting in different acculturative styles (Birman, 1998). The study findings indicated that acculturation to the US culture decreased risky sexual behaviors.

Even though the participants admitted tolerance of homosexuals (MSM) as people who “don’t bother them, back in Kenya, they could not see themselves associating with them. Tolerance did not mean acceptance of homosexuality. On the other hand,
homosexuality is illegal in Kenya and it was not clear whether having both men and
women sexual relationship at the same time was considered as homosexuality at all. This
finding resonates with Boykin’s (2006) who found the “down-low” phenomenon among
most African American bisexuals characterized by not associating with gays and
frequently reporting sexual orientation as “straight” or heterosexual. A different study
survey by UNAIDS (2004) of Kenyan males found only 22% of Kenyan men reported
being bisexual and no one reported being homosexual.

Participants saw stark differences in behaviors of American from Kenyan women
with regard to asserting their rights and demanding behavioral changes from their male
partners. Participants married to American women reported changes in their behaviors
towards women. Although they assumed more traditional roles expected of them in
Kenya, they were cognizant of their changed views about women, according them greater
respect and shared power. By contrast, participants who married Kenyan women
cognitively recognized the differences between American and Kenyan cultures but were
more likely to retain Kenyan traditional behaviors towards their wives.

In summary, the study findings uncovered presence of pull and push factors
towards superstructural changes among the Kenyan immigrant men in the US. Among
the push factors for change were infrastructural incentives brought about by higher
education and economic productivity which produced a consequent appreciation of better
life chances for participants. The prospect of obtaining a secure employment and being
promoted in one’s job is a value consistent with participants’ aspiration to move out of
poverty. Modernity, technology, information availability and quality of health services
have created a consciousness that one can realize his potential if he takes the challenge
through hard work and perseverance. As a result, participants were motivated in taking more responsibility in staying healthy and alive as they saw the possibility of a better future for themselves and their loved ones. The new sociocultural milieu enabled them to have greater control of events in their lives. Participants recognized the American value of egalitarianism that is reflected in the status of women. They were keenly aware of the legal mandate and enforcement of equal rights of women in the US.

The intermarriage with American women was revealed a strong push for change in participants’ attitudes and behaviors towards women. Greater understanding of HIV transmission and control has engendered less stigmatization associated with the disease. Similarly, freedom of sexual expression has fostered understanding of MSM and homosexuality, and tolerance of gay men. Legalization and recognition of homosexuality in the US have decreased the stigma toward gay men and prompted the shift in participants’ views of them as well.

Participants described the freedom of sexual expression in the US as liberating and instructive. As a result they have gained greater tolerance of groups previously stigmatized and marginalized in Kenya. Having been exposed to the current information and treatment of HIV in the US, participants gained a broader and more accurate understanding of how HIV can be transmitted and the availability of more effective treatments. They provided contrasting views regarding the HIV infected in Kenya and in the US. Compared to the health system in Kenya, health services in the US were perceived to have better quality, making possible for the HIV infected to live longer.

The pull factors against change include resistance of towards use of condoms among participants. This finding is in agreement with those of another study of East
African male immigrants in Canada by Tharao, Calzavara and Myers (2000) which found that they did not change their sexual attitudes after migration. The lasting influence of indigenous cultural values of sex associated with reproduction and masculine virility is evident in the continuing non-acceptance of using condoms when having intercourse.

The predisposition to engage in intercourse with casual partners was evident especially during visits in Kenya. Indeed, UNAIDS (2004) found that 30% of Kenyan male respondents could not remember the number of sexual partners in the previous three years. The tradition of polygamy has been well-documented in sub-Saharan Africa. This tradition differentiates roles and power between males and females. There is expectation of males engaging in multiple sex partners and tacit acceptance of such behaviors by females.

Gender separated socialization was particularly a strong resistance for change. The Kenyan immigrant men found themselves tied to group expectations of Kenyan traditional practices in exchange for financial assurance should tragedy happen in their lives. Beyond the loyalty to these groups, the constant meetings in traditional Kenyan set up reinforce and promote cultural behaviors and attitudes that include multiple sex partners and unprotected sex. Frequent visits to Kenya further reinforced such behaviors through tribal and clan expected conduct. The participant accounts reveal that in Kenya there is lack of tolerance and acceptance of homosexuality, masculinity is a norm, and multiple sex behaviors with “manyanga’s” are accepted. It is reasonable to project that the visits to Kenya the immigrants have, the more likely they are to delay or resist health promoting behaviors and attitudes of monogamy and protected sex particularly with casual partners.
7.1 Study Implications

The study findings supported the relevance and appropriateness of CM in analyzing the factors that play a significant role in promoting changes in risky sexual attitudes and behaviors for immigrant males from Kenya. The study findings support simultaneous efforts addressing social and cultural context in promoting changes in sexual attitudes and behaviors. Programs that can effectively bring the change need to simultaneously focus on the three components of the sociocultural system. Working with the socialization and networking groups in the Kenyan communities in the US is likely to facilitate health seeking as well as health promoting behaviors. Economic productivity and security create greater motivation to staying healthy and avoiding risks. These steps are especially critical during the initial phase of migration when immigrants feel lonely, isolated and vulnerable.

Perhaps the concept of social capital (Putnam, 2000; Bourdieu, 1986; Portes, 1998) deserves serious attention to uncover the specific inner workings of the social networks within the Kenyan communities in the US. In his *Bowling Alone*, Putnam (2000) findings show that people in urban areas have become more isolated and less active in the civil society. They have become less engaging in daily social affairs of their communities. The Kenyan immigrant men just like other immigrant groups in the US tend to segregate themselves into smaller withdrawn “cells” that reduce social cohesiveness of the community and hence the social capital. Social capital as the interconnectedness among individuals in social environment nurtures reciprocity and trustworthiness within groups and between groups.
Even though the sociocultural milieu would be expected to be beneficial to the Kenyan immigrant men, self-segregation in order to satisfy the expected conduct from various Kenyan groups in the US causes the Kenyan immigrant men to have a lesser role in collective participation within the US society. The Kenyan groups offer a sense of belonging to the newly arrived immigrants. Normally such groups have fewer conditions for memberships and are open to all Kenyans in the US. However, the interviews indicated that there is always unexpressed expectation of commitment, loyalty and adherence to the community norms set by the presumed leaders of the groups. In reciprocity and as reported in the individual interviews, the members receive support in form of financial contributions in case of a family tragedy, lose of a job, police arrests or illness. While these groups have an advantage of offering free informal education about the US sociocultural context to its new members, the degree of acculturation of the new members could depend on the expectations of the community leaders. More traditional group leaders would expect the new immigrant men to resist change towards the US way of life and hence delay the acculturation process. Putnam (2000) works support the assertion that the Kenyan immigrant men could benefit from their network groups by introducing reciprocity build around health protective behaviors.

While the work of Putnam (2000) shows how ethnic and social groups could benefit from closely knit organizations, Bourdieu (1983) posits that groups build around social capital are deliberately formed to cover up economic or political profiteering of the group leaders despite the consequences. Interview reports indicated that the participants were always afraid to behave in any way that would be in conflict with their group expectations. The reports further show that the Kenyan groups had leaders who made
informal rules and norms that they expected others to follow. Failure to comply with
group norms could result to lack of participation in case of a family tragedy or a financial
need. Coleman (1990) argues that though these groups are informal, they come together
to carry out certain roles for the benefit of the members of the group. While the work of
Coleman (1990) show the good and optimistic side of the social Kenyan immigrant social
networks, Bourdiue’s (1983) work exposes the bad side of the social networks leaving the
newly arrived immigrants at a dilemma. As a result, the Kenyan immigrant men
occasionally fall victim of slowed acculturation and subconsciously being forced to
adhere to Kenyan traditional norms of multiple sex partners and unprotected sex in
exchange for financial or emotional support.

Perhaps an important piece of Bourdie’s (1986) work that could better inform
this study is the concept of cultural capital. Bourdie argued that Cultural Capital has
three subtypes: embodied, objectified and institutionalized. The embodied type describes
the inherited and experience acquired characteristics of one’s self- the habitus. It is
important to highlight the habitus element in this research because the individual
willingness to adapt to the US sociocultural context is significant. The reports from the
individual interviews show that some participants were more willing to learn the English
language change their accents and conform to the US way of life than others. The
objectified type refers to the material possessions. Not only that the Kenyan groups
already living in the US possess more material wealth than the newly arrived immigrants,
but also have undergone more sociocultural transformation and understand how to
navigate the US social system better. The interview reports indicated that the new
immigrants needed both. The institutionalized type refers credentials and qualifications
acceptable to the US institutions for job offers. These include academic and other trade certificates. Such qualifications translate to better jobs with more potential for economic achievement. As indicated in the participant reports, most of the Kenyan immigrant men come to the US on educational grounds. It is therefore expected that the immigrants with longer stays in the US are likely to be older and have better education and therefore would be expected to possess higher level of institutional capital. Clearly, the possession of material wealth and institutional capital could be utilized as a basis of adverse or positive influence to the newly arrived Kenyan Immigrant men who need financial support. Healthcare interventions geared towards reducing risky sexual behaviors will need to understand the group leaders from cultural capital perspective.

Portes (1998) argued for “social capital” as the social structures that contribute to individual or collective economic and personal advantages. Social networks are loosely connected and mostly come together through mutual interest, norms, challenges or obligations. In his work, Porte found that the ethnic enclaves and immigrant networks play a crucial role in adaptation of the newly arrived immigrants into the US social context. While trying to stay loyal their groups, its likely that the newly arrived immigrants behave, choose careers, and even work in jobs provided or referred to by other group members. This kind of networking can easily keep new immigrants within the same ethnic enclave and network for a very long time. The implications of such continued contact within the same ethnic network is the possibility of continued reinforcement of risky sexual behaviors practiced back in Kenya. In contrast, association with groups that discourage risky sexual behaviors could lead to health protective behaviors.
Reconciling the work of Putnam (2000), Bourdieu (1983), Porte (1998) and Coleman (1990), the community leaders in ethnic and social groups are considerably powerful figures that could turn a serious health problem into a solution or vise versa. As the Kenyan immigrant men continue to acquire institutional capital, they are initially likely to be more influenced by their ethnic network groups and group leaders. A significant burden of pushing for change among the Kenyan immigrant men lies with the US healthcare workers to understand the Kenyan social networks and help the Kenyan community leaders adapt health protective behaviors. The acceptance of health protective behaviors by these community leaders is likely to permeate and trickle down to all the members of such networks.

7.2 Study Strengths and Limitations
The mixed method generated a fuller understanding of the complex factors that influence the phenomenon of sexual attitudes and behaviors. These phenomena are embedded within the social and cultural contexts of Kenyan immigrant lives. The qualitative method gave a fuller understanding of the explanations behind participants’ attitudes and behaviors.

The study is original as there are no studies conducted in the US on Kenyan immigrant males on this topic. The study fills an important gap in the literature as HIV/AIDS is a global problem with sub-Saharan Africa as the most affected. In the US, one of the population groups with the highest prevalence of HIV is the Black community. In fact, Kent (2005) did find that in Kings County, Washington the proportion of HIV diagnosis among foreign-born Blacks outpaced the rate of increase in native-born Blacks.
The study used a purposive non-randomized sample which limits the generalization of the findings to other Kenyan immigrant men in the US. The sample was comprised by relatively more educated and gainfully employed Kenyan males who do not represent the general population of Kenyan men in the country. Data analysis indicated that the sample was homogeneous and was mainly comprised of Kamba and Kikuyu tribes who may not necessarily represent views of all other unrepresented tribes in Kenya. Sexual attitudes and behaviors are generally private and considered social “taboos” in Kenya so there was great possibility that participants were less forthcoming. The fact that homosexuality is illegal in Kenya participants may not freely disclose any MSM practices. Eyre, Hoffman & Millstein (1998) found that men in Kenya tend to boast about having multiple sex partners and carry condoms to impress others of their sexual adventures but do not use them actually. As the study was based mainly on self-reports, there is possibility that participants’ responses may not reflect the true reality. This was partially prevented by using mixed methods that offered triangulation of findings.

The study used a cross-sectional design which captured a one-time view of the phenomenon being studied. A longitudinal cohort study would yield data over time and shed light on these changes as participants experience further changes in their lives.

As both the qualitative and quantitative data analyses occurred after the data collection was completed, there was no opportunity to develop further questions to address gaps that were not originally identified. One area that was not asked is whether participants have primary partners in both Kenya and the US. It would have been more informative if another question focused on
behaviors during visits in Kenya when not accompanied by a primary partner from the US.

The social networks within which the Kenyan communities operate will need further investigations particularly how they influence individual behaviors of the newly arrived immigrants. In particular, the cultural capital warrants further inquiry especially how the immigrants’ sociocultural adaptation is directed by the individual habitus and influenced by the objectified and institutionalized capital within the Kenyan groups. Findings would help in understanding how Kenyan immigrant men interact within their social networks in the US. Healthcare providers would in turn acquire helpful information on how to formulate specific intervention for Kenyan immigrant men within their communities.

Further, this research would have been better informed if there had been more interview questions on the specific ethnic groups that the participants belonged to and the length of time they participated in them (Porte, 1998). It’s important to note that Kenyan immigrant men not only join their ethnic network groups but also other non-Kenyan social networks. Since majority of them come as students, how their international student offices and other student organizations influence their sociocultural adaptation is worth further inquiry. Such information will lead to better understanding of how individual conduct and social network norms influence risky sexual behaviors among the Kenyan immigrant men in the US.
APPENDIX. A

DEMOGRAPHIC SURVEY

Code ____

SECTION I: Demographics
Please answer each question by filling in the blanks or choosing the category that best applies to you.

1. My age is ____________

2. My tribe is ____________

3. My religion is
   1. Catholic
   2. Protestant
   3. Muslim
   4. Non-Denominational
   5. Other (Please specify) ____________

4. I have been living in the U.S. for ____________ years

5. My employment status is
   1. Employed
   2. Unemployed
   3. Full-time student
   4. Work in Healthcare
   5. Non-healthcare worker

6. The highest level of education I completed is
   1. High School
   2. College
   3. Some graduate work
   4. Graduate

7. My personal Income level is
   1. Less than 20,000
   2. 21,000-30,000
   3. 31,000-40,000
   4. 41,000-50,000
   5. 51,000-60,000
   6. >61,000

8. I have Health insurance
   1. Yes
   2. No

9. I had my first sexual contact (oral, anal, or vaginal intercourse) with another person at ____________ years of age.

10. My marital status is
    1. Single
    2. Married
    3. Divorced
    4. Widowed
5. Living with sexual partner of opposite gender

11. Before migrating to the US, I participated in some orientation seminar to learn preventive behaviors against HIV/AIDS once I arrive in the US.
   1. Yes if Yes how many times________
   2. No
   3. Don’t remember

12. Since I arrived in the US, I have participated in HIV/AIDS preventive seminars
   1. Yes if Yes how many times________
   2. No
   3. Don’t remember

13. Before migrating to the US I have had an HIV blood test
   1. Yes
   2. NO

14. After I arrived in the US I have had an HIV blood test
   1. Yes
   2. No

15. I have had __________ visits to Kenya in the last two years
APPENDIX. B

FORM A

Section II: My sexual behaviors in the US with my primary partner. Note: Primary partner means regular sex partner such as your spouse or others.
1. My primary partner is
   1. Female
   2. Male

2. I used condoms whenever I had vaginal penetrative sex with my primary sex partner.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

3. I used condoms whenever I had anal penetrative sex with my primary sex partner.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

4. I used condoms whenever I had oral sex with my primary sex partner.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

Section III: My sexual behaviors in the US with casual partner. Note: Casual partner means someone other than my primary partner
1. Do you have a casual partner?
   1. Yes – continue to question two.
   2. No - Discontinue

2. I have had penetrative sexual contact with someone other than my primary sex partner
   1. Yes with Men How many times
   2. Yes with women How many times
   3. Yes with both men and women How many times
   4. No sexual contact

3. I used condoms whenever I had vaginal penetrative sex with my casual sex partner.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

4. I used condoms whenever I had anal penetrative sex with my casual sex partner.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
5. Not had sex

5. I used condoms whenever I had oral sex with my casual sex partner.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

Section IV. Answer the following questions indicating the level of at which is comfortable for you; Never, Very occasionally, Frequently, and Very frequently.

I do not use a condom because:

1. I want to show my partner that he/she is somebody special.

2. My partner will respect me more if we don't use a condom.

3. I feel pressured by my partner not to use a condom.

4. If I suggest using a condom my partner will suspect that I have been unsafe.

5. I've had unsafe sex so many times so why bother being safe now.

6. My partner is the same HIV status as me so it doesn't matter.

7. I enjoy sex more without a condom.

8. My partner may reject me if I suggest using a condom.

9. My partner or I will withdraw before ejaculation and this will be safe.

10. My wishing to use a condom would suggest to partner that I think he/she may have been promiscuous.

11. I have very little to look forward to in life, so there is no point in practicing safer sex.

12. We get so far sometimes that it's not worth using a condom.


13. My partner may get angry/upset if I suggest using a condom.


14. My partner may lose his or her erection if a condom is used.


15. Unsafe sex is just one of life's many risks.


16. My partner will like me more if we don't use a condom.


17. Most of the time I'm careful, it won't matter just this once.


18. If I say I want to use a condom my partner may think I have doubts about how safe he/she has been in the past.


19. I think my partner doesn't want to use a condom so we don't.


20. If I suggest using a condom my partner may think that I have been promiscuous.


21. Sex is more exciting without a condom.


22. We have already had unsafe sex, what's the point of using condom this time.

APPENDIX. C

FORM B.
Now I want you to take time and think of the last time you visited Kenya.

Section V. My sex behaviors during visits in Kenya. Note: Primary partner means regular sex partner such as your spouse or others.
1. In the last time I visited Kenya, my primary sexual partner was
   1. Female
   2. Male

2. I used condoms whenever I had vaginal penetrative sex with my primary sex partner during my visits in Kenya.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

3. I used condoms whenever I had anal penetrative sex with my primary sex partner during my visits in Kenya.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

4. I used condoms whenever I had oral sex with my primary sex partner during my visits in Kenya.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

Section VI: My sexual behaviors in the Kenya with casual partner. Note: Casual partner means someone other than my primary partner.

1. During your last visit in Kenya, did you have a casual partner?
   1. Yes – continue to question two.
   2. No- Discontinue

2. During visits in Kenya, I had penetrative sexual contact with someone other than my primary sex partner
   1. Yes with men How many times ___________
   2. Yes with women How many times ___________
   3. Yes with both men and women How many times ___________
   4. No sexual contact._______________________

3. I used condoms whenever I had vaginal penetrative sex with my casual sex partner during my visits in Kenya.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

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4. I used condoms whenever I had anal penetrative sex with my casual sex partner during my visits in Kenya.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

5. I used condoms whenever I had oral sex with my casual sex partner during my visits in Kenya.
   1. All the time
   2. Most of the time
   3. Sometimes
   4. Never
   5. Not had sex

Section VII.
During visits in Kenya, I do not use a condom because:

1. I want to show my partner that he/she is somebody special.

2. My partner will respect me more if we don't use a condom.

3. I feel pressured by my partner not to use a condom.

4. If I suggest using a condom my partner will suspect that I have been unsafe.

5. I've had unsafe sex so many times so why bother being safe now.

6. My partner is the same HIV status as me so it doesn't matter.

7. I enjoy sex more without a condom.

8. My partner may reject me if I suggest using a condom.

9. My partner or I will withdraw before ejaculation and this will be safe.

10. My wishing to use a condom would suggest to partner that I think he/she may have been promiscuous.

11. I have very little to look forward to in life, so there is no point in practicing safer sex.


12. We get so far sometimes that it's not worth using a condom.


13. My partner may get angry/upset if I suggest using a condom.


14. My partner may lose his or her erection if a condom is used.


15. Unsafe sex is just one of life's many risks.


16. My partner will like me more if we don't use a condom.


17. Most of the time I'm careful, it won't matter just this once.


18. If I say I want to use a condom my partner may think I have doubts about how safe he/she has been in the past.


19. I think my partner doesn't want to use a condom so we don't.


20. If I suggest using a condom my partner may think that I have been promiscuous.


21. Sex is more exciting without a condom.


22. We have already had unsafe sex, what's the point of using condom this time.

APPENDIX. D

Qualitative Interview Guide

Life in the US

1. Tell me about your experience in settling in the US?
   Where did you settle and why?
   How similar or different is this place from your home in Kenya?

2. Have you moved from your initial residence?
   Where?
   Why did you move?

3. Do you plan to continue living in the same place where you live now?
   Why?

4. How different is your life here in the US from back home?
   What are the advantages of living here?
   What are the disadvantages?
   What helped you most in adapting to the US?

5. What changes in yourself do you see and experience since coming to the US?
   Give me some examples (at work, at home, with friends or family)
   How do see yourself differently from other Kenyan male immigrants?

6. Do you see any differences between the ways of life here in the US from Kenya?
   Tell me some of the differences.
   Are there similarities?
   During visits, do you maintain the same lifestyle or you switch to Kenyan lifestyle?

Perception of HIV/AIDS

1. What are some of your beliefs and feelings regarding HIV/AIDS?
   Has there been a change in your beliefs and feelings since you came to the US?
   What are these changes?
   What factors contributed to these changes?
   Are these beliefs and feelings the same when you visit Kenya?

Beliefs about sex and sexual partners

1. What are your beliefs about sex and sexual partners?
   Where do these beliefs originate?
   How different are your beliefs from other Kenyan males?
   What factors contribute to these differences?
2. Have your beliefs changed since you came to the US?
   In what way are they different from before?
   What factors contributed to these changes?
   How do these beliefs affect your sexual behaviors when you visit Kenya?

3. How different are your beliefs and practices from other Kenyan male immigrants?
   What factors contribute to these differences?

**Multiple Sex partners**

1. Tell me about your experience with multiple sex partners.
   Were your sex partners men, women, or both?
   In what way has your married status affected this practice?
   How different is your experience from other Kenyan males?

2. Compare your experiences with multiple sex partners in the US versus your visits back home?
   Is your experience different in the US from your experience when you visit Kenya?
   What factors contribute to these differences?
   How do you compare your experiences with those of other Kenyan males?
   How do you explain the differences?
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