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Factors Associated with Primary and Secondary Sexual Transmission of HIV in Concurrent Relationships in Kenya

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Abstract

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by

Daphne Parker

MS Ed., Long Island University, 1999

BA, College of New Rochelle, 1997

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

This phenomenological study was designed to understand the lived experiences of a purposive sample of 9 participants from local villages in Nairobi, Kenya, who had sexual behaviors that contributed to higher HIV risk exposure. Past studies have provided information about the increased rates of HIV infection; however, little has been done to identify the solutions for minimizing the negative impact of HIV among concurrent partnerships. The study investigated the role of high risk cultural practices among participants in married and cohabitating unions. The conceptual framework of the study was gender and power theory, which addresses the complex sexual relationships between men and women. Semi-structured, open-ended questions were used to obtain data from 4 males and 5 females between the ages of 28 and 46 who had been sexually active for more than 12 months. Data was collected on participants' cultural perspectives on condom use, HIV risk behaviors, and sexual morality. The interviews were transcribed and reviewed for consistent patterns of high risk sexual behaviors prior to coding. Through the use of NVivo, seven emergent themes were common among the participants. Findings from the small scale sexual risk behavioral data showed that among these participants, condom use and partner fidelity in unequal partnerships were low. The study also indicated the importance of developing an HIV intervention that focuses on gender and power in long-term sexual partnerships. The implications for positive social change included awareness that gender inequality exists among concurrent unions and formulating an effective cultural HIV prevention strategy for couples.

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Dedication

A special thank you goes out to the late Dr. Rodger Beatty for his great effort in working closely with me on program evaluation for public health interventions. May you rest in peace.

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Chapter 1: Introduction

Background

The body of research on HIV/AIDS has grown steadily since 1981 it was first identified in the United States and three years later on the continent of Africa (CDC, 2014). This increase has been largely due to the increased rate of infection and the new methods used to combat the rise of the disease (Steen, Elvira, Kamali, & Ndowa, 2009). In 2014, the most recent studies covered a vast range of topics, ranging from strictly medical studies to the social, ethnic, and demographic factors, as well as preventative measures and interventions (Carter, 2014).

Since the late 1980's, qualitative research methods have been the most commonly used in HIV studies in many parts of Africa (Ponterotto, 2010). Qualitative research has proven extremely valuable because it takes into account data which include unique characteristics (Ponterotto, 2010). Qualitative research is mainly used to provide a description, explore, and explain phenomena being studied (Creswell, 2013). Qualitative research involves research in the form of interrogatives, that is, What is this? or What is happening here?

This chapter provided an analysis and summary of the impact of HIV and AIDS in Kenya, while surveying cultural and socioeconomic barriers that need to be addressed in high-risk concurrent partnerships. It has also provided an overview of variables that have been associated with HIV/AIDS behavior, such as partner violence,

gender inequality, and multiple sex partners. These variables are used to support the foundation of this study.

In 2014, HIV epidemic continues to expand in the United States and many parts of Africa. Billions of dollars of crisis and research funding are available to African countries, and despite new vaccines that prevent the spread of the virus from mothers to their unborn children, the disease continues to be the primary focus of public health across sub-Saharan Africa (Aarø, Mathews, Kaaya, Ruhweza, Onya, Abraham, & de Vries, 2014). According to the World Health Organization (WHO, 2013), nearly 35 million people were living with HIV/AIDS globally in 2011 and during that same period, over 30 million died of AIDS-related opportunistic illnesses. Moreover, in sub-Saharan Africa, where nearly 2 million people are living with HIV/AIDS along with multiple infectious illnesses, over 90% of females of childbearing age who were screened tested positive for HIV during prenatal care (UNAIDS, 2012). Of 48 countries in sub-Saharan Africa, Kenya reported an increase in HIV cases, totaling over 1.5 million (UNAIDS, 2012).

Numerous hindrances to HIV prevention and treatment services have diminished an effective public health response. These include the cultural and social discrimination and stigma that prevent the proper education of citizens in high-risk countries. Because there are populations in east Africa, such as Kenya, with both Christian and Muslim beliefs, condom use among cohabitating or married partners poses a significant challenge to these cultures, despite the fact that the prevalence of HIV among concurrent unions has

increased over the past decade (Umar & Oche, 2012). Dibua (2009) suggested that females in these sexual unions are dependent on their male spouses to provide daily necessities in exchange for sex. These types of relationship have social and economic implications and can ultimately lead to increased sexual transmission of HIV infection (Dibua, 2009).

It is likely that the HIV epidemic among concurrent couples in Kenya is due to increased sexual behavior (Umar & Oche, 2012). However, if cultural interventions can be refined to increase the knowledge and attitudes of couples regarding HIV education, testing, and treatment, higher levels of gender equity could possibly improve prevention efforts. This is a relevant issue, as the educational system, is a relevant conduit to increase HIV knowledge for a vast number of people in African countries (Duflo, Dupas, & Kremer, 2009).

Educating citizens of East Africa, starting with Kenya, is vital because awareness bring about a new understanding of cultural stigmas that are related to acquiring the disease. One report suggested that safer sex practices among females under 21 years of age can slow the spread of the disease as they develop into adulthood later in years (World Bank, 2012).

Although Kenya's government has invested millions of dollars to support services related to universal access to HIV prevention, treatment, and care for individuals (U.S. President's Emergency Program For AIDS Relief, 2013), these interventions may still be deemed ineffective without tailoring them to be culturally sensitive to the population's

needs. The factors underlying behavioral and health compliance for concurrent partnerships suggest working with couples as a pair and individually to address gender roles and attitudes toward HIV risk and informed decision making. In concurrent partnerships, women are disproportionately affected by HIV than their male sexual partners, and they continue to be the more vulnerable population. In the next section, I will provide a background on the HIV epidemic on high risk individuals residing in Kenya.

Background of Study

Since 2000, most parts of East Africa have experienced an increased rate of HIV infection (Camlin, Kwena, Dworkin, Cohen, & Bukusi, 2014). Cities such as Nairobi have been decimated by the disease, with infection rates among the highest of all African countries. Also, higher concentrations of people living with the disease are living in highly populated areas. In addition, those living in low socioeconomic communities have become highly susceptible to engaging in risky behaviors, which can lead to HIV infection (Joint United Nations Programme on HIV/AIDS (UNAIDS, 2013). Higher infection rates, combined with internal residential shifts, are playing a major role in patterns of increased infection in East Africa (Higgins, Hoffman, & Dworkin, 2010). Because these regions have a lower cost of living, a greater number of residential transplants enter into these countries, thus worsening the problem of the spread of the disease.

The Kenyan government is currently embarking on preventive measures that would help reduce sexual transmission of HIV, including HIV education and male circumcision (Camlin et al., 2014). These preventive measures have focused on the increased treatment and care of sexually transmitted infections, as well as methods to delay early-age sexual intercourse (Camlin et al., 2014).

Women and girls have become a growing proportion of those living with HIV over the past two decades. Three reasons for these trends among women are (a) interrelated domestic violence, (b) the cultural pressures to have children and, (c) infidelity on the part of husbands (Lee, 2012). Overall, the factors leading to young women being infected seem to be far greater than those affecting men, while also contributing to stigma and discrimination surrounding the infection. In 2010, young women between the ages of 15 and 24 were more prone to get infected than young men of the same age (Lee, 2012). School age females are less likely to become sexually active at an early age and more likely to use condoms with proper education (Lee, 2012). Without proper education, a woman is more likely to depend on marriage, especially to an older man, for financial support. This, in turn, heightens her chances of infection, as concurrent relationships are the leading cause of HIV infection.

The HIV/AIDS pandemic brings about increased behavioral risk for people, especially in Kenya, because approximately 50% of the population lives in absolute poverty (Camlin et al., 2014)–the result of sociocultural systems that bring about gender inequality. Gender inequality and lack of education can increase HIV infection rates

among those in poverty. Behavioral and medical care that focuses on preventative measures is not easily available in poor settings and therefore, services such as HIV testing and treatment may be inadvertently missed during routine medical appointments (Akwara, Madise, & Hinde, 2011). When barriers to healthcare access occur, it can naturally increase both the chance of heterosexual transmission of HIV and the passing of the disease from a pregnant mother to a child. Next, a woman who engages in commercial sex work has a higher chance for the virus to be transmitted from male sexual partners (Oster, 2012). Gender inequality occurs because men are entitled to control the household's financial resources (Camlin et al., 2014). One of the outcomes of gender inequality is that women in poverty stricken societies are often submissive to the decisions of their male partners, which leads to widespread HIV risk. Women who are financially and socially vulnerable in long-term partnerships are often disempowered from making sexual decisions (Camlin et al., 2014).

In addition to unequal balance of gender and power, gender-based violence (GBV) has also contributed to HIV infections because they disrupt the social structures of the community (USAID, 2014). In addition, cultural attitudes and lack of knowledge may diminish women's rights to make informed sexual decisions in order to gain access to basic needs. Lack of knowledge can bring about exposure to higher risks of HIV infection (USAID, 2014). Due to lack of knowledge, many pregnant women are not accessing prenatal care in time to prevent mother-to-child transmission of HIV. In Kenya, females in male-dominant concurrent relationships may not be able to make informed

reproductive health decisions (Kumar, 2012). Therefore, it is critically important to identify cultural barriers that would hinder male sexual partners from reducing their women sexual partner's risk of contracting HIV.

Problem Statement

Kenya has the fourth-leading HIV epidemic on the continent, totaling 98 million new HIV infections since 2013 (Carter, 2014). HIV is not only a major public health challenge on the continent of Africa; it also poses a devastating threat to long-term heterosexual relationships in Kenya. As active-agent transmitters of HIV infection, men are likely to assert sexual power and privileges in unequal partnerships, causing women to be susceptible to adverse health outcomes (Higgins, Hoffman, & Dworkin, 2010). The transmission of HIV infection among females in cohabitating or married unions in Kenya occurs most frequently due to sexual behavioral patterns (Gass, Stein, William, & Seedat, 2010). Therefore, it is important to understand the level of female bargaining power in reducing HIV risk among concurrent relationships in Kenya. In concurrent partnerships, women are disproportionately affected by HIV than their male sexual partners, and these women continue to be the most vulnerable population. Contributing factors include unequal balances of gender and power, intimate partner abuse and socioeconomic barriers. Men with multiple sex partners do not consistently use male condoms with their casual sex partners (Mah & Haperin, 2010). This also creates an opportunity for men to transmit STI and HIV infections to their concurrent female sexual partners. DePadilla, Windle, Wingood, Cooper, and DiClemente (2011) distinguish serial monogamy from

concurrency. The former refers to individuals who do not engage in overlapping relationships, despite the fact that they may have many sexual partners.

Purpose of the Study

The purpose of this qualitative study was to explore the lived experiences of married couples and cohabitating partners who may be engaging in HIV-risk sexual behaviors in Nairobi, Kenya. This was addressed by (a) ascertaining the knowledge, skills and attitudes of men and women in high risk concurrent unions, (b) identifying cultural and socioeconomic influences that lead to HIV-risk sexual behaviors, and (c) discovering culturally acceptable sexual practices that are amenable to both male and female partners.

As stated before, women who engage in multiple concurrent partnerships increase their chances of contracting HIV. Because of financial instability, many women in these relationships encounter barriers to sexual discourse with their male sexual partners (Mah & Halperin, 2010). The unequal balance of power in social and sexual decision making between a male and female within concurrent unions leads to vulnerability to HIV infection. Strong gender-based cultural norms and socioeconomic pressures have exacerbated the risk level of sexual coercion and poor behavior patterns (Mah & Halperin, 2010). Concurrent sexual partners are described as individuals who are in two or more active sexual relationships that overlap in a 12 month period (Mishra & Bignanmi, 2009). In this instance, there are individuals with multiple sexual partners who engage in concurrent sexual relationships (Johnson, Dorrington, Pillay-van Wyk, &

Rehle, 2009) and are in relationships where men control sexual decisions. Men in long-term concurrent relationships tend to have at least two sexual partners (Mah & Haperin, 2010).

In isolated cases, individuals engaged in concurrent sexual relationships may not have many lifetime sexual partners. This is because certain concurrent partnerships, such as polygamy, are closed, stable, long-term relationships (Mishra, Bignanmi, & Van Assche, 2009). However, there is much controversy about the different cultural traditions and risks that occur in such relationships.

As suggested by Kashesya and Kaharuza (2009), such discoveries have been instrumental in noting the many cultural factors that have contributed to higher rates of HIV infection in East African countries such as Kenya. Child fertility practices, in which families are pressured to bear children, may play a role in the decreased use of contraceptives as a preventative measure. Couples who want children are prone to neglect the risks of HIV infection in order to start families that can carry on the family name, or to replace a dead child (Kashesya & Kaharuza, 2009). This practice increases the risk of transmission from spouse to spouse, but more directly, from mother to child (Kumar, 2012). When all of these factors are combined with gender inequality, in which the female does not have rights over her body, then widespread infections occur.

Research Questions

1. What are some of the primary barriers to preventing the spread of HIV among individuals who engage in concurrent sexual partnerships in Kenya?

2. What are the attitudes and knowledge of Kenyan males and females concerning HIV risk reduction techniques?
3. What role do cultural practices such as polygamy and gender inequality play in the current infection rate of married or cohabitating couples in Kenya?

Nature of the Study

A phenomenological qualitative study using an inductive approach was employed to emphasize matters relating to richness and feeling for raw data. This design is effective in learning about the culture of concurrent partnerships in Kenya and obtaining insights into the limitations on improving balances of sexual power between men and women. A qualitative approach helps to explain the how and the why high risk behaviors are exhibited among married and cohabitating couples. Qualitative research also identifies the effectiveness of gaining greater insight into culturally appropriate HIV prevention programs. It also focused on heterosexual couples. In addition, the study has utilized key techniques such as semi-structured interviews to collect information on the cultural views, HIV risk and prevention knowledge surrounding concurrent partnerships. Key participants included four males and five females ranging from 28 to 46 years old who live in the surrounding areas of Nairobi, Kenya and who have been married or cohabitating for more than 12 months. The recruitment process and sampling strategy is discussed in Chapter 3.

Conceptual Framework

Several scholars have proposed a number of theories that address the social and cultural context surrounding HIV/AIDS prevention among Kenya. However, the discussion of economic and sexual imbalances, particularly in heterosexual relationships, are the basis of the conflict between women's health and rights to decision making. Among the various perspectives that seek to define women's risks of HIV transmission, the theory of gender and power fits the best. Wingood and DiClemente (2000) argued that this theory represents a social framework that derives its strength from social discussion on sexual inequality, power, and gender imbalance.

Based on the theory of gender and power, the relationship between men and women is characterized by a number of critical social structures (Wingood & DiClemente, 2000). One of them is a division of labor that demonstrates the relationship between male dominance and economics (Rosentahl & Levy, 2010). Another social structure is a division of power that describes the relationship between men's monopoly on power and authority and the control of social institutions (Wingood & DiClemente, 2000). Another social structure is called *cathexis*, which dictates "suitable" sexual behaviors for women (De Coninck & Marrone, 2012). *Cathexis* also demonstrates how expectations of society not only affect the sexuality of women, but also limit their experiences in life (Wingood & DiClemente, 2000).

Researchers who have used behavioral interventions to assess or address power in sexual relationships often implicitly assumed a model in which specific outcomes within

the various domains of sexual and reproductive health resulted from an interrelated set of factors (Hosek, Brothers, & Lemos, 2012; Ayala, & Elder, 2011). These factors included individual-, couples-, family-, and community-level characteristics, as well as access to and use of services (De Coninck & Marrone, 2012). Usually, the underlying model is not made explicit. The framework of the relationship between (a) the balance of power in sexual relationships and (b) sexual and reproductive health will be demonstrated in the literature review.

At the individual level, socioeconomic and demographic characteristics are hypothesized to influence both the balance of power in sexual relationships and the extent to which individuals have access to and actually use reproductive health services (Wingood & DiClemente, 2000). At the level of the relationship or couple, characteristics such as relationship status (for example, marriage, and cohabitation, commercial, casual) and communication between partners also have an effect on power relations and use of HIV-related services (Wingood & DiClemente, 2000). Similarly, family or household characteristics, such as co-residence with social networks and the nature of the household economy, affect the balance of power and the use of services (Wingood & DiClemente, 2000). Finally, the social, political, and economic characteristics of the community condition the context within which power relations between partners are determined as well as the extent to which individuals have access to and use services. A multilevel relational approach implies that there is a greater need for dual protections against sexual

infidelity and couple intervention to negotiate safer sex practices and healthy decision making skills (Foege, 2010).

Since sex is the primary means of transmitting HIV infection, researchers have conducted in-depth studies that explore certain variables in relation to age, social factors, and marriage status (Nearns, Baldwin & Clayton, 2009). All three of these criteria provide insight into the factors that affect the measure of transmission and prevention.

The age of young women who begin sexual activity serves as the most visible quality in determining qualitative data. This is because age usually marks the beginning of both concurrent relationships and sexual activity in Kenya. Young girls, who are made to marry older men, sometimes two generations older, seem to exhibit one of the demographics of new HIV infection (Tigawalana, 2010). In less economically stable regions, such as Kibera, the marriage of young girls to older men seems to lead to gender inequality and thus leads to little or no discussion between the married couple about safe sex and preventative counseling (Tigawalana, 2010).

Older women who do not marry are also susceptible to dangerous trends of HIV infection (Magadi & Agwanda, 2009). This is because the women who do not marry at a younger age often have more sexual partners than their teenage counterparts. When a woman or young girl postpones marriage or chooses to cohabit, she puts herself at a higher risk of infection. In neither instance has it been established that women are being properly educated with HIV information or provided with knowledge of reproductive health and safe sexual practices.

Sexual Power and Control as Risk Factors

One potential effort to slow the rate of new HIV infections within concurrent partnerships in Kenya would mean changing the attitudes and beliefs of both males and females. However, as a result of their lack of economic and social power, many of these women are unable to negotiate safer sex options, including abstinence, monogamous unions and use of male condoms. Cultural attitudes and behaviors, including male dominance, may have an important impact on HIV risk.

The theory of gender and power (TGP) was formally established in the early 1900's by Robert Connell, whose aim was to address broader issues in the environmental and social context, such as disparity of sexuality, gender, and power. This theory has proven to be groundbreaking, as it was not primarily focused on ethnocentricity but gender. It sought to prove the hypothesis that the cultural influence of gender inequality has subsequent effects on the rise of HIV infection (Rosentahl & Levy, 2010). TGP examines the social structure between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis (Wingood & Diclemente, 2000). These three social structures are examined by sociologists to reveal many behavioral, biological, and social factors that place women at extreme risk for HIV transmission (Wingood & DiClemente, 2000).

The theory further argues that women's difficulty in protecting themselves is a result of several conditions, such as economic insufficiency, domestic partner abuse, and the lack of socialization skills, resulting in sexual ignorance (Stephenson, 2010).

According to TGP, these factors could stem the transmission of HIV in suppressed relationships, where women are not at liberty to make informed decisions about their health and sexuality (Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011).

TGP views the social norm and spiritual connections as being socially supported without condemning women with HIVwhich are experienced in the community, church, and family institutions as described in one study (Speakman, 2011). Communities play a role because they laid a traditional foundation by which women and men will follow and teach their children, such as size of family, gender roles, and education. Churches serve as a moral barometer that either forbids or allows certain practices, such as polygamy, contraceptive measures, and/or interfaith relationships. All of these levels are potentially strong factors in identifying and reducing risk factors of HIV transmission.

Through lens of TGP, the culture's social norms among high risk couples will interpret HIV behaviors about condom use and additional risk reduction techniques (Ramjee & Daniels, 2013). This is true because of the recurring cycle of infection that is likely to occur in the lives of the children of the infected and because of the social stigma and discrimination associated with the disease. This theory will identify the level of confidence women have in communicating their sexual concerns to their male sexual partners (sexual division of power) and making informed decisions even when conflict arises between male and female sexual partners (sexual division of labor).

Definition of Terms

AIDS (Acquired Immune Deficiency Syndrome) - A disease caused by HIV that weakens the immune system (CDC, 2014).

Gender based violence (GBV) - Hostile behavior directly related to an individual's gender (Gass, Stein, & Sedat, 2010).

Human Immunodeficiency Virus (HIV) - Mutating virus that leads to AIDS (CDC, 2014).

Joint United Nations Programme for HIV/AIDS. (UNAIDS) - Joint partnership which leads to universal access to HIV testing.

National AIDS and STI Control Programme (NASCOP) - Spearheads the Ministry of Health intervention programming.

Sexual concurrency - Overlap of several relationships in which one partner facilitates sexual intercourse with other sexual partners (Mah & Halperin, 2010)

Theory of Gender and Power (TGP) - A social structure theory based upon unequal balance of power among one gender (Wingood & Diclemente, 2000).

World Health Organization (WHO) - A United Nation's agency responsible for improving the health of populations and controlling communicable diseases.

Assumptions

It was assumed that all the questions were understood and answered in a clear understanding of enhance accuracy, the reliability and validity of the research results. In addition, all the areas of study were made accessible through providing each participant

with six U.S. dollars for transportation assistance. However, several people declined participation in the study due to additional social barriers that were not factored into the study. In addition, an assumption was made that during the follow-up, all the participants who initially took part in the study will again be available for a proper analysis and comparison (Mishra & Bignanmi, 2009). However, one participant was lost to follow up due to time constraint.

Limitations

This study was subject to a two area of limitations:

1. Language barriers in parts of Nairobi may include rural areas where individuals with linguistic barriers may not consent to adequately represent the diversity of this population (Petty, Thomson, & Stew, 2012). Although a language interpreter was made available at the clinic to assist participants in the study, all of the participants elected to be interviewed via telephone in their homes without the assistance of a language interpreter present.

2. Also, the inability to recruit 50% of men in the study (Qu & Dumay, 2011) poses an issue in terms of adequate representation of male participants in hard to reach locations.

Significance and Social Change Implication

This study focused on a social structure that is related to the infection rates of HIV and AIDS. As such, it is expected to play a significant role in leading to gender equality, as well as in reducing social and economic equalities—the main factors that lead

to the high spread of the HIV and AIDS infections. This study has helped to identify specific around gender inequality, knowledge and attitudes around HIV risk reduction techniques and sexual behaviors the disease spread. As such, it is expected to help in the formulation of strategies to deal with each of these areas. It is expected that a social change will result with respect to the behavior of couples as well as in terms of the gender awareness and economic balances of individuals in married and cohabitating unions (Higgins, Hoffman, & Dworkin, 2010).

Summary

The use of gender and power as a framework will help to identify behaviors that bring about HIV risk and transmission. Concurrent relations and gender differences may be some of the major issues that characterize the spread of HIV in Kenya. This could occur because there is lack of sufficient knowledge about the issues and thus the people in the country end up engaging in activities that lead to HIV infection. Gender roles can also create disparity in access to information that would help prevent HIV infection. Additionally, the high level of poverty within the nation also play a crucial role in the epidemic in that it creates channels where people engage in concurrent relationships for financial and social survival.

The theory of gender and power describes such substantial challenges of prevention, education, and treatment, in which governments and health care providers are unable to control the spread of the disease without both sexual partners taking the responsibility to consistently negotiate safer sex practices.

In Chapter 2, a review of literature discusses cultural and social factors with respect to HIV risk in concurrent relationships. Chapter 3, on the methodology and design of the study, will explain the data collection and analysis techniques used, participant eligibility, and the interview process. Chapter 4 will assess the collected data gathered from participant interviews. Finally, Chapter 5 will deliver the interpretation of the findings, including relevant recommendations and conclusions.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative study was to explore the lived experiences of married couples and cohabitating partners who may be engaging in HIV-risk sexual behaviors in Nairobi, Kenya. A substantial volume of literature has been examined to understand the challenges of HIV prevention. In Kenya, HIV/AIDS has been viewed primarily as a health concern affecting specific groups of people. Because of this, the bulk of preventative measures were directed at those considered to be the most vulnerable, a subgroup that included sex workers, habitual drug users, and men who have sex with men. The belief was that if these individuals were targeted with the proper education and prevention methods, then health care planners would succeed in containing the pandemic. However, this theory and methodology have proven to be erroneous. The scope of the problem among concurrent sex unions was increasingly evident as the disease continued to spread across social and ethnic classes.

The epidemic of HIV/AIDS in Kenya emphasizes the age and economic status of women, which places them at a disadvantage, especially women of childbearing age. The unequal balance of gender and sexual power will be discussed as a way to understand the perception of HIV risk factors among concurrent relationships and as a way to explore the barriers around social and cultural norms in Kenya.

To address the research questions, I searched for peer-reviewed articles published within the last five and a half years, 2008-2014. Articles, older than 2008, were used to

support sufficient data on HIV and couples whenever additional information was needed. I also used various websites as foundational sources, such as Centers for Disease Control and Prevention (CDC), United Nation Joint Program on HIV/AIDS (UNAID), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and World Health Organization (WHO). Various key search terms and sequence of relations used for the literature hunt included: *concurrent unions and HIV in Kenya, cultural barriers to HIV in Kenya, gender inequality and HIV in Kenya, HIV and couples in Kenya, HIV/AIDS and Kenya, HIV and condom use in Kenya, HIV/AIDS and sub-Saharan Africa, HIV prevention in Kenya, HIV prevention and cultural barriers in Kenya, HIV and Kenya, HIV and women in Kenya, and polygamy and HIV in Kenya.*

In developing the literature review, I divided this chapter into five main sections. The first section addresses the alignment between the purpose of the study and the problem. The second section offers information regarding the lethal combination of HIV risk between sex and intimate partner violence within long-term relationships. The third section guides the study toward information regarding HIV prevalence among those of low socioeconomic status in Kenya. The fourth section of this chapter discusses HIV and decision making around healthcare. This segment also details voluntary HIV testing that has been put in place for couples and offers further consideration of culturally sensitive approaches. The fifth section develops around the socio-cultural context of HIV in Kenya.

HIV Infection in Kenya

According to Maharaj, Neema, Cleland, Busza, and Shah (2012), male partners are the main source of infection among serodiscordant couples. The underlying reason for this conclusion is that men often acquire the infection from external sources such as extramarital affairs (Maharaj et al., 2012). This could be a clear indication that women are at a greater risk of being infected with HIV because they do not use condoms and perhaps do not take part in marital infidelity. For instance, Kaiser et al. (2011) stated that heterosexual intercourse is the primary cause of HIV infection in Kenya. However, primary behavior changes play a significant role in managing HIV infection among married couples. Examples of such behavior changes include increased condom use, reduced sexual relations, and delayed age of sexual exposure. The actions are triggered by increased public awareness regarding HIV/AIDS, as well as growing anxiety with reference to effects of the virus (WHO, 2013; UNAID, 2013).

There is a compelling relationship between cultural and gender barriers among married and long-term sexual partners and HIV transmission in Kenya. Despite the fact that many of these relationships seem to value the sanctity of long-lasting unions, morals, and family values, approximately 45% of all new HIV transmissions affect stable sexual partners, resulting from casual sex outside of the relationship (National AIDS and STI Control Programme, 2013).

Inconsistent condom use, according to De Coninck & Marrone (2012), is a targeted indicator of risky sexual conduct, which is also a predictor of imminent HIV

infection frequencies in sub-Saharan Africa. Contrary to traditional views, one study suggests that marriage does not prevent HIV infection in either male or female sexual partners (Epstein, 2013). The main reason for this is infidelity within relationships. However, nearly one-half of all cohabitating or married partners have at least one infected partner (National AIDS and STI Control Programme, 2013). The use of male condoms varies within heterosexual couples and depends on several factors: the couple planning for procreation (Mmeje, Cohen, & Cohan, 2012), the issue of mistrust (Larsson, Thorson, Nsabagasani, Namusoko, Popenoe, & Ekstrom, 2012), and the association of condoms with infidelity (Epstein, 2010).

In many instances, the linkage between HIV and sexually transmitted infections (STIs), particularly herpes simplex virus (HSV) infection, serves as a primary risk factor for the acquisition of HIV (National AIDS and STI Control Programme, 2013). Women in heterosexual relationships in Kenya are far more affected by human immunodeficiency virus (HIV) than any other high risk group (Lee, 2012).

There is a strong correlation between Sexually Transmitted Infections (STI) and HIV, as the behaviors and circumstances that put people at risk for STIs also put them at risk for HIV (May, Chretien, and Pavlin, 2009). Further, having an untreated STI can make a person more susceptible for HIV infection. In fact, being infected with genital herpes increases the likelihood of being infected with HIV, if exposed. It has been reported that over 70% of Kenyan men in long-term relationships are accessing STI clinics for testing and treatment (May, Chretien, and Pavlin, 2009). Yet, many women of

childbearing age within these couples are not accessing STI testing and treatment until prenatal care is needed *(*Singa, Glick, Bock, Walson, Chaba, Odek, McClelland, Diomand, Gao, & John-Stewart, 2013). The level of sexual HIV transmission among long-term unions in Kenya must be reduced. Women should play an integral role in the sexual negotiation process and open a dialogue on the issue to develop trust and to provide a bargaining point for additional HIV prevention services.

The greatest challenge facing sub-Saharan Africa is the HIV/AIDS epidemic. In 2009, over twenty thousand individuals were infected with the virus in the sub-Saharan region (UNAIDS, 2010). The total infected population is estimated to be 67.8% of the entire world's ailing group. Statistics also indicate that five percent of adults who reside in the region have tested HIV positive (UNAIDS, 2013). There exists a serious challenge to prevent the transmission of HIV among discordant couples. The purpose of this paper is to determine the various cultural and social factors leading to the high rates of sexual HIV transmission in concurrent unions throughout Kenya.

The rate of HIV transmission among concurrent unions has become the focal point of public health in Kenya (Gass, Stein, William, & Seedat, 2010). Within the context of this chapter, an inclusive review of related literature pertinent to the original research will be presented. Furthermore, the literature review will include cultural barriers that correlate to sexual risk patterns leading to the acquisition of HIV among concurrent unions in Kenya. Finally, the use of effective couple intervention strategies to address socioeconomic and gender equality among concurrent unions are examined.

HIV, Sex, and Violence within Marriage

According to Gupta, Parkhurst, Ogden, Aggleton, and Mahal, (2010), of every ten couples residing in Kenya, at least one partner lives with HIV. The trend is also common in other parts of Africa. According to Kaiser et al. (2011), it is evident that two-thirds of couples who are HIV-infected are serodiscordant, which means that one partner is HIV-positive while the other is HIV-negative. It is also estimated that half of the new HIV infections in Zambia and Rwanda occur in cohabitating relationships and marriages (Anglewicz, Simona, & Shelley, 2010).

Even though HIV transmission risks among discordant couples can be reduced significantly, the challenge could potentially be in having high-risk sexual partners tested for HIV and disclosing their outcomes in order to prevent HIV transmission, according to Cohen, Lingappa, Baeten, Ngayo, and Spiegel (2012). This is the primary factor that contributes to more infections among married couples (Dunkle, Stevenson, Karita, Chomba, Kayitenkore, Vwalika, Greenberg, & Allen, 2008). The use of condoms is also uncommon among married individuals for various reasons. According to Cohen et al. (2012), some of these reasons include partners' intentions to have children and the widespread association of condoms with a lack of trust and infidelity.

These trends are also common in other African countries. This consistent rate of infection in the region reveals that the underlying factors for HIV contraction are congruent. Epstein and Morris (2011) noted that concurrency seemed to be the greatest factor in the transmission of HIV within marriage. When concurrent sexual relationships

occur, the HIV transmission risk can become 10-30 times higher, according to Epstein and Morris (2011). It appears that concurrent sexual partners create a network effect that removes the protective barrier of monogamy that safeguards two HIV negative sexual partners from exposure.

The number of couples willing to undertake HIV tests remains low in countries that are highly affected by the epidemic. Even though HIV transmission risks among discordant couples can be reduced significantly, partners still resist testing. This is the primary factor that contributes to more infections among married couples. In the past 10 years, one prevalent study relating to HIV has connected sex, gender inequality, and intimate violent relationships (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2010). In this study, the authors stated that exposure of women to gender-based violence played a significant role in enhancing their susceptibility to HIV infection. The ability of women to negotiate with their partners to use condoms is also hindered through forced sex. Equally, women fear requesting the use of contraceptives because they are usually threatened physically. Husbands also view wives who request condom use as being unfaithful and accuse them of infidelity. Married women around the globe have little legal protection when it comes to physical violence. However, Kenya passed into law the Sexual Offenses Act in 2006 (Akwara, Madise, & Hinde, 2011). The primary objective of the Act was to strengthen the sexual violence laws that were already in existence. In spite of enactment of laws, women in Kenya still report sexual and physical abuse by their husbands (Gupta et al., 2010).

The unique connection between domestic violence and HIV transmission has also been reported. Gupta et al. (2010) revealed that before being tested for HIV, 28% of women reported previous domestic violence from their husbands or cohabitating partners. This domestic abuse was associated with higher rates of HIV infection. Domestic violence resulted in a lower number of couples entering preventative counseling that would reduce the chance of transmission. The findings in this article solidified the evidence that domestic violence before testing limits partner involvement in measures to prevent mother-to-child transmission.

Since the 1990, behavioral prevention has been a key component in stemming the tide of HIV transmission as either as a consequence of or factor in domestic violence. One study reported on the unique associations with HIV risk behavior among young men in the Eastern Cape, South Africa (Dude, 2011). Various factors such as the connection between domestic violence and risk associated with HIV transmission were considered in new studies that helped researchers further develop theories to analyze certain areas of South Africa. Dude (2011) conducted interviews with 1275 sexually active men between the ages of 15-26 from 70 villages in the rural Eastern Cape. Sexual questions relating to frequency and timing of violence were administered. The goal was to find possible links between the violence and sexually risky behaviors. The results showed that nearly one-third of men in the study had committed acts of violence against their female partners. The findings within this test group were substantially laden with male participant HIV risk behaviors. Among those male participants that had perpetrated violence upon their

female partners, higher rates of substance abuse, transactional sex, and higher numbers of sexual partners were frequent in these relationships. The study concluded that young men 15 to 26 years old were at a greater risk of both contraction and transmission as a result of sexual risky behavior. In addition, the study pointed out that it would seem more practical that HIV prevention methods in Africa should clearly communicate the connection between intimate partner violence and increased HIV risk behavior among men.

Shamu, Abrahams, Temmerman, Musekiwa, and Zarowsky (2011) also noted the frequency of intimate partner violence (IPV) and barriers to prenatal care. The purpose of their study was to discover whether maternal and child health outcomes were associated with violence among high risk pregnant women. The hypothesis considered whether fear of responsibilities or the shame, guilt, and stigma of violence played a role in preventing male partners from supporting pregnant women in their prenatal treatment and care. The study sought to do three things: i) establish the number of incidences of intimate spousal abuse, ii) identify behavior risk for intimate spousal abuse and iii) link the association between intimate spousal abuse and HIV prevention interventions specifically within the context of the prevention of mother-to-child transmission of HIV program (PMTCT).

Shamu et al. (2011) interviewed 300 participants, including women and men, from the East African countries, such as Tanzania and Ethiopia. The interview questions were related to sociodemographic characteristics of the woman and her family. The questions also extended to male spouses, prenatal and postnatal experience related to the youngest child, prenatal HIV testing, perceptions regarding the marital relationship, and

spousal abuse. The research showed that 14% had suffered violence within the last 12 months. The corresponding results related to other unique criteria were revealed as such: higher levels of education in women and fulfilling marriages were found to be at a lower risk of spousal abuse, while those living within rural residences and the husband having another partner were associated with higher risk of intimate spousal abuse. Sexual coercion, alcohol use, and lifetime physical violence were also highly connected. Focus group discussions concluded that abused women often delay prenatal care, fear and decline voluntary HIV testing, refuse to disclose their HIV test results, and lack motivation to request condom use because of fear of spousal abuse.

The research concluded that intimate partner abuse is prevalent within eastern Africa. The underlying theory is that spousal abuse is primarily related to gender inequality, multiple concurrent relationships, substance use, and poverty. As with previous studies, researchers concluded the need to target these specific dynamics with couples' intervention and other preventative treatments.

Dude (2011) noted findings of IPV and its relation to HIV infection among married Rwandan women. The study, which focused south of the highly researched Uganda, sought to show that the 3.1% HIV prevalence was directly related to IPV. The report confirmed previous results from researchers north of the country that intimate partner violence is frequently associated with increased HIV risk in women. The findings hypothesized that men who committed physical or sexual abuse against their spouses or significant others manifested riskier sexual behaviors. Population data provided from the

2005 Rwanda Demographic and Health Survey indicated that women with fewer sexual risk factors who had experienced any form of domestic abuse within their marriages were 1.61–3.46 times as likely to test positive for HIV. This report was further evidence of the direct correlation between intimate partner violence as a contributing factor to HIV transmission and infection in Rwanda.

The political state of East Africa has been studied to reveal factors that are contributing to extremely high rates of HIV infection (Yoder, Nyandiko, Winstone, Vreeman, Ayaya, Gisore, Braitstein, & Wiehe, 2012). The author conducted a study that focused on this unique trend as it related to Kenya. The findings revealed that increased knowledge and application of culturally appropriate risk reduction techniques such as male circumcision could actually reduce the risk of HIV contraction for female sexual partners.

The variables in the study were limited to statistics. In Kenya, women with low socioeconomic status are primarily and economically dependent upon their husbands (Yoder et al., 2012). This negates the power that they possess in negotiating safe sex practices or leaving the marriage when infidelity occurs. Both of these key components are contributing factors to the risks women face when they marry.

HIV Infection and Socioeconomic Status

There are some controversies regarding the relationship between HIV prevalence and socioeconomic status. Health surveys that were conducted in Kenya indicated that the rate of HIV infection is higher among wealthy couples or individuals (Matovu, 2010).

For instance, wealthiest Kenyan women are three times more vulnerable to HIV infection than their poor counterparts (Kaiser et al., 2011). In contrast, Akwara, Madise, and Hinde (2011) argued that economic deprivation is a major contributing factor to risky sexual behavior among women in Kenya. The authors also pointed out that an individual's susceptibility to HIV infection is compounded by poverty. They concluded urban poverty is more severe than rural food insufficiency, which coerces deprived women in towns to take part in risky sexual behaviors so that they can earn a living.

The mobility of the despondent in Africa also has much to do with the prevalence of HIV infection and transmission. Kwena, Camlin, Shisanya, Mwanzo, and Bukusi (2013) conducted a study of HIV infection among married couples in the fishing communities. The study provided 1090 gender-matched interviews and rapid HIV testing for 545 couples in Kisumu, Kenya. The research assessed both socioeconomic and behavioral data. The findings revealed a specific variance and difference in the frequency of journeys women undertook in the month preceding their interviews. The study concluded that the prevalence of HIV found in women was 22.7%, compared to the prevalence of HIV found in their male partners at 20.9%. This was an indicator to researchers that mobile women are 2.1 times more likely to be infected with HIV than non-mobile women spouses. The evidence of women contracting HIV from their male partners in fishing careers was unsubstantiated. The need to travel created a greater chance of infection.

HIV and Healthcare Decision-Making

There are structural barriers hindering women's decision making, including spousal refusal for them to access contraceptive counseling (Njuki et al., 2012). As a result, the lack of autonomy of women makes it difficult for them to receive HIV treatment in a timely fashion. Empowered women are in a better position to make informed decisions regarding their health. For instance, they can choose to have protected sex with their husbands if they are not sure about their HIV status (Njuki et al., 2012).

In Zambia, there are new community-based promotions being implemented in order to encourage couple HIV counseling and testing. The ANRS 12127 Prenahtest trial has recently studied the effects of prenatal couple-oriented HIV counseling (COC) (Tchendjou et al., 2011). These studies have been conducted in conjunction with reproductive and HIV prevention behaviors and mutual testing of partners of HIV patients. This new COC model has begun to replace the standard post-test HIV counseling delivered to pregnant women that many have considered outdated.

In 2005, a sectional study was conducted using quantitative data techniques to verify the rate of voluntary HIV counseling and testing as a preventive measure in Uganda (Bwambale, Ssali, Byaruhanga, Kalyango, & Karamagi, 2008)**.** This study focused on 780 men over the age of 18 years who reside in the Kasese district of Western Uganda. The study reported that four focus group discussions and 10 key informant interviews were conducted. Bwambale, Ssali, Byaruhanga, Kalyango, and Karamagi (2008) noted that the voluntary counseling use among men in Uganda was 23.3%. Forty-

six percent had pretest counseling and 25.9% had HIV testing. The report also revealed that 96% of the test subjects would later return for posttest counseling while receiving their personal HIV results. There were higher rates of voluntary counseling and testing (VCT) among men age 35 and below. Further into this study, the authors revealed that the implementation of VCT as a preventative method among men in Bukonzon, Uganda is still flawed. The stigma of HIV remains the greatest barrier to more widespread testing of those in high risk areas. Routine counseling via health care units, home-based VCT programs, and community development are necessary to strengthen the use of VCT programs as a direct preventative measure. More studies are currently being done in the field of HIV prevention studying the overall usefulness of VCTs in other sub-Saharan regions.

The HIV epidemic in the sub-Saharan region has led to focusing on serodiscordant relationships. Couple-centered testing has become widely prevalent, as HIV infections often have the highest rates of transmission in seemingly stable relationships. Desgrees-du-Lou and Orne-Gliemann (2008) verified that a large portion of the most recent HIV infections occurring in monogamous relationships were in large part due to previous infection of at least one partner or the presence of infidelity in the relationship. The rate of infection in either male or female remained at fifty percent in five African countries where at least one partner was serodiscordant. This report paralleled the findings of (Beyeza-Kashesya, Kaharuza, Mirembe, Neema, Ekstrom and Kulane (2009) that sixty percent of new HIV transmission in Uganda occurred in

serodiscordant relationships. When the variable of child fertility practices in Uganda was taken into account, researchers arrived at the hypothesis that non-protected sex was widespread due to the pressure to either start a family or replace a dead child. These findings revealed that individuals who desired children and those with more than one sexual partner were less likely to use birth control during sexual intercourse. In Uganda and other sub-Saharan countries, the pressures for child birth include the procuring of family lineage, possessing long-term relationships, and pressure from relatives to reproduce (Beyeza-Kashesya et al., 2009). With this unique demand to bear children, the common health challenge is the risk of HIV transmission. The most prominent of these risks are transmission to partner and child, lack of negotiating power for safer sex, and failure of health systems to offer safe methods of reproduction.

The Beyeza-Kashesya et al. (2009) study concluded that HIV serodiscordant couples with the intentions of procreation place themselves at a greater risk of HIV infection or infecting their spouse. According to their study, counseling and voluntary testing (CVT) must address gender issues, risky behavior and reproductive health services for HIV serodiscordant couples.

Both Bwambale et al. (2008) and Beyeza-Kashesya et al. (2009) strongly suggested that there is an urgent need to clearly define strategies to stem the tide of HIV infections in couple relationships. Bwambale et al. (2008) noted that while previous prevention methods were focused primarily on an individualistic, sex-specific, and pre-natal prevention, the increased transmission of HIV has become a new threat to the fight

against the infection. Both studies proposed a couple-centered counseling approach to keep up with the outbreak of the disease. The final conclusion was the need to promote large-scale prevention methods by counseling couples in monogamous, married, and stable relationships.

HIV Infection and Sociocultural Contexts

According to Bove and Valeggia (2009), some cultural practices play a significant role in oppressing HIV infected women. The authors also reported that early marriages increase the rate at which women are infected with the virus because they tend to raise the rate at which they engage in unprotected sex. This is especially true with older men who have multiple sexual partners (Bove & Valeggia, 2009). Another cultural practice that promotes the spread of HIV infection in Sub-Saharan Africa is wife inheritance (Bove & Valeggia, 2009). This practice increases the risk of infection because men are allowed to have sex with widowed women whose HIV status is not known. Similarly, some religions promote gender-based violence, resulting in marital rape and the risk of HIV infection (Clark, 2009).

The increased tendency to oppress women led Patterson and London (2009) to conclude that female partners, who were discriminated against, stigmatized and marginalized in society before the emergence of HIV/AIDS with time become highly vulnerable to HIV infection. This is the underlying reason efforts are channeled toward changing cultural practices associated with increased HIV infection. It is also evident from various studies that women who conform to traditional norms have higher chances

of engaging in behaviors that increase their risk of being infected with HIV (Clark, 2009). The interaction of cultural and gender norms, therefore, intensifies the risk of HIV infection among ethnic minority women.

Religion is a social force in Africa which plays a significant role in contributing to HIV stigma (Campbell, Skovdal, & Gibbs, 2011). The challenge of separating religious beliefs from cultural practices makes it extremely difficult to comprehend the role that religion plays in HIV infection. In Kenya, Pentecostal and Evangelical churches speak against Polygamous unions and promote abstinence before marriage in efforts to reduce HIV infection (Campbell, Skovdal, & Gibbs, 2011). However, few women in these congregations are knowledgeable about how to protect themselves from HIV infection (Speakman, 2011). Muslim religion is another faith that is practiced in Kenya. One study concluded that there is a negative correlation between HIV prevalence and Muslim religious identification (Matovu, 2010). However, there are mixed results among surveys that endeavored to find out HIV risk factors among Muslim communities. For example, male circumcision is a practice that is linked with low HIV prevalence in Muslim communities. The practice is also utilized to elucidate low prevalence of HIV infection among Muslims. On the other hand, women who belong to more liberal religious groups such as Protestants and Catholics have a higher tendency to engage in premarital sex compared to those in conservative conventional religions or sectarian Christianity (Matovu, 2010).

Religious institutions also act as a basis for community norms and values that are socially sanctioned and culturally determined. For instance, Catholicism is the most prominent religion among Latin Americans (Patterson & London, 2009). As a religion, it prohibits its believers from using contraceptives. The acceptability and social identity of Latin American women are also determined culturally by their fertility levels, which is the underlying reason why contraceptive use is lower in contrast to White women. Additionally, among Latin American women, engaging in unprotected anal sex are considered to be a contraceptive strategy and an effective and perfect way of preserving their virginity (Patterson & London, 2009). These strategies significantly contribute to increased HIV infection among Latin American women. Therefore, religious institutions, cultural norms, and gender rules might instill harmful beliefs and expectations in women and even restrict their options regarding the use of contraceptives.

Age is the most significant factor when it comes to landmark cultural events such as marriage. In some villages of Kenya, women are often forced to marry older men who are the ages of their grandfathers. In such relationships, female partners exhibit little authority to talk about having protected sex and HIV testing before marriage (Clark, 2009). Similarly, Hindin and Fatusi (2009) point out that the preference by men for younger girls and postponement of marriage by most women as they interact with numerous sexual partners enhance the rate of HIV infection among married or cohabitating couples (Hindin & Fatusi, 2009). The most serious risk factor when it comes to HIV infection is early marriage. Clark (2009) points out that married women are more

likely to contract HIV than unmarried ones because of high sex frequency and low condom use in many parts of sub-Saharan Africa. In some instances, married women have little knowledge about reproductive health and safe sexual practices. Young girls who marry at a tender age also fear seeking reproductive healthcare services because of their likelihood of needing to drop out of school to take care of their household (Hindin & Fatusi, 2009).

Furthermore, married couples in sub-Saharan Africa are often categorized based on their HIV status. The "-" and "+" superscripts are often utilized to indicate absence or presence of HIV infection. However, varied outcomes exist regarding HIV infection among married couples. For instance, in regions with high HIV/AIDS prevalence, some people are infected even before they get married. Women also have a higher chance of being infected compared to their male counterparts in discordant couples (Ramjee & Daniels, 2013).

HIV infection risk factors among married or cohabitating couples are also extremely complex. The underlying reason is that infection greatly depends on a broad variety of sexual behavior and sociodemographic factors (Ramjee & Daniels. 2013). The determinants are often linked with both HIV and marital status. Demographic variables such as the respondent age, race, sex, and socioeconomic status play a significant role in enhancing the spread of HIV among married and cohabitating couples. Therefore, it is important to involve married couples or cohabitating partners in prevention interventions that focus on behavioral determinants. The prevention program's aim is to sensitize

people to the risks of being infected with HIV. Married couples, as suggested by Ramjee & Daniels (2013), also need to know their status in order to take appropriate measures to control or prevent the spread of HIV infection.

The analysis of De Walque (2009) demonstrated unique findings related to the age of the infected in certain African countries. The HIV prevalence among all adults in Lesotho is higher than in the other countries in the surrounding area. Twenty-six percent of all females aged 15-49 and 23.5 percent of all males in the same age range are infected. De Walque (2009) also pointed out that the HIV prevalence in eastern African areas such as Cameroon and Ghana is higher in urban areas.

Gender Role and Sexual HIV Risk Factors

There are multiple steps that help in limiting the vulnerability of married men and women to HIV infection. Some of the strategies that can be utilized include use of effective prevention strategies, stronger policies, and transformation of harmful social norms (WHO, 2013). The steps take into consideration the creation of awareness among married women and men about social norms and rules. This awareness enables them to comprehend how norms negatively impact their health. Another strategy is to establish political will with an aim of reforming and enacting policies that limit the vulnerability of women to HIV infection.

It is also important to enforce and enact laws that against marital rape and domestic violence. Additionally, there is a need to increase HIV testing and counseling among couples as well as to develop programs that promote the use of condoms among

married people. Integration of HIV services with reproductive health and family planning programs can potentially reach out more to married women to provide them with support and information. The programs are also essential in encouraging men to get involved in making decisions about reproductive health, as mentioned by WHO (2013).

In conclusion, HIV risk factors among cohabiting and married couples are more related to individuals' cultural practices in Kenya. Some of the practices include wife inheritance, gender-based violence, early marriage, and some religious beliefs. It is, therefore, important for the public to be educated on the seriousness of HIV in order to control its spread. Evidence from this literature review clearly delineates a serious gap between understanding HIV risk barriers and acceptable risk reduction strategies among concurrent unions in Kenya. The goal of the study is to close these gaps and present appropriate recommendations to support a suitable couple intervention for this population.

Summary

Chapter 2, the literature review provided a framework of cultural and social delineation of HIV risk in long-term marriages and cohabitating partnerships. HIV transmission in sub-Saharan Africa is primarily a result of heterosexual intercourse. Among couples in the region, HIV discordance is highly prevalent in cohabitating partners. According to the literature, little is known about identifying barriers and solutions for minimizing the negative impact of HIV among heterosexual concurrent partners.

In Chapter 3, I reviewed the phenomenological research methodology and how it will be used to help understand the social and cultural factors around HIV-risk behavior in concurrent relationships.

Chapter 3: Methodology of the Study

Introduction

The purpose of this qualitative study was to explore the lived experience of married couples and cohabitating partners who may be engaging in HIV-risk sexual behaviors in Nairobi, Kenya.

Chapter 3 will provide an overview of the research design and method used in this study to gain greater understanding of the HIV sexual risk among concurrent partnerships and to identify gaps in knowledge related to social and cultural behaviors. Oster (2012) posits that one of the greatest health challenges in sub-Saharan Africa is HIV/AIDS, through sexual behavior. This occur either in marital union, in which the husband may be unfaithful through socioeconomic privilege, or through lack of safe sex methods in which pressure to rear children or to be financially supported are factored (Stephenson, 2010). The risk of HIV transmission has a tremendous impact on women in poverty stricken villages of Kenya leading these women in concurrent unions to conform to social and cultural survival strategies.

In this chapter, you will find information about the qualitative method which was used in understanding the experiences of HIV-risk sexual practices of concurrent partners in Nairobi, Kenya. This chapter describes the research design, justification for use of method, role of the researcher, ethical considerations, data collection, data analysis and dissemination.

Research Design

I used a qualitative approach to conduct an in-depth assessment of the knowledge, skills and attitudes around social and cultural behavioral which influences high risk sexual practices. There are other factors why researchers are turning towards qualitative data research rather than to quantitative data research. Qualitative data analysis does not focus primarily on statistical analysis, but on patterns found within the data (Creswell, 2013). This is one reason why coding has been so crucial in determining certain risk factors as it relates to the rise of HIV in Kenya. Qualitative approaches seek to incorporate and dissect the phenomenon of HIV risk behaviors as it relates to concurrent unions. By using qualitative phenomenological research method, greater findings can be explained in order to obtain direct links in common factors of HIV infection and transmission. This thematic approach is not limited to empirical inference, but allows for generalizations to be made upon the phenomenon that is being studied (Polit & Beck, 2010).

One of the most reflective approaches to gathering data in phenomenological research is through semi-structured interviewing (Qu & Dumay, 2011). Semi-structured interviewing verbally approximates questions with explicit goals in research. As the researcher set in motion to interpret the thoughts, perceptions, and beliefs of participants, a strategy of questions are needed to be asked in order to identify patterns of attitudes and beliefs about sexual HIV risk (Petty, Thomson, & Stew, 2012). I selected semi-structured interviews in this study as an appropriate style to ensure that participant's responses were

not limited and to acquire an adequate amount of information. Questions were addressed through free flow participation which has allowed participants to respond as he or she chooses without the influence of the researcher (Polit & Beck, 2010). Probing questions were used to encourage participants to expand on their responses in greater detail.

Justification for Phenomenology

Phenomenological research is effective in ascertaining why persons conduct themselves in a certain way over a period of time and within a natural setting. It relies on interviews with participants in a naturally occurring situation. According to Greenwood and Mackenzie (2010) phenomenology involves conducting focus groups and interviewing, rather than manipulating variables by external instruments. This will enable participants to express themselves freely to what is happening at the moment.

Another characteristic is that the phenomenological approach does not formulate the hypothesis prior to the research (Johnston and Everett 2012; Nurani, 2008; Tuckman, 1999). The hypothesis will emerge as the data collection occurs, which could ultimately lead to future quantitative research studies. Since the main objective of the phenomenological approach is to provide a detailed description of the situation people bring to the forefront. Since this description becomes the basis of the absence of the hypothesis at the initial stage of research, it helps researchers avoid any ideas aroused from the hypothesis which will influence accuracy of the interpretation.

Another advantage of using qualitative phenomenological approach over case study, ethnography, grounded theory, and narrative research is the naturalistic manner in

which it is carried out and its emphasis on understanding the inside/local perspective (Sorensen & Iedema, 2007). Interpreting the perception of participant's experience in its natural context can generate insights that other forms of research cannot (Kelly & Kelly, 2013).

The Researcher's Role

My role as a phenomenological researcher was to identify the cultural intricacies and to decipher the social behavior of concurrent unions within community settings of Nairobi, Kenya. I used a designated hospital staff to circulate flyers and recruit participants in the area where the local clinic is centrally located. The flyer included information about the Researcher's email address and cell phone number to schedule a date and time of each interview. Participants were able to schedule an appointment with the Researcher either through text messaging through the use of the communication tool called, "Whatsapp" or by email. I have scheduled the interview sessions in an effort to obtain first-hand knowledge. Interviews were conducted through either Skype internet or by telephone as it pertained to the structural expression of individual behavior and how it is associated to the social issue of HIV risk. When requested by participants or me, an assigned language interpreter was available to assist in the project. As the researcher, I have gained full access to all documented data. Data collection was obtained through one-on-one interview with each participant. Participants were asked to provide informed recorded consent at the beginning of the interview. I have obtained permission to use the questions for the interviews and collected any pertinent data from the assigned hospital

staff, approved by Kenya's IRB committee. The designated hospital staff was instructed to distribute flyers about the project throughout the communities and provide participants with access into the hospital where Skype Internet interviewing will take place. I have also coded and transcribed relevant contents from note taking and audio recording of Skype video and telephone calls. Each participant was informed; verbally, that recording of their interview will take place, if agreed. Since working in HIV prevention programs since 2004, I have been cognizant around identifying my personal biases so that it doesn't impact my interview process, note taking and data analysis. Lastly, after completing the study, I will analyze and disseminate all data results to Mater Hospital Committee and to members of the villages of Nairobi, Kenya in writing.

Setting and Participants

The setting of this research study was expected to take place in the city of Nairobi, Kenya, either at a local hospital, which is conveniently located for participants to access a computer, internet service and telephone service or in the home of the participant where a telephone interview was conducted. I facilitated the study from my home office in New York City where I had access to private space, the Internet, and telephone service. The target group of this study was comprised of 4 males and 5 females between the ages of 28 to 46 who are sexually active with at least one sexual partner for more than one year in Nairobi, Kenya. Six additional males and females will be used as alternatives in the study in the event someone prematurely drops out of the project. The assigned hospital staff has circulated a flyer about the research study. Interested participants were

able to contact me through my cell phone. I asked each candidate a series of three questions to determine eligibility: 1) How old are you? 2) Are you in a sexual relationship? If so, how long? 3) Do you live in the region of Nairobi?

Official languages in Kenya. There are two languages used in Kenya: English and Kiswahili. The average Kenyans have general knowledge and use of the English language. In schools, institutions of learning, government organizations, and most households throughout Kenya, English is used as the official language (Gains, 2011). On the other hand, Kiswahili, a Bantu language, is the national language most frequently spoken in Kenya. People from various linguistic geographic settings utilize Kiswahili as the language of communication in public settings (Gains, 2011). To avoid miscommunication or ambiguity of dialogue between participants and me, I requested a language interpreter to participate in the study.

Literacy Levels in Kenya. Literacy has been commonly recognized as a key component for ensuring uninterrupted growth in human advancement. Yet, in many parts of Africa, literacy continues to be the most neglected elements to education (World Bank, 2010). According to the National AIDS and STI Control Programme (NASCOP, 2012), the literacy rates in Kenya- 83% for females and 90% for males- are substantially higher than areas in sub-Saharan Africa. In addition, the rate of individuals completing primary schools in Kenya is approximately 80% as compared to 49% of individuals completing secondary school in Kenya (NASCOP, 2012). Needless to say, Kenya has the poor lowest literacy rate in adults, less than 27% (NASCOP, 2012). Since low levels of literacy rates

tend to be significantly higher in slum settlements and rural areas, specific health education targets are needed in areas where the status of formal education is poor. In my study, I may build an understanding as to whether or not poor language comprehension and literacy level leads to poorer health and behavior outcomes.

Sampling Strategy. I used purposive sampling as my sampling technique for this study. This strategy was used through the facilitation of a hospital staff, particularly a registered nurse, who has keen knowledge of the background and experience of the community. The Registered Nurse distributed flyers about the study to members in the community. My goal was to recruit at least ten participants for this study. Due to the intensity of the study of the particular, a sample size of eight, four males and four females is an acceptable size for a phenomenological study (Rouleau, Cote, & Cara, 2012). However, as a backup, I attempted to recruit an additional six participants in the event someone drops out of the study. It was my intention to utilize some of the participants to recruit other potential participants as a snowball effect, which will be typically sufficient to reach saturation in phenomenological study (Groenewald, 2010).

Interviewing. Prior to and during the interview process, participants were informed that a language interpreter will be available upon his or her request. The use of a language interpreter on site was intended to help prevent participants from feeling intimidated and has clarified any misperception for both the researcher and participant. It also provided me an opportunity to present an overall and clear reflection of participants' expression without unintentional misrepresentation of their discussion.

Interview sessions for each participant were voluntary and were required approximately 30 minutes to complete. The research project and participants' expectation was explained prior to the interview session. Also participants were required to provide informed recorded consent at the beginning of the interview. Interviews were conducted through either Skype internet or by telephone at the discretion of participants. Participants were expected to have access to and were expected to be escorted by an assigned healthcare worker to a designated room in the hospital where internet and computer access was accessible. Prior to the interviewing participants, a pilot run of an audio and video Skype interview was scheduled by a designated staff and me.

I asked each question and recorded all responses, both electronically and by taking handwritten notes on a copy of the questionnaire. Participants were asked three categories of questions around HIV prevention knowledge, HIV risk reduction attitudes, and cultural background information pertaining to sexual habits. An alphanumeric approach was used to identify participants using the first letter of the name "Walden" and the order of the interview, (i.e. W1, W2, and W3). Participants were asked to take a few minutes to review with me and revise any responses for accuracy and clarity after each interview has been completed.

Research Questions

The interview was grounded on purposive sampling. The interview consisted of 10 open-ended questions and follow-up questions to support the quality of collecting viable data and to understand the ethical dilemma impacting the barriers around the

reduction of HIV transmission. Eligible participants were recruited by the designated healthcare worker approved by the hospital's IRB committee, by circulating flyers around the vicinity of the clinic and through word of mouth. The healthcare worker was able to make an explicit choice, predicated by their own knowledge and by the study's eligibility criteria, about who should be recruited for the study (Prince-Inniss, 2010).

The interview study was guided by three research questions: 1. What are some of the primary barriers to preventing the spread of HIV among individuals who engage in concurrent sexual partnerships in Kenya?

2. What are the attitudes and knowledge of Kenyan males and females concerning HIV risk reduction techniques?
3. What role do cultural practices such as polygamy and gender inequality play in the current infection rate of married or cohabitating couples in Kenya?

Based upon the aforementioned questions, I developed an interview protocol that entailed semi-structured questions targeted at soliciting in-depth information to provide greater meaning around social and cultural barriers leading to HIV sexual risk in concurrent partnerships.

Data Collection and Analyzing

The interview guide was adapted from three sources: (a) The sexual desire inventory questionnaire was conducted by Spector, Carey, and Steinberg (1996). (b) The HIV knowledge questionnaire was conducted by Carey and Schroader (2002). (c) The sexual risk behavior questionnaire was conducted by Lundberg, Johansson, Okello,

Allebeck, and Thorson (2012). Permission for these guides were obtained and proper citation were used where applicable prior to submitting my IRB application to Walden University.

The data were intended to be collected through Skype interview or via telephone, consisting of open-ended questions. Prior to administering the questions, I provided an explanation to participants that every response obtained in the study will be upheld in the most rigorous confidential approach. Therefore, no names were divulged. As data were gathered and recorded, notes were written and coded confidentially. I used NVivo 10 to support the analysis and administration of the data. Data input into the computer was password protected to safeguard all information. NVivo 10 assisted me in establishing themes in qualitative data (QSR International, 2007).

One pivotal step in analyzing content is to establish the unit of analysis and to compile data that will ultimately tell a story (Garcia, Standlee, Bechkoff, & Cui, 2009). In this study, the units of analysis are the cultural and social beliefs of the population. I discovered patterns and themes that were recurrent and parallel to each response based upon the type of response given.

Measurements

According to Miller and Daly (2010), "Combining scale measure data with qualitative data can help address some concerns of unmet needs" (p. 15). In this research study, several factors were considered for using an ordinal measure to determine the knowledge, skills and attitudes associated with HIV risk behaviors.

Internal and External Validity

I reviewed the literature to ensure validation of the theory and to place it in a scholarly framework. To safeguard the internal validity of data being collected, the researcher utilized research logs and repeated back to participants on their responses to verify and validate qualitative analysis. These methods will also be assessed to ensure that information is clear.

Van Manen (2007) asserted that the value of phenomenological study is predicated on the lived experience of human beings and is responded to by the researcher as thoughtful, and carries out a formative affect. Validity of the outcomes of this study depends upon the accumulative impact of small concepts that brings together heavy volume of evidence. Van Manen (2007) further asserted that phenomenological research can also be validated in terms of whether the researcher's process and data collection methods will be adequately flexible to capture theme specific data and to ensure that an in-depth understanding of a complete picture has been attained (p.13).

I addressed the reliability issue of this study by including relevant questions in the questionnaire instrument that were considered purposeful measure of factors contributing to sexual HIV transmission among heterosexual couples in Kenya. These factors were conceptualized and established based on phenomenological design. Prior to implementing the interview with participants, the instrument of questions was subjected to the following validation procedures: First, the contents and applicability of questions were screened by a key informant, also a member of Nairobi residence who was provided with

a copy of these instruments. I contacted the key informant via telephone to explain the purpose of the research study, and then requested the informant to review and evaluate the instrument's design, contents, and application. Key informant included a registered nurse who works in the emergency department at the hospital.

In addition, to enhance the accuracy and reliability of the questionnaire instrument in Kenya, I provided oversight to the support of the key informant assisting in flyer distribution for recruiting participants into the project (Ellis, Adams, & Bochner, p. 35, 2011). Despite the fact that I conducted interviews via telephone to collect data, processes were put in place to ensure ethical concerns are addressed and confidentiality were ensued. The responses of interview questions were coded and assessed by the researcher to ensure that each question has been completed.

Ethical Considerations

Human rights are predicated on moral principles that are inherent to all individual and should be protected in research. When individuals accepted their participation in the study, I have taken into consideration the principle of safety and principle of respect for human dignity, which includes informed decision making. The right to making informed decisions by potential participants resulted in their right to contribute in the study without the risk of penalties or incurring domestic abuse. It was, therefore, necessary that I informed each participant of their right to withdraw from the study at any time without being penalized. Participants were ensured of confidentiality that any information they choose to provide were not publicly reported in a manner that identified the participant.

Ethical Issues Using Skype Interviewing

There are universally agreed issues concerning the interests of participants of a qualitative study in terms of protection of privacy and consequently the responsibilities of the researcher to handle personal information in a confidential manner (Zea, Aguilar-Pardo, Betancourt, Reisen, & Gonzales, 2014). In my study to explore the lived experience of married couples and cohabitating partners who may be engaging in HIV-risk sexual behaviors in Kenya, I offered participants an option to be interviewed through Skype internet or by telephone. Skype is encrypted digital software with controls that are safeguarded to prevent or minimize security risks (Hartman, 2011). Participants can join the Skype interview without identifying themselves.

To address the measures of ethical protection, I informed participants of his or her rights and was asked to provide informed recorded consent at the beginning of the interview. This process allowed participants to be guaranteed protection from any form of harm (Kaiser, 2009). I used recorded oral consent to ensure the rights of participant's confidentiality and a comfortable environment to respond honestly (Nappa, Fattori, Balduzzi, Dell-Amico, & Cavallaro, 2010).

Interviews were conducted where participants would be placed in an assigned exam room at the Mater Clinic. The clinic was registered on one Skype account and Internet connection for participants to use multiple accesses. This allowed participants to communicate confidentially and with minimum interference of breaches. The researcher was located in a small office where she can be visibly seen by her participants to ensure

their privacy. Since Skype is among the world's most widely used internet communication software for personal and professional use, confidentiality is relatively high, in which participants will be made aware of this (Laurikainen, 2010). Participants were also assured, through verbal agreement, that their identities shall remain confidential and that the data recorded shall be destroyed five years after the study has concluded. The interview involved participants to respond to prearranged open ended interview questions where they were given an allowance of three to five minutes to respond to each. Follow-up questions were also presented whenever an idea was not very clear. The questions were presented in an informal manner in a language and tone that participants understood clearly and feel adequately comfortable. Each participant's response was tape recorded separately. The interview began with confirmation of their consent and ended with thanking them for taking part in the study and reassuring them of their privacy. Again, participants were assured, through verbal recorded consent, which the information will not be disclosed to anyone and it will be destroyed five years after the study has been completed.

Once participants were done answering all of the questions and I had fulfilled my purpose, I thanked them for participating in the study and gave them a gift.

Summary

In this chapter, I included a description of the qualitative design and a phenomenological approach to be used in this study. The population consisted of men and women between the ages of 28 to 46 years old who are sexually active with at least

one or more sexual partners and reside in Nairobi, Kenya. Data collection and analysis facilitated the emergence of concepts and themes which is appropriate in understanding the phenomena of cultural and sexual practices. This study has completed all required elements of Walden University's institutional review board and prior approval from Mater Hospital's IRB in Kenya regarding privacy and confidentiality of participants, informed consent and their rights to voluntary participation.

In Chapter 4, I will provide an overview of demographics, discussed the recruitment process, describe data management and present the findings from data collected during the interview. I will also list the themes and subthemes emerged from the data. Finally, I will provide a general summary of the details outlined in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore the lived experiences of married couples and cohabitating partners who may be engaging in HIV-risk sexual behaviors in Nairobi, Kenya. While several studies have focused primarily on factors that contribute to an individual's risky behaviors, the current literature has not entirely accounted for secondary risk associated with a partner's behavior in addition to the socioeconomic contexts that affect an individual's sexual decision-making. It is expected that this study will help researchers and public health professionals better understand the cultural and socioeconomic influence of high-risk HIV sexual behaviors on the lives of Kenyan couples.

This chapter presents the findings acquired through telephone interviews with married and cohabitating adults between the ages of 28 to 46 years old who resides in Nairobi, Kenya. In the first section of this chapter, I describe the study participants and present an overview of the demographics. Then I offer details about the research tool, community partners, recruitment strategy, study settings, data collection and data management. Next, I discuss the data analysis and provide a synopsis of participants' responses. As I describe data analysis, I list the themes and subthemes that arose through analysis of the coding. The final section presents the qualitative results that were guided by three research questions:

1. What are some of the primary barriers to preventing the spread of HIV among

individuals who engage in concurrent sexual partnerships in Kenya?

2. What are the attitudes and knowledge of Kenyan males and females concerning HIV risk reduction techniques?
3. What role do cultural practices such as polygamy and gender inequality play in the current infection rate of married or cohabitating couples in Kenya?

As previously mentioned in Chapter 3, I used the interview protocol that consisted of 10 open-ended questions, probes, and additional follow-up questions. I used NVivo 10 software to analyze and code the data into themes that responded to the guiding questions on which this study was based. The use of NVivo software will be discussed later in the chapter. Seven major themes were divided and paired up into thirteen subthemes. Chapter 5 will address the interpretation of the findings.

Research Tools

I used a pre-existing interview guide consisting of 10 open-ended questions and follow up questions which were used as probes (Appendix E in English and Appendix F in Kiswahili). The first segment of the interview was used as an icebreaker to obtain general information around participant's level of education, age, marital status and area in which they live. All of the participants were very receptive in sharing this information. The second segment of the interview guide consisted of questions pertaining to: (a) Cultural beliefs, (b) Sexual risk and (2) HIV knowledge.

Community Partners

In order to recruit participants for the study, I collaborated with Mater Comprehensive Care Clinic which is centrally located in Nairobi, Kenya. I submitted an IRB application to the Mater Comprehensive Care Clinic's committee. Once approved, I emailed Mr. Joseph Vaughan, Mater Comprehensive Care Clinic, a letter of cooperation from an Interpreter (see Appendix G) reiterating the purpose of the study and describing my role and expectation as a researcher and Mater Comprehensive Care Clinic as the community partner.

After receiving approval from Mater Comprehensive Care Clinic, I submitted an application to Walden IRB committee for approval to conduct my study in Kenya. When the IRB approval was granted from Walden (IRB 02-19-15-0156682), I received a letter of cooperation from Mater Comprehensive Care Clinic committee to implement the study (See Appendix H). I began the recruitment process. I emailed Mr. Kituku a copy of the flyer, in both Kiswahili and English (See Appendix C in English & Appendix D in Kiswahili). Flyers were distributed in the Clinic and outside of the building. My contact information, consisting of name, email address and cell phone number, was listed on the flyer. Another recruitment strategy I used to increase participation was through the snowball method. During this process, each participant was able to identify and refer at least one person from within their social network. Through the course of both recruitment strategies, in less than 72 hours of recruitment, I received numerous text messages and email messages from perspective participants about the research study.

Study Setting

This study was expected to take place at Mater Comprehensive Care Clinic via Skype internet. However, all participants preferred to be interviewed in their home via cell phones. Participants who responded to the recruitment flyer resided in four residential estates ranging from low to middle income housing in Nairobi: Umoja, Greenfields, South B and Lucky Summer.

Umoja Estate

Most of the population in Umoja estate is individuals who have migrated from rural areas in an effort to attain employment in Nairobi. Within the estate, many of the families live in a standard bungalow design and multiple storied apartments positioned on various courts, with asphalt access roads and street lighting (Embakasi West Constituents, 2014). There are several key issues which impact the lives of individuals residing in Umoja estate: unemployment, substance and alcohol abuse, poor infrastructure, and poor quality of air and water (Embakasi West Constituents, 2014). Five participants were recruited and selected in the study from Umoja estate.

Greenfields Estate

Greenfields estate is one of the latest housing developments since the 1990s. Most of the developments are owned by residents occupying it. Many families live in two-story, three bedroom maisonettes. Omukubi (2011) points out that low income family are facing chronic unemployment and lack of socioeconomic security in Greenfields Estate. Two participants were recruited and selected into the study from Greenfields estate.

South B Estate

South B estate is mostly middle class housing and is recognized for its minibus, which is used for public transportation (Namatsi, 2014). South B estates also consist of the Capital Centre Mall. The demand for residency in South B is relatively high due to the close proximity and attraction of the Central Business District. Nearly half of the working population in this estate is employed in the Nairobi industrial area (Cities Alliance, 2014). Approximately 40% of the population is self-employed, while the remaining 10% are unemployed or housewives. Only one female participant was recruited and selected in the study from South B estate. However, this participant declined further involvement in the study. She was provided with a gift incentive for her participation.

Lucky Summer

Lucky Summer estate has a population of over 20,000 male and females (Kenya National Bureau of Statistics, 2013). The land was originally purchased by a group of farmers from Kiambu County. Most of Lucky Summer estate houses low income population. Housing developments ranges from single rooms to one family flats. An example of an apartment set up consists of an entrance small lobby with wash hand basin, living room, kitchen, and a shower room.

After flyers were circulated throughout the clinic and throughout various parts of Nairobi, participants reached out to me about the study via text messages, emails, and cell phone. I provided them with information about the study, explained the eligibility

criteria, and offered them two interview locations: (a) Participants who would like to be interviewed via telephone in the comfort of their home will receive a monetary gift of $16 USD after the interview has been completed. (b) Participants who would like to be interviewed via Skype video at Mater Comprehensive Care Clinic will receive a care package consisting of shampoo, conditioner, body wash, body lotion, toothpaste and toothbrush, at a value of $16 USD after the interview has been completed.

Most participants inquiring about the study showed a genuine interest in supporting the project. However, several participants were only interested in the monetary gift and requested that I increase the value amount being offered. As a result, I relied on my own intuition and decided not to include several potential participants into the study for fear of receiving misrepresented information during the interview. However, although four potential candidates have met the age requirements for the study, they were not married or in a cohabitating relationship for more than one year, which did not meet the eligibility criteria.

Participant Selection

I used purposeful sampling to identify participants who had keen insight to the phenomena being studied. Five female participants and four male participants, ranging from age 28 to 46, were eligible for the study. Five participants lived in Umoja, three participants lived in Greenfield, one participant lived in Lucky Summer, and one participant who dropped out of the study lived in South B. (see Table 1).

Table 1

Number of Participants Recruited from Four Estates in Nairobi

Division (Estates)	Number of Participants	Number of Males	Number of Females
Umoja	5	2	3
Green Field	3	1	2
South B (dropped out)	1	0	1
Lucky Summer	1	1	0

The participants and I had agreed on a specific date, time, and place for the interview to be conducted. Because of the 7-hour time difference between New York where I reside and Kenya where all of the participants reside, all of the interviews were conducted between 8am and 10am Eastern Standard Time which was equivalent to 3pm to 6pm eastern Africa time. Each participant was told about the purpose, design, and inclusion criteria of the study; I responded to questions about that were asked by participants such as when and where they can collect their cash incentives. I also informed participants that the purpose in completing this research project was to meet the requirements for attaining a doctoral degree from Walden University and to explore the lived experiences of married couples and cohabitating partners who may be engaging in HIV-risk sexual behaviors in Kenya.

Data Collection and Management

Twenty-three inquiries were screened for eligibility and a total of 10 participants were accepted for an initial interview, which was conducted between February 27, 2015 and May 31, 2015. Additional follow up questions were also conducted in May 2015 in order to delve deeper into participants' real life experiences. Unfortunately, one participant was lost to follow up. All interviews were conducted in the English language. At the participants' request, interview sessions took place in each of their homes and over the telephone as oppose to conducting interviews via use of Skype video service at Mater Comprehensive Care Clinic. Participants were informed of the purpose of the study followed by recording each participant's informed consent through audio tape. I dated and signed my name as the researcher, and recorded the ID number assigned for each respondent. Also, all participants were verbally informed of their assigned ID number. Following each interview, the audio recorded consent form, written notes, and the audio tape recorder of the transcriptions were then locked in a file drawer accessible only to the researcher. The interview sessions continued until adequate capacity of the data was attained. After the 9th interview was completed, no new information was obtained. Therefore, data collection had ended. One challenge I had faced during the interview process was difficulty understanding participants' response because of their heavy accent. Therefore, during each interview session, I repeated back each response of the participant to ensure that I understood what was being expressed. I had to use probes and follow-up questions so that participants would expand on their thoughts. The interview times ranged

from 30 to 45 minutes each. None of the participants reported emotional distress or fatigue during the interview. However, at the end of each interview, I made every effort to discuss and offer participants with a list of faith based organizations for spiritual counseling and STD clinics where additional HIV education and testing were offered (see Appendix I in English and Appendix J in Kiswahili). All interviews were audio recorded on a Galaxy Note Tablet, saved, and later transcribed onto written notes. I then converted the field notes into Microsoft Word document onto a private desktop computer. My computer is password protected and no one else has access to it. The data was then transferred onto NVivo 10 software package for qualitative analysis. I transcribed a file within the software package marked with each interview record using the participant's code name for identification purposes during the process in which data was analyzed.

Throughout the course of and after the conclusion of this research study, I reviewed the confidentiality clause outlined in the consent form to ensure that each participant understood their right to privacy and confidentiality. I followed the protocols and procedures of Walden University for the ethical management of research participants. For example, I provided each participant with thorough and detailed information about their rights to privacy and voluntary participation prior to their recorded informed consent. I further ensured adequate protection of participant's privacy by not discussing the study with anyone who worked at the Mater Comprehensive Care Clinic or in public areas where I reside and work. In addition, each participant was assigned an identification code known only to the researcher.

This study was strictly voluntary and compensation was given to all participants. In addition, I provided each participant details about the risks and benefits of participating in this interview study. Minimal risks were involved. Participants who may have experienced weariness did not verbalize this during or after the interview session.

Data Analysis

In section one, I presented the essential demographic of participants by gender and age. I intended to interview an equal number of male and female participants; however, females were more receptive in participating in the study than their male counterparts. I also described how themes and subthemes were categorized in this section. The last part of this section will include quotes that focused on this study's research questions.

Coding Analysis

I used NVivo 10 software to code the data into themes ensuring that each research question was addressed. After reviewing the transcripts several times for accurate coding and identifying themes, I linked participants' responses to the interview questions. Next, I gathered all of the data and grouped it with the interview questions to develop an inductive coding analysis. The data seem to have lacked sufficient enriched information from participants. Since I had difficulty in fully understanding some of the wording of participants, I had to carefully review the audiotaped recordings of the interview a second time to ensure that I had captured information I may have missed initially. I then included these additional responses to the written transcript and uploaded the transcripts back into

NVivo software to update the themes and subthemes. Next, after following the instructions provided from NVivo's tutorial session and closely reviewing the text in each transcript, categories were created and coded. I had to organize the subcategories that tied in with each of the research questions. The subcategories were extremely helpful in allowing me to later evaluate between each participant's responses about their attitudes and knowledge in engaging in high risk sexual behaviors and understanding the barriers that limit their ability to change these behaviors.

Research Findings

The findings in the study are presented in this section. This section is divided into three sections. The first category of information contains general demographic information about each participant such as age, education, estate in which they reside and marital status. The next category of information contains information about participants' cultural beliefs, sexual risk and HIV knowledge. The last section correlates the interview answers to all three research questions. Based upon the research findings, several themes emerged from the analysis of my transcript which enhanced the validity of information obtained.

Demographic Data

In the first section of the interview, I spent approximately 5 minutes to capture general information about each participant. Five females and four males participated in telephone interviews. The questions were open-ended followed by probes used for follow

up questions. In effort to maintain confidentiality of participants, I did not ask any unique identifying information such as home address or date of birth (see Table 2).

Table 2

Demographics of Participants

Name	Jane	Don	Kar	Bridget	Willie	Joseph	Margaret	Kenny	Annette
(Age)	(46)	(34)	(28)	(36)	(30)	(38)	(32)	(41)	(30)
Marital Status	M	S	S	S	S	M	S	M	S
Education Level	A.A Degree	Assoc. Degree	HS Grad	HS Grad	HS Grad	HS Dropout	Some College	A.A. Degree	Some college
No. of Children	1	—	1	1	Partner is Pregnant	3	1	3	—

All nine participants who completed the study were born and raised in Nairobi. Participant's ages ranged from 28 to 46 years of age with a mean age of 35.6. Two participants were married between 12–17 years. One participant had been married twice. His most recent marriage union commenced over one year ago. The remaining six participants were cohabitating with their intimate partners for more than eighteen months. Participant's level of education varied: one did not complete high school, four completed high school, two had college experience but did not complete college, and three obtained associate degrees. Finally, the number of children for each participant varied from no children (*n=2*), pregnancy (*n=1*), one child (*n=3*) and three children (*n=3*).

Themes

Seven major themes emerged from the responses of my participants: financial dependency, economic inequality, task and assignments, beliefs, risk factors, marriages,

and aggression. In addition, thirteen subthemes emerged: survival skill, faithfulness and commitment, benefits of a local clinic, distribution and power, values from home, family and marriage principles, sexual behavior, motivation for care, protection, helping your mate, healthy decision making, morals and control.

Table 3

Major Themes with Subthemes

Theme	Subtheme
Financial dependency	*Survival skills, faithfulness & commitment*
Economic inequality	*Benefits of a local clinic, distribution of power*
Task and assignments	*Values from home*
Beliefs	*Family and marriage principles*
Risk factors	*Sexual behavior, motivation for care, protection, helping your mate, health decision making*
Marriages	*Morals*
Aggression	*Control*

As I analyzed each response, I began to look for consistency in connection to the interview questions, probes and follow ups. Gale, Heath, Cameron, Rashid and Redwood (2013) posits that in order to search for logical patterns and themes, the data must generate narratives that are suitable to shed light on the existing phenomenon.

Research Questions

The overarching goal was to understand the real life experiences of nine participants regarding their HIV risk through cultural lifestyles and socioeconomic conditions. Ten interview questions and additional follow up questions were used to elicit participants' responses to gain their overall perspectives and experiences on sexual risk. These responses were used to support my analysis.

Research Question 1

What are some of the primary barriers to preventing the spread of HIV among individuals who engage in concurrent sexual partnerships in Kenya?

In order to answer this research question, I asked open-ended questions guide. As a method to determine a criterion of HIV risk around social and family environments, I asked participants to describe their perceptions of family values and polygamous lifestyles.

Theme 1: Financial dependency. The first theme that emerged from these questions was financial dependency.

Subtheme 1: Survival skill. Participants were asked to explain their views on how men and women use sex to their advantage. Seven out of nine participants believed that prostitutes, married, and single women use sex for money and as a strategy to provide food and shelter for their families.

> Joseph: They [single women] have sex with married men as a way to support them with cash benefits.

Willie: These women [young prostitutes] are desperate and need food.

Kenny: With women [all types], they use sex to get money.

Margaret: Prostitutes flirt and use it [sex] to their advantage to eat.

Karen: These women (single women) are really desperate to have sex with different men to gain money for drugs and to support their children.

Brigette: Sex is a source of income.

Brigette claims that the economy in Kenya is declining and the unemployment rate is increasing. She also states that many people are getting laid off work and women are resulting to caregiver jobs or remaining at home with the children. This places women in a vulnerable state of financial dependency upon their male significant others to financially support them or prostitute their bodies in exchange for food or cash. Brigette claims that, men, on the other hand, are obtaining odd jobs such as selling goods out in the street or working part time.

Willie believes that it is too risky for men to engage in unprotected sexual intercourse with these women who may "have HIV and infect them all." Moreover, male participants feel that both married women and single women use sex as a basic survival skill. Three of the male participants shared their views on married men who cheat on their wives and described how these men in general perceive women who prostitute themselves: They have "no respect" for such women (Donald), they see them as "sluts and whores" (Joseph), and they treat these women "like trash" (Willie).

In a follow-up question, I asked participants to identify what sex means in their own lives. All of the male participants described their sexual experience using a language of intimacy: It is "a way that I communicate" (Joseph) and it is "special when I can share it with one person" (Willie). They reported that sex is a way to express their affection and vulnerable side.

Three out of five of the women participants described their sex life as a responsibility, an obligation or a trade-off. The man provides finances for the home while the woman rewards him with sex to keep him from having sex with other women.

Jane: In my marriage, my husband provides for the family with finances and then he expects to have sex.

Brigette: I was afraid that my son and I would not be able to eat if I left him.

Margaret: I avoid the fights and give in [to sex] at any time.

Annette: Sometimes he convinces me but sometimes it doesn't work.

These participants believe that sex is not also valuable in their relationship, but it balances out pleasing their mates while their mates continue to serve as a provision to the family's basic needs of food and shelter.

Subtheme 2: Faithfulness and commitment. Participants were asked if they had ever had sexual encounters with more than one partner at the same time and if they have had any sexual encounters for only one night.

Despite the fact two of the female participants' male sex partners cheated on them multiple times, these women tend to remain faithful in their relationship to their male

sexual partners as they felt that it was necessary to uphold the standards of Christianity. However, this was not a factor for men.

Jane: As a Christian, I do not take fidelity for granted no matter what my husband chooses to do outside of the marriage.

Margaret: I am a Christian and I don't believe in cheating.

Jane reported that since being brought up in a Christian home, she was taught that it was wrong to cheat on her mate. Jane also reported that her husband was brought up as a Muslim and having sex with multiple women is acceptable by his family upbringings. Jane was not very pleased with her husband's infidelity. However, she chooses to stay in her marriage for religious reasons and to maintain financial provision from her husband.

Margaret attends Bible school and has been taught that cheating is wrong. Margaret states that she is prepared to "use condoms" to avoid getting a sexually transmitted disease, especially HIV, if she ever finds out that her fiancé' has been cheating on her. Her second alternative in dealing with infidelity is to leave her fiancé' where she and her mother will return home to be with the rest of her family.

Two of the women felt that they would never cheat on their mates. However, their mates did admit to engaging in one night stands with unknown female sexual partners.

Annette: I didn't even know that he slept with another woman but word got around and he admitted it to me when I confronted him.

Brigette: I didn't realize it until recently I caught him in a lie.

Karen: Dealing with different women...I didn't ask for that!

These female participants were surprisingly unaware that their male sexual partners were unfaithful to them. They also expressed feelings of shame and betrayal. However, when I asked these women how their male partners would feel if he found out that she cheated on him, they felt strongly that their male partners would react with violence.

Karen: He would kill me.

Brigette: We would fight.

Annette: He would probably hurt me [physically].

Most of the male participants felt stated that they cheated with another woman at least twice, either because they were under the influence of alcohol or to fulfill their sexual desires. None of these men reported the use of condoms consistently while engaging in solicited sex outside of their marriage or cohabitating unions.

Kenny: I did it three times with another lady.

Willie: Whenever I wanted to have sex, I would go to the bar and pick up women.

Joseph: We would hook up and date for about 2 weeks or so before we had sex.

Theme 2: Economic inequality. The second theme emerged from the interview questions was economic inequality.

Subtheme 1: Benefits of a local clinic. Participants were asked how and where they obtained condoms. All of the male participants were aware that their local clinics provide condoms to anyone free of charge. Although condoms are made available free of charge, two of the male participants expressed some resistance about using condoms consistently

in their current relationship. Kenny says, “Although I do not like to use condoms, I know where to get it for free, at the clinic.” Later in the interview session, Kenny admitted to inconsistent use of condoms with his wife because it “messes up the mood”. When Joseph was asked where he gets his condoms from, he replied, “I get them from my friend down the block.” Joseph also revealed that his friend obtained free condoms at the clinic. Four out of five women participants felt that part of the responsibility of their male sexual partners was to pick up condoms at their local clinics.

> Annette: He [boyfriend] would take care of paying expenses...condoms, everything.
>
> Brigette: My boyfriend picks up condoms at the clinic at no cost to him.
>
> Karen: My boyfriend always picks up condoms for us at the clinic every other week.
>
> Margaret: My fiancé’ usually get it (condoms) from the clinic

Jane was the only female participant who initiated picking up condoms since her husband refuses to use condoms, remains unfaithful to her and because condoms are seen as a “taboo” in the Muslim community, as she was told by her husband.

Subtheme 2: Distribution and power. Participants were asked who is responsible for managing the finances in their household. All of the male participants assumed the responsibility of the man in the house to handle bills for the family and provide for the basic needs of the home. All of the female participants acquiesced that their male sex partners’ role is to manage the finances. Financial management gives the man command

over their wives decision to have sex, to use condoms, purchase condoms and any household decisions made as implicated by all participants in this study.

Annette: "He would take care of everything and manage the money

Brigette: "He is the breadwinner or the family."

Margaret: "He manages the finances."

Karen: "He handles the money and provides for us."

Joseph: "I manage the finances and the bills."

Willie: "I bring in the money."

Donald: I'm still handling the little finances we have."

Kenny: "It is my job to handle the cash."

Jane: "He is in charge of the home and manages the cash."

Insufficient time did not allow me to follow up on how the female participants truly felt about their husbands being in complete control of the household finances. Therefore, I was unable to ascertain any strategies they might have developed to manage finances.

Theme 3: Task and assignments. The theme emerged from this question was gender responsibility.

Subtheme 1: Values from home. Participants were asked to explain their role as a male or female in the household. All of the participants shared common beliefs that females in the home are responsible for cooking, cleaning the house and clothes, and caring for the children. Male responsibilities, in the household, on the other hand, are to manage the

finances, protect the family, and decide in using condoms. These roles have been passed down and accepted from participants' grandparents down to their parents. Five of the participants were able to express why they accept the responsibility in cooking and cleaning for their male partners. Many of these participants shared that these attributes were taught in their parent's home.

> Jane: I also have to take care of my husband since he provides the money...This is what I was taught by my mother as a little girl.
>
> Annette: I learned how to do laundry, cook and clean. This teaches me how to take care of my family when I have a family as my mother taught me.
>
> Willie: My job is to provide money for my family as I witnessed my father do when I was a child.
>
> Joseph: I must take care of my family financially like my grandfather did for his family and my father did for his family.
>
> Donald: I learned from my father to take care of my family and provide finances

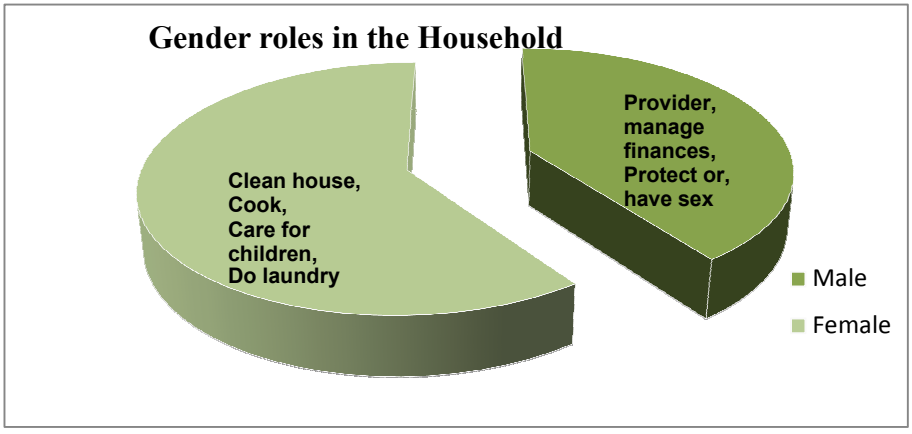

Figure 1. Gender roles in the household: tasks and assignments.

Theme 4: Beliefs. The theme that emerged from this question was beliefs.

Subtheme 1: family and marriage principles. One aspect in understanding cultural norms and sexual acceptance is by examining what participants believe to be valuable in marriages and ways in preventing HIV. Participants were asked what values they grew up with in regards to family and marriage. All five female participants had their own personal views about marriage and family based on what they were taught at home and through religious experiences.

> Jane: I learned at home and church that marriage is a commitment and you have to be faithful.
>
> Karen: My father was out of the house half the time. He had other women on the side and also my mother didn't seem to mind.
>
> Brigette: When I was growing up, my parents' marriage was sacred. There was trust, worth and unity in a marriage.
>
> Margaret: There is marriage before sex. That's what our church family taught us.
>
> Annette: Grow your family with love and allow God to order your steps, especially with life changing decisions. That's what the Bible taught me.

All of the male participants were taught about good family and marriage principles by watching their own parents endure in their marriages.

> Willie: You have to work it out because you made a vow together. My parents taught me this.
>
> Donald: No matter what happened in their marriage, my parents stayed together

Kenny: My father and mother were married for a long time and stayed faithful to each other.

Joseph: Be accepting and tolerant to each other. My father and mother showed me this in their marriage to each other.

Although they observed positive interaction from their parents' relationship, these men did not follow certain attributes of endurance, tolerance, acceptance and faithfulness as oppose to the women participants who acquired and followed these attributes.

Research Question 2:

What are the attitudes and knowledge of Kenyan males and females concerning HIV risk reduction techniques?

Theme 5: Risk factors. The theme emerged from this discussion was risk factors.

Subtheme 1 Sexual behavior. Participants were asked what ways can a person becomes infected with HIV. Eight participants were able to provide general knowledge about ways people can get infected with HIV.

Jane: By sexual intercourse...and also sharing a needle.

Annette: You can get infected through blood transfusion.

Willie: If someone is sick with HIV and you have sex with them, then you will get infected.

Joseph: An infected person's blood or semen can be passed on to another uninfected person's blood.

Margaret: An infected mother can pass it on to her baby through breast milk.

Donald: A person can get HIV if they are pricked by an infected needle.

Kenny: You can get infected by another person when having sex without protection.

Brigette: Unprotected sex and through blood transfusion.

Karen was able to identify ways someone can get infected with HIV. However, she referred to the word "AIDS" rather than HIV.

Karen: People can get AIDS by having sexual intercourse and sharing needles.

To further understand if participants had a clear understanding of the infection, I used a probe to ask participants, "What is the difference between HIV and AIDS?"

Jane: HIV is caused by a virus and AIDS is when a person's immune system breaks down.

Donald: HIV is a virus. AIDS is a disease that comes from HIV.

Brigette: HIV is a virus found in your blood. AIDS is a disease discovered by a doctor.

Annette: It is a virus (HIV) and AIDS is when…certain illnesses take over your body like pneumonia or a sexually transmitted disease.

Kenny: HIV is transmitted from one person to another. AIDS is a condition.

Joseph: HIV is present in the blood. AIDS is when your immune system weakens.

Two participants were not able to distinguish the difference between HIV and AIDS. The terms HIV and AIDS were somewhat convoluted for Karen and Willie to

describe since both terms define the disease similarly. Yet, Karen and Willie clearly understood that AIDS is the advance stage of HIV.

Karen: People who get other infections like STD or pneumonia have AIDS.

Willie: People who are really sick have AIDS.

Subtheme 2: Motivation for care. Participants were asked if they have ever been tested for HIV. Six participants have never taken an HIV test before. Three participants felt motivated to taking an HIV test either as part of their annual physical examination or because of spousal infidelity.

Thomas: My wife and I took an HIV test when she found out that I cheated on her the second time.

Jane: I took an HIV test after I first found out that my husband was cheating.

Donald: We try to get tested every year during our yearly visit to the doctor.

Two female participants managed to stay connected to medical care and engaged in previous conversations with their medical provider. As a result, they have contemplated in taking an HIV test at their local clinic during a routine examination.

Annette: My gynecological doctor suggested that I get an HIV test every year as a routine.

Karen: I will be getting tested for HIV next month as my doctor suggested.

One male participant has thoughts about accessing HIV testing as a preventive measure and to be informed of his HIV status to ease his consciousness of the reality that HIV exists.

Willie: I would probably get one during my annual checkup just to make sure that I am ok.

Subtheme 3: Protection. Participants were asked what types of risk reduction activities they use to keep themselves from being infected with HIV. Five participants considered condoms as the safest barrier to protect them from getting infected with HIV.

Annette: Use condoms until we are married.

Joseph: Use condoms.

Margaret: Don't have sex or just use condoms.

Donald: Using condoms to protect me from infected blood.

Brigette: Keep one partner and use protection (condoms).

One participant felt that partial protection of HIV transmission such as male circumcision is a protective barrier for him to reduce his risk of getting infected with HIV.

Kenny: I am circumcised which protects me from getting HIV. This is what the government says.

One female participant expressed her belief that divine intervention would serve as an effective risk reduction technique. However, in her interview session, Jane reported that her husband continues to cheat on her. Yet because of his upbringing as a Muslim, condom use is not being practiced consistently in her home.

Jane: I pray to God that he keeps my husband clean and me from ever getting infected.

Two participants who are single but currently in an intimate relationship reported that the best and safest way they can be sure that they are not at risk for HIV infection is to remain faithful to one sex partner.

Willie: I am with one partner and be faithful.

Karen: Being abstinent if I was alone. But I am with just only my boyfriend.

The Abstinence, Be faithful, use Condoms (ABC) model of HIV prevention has played a large role in reducing HIV risk since the late 1980s. Willie and Karen preferred using the ABC model.

Subtheme 4: Helping your mate. Participants were asked how they would react if they found out that their sexual partners were HIV positive. All of the women participants stated that they would remain in their relationship with their HIV positive sex partners. However, they shared their reservations about having sex with their male partners at all or with condoms.

Jane: I would stay and take care of him because it is obvious that I love him unconditionally. But I would beg him to use a condom every time we have sex.

Brigette: He would need me to help him and I would try to help him get through the transition of being positive. But no sex.

Karen: I would not engage in sex with him but I would help him.

Annette: I would probably stay and help because I care very deeply for him. I would have to be very careful having sex with him so I don't get infected.

Margaret: Take care of him but protect myself from coming in contact with his blood and also use condoms.

Three of the male participants expressed their feelings of betrayal and lack of trust in staying with their sexual partners after discovering that she was HIV positive.

Joseph: I would treat her like a stranger because my thought is she betrayed me!

Donald: It only takes one time to get infected with HIV. I would leave her.

Kenny: This would really affect our marriage. I don't know maybe I would leave her.

Subtheme 5: Health decision making. Participants were asked to explain their belief about condom use?" Three of the male participants "prefers not to use condoms" due to feelings of discomfort and also feels that using condoms implicates a "lack of trust somewhere". However, when asked how infidelity would play a role in their decision to use condoms with their female sex partners, all of the male participants were strongly supported the use of condoms as a way of protecting themselves from HIV infection.

Kenny: I would be more conscious and use it (condoms) all the time.

Willie: I don't like the way it feels but my wife and I would have to use it.

Donald: If I found out she was cheating on me, then I would use protection (condoms).

Joseph: Everyday

Female participants explained that they would prefer to use condoms consistently with their male sexual partners in order to prevent them from being infected with HIV or

other sexually transmitted infections. Female participants also reported that their male sexual partners were adamant about using condoms because of the discomfort in the way it feels or due to their religious beliefs that condoms are a "taboo". Instead, female participants reported that their male partners prefer using the rhythm technique or oral contraceptives such as birth control pills. In these instances, all five female participants reported sole financial dependence on their male sexual partners to provide for their families, resulting in these females to feel powerless to making informed decision on condom use.

> Jane: I talk to him about it a lot but he ignores me.
>
> Annette: I don't have a choice.
>
> Margaret: He would probably stop giving me spending money if I make him use condoms.
>
> Karen: I want to use condoms but we do not use it all the time because he said it makes him itch.
>
> Brigette: I asked him all the time. Since we are Christians and he said he didn't believe we needed to use it.

Research Question 3

What role do cultural practices such as polygamy and gender inequality play in the current infection rate of married or cohabitating couples in Kenya?

Theme 6: Marriage. The major theme that emerged from interview questions 2 and 7 was marriage.

Subtheme 1: Morals. Participants were asked to explain their thoughts about polygamy. All of the participants expressed a distaste of polygamous marriages due to moral or religious beliefs.

Kenny: I don't like it! I only like to have one wife. Polygamy has to deal with more than one wife. I cannot afford it anyway.

Annette: It's dangerous because if one person has HIV, then it could spread to the other spouses.

Willie: I don't think people should do it anymore because of the increase risk of HIV and men cheating on all of their wives.

Joseph: It doesn't benefit me emotionally to give myself to more than one woman.

Margaret: Polygamous marriages are just for lust. It could bring in diseases like HIV and you won't trust your spouse anymore.

Donald: It is no good because it means that some man who has a wife is permitted to sleep with other women.

Karen: I don't like polygamy because Christians like me believes that marriage should be for two people, a man and a woman.

Brigette: But for Christians, polygamy is not allowed for us to be involved in.

Jane: I do not believe in polygamy because the Bible tells us a woman and man shall leave their parents' home and the two shall become one, not three or more.

All except one respondent reported that their grandparent and great grandparents were involved in polygamous marriages. Participants relied on what was told to them

about their ancestor involvement in polygamous unions. They did not have adequate information to share on how money was divided among the families or if any of the wives were favored over another. Many of the participants remembered what was told to them about their grandfathers and their wives living arrangements:

Jane: They all lived in the same home with my grandmother.

Annette: They lived in separate homes.

Willie: Two of his wives lived in the same house and the main wife (my grandmother) lived in her own dwelling.

Margaret: Each of their wives lived in separate homes with their children.

Donald: My grandfather had all three of his wives live in his ½ acre land.

Karen: Each of their wives lived together with their children.

Brigette: My grandfather had three wives living in the same home.

Kenny: They had more than one wife and they lived in different homes.

Theme 7: Aggression. The major theme that emerged from this discussion was aggression.

Subtheme 1: Control. Female participants were asked if they ever been forced to have sex with their past or current partners. Three out of five female participants had experienced being forced to have sex with their male sexual partners. They had no sense of power or control over making a decision to accept or decline sexual intercourse with their male partners.

Jane: He only cares about himself. When I say no to sex, then I want him to understand that I don't want it.

Margaret: He would beat me for no reason and then force me to have sex.

Karen: I would just take it (have sex) and don't complain.

Ultimately, all of the women had general knowledge of community resources that can help them overcome abusive and sexually violent relationships. Participants were able to identify several community resources ranging from a national hotline, pastors in churches, and local clinics.

Two of the male participants in this study also used their dominance and money to control their female partners' decision over having sex or not.

Kenny: It is my wife's duty to give me sex as I give her money and other things that she needs.

Willie: It is a wife's or a girlfriend's duty to give up sex to her mate, especially my girlfriend when I provide for her financially.

Male participants were asked if they ever forced their women to have sex. Most of them denied using force. However, in a follow up discussion, I asked the male participants to define what forced sex meant. Their responses ranged from "when you rape someone" to "taking her rights away". Kenny and Willie also reported that it was acceptable to persuade their female partners to engage in sexual intercourse even when these women say no to sexual activities.

Kenny: My wife didn't want to have sex and I needed to persuade her to have sex with me.

Willie: It is a matter of getting her in the mood to have sex even when she doesn't want to.

Evidence of Quality

In this section, I will discuss the ability for this study to be trustworthy and credible to past research in the field of sexual behaviors and gender inequality depended upon quality of data collected, data analyzed and the authentication of data. Qualitative phenomenological studies are the cornerstone of knowledge about human phenomena (Morrissey & Higgs, 2006, p.162). In an effort to guarantee a flexible, credible and dependable study, specific protocols and procedures were implemented during data collection and data analysis

Flexibility

In this qualitative study, I provided a positive environment for participants to respond to three research questions. Prior to and during each session, participants were provided an opportunity to choose refuse or accept contributing to the research. This process was necessary to ensure that the data collection phase involved only those who were genuinely cooperative to offer data freely and without coercion.

Credibility

The credibility of this study implies the idea of internal consistency. The core issue of internal consistency depended upon how I was able to ensure rigor in the

research process and how information was communicated to each participant (Lincoln & Guba, 2000) through data triangulation. Ten questions and probes were consistently used to collect data in this study to elicit responses from participants who lived in various estates throughout Nairobi. This process allowed me to depict direct quotes from the participants to support reliable findings of their experiences.

Dependability

In this study, the principle of dependability evolves around the core issue that the manner in which this study was conducted and its consistency across time, researchers, and analysis techniques (Gasson, 2004). The use of an audio recorded tablet enabled me to retrieve a reliable and explicit account of the information collected. The audio recorded tablet allows me to retain the data for up to five years in the event I need to refer back to the interview sessions at a later time. Prior to the start of the interview sessions, each participant recorded his or her consent to be audio taped.

Summary

The purpose of this qualitative study was to explore the lived experience of these individuals who may be engaging in HIV-risk sexual behaviors in Kenya. This chapter provided detailed results of the data collected. Telephone interviews in this study offer an in-depth insight of the lived experience of how people behave sexually and their perception around HIV risk. The first research question explored values within the family and marriage system. Each of the participants in the study had a clear understanding of self-worth and learned beliefs within these systems.

The second research question addressed participants' level of HIV knowledge and understanding their risk in acquiring HIV infection. All of the participants had a general understanding of how HIV is transmitted and identified some of the risk factors of HIV. Most of the participants were able to provide a distinction between HIV and AIDS. In addition, this question investigated the participants' reaction to if their sexual partners were HIV positive. All of the females have agreed to remain faithful to their sexual partners. However, they feared HIV transmission and expressed the need to protect themselves by using condoms consistently during sex. The majority of male participants expressed their need to explore why their female sexual partners were unfaithful and found it difficult to remain in a sexual relationship with them.

One discovery in the third research question was to understand the roles and expectation for males and females living in the household. All of the female participants shared common roles such as household cleaning, caring for their children, cooking for their families and being available to have sex with their mates. All of the male participants agreed to the same standards in managing and providing finances, and protecting their family. The issue of forced sex and community support was also identified by three of the female participant in this study. All of the male participants clearly understood what forced sex meant and denied the use of force to get women to participate in sexual activities. Lastly, participants also provided detailed insight to their view on polygamous unions. The majority of participants expressed no interest in continuing polygamous unions that were passed down from their grandfathers. In

addition, participants were able to identify their grandfather's level of HIV risk as high as a result in his sexual encounters without use of condoms with multiple sex partners.

The last section in this chapter revealed the intricacies of evidence of data quality. The first measure to ensure quality was a process for credibility. To ensure flexibility, all participants were allowed to engage in discussion and to disclose sensitive information openly and freely without any adverse reaction from the researcher. Secondly, to ensure the quality of dependability, interviews were recorded through audio taped and granted the researcher permission to do so. Audio tape recordings of the interviews ensured that the information provided by each participant was captured accurately during the interview. To ensure credibility in my study, data triangulation was used to ensure the validity of data collected for each research question.

Chapter 5 provides a discussion of the analysis, theoretical consideration, implication for social change, reflection on researcher's experience, dissemination of the findings, recommendation for further study and conclusion of the study.

Chapter 5: Discussion, conclusion and recommendations

Introduction

The purpose of this qualitative study was to explore the lived experiences of married couples and cohabitating partners who may be engaging in HIV-risk sexual behaviors in Nairobi, Kenya. Condom use and the risk perception to HIV among these unions were low. In addition, the unequal distribution of power and gender relation governs the inconsistency of condom use. The use of phenomenological approach was to provide an understanding of individuals who have lived the experience and to communicate these experiences to the outside world (Mapp, 2008).

One method to reduce the likelihood of HIV transmission among these unions is to increase the risk-perception of male and females in these unions. Individuals who consider themselves to be at low risk of HIV infection can also be taught about how the infection of one person can spread the virus to others within their social and sexual networks. Creating open discussions around HIV prevention can also be carried out through couples and individual sessions at local clinics.

Interviews were guided by 3 research questions which this study was based on:

Research Question 1: What are some of the primary barriers to preventing the spread of HIV among individuals who engage in concurrent sexual partnerships in Kenya?

Research Question 2: What are the attitudes and knowledge of Kenyan males and females concerning HIV risk reduction techniques?

Research Question 3: What role does cultural practices such as polygamy and gender inequality play in the current infection rate of married or cohabitating couples in Kenya?

Telephone interviews were the preferred method of data collection, and 9 participants were the final interviewees after a process of sampling and elimination to achieve desired sample size and quality. The interviews were audio consent and to ensure accuracy in the verbatim transcription. I ensured that the data were managed through NVivo10 on a password-protected computer. For data analysis, I used an inductive coding method. Inductive coding allowed me to extract meaningful themes from participant's responses. The data were recorded, transcribed, and then analyzed.

This chapter includes the interpretation of the findings based on the major themes found in Chapter 4. Next, I will discuss the conceptual framework that served as a focal point to the study. Finally, I will provide the limitations of the study, recommendations for further research, social change implications, and my reflection as a researcher conducting the dissertation study.

Demographics

The demographics of participants entailed information around their education level, marital status, age, and number of children. Participants' education level ranged from less than high school to completing a 2-year degree. Five (5) participants were unemployed. Three (3) participants were married and six (6) of participants had been involved in one relationship for more than 18 months. The ages of the participants ranged

from 28-46 years old. Finally, the number of children of the participants ranged from zero to three.

Housing

All of the participants resided in four estates in Nairobi, Kenya: Umoja, Greenfields, South B and Lucky Summer. Based upon the information collected, two males and three female participants residing in Umoja lived with two or more relatives and lived in a Bungalow design. One male and two female participants residing in Greenfields lived with their sexual partners and children in a small one family home. One female participant who was dropped out of the study during the follow up interview lived in South B estates with her spouse and three children in a two story, three bedroom maisonettes. One male participant lived in Lucky Summer with his wife and three children. All of the participants lived within close proximity of their siblings and parents.

Interpretation of Findings

The three research questions described in detail cultural practices and their effects on the current rate of infections in couples in Kenya: attitudes and knowledge of Kenyans in respect to HIV infection risk reduction strategies: and the primary barriers towards stopping the prevalence of HIV among individuals with multiple sexual partners in Kenya.

From the results**,** seven main themes were developed; financial dependency, economic inequality, task and assignments, beliefs, risk factors, marriages and aggression. Various subthemes were also discovered and responses were elicited from the

respondents during the interviews. Gender and power were the main characteristics behind the themes, and how they eventually led to heightened risk of infection. Although gender imbalance appeared to limit the capacity for women to negotiate self-advocacy of their sexual and economic freedom of choice, both male and female participants in the study accepted the subordinate position that gender power interactions placed on women in society (Wyrod, 2011). In addition, consistent messages about HIV prevention such as condom use were mostly voiced by the female participants as a way of protecting themselves from sexually transmitted infections including HIV infection.

Research Question 1

Financial dependency

Based on the analysis of the responses of the men and women participants in this in-depth interview, all of the women participants solely relied on their male sex partners to provide financial support. These women who lacked a stable job and have family responsibilities believed that sex is a "trade-off", since their male partners provide finances and settle bills. Despite of their suspicion about their male partner's infidelity, these women admitted that financial ties of dependency, unequal gender relations and their religious beliefs hinder the consistent use of condoms, and in some cases, no condom use at all.

All of the male participants in the study perceived sexuality in a negative context where the solicitation of sex for money and drugs or through forced sex was unacceptable and a strong indicator of HIV risk. One study pointed out that the spread of HIV was

found extensively among 66% of prostitutes in low socioeconomic communities (Chege, 2012). This was also associated with possible high levels of alcohol consumption and low education attainment. On the other hand, female participants in the study believed that sex and money was a power struggle for women who prostitute. Participants believed that some of these women prostitute because they were desperately in need of food and shelter. Women participants also viewed positive sexual encounters of married people for the purposes of procreation and obligation to their male sexual partners. Bledsoe (1990) pointed out that in African marriages, sexual intercourse plays an integral role in regulating fertility. Women who fear in losing their male sexual partners were less likely to use condoms.

Due to time constraints, female participants in this study were unable to provide sufficient information about the impact on financial power can place on their relationship. The CDC (2015) defines the use of sex for income or non-monetary items such as food, shelter or drugs as survival. Because of their financial dependency on men and social vulnerabilities, literature found that women in low economic status were more susceptible and less confident to negotiate safer sex (Gysels, Pool, & Nnalusibai, 2002; Scorgie, Chersich, Ntaganira, Gerbase, Lule, & Lo, 2012). This kind of survival can increase the individual's risk or can pass HIV infection on to another person while engaging in unsafe sexual practices. None of the participants in this study reported consistent condom use with their sexual partners. However, four of the women participant admitted that their

long term sex partners were unfaithful to them whereas three of the male participants admitted to cheating on their long term sex partners

Economic inequality

There is a strong correlation between economic inequality and the prevalence of HIV in Nairobi, Kenya. Since the early 1990s, hundreds of articles were published on the topics of economic inequality and health conditions throughout the continent of Africa. These articles suggest that socio economic factors played a significant role of HIV infection throughout several countries in sub-Saharan Africa (Durevall & Lindsay, 2012; Fox, 2010). Based upon the report of participants, unstable economic conditions and financial resources were spread thinly throughout the four estates discussed in this study. In gathering an understanding of economic inequality, patterns of unequal sexual decision making and financial power over women were discovered in this study. Gender and economic inequality were relationships to HIV risk due to risky sexual behavior and intimate partner violence which are most common in unequal societies. Participants pointed out that men have the final say over finances in the household. Also women participants described their inability to make autonomous decisions about spending.

In poorer communities where women have limited economic opportunities and depend on their male sexual partners for financial support, condom purchases or condom use are not realistic choices (Kim & Watts, 2005). Economic inequality is a central barrier in controlling HIV and AIDS in Kenya. Several participants reported the fact that men are the responsible party in the household who manages the finances. Although all

of the participants are aware of and have access in obtaining free condoms at the local clinic, they reported that men are in control of the managing the finances, deciding when to obtain free condoms and when to use it. One study reported that men struggle with the social expectation that they should always be the breadwinner (Vogler, Lyonette, & Wiggins, 2008).

Task and Assignments

Gender plays an integral role as to how people understand themselves and others. Overall, the belief and family upbringings about gender roles and responsibilities in the household were analyzed from both a gender and socio-cultural perspective. All of the participants in the study perceived male roles to be the decision-maker over finances and sex and the protector over the family. Whereas, all participants felt that the female roles were perceived as caretakers, housekeepers and sex-pleasers. Most of the women participants expressed that they learned submissive roles through religious and family upbringings. Male participants learned their patriarch values of being the financial provider and protector through observing what they saw in their father's home. These influences and assignments give men a dominant role in decision making including power over his female partner's health decision. Literature points out that women in long term relationships tend to report approval of intimate partner violence, male dominant behaviors and reduced power to negotiate safer sex practices (Harrison, O'Sullivan, Hoffman, Dolezal, & Morrell, 2006).

Beliefs

Based upon the report of participants, three out of nine participants were married between eighteen months and seventeen years. Participants in cohabitating relationships were living together between 18 months and 5 years. This data describes participants' belief around the traditional values and family upbringings were intended to protect and preserve their long-term commitment to their married or cohabitating partners. On the contrary, cohabitation has become one of the emerging trends where men and women are living together less than 4 months into the relationship without a formal marriage. As a result in the living arrangement, family instability is inflicted with the acquisition of multiple sex partners, incompatibility and lack of social and moral support for some of the female participants in this study. As a result, three households were headed by female participants who resulted in delayed marriage and increased tolerance of sexual promiscuity by their former cohabitating male partners. Family obligations and financial dependency have held these women from taking the bold step of quitting on a relationship that is full of cheating and might lead to contraction of HIV/AIDS.

Participants have provided details about their cherished family rituals and legends which were eventually developed into a belief system that wasn't necessarily practiced during their adulthood. For example, some of the male participants were taught to be faithful and tolerant to your spouse. Yet, two of the male participants admitted to cheating on their spouses. On the other hand, female participants adhered to the belief that spouses are to trust, love one another unconditionally, and endure in a marriage. The

majority of female participants remain in the relationship where there was partner infidelity by focusing on their male partner's ability to provide important facets such as finances, food and shelter. One study found that when children internalizes societal implications about behaviors that are expected from males and females, these behavioral norms and upbringings promote imbalances of gender roles and responsibilities (Pulerwitz, Michaelis, Verma & Weiss, 2010). These patterns of belief systems can also influence high risk sexual behaviors that place women and their male sexual partners at risk of poor health outcomes.

Research Question 2

Risk Factors

The majority of participants had a good understanding of behaviors that places individuals at a much higher risk of contracting HIV. Moreover, these participants did have knowledge that the transmission and infection of HIV are exhibited through having unprotected sex with an infected person and body fluids of an infected person getting into contact with a healthy individual. Most of the participants understood the relationship between HIV and AIDS. These participants were able to articulate that HIV is a virus which can lead to a condition called AIDS. They understood that once you have HIV, you have the virus for life. Past study reported that women who perceive themselves at risk of AIDS or have known someone living with HIV/AIDS were more likely to report behavior change, including increased condom use with their male sexual partners (Lindan, Allen, Carael, Nsengumuremyi, Tice, & Black, 1991). There were several

factors, including economics and power dynamics which contributed to inconsistent condoms use. Female participants were significantly in less control to carry out their decision in using condoms with their male sexual partners. Married participants reported inconsistent condom use with their spouses yet partner infidelity was high. These women feared losing financial support from their significant others or losing their significant others to other women. Therefore, condom use was a challenge in some of these relationships. The majority of male participants were adamant about consistent condom use as they reported either having discomfort in their use of condoms or believed that condoms are a sign of cheating on their significant others. However, the majority of male and female participants reported that it was necessary to use condoms if they were aware that their significant others were HIV positive. In this instance, their level of consciousness is raised when knowing that their partners are HIV positive. Participants felt that it was important to protect themselves from HIV transmission by using condoms regardless of their feelings of discomfort, religious beliefs or threats of financial loss from their sex partners.

The majority of participants were aware of HIV testing. According to CDC (2015), over 18% of adults and teens living with HIV infection were unaware of their HIV status in 2009. Many of participants were aware of prevention and treatment services such as HIV/STI testing at their local clinics. However, five participants never took an HIV test. After engaging in previous discussion with their primary care physicians, two participants reported that they will obtain HIV testing over the next

twelve months during a routine doctor visit. These participants also inquired on additional educational resources around HIV prevention methods such as pre-exposure prophylaxis and post-exposure prophylaxis. I referred two participants to the Mater Comprehensive Care Clinic for additional HIV resources.

Research Question 3

Marriages

The majority of participants delineated the importance of sex in marriages based upon their religious belief, family values and upbringing. For many of the female participants, marriage is seen as a well-respected institution guided by love. Because sex is viewed as a cornerstone to their marriages, the attitudes found in male participants were that sex is used to receive pleasure from their female partners in concurrent relationships. Sex drive in married men was more frequent and intense than married women (Baumeister, Catanese, & Vohs, 2001). The engagement of polygamous unions was less favorable among all of the participants in my study and in Nairobi over the past decade (Baloyi, 2013). Both male and female participants pointed out that their grandfathers and great grandfathers have participated in polygamous unions with at least two wives. Participants agreed that polygamy increases the number of sexual partners in a marriage. Two female participants reported that their Christian faith is against polygamy while other religions such as Islam, accepts polygamy and encourages it among the Muslim men. One female participant in my study refused to accept her husband's involvement in polygamous relationships. She also understood the greater risk of HIV transmission where there are multiple sex partners involved and without the use of risk

reduction techniques such as condom use. In order for polygamy to work, wives must be in compliance with the tradition (Baloyi, 2013).

Aggression

Based upon the reports from female participants, their male sexual partners forced them to have sex even when they lacked the drive to have it whereas most of the male participants admitted to the use of forced sex by giving their women ultimatums taking advantage of her vulnerable financial status. This shows that some Kenyan men are brutal in their sexual relationships and they see themselves as the owner of their women. Most of the male participants in this study believe that his sexual desires must be fulfilled and his female sex partner must have sex whenever he wants it and whichever way he deems fit. One study reported that long term and concurrent unions had the most common perpetrators of forced sex in Kenya (Adudans, Montandon, Kwena, Bukusi, & Cohen, 2011). Through these instances, female participants reported no condom use during forced sex and their sexual relationships attributed to feelings of low self-confidence. These women are vulnerable and lack empowerment to negotiate safer sex practices as a result in having to rely on imbalanced relationships.

Given that the myriad of vital needs for basic survival is a priority, the risk of HIV infection is viewed as less of a priority imposed on these women participants as they expressed their lack of social and economic power. Sexual force plays a central role in women disempowerment. In the few examples in which female sexual partners were unable to make informed sexual decisions or negotiate condom use, it resulted in their

feelings of resentment, insult and shamefulness prohibiting them from enjoying a healthy sex life (Erulkar, 2004).

Theoretical Consideration

The theory of gender and power with variables in age social factors and marriage status were considered. This was incorporated with social structures and environmental milieu that affect the demographic characteristics herein identified. This can be well reflected in the concept that HIV in Africa is not a single epidemic, but a series of them, perpetuated and escalated by poverty, inequality, and lack of information and education, and more so negatively inclined against women who bear the greatest burden (Hardré, Garcia, Apamo, Mutheu, & Ndege, 2012).

The theory of gender and power was adopted to view the aforementioned matters and put them in context to the HIV/AIDS scourge in Nairobi, a city in Kenya from the East Africa region of Africa. Wyrod (2011) contend that gender is a social foundation that constructs long-lasting models of social interactions that mirror existing power dynamics, manifesting itself in gender hierarchies and disparities.

Gender imbalances and HIV risky sexual behaviors were connected to the three structures of the Theory of Gender and Power.

Sexual division of labor. This study found that economic vulnerability endangers women to sexual coercion and violence. The structure of sexual division of labor posits that cohabitating and married women that are economically imbalanced are financially dependent upon their male sex partners. This can position women to be socially

vulnerable, fail to leave their unfaithful relationships or lack the use condoms consistently.

Sexual division of power. This study found that the perception of the male gender role as a more powerful partner in cohabitating and marriage unions is enhanced by their resource ownership and disapproval of condom use. Under this structure, men abuse their authority through sexual coercion and assume ownership over his female sex partner's body. It is suggested that because men exercises satisfaction and power through sex, these gratifications places women in powerless positions over condom use which amplifies their risk of HIV transmission (Rosenthal & Levy, 2010).

Cathexis. This study has found that as a result in societal norms and gender expectations regarding women's sexual behavior characterized by their moral, religious beliefs and emotional attachments to their male sexual partners, women find it difficult to abandon sexually abusive partnerships. Through societal expectations, women in cohabitating unions and marriages develop a high level of tolerance and live through their experiences in silence which increases their risk of HIV acquisition (Mbonu, Borne, & De Vries, 2010).

Implications for Social Change

It has been established that there exists certain condition that put women at a disadvantage in sexually active couples. All this is framed in environmental and socioeconomic factors that make it impossible to have safe sex and promote use of precautionary measures within these couples. As indicated by Aarø, Mathews, Kaaya,

Katahoire, Onya, Abraham, & de Vries (2014), behavioral intercessions aiming sexually active couples may contribute to reducing the incidence of HIV infections in two ways: (i) promoting consistent use of condoms once sexually involved, and (ii) reducing the number of concurrent sexual partners.

Empowerment can work towards addressing the hindrances that are identified to impact on safety from infections. Even when people have knowledge about AIDS, their choice and autonomy may be socially or culturally constrained (Hardré et al., 2012). Insecurities that are brought about by vulnerabilities, especially due to economic aspects should not be an excuse for heightened sexual proclivity among sexually active couples. Women need participation that is more vocal because they disproportionately suffer dangerous sexually related consequences due to biological susceptibility and economic and societal gender inequities (Alexander, Coleman, Deatrick, & Jemmott, 2012).

Reflection on Researcher's Experience

HIV/AIDS is a topic of concern all over the globe, but its prevalence in Africa has given me an inclination to probe for new insights at its prevalence, causes, and possible intervention methods. The Sub- Saharan Africa is the most affected by the ravages of HIV/AIDS globally (Oluga, Kiragu, Mohamed, & Walli, 2010). For over ten years, I had the opportunity to work with minorities, including women, who were vulnerably at risk for acquiring HIV through intravenous drug use and heterosexual contact. I was able to monitor several government contracts on gender and HIV/AIDS in the United States. The main focus of these contracts were based upon empowering vulnerable women through

HIV education and group interventions to remove the barriers of HIV stigma in relation to women receiving HIV test, access to care, and peer support (Wyrod, 2011). However, while conducting my interviews with participants living in Nairobi, Kenya, I realize that females have a greater disadvantage in creating an empowerment social environment. Male dominance is an acceptable role in concurrent unions, and more importantly, they play a crucial part in dissuading women from making informed sexual choices, such as condom use. The absence of these discussions in concurrent unions increases the impact of HIV transmission. It should be understood that in regions of the world most affected by HIV/AIDS, the pandemic is occurring in the context of poor environmental and societal changes as well (Talman, Bolton, & Walson, 2013).

Sex is one of the main ways through which the HIV virus is transmitted, and its utmost importance lies in the choice of heterosexual partners being able to practice safe sex, and have conversations about it. Two of the female participants in my study admitted to the imbalanced of sexual communication in their marriages. Unfortunately, the chief way through which HIV/AIDS is transmitted is via heterosexual contact, and women are infected more than their male counterparts (Oluga et al., 2010). This is influenced by a confluence of factors that put women in the relationship at a disadvantage. Whether this is a deliberate move on part of males, an environmental influence, or a socially acceptable cultural practice, it needs further elaboration.

Dissemination of the Findings

The results will be best disseminated through mail distribution to Mater Comprehensive Care Clinic, publishing journal articles, facilitate Skype video presentations to participants in the study, and other constituents, paper presentations at national and international conferences, and through a myriad of public speaking engagements. One primary method in which I am interested in disseminating my findings is through a press release in Kenya. Health communication public information such as press releases and interviews at radio stations can reach stakeholders such as World Health Organizations and the Government of Kenya. Reaching out to these government entities can help to highlight gender inequities and advocate for innovative health programs for couples in long term relationships. Another method in which I would like to disseminate my findings is to publish through public health journals. There are so many degrees to why dissemination methods through health communication public information are effective and critical. It can expand knowledge, reach unintended audiences, improve HIV prevention programs, and allocate limited resources (Bernhardt, 2004).

Scope and Delimitations

One specific aspect of the study was the focus on the knowledge and attitudes of married and cohabitating partners towards risk reduction techniques such as condom use. The specific focus was selected because HIV transmission is mostly transmitted through sexual behavior in Kenya (Oster, 2012). The study included discussion around sexual

violence, sexual aggression and risk reduction techniques, which measured the level of power and control a woman has over making informed decisions about her health.

The first delimitation of the study was the retention of sample of male and females 18 and over while individuals under 18 years of age were excluded from the study.

The purpose for the exclusion of people less than 18 years of age is that youths and children in this age group could be a potential risk for misunderstanding information provided which could cause psychological trauma and engagement in high risk behaviors.

A second delimitation was the criteria set for the study setting. Only participants who lived in Nairobi, Kenya were allowed to take part in the study, while individuals who lived in nearby countries in sub-Saharan Africa such as Tanzania were excluded from the study. The purpose for the exclusion was to capture the lived experience of citizens residing in Kenya, which is one of the primary countries high HIV prevalence and nearly 60,000 new HIV infections since 2011 (Avert.org, 2014).

Limitations of the Study

In Chapter 1, I was able to identify two limitations to the study: (a) Language barrier posed an issue and a language interpreter was assigned to assist me in the study. However, all of the participants chose to conduct the interview sessions in their home and over the telephone instead of using Skype Internet at Mater Comprehensive Care Clinic. Therefore, I could not use the language interpreter for any of the interviews conducted in the home. For the most part of the study, the dialogue was clearly understood between

participants and me. When clarifications needed to be made, I repeated back what the participant stated to ensure accurate data was collected. All of the participants spoke English and interpret the English language clearly. However, transcribing the data was labor intensive and tedious. (b) The second limitation to the study was the inability to recruit the intended sample size of participants. The intent of the study was to recruit a small random sample size of 5 females, 5 males and an additional 6 individuals in case one of the original ten participants would drop out of the study. I was able to recruit sixteen individuals and ten individuals fit the eligibility criteria of the study. Six of the potential participants were not eligible for the study and consequently one of the eligible female participants dropped out of the study for unknown reasons. The final sample size of participants completing the study was nine. Nine participants were sufficient in this study which represented an effective means of reflection (Onwuegbuzie & Leech, 2005).

Recommendation for Further Study

From the research findings, there is a relationship between HIV infections and the gender power in any sexual relationship. The challenge is getting the woman equally involved to develop a vocal perspective on her sexuality and the use of precautionary measure to protect herself from infection if she feels she is placed at risk by either her own behavior or from her male sexual partner. The way a woman can be empowered under restricting circumstances would be an area that might benefit from further studies. On the other hand, socioeconomic turmoil and financial instability can be devastating for men in Nairobi, especially since their role is seen as the breadwinner in the household.

Less income and low education can cause the family to endure greater struggle. Men, in particular, can feel a depreciating value of self-worth, a loss of self-control, become sexually aggressive and potentially increase use of alcohol and drug use in order to contain their stress level. Further studies may include research on gender inequities perpetuated through the lens of married men's perception and identification of their own sexually aggressive behaviors, inside and outside of the marriage, which heightens the risk of HIV/STD among their female sexual partners.

Conclusion

Results from this study have shed a light on the aspect of gender and power, and what cultural and socioeconomic behaviors influence the risk of HIV in heterosexual sexually active couples. Effective intervention strategies that will impact the way couples communicate with one another is necessary for protecting themselves from behavioral risks and make informed choice on health sexual relationships. The message that couples should be provided with information and education about preventive measures is not enough. It will be better if HIV educational messages be transformed into an action plan to develop and implement an intervention strategy where couples can voice their concerns and understand what is really at stake as they go through their daily lives.

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Appendix C: Flyer (English)

Volunteers Needed for Research Study

I need participants for my HIV Prevention dissertation research study

Description of Project: This project will help me to understand how sexual behaviors increase the risk of HIV transmission in cohabitating relationships in Kenya. I hope to use what I've learned to develop HIV prevention and educati1-516-784-7442onal programs for couples who place themselves at high risk for developing HIV/STD infection. Your participation will take about 45 minutes. I will ask you to participate in a Skype video or telephone interview at Mater Comprehensive Care Center or in the comfort of your home.

To participate: You must be male or female at least 18 years old, married or cohabitating with one or more partners for at least one year and live in Nairobi.

A language Interpreter will be available to you.

Participants who are interviewed at the Clinic will receive a transportation voucher and a care package valued at $16 USD **or** Participants who are interviewed in their home will receive $16 cash incentive, which is the value of transportation and care package.

To learn more or to schedule an appointment, please contact the principle investigator of the study, Daphne Parker, at 1-516-784-7442 or dparker.consultant@gmail.com .

This project is conducted for my PhD dissertation research purposes and has been reviewed and approved by Walden University's Institutional Review Board.

Daphne Parker
Dparker.consultant@gmail.com
1-516-784-7442
HIV Prevention Study

Appendix D: Flyer (Kiswahili)

Volunteers Inahitajika kwa ajili **ya Utafiti Utafiti**

Mimi haja ya washiriki kwa ajili yangu Kuzuia VVU dissertation utafiti unaoendelea

Maelezo ya mradi: Mradi huu utasaidia mimi kuelewa jinsi tabia ya ngono kuongeza hatari ya maambukizi ya VVU katika cohabitating mahusiano katika Kenya. Natumaini ya kutumia nini nimejifunza kuendeleza programu za kuzuia na elimu ya VVU kwa wanandoa ambao mahali wenyewe katika hatari kubwa kwa ajili ya kuendeleza HIV / STD maambukizi. Ushiriki wako itachukua muda wa dakika 45. Mimi kuuliza wewe kushiriki katika Skype video au simu mahojiano katika Mater Comprehensive Care Center au katika faraja ya nyumba yako.

Kushiriki: Kushiriki Lazima kuwa mwanamume au mwanamke angalau umri wa miaka 18, ndoa au cohabitating na washirika moja au zaidi kwa angalau mwaka mmoja na kuishi katika Nairobi.
Interpreter lugha itakuwa inapatikana na wewe.

Washiriki ambao ni waliohojiwa katika kliniki kupokea vocha za usafirishaji na mfuko wa huduma yenye thamani ya dola $ 16 au Washiriki ambao ni waliohojiwa katika nyumba zao watapata $ 16 fedha motisha, ambayo ni thamani ya usafiri na huduma mfuko.

Ili kujifunza zaidi au ratiba ya uteuzi, tafadhali wasiliana mpelelezi kanuni ya utafiti, Daphne Parker, katika 1-516-784-7442 au dparker.consultant@gmail.com.

Mradi huu uliofanywa kwa PhD dissertation madhumuni yangu utafiti na imekuwa upya na kupitishwa na Chuo Kikuu cha Walden Taasisi Review Bodi.

Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study	Daphne Parker Dparker.consultant@gmail.com 1-516-784-7442 HIV Prevention Study

Appendix E: Interview Guide (English)

The following is an outline of interview questions for women and men over the age of 18 years who are involved in concurrent relationships**.**

- Introduction of the study
- Self-introduction and explanation of Process— Researcher will share with participants about the manner in which information from their interview would be incorporated into the findings of the study. i.e. This study will help me to understand the way in which men and women in long term relationships regularly participate in high risk behaviors leading to HIV transmission. I will collect the information from participants and study it to discover if any cultural or socio-economic aspects influences HIV acquisition and why.
- Explanation of taping, mirror, consent form (permission to interview again).

Part One

Demographics

How old are you?
What is your highest level of education?
What is your marital status? How long were you married/living together?
Which estate do you live?

Part Two

Cultural beliefs

I would like to start by asking general questions about your environment, life and about your relationship with other people.

1. Please tell me about your environment and social living conditions?

Probes:
With whom?
Family?
Spiritual belief?
How do you earn a living?
Describe your role in the household?
Describe your partner's role in the household?

2. Please tell me about your relationship with your family?

Probes:
Tell me more!

Parents, spouse/sexual partner, siblings, in-laws?
What is your view on polygamy?
Describe your family history on polygamy?
What are your thoughts on condoms use in polygamous unions?

Sexual Risk
The research I am doing is about how people in married or cohabitating relationships behave. I am especially interested in individual's sexual behaviors. Many people are not used to talking about sex in ordinary everyday conversations. Some of these questions may make you feel a little uncomfortable, and therefore I very much appreciate your sharing. Again, if you choose not to participate, there is no penalty to do so and you will still receive an incentive. I would also like remind you that the information you share with me will be confidential and not communicated to anyone outside of my University. Your participation is very important for my research.

3. Please tell me what you think sex means to people in general?
Probes:
Tell me more! How?
Why do people have sex?
What's the difference between men and women?
How can sex be something positive?
How can sex be something negative?

4. Could you please share with me what sex means in your life?
Probes:
Tell me more! How?
What does it mean for you to have sex with somebody?
Could you give me an example of why you would have sex with somebody?

5. Have you had any other sexual encounters during the last year- for example very short relationships or one night stands?
Probes:
Tell me more!
Concurrent with other partners?
Condom use?
Drink alcohol or use drugs when sex?

6. Have you ever had several sexual partners at the same time?
Probe:
If yes, how many sexual partners did you have in one period of time?
Does your sexual partner/spouse often have several sexual partners at the same time?
How many?

How do you feel about this?

7. Have you ever been forced to have sex?
Probes: Tell me more? What happened?
Relationship to the person?
How and where did it happen?

Male participant: How do you define forced sex?

Thank you so much for your valuable answers so far. I will now go on and ask you a few questions about HIV risk and knowledge.

HIV Knowledge
Thank you very much for your valuable answers so far. I will now go on and ask a few questions about HIV knowledge and risk. Again I remind you that the information you give me will be used for research purposes only. There is no right or wrong answer and the answers that you are giving will not disclosed to anyone outside of the University. All answers will remain confidential.

8. Please tell me in your own words, what is HIV?
Probe: What are ways in which a person can become infected?
Probe: What is the difference between HIV and AIDS?

9. What kinds of risk reduction activities do you do to keep yourself HIV negative?

10. What is your belief about condom use if your sexual partner was cheating?
Probes: How do you feel about using condoms?
How does your partner feel about using condoms during sexual intercourse?

End of Interview: Close and ask respondents if they would like to ask any questions. Incentives offered.

Appendix F: Interview Guide (Kiswahili)

zifuatazo ni muhtasari wa maswali mahojiano kwa wanawake na wanaume zaidi ya umri wa miaka 18 ambao wanashiriki katika mahusiano wenza.

- • Kuanzishwa kwa utafiti
- • Self-kuanzishwa na maelezo ya usindikaji wa Mtafiti kushiriki na washiriki kuhusu namna ambayo habari kutoka mahojiano yao bila kuingizwa katika matokeo ya utafiti. Yaani Utafiti huu utasaidia mimi kuelewa njia ambayo wanaume na wanawake katika mahusiano ya muda mrefu mara kwa mara kushiriki katika katika tabia hatari kubwa na kusababisha maambukizi ya VVU. Nami kukusanya taarifa kutoka kwa washiriki na kujifunza kugundua kama masuala yoyote utamaduni au kiuchumi na kijamii mvuto upatikanaji VVU na nini.
- • Maelezo ya taping, kioo, aina ridhaa (ruhusa kwa mahojiano tena).

Sehemu ya Kwanza
Idadi ya watu
Una umri gani?
Ni kiwango chako cha juu cha elimu ni nini?
Ni hali yako ya ndoa ni nini? Muda gani walikuwa yenu ya ndoa / kuishi pamoja?

Ambayo isiyohamishika Unaishi?

Sehemu ya Pili

Imani za kitamaduni

Ningependa kuanza kwa kuuliza maswali ya jumla kuhusu mazingira yako, maisha na kuhusu uhusiano wako na watu wengine.

1. Naomba uniambie kuhusu mazingira yako na hali ya maisha ya kijamii?
Probes
Kwa nani?
Familia?
Imani ya kiroho?
Jinsi gani unaweza kuendesha maisha?
Kuelezea jukumu lako katika kaya?
Kuelezea jukumu mpenzi wako katika kaya?

2. Naomba uniambie kuhusu uhusiano wako na familia yako?
Probes
Kuniambia zaidi!
Wazazi, mke / mpenzi kimapenzi, ndugu, wakwe?
Nini maoni yako juu ya mitala ni nini?
Kuelezea historia ya familia yako kwenye mitala?

Je, ni mawazo yako juu ya kondomu kutumia katika vyama vya mitala?

Naomba uniambie kuhusu mazingira yako na hali ya maisha ya kijamii?
Probes
Kwa nani?
Familia?
Imani ya kiroho?
Jinsi gani unaweza kuendesha maisha?
Kuelezea jukumu lako katika kaya?
Kuelezea jukumu mpenzi wako katika h

Hatari ya ngono
utafiti mimi kufanya ni kuhusu jinsi watu katika mahusiano ya ndoa au cohabitating kuishi. Mimi ni nia hasa katika tabia ya ngono ya mtu binafsi. Watu wengi si kutumika kuongea kuhusu ngono katika mazungumzo ya kawaida ya kila siku. Baadhi ya maswali haya huenda kufanya kujisikia kidogo wasiwasi, na kwa hiyo mimi sana kufahamu kugawana yako. Tena, kama wewe kuchagua si kushiriki, hakuna adhabu kwa kufanya hivyo na wewe bado kupokea motisha. Napenda pia kuwakumbusha kwamba habari wewe kushiriki pamoja nami yatakuwa ni siri na si aliwasiliana na mtu yeyote nje ya Chuo Kikuu yangu.
Ushiriki wako ni muhimu sana kwa ajili ya utafiti wangu.

3. Naomba uniambie nini unafikiri ngono maana ya watu kwa ujumla?
Probes
Kuniambia zaidi! Jinsi gani?
Kwa nini watu kufanya ngono?
Nini tofauti kati ya wanaume na wanawake?
Jinsi gani wanaweza kufanya mapenzi kuwa ni kitu chanya?
Jinsi gani wanaweza kufanya mapenzi kuwa kitu mbaya?

4. Unaweza tafadhali kushiriki na mimi nini ngono ina maana katika maisha yako?
Probes
Kuniambia zaidi! Jinsi gani?
Ni nini maana kwa ajili yenu kufanya ngono na mtu?

Unaweza kunipa mfano wa nini ungependa kufanya mapenzi na mtu?

5. Je, alikuwa yoyote nyingine nao ngono wakati wa year- mwisho kwa mfano uhusiano mfupi sana au anasimama usiku mmoja?
Probes
Kuniambia zaidi!
Concurrent na wadau wengine?
Matumizi ya kondomu?

Kunywa pombe au kutumia madawa ya kulevya wakati wa ngono?

Naomba uniambie nini unafikiri ngono ina maana t

6. Umewahi washirika kadhaa wa kijinsia kwa wakati mmoja?
Probe
Kama ndiyo, ni wangapi ngono washirika hakuwa una katika kipindi kimoja cha wakati?
Je, mpenzi wako / mke au mume mara nyingi kuwa washirika kadhaa wa kijinsia kwa wakati mmoja?
Wangapi?

Unajisikiaje kuhusu hili?

7. Je, umewahi wamelazimika kufanya ngono?
Probes Niambie zaidi? Ni nini kilichotokea?
Uhusiano wa mtu?
Jinsi na wapi ni kutokea?
Mshiriki kiume Jinsi gani unaweza kufafanua kulazimishwa ngono?

Asante sana kwa majibu yako thamani hadi sasa. Mimi sasa kwenda juu na kuuliza maswali machache kuhusu hatari ya VVU na maarifa.

VVU Maarifa
Asante sana kwa majibu yako thamani hadi sasa. Mimi sasa kwenda juu na kuuliza maswali machache kuhusu elimu ya VVU na hatari. Tena mimi kuwakumbusha kwamba habari wewe nipe zitatumika kwa madhumuni ya utafiti tu. Hakuna haki au jibu sahihi na majibu kwamba wewe ni kutoa si wazi kwa mtu yeyote nje ya Chuo Kikuu.
Majibu yote utabaki siri.

8. Naomba uniambie kwa maneno yako mwenyewe, je, ni virusi vya ukimwi?
Probe Je, ni njia ambazo mtu anaweza becom kuambukizwa?
Kuchunguza tofauti kati ya VVU na UKIMWI ni nini?

9. Ni aina gani ya shughuli za kupunguza hatari gani unaweza kufanya ili kujiweka VVU hasi?

10. Ni imani yako kuhusu matumizi ya kondomu kama mpenzi wako wa ngono alikuwa cheating nini?
Probes Unajisikiaje kuhusu kutumia kondomu?

Ni kwa jinsi gani mpenzi wako kuhisi kuhusu kutumia kondomu wakati wa kujamiiana?

Mwishoni mwa Mahojiano Karibu na kuuliza waliohojiwa kama wangependa kuuliza maswali yoyote.

Motisha inayotolewa.

Appendix G: Letter of Cooperation from an Interpreter

January 21, 2015

Dear Mr. Kituku (Interpreter),

As we discussed earlier, our plan for your involvement in my study involves the following tasks:

- Facilitate communication between the Researcher and participants
- Identify and resolve conflicts related to the meanings of words, concepts, practices, or behaviors.
- give an accurate translation of the interview in English into Kiswahili language to all participants

If you agree to be part of this research project, my university requires that all interpreters maintain complete confidentiality. During the course of your involvement in this study, you will have access to information that is confidential and should not be disclosed. By agreeing to serve as an interpreter, you are agreeing to the following confidentiality standards:

1. The data yielded by participants must be kept confidential during the data collection process, which means that no one is permitted to see or overhear a participant's data, including other participants and family/friends of the participant.
2. Participant identities are confidential. You will not disclose to anyone who participated and who didn't.
3. You will not disclose or discuss any confidential information with others, including your friends or family.
4. You will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized by the researcher in this document.
5. You will not discuss confidential information where others can overhear the conversation (such disclosures are inappropriate even if the participant's name is not used).
6. You will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
7. You will store research data in a secure manner, under lock and key (or password protection, in the case of electronic files).
8. You will keep data in a manner that protects the privacy of participants and ensures that individual participants are not identifiable by outside parties.
9. You agree that any obligations under this agreement will continue after completion of the research tasks.

My university also requires that you uphold the following ethical principles for research outlined:

1. Informed consent must be obtained from all research participants. This means that they must be fully informed about the study before being asked to make a decision about participation.
2. For example, it is not appropriate for people to be recruited while they are waiting for a health provider appointment (afterward would be less coercive). Further, no one who is an authority figure or service provider may be involved in participant recruitment because it would be difficult for a person to say no.
3. Potential harms to participants must be minimized. Any time that you suspect a person's participation might result in psychological, physical, social, or professional harm, you should let me know right away so we can terminate their participation in the study in a non-stigmatizing manner.

As the principal investigator in this research project, my responsibilities include the following:

1. I must train you in the ethical principles of informed consent, voluntary research participation, research confidentiality, and protection of human subjects prior to your interaction with research participants.
2. I must report any unexpected or adverse events that occur during data collection to my university's ethics committee (Institutional Review Board) within 1 week.
3. I must coordinate a system that will allow you to report any unexpected or adverse events to me within 24 hours, if I am not physically present with you during participant recruitment or data collection.
4. I must request my university ethics committee's (IRB's) approval before making any modification to the research procedures or forms (this means that you may not implement modifications until I have confirmation of approval).
5. I must maintain complete and accurate records of all research activities (including consent forms and collected data).
6. I am liable for your actions within the context of this research study. I must address any grievances or claims that are formally filed against you within the justice system or any other organization's system.

I will coordinate the exact dates and times of data collection with you at a later time. If your circumstances change, please contact me via dparker.consultant@gmail.com so we can amend this agreement.

I am requesting that you reply to this email with "I agree" to document that we have mutually agreed upon our roles and responsibilities within this study.

Sincerely,

Daphne Parker

Daphne Parker

Printed Name of Interpreter	Dominic Kituku
Date	22/01/2015
Interpreter's Written or Electronic* Signature	
Researcher's Written or Electronic* Signature	Daphne.parker@waldenu.edu

Appendix H: Letter of Clinic Cooperation

Mater Comprehensive Clinic
Nairobi, Kenya

January 24, 2015

Dear Daphne Parker,

Based on my review of your research proposal, I give permission for you to conduct the study entitled, "Factors associated with primary and secondary sexual transmission of HIV in concurrent relationships in Kenya." within Mater Hospital. As part of this study, I authorize you to interview up to 16 participants through the use of Skype video or telephone in a designated private room of the hospital for 45 minutes each person. Participants will have access to a computer for the sole purposes of Skype interview. You will be responsible for paying for minutes needed on the telephone. You will also be responsible for conducting recruiting activities and interviewing participants for your study. You will provide the hospital liaison with results of the study through written communication and follow up telephone call, if necessary. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: Provide the use of a language interpreter, distribute flyers to individuals within the vicinity of the Clinic, collaborate with the Researcher on any administrative activities, when needed, and offer participants remote access to a confidential space and computer, ensuring their privacy and no interruption. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the researcher's site location without permission from the Walden University IRB.

Sincerely, 

Medical Director

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform

Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verifies any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file on file with Walden).

Appendix I: Community Resource Referral (English)

If you experience any fatigue, sadness or become upset after your participation in my dissertation research study, please reach out to one of the following programs for additional support:

Counseling Services
Counseling and support
Nairobi Baptist Church
P.O.Box 44128
Nairobi, Kenya
+254 20 2728400
Jubilee Christian Church
Forest Lane
Nairobi, Kenya
+254 20 3754289
Nairobi Lighthouse Church
Garden Estate Road
Nairobi, Kenya
+254 718 652652
Kenya Medical Training College,
P. O. Box 30195, 00100
Nairobi, Kenya
Phone: (+254) 020 725711/2/3/4

Mater Comprehensive Care Clinic
P. O. Box 30325
Along Mukenia &
Dunga Road, South B
Postal Code : (00100)
City : Nairobi
6531199,6903000 Ext 3187,6903187

HIV Education and Testing

Mater Comprehensive Care Clinic
P. O. Box 30325
Along Mukenia &
Dunga Road, South B
Postal Code : (00100)
City : Nairobi

6531199,6903000 Ext 3187,6903187

Appendix J: Community Resource Referral (Kiswahili)

Kama uzoefu uchovu yoyote, huzuni au kuwa upset baada ya ushiriki wako katika dissertation utafiti wangu utafiti, tafadhali kufikia nje Kwa moja ya programu zifuatazo Kwa msaada wa ziada:

Huduma za ushauri

Nairobi Baptist Church
P.O.Box 44128
Nairobi
+254 20 2728400
Jubilee Christian Church
Forest Lane
Nairobi
+254 20 3754289
Nairobi Lighthouse Church
Garden Estate Road
Nairobi
+254 718 652652
Kenya Medical Training College,
P. O. Box 30195, 00100
Nairobi
(+254) 020 725711/2/3/4

Mater Comprehensive Care Clinic
P. O. Box 30325
Pamoja Mukenia &
Dunga Road, South B
Nairobi
6531199,6903000 Ext 3187,6903187

Elimu ya VVU na upimaji

Mater Comprehensive Care Clinic
P. O. Box 30325
Pamoja Mukenia &
Dunga Road, South B
(00100)
City : Nairobi

6531199,6903000 Ext 3187,6903187