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# *Potential HIV Risk Behaviors among Ethiopians and Eritreans in the Diaspora: A Bird's-Eye View*

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## **Abstract**

*Objectives:* Significant gaps exist in addressing the HIV/AIDS prevention needs of culturally diverse populations in the United States, particularly in African immigrant communities. This anthropological research examines culturally specific factors that impede understanding of HIV transmission and prevention education among African immigrants in California.

*Methods:* One hundred twenty study participants (60 men and 60 women) were recruited through community organizations; 33 percent were Ethiopian and Eritrean immigrants. The study methods consisted of focus group interviews with key informants, in-depth individual interviews, and a brief self-reported HIV risk behavior survey. This study reports data pertaining only to Ethiopian and Eritrean immigrants. Relevant research literature and government HIV/AIDS statistics also were reviewed.

*Results:* Members of the immigrant community are aware of HIV/AIDS; however, they do not recognize their own HIV risk behaviors. Potential HIV risk behaviors reported among these immigrants include not using condoms, having multiple sexual partners; consuming alcohol; stigma, denial, and fear surrounding HIV testing; and risk behaviors associated with vacationers traveling back and forth between Ethiopia, Eritrea, and the United States.

*Conclusion and Recommendations:* Ethiopian and Eritrean immigrants in California hold similar attitudes and behaviors to those found in their country

of origin, and they underestimate their HIV risk from engaging in various risky behaviors. The various barriers to HIV testing must be addressed if these immigrants are to take advantage of access to early treatment and prevent further HIV infection in the community. There is an urgent need for community leaders in these two immigrant groups to provide culturally appropriate venues for breaking the silence surrounding HIV risks in the community before the situation worsens.

## ***Introduction***

Epidemiological data from many countries show that immigrants may be at greater risk for HIV infection than native populations (UNESCO/UNAIDS 2000). The changing demographics of the United States continue to challenge Western health care providers to offer relevant and sensitive HIV prevention and education services to members of diverse groups. The most challenging groups to reach are recent immigrants and refugees (Ackerman 1999; Gavagan and Brodyaga 1998). Messages in most HIV/AIDS programs reflect Western cultural values regarding sexual relations and communication, and rarely penetrate the cultural barriers of immigrant populations. For recent immigrants and refugees from non-Western countries, barriers to HIV education are reinforced by language differences and cultural values concerning health and sexuality, and by lack of access and knowledge about available health services.

Although there is increasing concern about addressing the HIV/AIDS prevention needs of culturally diverse populations in the United States, significant gaps still exist in our knowledge, particularly about African immigrants. This study is the first formal study to address HIV risk in African immigrants in the United States.

This paper is based on findings from an ongoing three-year qualitative study examining knowledge, beliefs, attitudes, and risks of HIV/AIDS among African immigrants in California. Its long-term goals are to provide vital cultural and behavioral data to inform HIV prevention, education, and intervention efforts targeting these immigrant groups, and to identify those culturally specific factors that impede understanding of HIV/AIDS transmission.

## **Methods**

One hundred twenty study participants (60 men and 60 women) were recruited through community organizations and mutual assistance associations; 40 (33 percent) of them were Ethiopian and Eritrean immigrants. The study methods consisted of focus group interviews, in-depth individual interviews, and a brief self-reported HIV risk behavior survey. In addition, community leaders and non-African healthcare professionals were asked their views on and concerns about HIV risks in the African immigrant communities. The age of the participants ranged from 24 to 50 years. Participants were interviewed once, with interviews conducted in English. Interviews consisted of some structured questions and many open-ended questions and lasted approximately one to one and a half hours.

Topics discussed pertained to community members' awareness of HIV/AIDS, causes people attribute to AIDS, how AIDS is recognized, general knowledge about HIV transmission, the difference between HIV and AIDS, observed HIV risk behaviors among African immigrants, the characteristics of individuals perceived to be at risk, attitudes toward people with HIV in the community, the availability and nature of support systems for HIV-positive community members, attitudes about HIV testing, beliefs and attitudes about the use of condoms, knowledge of sexually transmitted diseases (STDs) and prevention, cultural norms and barriers to discussing sexual matters with potential sexual partner(s), access to information on health, and community input for prevention education, such as ideas about what should be done to make African immigrants more aware of HIV risks and ways to promote testing and prevention education.

Interviews were tape recorded and transcribed verbatim. This paper reports only the data pertaining to Ethiopian and Eritrean participants, the second largest group of African immigrants in the United States. Relevant research literature and government HIV/AIDS statistics also were reviewed.

## ***HIV/AIDS among African Immigrants in North America, Europe, and the Middle East***

Reports indicate that HIV infection is widespread and increasing among African immigrants living in Europe and North America. In Britain, for exam-

ple, the number of African immigrants with HIV has tripled in the past five years (Browne 2002; McLean 2002); 50 to 60 percent of all new cases in London are from sub-Saharan Africa (Browne 2002). Of the 22,000 people known to be living with HIV in Britain, more than 5,000 are from Africa, including refugees, students, nurses, others with work permits, and visitors. There are concerns about HIV-positive African immigrants burdening the British health care system; a case of an asylum-seeking HIV-positive mother from Ethiopia who could not afford to buy formula milk, for example, made headlines in the *Guardian* (Dyer 2002).

HIV infection among African immigrants is a significant problem in other countries as well. In Sweden, HIV prevalence among immigrants from sub-Saharan Africa residing in Stockholm was estimated to be four percent in 1994 (Christenson and Stillstorm 1995). In Italy, African immigrants accounted for 51 percent of non-European Union members with HIV/AIDS (Manfredi et al. 2001). In Israel, the prevalence of HIV among immigrants from Ethiopia increased from 3 percent in 1991 to 7 percent in 1996, and at the end of 1999 the Ethiopian immigrant group constituted 50 percent of all HIV seropositive adults in Israel (Kaplan et al. 1998).

In Canada, a University of Toronto study found a disproportionately high prevalence of HIV infection among African immigrants: up to 60 times that of other Canadians, with as many as 450 new cases of HIV a year (Health Canada 2001; Calzavara et al. 2000). In some regions their numbers are even higher than the rates of intravenous drug users in Canada. Data from the Ontario HIV Pediatric Network indicate that 41 percent of 281 HIV-infected babies were born to immigrant women from HIV-endemic countries (Remis and Whittingham 1999).

Calculating the rate of HIV/AIDS infection in African immigrants in the United States is difficult due to the lack of discrete population data for African immigrant populations. Census data subsume African immigrants into the larger categories of African Americans or "other foreign born."

Community-based data and data from the long household survey form of the 2000 Census, however, show a surge in African migration to the United States. The long household survey, for example, indicated that those who described

themselves as sub-Saharan Africans rose by 229 percent between 1990 and 2000 (Census 2000). In New York City alone, the number of people who identified their ancestry as sub-Saharan African rose by 137 percent (NYC 2001). According to the *U.S. Immigration and Naturalization Yearbook* of 1999, the largest groups of African immigrants are from Nigeria (18.4 percent), Ethiopia (14.3 percent), and Egypt (12.5 percent) (INS 2002).

There is a real concern that African immigrants in the United States may not receive adequate health care and HIV prevention education. Most recently, some community clinics and state health departments reported that HIV/AIDS is a growing concern in the African immigrant communities. In Massachusetts, for example, the proportion of AIDS diagnoses among non-U.S. born individuals increased from 9 percent in 1990 to 22 percent in 2000. Among the foreign-born groups, sub-Saharan Africans accounted for most (21 percent) new HIV infections (Massachusetts HIV/AIDS Prevalence 2002). In Seattle, clinics working with African immigrants reported that a large number of them are HIV positive and that Ethiopians comprise the largest among all immigrant groups (Didier 2001; Eteni and Wood 2003).

Minnesota has a large population of African immigrants—as many as 35,000—concentrated mainly in Minneapolis/St. Paul. Many are refugees from Ethiopia and Somalia. According to 2001 figures from the Minnesota Health Department, African immigrants had the highest number of reported cases of HIV infection in the state (266). Fifty-three percent of them were men and 47 percent were women. HIV infection among African-born women increased nine-fold between 1990 and 2001. Similarly, African immigrant women were the only female immigrant group to show increased HIV infection rates from 2000 to 2001. About 40 percent of them had already developed AIDS at the time of diagnosis, suggesting that they probably had lived with the virus ten or more years before becoming ill (Minnesota HIV/AIDS Surveillance 2002).

In California, data from the 1997–2001 AIDS Registry reveal that African immigrants accounted for 75 percent of the 251 non-U.S. born cases identified in California during that period. The data also show an increase in the proportion of AIDS cases among African immigrants in California, from 62 percent in 1997 to 85 percent in 2001 (California Office of HIV/AIDS 2002).

### ***Ethiopian and Eritrean Immigrants in the United States***

The terms “Ethiopian” and “Eritrean” represent national and political entities, not distinct cultural groups. Northern Ethiopians and Eritreans speak the same language, and Ethiopia included Eritrea until May 1993, when a political resolution was reached ending a long-standing and bitter internal conflict that had divided the country. Existing literature treats Ethiopians and Eritreans as members of the same cultural group, and community studies from as recently as 2001 still grouped Ethiopians and Eritreans together (Brooking Institution 2001). While Ethiopia and Eritrea are multiethnic, multireligious nations with many different political factions and considerable regional variation, similar core cultural values inform the behavior of most Ethiopians and Eritreans (Levine 1974).

Compared to other immigrant groups in the United States, the Ethiopian and Eritrean communities are relatively new and small. The exact size is unknown due to lack of separated U.S. census data on African immigrants; however, in 1999 a joint report submitted by the Ethiopian and Eritrean Catholic Apostolate in the United States estimated the entire U.S. population of Ethiopians and Eritreans to be somewhere between 250,000 and 350,000 persons. Based on 2003 Western Union remittance information, the Ethiopian government estimates about 500,000 Ethiopian immigrants living in the United States.

Large numbers of Ethiopians and Eritreans immigrated to the United States in the 1980s and 1990s. Immigrant groups arriving since 1991 did so under a provision of the Immigration Act of 1990, which expanded the number and diversity of countries from which people were granted permanent visas. The U.S. Immigration and Naturalization statistics for 1999 indicate that Ethiopians/Eritreans accounted for 14 percent of the 33,740 African immigrants admitted. In addition, they comprised 15 percent of the 15,526 diversity visas granted, thus constituting the second largest group of African immigrants granted such visas.

Between 1981 and 1999, Ethiopians/Eritreans represented the largest group of refugees and asylees from Africa, accounting for 49 percent of the 79,833 African refugees and asylees in the United States (INS 2002). Most of them have an urban background and currently live in major metropolitan cities on

the east and west coasts. Washington, D.C., Los Angeles, Atlanta, Houston, Seattle, and the San Francisco Bay area all have substantial Ethiopian and Eritrean populations.

Young single adults dominate the Ethiopian and Eritrean immigrant communities, with 70 percent being under age 40; 66 percent are male and 34 percent are female. Ethiopians and Eritreans are employed across the entire job spectrum, from working at low-paying "dead end" jobs to holding esteemed positions in academia, medicine, and high-tech electronic and computer engineering companies. Most, however, work in a variety of service jobs, particularly in restaurants and hotels as parking lot attendants and taxi drivers (ECDC 1990).

### ***HIV/AIDS among Ethiopian and Eritrean Immigrants***

Although the data are limited, Ethiopian and Eritrean immigrants seem to have the highest reported cases of AIDS among all African immigrant groups in the United States. In both Seattle and Massachusetts, for example, Ethiopians are among the largest groups of African immigrants with AIDS. In Minnesota, where most AIDS cases were in African immigrant communities, Ethiopians accounted for 27 percent of reported HIV/AIDS cases, followed by Liberians at 14 percent (Sides 2002). In California, 1997–2001 data show that Ethiopians accounted for 39.4 percent of all AIDS cases among African immigrants, followed by Ugandans (12.2 percent), Nigerians (11.2 percent), Kenyans (6.4 percent), and South Africans (5.3 percent). Between 1997 and 2001, the highest annual increases in AIDS cases were recorded among Ethiopians, ranging from 45 percent in 1997 to 48 percent in 2001 (California Office of HIV/AIDS 2002).

Similarly, Wuhib and Wortley (2000) reported that between 1987 and 1998, a total of 360 Ethiopian cases were reported, of which 18 percent were HIV positive and 82 percent had developed AIDS. Most reported AIDS cases were from California (25 percent), followed by the metropolitan sectors of Virginia, Maryland, and the District of Columbia (20 percent). AIDS cases by metropolitan areas indicate that higher rates (19.8 percent) were reported from the larger Washington, D.C./Maryland/Virginia area, followed by Los Angeles (10.4 percent) and Seattle (8.3 percent). Sixty-eight percent of HIV/AIDS cases

were male and 32 percent were female. The highest rate of infection was reported between 1994 and 1998; 88.6 percent of those infected were 15 to 49 years old, 25 percent were men who have sex with men, 14 percent were injection drug users, 47 percent were heterosexuals, and 5 percent were undetermined. As in Africa, HIV infection within the African immigrant communities both in Europe and North America has been transmitted mainly through heterosexual contact (Health Canada 2002; Massachusetts HIV/AIDS Prevalence 2002; McLean 2002; Minnesota HIV/AIDS Surveillance 2002; Wuhib and Wortley 2000).

### **Barriers to HIV Prevention and Treatment**

Findings in this study are similar to those in other countries with large groups of Ethiopian and Eritrean immigrants (Calzavara et al. 2000; McLean 2002). Stigma, the isolation of HIV-positive individuals, cultural beliefs, linguistic barriers to treatment, and access to health care are critical factors in HIV prevention education among African immigrant communities. Additional barriers to HIV prevention among these immigrants in California are lack of discussion about HIV and sexual matters, denial about HIV risks, fear of HIV testing, and HIV risk behaviors. Such risk behaviors include not using condoms and having multiple sexual partners, substance abuse (including alcohol abuse), and HIV risks associated with intercontinental travel between Ethiopia, Eritrea, and the United States. HIV/AIDS prevention in these immigrant communities is further hampered by lack of adequate reporting of HIV/AIDS cases.

### **Lack of Adequate Data**

AIDS data pertinent only to Ethiopian and Eritrean immigrants in the United States are not easily accessible because HIV/AIDS data about African immigrants are included with those of African Americans. Obtaining California AIDS data for non-native born residents requires a special request, as they are not included with official state-reported AIDS surveillance data. Even then, the data are incomplete. In California, for example, out of 565 non-U.S. born individuals with AIDS whose cases were registered from 1997 to 2002, 55.6 percent were not identified with any particular country of origin

(California Office of HIV/AIDS 2002). There is very limited data about the trends of HIV infections among African immigrant communities in the United States. Not separating African-born immigrants from African Americans for HIV/AIDS case reporting in the United States creates a barrier to reaching these communities and impacts HIV prevention. Reaching these immigrant communities requires a culturally specific approach.

### ***Cultural Beliefs, Stigma, Denial, and Impact on HIV Risks***

#### **Degree of HIV Awareness and Denial**

The prevalence of AIDS in Africa is so extensive that most Ethiopian and Eritrean immigrants are aware of its impact and are concerned about the devastation the epidemic has caused there. Yet there is an obvious gap of knowledge about HIV/AIDS within these immigrant communities. For the most part, members of the immigrant community are knowledgeable about the risks of blood contact and sexual modes of HIV transmission, but some respondents also cited casual contact, kissing, and sharing eating utensils as possible routes of transmission. Overall, they determine whether or not someone is at high risk for HIV by appearance and social standing.

While members of the Ethiopian and Eritrean immigrant communities are aware of HIV infection and transmission, they do not discuss this topic with their friends, and individuals do not recognize their own HIV risk behaviors. Although study participants are aware that heterosexual sexual relations are the predominant mode of HIV transmission in Africa, a large number of them believe that HIV/AIDS in the United States is a disease of prostitutes, drug users, and homosexuals. Most believe that HIV/AIDS in heterosexuals is a problem only in Africa and that HIV and AIDS therefore would not affect them, their friends, or their family here in the United States.

Those who had immigrated recently had firsthand knowledge of someone who died of AIDS; still, they felt that "AIDS is left in Africa" and did not see the need to be vigilant about behaviors that increase HIV risk. In comparison, none of the long-term Ethiopian and Eritrean residents knew anyone with HIV/AIDS, though a few talked about a family member back home who had died of AIDS.

### **Stigma, Denial, and HIV/AIDS**

Most participants expressed anxiety when discussing HIV testing. Recent immigrants had been screened for HIV as part of U.S. visa requirements. In contrast, few long-term Ethiopian and Eritrean residents had been HIV tested. Regardless of their testing status, however, study participants said that many people in the community simply do not want to know if they are HIV-infected for fear that they would be isolated from the community if their status were known. One participant who had been tested for HIV said that he would not discuss HIV testing with friends even though he tested negative, for fear that his testing alone would raise suspicion among his friends.

Interviews with key community members and healthcare and service providers in Los Angeles and the San Francisco Bay area corroborated the evidence that people who tested HIV positive kept it a secret from family and friends for fear of stigma and isolation. A healthcare provider from a community clinic with HIV positive patients from Ethiopia, Eritrea, Cameroon, Kenya, Nigeria, Zimbabwe, and Uganda reported that patients do not tell their friends or families for fear of rejection. In fact, some of her patients with AIDS had returned to Africa to avoid revealing their HIV status.

Healthcare providers are struck by the extreme stigma of HIV/AIDS in the Ethiopian and Eritrean communities. HIV positive individuals literally hide from other Ethiopians and Eritreans who come to the clinic even though they could be there for the same reasons. Indeed, the stigma and fear associated with having HIV/AIDS is so strong that recruiting participants for this study was difficult, as people were afraid that merely participating in the study would be interpreted by others as an indication that they were HIV positive. All potential participants were cautious in the beginning and agreed to participate only after they were assured that the objective of the study was not to find out about their HIV status, but rather to hear their concerns about HIV; even so, a large number refused. Once they agreed to be interviewed, however, many spoke surprisingly freely about HIV/AIDS.

Among most African cultures, sex and death are two very important and sensitive issues; AIDS has brought these two issues together. HIV carries a strong stigma because it is associated with socially sanctioned behaviors such

as illicit sex and injection drug use. Ethiopian and Eritrean immigrants come from a traditional, religious society where sexual matters are never discussed and homosexuality is not accepted. Premarital sex and homosexuality are taboo in both the Coptic Orthodox traditions as well as the born-again Pentecostal groups. Participants from born-again Pentecostal churches expressed strong denial of HIV and dismissed the need to test for HIV even though they knew that some church members might be at risk. These participants said that the past was forgiven and that their strong religious belief could cure HIV as well as other chronic conditions such as diabetes.

Religion and religious involvement have unique political, cultural, historical, and social meanings. Religious beliefs help make life bearable for people; determine their relationship to the supernatural, to the environment, to time, and to activity; and enhance their self-worth (Baer and Singer 1990). Most Ethiopians and Eritreans place great reliance on religion and religious leaders (Bishaw 1991). Mobilizing and educating the religious leaders in the Ethiopian and Eritrean immigrant communities will be essential in order to maximize their contribution to HIV prevention in their congregations, as indicated by Surur and Kaba in this issue.

### ***Discussing Sexuality***

Discussions about sex continue to be taboo in many spheres of society, particularly among immigrants from traditional societies. Lack of open discussion of sexual issues affects attitudes toward sexuality and thus about HIV prevention and transmission (Venier et al. 1997; Taffa et al. 1999). Both men and women in the Ethiopian and Eritrean immigrant communities said that it was difficult to talk to a partner or potential partner about sexual issues because of cultural taboos. Some men believed that a woman's sexual history prior to their meeting was unimportant. The attitude held by both men and women was "No one would be honest with their sexual history, so why bother?" Some said that if they really wanted to find out about a woman's sexual past they would ask others. When participants were asked if they would advise a friend at risk for HIV, most said that sexual matters were very private and that they did not feel comfortable warning a friend about sexual risk behaviors. One participant said all he could say to a friend at risk was "watch out."

Information about sexuality is inconsistent and learned from peers of the same sex, who are not knowledgeable, as well as from the media. Even those who immigrated to the United States with their parents as teenagers said that peers and school are their primary source of information on sex. Some of the participants said that although their parents have been in the United States for a long time and that they were educated here, they nonetheless felt uncomfortable and awkward discussing sexual issues with their children. Most parental communication on sex consisted of inauspicious warnings such as “don’t do it” or “be careful.” Some participants, however, said that they had taken the responsibility to talk to their younger siblings on sexual matters.

Some participants were concerned about intergenerational and intercultural conflict between Ethiopian and Eritrean immigrant youth and their parents. By and large, behavioral norms for American youth are perceived as wrong by most Ethiopian and Eritrean immigrant parents, which can result in overly restrictive parenting that may increase the likelihood of youth to become rebellious. Some parents try to delay the sexual awareness of their teenage children and shield them from peer influence by forbidding friendships with American peers who appear to be sexually active. Most immigrant youth are caught in conflict between two cultures, and Ethiopian and Eritrean immigrant youth growing up in the United States need to be supported to develop self-esteem and decision-making skills that will enable them to protect themselves.

Various studies show that in most traditional societies such as those in Ethiopia and Eritrea, parents are the non-preferred source of sex education and are not adequately knowledgeable about sexuality and HIV/AIDS. The knowledge of young people about sexuality is incomplete and insufficient to avoid HIV risk-taking behaviors (Taffa et al. 1999). HIV/AIDS prevention efforts should also involve immigrant parents.

### ***Gender Roles***

Gender is one of the most important factors influencing sexual attitudes and behaviors in the Ethiopian and Eritrean immigrant communities. Strong cultural gender norms discourage communication about sex and minimize women’s sexual decision-making abilities (Decosas and Pendneault 1992). Ethiopian and Eritrean immigrants arriving in the United States encounter

gender-related norms that are dissimilar to those existing in their country of origin. Ethiopian and Eritrean immigrant women in this study said that they did not ask about a partner's sexual history. They also did not want to talk about protection or HIV with a potential partner out of fear of being rejected. As one woman participant said, "It is not easy to talk to these men about condoms. If you insist that he should use a condom, he would begin to suspect you and then it would be the end of the relationship." This is a cause for concern with regard to HIV transmission, as women are not able to negotiate safe sex and take a proactive role in HIV prevention.

The same social determinants that tend to make women particularly vulnerable to the HIV infection also result in many HIV-positive women receiving substandard care (Decosas and Pedneault 1992; Ulin 1992). Further, the higher vulnerability of women to sexual abuse and domestic violence also places them at risk for HIV and other sexually transmitted diseases. Women who are HIV-positive are often isolated and may lack supportive social networks. The stigma associated with HIV infection is very real for women, especially in traditional societies such as those in Ethiopia and Eritrea, where men are bestowed liberal sexual rights and their sexual adventures are considered manly. For women, chastity is required, and the stigma attached to an HIV positive woman is stronger than that for men.

There is also concern for gender and power relationships in newcomer communities and increased risk for transmission of HIV to vulnerable partners in abusive relationships. As evidenced in this study and other immigrant communities in the United States (Gomez et al. 1999), strong cultural gender norms discourage communication about sex and minimize the women's sexual decision-making abilities.

The gender disparity and status of women are usually linked to their role and status within the family and thus define the relationship to their male partners. Ethiopian and Eritrean women are particularly affected by such gender role differentiation, as they tend to hold submissive social and cultural roles and less social power than men (Pankhurst 1992; Wilson 1991). Thus, the social position of Ethiopian and Eritrean women affects both their educational attainment and their ability to earn a living, and especially their empowerment in regard to negotiating safe sex. This concern is particularly worrisome among

first generation Ethiopian and Eritrean immigrants who continue to manifest the same social and cultural roles as in Ethiopia and Eritrea. Ethiopian and Eritrean immigrant women need culturally congruent and gender-specific interventions.

### ***Access to Health Care***

Additional barriers to HIV testing and prevention are lack of access to medical services and communication problems with healthcare personnel (Gavagan and Brodyaga 1998). Since immigrants who are HIV-positive are subject to stigmatization and discrimination, they may not always use available support services (Flaskerud and Kim 1999; UNESCO/UNAIDS 2000). Data from Europe and North America indicate that sub-Saharan African immigrants constitute the largest heterosexually infected HIV groups. More than one-third of HIV-infected patients were not cognizant of their HIV risk before testing, a condition significantly associated with heterosexual intercourse as the only HIV risk behavior (Samet et al. 2001).

Most Ethiopian and Eritrean immigrants have no health insurance and therefore see physicians only in the emergency room. Without routine medical care or testing, and with the long HIV incubation period, they may never suspect they are infected until they come down with some kind of illness that won't go away. Lack of access to medical care is compounded by cultural beliefs and patterns of health care seeking behaviors, such as delay in seeking medical advice unless very ill, not sharing or discussing health problems with others (Beyene 1992), and fatalistic beliefs (Hodes 2002; Bishaw 1991). Mindsets like "what will be will be" or "you have to die of something" or "should not fear death and enjoy life" are further barriers to HIV testing. HIV prevention in immigrant communities is a challenge since they are not being reached by normal awareness campaigns and are not accustomed to seeking preventive medical care; as a result, most cases fall between the cracks.

### ***HIV Risk Behaviors***

Risk behaviors such as not using condoms, having multiple sexual partners, and alcohol use are common in Ethiopian and Eritrean immigrant communi-

ties. Most study participants seemed to lack knowledge of the various STDs except gonorrhea and syphilis. Participants also raised concerns regarding HIV risk behaviors associated with vacationers traveling back and forth between Ethiopia, Eritrea, and the United States.

### **Failure to Use Condoms**

Most participants knew about HIV protection but did not act on this knowledge. Both men and women said that they could not discuss condom use in a new or established relationship because of issues of trust. Women stated that use of a condom was the male sexual partner's decision, and they were reluctant to ask their partner to use condoms for fear of creating mistrust in the relationship. When asked how they would feel if a woman carried condoms with her, both men and women participants said that it would be unacceptable because she would be viewed as someone who sleeps around, and no man in the community would seek out a long-term relationship with such a woman.

Another important factor influencing condom use is the ethnic origin of the female partner. Unprotected sex occurred most often when the partner belonged to the same ethnic group as the respondents and least often when she was an American woman because American women insisted on condom use. Some men said that sex with an American woman would be more risky than sex with a woman from their own ethnic group. Some said that they often "know" a potential partner of their own ethnic background or her family and assume that if she had a disease or a reputation of sex with many men, they would find out through friends or family members. Furthermore, cultural notions of trust outweighed any knowledge regarding protection. In serial monogamy, most men claimed that they used condoms at first, but that after seeing the same girl for a few months they discarded the condoms. They assumed that the girl was healthy because of time spent together without HIV testing.

### **Substance Abuse**

Findings in this study suggest that alcohol abuse is a significant HIV risk behavior in the Ethiopian and Eritrean immigrant communities. Several studies on HIV and alcohol (Strunin 1999; Castilla et al. 1999; Brown 2000) indi-

cate that drinking impairs good judgment and may promote nonuse of condoms and taking increased sexual risks such as having more than one partner. Failure to use condoms occurs frequently among persons who drink alcohol, and excessive consumption of alcohol and cannabis are independently associated with risky sexual behaviors.

A survey of a representative sample of 10,203 adults in Addis Ababa found that substance abuse is a significant health concern among Ethiopian men (Kebede et al. 1999.) In the United States, alcohol abuse by Ethiopian and Eritrean immigrants may be aggravated by traumatic events, refugee experiences, stress caused by immigration, racial discrimination, and coping with a new environment (Holman et al. 2000; Okafor 2001; Rousseau et al. 2001). Ethiopian and Eritrean immigrants should be worried about the level of alcohol consumption in their communities. Drinking among immigrant women raises an additional concern.

Some study participants ranked drinking as the number one risk factor for HIV/AIDS infection. Although men were viewed as less responsible and more likely to be drunk, women were also reported to drink. In a survey of behavioral risk among 100 African immigrants in California, of whom 33 percent were Ethiopians and Eritreans, 49 percent of the women drank alcohol, with 46 percent reporting that they occasionally got drunk. Of the men, 67.4 percent drank alcohol and 58 percent said that they occasionally got drunk (Beyene 2002). The preferred drinks among Ethiopians and Eritreans are whisky and cognac. Participants stated that Ethiopian and Eritrean immigrants are known for the amount of hard liquor they consume at social occasions and special gatherings such as the community soccer tournament, which is held every year in a major U.S. city.

Participants also expressed concern about illicit drug use, such as that of marijuana, among the immigrant youth. Some of the reported substance abuse among Ethiopian immigrants in the United States appears to have its origin in Ethiopia, where the use of low-cost alcohol and *chat* (*Catha edulis*, a plant stimulant) is widespread among the poor (see, e.g., Tadele 2000), and the use of high-cost liquor and narcotics is widespread among professionals.

The same study with African immigrants (Beyene 2002) also indicated that among those who said they were sexually active, 30 percent allegedly had had

two to five sexual partners in the last 12 months, and 13.5 percent claimed to have had sex with someone they didn't know before. Besides high alcohol consumption, serial monogamy and multiple sexual partners are additional HIV risk factors in the Ethiopian and Eritrean communities. Men related this to a "point system" of popularity and an attempt by women to gain acceptance. However, amongst women, sleeping around was associated with low self-esteem.

### **Intercontinental Travel and HIV Risk**

Participants also expressed concern about the increased risk of HIV infection associated with intercontinental travel, particularly about vacationers who frequently traveled back and forth between Ethiopia/Eritrea and the United States. Since late 1991, many Ethiopian and Eritrean immigrants have frequently visited their counties of origin. Some expressed concern that most men go to have a "good time," which usually involves drinking and possibly engaging in unprotected sex with local women. Ethiopian and Eritrean immigrants reported that men go home to get a young bride or to reestablish old relationships. Immigrant men return to their country of origin with money and are more attractive than local men to the local women. The unprotected sex these men may have in their country of origin while visiting puts them at increased risk for HIV infection, as well as the partners with whom they have unprotected sex after returning to the United States.

Although few studies provide reliable data on the specific factors that facilitate transmission of HIV in the context of migration, it is clear that frequent travel to and from endemic regions contributes to transmission of HIV infection (Adrien et al. 1999). Studies in Canada, Europe, and North America, for example, indicate that most of the HIV infections among Africans occur among those who were born in Africa or have traveled there recently (Sides 2002; Gras et al. 2001). A study of African immigrants in the Netherlands indicated that many male immigrants, after settling in the Netherlands, frequently visited their homeland and engaged in sex while there. Twenty-four percent of African immigrants in the study reported having had at least one sexual partner in their country of origin during the past five years. The study also noted that unprotected sex occurred in 39 percent of the partnerships. The same study showed

that engaging in unprotected sex in a home country was correlated with having unprotected sex in the Netherlands (Gras et al. 2001).

Since the fall of the military government in Ethiopia in 1991, Ethiopians and Eritreans have increasingly traveled there. Anecdotal information suggests the likelihood that some Ethiopian immigrants became infected during their travels back to Ethiopia. The potential HIV risks associated with "having a good time" while visiting home, including consuming alcohol and having unprotected sex, need to be highlighted in the Ethiopian and Eritrean immigrant communities.

### ***Conclusion and Recommendations***

The AIDS epidemic and increased migration are two salient trends. All existing data on African immigrants in Europe, Canada, and the United States indicate that HIV/AIDS cases among these immigrants are increasing rapidly. Among African immigrants in California and Minnesota, Ethiopians have been the most affected by HIV/AIDS, and there are indications that data of other state health departments show a similar pattern.

Several consistent thematic findings were revealed across all groups of participants. Findings from this qualitative study suggest that Ethiopian and Eritrean immigrants hold beliefs and partake in HIV risk behaviors similar to those found in their country of origin (Mathiot 2001; Sahlu et al. 1999). These immigrants are knowledgeable about HIV prevention measures, yet they underestimate their HIV risk despite their engagement in various risky behaviors. Mobilizing the Ethiopian and Eritrean immigrant communities and involving key members of these communities in conducting outreach is essential for HIV intervention activities. The most favorable means to achieve outreach goals would be through small groups and by integrating HIV prevention with other health promotion outreach. Unfortunately, unlike Latino and Asian immigrants, African immigrant communities in the United States do not have any social structures targeted specifically to their needs in the area of health promotion and disease prevention. Because of social and cultural differences, services provided by other ethnic minorities are not accessible to immigrants from sub-Saharan Africa. It is therefore important to look at this population closely in an attempt to make visible issues, such as HIV risks, that are affecting them.

The various barriers to HIV testing must be addressed if Ethiopian and Eritrean immigrants are to take advantage of early access to treatment in order to prevent further HIV infection in the community. Key actions should include developing education programs that target the Ethiopian and Eritrean immigrant communities and changing the long-standing fears and myths about HIV. Ethiopian and Eritrean immigrants will seek out HIV testing only when they feel that their community will not shun them. Most Ethiopian and Eritrean immigrants are single adults and date across all ethnic groups, and their lack of knowledge regarding their HIV status and risk for HIV infection places them and their sexual partners at risk for contracting HIV. There is an urgent need for community leaders in these immigrant groups to provide culturally acceptable venues for breaking the silence of HIV risks in the community before the situation gets worse, and to develop HIV prevention programs that actively engage community members in discussion about how to reduce high-risk behavior.

Furthermore, the lack of a reliable census of African immigrant populations in the United States is a problem, particularly in addressing health risks such as HIV/AIDS in these communities. The aggregation of African immigrants with native-born African Americans is an oversight, with serious setbacks in HIV/AIDS prevention efforts, that should be addressed.

The findings also indicate that Ethiopian and Eritrean immigrant women are at risk for HIV infections. Culturally congruent and gender-specific interventions that provide information and behavioral skills to these immigrant women as well as increase their self-esteem and motivation to adopt safer sexual behaviors are needed.

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