AFRICAN IMMIGRANT PROJECT

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

FINAL REPORT JUNE 23, 2003

Drs. Longondo Eteni ("Das") & Robert Wood

The Concern

Many people have been worried about the HIV/AIDS prevention and care needs among the growing African immigrant population, potentially numbering over 20,000 in our urban region of Washington State. HIV and AIDS surveillance data have also been of concern, showing that about 40% of blacks recently reported (2000-2002) and living locally with HIV and AIDS were born outside the US, mostly in African countries. Finally, the HIV infection rates in sub-Saharan Africa countries are very high, suggesting the possibility that immigrants from that region may have acquired HIV infection there. Thus, we began a project designed to study black immigrants, locally and nationally.

Our Methods

THE PROJECT INVOLVED 5 STAGES

1. We worked to obtain local estimates of the sizes of African Immigrant populations.

2. We determined estimated rates of HIV infection in the various sub-Saharan African populations.

3. We reviewed the details of the local HIV/AIDS monitoring data.

4. We looked for other reports from our region and other urban areas which have tried to describe their African Immigrants, their risks for HIV/AIDS, and disease burden, knowledge levels, etc.

5. We designed an anonymous self-administered Survey of African Immigrants to yield cross-sectional data on 42 variables, including: the relative sizes of immigrant populations from the countries of Africa; age, sex, zip codes of residence, and marital status; knowledge about HIV/AIDS; year of immigration to the US; sexual and other risk experiences in Africa; sexual risk experiences in the US; whether respondents would be willing to be tested for HIV, or whether they had tested for HIV (including when last tested and test results); and whether HIV-infected respondents were receiving care, and were aware that care and treatment was available to all. Several thousand legal-sized surveys were distributed in 5 languages (English, French, Swahili, Amharic, and Somali), designed to be self-completed without identifiers, folded, taped, and returned free by franked mail. We used a snowball method to access populations through local organizations and groups of immigrants.

Findings

1 Estimates of population sizes

We discovered that census data can provide limited information about African-born immigrants. According to the US census of 2000, the population of King County was 1,737,034. Of this number, 268,285 (15%) were born outside the US. Nearly half of these 268,285 (131,848 or 49%) entered the US in since 1990, in the past decade. Another 65,728 (24%) arrived between 1980 and 1990. Thus, about three-quarters of these immigrants came after the onset of AIDS. Of the 268,285 immigrants, according to census data, 14,232 came from Africa, including 3,899 from Ethiopia, 5,392 from other Eastern African nations (primarily Somalia), 84 from Middle Africa, 909 from Southern African nations, and 1,521 from Western African nations. Thus, immigrants from sub-Saharan countries might number about 11,805, and 8,800 may have immigrated since HIV began to spread. Discussions with local experts on immigrants and refugees estimated that about 60% of 150,000 African immigrants to the state live in the King County region, including 3-4,000 Somalians, 4-5,000 Ethiopians, 3-4,000 Eritreans, and 5,000 from other African countries.

2 Rates of HIV infection by African Country

We reviewed UNAIDS estimates of HIV infection rates by Sub-Saharan African Country (see Table 1), and added columns estimating each country's population and the proportion of the region's population attributable to each country. As the table shows, the overall HIV seroprevalence for these countries with a total population of nearly 700 million persons is 3.6%, but some countries have very high rates while other countries have lower rates of infection. Taking 3.6% of the 15,000 immigrants from Africa since HIV began spreading, estimated in section 1 above, yields an estimate of 540 possible persons with HIV infection who were born in Africa. Of course, census data may have incompletely captured immigrants from African and elsewhere, so these numbers may be considered minimal estimates.

3 King County HIV/AIDS monitoring data

Nearly a quarter (22% or 188 of 862) of black persons cumulatively reported (since the start of the epidemics, including those deceased and those still living) with HIV and AIDS in King County were born outside the US. Of the 188 black persons, 171 (91%) were born in Africa and over half (88, or 51%) of these were born in Ethiopia. The next largest groups were born in Kenya, Sudan, Ivory Coast, Somali Republic, and Tanzania. Another 21 countries were the home to 5 or fewer cases. Of 670 blacks currently living with HIV/AIDS in King County a slightly larger share (171 or 26%) were born outside the US, and of these 171 black persons 63% are male and 37% female. Figure 1 on page 4 compares the risks for HIV among blacks living with HIV/AIDS at the end of 2002 who were foreign-born to those born in the US.

Table 1

Sub-Saharan African Countries, including populations, estimated number of HIV-infected persons, and HIV seroprevalence rates (12/2002 UNAIDS estimates)

COUNTRIES	Population	% Sub-Saharan Africa Population	# HIV+	HIV Prev.
Angola	10,366,031	1.5%	200,000	2.0%
Benin	6,590,782	1.0%	84,000	1.2%
Botswana	1,586,119	0.2%	350,000	22.0%
Burkina Faso	12,272,289	1.8%	420,000	3.4%
Burundi	6,223,897	0.9%	460,000	7.4%
Cameroon	15,803,220	2.3%	650,000	4.2%
Central African Republic	3,576,884	0.5%	280,000	7.8%
Chad	8,707,078	1.3%	120,000	1.3%
Congo (Zaire)	53,624,718	7.9%	1,500,000	5.1%
Congo Republic	2,894,336	0.4%	120,000	0.7%
Cote D'Ivoire	16,393,221	2.4%	910,000	5.5%
Djibouti	460,700	0.1%	50,000	10.2%
Equatorial Guinea	486,060	0.1%	1,400	0.2%
Eritrea	4,298,269	0.6%	429,827	10.0%
Ethiopia	65,891,874	9.7%	3,800,000	5.7%
Gabon	1,221,175	0.2%	31,000	2.5%
Gambia, The	1,411,205	0.2%	17,000	1.2%
Ghana	19,894,014	2.9%	410,000	2.0%
Guinea	7,613,870	1.1%	70,000	0.9%
Guinea Bissau	1,315,822	0.2%	19,000	0.1%
Kenya	30,765,916	4.5%	2,500,000	8.1%
Lesotho	2,177,062	0.3%	330,000	15.1%
Liberia	3,225,837	0.5%	53,000	7.6%
Madagascar	15,982,563	2.3%	13,000	0.1%
Malawi	10,548,250	1.5%	960,000	9.1%
Mali	11,008,518	1.6%	140,000	1.2%
Mauritania	2,747,312	0.4%	8,900	0.3%
Mozambique	19,371,057	2.8%	1,500,000	7.7%
Namibia	1,797,677	0.3%	190,000	10.5%
Niger	10,355,156	1.5%	87,000	0.8%
Nigeria	126,635,626	18.5%	3,200,000	2.5%
Rwanda	7,312,756	1.1%	480,000	6.5%
Senegal	10,284,929	1.5%	95,000	1.0%
Sierra Leone	5,426,618	0.8%	92,000	1.6%
Somalia	7,488,773	1.1%	224,663	3.0%
South Africa	43,586,097	6.4%	5,100,000	11.7%
Sudan	36,080,373	5.3%	938,090	2.6%
Swaziland	1,104,343	0.2%	150,000	13.5%
Tanzania	36,232,074	5.3%	1,500,000	4.2%
Togo	5,153,088	0.8%	150,000	3.0%
Tunisia	9,705,102	1.4%	21,351	0.2%
Uganda	23,985,712	3.5%	650,000	0.2%
Zambia	9,770,199	1.4%	1,000,000	10.2%
Zimbabwe	11,365,366	1.7%	1,800,000	16.0%
TOTAL	**682,741,968**	100.0%	**31,105,231**	**3.6%**

As the figure shows, over half (57%) of U.S.-born blacks indicated either male-male sex (MSM) or male-male sex and injection drug use (MSM-IDU) as their risk for acquiring HIV, while among foreign-born blacks the proportion accounted for by either MSM or MSM-IDU risk was nearly 10 times lower (5.8%). Similarly, injection drug use (IDU) risk is much more common among U.S.-born blacks with HIV (19%) than among foreign-born (1%). The main risk categories among foreign-born blacks were heterosexual sex with someone with HIV (57%) and unknown risk (34%), i.e., no history of known high risk behavior such as injection drug use, male-male sex, or the receipt of blood products. Although HIV and AIDS monitoring data do not clarify when people born abroad moved to this country, these data suggest that many or most foreign-born blacks may have acquired HIV prior to arriving in the US, since evidence of MSM, MSM-IDU, and IDU risk is lacking in most African countries.

The trends in cases of HIV/AIDS reported in the past 13 years show an increase in foreign-born blacks in recent years, as shown on page 5 in Figure 2. Until 1995 foreign-born blacks accounted for only about 10% of black cases. For the next 5 years the proportion of foreign-born cases varied from 20 to 40%, while in the past 3 years foreign-born cases have averaged about 40% of reported cases of HIV/AIDS. However, some (30) of these persons captured in the HIV/AIDS surveillance system came to King County as refugees known to have HIV infection. This HIV+ refugee program was begun in the fall of 2000 and lasted until 9/11 of 2001, but

Foreign-born versus US-born Blacks Living with HIV

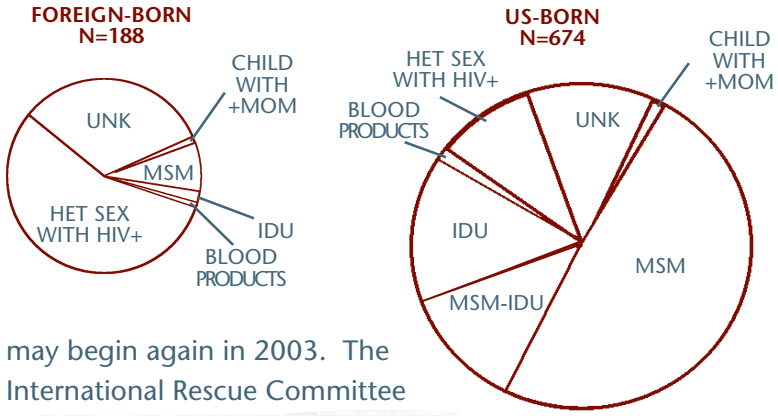

Figure 1
Risk for HIV among Blacks Living with HIV in King County (as of 12/31/02)

may begin again in 2003. The International Rescue Committee of Seattle was the prime sponsor of this program, provided case-management services, and worked with the HIV/AIDS and TB, and immigrant screening programs of Public Health - Seattle & King County and with Harborview Medical Center's Madison Clinic and other community partners to be sure care needs were met.

Finally, data from the AIDS Spectrum of Disease Study, which monitors a number of local medical practices to better understand the medical care needs and experiences of persons living with HIV, suggest that foreign-born blacks are more likely than other blacks to be diagnosed with HIV infection late, with CD4 cell counts often at lower levels, indicating a potentially dangerous delay in HIV testing and awareness of infection in this population.

4 Other Reports & Studies

In the summer of 2001, the Seattle Treatment Education Project (STEP) published an article based on an interview with Sami Fick, Case-Manager for Harborview's Madison Clinic. Ms. Fick is quoted as saying that "there is a large group of Africans [living here] who are

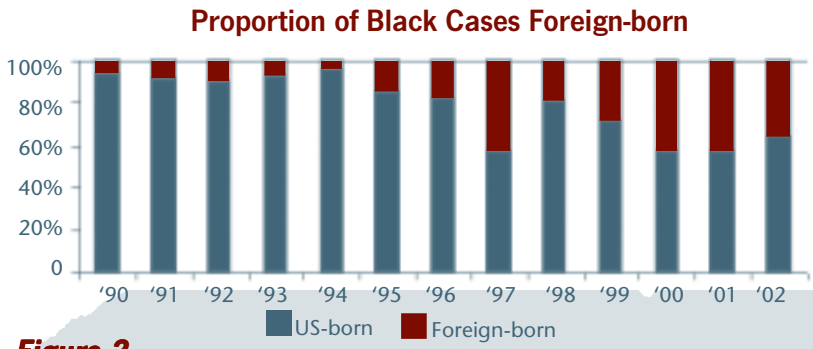

Figure 2
Recent increase in Foreign-born Cases Among Blacks in King County

positive." Among her clients Ethiopians comprised the largest group, but "she also has Somalian and Sudanese clients, as well as small numbers of people from many other East and West African countries." In the article Fick noted extreme stigma of HIV/AIDS in African communities, where she'd "never seen such fear." Some of the fear relates to the association between HIV/AIDS and illicit sex; another reason is that some of the immigrants are here illegally and afraid that they might be returned to Africa.

In the *Seattle Times* of Sunday, 1/5/03, an article featuring Ethiopian Christmas celebrations, states that Seattle's Ethiopian population "has more than quadrupled in the past decade - from 888 in 1990 to 4,035 in 2000, according to census data" adding that "Wars, famines, and ethnic tension have sent thousands of Ethiopians to the United States since the mid-1970s."

Seattle's Ethiopian population has more than quadrupled in the past decade.

From other regions of the country, we have only been able to find substantial investigation of African immigrant populations done in Minnesota. Monitoring data from that state show a gradual rise in HIV/AIDS cases in black immigrants from Africa, beginning about 1994, to about 60 (38%) of 160 black cases in that state in the years 2000 and 2001. Their African-born male immigrants also outnumbered females by 54% to 46%. As of 2001 of 213 foreign-born black HIV/AIDS cases, 42% had progressed to and AIDS diagnosis.

Finally, a report in the *Boston Herald* (4/20/02) also reports high levels of HIV/AIDS stigma in Boston African immigrant populations, which that city has also been unable to estimate. The estimated number given for the state, however, is 100,000, with the largest populations from Cape Verde, Nigeria, Ghana, and Uganda. It was stated that the HIV prevalence in these populations is probably greater than in blacks generally in the state (estimated to be ~1.2%).

5 King County Survey results

a. Demographics- Of 203 respondents, 58% were male, ages ranged 17-64 (mean 38). Over half (51%) were single; 28% were married; and 20% previously married. Most immigrants (150 persons) responded that they are here (in the US) with other family members (including 59 with a spouse, 85 with children, 26 with parents, and 71 with other family members).

b. Countries of origin, Time in the US- At least 10 respondents indicated they were born in each of the following countries: Somalia, Ethiopia, Tanzania, Nigeria, Ghana, Cote D'Ivoire, Kenya, and Eritrea (see Table 3). Respondents report that they have been in the US from 1-54 (mean 8.3) years. Most respondents, however, have arrived in recent years;

Table 3: Number and percent of survey respondents by birth country

Somalia	38	18.7%
Ethiopia	34	16.7%
Tanzania	18	8.9%
Nigeria	16	7.9%
Ghana	14	6.9%
Cote D'Ivoire	13	6.4%
Kenya	11	5.4%
Eritrea	10	4.9%
Burkina Faso	6	3.0%
Sudan	6	3.0%
Zimbabwe	6	3.0%
Other	31	15.3%
Total	**203**	**100.0%**

only about 5% have been here over 20 years, before HIV became prevalent globally. Figure 3, below, shows respondents' reported years of coming to the US, indicating that most of these persons came here after 1990, and especially after 1996.

c. Risks for HIV - Nearly all (93%) reported having sex with persons in Africa before coming here (the estimated average number of sex partners was 15). Only 5% reported using condoms consistently; 52% never used condoms with African partners. Other reported risks in Africa included: receiving a blood transfusion (41%),[1] receiving injections with possibly used needles (81%), and a history of surgery (44%). Also, 156 (77%) respondents reported having sex after coming to the US, 118 of these persons (76%) had sex partners who lived in Africa.

d. HIV Testing, Infection, and Care - Only 72 (35%) of respondents had ever tested for HIV (an average of 6 years ago), and 11 (15% of those 72 tested) reported that they were HIV-seropositive. Of the 11 HIV+ respondents, 10 believe they got infected in Africa, and **only 4 (36% of the 11 HIV+) reported that they are getting HIV/AIDS care.** Of 203

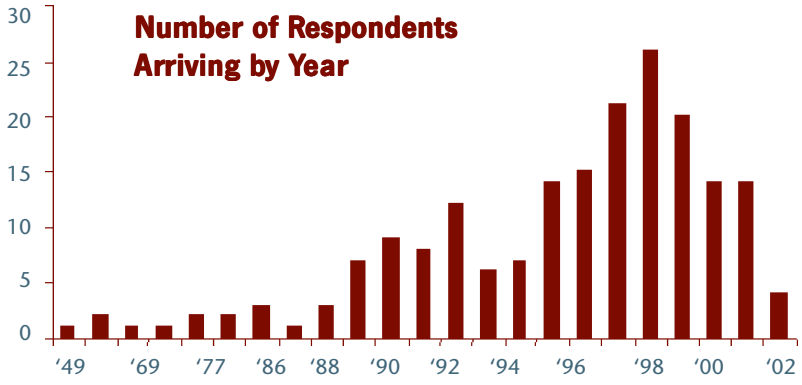

Figure 3: Years when Respondents Came to US

[1] On 2/24/03, at a meeting of King County African-American religious and health leaders to provide direction to an African-American HIV/AIDS initiative spear-headed by King County Executive Ron Sims, some participants questioned such high reported levels of respondents' reporting "transfusions" in Africa. We have since found a large number of reports that Africans do receive more transfusions, often because of malaria which causes profound anemia in those regions. In addition, there is solid evidence of the use of unsterile injection equipment in Africa by medical providers; and a recent article including a King County researcher, speculates that much of HIV transmission in Africa results from non-sexual exposures.

Table 5
Number (%) of 203 respondents who answered the following questions "yes" (shaded cells are untrue statements).

HIV/AIDS does not exist (was made up to combat sex immorality)	7 (3%)	
HIV/AIDS can be cured by having sex with a virgin	30 (15%)	
HIV/AIDS exists but does not kill	33 (16%)	
HIV is a government-made virus spread to kill Africans & others	59 (29%)	FALSE
HIV/AIDS can definitely be cured so no life-long treatment is needed	34 (17%)	
HIV can be spread by holding hands, kissing, and sharing eating utensils	32 (16%)	
HIV/AIDS is a curse caused by evil spirits or witches	29 (14%)	
HIV can be spread my mosquitoes	59 (29%)	
HIV can be spread from a mother to baby by breast feeding	68 (33%)	
HIV/AIDS cannot be cured but is treatable with expensive, lifelong meds	109 (54%)	
HIV/AIDS is a fatal disease transmitted mostly by unprotected sex	141 (69%)	TRUE
HIV can be spread by blood (transfusions and shared needles)	156 (77%)	

Only 46 (23%) of the respondents were aware that anyone with HIV or AIDS could get free care and treatment for HIV here in King County.

persons, 142 (70%) of the respondents indicated willingness to be tested if testing were free and easy.

e. Knowledge about HIV/AIDS - About one in 6 (16%) knew "lots" about HIV/AIDS; 145 (71%) knew "a little"; and 22 (11%) knew "nothing;" on average they knew "a little". Table 5 shows the percents of respondents who answered "yes" to a series of 12 questions.

f. Estimating Possible HIV-infected Immigrants-
As noted from the HIV/AIDS surveillance data above, only 156 blacks currently living with HIV/AIDS have been reported. We need to know whether (we hope that) all African immigrants have at least been offered testing for HIV; however, it seems likely that many have not yet been offered a test or convinced of the value of knowing one's HIV sero-status. A likely smaller number of persons may know they have HIV infection but are not yet aware that care and anti-retroviral treatment is available to all HIV+s in Washington State. Or they may not yet have the courage to seek further clinical evaluation, as survey and other evidence suggests there are high HIV/AIDS stigmas in their communities. Clearly, increased efforts to bring HIV/AIDS services to these populations seem warranted. These services should include free and easy counseling and testing and HIV case-finding, and more accurate information about HIV/AIDS and about the availability of access to care to prevent life-threatening disease.

Conclusions

This project has strengthened reasons to be concerned about HIV/AIDS for local populations of African immigrants. Among those reportedly tested for HIV, HIV sero-prevalence rates are already high (15%), but more than half of the respondents haven't been tested (and respondents may be the best acculturated of all immigrants). In addition, many respondents came to the US in recent years and cite sexual and other significant risks for acquiring HIV both in Africa and after arriving here in the US. Thus, many more immigrants (perhaps even more than 1,000) may be infected and not know it. Finally, of those aware of their infection among survey respondents, only 4 in 11 report that they are receiving care.

Of further concern are the high levels of incorrect information among survey respondents. While 70-75% understand that HIV is a serious disease transmitted mostly by sex and unsterile injection equipment, substantial proportions believe HIV can be spread casually, by mosquitoes, that it results from witchcraft, can be cured so that life-long treatment is not needed, and that it can be cured by sex with a virgin. In addition, we hear that stigma around these conditions among those born in Africa may be even higher than among American-born persons, where stigma is already considerable. Clearly more education, testing and care services are needed, and the survey shows that many would be willing to test if testing were free and easy. Thus, free and easy testing should be recommended and brought to these populations who we now find easier to reach, knowing more about where they live.

Suggestions for Interventions

- HIV case-finding is very important, through culturally sensitive HIV counseling and testing – so that persons with infection can benefit from treatments available here, and can take steps to avoid further transmission of HIV. Of the 203 survey respondents, most said they would be willing to be tested if it were free and easy.
- Education about HIV/AIDS is important with such high levels of misinformation, as demonstrated in the survey. Education could be accomplished in three ways:

1. through the development of materials written in at least the 5 languages needed for the survey (French, Swahili, Amharic, Eritrean, and English),
2. trained outreach workers ideally from the communities themselves who could do one-on-one education with people reached, and
3. group educational sessions by country of origin, again using indigenous trained educators, if possible.

- Prevention and Outreach Training for HIV-infected persons. We believe at least some of the African immigrants currently in treatment for HIV might be recruited to help locate their compatriots for access, education, and reassurance about HIV counseling and testing and HIV and AIDS care. In addition, people with HIV may still have misperceptions about the disease and its transmission and may need additional information and help.

alternative formats available