HIV/AIDS and immigrants: knowledge and perceptions of Eastern African refugees in metropolitan Atlanta.

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The purpose of this study was to examine the knowledge and perceptions of Eastern African refugees regarding HIV/AIDS and its interventions in metropolitan Atlanta, Georgia. The study was guided by the following research questions: 1) What did Eastern African refugees know about HIV/AIDS and its importance? 2) How did Eastern African refugees and their families learn about HIV/AIDS prevention and treatment? 3) How did Eastern African refugees perceive HIV/AIDS and those suffering from HIV/AIDS in their families and communities? 4) What were the perceptions of Eastern African refugees regarding participation in the interventions offered by public and private organizations? Study participants were refugees from Somalia and southern Sudan who had settled in metropolitan Atlanta. The sample of 80 participants was selected based on age, immigration status, and willingness to share information about sex and sexuality. To collect data, the researcher used a structured survey instrument that was administered in a
face-to-face interview format with the 80 participants. Qualitative and quantitative analyses of participant responses were conducted.

Six themes emerged from the qualitative analysis, namely: Knowledge, Openness, Stigma, Attitude, Willingness, and Trust. Participants indicated basic knowledge of HIV/AIDS and its transmission. They also exhibited openness in discussing HIV/AIDS. However, participant responses manifested strong stigma against HIV/AIDS and its victims. Participants who had lived longer in the United States showed negative attitudes towards HIV/AIDS treatment, the healthcare system, and service providers. There was willingness to contribute towards HIV/AIDS interventions and community services. Participants exhibited mistrust towards health institutions, sources of HIV/AIDS information, and the context of the HIV/AIDS information. Results from the quantitative analysis indicated a strong and positive correlation between knowledge and openness. Stigma against HIV/AIDS disease and victims was strongly correlated with knowledge, openness, and attitude. Attitude positively correlated with openness and with knowledge, while trust was moderately correlated to knowledge.

The study findings confirm previous research among similar populations that reported limited knowledge of HIV/AIDS, entrenched stigma about the disease and its victims, negative attitudes and mistrust towards health institutions and service providers as well as the potency of the duration factor regarding immigrants’ resettlement process.
HIV/AIDS AND IMMIGRANTS:
KNOWLEDGE AND PERCEPTIONS OF
EASTERN AFRICAN REFUGEES IN METROPOLITAN ATLANTA

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
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ATLANTA, GEORGIA

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In the Name of Allah the Most Gracious and the Most Merciful.

This dissertation is dedicated to my dear children, Shukri Simbwa Gyagenda and Shahida Safiya Gyagenda, whose presence has brought joy and blessings to our lives. Gratitude goes to the Almighty God for all the blessings in my life. I would like to thank my dissertation committee chair, Dr. Art Hansen, and the other members, Dr. Kwaku Danso and Dr. Alawode Oladele, for supporting and guiding me in the dissertation process. Many thanks go to my best friend, my love, and my husband, Dr. Ismail Simbwa Gyagenda. I appreciate his selfless moral and academic support during the course of my doctoral studies and the dissertation writing process. You are my hero and my God-sent angel. To our children Shabaz, Shuruq, Shafiq, Sharif, Shukri, and Shahida, thanks for encouraging me to pursue this struggle to the end. Blessings and happiness go to my family in Uganda. My mother, Safiya Ali Khalfan, my father, Rajab Ali Ahmed, and my siblings, Ahmed Rajab, Adam Rajab, Hawa Rajab, Naima Issa, Hanifa Kizito, Ali Rajab, Hadijah Rajab, Swalha Rajab, Sadam Rajab, Yusuf Rajab, Atuni Rajab, and Nawaz Rajab, for their endless love and prayers towards our success in life. I also thank my brothers in-law, Hamid Mitchel Hassan, Issa Suleiman, and Hajj Issa Kizito, for their constant unfailing support. To my nieces and nephews in Jinja, I love you from the bottom of my heart. Please follow my example. To Dr. Hassan Danesi, Musah and Aisha Mumuni, thanks for your support. I would also like to thank my colleagues and friends at the DeKalb County Board of Health for their endless support. I love you Sistah’s!
# TABLE OF CONTENTS

**ACKNOWLEDGEMENTS**........................................................................................................... ii

**CHAPTER I** INTRODUCTION .................................................................................................. 1

  Background and Rationale of Study ......................................................................................... 1
  Immigrants into the United States of America ............................................................................ 2
  Refugee Resettlement in the United States of America ............................................................... 4
  Refugee Resettlement in Georgia and Atlanta ........................................................................... 6
  HIV/AIDS and African Refugees ............................................................................................... 7
  Cultural Diversity and HIV/AIDS with Resettled African Refugees .......................................... 10
  Purpose .................................................................................................................................... 12
  Research Questions .................................................................................................................. 12
  Definition of Terms .................................................................................................................. 13
  Methodology ............................................................................................................................ 17
  Findings .................................................................................................................................... 18
  Limitations of the Study ........................................................................................................... 19
  Significance of the Study .......................................................................................................... 21
  Organization of the Dissertation .............................................................................................. 22

**CHAPTER II** REVIEW OF RELATED LITERATURE ............................................................... 23

  Overview ................................................................................................................................... 23
  Access to Health Care Services ................................................................................................ 23
  Health Service Provision .......................................................................................................... 27
  HIV/AIDS and Immigrants ...................................................................................................... 30
  Conceptual Framework ............................................................................................................ 33

**CHAPTER III** PEOPLE AND PLACES ................................................................................. 38

  Overview ................................................................................................................................... 38
  Somalia and the Somali People ................................................................................................ 38
  Sudan and the Southern Sudanese People ................................................................................ 44
  The Somali and Sudanese Communities in Metro Atlanta ....................................................... 50

**CHAPTER IV** RESEARCH METHODOLOGY ....................................................................... 53

  Overview ................................................................................................................................... 53
  Inclusion Criteria ....................................................................................................................... 53
  Sample ....................................................................................................................................... 53
  Data Collection .......................................................................................................................... 56
  Data Collection Procedure ...................................................................................................... 57
  Data Analysis ............................................................................................................................. 60
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER V</th>
<th>DATA ANALYSIS AND FINDINGS</th>
<th>63</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>...............................................</td>
<td>63</td>
</tr>
<tr>
<td>Research Questions</td>
<td>...............................................</td>
<td>63</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>...............................................</td>
<td>63</td>
</tr>
<tr>
<td>Findings from Qualitative Analysis</td>
<td>...............................................</td>
<td>64</td>
</tr>
<tr>
<td>Findings from Quantitative Analysis</td>
<td>...............................................</td>
<td>84</td>
</tr>
<tr>
<td>Discussion of Findings</td>
<td>...............................................</td>
<td>87</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER VI</th>
<th>DURATION AND STIGMA FACTORS</th>
<th>95</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>...............................................</td>
<td>95</td>
</tr>
<tr>
<td>The Duration Factor</td>
<td>...............................................</td>
<td>95</td>
</tr>
<tr>
<td>The Stigma Factor</td>
<td>...............................................</td>
<td>99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER VII</th>
<th>SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS</th>
<th>101</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>...............................................</td>
<td>101</td>
</tr>
<tr>
<td>Summary</td>
<td>...............................................</td>
<td>101</td>
</tr>
<tr>
<td>Conclusions</td>
<td>...............................................</td>
<td>103</td>
</tr>
<tr>
<td>Recommendations for Service Providers and Policy Makers</td>
<td>...............................................</td>
<td>104</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>...............................................</td>
<td>108</td>
</tr>
</tbody>
</table>

| APPENDIX | Sample Questions | 110 |

| REFERENCES | ............................................... | 113 |
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>The Conceptual Framework</td>
<td>36</td>
</tr>
<tr>
<td>3.</td>
<td>Geographical Location of Eastern African Countries</td>
<td>39</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An Illustration of the Sample Grouping</td>
<td>55</td>
</tr>
<tr>
<td>2. Study Sample Subdivided by Gender and Ethnicity</td>
<td>55</td>
</tr>
<tr>
<td>3. Participant Demographic Data</td>
<td>61</td>
</tr>
<tr>
<td>4. Participant Knowledge of HIV/AIDS</td>
<td>65</td>
</tr>
<tr>
<td>5. Cross Tabulation of Knowledge by Ethnicity and Gender</td>
<td>66</td>
</tr>
<tr>
<td>6. Cross Tabulation of Knowledge by Years in the USA and Ethnicity</td>
<td>67</td>
</tr>
<tr>
<td>7. Participant Openness of HIV/AIDS</td>
<td>69</td>
</tr>
<tr>
<td>8. Cross Tabulation of Openness by Ethnicity and Gender</td>
<td>69</td>
</tr>
<tr>
<td>9. Cross Tabulation of Openness by Years in the USA and Ethnicity</td>
<td>70</td>
</tr>
<tr>
<td>10. Participant Attitude towards HIV/AIDS</td>
<td>72</td>
</tr>
<tr>
<td>11. Cross Tabulation of Attitude by Ethnicity and Gender</td>
<td>73</td>
</tr>
<tr>
<td>12. Cross Tabulation of Attitude by Years in the USA and Ethnicity</td>
<td>74</td>
</tr>
<tr>
<td>13. Participant Stigma of HIV/AIDS</td>
<td>75</td>
</tr>
<tr>
<td>14. Cross Tabulation of Stigma by Ethnicity and Gender</td>
<td>76</td>
</tr>
<tr>
<td>15. Cross Tabulation of Stigma by Years in the USA and Ethnicity</td>
<td>77</td>
</tr>
<tr>
<td>16. Participant Willingness of HIV/AIDS</td>
<td>79</td>
</tr>
<tr>
<td>17. Cross Tabulation of Willingness by Ethnicity and Gender</td>
<td>80</td>
</tr>
<tr>
<td>18. Cross Tabulation of Willingness by Years in the USA and Ethnicity</td>
<td>81</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Trust towards HIV/AIDS Information and Health Institutions</td>
<td>82</td>
</tr>
<tr>
<td>20. Cross Tabulation of Trust by Ethnicity and Gender</td>
<td>83</td>
</tr>
<tr>
<td>21. Cross Tabulation of Trust by Years in the USA and Ethnicity</td>
<td>84</td>
</tr>
<tr>
<td>22. Results of Correlation Analysis</td>
<td>86</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Background and Rationale of Study

Globalization has made international mobility and migration an increasing phenomenon in world affairs. The migration, consisting of both voluntary and forced migrants, has also created increasing cultural and linguistic diversity in countries and regions that received the migrants. This has had implications for health service providers in the receiving areas, and they have often encountered difficulties when attempting to communicate with and treat their increasingly diverse populations. The difficulties in providing cross-cultural health care have been even greater in receiving areas that were unaccustomed to global immigrants or to immigrants from developing countries who differed culturally and economically from previous waves of newcomers.

Another increasing phenomenon around the world has been the spread of the Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome (HIV/AIDS). Governments and health service providers have recognized the importance of controlling HIV/AIDS, but prevention and education interventions have been inhibited by popular negative attitudes toward sexually transmitted diseases (STDs) and people suffering from STDs, as well as people’s inhibitions in discussing intimate, or sexual, matters. The difficulties that health service providers have encountered in communicating and treating culturally-diverse immigrant populations have been compounded when dealing with the sensitive issues of sexually transmitted diseases and HIV/AIDS.
One location where these difficulties occurred was metropolitan Atlanta. Although the region was accustomed to immigration, immigrants were primarily from within the United States. In terms of receiving international immigrants, especially from developing countries, Atlanta was considered a “new settlement site” (Hansen, 2005). Among these new immigrants were African refugees, whose cultural attitudes and knowledge of STDs and HIV/AIDS were little understood by US health care providers. Uncovering those attitudes and the extent of their knowledge was the goal of this research.

*Immigration into the United States of America*

Immigration was an integral part of the social, economic, and political history of the United States of America (USA), sometimes referred to as “the land of immigrants.” Ever since the first wave of European immigrants set ashore on the American continent in the 16th century, millions had followed over the years, coming mostly from Europe.

The face of immigration in the USA changed after the 1960s. As Isbister (1996) pointed out, the majority of more recent immigrants came from developing countries as opposed to the early and mid-1900s when most came from developed countries. These “new immigrants” came with widely diverse cultural backgrounds. In addition, these new waves of immigrants began to settle in areas that were not accustomed to international and cross-cultural immigration (Hansen, 2005).

The US government broadly defined an immigrant as “any alien residing in the country except one who was legally admitted under specific nonimmigrant categories”
(Immigration and Nationality Act/INA section 101(a) (15)). These aliens were grouped in four major subpopulations:

1) Legal immigrants, consisting of permanent residents and people who had been adopted by legal permanent residents and/or US citizens.

2) Undocumented immigrants, sometimes referred to as “illegal residents or aliens,” consisting of aliens who had entered the USA without authorized visas or had overstayed their authorized visas.

3) Non-immigrants, consisting of aliens visiting the USA for a short time while maintaining residency in their countries of origin. This group included visitors, tourists, and students.

4) Humanitarian immigrants or forced immigrants, consisting of refugees and asylum seekers.

This research focused on the humanitarian immigrants and especially on refugees. The researcher wanted to explore whether there was any difference in knowledge and perceptions of HIV/AIDS among voluntary and forced immigrants. Besides, refugee data are more structured than data on most international immigrants in the United States. The number of refugees fleeing their countries for various reasons had been increasing over the decades. The United Nations High Commissioner for Refugees (UNHCR) indicated that, by the beginning of 2004, the number of people of concern registered to UNHCR was over 17 million (UNHCR, 2004). This population included refugees, asylum seekers, internally displaced people, returned refugees, and stateless persons. Of these, the global refugee estimate was 9.7 million, or more than half (57%) of UNHCR’s total population of people of concern.
To resolve refugee problems, UNHCR recognized three “Durable Solutions” (UNHCR, 2003). All three involved the refugee becoming a citizen of a country in which the refugee agreed to live. These solutions were voluntary repatriation, local integration, and resettlement. The first two involved two countries: the country of origin and the country of first asylum. The third solution involved a third country that would agree to receive and grant citizenship to refugees who were residing in a country of first asylum (Stein, 1986) According to Forced Migration Online (2007):

Voluntary repatriation - returning to one’s home country – is considered the most desirable solution. If returning home is not feasible because of ongoing instability or conflict, then establishing roots in the host or asylum country may be another option [local integration]. Finally, resettlement to a third country can be a solution for individuals who are not sufficiently protected in the original host country or who are considered to be particularly vulnerable for various reasons (e.g., disabled/injured, women-at-risk).

Refugee Resettlement in the United States of America

The USA has been one of ten western countries that have traditionally resettled refugees. The others have been: Australia, Canada, Denmark, Finland, the Netherlands, New Zealand, Norway, and Sweden.

Refugees came to the United States through the refugee resettlement program that was managed by the federal program in conjunction with a variety of state, local, and civil society organizations (mostly religious and community based organizations). The resettlement process was done through the US State Department, in consultation with the
US Congress, the US Department of Homeland Security, US Bureau of Citizenship and Immigration Services, UNHCR, and non-governmental organizations (NGOs). The US government recognized a limited number of large voluntary agencies (or volags) that provided resettlement services to the resettling refugees.

To initialize the process of refugee resettlement, the USA ensured that interviews, background checks, and medical examinations were conducted before refugees could depart their country of asylum for the USA. Country of origin and urgency of the refugee situation were taken into consideration in determining the priorities with which refugees were selected for resettlement (Patrick, 2004).

Priority I pertained to refugees identified by the UNHCR as in urgent need of resettlement. Priority II pertained to refugees identified by the State Department (in consultation with the NGOs, UNHCR, and the Bureau of Citizenship and Immigration Services) as people whose resettlement needs were different from the other two UNHCR defined durable solutions. Priority III pertained to refugees of a particular nationality who were immediate family members of refugees already resettled in the United States.

Once refugees were selected for resettlement, voluntary agencies (volags) under the supervision of the governments of their respective states provided the following services for refugee resettlement: sponsorship; reception upon arrival; basic needs support (for at least 30 days) including housing, furnishings, food, clothing, community orientation, referral to social service providers such as health care, employment, case management, and tracking for 90-180 days.
Refugee Resettlement in Georgia and Atlanta

Georgia was one of the states that received a considerable number of refugees from diverse cultural backgrounds. Data compiled by the Georgia refugee health program (Office of Refugee Health, 2005) documented that over 50,000 refugees were resettled in the State of Georgia between 1981 and 2004.

The vast majority of refugees coming to the state of Georgia were resettled in the metro-Atlanta area. The Atlanta metropolitan area was accustomed to migration, but its previous migration experience was domestic (people coming from other parts of the United States). The metropolitan area was unacquainted with international and cross-cultural immigration (people arriving with different languages and customs). This lack of familiarity with international and cross-cultural immigration from developing countries was occurring in other parts of the United States as well. Metropolitan Atlanta and those other areas in the USA were labeled “new settlement sites” because they were receiving international immigrants from developing countries for the first time (Hansen, 2005).

Counties in the metropolitan Atlanta area had to begin dealing with different refugee communities (Hansen, 2005-b), including refugees from Eastern Africa. These Eastern African refugees were chosen as the target population for this research. One reason for choosing refugees was because the data on newly arriving refugees was more structured and accessible than the data on most international immigrants in the United States. The researcher chose to study Eastern African refugees because African refugees had received less scientific attention than Asian refugees, the Eastern African refugee population was increasing in size in Georgia (See Figure 1); and the range of peoples...
within the population revealed the diversity, uniqueness, and complexities of cultures in sub-Saharan Africa.

Figure 1

*Resettlement of Eastern African Refugees in Georgia, 2000-2004*

\[ \text{Georgia's Eastern African Refugee Resettlement} \]

\[ 2000 - 2004 \]

\[ 1344 \]

\[ 788 \]

\[ 458 \]

\[ 69 \]

\[ 69 \]

\[ 2000 \]

\[ 2001 \]

\[ 2002 \]

\[ 2003 \]

\[ 2004 \]

**HIV/AIDS and African Refugees**

Human immunodeficiency virus (HIV) is a frequently mutating retrovirus that attacks the human immune system and has proven to cause Acquired Immune Deficiency Syndrome (AIDS). AIDS is a disease characterized by progressive destruction of the body's immune system.
The 2001 UNAIDS report noted that AIDS had become the fourth leading cause of death worldwide and the leading cause of death in Sub-Saharan Africa (UNHCR, 2003). Ever since the epidemic began about two decades ago, more than 60 million people worldwide had contracted the disease. By the year 2002, approximately 40 million people were living with HIV. Of these, about 28 million were in sub-Saharan Africa (Bernstein, 2002), which included Eastern Africa.

In 2005, World Health Organization estimated that the HIV prevalence among adults and children was 81,000 in Somalia (WHO, 2006a) and 580,000 in Sudan (WHO, 2006b). The estimated number of deaths due to AIDS in the same year was 8,000 in Somalia and 58,000 in Sudan.

Changes in life expectancy were among the best indicators of the effect of HIV/AIDS on countries with a high prevalence of HIV. The AIDS pandemic had drastically reduced life expectancy on the African continent (WHO, 2007). In Botswana, for example, life expectancy (by 2005) dropped from 60 to 42 years. South African life expectancy was 51 years and Zimbabwe's 42 years, whereas in Uganda it was beginning to rise back to 49 years. Life expectancy in Somalia was 45 years, while in Sudan life expectancy was 59 years.

Most of the deaths in sub-Saharan Africa (including Eastern Africa) were among people of productive age, including heads of households and the youth. This had a direct negative implication on economic growth, social, and political structures besides depriving children of their parents, school teachers, and government personnel.

In addition to the HIV/AIDS pandemic, the sub-Saharan African region was also ravaged by political and civil conflicts that produced millions of refugees and asylum
seekers over the decades. Studies had indicated that refugees often suffered from physical and psychological torture before and after fleeing from their home countries in search of security (Eyaga, 2002). The host countries of first asylum were often not very receptive, and immediate assistance, if any, was often limited to the provision of food and shelter.

Refugees were exposed to all forms of insecurity, including diseases such as malaria, cholera, tuberculosis, and HIV/AIDS (Neria, 2002). There was a profound fear that refugees and other displaced populations were prone to contracting HIV before and after displacement (UNAIDS, 1997). This was mainly because of the prevailing poverty, sexual violence, social and economic vulnerability, disruption of family structures, and non-existence of health services among refugee populations. Yet in terms of humanitarian medical assistance, attention was rarely paid to these diseases, especially HIV/AIDS.

On the other hand, refugees were sometimes perceived as “bringing AIDS” to the host communities. Such allegations caused tensions between refugees and their hosts, which increased refugee vulnerability. Consequently, the UN began advocating that the prevention and alleviation of HIV/AIDS be considered an essential component of refugee protection. Delaying addressing such problems would lead to an aggravation of the situation. This concern prompted the UN High Commissioner for Refugees, Mrs. Sadako Ogata, to emphasize the need to:

... act quickly to protect refugees from all forms of violence, abuse and intimidation from the very outset of a humanitarian emergency. Often the conditions prevailing during humanitarian crises ... war, physical insecurity, human rights abuses, and especially rape ... exacerbate the spread of HIV, notably for women and young girls. Therefore, preventing the transmission of
HIV and other sexually transmitted diseases should be an essential part of effective refugee protection measures and of reproductive health programs ... refugees have the same rights as we do (UNAIDS, 1997, p.3)

Such statements and general concerns raised around the world motivated the UNHCR in partnership with UNAIDS and WHO to develop a Strategic Plan on HIV/AIDS for 2002-2004. This plan included strategies to combat HIV/AIDS among refugees through the continuation and reinforcement of HIV/AIDS programs in refugee situations and the introduction of comprehensive pilot programs in selected sites.

Despite these efforts, there was still a gap in HIV/AIDS prevention among refugees around the world. The UNHCR plan was concentrated within selected refugee camps and settlements. Many refugees were not covered by country of asylum medical plans, and others did not want to disclose their HIV status for fear of being deported or denied asylum in the host country. Above all, there had been incidences of refugees being blamed and victimized as the ones who were spreading the virus. Eastern African refugees settling in the United States may not have been immune from these challenges and problems.

**Cultural Diversity and HIV/AIDS with Resettled African Refugees**

Metropolitan Atlanta was a “new settlement site,” and health service providers in metropolitan Atlanta had little experience with refugees from diverse cultures. As the providers addressed HIV/AIDS in the increasingly culturally diverse metropolitan population, the providers encountered unique challenges with resettled African refugees. The challenges included both epidemiological and social-cultural factors.
Cultural differences between hosts and refugees had significant implications for health service providers. The sociocultural challenge stemmed from the fact that the intervention programs targeting refugees occurred in cross-cultural environments in which the service providers had little knowledge of the refugees’ perspective.

Culture fundamentally shapes how individuals make meaning out of illness, suffering, and dying. With increasing diversity in the United States, encounters between patients and physicians of different backgrounds are becoming more common. Thus the risk for cross-cultural misunderstandings surrounding care is also increasing (Kagawa-Singer and Blackhall, 2001, p 2993).

Furthermore HIV/AIDS and other STDs were more sensitive topics than most other diseases. The cross-cultural challenges and possibilities for miscommunications were exacerbated when dealing with sensitive issues such as sexual transmission of diseases, sexual knowledge and practices, and the social perception of and interaction with people suffering from a threatening incurable disease such as HIV/AIDS. The sensitivity of discussing the infection, prevention, and treatment of HIV/AIDS was tied to the mode of disease transmission and cultural sensitivity about sexuality.

As a result of the increasing cultural diversity and cross-cultural challenges, HIV prevention and education efforts had to be skillfully tailored to meet the needs of African refugees. A failure to recognize and respond to the differences in cultural connotations and beliefs would widen health service gaps for these underserved populations. Rich (2004) suggested:

Many of the social and cultural issues that contribute to the spread of HIV in Africa are also found in African communities here. Fear of being ostracized by
family or community deters Africans from getting tested or treated. Africans are often uncomfortable addressing any issues around the HIV/AIDS, including sex. Getting Africans to seek treatment for HIV/AIDS is also a challenge since they fear leaving clues of their infection .... (p.12).

Rich contended that service providers had to integrate cross-cultural knowledge into their health care programs in order to come up with culturally appropriate HIV/AIDS intervention programs. It was important to go into those refugee communities to find out what they thought about HIV/AIDS and its prevention, education, and care. Once this information was obtained, it could form the basis for more effective services targeting the African refugee communities. This study attempted to address this need for information.

Purpose

The purpose of this study was to examine the knowledge and perceptions of Eastern African refugees regarding HIV/AIDS and its related educational and prevention programs (interventions) in metropolitan Atlanta, Georgia. The significance of this study was that its results might help in designing culturally sensitive and culturally appropriate HIV/AIDS prevention, education, and care interventions for African refugees who resettled in metropolitan Atlanta. Hopefully, findings from this study might also have meaningful implications for other US communities dealing with similar African refugee populations.

Research Questions

In order to address the stated problem, this study focused on finding the answers to the following four research questions:
1) What did Eastern African refugees know about HIV/AIDS and its importance?

2) How did Eastern African refugees and their families learn about HIV/AIDS prevention and treatment?

3) How did Eastern African refugees perceive HIV/AIDS and those suffering from HIV/AIDS in their families and communities?

4) What were the perceptions of Eastern African refugees regarding participation in the interventions offered by public and private organizations?

**Definition of Terms**

This section provides the definitions of key terms that were used in this dissertation. Terms with legal implications were defined according to the relevant US authorities.

**AIDS**

Acquired Immunodeficiency Syndrome (AIDS) is a disease of the body’s immune system caused by the human immunodeficiency virus (HIV). AIDS is characterized by the death of CD4 cells (an important part of the body’s immune system), which leaves the body vulnerable to life-threatening conditions such as infections and cancers (AIDSinfo, 2005).

**Culture**

The essence of a culture is not its artifacts, tools, or other tangible cultural elements but how the members of the group interpret, use, and perceive them. It is
the values, symbols, interpretations, and perspectives that distinguish one people from another in modernized societies; it is not material objects and other tangible aspects of human societies. People within a culture usually interpret the meaning of symbols, artifacts, and behaviors in the same or in similar ways (Banks, 1989).

**Cultural Competence**

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, 1989).

**Eastern Africa**

In this study, Eastern Africa referred to the following countries in the eastern part of Africa: Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, Sudan, Tanzania, and Uganda.

**HIV**

Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). HIV is in the retrovirus family, and two types have been identified: HIV-1 and HIV-2. HIV-1 is responsible for most HIV infections throughout the world, while HIV-2 is found primarily in West Africa (AIDSinfo, 2005).
Immigrant

The Immigration and Nationality Act (INA) broadly defined an immigrant as any alien in the United States, except one legally admitted under specific nonimmigrant categories (INA section 101(a) (15)) (United States Citizenship and Immigration Services).

Intervention

An intervention was a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy for delivering the prevention messages. An intervention had distinct process and outcome objectives and a protocol outlining the steps for implementation. For example: an Individual Level Intervention might have consisted of four related sessions, but they were all provided in a clinic, through one-on-one interaction, focusing on heterosexual risk behaviors among substance users (National Center for HIV, STD and TB Prevention Divisions of HIV/AIDS Prevention, 2005.) Interventions include education, prevention, treatment, and care.

Refugee

Any person, outside his or her country of nationality, who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on the alien’s race, religion, nationality, membership in a particular social group, or political opinion. People with no nationality
must generally be outside their country of last habitual residence to qualify as a refugee. (US Citizenship and Immigration Services, 2005).

The United Nation’s 1951 convention (Chapter 1, Article 1) defined refugees as persons who had left their country and could not return due to a “well-founded fear of persecution because of their race, religion, nationality, difference in political opinion or membership of a particular social group” (UNHCR, 1996). The 1969 Organization of African Unity (OAU) Refugee Convention and the 1984 Cartagena Declaration in Latin America expanded this definition to include persons who had fled their countries for other reasons, including war or civil conflict.

**Resettlement**

Resettlement to a third country was a “durable solution” for refugees who might not have been fully protected in their initial host country. Such groups were considered to be extremely vulnerable and in need of immediate attention. In most cases, the groups included women, children, the sick, and the disabled (Forced Migration Online, 2007).

**Tribe**

In this study, tribe refers to people in sub-Saharan Africa who share the same language and culture. They often live in the same geographical area, for example the Dinka of Southern Sudan, the Baganda of Uganda, and the Luo of Kenya.
Methodology

Instead of studying a composite population of all Eastern African refugees who had resettled in the metropolitan Atlanta area, the study selected refugees from Somalia and Southern Sudan.

The sample of 80 participants was selected according to several factors such as age, immigration status, willingness to share information about sex and sexuality (See Methodology Chapter IV, for details on the criteria). Another factor that might affect knowledge and attitudes was religion, especially the differences that might exist among Christians, Muslims, and practitioners of traditional African religions. The selection of Somalis and Sudanese allowed the possibility of finding differences between the Muslim Somali refugees in Atlanta and their Southern Sudanese counterparts, who were predominantly Christian.

The sample was divided into four subgroups: 20 Somali women, 20 Somali men, 20 Southern Sudanese women, and 20 Southern Sudanese men. They were also divided according to duration in the US with two resulting categories: those who had resettled in the US for four or less years, and those who had lived in the US for five or more years.

The study collected both secondary and primary data. For the primary data, the researcher used a structured survey instrument that was administered in a face-to-face interview format. The study used the snowball sampling technique to identify participants, and carefully selected interpreters helped in translating for those who were not fluent in English. Both the survey instrument and interview consent form were approved by the university’s Institutional Review Board (IRB).
The researcher conducted qualitative data analysis using as evidence the participants’ responses on the survey instrument. The quantitative analysis examined correlations among the six themes identified from the qualitative analysis namely: knowledge, openness, stigma, attitude, willingness, and trust.

Findings

Six themes emerged from the qualitative analysis of the data: Knowledge, Openness, Attitude, Stigma, Willingness, and Trust.

The majority of the participants had basic knowledge about HIV/AIDS but many had no access to intervention and/or care information. Women were less knowledgeable than men and Somali women were least knowledgeable among the four subgroups.

Although participants indicated they were open to discussing the topic of sex with others (including medical personnel), they reported that sex was not an open topic within family circles, and not between adults and the youth.

Participants indicated negative attitudes towards the health care system, providers, and HIV/AIDS treatment.

With regard to stigma, participants reported that widespread and strong stigma towards persons living with HIV/AIDS prevailed in their families and communities.

Participants indicated willingness to contribute towards HIV/AIDS interventions and community service.

However, most participants reported less trust towards health institutions, sources of HIV/AIDS information, and the context of the HIV/AIDS information.
The findings from the quantitative analysis indicated a strong and positive correlation between Knowledge (about HIV/AIDS) and Openness (in discussing the disease).

Stigma against persons living with HIV/AIDS was also strongly correlated with three variables of Knowledge (about HIV/AIDS), Openness, and Attitude.

Attitude positively correlated with Openness and with Knowledge, while Trust was moderately correlated to Knowledge.

Limitations of the Study

Like all research initiatives, this study had several limitations. Possible constraints that may impact the results of the study, as well as potential solutions, are highlighted. Four major limitations were identified: a) the sensitive nature of the study, b) methodological issues, c) potential research bias, and d) representativeness of the sample population.

The sensitive nature of the study

The subject of HIV/AIDS has been received with a lot of sensitivity in different communities (Fredriksson-Bass and Kanabus, 2006). Such sensitivities are also found within the Eastern African communities in the United States. To most Eastern Africans, it is a taboo to openly discuss HIV/AIDS due to the sensitive nature and stigma attributed to the disease. The level of denial and fear to seek medical attention is very high. The sensitivity might affect the validity of the answers in that some respondents may give
misleading answers because they are embarrassed, ashamed, or reluctant to verbally discuss this issue.

This has been found to be the biggest inhibition of prevention and education intervention efforts among the Eastern African communities in the United States. The researcher's expertise and experience of dealing with Eastern African communities helped to reduce the potential limitation related to the stigma and sensitivity attributed to the HIV/AIDS disease.

Methodological issues

It is also envisaged that methodological issues such as language use could be a potential limitation to this study. Some Somali and Southern Sudanese are not very fluent in the use of English language. Having an interpreter may largely solve most of this problem but it may also intensify sensitivity and introduce interpreter bias. Regarding the sensitivity problem, respondent's consent was sought before engaging the help of an interpreter while factors such as gender and age were used to find an interpreter that the respondents were comfortable with. Regarding interpreter bias, interpreters were trained to translate exactly what the questions and responses were rather than infusing their own judgment. Lastly, the researcher was present at all interviews and this helped in, for example, reading the body language and rephrasing certain questions.

Potential research bias

Another potential limitation that may affect the results of this study is the subjective interpretation of data inherent in qualitative studies. When a researcher collects
textual data in interviews, the researcher makes decisions about how much of that data to utilize and how to interpret the data. Care was taken to preserve and rely on the direct quotation of the respondents as evidence for the themes identified from the data.

Representativeness of the sample population.

The last limitation of the study is the extent to which the findings may be extrapolated to apply to all Somali refugees, Southern Sudanese refugees, and other Eastern African refugees in the metro-Atlanta area and the United States of America. The sample was not randomly selected to represent the Somali and Southern Sudanese populations in metro-Atlanta, and the refugees are not necessarily representative of all refugees resettled in the United States.

This was a purposeful sample of two populations both coming from the same region of sub-Saharan Africa but differing in religion and language. They were not randomly selected because it was practically impossible to identify all of the members of the two populations in order to select a random sample. Therefore, the results of the study may not be generalized to the Somalis, to the Southern Sudanese population, nor to the larger Eastern African community.

Significance of the Study

Although the results of this study can not be extrapolated with confidence because of the small and non-random sample used, the research purpose was to intensively analyze trends and themes so as to discover underlying relationships that may serve to guide future research. The significance of this study, therefore, was that it generated and
hypothesized relationships among important themes for future study. Secondly, to the best of the researcher's knowledge, no previous research had created thematic analysis (of beliefs and perceptions of communities on HIV/AIDS) similar to the one presented in this dissertation.

*Organization of the Dissertation*

The first chapter discusses the background and rationale for the study. The second chapter provides a comprehensive review of the literature related to access to healthcare services, provision of healthcare services, HIV/AIDS and immigrants, as well as the conceptual framework for the study. Chapter three describes a brief geography and socio-political history of the Somali and Southern Sudanese people as a context for understanding the HIV/AIDS related knowledge and attitudes of the targeted population in this study. The fourth chapter describes the methodology of the study, including the sample profile, data collection procedures, and analysis. Chapter five presents the data analysis and findings of the study as well as their discussion. Chapter six provides an interpretation of the findings on the duration and the stigma factors. The seventh and final chapter summarizes the study, states the study's conclusions, and provides recommendations for service providers, policy makers, and researchers.
CHAPTER II
REVIEW OF RELATED LITERATURE

Overview

This chapter reviews the literature on health care for immigrants and refugees in the United States of America (USA). The chapter was organized around the following themes:

1) Access to health care services from the perspective of the client.
2) Provision of health care services from the perspective of the provider.
3) HIV/AIDS and immigrants.
4) Conceptual framework of this research.

Access to Health Care Services

Access to health care is a prerequisite to quality health. Yet, challenges in accessing health care services were prominent among low-income households and worse still among low-income non-citizen populations. The literature pointed to several factors that perpetuated inequity in accessing health care services among non-citizen populations. These included issues in health care policy, immigration status, employment, language and culture, as well as fear. Stringent policies on health care coverage have a gross impact on immigrant access to health care services. Most immigrants do not have health care coverage either because they cannot afford private insurance due to their low income level and/or because they are not eligible for public insurance due to their
immigration status (American Academy of Pediatrics, 2005; Grieco, 2004; Kaiser Commission on Medicaid and the Uninsured, hereafter referred to as the Kaiser report, 2003; and Leclere, Jensen, & Biddlecom, 1994). The Kaiser report highlighted the lack of health coverage as a major problem among the immigrant communities and recommended the need to address coverage issues for the non-citizen US population. The report indicated that immigrants lack health care coverage in disproportional rates. It also pointed to recent federal policies that have restricted immigrant access to Medicaid. The Kaiser report stated that:

Lack of health insurance coverage is a major issue facing immigrant populations. Low-income non-citizens are more than twice as likely to be uninsured as low-income citizens. Of the 11 million non-citizens, 60 percent had no health insurance in 2001 and only 13 percent received Medicaid. In contrast, about 28 percent of low-income citizens were uninsured and about 30 percent had Medicaid (p. 1).

The Medicaid eligibility restriction was influenced by the Personal Responsibility and Work Opportunity Reconciliation (PRWORA) Act of 1996. This Act fundamentally reduced Medicaid coverage for legal immigrants specifically with respect to cash assistance and treatment, consequently affecting immigrants' access to health care services.

According to Grieco (2004), immigrants may not be able to access health care services due to their immigration status. Immigrants are more likely to be employed either as part-time or temporary workers and, as such, are not covered by employment based insurance nor would they be able to purchase private insurance. However, the
longer immigrants stay in the United States and acculturate, the more likely they are to be insured and therefore access health care services (Grieco, 2004 and Ku & Matani, 2001).

Ku & Matani (2001) analyzed data from the National Survey of America’s Families (NSAF) on how immigrant status affects insurance coverage and the use of medical, dental, and mental health services by adults and children. They concluded that “immigration status is an important component of racial and ethnic disparities in insurance coverage and access to care” (p. 247). They estimated that a citizen child with non-citizen parents would have an 8 percent higher risk of being uninsured than one with citizen parents. Immigrant access to ambulatory care was also significantly lower than for citizens. They had fewer emergency room visits. The rate of inaccess to:

... doctor/nurse or emergency room visits in a year (41 percent for noncitizen adults, 38 percent for noncitizen children, and 21 percent for citizen children with noncitizen parents) was roughly double the rate of native adults (21 percent) and children of citizens (13 percent). (p. 252)

The authors also lamented the distressing insurance gaps for citizen children of immigrant families given that these children are eligible for Medicaid and SCHIP, a federally funded children’s insurance program.

Wallace & Gutierrez (2004) reviewed Mexican immigrant’s health access and concluded that they used “fewer key preventive services than US-born Mexican Americans and non-Hispanic whites” (p. 1). This was attributed to the immigrant’s lack of usual source of care and low rates of health insurance. They recommended provision of health insurance to all working families and “increasing support for community clinics to provide preventive services” (p 2).
The National Conference of State Legislatures (NCSL, 2005) pointed out the lack of access to health insurance for many immigrants and refugees. As they explained:

Newcomers face several barriers to adequate, comprehensive health care. Institutional barriers, such as legal status and program eligibility requirements, prevent some categories of newcomers from participating in government-sponsored health care programs. Foreign languages and cultures contribute to miscommunication between service providers and newcomer patients. Economic obstacles prevent many newcomers from purchasing health care on their own. (p. 3)

They also pointed to the inadequate and fragmented federal programs that are meant for newcomers’ health care needs, plus the fact that the federal government has pushed health care responsibilities to state and local governments who have limited resources. The resultant lack of access to health care services has an impact on newcomer employment prospects, “self sufficiency, and successful integration into their new communities” (NCSL, 2005, p. 4). Moreover, integration into the new community is also affected by differences in culture and language which in turn prevent their access to adequate health care services.

Cultural and linguistic differences pose a challenge in accessing public services, including health care services. Specifically, immigrants with limited ability to speak English tend to have difficulties in accessing all kinds of services. Taking an example from the Latino community, the Kaiser report (2003) stated:

Research shows that language and citizenship status can affect children’s health coverage. Over 70 percent of Latino children in non-citizen Spanish-speaking
families were uninsured, compared to 26 percent of children in Latino citizen families who speak English (p. 2)

In addition to challenges from health care policy, immigration status, culture and language, immigrant’s limited access to health care services is also exacerbated by fear. Immigrants with certain kinds of diseases such as the HIV/AIDS disease tend to stay away from accessing health care services for fear of their immigration status and exposure to the community. On the other hand, undocumented immigrants tend to shy away from public service opportunities for fear of deportation where as immigrants with long-term goals of becoming United States citizens have the fear of becoming a public charge (American Academy of Pediatrics, 1997 and Dunlap & Hutchinson, 1993). This fear has also been articulated in the report from the Kaiser report (2003), as stated:

Even for immigrants who remain eligible for Medicaid benefits, fear and confusion create barriers to enrollment and concern about becoming a public charge and thus ineligible for citizenship. These fears remain despite Department of Justice clarifications that have reiterated that Medicaid and SCHIP coverage are not to be used in public charge determinations and outreach work by community groups at the local level. (p. 2)

Health Service Provision

Health care access and health care provision are essential components of quality health. While consumers (especially those among low income non-citizen populations) face challenges in accessing health care services in their new environment, providers in
the United States face similar challenges in the provision of health care services to the newcomers. These challenges may stem, in part, from dealing with unfamiliar situations.

Unfamiliarity from the providers' side is partially influenced by immigrants whose cultures, languages and diseases (such as congenital syphilis, malaria and other tropical diseases) are not similar to those that the providers are accustomed to (Centers for Disease Control and Prevention, 1995; Christenson & Fischer, 1993; Emanuel, Aronson, & Shulman, 1993; Franks, et al., 1989, Hayani, & Pickering, 1991, Iseman & Starke, 1995; McKenna, McCray, & Onorato, 1995; Wolfe, 1992). On the other hand, immigrants' lack of familiarity with the US structure makes it difficult for them to navigate the health care system that is different from what they have been exposed to (Kraut, 1990 & Muecke, 1983).

Unfamiliarity and uncertainty of health care service utilization is prominent among several immigrant groups who are left frustrated and confused and therefore, do not follow up with health care utilization unless in an emergency situation (Berk, Schur, Chavez, & Frankel, 2000; Flores, Abreau, Oliver, & Kastner, 1998, Martin, Rissmiller, & Beal, 1995; Miller, 2000).

Ryan, Hawkins, Parker, & Hawkins (2004) conducted a qualitative research to identify obstacles to health care utilization among Haitian immigrants living in Delray Beach, Florida. The study indicated several barriers to health care utilization including frustrations, lack of knowledge and ability to navigate the mainstream health care system. They stated that...

... impersonal care and long waiting periods in clinic settings intimidate and frustrate immigrants attempting to secure medical treatment. This sense of
frustration is compounded by a difference in worldview on the part of Haitian immigrants trying to understand the mainstream medical model health care system at odds with their own values and customs. (p. 30)

Another study conducted by Garcia, Saewyc, Resnick, Bearinger, & Duckett (2005) to describe immigrant Latino adolescents’ experiences in accessing health care services, including their perceived barriers and facilitators, revealed that immigrant Latino adolescents regarded a positive experience as indicated by providers’ demonstrated respect and kindness, and taking time to explain things. Negative experiences were perceived as inadequate treatment and rudeness. Their perceived barriers included “language, insurance requirements, and lacking knowledge ... (whereas family came out as) ... the strongest facilitator to accessing health care” (p.1). The study concluded that providers need to involve family in the health related information of immigrant Latino youths as opposed to clinging to confidentiality issues.

In respect to special health care needs and challenges faced by immigrant children and their families, the American Academy of Pediatrics (1997), issued a statement to practitioners suggesting ten different approaches to various aspects of immigrant care. These suggestions were based on the following notion:

Immigrant children and their families, a large diverse population group, have numerous risks to physical health and functioning and may be unfamiliar with our health care services. They often face many barriers to care, and their special risks and needs may not be familiar or readily apparent to many health care providers (p.153)
The ten suggested approaches to immigrant care encouraged pediatricians to 1) not deny services to any child living within the United States, 2) use available resources to better understand immigrant cultures and their health care needs, 3) tolerate and respect differences in attitudes and approaches to child-rearing so as to provide culturally effective health care, 4) be aware of special health needs that immigrant children are at risk of, 5) be educated about stresses that immigration can impose on children and families, 6) recognize and support extended family involvement in the provision of health care, 7) do continuous follow-up of health supervision in the event that immigrants or refugees received any health screening before entering the United States, 8) develop linguistically and culturally appropriate services in collaboration with community stakeholders, 9) assess impact of welfare reform so as to ensure access to medical services for all children, and 10) support and participate in community based activities that increase health care access to immigrant children.

**HIV/AIDS and Immigrants**

A lot has been articulated on challenges and perceptions of U.S health care providers and immigrants regarding equitable provision and access to quality health care services. While these challenges surround cultural and linguistic differences between providers and immigrants, they are intensified by the kind of diseases these immigrants have especially non-traditional diseases such as HIV/AIDS. The challenges surrounding the HIV/AIDS disease are influenced by both epidemiological and social-cultural factors. This is because the prevention, infection, and treatment of HIV/AIDS are more sensitive
topics than that of other diseases. This sensitivity is related to the mode of disease transmission and cultural sensitivity towards sexuality.

Immigrants may have expressed these sensitivities in their countries of origin and yet they are also exhibited in their new settlements in the United States. Rich (2004), on the issue if HIV/AIDS among African immigrant communities, contended:

Many of the social and cultural issues that contribute to the spread of HIV in Africa are also found in African communities here .... Fear of being ostracized by family or community deters Africans from getting tested or treated. Africans are often uncomfortable addressing any issues around the HIV/AIDS, including sex. Getting Africans to seek treatment for HIV/AIDS is also a challenge since they fear leaving clues of their infection .... (p.12)

Rich’s statement can be verified with findings from studies among similar populations. Khaliq, DuBois, Herrel, Jama, & Abdirahman (2004) noted that despite education and knowledge of the HIV/AIDS disease among the Somali community in Minnesota, societal and cultural factors influenced the manner in which Somali immigrants interacted with HIV positive people as well as the strategies used to prevent HIV/AIDS. The study indicated:

The fear of getting HIV/AIDS or being exposed to individuals causes some community members to stigmatize or pass judgment on the disease and on those people who have HIV/AIDS. Several of the focus group participants believed their religion could prevent Somalis from getting HIV/AIDS (p. 23)

The study concluded that there is need for further dialogue and education within the Somali community on the issue of HIV/AIDS so as to counter the negative effects of
stigma. A recommendation was also made to discuss the HIV/AIDS issue “at a policy level, so that funds are available for further research and for the development of targeted and culturally appropriate interventions” (Khaliq et al., 2004, p. 24).

On a similar note, a study conducted among 309 immigrants from 20 African nations residing in Houston, Texas revealed that African immigrants were highly knowledgeable about different modes of HIV/AIDS transmission (Rosenthal et al., 2003). About 79.5 percent had a low self-perceived risk of contracting the disease whereas 36.3 percent reported never to have used a condom. However, their perception levels of HIV/AIDS related stigma were discouraging. The need for education campaign to raise awareness was highlighted.

Foley (2005) also recommended culturally appropriate education about HIV prevention and treatment for African immigrants and highlighted the need for medical personnel to appreciate the experiences, fears, and concerns of the population. However, the realization that there is limited publication on demographic and epidemiological data among African immigrants and other populations was prominent (Kandula, Kersey, & Lurie, 2004). Related sentiments have been expressed among immigrant Asian/Pacific Islanders (Yoshikawa et al., 2005).

In order to address the issue of HIV/AIDS in the immigrant community, Shedlin, Decena, & Oliver-Velez (2005) suggested that, “the challenges and opportunities faced by these new communities must be distinguished from those of more acculturated immigrant populations if culturally appropriate interventions are to be developed” (p 325). This argument was based on a study conducted among recent Hispanic immigrants into the United States. The study finally concluded:
The risks of HIV/AIDS can be better identified and addressed by building on the strengths of emerging immigrant communities, developing partnerships with trusted leaders, mentoring and supporting potential leaders, and bringing community members into the process of creating prevention strategies that address new immigrant realities. (p. 365)

**Conceptual Framework**

Over time, there have evolved very different ways of conceptualizing immigration in the USA. Each of these ways correlated with assumptions about the relationship of immigrants to the US health care system.

An early theory emphasized the assimilation of newcomers into the American "melting pot." This approach, espoused by Park in the 1920s (Park and Burgess, 1921/1969) posited that, historically, immigrants had shed their earlier cultural perspectives and converted to become Americans. Park and Burgess (1921/1969, p. 735) defined assimilation as "a process of interpenetration and fusion in which persons and groups acquire the memories, sentiments, and attitudes of other persons and groups and, by sharing their experience and history, are incorporated with them in a common cultural life." Alba & Nee (1997, p. 828) summarized Park’s theory as equating “assimilation with the social processes that bring ethnic minorities into the mainstream of American life.” By assimilating (becoming like the hosts), the immigrants lost their previous cultural characteristics and no longer were differentiated from other Americans of the same economic level. The implications of such a theory for health care providers were that there was no need to provide special services because of cultural differences.
The theoretical pendulum swung away from that earlier theory to emphasize the opposite tendency, how immigrants remained “unmeltable ethnics” in the USA. This approach posited that immigrants retained the cultural perspective of their homelands, which was why the USA was more of a cultural “salad bowl” of different ingredients rather than being a melting pot in which differences had been erased. As Anderson (2000, p. 262) reported, “In 1999, we have more of a salad bowl than a melting pot. Rather than giving it up, racial and ethnic groups appear to embrace their particularism.” In an extreme form, this approach denied any assimilation to the American social and cultural mainstream.

Another approach recognized that immigrants went through both processes, retaining some characteristics of their homelands while adopting other characteristics of their new country and society. Research into this studied which arenas of daily life were more likely to express the culture of the homeland and which were more likely to express American culture. For example, Gibson’s (1988) study of Sikh immigrants in a US high school suggested the notion of integration as referring to accommodation without assimilation. Gibson implied that immigrants assimilated into “public” life and society, learning how to navigate and behave in schools, work sites, and government bureaucracies, while still retaining more of their original cultural beliefs and practices in the more “private” arenas of religion, diet, friendship, marriage, family, and sexuality. This approach gave more recognition to the importance of hyphenated identities. Immigrants became, for example, Polish-Americans, Chinese-Americans, or Somali-Americans because their identities and behaviors melded cultural features of both lands.
This research accepted the last theoretical perspective: the knowledge base and attitudes of immigrants would express a blend of what people had known and believed in the country of origin and what they had learned in the country of destination. Duration (length of time in the new country) was an important variable in that immigrants who had lived longer in the host country of destination had more time to learn US beliefs and more time to forget or lose touch with the beliefs of the homeland.

This theoretical orientation had significant implications for health care providers. The providers could not assume that immigrants shared American beliefs and attitudes or that all immigrants shared the same beliefs and attitudes. Each immigrant population might have a uniquely different body of knowledge and set of attitudes, which meant that each immigrant population had to be studied. This was especially true when dealing with beliefs and attitudes about illnesses that were more “private” than “public,” since the more private illnesses were less likely to show common American characteristics and more likely to express ideas and perspectives from the homeland. Sexuality was a private matter, as were sexually transmitted illnesses (STDs) such as HIV/AIDS.

This research recognized that there were differences among homeland cultures and that there might be differences in knowledge and attitudes that resulted from living longer in the US. These lay behind the researcher’s choice of a conceptual framework that took into consideration demographic, sociocultural, and epidemiologic factors.

The author created the conceptual framework shown in (Figure 2). In this framework, the African refugee features guided the study. Under the African refugee, the following three components were conceptualized:

1) The refugee’s characteristics prior to arrival
2) The refugee’s first four years in the USA.
3) The refugee’s five years plus experience in the USA.

Figure 2

*The Conceptual Framework*
Each of the above components was subdivided into the relevant demographic, sociocultural, and epidemiologic factors. Regarding the refugee’s characteristics prior to arrival (pre-arrival), the demographic factors were the refugee’s national origin, gender, and socio-economic status. The sociocultural factors were the refugee’s cosmopolitan experience and previous knowledge of the USA. The epidemiologic factor was the refugee’s prior health status.

With regard to the refugee’s first four years in the USA, one demographic factor was envisioned, the refugee’s migration status. One sociocultural factor was identified, the refugee’s hospitality experience, i.e., whether the refugee was hosted by a family, a friend, or a non-governmental organization.

The refugee’s five year experience in the U.S included sociocultural and epidemiologic factors. The sociocultural factors were the refugee’s resettlement experience and utilization and knowledge of U.S health and welfare institutions. These two factors were referred to as the refugee’s acculturation process. The epidemiologic factors were the refugee’s disease perception and knowledge, risk behaviors, and current health status.

In order to understand refugee perceptions of HIV/AIDS and its interventions, it was imperative to consider the refugees’ status, knowledge, and experiences prior to arrival in the United States, during their initial four years in the U.S, and their acculturation in the following five years. It was conceptualized that the prior experiences and characteristics would influence to some degree refugees’ risk behaviors, disease perception, ideas about how to deal with U.S health institutions, and ultimately their health status.
CHAPTER III

PEOPLE AND PLACES

Overview

In this section, a brief geography and socio-political history of the Somali and South Sudanese people is provided as a necessary context in order to understand the culture, beliefs, and perspectives of the respective immigrant and refugee population that is the target of this study.

Somalia and the Somali People

Geography

Somalia is located along the north-eastern coast of Africa (See Figure 3). It runs along the Horn of Africa, and, with the longest coast of any African nation, borders both the Red Sea and the Indian Ocean. Kenya lies to the South, Ethiopia to the west and Djibouti to the north. Most of the inland areas are plateaus, but the far north has several mountainous areas. Vegetation is sparse, and the climate is arid in the north, but the south experiences more rainfall. In 2007, the majority of Somalis lived in the rural area with herding of camels and sheep as the main occupation in the north and farming the main activity in the south. The herdsmen lived a nomadic or semi-nomadic life, looking for watering holes during the dry seasons. Fishing was also very common among those who lived on the coast.
Figure 3

Geographical Location of Eastern African Countries

Source: africaguide.com
Mogadishu, a port city, is Somalia’s capital, with about 1.5 million people in 2007 when the research for this dissertation was completed. The other major towns are Baidoa in the south, Hargeysa in the north, Berbera port on the Red Sea, and Kismayu port on the Indian Ocean.

*Origins*

The Somalis traced their origins from the Cushites, who lived in the Horn of Africa as far back as 1000 A.D. (Kellerman & Vemuri, 2006). Islam was introduced to the region in the 7th century, and 99% of Somalis were Sunni Muslims. The Somalis extended into what was known as the Ogaden region of eastern Ethiopia as well as into northern Kenya, establishing trade routes that lasted for centuries.

*Culture*

According to Kellerman & Vemuri (2006, p. 6), “Somali society is based on clans.” There were over 100 clans, but the majority of Somalis belonged to four main clans collectively known as “Sammal”. These were mainly nomadic herders. Decisions were made democratically, with each clan having a council of men or shir. The other two main clans were called the Sab, who lived in the south as farmers and were led by village leaders. As Kellerman & Vemuri suggested, “Clans provide protection, support and resources to their members, but also divide society when there is competition for resources” (p. 7).

As in most African societies, the extended family was a significant part of Somali life. Fathers were the heads of the family, but mothers were the heads of the household,
and Somali women "speak their minds and exert much power at home" (Kellerman & Vemuri, p. 7). They also owned property and ran their own businesses.

The great majority of Somalis are Muslims, and Islam plays an important part in the social-cultural life of the community. For example, marriage and divorce are carried out according to Islamic custom. Polygamy is practiced, but is not widespread. Families value their honor, and girls are especially expected to be modest to keep the family’s honor. Among the pastoralist Somalis in the north, boys are responsible for their family’s camels while girls help in looking after the goats and sheep. Unlike many Sub-Saharan African countries, Somalia is united by one language, Somaal. With northern, coastal, and south dialects, the Somaal language is the official language of Somalia.

Political History

Like the rest of Africa, Somalia was controlled by European colonial entities starting in the 1800s. France took the northernmost part, currently known as Djibouti. Britain controlled the northern part, which became known as British Somaliland. Italy controlled the south, creating a country called Italian Somaliland. In 1960, Britain and Italy ceded the two parts, which united to form the current borders of Somalia (Lewis, 1996). Djibouti remained in French hands until it gained independence in 1977.

A civilian government ruled Somalia from 1960 until it was overthrown in a military coup by Major-General Mohammed Siad Barre, who created a socialist military government. His popular support waned over the years, and he fell out with the Soviet Union when it supported Ethiopia in the war with Somalia over the disputed Ogaden region in 1977. The US started supplying Somalia with military and economic aid, but
this stopped due to human rights accusations in 1989. Internal opposition to General Siad Barre developed into clan-based conflicts that intensified into a full-blown civil war that raged from 1988 to 1991. General Barre ran into exile in January 1991. Afterwards, Somalia disintegrated into fiefdoms controlled by warlords and their militias. In the north (the former British Somaliland), clans negotiated a peaceful reconciliation and formed a state government called Somaliland that, as of 2007, was not recognized by the international community (Haviland, 2001).

The Transitional Government

In 2004, a Somali government, the Transitional Federal Government of the Somalia Republic, was formed after protracted negotiations in Nairobi, Kenya, among various Somali clans and factions. These negotiations were organized by the Intergovernmental Authority on Development (IGAD), an intergovernmental agency that comprised seven Eastern African countries: Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan, and Uganda.

The transitional government could not assert its authority inside Somalia because it lacked an army. It entered southern Somalia, in 2005, and established its headquarters in Baidoa, while the rest of Somalia continued to be ruled by various warlords. In the capital Mogadishu, the Union of Islamic Courts (UIC) had emerged as the controlling authority by 2004. The UIC controlled Mogadishu between 2004 and 2006, bringing a semblance of law and order in a city that had been ravaged by war and anarchy since 1989. However, the UIC was increasingly accused by the US of harboring terrorists linked to Al-Qaeda.
Meanwhile, the African Union (AU), supported by the United Nations, agreed to send peacekeeping forces to install and protect the transitional government. Before the AU could deploy its troops, clashes broke out in December 2006 between the UIC and the transitional government backed by neighboring Ethiopia, which accused the UIC of fermenting trouble on their common border. The clashes resulted into a full-blown, but short war that the well-armed Ethiopian army won easily. The UIC was chased out of Mogadishu, and the transitional government was installed in early 2007. The first contingent of African Union peacekeepers (1500 Ugandan troops) arrived in Mogadishu in March 2007 to help keep the peace. The Ethiopian troops were scheduled to be pulled out once all the 8,000 AU troops drawn from different African countries were deployed. Meanwhile, clashes between the defeated UIC and the Ethiopian forces continued, but Mogadishu in 2007 was finally controlled by the transitional government.

However, the fate of the break away Somaliland, which had had a functioning but unrecognized government since 1991, remained unclear. It was hoped that the transitional government, once it had established itself and consolidated its power, would embark on the reunification of Somalia.

*The Refugee Problem*

The tragic breakup of Somalia in the late 1980s and early 1990s led to untold human suffering with war, famine, and disease. According to Kemp (2007):

The continuous warfare, together with border clashes, has brought the Somali economy to near collapse. Mass starvation has ensued, and the level of inter-clan violence has become extreme, with rape and torture commonplace...
Humanitarian relief forces from the U.N. and the US attempted to intervene, but by Spring of 1994 all foreign troops had been withdrawn due to the instability. (p 318)

The conflict resulted in over 2 million refugees fleeing to the neighboring countries. Several thousands were resettled in Europe and the US. Some of the Somalis who came to the USA settled in the Clarkston area of DeKalb County, Georgia and were part of the target population of this study.

_Sudan and the Southern Sudanese People_

*Geography*

Sudan, covering 2.5 million square kilometers in area, is the largest country in Africa. It is bordered by 9 countries: Egypt to the north, Eritrea and Ethiopia to the east, Kenya, Uganda, and the Democratic Republic of Congo to the south, and Central African Republic, Chad, and Libya to the west. Simich (1998) colorfully described Sudan’s landscape:

Sudan, surrounded by mountains, is like a huge bowl. Lush and tropical in the south, the land slopes down toward the Sahara desert in the north. The waters of the Nile are the main source of irrigation and Sudan’s lifeline. From the humid southern forests, the wide river flows northward (from Uganda) through the enormous Sudd swamp region. At Khartoum, the branches of the Blue Nile and the White Nile meet to form the main stream of the Nile, which flows north through the desert in a giant S-curve to Egypt. (p. 3)
The north is much hotter, with summer temperatures averaging 40°C, than Southern Sudan, with its rain forests and tropical temperatures that average 26°C.

Southern Sudan is the region that consisted of three provinces located in the south of the Republic of Sudan: Equatoria (present-day Al Istiawai), Bahr al Ghazal, and Upper Nile (present-day Aali an Nil). According to Metz (1991), Southern Sudan was geographically characterized by three features: 1) the Nilotic Plain, which was dissected by the White Nile and included the Sudd, the largest swamp in the world; 2) the Ironstone Plateau (Jabal Hadid) to the south and west of the plains; and 3) the Imatong, Didinga, and Dongotona mountain ranges along the border with Uganda. The region experienced the rainy season from April to October (the south west had rainfall till December) and a dry season from November to March (Metz, 1991).

Origins

According to Simich (1998), the banks of the River Nile in what is present-day Sudan have seen human settlement for at least 9000 years. The Kingdom of Cush in the north-east corner of Sudan rivaled Egypt for over 1000 years. In the sixth century, the Kingdom of Nubia reached its zenith and slowly embraced Christianity. Collins (2006) traced the origins of one of the Southern Sudanese peoples called the Nilotes from Western Africa. They migrated centuries ago and began settling in the Nile valley in present-day Sudan. The Dinka and the Nuer, two of the largest Southern Sudan tribes, settled in the Bahr al Ghazal. Another group pushed south towards present day Uganda and Kenya. These included the Masai, Nandi, and Tai of Kenya, and the Karamojong of
Uganda. A third group comprised the Luo, who included the Acholi, Langi, and Japadhola of Uganda and the Luo of Kenya.

Wai (1973) identified two other groups of Southern Sudan in addition to the above Nilotes. The Nilo-Hamites, who probably originated from Ethiopia, included the Bari, Mundau and Nyangwara tribes. The third group, whom he called the Sudanic tribes, inhabited the southwest of Sudan; these included the Azande, the Ndongsere, and the Madi, who extended into Uganda.

**Culture**

Southern Sudan is a multi-tribal, multi-cultural society. Although the Dinka are the largest tribe in the south, numbering about a million people (Wai, 1973), followed by the Nuer, there are many other tribes. Like many African tribes, their cultures were manifested in their customs, traditions, and beliefs and revolved around the tribe. For communication, although rudimentary Arabic was the lingua-franca between the tribes and the language for commerce and education, “each tribe has its own language and sometimes several dialects” (Kemp, 2007, p. 2). The traditions surrounding such customs as marriage ceremonies, male or female initiation into adulthood, and the role of males and females in society vary from tribe to tribe.

As in most African societies, elders are highly respected, and it is tribal elders who resolve disputes among the communities. As Kemp (2007, p. 3) observed, “someone older than you is afforded utmost respect, and is referred to as ‘uncle’, or ‘aunty’, or even ‘father’ or ‘mother’ if related by blood”. Although men are heads of household, women are in charge of homes and the children.
The Dinka, who are dominant in the region, and the Nuer are proud pastoral people. They valued cattle, which “are the symbol of wealth ...” (Simich, 1998, p. 7). For the Dinka and the Nuer, exchanges of gifts for marriage purposes had to include cattle. Although some Southern Sudanese have embraced Christianity, African traditional religion was still highly practiced among the majority of the Southern Sudanese peoples. Attempts by the Northern Sudanese, who had always controlled government from Khartoum, to impose Islam have generally failed.

Political History

According to Simich (1998), Ottoman-Egyptian rulers controlled Sudan with British help from 1821 to 1885. In the 1880s, a Sudanese Islamic teacher, Muhammad Ahmad, declared himself a Mahdi, or guided one, and led a holy war (jihad) against the Ottoman rulers, capturing Khartoum in 1885 after a long siege. A British General, Charles George “Pasha” Gordon, was killed in the battle. In 1899, a joint force of British and Egyptian forces defeated the Mahdists and took control of Sudan until its independence in 1956.

During this colonial period, Southern Sudan, comprising the three regions of Equatoria, Bahr al Ghazal, and Upper Nile, was treated as a separate region by the British colonial masters, who “barred northern Sudanese from entering or working in the south. ... (because) the south was not ready for exposure to the modern world. As a result, the south remained isolated and backward under British rule” (Department of Immigration and Citizenship, Australia, 2007, p. 1). The north-south divide was exacerbated by Britain's attempt to prepare Southern Sudan to be integrated with British East Africa,
comprising Uganda, Kenya, and Tanganyika. This plan, however, never materialized as the push for Sudanese independence gained momentum.

Sudanese nationalists started agitating for independence after World War II, and Britain and Egypt agreed to grant Sudan self-government in 1953. On January 1, 1956, Sudan became an independent country.

The north-south rift erupted into a civil war months before independence, and this civil war lasted 17 years. The South was demanding equal share of resources or outright independence from the north because of northerners' absolute hold onto power and discrimination against the non-Arab and non-Muslim southern population.

This war, known as the first civil war, ended in 1972 when a peace agreement brokered by the Organization of African Unity was signed in Addis Ababa between the Anya Nya, southern rebels of the Southern Sudan Liberation Movement led by Joseph Lagu, and the military president of Sudan, General Jafar Numeiry. Under this agreement, the South was guaranteed autonomy and the rebels were integrated into the army.

The second civil war started, in 1983, and the Anya Nya II rebels formed the Sudanese People's Liberation Army (SPLA), accusing the Numeiry government of reneging on the Addis Ababa accords by redividing the south and imposing Islamic sharia law on the region.

This war raged for 21 years until January 9, 2005, when the Comprehensive Peace Agreement (CPA) was signed in Nairobi, Kenya between the SPLA and the Sudanese government. Under this accord, Southern Sudan was to be governed as an autonomous region and the two armies were to be left intact. Furthermore:
Islamic law, or *sharia*, (would) apply to the north but not the south. The south (would) have a six-year interim period of self-rule, after which it (would) vote in a referendum on whether to remain part of Sudan or secede. The agreement also (called) for Garang (the SPLA leader) to become Sudan's first vice president, replacing Taha (Kessler, 2005, p. A09).

*Affairs Post-Accord*

Tragic news befell Southern Sudan soon after the peace accord. On August 1, 2005, Dr. John Garang, the SPLA leader who had eight months earlier signed the peace accord, died in a helicopter crash on his way from visiting with President Museveni of Uganda. Garang's death resulted in riots by Southerners in many cities in Sudan, but calm was restored, and Garang's Deputy, Mr. Salva Kir, was quickly installed as Sudan's Vice President and President of Southern Sudan.

The government, based in the capital city of Juba near the Uganda border, was faced with a myriad of issues that characterized the building of a nation almost from scratch. These included repatriation of refugees, building infrastructures like roads, government buildings, schools, and hospitals, and dealing with massive unemployment. Although the accord seemed to be holding in 2007, the biggest political question facing Sudan was what would happen in the referendum that, according to the Nairobi peace treaty, was supposed to take place in 2011. In this referendum, Southern Sudanese would vote whether to remain part of Sudan or have their own independent nation.
The Refugee Problem

The Sudanese civil war between the south and north (the longest civil conflict in Africa) resulted in untold suffering for the people of the South. It was estimated that two million people died, directly as war casualties, or through starvation and flight from the war (Kemp, 2007). Kemp put the estimate for Sudanese refugees at over four million. These refugees scattered in the neighboring countries. Thousands of these refugees were absorbed by the United States. Georgia was hosting some of these refugees, many of whom were settled in the Clarkston area of DeKalb County. Participants in this study were drawn from this population.

The Somali and Sudanese Communities in Metro Atlanta

Between 1983 and 2004, refugees in the USA were resettled in cities with large foreign-born populations. “The largest resettlement areas have been in established immigrant gateways in California (Los Angeles, Orange County, San Jose, Sacramental), the mid-Atlantic region (New York) and Midwest (Chicago, Minneapolis – St Paul), as well as newer gateways including Washington, D.C, Seattle, WA, and Atlanta, GA” (Singer & Wilson, 2006, p. 1)

The state of Georgia, particularly the Atlanta area, was transformed by “the international immigration of the 1990s” (Hansen, 2005, p. 87). Describing the new Atlanta, Hansen wrote:

A social and political arena that used to host only two significant subpopulations – black and white Americans – became a more diverse mixture with arrival of the “other,” Hispanics, Asians, Europeans, and Africans. By 2000, one-tenth of metro
residents were foreign born, the majority having immigrated to the United States during the 1990s. (p. 87)

Among the new African arrivals referred to above were refugees from Somalia and Southern Sudan, who were mostly resettled in the Clarkston city of DeKalb County. This followed the pattern observed by Hansen (2005, p. 100) that “refugee resettlement in (Atlanta) has not been dispersed, remaining concentrated around a few visible enclaves.” DeKalb County, which is the second largest county in the state, “grew 22 percent during the 1990s,” and “has become the most diverse county in metro Atlanta with the highest proportion of international immigrants” (Hansen, 2005, p. 96). According to the Georgia Office of Refugee Health, the number of Somali refugees who arrived in Georgia between 1991 and 2002 was 4,010 (Hansen, 2005) and 1,785 between 2003 and 2006 (Office of Refugee Resettlement, 2006). The number of Sudanese refugees who arrived in Georgia between 2000 and 2006 was 875.

How were the Somali and Sudanese refugees in the Clarkston area coping in their new home? As Singer and Wilson (2006, p. 2) suggested, “Metropolitan areas are the critical context for refugees as they resettle into communities and become active members of their neighborhoods, schools, and workplaces.” The Somali and Sudanese refugees seemed to be integrating, albeit slowly, into their neighborhoods.

The Somalis in Clarkston were initially housed in apartments alongside the Memorial Drive corridor. However, some families had moved out and were renting or owning single homes in the area. They also owned several small businesses such as grocery stores, restaurants, boutiques, and hair salons. They also owned two mosques that catered to their spiritual needs and were building a new one. Weekend Islamic classes for
children were conducted at these mosques. The Somali youth had an organization that hosted an annual graduation ceremony for high school and college graduates. The community established a few non-profit organizations to advocate for social and economic services. The community also had two radio stations (Sagal and Quran).

The Southern Sudanese seemed to lag behind their Somali counterparts in metro-Atlanta in terms of operating businesses. This might have been due to their different backgrounds back home. Although both societies were primarily pastoralists, in Atlanta, more of the Southern Sudanese came from rural and pastoral backgrounds, whereas more of the Somali had lived in cosmopolitan areas, and many Somalis may have been merchants. However, even the Southern Sudanese were slowly opening their own businesses, and their children were attending colleges. They also had non-profit organizations advocating for services. They conducted Sunday services in one of the area churches, showing collaboration with host communities.

Area schools like Indian Creek Elementary school, Shamrock Middle School, Clarkston High School, and Druid Hills High School were enrolling increasing numbers of Somali and Sudanese children. Slowly but surely, therefore, the Somali and Southern Sudanese of Clarkston, who came from traumatic experiences in their home countries, were proudly redefining their lives and carving their own niche in metro-Atlanta.
CHAPTER IV
RESEARCH METHODOLOGY

Overview

This chapter describes the methodology of the study. It outlines the inclusion criteria, the sample profile, data collection procedures, and analysis.

Inclusion Criteria

This study focused on Eastern African refugees from Somalia and Southern Sudan who have resettled in the metropolitan Atlanta area. Participants were recruited based on the following criteria:

1) Be at least 18 years of age
2) Identify oneself as a Somali
3) Identify oneself as Southern Sudanese
4) Immigrated through the refugee resettlement program
5) Able to speak and understand English language
6) Willing to share information about sex and sexuality
7) Refugees at five years of stay in the United States.

Sample

In this study, Eastern African refugees from Somalia and Southern Sudan living
in the metro-Atlanta area were chosen as the target population. The decisive factor in selecting this study population included the following:

1) Refugee data are more structured than data on most international immigrants in the United States.

2) Somalis and Southern Sudanese depict diversity, uniqueness, and complexities of cultures that are a microcosm of the Sub-Saharan African societies. These include different ethnic groups, languages, and cultural backgrounds. Similarities on the two refugee groups are based on the fact that they both come from the Eastern region of sub-Saharan Africa and the majority of them are historically known as pastoralists. However, there is also a wide degree of cultural differences among the two populations namely, Somalis are predominantly Muslims while Southern Sudanese are predominantly Christians.

3) The Somali and Southern Sudanese constitute the majority of Eastern African refugees resettled in the state of GA (namely 55% and 22% respectively) (Office of Refugee Resettlement, 2004 data), and

4) Very limited study has been conducted on this population.

The study sample included 80 Eastern African refugees and was divided into two groups: \( R_{\text{SOM}} \) (Somali refugees) and \( R_{\text{SUD}} \) (Southern Sudanese refugees). These groups were further divided into two sub-groups. The first sub-group consisted of two categories: \( R_{\text{SOMNA}} \) (newly arrived refugees from Somalia) and \( R_{\text{SUDNA}} \) (newly arrived refugees from southern Sudan). The second sub-group consisted of \( R_{\text{SOMED}} \) (established refugees from Somalia) and \( R_{\text{SUDED}} \) (established refugees from southern Sudan). The categories are illustrated on a two by two matrix (Table 1) below.
Table 1

An Illustration of the Sample Grouping

<table>
<thead>
<tr>
<th>Groups</th>
<th>Somali refugees</th>
<th>Southern Sudanese refugees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly Arrived Refugees</td>
<td>$R_{SOMNA}$</td>
<td>$R_{SUDNA}$</td>
</tr>
<tr>
<td>Established Refugees</td>
<td>$R_{SODED}$</td>
<td>$R_{SUDED}$</td>
</tr>
</tbody>
</table>

In this study, newly arrived refugees were defined as those refugees who had resettled in the United States less than five years ago. Established refugees were defined as those refugees who resettled in the United States five or more years ago. The choice of five years as the dividing line between recent and not-recent resettlement was arbitrary.

The sample of 80 Eastern African refugees was characterized by ethnicity and gender; it included 40 Somalis (20 males and 20 females) and 40 Sudanese (20 males and 20 females) refugees (See Table 2).

Table 2

Study Sample Subdivided by Gender and Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Somali</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Sudanese</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>
These participants were selected using the non-probability method of purposive sampling techniques (Cottrell & McKenzie, 2005). Specifically, the snowball sampling technique was utilized. This sampling technique was considered most favorable for the research because of the following reasons: 1) lack of a standardized list of names to perform any meaningful random sample selection and 2) the sensitive nature of the subject matter. Snowballing introduces some bias because selection is not random, but in situations like this it is often the most appropriate way to identify people.

Participants were asked to identify other potential respondents for the study. Other potential respondents were also recruited through interpreters who helped to translate to participants with limited English speaking capabilities, others were recruited by the researcher’s friends and well wishers. Identification and referral of all potential respondents was done based on the researcher’s inclusion criteria mentioned above.

**Data Collection**

Data collection was deliberately structured to suit the unique situation of HIV/AIDS phenomenon among the Eastern African refugees living in metro-Atlanta. Information pertaining to knowledge, perceptions, and beliefs of the HIV/AIDS prevention, education, and care were collected.

Data sources underlying this study constituted: 1) Primary source from structured in-depth key informant interviews and, 2) Secondary source from literature reviews and library research. Primary data such as demographic, socio-economic, sociocultural, and educational data pertaining to HIV/AIDS perceptions among Eastern African refugees were collected through face to face interviews. These data were imperative in trying to
understand the socio-economic status and cultural beliefs of the refugees regarding the HIV/AIDS epidemic in their “new settlement site.”

Secondary data such as published studies, research findings, conference presentations, and manuals on HIV/AIDS prevention and education among different refugee and immigrant groups from similar countries and situations within and without the U.S were reviewed and collected. Studies on the target population in the USA were reviewed with the intention of exploring the cultural, social, and economic dynamics underlying this contagion. This included areas related but not limited to infectious diseases, sexuality, sexual and reproductive health, resettlement and forced migration.

A procedure was put in place before the commencement of all data collection and field exercises. This procedure was intended to keep the research focused on its stated purpose. The procedure was also used as a guide to provide structure to data collection with respect to recruitment, interviewing, data storage, and data analysis.

*Data Collection Procedure*

Data collection followed an explicit field exercise procedure. Specifically, the field application procedure outlined by Yin (2003) was used to guide this process. Yin recommends that researchers should take certain measures into consideration before embarking on the data collection activity. This procedure incorporates: 1) Gaining access to key respondents, 2) having sufficient resources for data collection while in the field, 3) developing a procedure for assistance and guidance, 4) developing a clear data collection time line, and 5) providing for unanticipated events.
Gain access to key respondents

Snowball sampling technique was used to identify a specific number of participants per target group. Participants who suited the inclusion criteria were targeted and their informed consent was received prior to recruitment. Indeed participants were able to identity and refer other potential respondents with similar characteristics, who were willing to discuss HIV/AIDS. As a result, a total of 80 face-to-face interviews were conducted with 40 Somali and 40 Southern Sudanese refugees. This number included 20 women and 20 men for each ethnic category.

Having sufficient resources for data collection

A structured questionnaire/interview tool was developed (See Appendix for sample questions) for purposes of data collection. Questions on the interview tool ranged from demographic characteristics to questions on knowledge, attitude, cultural beliefs, and perceptions of HIV/AIDS, its prevention and education in their communities. To ensure that the researcher had sufficient resources in the field, a resource checklist was developed and this included questionnaires, three pens, one note pad, an umbrella, a time watch, parking fee, and cell phone.

Procedure for assistance and guidance

 Interviews were primarily conducted in English. In the event that a respondent was not fluent in the English language, the help of an interpreter was sought. The researcher’s supervisor provided guidance with respect to the involvement of interpreters. The researcher ensured that interpreters were not personally known to the respondents.
and they were trained to adhere to translating the questions and responses. This caution was instilled as a measure to avoid interpreter bias and avoid discomfort on the part of the participant as they discussed very sensitive topics.

**Develop a clear data collection timeline**

Questions on the data collection tool were pre-tested to some Somali and Sudanese refugees. On average, interview time took about 45 minutes without an interpreter and 30 minutes more with an interpreter. This time was used to develop a data collection timeline. It was anticipated that data collection would take a total of eight weeks. This translates to at least 10 interviews per week (450 minutes), 40 interviews in a month (1,800 minutes), and 80 interviews in two months (3,600 minutes).

**Provide for unanticipated events**

Interviews were conducted at pre-selected venues and time agreed upon by the researcher and the respondent. Some of the interviews were conducted in participant homes, their place of work, schools, and/or public places. Care was taken to ensure that these venues were safe, secure, and void of distractions during the interview. Interview questions were well structured and culturally appropriate. Considering the sensitive nature of this study, it was imperative that the interviewer stayed focused on the subject matter while exhibiting a high degree of respect and courtesy. This was important in creating comfort while generating genuine reactions from respondents.
Data Analysis

Once data from the field were collected, data were entered into Microsoft Excel for storage and cleaning. Cleaned data were converted to CSV files that were later used to convert data into SAS data files for analysis. Self-reported demographic features of the study population are illustrated below (See Table 3 on the next page).

Control of the English language (ranging from “not at all” to “very well”) was measured in two ways. First, respondents were asked to rank their own proficiency. Next, during the interviewing, the researcher also scored their ability to converse in English.

In this study, two data analyses were conducted. A qualitative analysis used primary data to obtain common themes on participants’ knowledge about and attitude towards HIV/AIDS, its prevention, education, and care interventions. A quantitative analysis was subsequently conducted to examine correlations among the themes that had emerged from the qualitative analysis.

With regards to the qualitative analysis, data were coded in order to make meaningful interpretations. Data coding as explained by Miles and Huberman (1994) are:

... tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study. Codes usually are attached to “chunks” of varying size – words, phrases, sentences, or whole paragraphs, connected or unconnected to a specific setting. They can take the form of a straight forward category label or a more complex one (e.g. a metaphor). (p. 56)

Qualitative analysis was based on themes that emerged from participants’ responses to interview questions. Analysis was also based on national origin, gender, and number of years a respondent had stayed in the United States.
Table 3

Participant Demographic Data

<table>
<thead>
<tr>
<th>Age Range</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>31</td>
</tr>
<tr>
<td>26-35</td>
<td>41</td>
</tr>
<tr>
<td>36-45</td>
<td>20</td>
</tr>
<tr>
<td>46-55</td>
<td>8</td>
</tr>
</tbody>
</table>

Education Level

<table>
<thead>
<tr>
<th>Level</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>24</td>
</tr>
<tr>
<td>Some high school</td>
<td>10</td>
</tr>
<tr>
<td>Completed high school</td>
<td>20</td>
</tr>
<tr>
<td>Some college</td>
<td>35</td>
</tr>
</tbody>
</table>

English Language

<table>
<thead>
<tr>
<th>Level</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>15</td>
</tr>
<tr>
<td>Not well</td>
<td>11</td>
</tr>
<tr>
<td>Well</td>
<td>25</td>
</tr>
<tr>
<td>Very well</td>
<td>49</td>
</tr>
</tbody>
</table>

Annual Household Income

<table>
<thead>
<tr>
<th>Income</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$18,000 or less</td>
<td>56</td>
</tr>
<tr>
<td>$18,000 - 27,000</td>
<td>31</td>
</tr>
<tr>
<td>$28,000 - 37,000</td>
<td>11</td>
</tr>
<tr>
<td>$48,000 or more</td>
<td>1</td>
</tr>
</tbody>
</table>

Years Lived in USA

<table>
<thead>
<tr>
<th>Years</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 or less</td>
<td>43</td>
</tr>
<tr>
<td>5 or more</td>
<td>58</td>
</tr>
</tbody>
</table>
Regarding the quantitative analysis, data analysis was based on the themes that emerged from the qualitative analysis. These themes were used as variables. A correlation analysis of the variables was conducted to find a relationship between variables in order to further understand findings from the qualitative analysis.
CHAPTER V
DATA ANALYSIS AND FINDINGS

Overview

This chapter simultaneously presents data analysis and findings of the study. Discussion of the findings follows. Analysis and findings are categorized and organized according to the research questions. The following research questions guided the study.

Research Questions

Research Question 1. What did Eastern African refugees know about HIV/AIDS and its importance?

Research Question 2. How did Eastern African refugees and their families learn about HIV/AIDS prevention and treatment?

Research Question 3. How did Eastern African refugees perceive HIV/AIDS in their families and communities?

Research Question 4. What were the perceptions of Eastern African refugees regarding participation in the interventions offered by public and private organizations?

Data Analysis

This study was mainly a qualitative research. However, a quantitative analysis was conducted to complement the results of the qualitative analysis. Data analysis took the following order: After data collection, data were coded in a specific code book.
Six common themes emerged from the primary data and were identified after coding the data. These themes were Knowledge, Openness, Attitude, Stigma, Willingness, and Trust. A qualitative analysis of these themes and their meaning was conducted with examples of quotations from participants as evidence. These themes were also analyzed quantitatively as variables to find out if there are any meaningful correlations between them. Statistical packages including Microsoft Excel and SAS were used to conduct the analyses (see a thorough description of data analysis in chapter III).

Findings from Qualitative Analysis

Research Question 1

What did Eastern African refugees know about HIV/AIDS and its importance?

With regard to research question 1, a majority of the participants demonstrated some level of knowledge of HIV/AIDS and its importance. The knowledge theme was an aggregate of participant responses on six questions that probed participant’s knowledge of a) the HIV/AIDS disease, b) causes of HIV infection, c) protection against HIV infection, d) persons living with HIV/AIDS, e) HIV/AIDS intervention information, and f) access to HIV/AIDS prevention and care information.

For each question on knowledge, participants’ responses that demonstrated limited or no knowledge scored low, and those whose responses indicated knowledge scored high. For example, on the question of how to protect against HIV infection, those who responded “Don’t Know” were given a score of 1 whereas those who responded “Safe Sex” were given a score of 4.
For example, on the question of causes of HIV infection, a Sudanese male reported “Unsafe sex ... infected or transmission through injection and blood transfusion is the most important way HIV can be transmitted, pregnant women at delivery may be infected with the instruments.” A Somali female indicated that people get HIV “when they go into each other.” A male Somali student said “you can get it through unsafe sex.”

Participants who scored highly on the above six components of knowledge were classified as more knowledgeable and those who scored low were classified as less knowledgeable (See Table 4). 71.25% of the entire sample were identified to be more knowledgeable and 28.75% were identified as less knowledgeable.

<table>
<thead>
<tr>
<th>Participant Knowledge of HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
</tr>
<tr>
<td>Less-knowledgeable</td>
</tr>
<tr>
<td>More-knowledgeable</td>
</tr>
</tbody>
</table>

A cross tabulation of knowledge by ethnicity and gender indicated that females were less knowledgeable. A higher percentage of Somali females were found to be less knowledgeable about HIV/AIDS relative to their Sudanese counterparts at 15% and 6.3% respectively. On the other hand, the same percentage of Somali and Sudanese males (21.3%) was identified as more knowledgeable (See Table 5).
A cross tabulation of knowledge by number of years lived in the United States indicated that a higher percentage of refugees who have lived in the USA for five years or more were more knowledgeable (43.8%) compared to those who have lived in the USA for four years or less (27.5%). Interestingly, there were ethnic differences in this category. A similar percentage of Sudanese who have lived in the USA for four years or less were classified as more knowledgeable about HIV/AIDS as those who have lived longer in the United States (20% respectively). On the other hand, a higher percentage (23.8%) of Somalis who have lived in the USA for five years or more were identified as more knowledgeable compared to their counterparts who have lived in the USA for four years or less (7.5%) (See Table 6).
Table 6

Cross Tabulation of Knowledge by Years in the USA and Ethnicity

<table>
<thead>
<tr>
<th>USA Years</th>
<th>Knowledge</th>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Somali</td>
<td>Sudanese</td>
</tr>
<tr>
<td>4 or Less</td>
<td>Less-knowledgeable</td>
<td>11.3</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>More-knowledgeable</td>
<td>7.5</td>
<td>20.0</td>
</tr>
<tr>
<td>5 Plus</td>
<td>Less-knowledgeable</td>
<td>7.5</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td>More-knowledgeable</td>
<td>23.8</td>
<td>20.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Research Question 2

How did Eastern African refugees and their families learn about HIV/AIDS prevention and treatment?

With regard to Research Question 2, a majority of the participants demonstrated some level of openness and attitude towards HIV/AIDS prevention, education, and treatment.

The openness theme was an aggregate of participant responses on six questions that probed participant’s openness to a) discussing HIV/AIDS among themselves, b) discussing HIV/AIDS with someone else, c) existing HIV/AIDS information, d) content of the HIV/AIDS information, e) suggestions to their community, and f) suggestions to providers.

For each question on openness, participants’ responses that demonstrated limited or no openness scored low, and those whose responses indicated openness scored high. For example, on the question of openness to discussions about HIV/AIDS, those who
responded “Don’t Know” were given a score of 1 whereas those who responded “Very Open” were given a score of 4.

For example, on the question of how openly members of the community discuss HIV/AIDS among themselves, one Somali male reported that, “our people talk freely about HIV/AIDS; they talk to their children how to prevent it and not to have sex before getting married. You see, Somali’s don't believe in safe sex practices, they believe in stopping fornication.” Another Somali male stated that “yes, they are open, they can communicate if you talk to them.” On the question of who they would prefer to discuss with, most respondent stated they would prefer to discuss with physicians. A Sudanese female respondent stated, “sometimes they talk to family but most times people just keep quiet...they don’t want you to know about their disease.” However, another Somali male stated that “these people don't discuss at all, they are very discrete, this is a big problem you know.” When asked to make suggestions to the community and providers about HIV/AIDS services, A Sudanese male said that “people need to be tested, they need a lot of information about the disease, recommend how to make safe sex because people say if you use condom you can get AIDS...This is the belief back home but in America it is different.” Another Sudanese male said, “They need to understand how to deal with other people's cultures” and a Somali female stated, “they need to talk to us about what we need, not just send people anyhow.”

Participants who scored highly on the above six components of openness were classified as more open and those who scored low were classified as less open (See Table 7). 70% of the entire sample were classified as more open and 30% were classified as less open.
Table 7

*Participant Openness of HIV/AIDS*

<table>
<thead>
<tr>
<th>Openness</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less-open</td>
<td>30.00</td>
</tr>
<tr>
<td>More-open</td>
<td>70.00</td>
</tr>
</tbody>
</table>

A cross tabulation of *openness* by ethnicity and gender indicated that males were *more open* than females (40.1% and 30.1%, respectively). More Somali females were found to be *less open* towards HIV/AIDS issues than their Sudanese counterparts at 13.8% and 6.3% respectively. More Sudanese males were found to be *more open* on issues pertaining to HIV/AIDS than the Somali males at 21.3% and 18.8% respectively (See Table 8).

Table 8

*Cross Tabulation of Openness by Ethnicity and Gender*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Openness</th>
<th>Gender</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Somali</td>
<td><em>Less-open</em></td>
<td>6.3</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td><em>More-open</em></td>
<td>18.8</td>
<td>11.3</td>
</tr>
<tr>
<td>Sudanese</td>
<td><em>Less-open</em></td>
<td>3.8</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td><em>More-open</em></td>
<td>21.3</td>
<td>18.8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>
On the other hand, a cross tabulation of openness by number of years lived in the United States indicated that a higher percentage of refugees who have lived in the USA for five years or more were *more open* (43.8%) compared to those who have lived in the USA for four years or less (26.3%). From the ethnicity perspective, Sudanese who have lived in the USA for four years or less seem to be as *more open* about HIV/AIDS as those who have lived longer in the United States (20% respectively). On the other hand, Somalis who have lived in the USA for five years or more were identified as *more open* (23.8%) relative to their counterparts who have lived in the USA for four years or less (6.3%) (See Table 9).

Table 9

**Cross Tabulation of Openness by years in the USA and Ethnicity**

<table>
<thead>
<tr>
<th>USA years</th>
<th>Openness</th>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Somali</td>
<td>Sudanese</td>
</tr>
<tr>
<td>4 or Less</td>
<td><em>Less-open</em></td>
<td>12.5</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td><em>More-open</em></td>
<td>6.3</td>
<td>20.0</td>
</tr>
<tr>
<td>5 Plus</td>
<td><em>Less-open</em></td>
<td>7.5</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td><em>More-open</em></td>
<td>23.8</td>
<td>20.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

The attitude theme was an aggregate of participant responses on five questions that probed participant’s attitude towards a) the healthcare system, b) health care providers, c) HIV/AIDS treatment, d) religious, and e) cultural perspective of HIV/AIDS.
For each question on attitude, participants’ responses that demonstrated negative attitude scored low, and those whose responses indicated positive attitude scored high. For example, on the question of relationship with health care providers, those who responded “Very Uncomfortable” were given a score of 1 whereas those who responded “Very Comfortable” were given a score of 4.

For example, on the question of whether religious beliefs affect members of the community to learn about HIV/AIDS, one Somali male said that, “Our religion allows us to learn and talk about anything that is good to our health.” On questions regarding people’s attitude towards treatment and care, the following quotations illustrate a range of views:

1) “This is a big problem, people who have no insurance will be afraid to go to the doctor” (Sudanese male).
2) “Because they are shy about the disease, some go straight to the hospital and some stay home” (Somali female).
3) “Sometime they don't have money or job, they are ashamed and scared” (Somali female).
4) “Some people are illegal, they don't even have insurance, let alone having the HIV virus... You see, they can deport you if they find that you have HIV” (Somali male)
5) “They feel ashamed and scared to go anywhere” (Sudanese female).
6) “People don’t want to go to public hospital because they are afraid they will be cut off by their community” (Sudanese male).
7) “Some of us can not speak English, don’t you see that is a problem” (Sudanese male).

Asked whether belonging to a cultural or ethnic group would affect one from learning about HIV/AIDS, one Somali male stated, “yes, they do not want to be tested; they think if they are positive they will get in trouble, it will be terrible for them.”

Participants who scored highly on the above five components of attitude were classified as having positive attitude and those who scored low were classified as having negative attitude (See Table 10). 55% of the entire sample were classified as having negative attitude and 45% were classified as having positive attitude.

Table 10

*Participant Attitude Towards HIV/AIDS*

<table>
<thead>
<tr>
<th>Attitude</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative-attitude</td>
<td>55.00</td>
</tr>
<tr>
<td>Positive-attitude</td>
<td>45.00</td>
</tr>
</tbody>
</table>

A cross tabulation of attitude by ethnicity and gender showed that more males (31.3%) demonstrated having negative attitude towards HIV/AIDS issues than females (23.8%). Almost similar percentages among Sudanese and Somali males (16.3% and 15%, respectively) demonstrated negative attitude towards HIV/AIDS issues. Likewise, similar percentages among Somali and Sudanese females demonstrated positive attitude towards issues pertaining to HIV/AIDS (13.8% and 12.5%, respectively) (See Table 11).
On the other hand, a cross tabulation of attitude by number of years lived in the United States indicated that a higher percentage of refugees who have lived in the USA for five years or more (36.3%) had negative attitude compared to only 18.8% among those who have lived here for four years or less. Somalis who have lived in the USA for five years or more had negative attitude towards HIV/AIDS issues compared to those who have lived for four years or less in the United States (21.3% and 5%, respectively). Sudanese who have lived in the USA for five years or more demonstrated negative attitude towards HIV/AIDS issues in similar proportion to their counter parts who have lived in the USA for four years or less (15% and 13.8%, respectively) (See Table 12).
Table 12

*Cross Tabulation of Attitude by Years in the USA and Ethnicity*

<table>
<thead>
<tr>
<th>USAyears</th>
<th>Attitude</th>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Somali</td>
<td>Sudanese</td>
</tr>
<tr>
<td>4 or Less</td>
<td><em>Negative-attitude</em></td>
<td>5.0</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td><em>Positive-attitude</em></td>
<td>13.8</td>
<td>10.0</td>
</tr>
<tr>
<td>5 Plus</td>
<td><em>Negative-attitude</em></td>
<td>21.3</td>
<td>15.0</td>
</tr>
<tr>
<td></td>
<td><em>Positive-attitude</em></td>
<td>10.0</td>
<td>11.3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

*Research Question 3*

How do Eastern African refugees perceive HIV/AIDS in their families and communities?

With regard to Research Question 3, a majority of the participants demonstrated some level of family and community *stigma* towards HIV/AIDS. The *stigma* theme was an aggregate of participant responses on five questions that probed a) family humiliation of persons living with HIV/AIDS, b) family shunning persons living with HIV/AIDS, c) community humiliation of persons living with HIV/AIDS, d) community shunning persons living with HIV/AIDS, and e) attitude towards HIV/AIDS treatment.

For each question on *stigma*, participants’ responses that demonstrated limited or no *stigma* scored low, and those whose responses indicated *stigma* scored high. For example, on the question of shunning persons living with HIV/AIDS, those who responded “*Don’t Know*” were given a score of 1 whereas those who indicated “*Shunning*” were given a score of 4.
For example, on the question of family and community response towards HIV positive individuals, the following quotations illustrate the range of responses:

1) “Some people are good and others are not, just like our fingers they are different”  
   (Sudanese female)

2) “Some people are too conservative, they think it is a punishment from God”  
   (Somali male).

3) “Yes, that is what they believe, if you are HIV positive they kick your a**”  
   (Somali male).

4) “You can be abandoned and ashamed by the community because they do not have knowledge of the disease, they do not see the consequences” (Sudanese male).

5) “I do not communicate with people who have it or even have contact with them...I just pray for them...I feel sorry for them” (Somali female).

Participants who scored highly on the above five components of stigma were classified as having high stigma and those who scored low were classified as having less stigma (See Table 13). 70% of the entire sample were classified as having high stigma and 30% were classified as having less stigma.

Table 13

<table>
<thead>
<tr>
<th>Participant Stigma of HIV/AIDS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less-stigma</td>
<td>30.00</td>
</tr>
<tr>
<td>High-stigma</td>
<td>70.00</td>
</tr>
</tbody>
</table>
A cross tabulation of stigma by ethnicity and gender indicated that more males demonstrated high stigma than females. More Somali females were found to have less stigma of HIV/AIDS relative to their Sudanese counterparts at 15% and 6.3% respectively. However, similar percentages of Sudanese and Somali males demonstrated high stigma for HIV/AIDS at 21.3% and 20% respectively (See Table 14)

Table 14

Cross Tabulation of Stigma by Ethnicity and Gender

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Stigma</th>
<th>Gender</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Somali</td>
<td>Less-stigma</td>
<td>5.0</td>
<td>15.0</td>
</tr>
<tr>
<td></td>
<td>High-stigma</td>
<td>20.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Sudanese</td>
<td>Less-stigma</td>
<td>3.8</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td>High-stigma</td>
<td>21.3</td>
<td>18.8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

On the other hand, a cross tabulation of stigma by number of years lived in the United States indicated that more refugees who have lived in the USA for five years or more have high stigma (42.5%) compared to those who have lived in the USA for four years or less (27.5%). However, less stigma level is proportionately equal among refugees who have lived in the United States for five years or more and for four years or less (15% respectively). Interestingly, high stigma was ascribed to similar percentages of Sudanese who have lived in the USA for four years or less as to those who have lived here for five years or more (20%). However, a bigger percentage (22.5%) of Somali
refugees who have lived in the USA for five years or more, were found to have high stigma compared to their counter parts who have lived in the USA for four years or less (7.5%) (See Table 15).

Table 15

Cross Tabulation of Stigma by Years in the USA and Ethnicity

<table>
<thead>
<tr>
<th>USAyears</th>
<th>Stigma</th>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Somali</td>
<td>Sudanese</td>
</tr>
<tr>
<td>4 or Less</td>
<td><em>Less-stigma</em></td>
<td>11.3</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td><em>High-stigma</em></td>
<td>7.5</td>
<td>20.0</td>
</tr>
<tr>
<td>5 Plus</td>
<td><em>Less-stigma</em></td>
<td>8.8</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td><em>High-stigma</em></td>
<td>22.5</td>
<td>20.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Research Question 4

What are the perceptions of Eastern African refugees regarding participation in the interventions offered by public and private organizations?

With regard to Research Question 4, a majority of the participants demonstrated some level of willingness and trust in the interventions offered by public and private organizations. The willingness theme was an aggregate of participant responses on three questions that probed participant’s willingness to contribute at least a) five, b) fifteen, or c) twenty five dollars towards HIV/AIDS interventions and community services.

For each question on willingness, participants’ responses that demonstrated limited or no willingness scored low, and those whose responses indicated willingness
scored high. For example, on the question of willingness to contribute twenty five dollars towards HIV/AIDS interventions and community services, those who responded “Don’t Know” were given a score of 1 whereas those who indicated “willingness were given a score of 4.

For example, on the question of participant willingness to contribute financially towards HIV/AIDS interventions and community services, the following quotations illustrate participant’s perspectives on the issue.

1) “I am accepting to contribute just because they are my tribe’s men, other wise they looked for it” (Somali male).
2) “It is good to be kind to people, they will be good to you too” (Sudanese male).
3) “I will contribute if I am sure that these services will be provided to us...some people come here to ask for contributions, they take our money and eat it how can I trust them?” (Somali male).
4) “Why should I contribute when I do not have enough money for myself” (Somali female).
5) “Government is already treating people who have this disease” (Sudanese female).
6) “I do not have the disease and my people do not have this disease, it is all rumors” (Sudanese male).
7) “I do not know anything about HIV, I do not want to hear or even talk about this disease...I can not contribute any money for something that I am not sure about” (Somali female).
Participants who scored highly on the above three components of willingness were classified as *more willing* and those who scored low were classified as *less willing* (See table 16). 51.25% of the entire sample were classified as *more willing* and 48.75% were classified as *less willing*.

Table 16  

*Participant Willingness of HIV/AIDS*

<table>
<thead>
<tr>
<th>Willingness</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less- willig</td>
<td>48.75</td>
</tr>
<tr>
<td>More- willig</td>
<td>51.25</td>
</tr>
</tbody>
</table>

A cross tabulation of *willingness* by ethnicity and gender indicated that more males (37.6%) were *more willing* to contribute towards HIV/AIDS interventions and community services than females (13.8%). Sudanese and Somali females indicated similar percentages (18.8% and 17.5%, respectively) of being *less willing* to contribute towards HIV/AIDS interventions and community services. On the other hand, both Sudanese and Somali males indicated equal percentage of being *more willing* to contribute towards HIV/AIDS interventions and community services at 18.8%, respectively (See Table 17).
Table 17

Cross Tabulation of Willingness by Ethnicity and Gender

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Willingness</th>
<th>Gender</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Somali</td>
<td>Less- willing</td>
<td>6.3</td>
<td>17.5</td>
</tr>
<tr>
<td></td>
<td>More- willing</td>
<td>18.8</td>
<td>7.5</td>
</tr>
<tr>
<td>Sudanese</td>
<td>Less- willing</td>
<td>6.3</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>More- willing</td>
<td>18.8</td>
<td>6.3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

On the other hand, a cross tabulation of willingness by number of years lived in the United States indicated that refugees who have lived in the USA for five years or more were more willing (32.5%) to contribute towards HIV/AIDS interventions and community services compared to those who have lived in the USA for four years or less (18.8%).

Both Somalis (18.8%) and Sudanese (13.8%) refugees who have lived in the USA for five years or more seem to be more willing to contribute towards HIV/AIDS interventions and community services compared to those who have lived in the United States for four years or less (7.5% and 11.3% respectively). Somalis who have lived in the USA for five years or more indicated similar percentage of being less willing to contribute towards HIV/AIDS interventions and community services as their counterparts who have lived in the USA for four years or less (12.5% and 11.3%, respectively). Sudanese who have lived in the United States for longer and shorter years exhibited in equal proportions less willingness to contribute (12.5%) (See Table 18).
Table 18

Cross Tabulation of Willingness by Years in the USA and Ethnicity

<table>
<thead>
<tr>
<th>USA Years</th>
<th>Willingness</th>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Somali</td>
<td>Sudanese</td>
</tr>
<tr>
<td>4 or Less</td>
<td>Less-willing</td>
<td>11.3</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>More-willing</td>
<td>7.5</td>
<td>11.3</td>
</tr>
<tr>
<td>5 Plus</td>
<td>Less-willing</td>
<td>12.5</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>More-willing</td>
<td>18.8</td>
<td>13.8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

The trust theme was an aggregate of participant responses on four questions that probed participant’s confidence in a) health institutions, b) sources of HIV/AIDS information, c) context of the HIV/AIDS information, and d) content of the HIV/AIDS information.

For each question on trust, participants’ responses that demonstrated less trust scored low, and those whose responses indicated more trust scored high. For example, on the question of trust in sources of information, those whose response was “Not Applicable” were given a score of 1 whereas those who responded “Trusted all sources” were given a score of 4.

A respondent who was asked whether she trusted any health institutions responded that “it depends on the doctor” (Somali female). A Somali male stated that “I don't think you want to know”. Participant responses towards the context and content of HIV/AIDS information included:
1) "I don't know nothing, we don't have these problems, I know HIV comes from other people why should I read about them" (Somali male).

2) "How can you bring to me what I do not know about" (Sudanese male).

3) "Who came to talk to us about our problem? How can you say that something is good for me, I know what is good for me?" (Sudanese male)

4) "See, certain things are very sensitive, our people are very complicated you can not just come and impose on them something that they do not know, you need to include them" (Somali male)

Participants who scored highly on the above four components of trust were classified as having more trust and those who scored low were classified as having less trust (See Table 19). 66.25% of the entire sample were classified as having less trust and 33.75% were classified as having more trust.

Table 19

Trust Towards HIV/AIDS Information and Health Institutions

<table>
<thead>
<tr>
<th>Trust</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less- trust</td>
<td>66.25</td>
</tr>
<tr>
<td>More- trust</td>
<td>33.75</td>
</tr>
</tbody>
</table>

A cross tabulation of trust by ethnicity and gender indicated similar responses between males and females. Similar percentages of males and females indicated having less trust towards HIV/AIDS information and health institutions (31.25% and 35%, respectively). Likewise, similar percentages of males and females indicated having more
trust towards HIV/AIDS information and health institutions (18.75% and 15%, respectively). Somali females were almost twice as more likely to have less trust towards HIV/AIDS information and health institutions as their Sudanese counter parts at 22.5% and 12.5% respectively (See Table 20).

Table 20

Cross Tabulation of Trust by Ethnicity and Gender

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Trust</th>
<th>Gender</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More- trust</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Somali</td>
<td>Less- trust</td>
<td>16.25</td>
<td>22.5</td>
</tr>
<tr>
<td></td>
<td>More- trust</td>
<td>8.75</td>
<td>2.5</td>
</tr>
<tr>
<td>Sudanese</td>
<td>Less- trust</td>
<td>15</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>More- trust</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

On the other hand, a cross tabulation of trust by number of years lived in the United States (See Table 21) indicated that a higher percentage of refugees who have lived in USA for five years or more have more trust (21.3%) compared to those who have lived here four years or less (12.5%). Somalis who have lived in the USA for five years or more seem to have less trust towards HIV/AIDS information and health institutions compared to those who have lived here for four years or less (22.5% and 16.3%, respectively)
Table 21

Cross Tabulation of Trust by Years in the USA and Ethnicity

<table>
<thead>
<tr>
<th>USA years</th>
<th>Trust</th>
<th>Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Somali</td>
<td>Sudanese</td>
</tr>
<tr>
<td>4 or Less</td>
<td>Less trust</td>
<td>16.3</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td>More trust</td>
<td>2.5</td>
<td>10.0</td>
</tr>
<tr>
<td>5 Plus</td>
<td>Less trust</td>
<td>22.5</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td>More trust</td>
<td>8.8</td>
<td>12.5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Furthermore, Somalis (8.8%) who have lived in the USA for five years or more were four times more likely to have more trust relative to their counterparts who have lived in the USA for four years or less (2.5%). Sudanese who have lived in the USA for five years or more were as likely to have less trust as those who have lived here for four years or less (13.8%). Likewise, Sudanese who have lived in the USA for five years or more were as likely to have more trust as those who have lived here for four years or less (12.5% and 10%, respectively).

Findings from Quantitative Analysis

After the qualitative analysis, the above six themes of knowledge, openness, attitude, stigma, willingness, and trust were used as variables in the quantitative analysis. A correlation analysis was conducted to find out the strength of the relationships between the variables and whether these relationships were statistically significant at p < 0.05. Relationships with Pearson correlation estimates (using the Fisher's z Transformation)
(Spiegel, 2000) that were less than 0.5 were considered weak, those between 0.5 and below 0.6 were considered moderate, and those that were 0.6 and above were considered strong. Pearson's correlation assumes a linear relationship between variables with normally distributed values of both variables (David, 1949). Considering that the values of variables used in this study may not have been normally distributed, the Fisher's Z transformation was consequently used to convert Person's estimates to a normally distributed z variable (Whittaker & Robinson, 1967).

As Table 22 illustrates, the following correlation estimates were strong: Knowledge and Openness, Knowledge and Stigma, Openness and Stigma, Attitude and Stigma, and Attitude and Openness. The following correlation estimates were moderate: Knowledge and Attitude as well as Knowledge and Trust. The rest of the correlation estimates were considered weak.
Table 22

Results of Correlation Analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>With Variable</th>
<th>N</th>
<th>Fisher's z</th>
<th>Correlation Estimate</th>
<th>p Value for H0:Rho&lt;=0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Openness</td>
<td>80</td>
<td>1.41</td>
<td>0.89</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Stigma</td>
<td>80</td>
<td>1.36</td>
<td>0.88</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Stigma</td>
<td>Openness</td>
<td>80</td>
<td>1.34</td>
<td>0.87</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Stigma</td>
<td>Attitude</td>
<td>80</td>
<td>0.87</td>
<td>0.70</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Attitude</td>
<td>Openness</td>
<td>80</td>
<td>0.71</td>
<td>0.61</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Attitude</td>
<td>Knowledge</td>
<td>80</td>
<td>0.65</td>
<td>0.57</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Trust</td>
<td>Knowledge</td>
<td>80</td>
<td>0.62</td>
<td>0.55</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Willingness</td>
<td>Knowledge</td>
<td>80</td>
<td>0.55</td>
<td>0.50</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Willingness</td>
<td>Openness</td>
<td>80</td>
<td>0.54</td>
<td>0.49</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Trust</td>
<td>Openness</td>
<td>80</td>
<td>0.54</td>
<td>0.49</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Stigma</td>
<td>Willingness</td>
<td>80</td>
<td>0.45</td>
<td>0.42</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Trust</td>
<td>Stigma</td>
<td>80</td>
<td>0.40</td>
<td>0.38</td>
<td>0.0002</td>
</tr>
<tr>
<td>Attitude</td>
<td>Willingness</td>
<td>80</td>
<td>0.38</td>
<td>0.36</td>
<td>0.0004</td>
</tr>
<tr>
<td>Trust</td>
<td>Willingness</td>
<td>80</td>
<td>0.31</td>
<td>0.30</td>
<td>0.0031</td>
</tr>
<tr>
<td>Trust</td>
<td>Attitude</td>
<td>80</td>
<td>0.28</td>
<td>0.27</td>
<td>0.0071</td>
</tr>
</tbody>
</table>
Discussion of Findings

In this chapter, general interpretations of the findings are provided. The researcher discusses the meaning of the study findings. The study results encompassed findings from both qualitative and quantitative analyses. Results were grouped by six themes that emerged from the data. These themes were: Knowledge, Openness, Attitude, Stigma, Willingness, and Trust. The duration and stigma factors are discussed at length in the following chapter.

Qualitative Findings

Knowledge.

From the qualitative analysis, a majority of the participants demonstrated having knowledge of HIV/AIDS and its importance, how it is transmitted, and how it can be prevented. However, a good number did not know anything about the disease while most of them did not have access to intervention and/or care information. It is important to note that the knowledge questions were seeking basic HIV/AIDS knowledge and yet many participants, especially those among the Somali community, demonstrated little or no awareness of the disease. Some of the knowledge was based on myths such as the response quoted in the previous section: “how deadly this disease is” and the fact that it really is not a “Somali problem.”

This finding tallies with other studies such as Rosenthal et al. (2003), Ryan et al. (2004), and Khaliq et al. (2004) that found a need for increased education about HIV/AIDS among immigrant communities.
The ethnicity and gender analysis indicated that women were less knowledgeable and Somali women were least knowledgeable of the four subgroups. This finding may mean that the women participants in the sample were not interacting with the mainstream as well as the men.

*Openness.*

Regarding the openness theme, most participants indicated being open to discussing issues pertaining to HIV/AIDS. What was found most striking about this openness was the fact that most of the participants reported being more comfortable discussing these issues with other people (including medical personnel) than their own family members and/or very close friends. Adults seemed to be more open discussing among adults, while the young discussed among themselves. One could argue that this was a cultural thing where African parents did not directly talk to their teenagers about sex but rather talked to them through close relatives (aunties and uncles), while other parents just kept quiet and hoped that their children did not indulge in sex outside marriage and somehow learned about sex when they got married.

The ethnicity and gender analysis indicated that males were more open than females and Somali females were least open of the four subgroups. Sudanese males were the most open of the four subgroups. This could have been due to male interaction with the mainstream compared to females. Somali females may have been the most insular because they probably kept within their close knit communities.
**Attitude.**

The attitude theme generated some interesting results with more participants indicating negative attitudes towards the health care system, health care providers, and HIV/AIDS treatment. Most participants reported that the health care system was not in their favor and the providers did not understand what was good for the patients. One could deduce that this negative attitude may have been a result of uncertainty and cultural differences in addressing the meaning of disease and care in a "new settlement site." Some of the prominent issues that featured as negative attitudes included fear, shame, lack of insurance, English proficiency, and immigration status.

This finding was consistent with results from studies conducted by the Kaiser Commission on Medicaid and the Uninsured (2003), Ryan, et al. (2004) and Garcia, et al. (2005). These studies reported fear, frustrations, lack of insurance, and inability to navigate the mainstream health care system. These factors could have been a major source of anxiety among immigrants and refugees, and may have engendered negative attitudes towards the health care system.

**Stigma.**

Stigma of the participants towards persons living with HIV/AIDS was profound. Participants reported that stigma was highly entrenched within their families and their communities. This level of stigma could have been attributed to the mode of HIV/AIDS transmission or risk factor. Most participants believed that HIV/AIDS was transmitted through sex, specifically through promiscuous acts. Promiscuity, fornication, or adultery was a sin and taboo in most African communities. These behaviors were also condemned
by the participants’ preferred faiths (Islam and Christianity). Most African families were unclear about how to deal with teenage sex and pregnancy or spousal cheating to the extent that it was usually handled as a family secret. The onset of HIV/AIDS therefore, was regarded as a “punishment for these sins.”

A study (Khaliq, et al. 2004) conducted among Somali communities in Minnesota also indicated a significant level of stigma in the community. This phenomenon was also reported by Rosenthal, et al. (2003) among African immigrants in the Texas area. (See chapter VI for a discussion of the stigma factor).

The ethnicity and gender analysis indicated that more males demonstrated high stigma than females. Somali females were found to have less stigma among the four subgroups. The gender difference may have been due to the nurturing nature of women.

Willingness.

Participant willingness to contribute towards HIV/AIDS interventions and community service was a positive highlight of the study. Most participants were willing to contribute at different levels towards such efforts. This contradicted the negative attitude and high stigma towards HIV/AIDS. One would have expected that, since the majority of the participants had such negative attitudes and strong stigma levels, they would not want to associate with any HIV/AIDS initiatives. This was a probable indication of individual realization of the magnitude of the problem, or that they were generous people towards the ill and suffering, or it was an example of the African tradition of taking communal responsibility for the sick and weak members.
The ethnicity and gender analysis reported that males were more willing to contribute than females. This could have been due to their income levels and males may have been more available than females to participate in community services.

**Trust.**

Another interesting finding was from the trust theme. Most participants indicated less trust towards health institutions, sources of HIV/AIDS information, and the context of the HIV/AIDS information. This was consistent with the sentiments illustrated under the attitude theme. Concerns such as “this problem does not belong to me” or “this information is not for me” may have triggered the cultural competence question. It may not have been necessarily that these communities did not trust the information out there, but rather they did not see themselves as part and parcel of the information and, therefore, it could not be embraced.

The ethnicity and gender analysis showed little difference between the males and females regarding trust. It seemed that there was a pervasive lack of trust in the community towards HIV/AIDS information and health institutions.

**Quantitative Findings**

The six themes from the qualitative analysis were used as variables to conduct correlation analyses to explore the relationships among the variables. Results from the correlation analysis illustrated some remarkable relationships among the themes. Some of the relationships were strong, others moderate, and others weak. This discussion will only center on strong and moderate correlations.
Knowledge and Openness.

The analysis found a statistically significant and a strong positive correlation estimate between Knowledge and Openness. This was consistent with findings in the qualitative analysis. This strong positive relationship suggested that the more knowledgeable participants were about HIV/AIDS, the more open they were towards discussing HIV/AIDS within and without the community.

Knowledge and Stigma.

On the other hand, there was a statistically significant and a strong positive relationship between Knowledge and Stigma. This result suggested that participant's basic knowledge of HIV/AIDS did not lead to less feeling of fear and shame. One plausible explanation was that participants considered the transmission of HIV/AIDS to be through promiscuous "sinful" behaviors. It was likely that the more they thought of HIV/AIDS as a promiscuous disease, the more they stigmatized people living with HIV/AIDS.

Stigma and Openness.

The relationship between Stigma and Openness was another interesting finding. Results indicated a statistically significant and a strong positive relationship between the two variables. Ideally, one would consider not talking about a subject matter if there were a high sense of stigma associated with it. On the contrary, this finding implied that people were more open to talk about the disease. However, although findings from the qualitative analysis indicated that more participants were more open, most of the
participants seemed to be more comfortable discussing these issues with other people (including medical personnel) than their own family members and/or very close friends. Adults seemed to be more open discussing among adults, and the young discussed among themselves. Participant openness, therefore, seemed to be restrictive and not all embracing. This result indicated the strong influence of stigma on the participants.

Stigma and Attitude.

The finding of a strong correlation between Stigma and Attitude was not surprising. One would expect people with negative attitude to have strong stigma. The result on stigma and attitude seemed to suggest that the two reinforced each other among the participants. It was unknown which of the two influenced the other more.

Attitude and Openness.

The correlation results between Attitude and Openness were statistically significant and strong. Positive attitude was expected to generate more openness while negative attitude would generate less openness. Findings in this study showed most participants had negative attitude yet reported more openness. This may have been due to the strong influence of stigma. They were open in talking about the disease, but they felt strongly negative about it.

Attitude and Knowledge.

Results indicated a statistically significant and a moderate positive relationship between Attitude and Knowledge. The moderate relationship may be explained in three
different ways: 1) Irrespective of the knowledge base, the participant’s attitude was not strongly affected. 2) The strong stigma of participants towards HIV/AIDS checked the influence of knowledge on their attitude. 3) The knowledge was on basic awareness of HIV/AIDS and was not broad enough to translate into a strong positive relationship with attitude towards HIV/AIDS services.

Trust and Knowledge.

There was a moderate correlation between Trust and Knowledge, and this correlation was statistically significant. This moderate correlation may be because the knowledge question was on basic awareness of HIV/AIDS rather than on the services and health institutions. Therefore, participants did not know enough about providers and health systems to trust it. On the other hand, the strong stigma level among participants may have negatively influenced their trust level irrespective of their knowledge base.
CHAPTER VI
DURATION AND STIGMA FACTORS

Overview

In this chapter, interpretations of findings with respect to immigrants’ duration of stay in the United States are provided. The issue of stigma is also discussed from a theoretical perspective so as to better understand its stance in the community.

The Duration Factor

The conceptual framework of this study (See Chapter II) highlighted three theoretical perspectives that undergirded immigrant experience as they settled in the United States of America. The first was the assimilation theory, which posited that over time immigrants give up their homeland cultures and habits and melted into the mainstream. The second perspective, sometimes referred to as the “salad bowl” theory, suggested that immigrants retained their homeland cultures while interacting with but not melting into the mainstream. The third perspective, which this study espoused, noted that over time immigrants retained some of their homeland cultural features and habits while adopting some cultural features and habits from the mainstream. What did the study findings regarding the duration factor mean?

Before interpreting the findings on duration and stigma factors, it is pertinent to point out the sampling error limitation of the study. This study, as earlier mentioned, used a non-random sampling technique to recruit participants. Differences among Somali and
Southern Sudanese subgroups may, therefore, be due to sampling error.

Knowledge

Refugees who had lived in the USA for five or more years were classified as more knowledgeable than those who had lived here for four years or less. Somalis who had lived here longer were more knowledgeable than those who had lived here for four years or less. However, among the Southern Sudanese, similar proportions were classified as more knowledge about HIV/AIDS. Duration seemed to positively influence the Somalis’ knowledge of HIV/AIDS. The cause for this discrepancy between the two groups is unknown. It could be a result of outreach among the Somali community or their interaction with the main stream.

Openness

Interestingly the findings on openness and duration are similar to those on knowledge and duration. The participants who had lived here longest were more open than those who had lived here for four years or less. Among Somalis, participants who had lived here longer were more open than those who had lived here for four years or less. There were no differences between the Southern Sudanese subgroups. Increased interaction with the mainstream or increased knowledge of the American system may have positively influenced the Somalis’ openness. As Grieco (2004) and Ku & Martin (2001) contended, the longer immigrants stay in the US and acculturate the more likely they are to be insured and therefore access health care services.
**Attitude**

Higher percentages of participants who had lived here for five or more years exhibited negative attitudes compared to those who had lived here for four years or less. Between the Somali subgroups, a higher proportion of participants with negative attitude was among those who had lived here for five years or more. The Southern Sudanese subgroups were more or less similar. One plausible explanation for the finding among the Somalis is that Somalis who had lived here longer may have acculturated to the American habit of strongly vocalizing their concerns. Another explanation for negative attitude may be unfamiliarity and uncertainty of health care service utilization which is prominent among several immigrant groups (Berk, Schur, Chavez, & Frankel, 2000; Miller, 2000). The difference between the Somalis and Southern Sudanese may indicate a cultural difference between the two groups, with the former being more vocal and the latter being more laid back.

**Stigma**

A higher percentage of participants who had lived here for five or more years exhibited high stigma compared to those who had lived here for four or less years. There was a difference between the two ethnic groups. Somalis who had lived here for five years or more were three times more likely to have high stigma than those who had lived here for four years or less. The high-stigma proportions for the two Southern Sudanese subgroups were identical. Duration may be emboldening the Somalis to express their feelings. Another explanation may be that more knowledge about HIV/AIDS exhibited in the five year plus Somali subgroup may make them more entrenched in their stigma
about HIV/AIDS. This may be due to their negative perceptions regarding HIV transmission.

Willingness

Higher proportions of participants who had lived here longer exhibited more willingness to contribute towards HIV/AIDS interventions and community services compared to those who had lived here for four years or less. Interestingly, the Somalis who had lived here five years or more were three times more willing to contribute than those who had lived here for four years or less. This was in spite of the negative attitude and high stigma found among this subgroup. This apparent contradiction may be due to religious and cultural beliefs of aiding the sick irrespective of their disease. Alternatively, this subgroup may be more financially stable than those who have only lived here for four or less years.

Trust

There was a pervasive lack of trust among all subgroups, but especially among Somalis, with regard to health institutions, as well as sources, content, and context of HIV/AIDS information. The high proportion of Somalis exhibiting less trust may be due to their being vocal in expressing their feelings. It may also be a reaction to HIV/AIDS related provider services and/or messages that may be viewed by Somalis as culturally inappropriate or insensitive. Another factor may be difficulty in navigating the US health care system among immigrants as reported in earlier studies (Garcia, et al. 2005; Kraut, 1990; Muecke, 1983; Ryan, et al. 2004).
The qualitative and quantitative analyses both indicated that stigma was highly entrenched among the study participants. Apparently, more knowledge, more openness, and positive attitude towards the HIV/AIDS disease did not reduce stigma among the participants. Why was stigma such a potent and enduring phenomenon among the participants?

Berger and Luckmann’s (1966) theory of social construction of reality may provide plausible insights for this stigma factor. They posited that reality is socially constructed and that the subjective reality of individuals becomes objective in their consciousness because they experience it in their everyday life. Berger and Luckmann’s theory asserts that, “everyday life presents itself as a reality interpreted by men and subjectively meaningful to them as a coherent world” (p.19). They emphasized that:

Among the multiple realities there is one that presents itself as the reality par excellence. This is the reality of every day life. Its privileged position entitles it to the designation of paramount reality. The tension of consciousness is highest in everyday life, that is, the latter imposes itself upon consciousness in the most massive, urgent and intense manner. It is impossible to ignore, difficult even to weaken in its imperative presence. (p.21)

Furthermore, this reality is shared with others and:

... is as real to others as it is to myself. Indeed I can not exist in everyday life without continually interacting and communicating with others. I know that my natural attitude to this world corresponds to the natural attitude of others .... (p. 22)
Participant perceptions of HIV/AIDS may be strongly defined and influenced by the attitudes and beliefs expressed daily in their communities. If in their everyday lives, HIV/AIDS is believed to be transmitted through illicit sex which is considered a sin, then it may explain the level of stigma attached to the disease and its victims.

The collective yet subjective “reality” surrounding HIV/AIDS and its modes of transmission becomes “objective” and “factual” in their consciousness and is difficult to erase through simple education initiatives on pamphlets and brochures. This may explain why in this study stigma was not affected by more knowledge, openness, or even duration of stay in the United States. The collective reality of participants in this study may also have been enhanced by their resettlement experience.

The Somali and Southern Sudanese refugees were resettled as clusters of families and communities in a small suburban town of Clarkston, DeKalb County, Georgia. Here, they have continued, almost uninterrupted, to live their everyday lives interacting and socializing with one another within their close knit communities. Their perceptions on such a sensitive issue as HIV/AIDS are likely to be socially constructed and heavily influenced by their beliefs, traditions, and social structures. On the other hand, voluntary immigrants who usually settle as individuals are likely to interact and quickly adopt the mainstream as their community. Their everyday realities are shaped by the diverse communities they encounter.

The strong stigma exhibited by the participants, against the HIV/AIDS disease and its victims, may therefore be a result of their socially constructed reality which has in turn been consolidated by the nature of their resettlement in close knit environments.
CHAPTER VII
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Overview

This chapter briefly describes the purpose, the sample, and the methodology of the study. It also provides the conclusions based on the findings of the study. The chapter ends with recommendations for service providers, policy makers, and researchers.

Summary

The purpose of this study was to explore the knowledge and perceptions of Eastern African refugees regarding HIV/AIDS and its educational and prevention programs (interventions) in metropolitan Atlanta, Georgia. The study was guided by the following four research questions: 1) What did Eastern African refugees know about HIV/AIDS and its importance? 2) How did Eastern African refugees and their families learn about HIV/AIDS prevention and treatment? 3) How did Eastern African refugees perceive HIV/AIDS and those suffering from HIV/AIDS in their families and communities? 4) What were the perceptions of Eastern African refugees regarding participation in the interventions offered by public and private organizations?

Study participants were refugees from Somalia and Southern Sudan who had settled in metropolitan Atlanta. The sample of 80 participants was selected based on several factors such as age, immigration status, willingness to share information about sex and sexuality. The sample was divided into four subgroups: 20 Somali women,
20 Somali men, 20 Southern Sudanese women, and 20 Southern Sudanese men. They were also divided according to duration in the USA with two resulting categories: those who had resettled in the USA for four or less years, and those who had lived in the USA for five or more years.

The study collected both secondary and primary data. For the primary data, the researcher used a structured survey instrument that was administered in a face-to-face interview format. The study used the snowball sampling technique to identify participants and carefully selected interpreters helped in translating for those who were not fluent in English. The researcher conducted qualitative data analysis using as evidence the participants' responses on the survey instrument. The quantitative analysis examined correlations among the six themes identified from the qualitative analysis namely: knowledge, openness, stigma, attitude, willingness, and trust.

This study was based on a theoretical perspective that recognized immigrants as going through a process of retention and integration. They retain some characteristics of their homelands such as religious beliefs, diet, costumes, and traditions while adopting other characteristics of their new country and society such as openness, public discourse, and American work ethic. This process is also influenced by how long immigrants stayed in the United States of America. In the long run immigrants regard themselves as, for example, Chinese-Americans, Somali-Americans, Ugandan-Americans, or Sudanese-Americans because their identities and behaviors melded cultural features of both lands.
Conclusions

This study showed that most participants had knowledge of the HIV/AIDS disease. However, their knowledge base was basic and some of it was dependent upon myths and imaginations. Female participants were less knowledgeable than male participants.

Participants in the study seemed to be generally open to discussing issues pertaining to HIV/AIDS. However, their openness was limited to people outside their communities. Evidently, HIV/AIDS was still a taboo subject within the communities.

Participants’ attitude towards the health care system, service providers, and HIV/AIDS treatment was mostly negative. Regarding attitude towards treatment, most participants reported fear and lack of insurance or financial assistance to facilitate medical visits.

Findings on stigma indicated that it was entrenched within the community especially among males. It seems knowledge, openness, willingness, and duration had no positive impact on stigma towards the disease and persons living positively with HIV.

In spite of the negative findings on attitude and stigma, participants especially males were willing to contribute towards HIV/AIDS interventions and community service. However, most participants had little trust towards health institutions, sources of HIV/AIDS information, and the context of the HIV/AIDS information.

The study findings seem to suggest that the longer refugees stayed in the United States, the more likely they are to be more knowledgeable on HIV/AIDS, more open to discussing the disease, and more willing to participate in HIV/AIDS interventions and community services. This research did not study causality. Therefore, the researcher can
not state with certainty why these correlations existed. However, the researcher hypothesizes that duration of stay in the United States may have exposed participants to more information on HIV/AIDS than in their countries of origin. Longer stay may also have led to the acculturation of participants and resulted in their being more open in discussing issues pertaining to sex and sexuality. Their willingness to participate in HIV/AIDS intervention and community service may also be due to acculturation.

The results of this study on refugees are similar to findings from studies on immigrants in general. This may not be surprising because refugees (forced immigrants), in spite of their unique resettlement experience, share the same knowledge and perceptions regarding HIV/AIDS and its interventions as their counterparts (voluntary immigrants).

**Recommendations for Service Providers and Policy Makers**

Recommendations are discussed by themes that were generated from the qualitative analysis. In summary, there seem to be a need to gear culturally sensitive and culturally competent interventions towards the Eastern African refugee communities and also involve them in the process of developing these interventions so as to gain their confidence and trust.

**Knowledge**

There is a need for increasing education and awareness of not just the basic HIV 101, but on such issues as knowledge on treatment, access to services, refugee rights, and confidentiality.
US service providers, such as personnel at hospitals and county clinics, should not assume that these communities are aware and knowledgeable about these issues. They should make a deliberate effort to learn about the needs and knowledge gaps of immigrants and refugees in their communities so that they can equip themselves to better serve these communities. They should also seek community inputs in preparing culturally appropriate and sensitive educational and preventive materials for the targeted population.

US policy makers at the federal, state, and local levels need to earmark resources to enable providers to avail the above services. There is a need to classify immigrants and refugees as a priority population. Culturally appropriate education and prevention interventions should be tailored to suit these communities especially women who in the study were found to be the least knowledgeable about HIV/AIDS and yet they are the most vulnerable subgroup. Findings from the duration factor imply that even refugees who have stayed in USA longer need these targeted services.

*Openness*

Study findings indicated that participants were more comfortable talking to outsiders about sex and HIV/AIDS than talking among themselves. There is, therefore, a need for policy makers and providers to sensitize and empower immigrant and refugee parents, elders, and community leaders about the importance of open discussion among themselves about HIV/AIDS. These adults should then take the lead to openly talk about sex and related diseases with their youth.
US service providers should use every opportunity, such as doctor visits and community events, to remind adults to talk openly and also talk to their youth about sex, responsible behavior, and health preventive measures.

US policy makers should involve community leaders and youth in the planning and implementation of HIV/AIDS initiatives in their community.

The policy makers and service providers need to collaborate with community and faith based organizations to tackle the issue of openness among targeted subgroups such as men, women, youth, and religious leaders.

**Attitude and Trust**

The study results suggested a general negative attitude and mistrust among the participants towards service providers and the healthcare system. To gain the immigrant and refugee trust, providers and policy makers should deliberately engage the communities in understanding the American healthcare system and how to navigate it.

Emphasis on cultural awareness, appropriateness, and sensitivity has been one-sided, always geared towards providers and policy makers. It is important that immigrants and refugees become culturally aware and competent in navigating the American system. It is incumbent upon providers and policy makers to make this happen rather than leave it to chance as seems to be the current practice.

**Stigma**

One of the most intriguing findings of this study is the entrenched stigma participants had towards HIV/AIDS and people living positively with the disease.
is an urgent need for policy makers and providers to undertake a focused campaign to address stigma in these communities. Stigma will not go away overnight. It will require a systematic multifaceted strategy on the part of policy makers to fight it.

These strategies should be worked out with the help and involvement of opinion leaders in the targeted communities. One such strategy could be recruiting religious leaders who carry a lot of clout in their communities. They could be encouraged to include in their weekly sermons messages that dispel stigma against sexually transmitted diseases and their victims while encouraging members to seek treatment and care.

Another strategy could be to involve school administrators to embed issues of stigma in their sex education curriculum. Specifically, administrators should encourage parents of immigrant and refugee students to allow their children to attend these classes. This may help the young generation to be more tolerant towards victims of sexually transmitted diseases.

Willingness

There is a need to capitalize on the positive aspect of willingness to participate and contribute towards HIV/AIDS interventions and community services to bring out the untapped goodwill of the communities.

For example, providers could encourage immigrants and refugees to work as volunteers in health institutions that provide HIV/AIDS services. Such engagement would help the community be more tolerant and sensitive towards people living positively with HIV.
Recommendations for Future Research

Studies on immigrant and refugee health are a recent phenomenon in the United States. Specifically, immigrants and refugees from sub-Saharan Africa have mostly been categorized as “Black / African Americans.” As such data on this population has seldom been represented except as that for African Americans. Consequently, the plight of African immigrant and refugee health has rarely been addressed since they do not fit the CDC defined “Priority population”. In an attempt to fill the data and literature gap, this study explored the knowledge and perceptions of Eastern African refugees regarding HIV/AIDS and its interventions. The findings of this study pointed to a need for research in several critical areas with respect to African immigrant and refugee communities in the USA.

First, there is a need for a similar study that has a larger sample and involving other African refugee and immigrant populations.

Second, there is a need for a systematic study on the underlying causes of stigma in its various manifestations or HIV/AIDS in the communities.

Third, there is a need for quantitative studies that focus on some of the variables in this study and analyze the causal-comparative relationships among these variables. For example, what variables are strong predictors of stigma?

Fourth, there is a need to explore the perspectives of service providers and policy makers regarding services to these communities. What challenges do they encounter in servicing these communities?
Finally, there is a need to explore theories that would underlie culturally appropriate and culturally relevant education, prevention, and care interventions targeted specifically at the African immigrant and refugee populations.

This study attempted to find out what Somali and Southern Sudanese refugees in metro Atlanta knew about HIV/AIDS and what their perceptions and beliefs were toward HIV/AIDS related issues. The study helped to fill a gap in the literature on African immigrants in the United States of America. The findings of the study provided food for thought for community activists, service providers, policy makers, and researchers. Therefore, the struggle to address the multifaceted HIV/AIDS related challenges in the African immigrant community must continue.
Sample Questions

1. Please name hospitals and clinics where members of your community go for health care services.

2. How much do members of your community trust the information they get from these hospitals and clinics?

3. How comfortable are members of your community in discussing with the health care providers?

4. Are there some problems that members of your community are uncomfortable discussing?

5. Which problems are these?

6. Have you ever received any health care services during your stay in the United States?

7. Have you ever heard of HIV/AIDS?

8. Do you think HIV/AIDS was introduced to your community by foreigners or is it native to your community?

9. How would you know if someone was sick with HIV/AIDS?

10. What do you think are the main causes of HIV/AIDS?

11. Do you consider HIV/AIDS a common illness in your community or is it rare?

12. How concerned are you about being infected with the HIV/AIDS disease?

13. What would you say are the best ways of protecting oneself from being infected?

14. Have you ever had any HIV/AIDS prevention/education information?

15. Have you received any information about HIV/AIDS prevention and education at the hospitals and clinics that you mentioned at an earlier question?

16. Did you trust the source of information that you received?

17. Do you think members of your community have access to HIV/AIDS information?

18. Do you think adult members of your community discuss openly about HIV/AIDS?

19. Who would members of your community prefer to discuss HIV/AIDS with?

- What problems would you think that HIV positive members of your community face within their families? Would they:

20. Receive sympathy

21. Receive help
22. Be ashamed
23. Be abandoned

* Now, not mentioning family, what problems would you think that HIV positive members of your community face within the community? Would they:

24. Receive sympathy
25. Receive help
26. Be ashamed
27. Be abandoned

28. What problems would you think that HIV positive members of your community face within the health care system?

29. Do you think some HIV positive members of your community stay away from getting treatment?

30. Do you think religious beliefs affect members of your community in terms of learning about HIV/AIDS?

31. Do you think religious beliefs affect members of your community in terms of taking action to prevent becoming infected?

32. Do you think religious beliefs affect members of your community in terms of deciding to be tested?

33. Do you think religious beliefs affect members of your community in deciding when to seek treatment?

34. Do you think being (Somali / Sudanese) affects people in terms of learning about HIV/AIDS?

35. Do you think being (Somali / Sudanese) affects people in terms of taking action to prevent becoming infected?

36. Do you think being (Somali / Sudanese) affects people in terms of deciding to be tested?

37. Do you think being (Somali / Sudanese) affects people in deciding when to seek treatment?

38. Could you please make any suggestions regarding HIV/AIDS services to your community members?

39. Could you please make any suggestions to medical people in the U.S about how they provide help to the immigrant community?

40. Would you contribute $15 if that is how much it will take to save members of your community?
REFERENCES


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