Breaking the Silence: Interpreting African-Born Women’s Knowledge about HIV and Concurrency

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This article focuses on African-born women’s knowledge of HIV and multiple sexual relationships. Data were drawn from a study with the black community in Washington State that aimed to develop HIV prevention and concurrency messaging. This article is based on secondary data collected in key informant interviews (n = 8) and three focus groups (n = 13) with African-born women (N = 21) in Seattle and King County, Washington. Thematic data analysis was used for analysis. Three predominant themes for African-born women were (1) lack of knowledge or awareness of HIV prevalence and its intersection with concurrency; (2) ambivalent silence as a reaction to concurrency; and (3) gender differences in perceptions of concurrency. African-born women perceived HIV as a problem in Africa and not in the United States. The second theme illustrated sociocultural pressures on women that silence them from voicing their concerns about partners’ concurrent relationships and their risks of HIV infection. Gender differences in perceptions of concurrent practices favoring men were also highlighted. Results suggest a need for prevention interventions promoting sexual health communication among African-born women and their communities and culturally appropriate education. These components may be critical for breaking the silence and improving HIV prevention interventions.

KEY WORDS: African-born women; HIV and concurrency; HIV education and information; sociocultural practices

The HIV/AIDS pandemic continues to disproportionately affect African-born immigrants in the United States and African Americans (Adimora, Schoenbach, & Doherty, 2006; Maposa, 2010; Morris, Kurth, Hamilton, Moody, & Wakefield, 2009). From 2006 to 2010, foreign-born black people (from Africa and the Caribbean) comprised 46 percent of new HIV infection cases among black people in Washington State (Washington State Department of Health, 2012a). During this period, new HIV cases per 100,000 populations were higher for African-born black females (109.7) than for males (105.4), and higher for African-born black females (109.7) than for African American females (10.5). HIV prevalence is highest for African-born black people who have immigrated from Ethiopia (32 percent), Kenya (12 percent), Somalia (3 percent), and Zambia (3 percent) (Washington State Department of Health, 2004, 2012a; Wood & Eteni, 2003), and the majority of African-born HIV-positive individuals living in Washington State (75 percent) reside in Seattle or King County. These data underscore the need for culturally specific information and education prevention interventions for African immigrant populations in the state.

This article focuses on African-born women in Washington State. Data were drawn from a project that used community-based participatory research (CBPR) to develop for the black community HIV information prevention and messaging on multiple sexual relationships that overlap in time, or concurrency (Andrasik et al., 2012). We analyzed the formative data to explore African-born women’s awareness and perceptions of HIV risks, concurrent sexual behaviors and HIV transmission, and prevalence in their community.

BACKGROUND

African-born women bear the greatest burden of HIV in the Seattle and King County black community, and little is known about their knowledge of HIV and the connection between disease transmission and concurrent sexual behavior. HIV/AIDS surveillance data for African-born women are often
lumped with data for the larger African American community, which makes it hard to tease out within-group differences. However, even though desegregated data distinguishing African-born women from African Americans are rare, existing data clearly establish the disproportionate impact of HIV/AIDS among black women. Desegregated surveillance data collected in the Seattle–King County area of Washington State indicate that as of December 2011, the number of black non-Hispanic women presumed to be living with HIV (N = 1,136) was higher for foreign-born black women (19 percent) compared with U.S.-born black women (12.4 percent) (Washington State Department of Health, 2011).

Aggregate national HIV surveillance data from 2009 indicate that African Americans constituted 57 percent of new HIV infections among women, compared with 21 percent white Americans and 16 percent identified as Latinas. African American women rank third for rates of new HIV infections by group, following African American men and Latino men (Centers for Disease Control and Prevention [CDC], 2009). In 2010, black women accounted for 13 percent of all new HIV infections in the United States and 64 percent of all new infections among women (CDC, 2012a). The majority of HIV-seropositive black women (87 percent) were infected through heterosexual sex (CDC, 2012a). Many black women are unaware of their HIV infection, new infections often remain undiagnosed for years, and treatment is delayed. As a result, HIV has ranked among the top five leading causes of death among black women ages 25–44 for the past decade (Watkins-Hayes & Pittman-Gay, 2012).

If current trends continue, 1 in 32 black or African American women will be diagnosed with HIV infection in their lifetime, compared with 1 in 106 Hispanic or Latina women and 1 in 526 of white women (CDC, 2012b). Surveillance data from 2007 to 2010 indicate that although incidence rates are declining in the local African American community, the rates are rising in the local African-born community (CDC, 2012a; Hall et al., 2008).

HIV surveillance data from Public Health Seattle & King County (PHSKC) indicate that foreign-born black people comprise an increasing share of infections among blacks living with HIV/AIDS. The population of foreign-born black immigrants has grown at a rapid rate in the last two decades. This population growth has coincided with increased incidence and prevalence rates of HIV. However, the Washington State Department of Health data are not clear on whether foreign-born immigrants were infected before or after their arrival in the United States (Washington State Department of Health, 2012b). Data presented by Wood and Eteni (2003) suggest that many or most foreign-born blacks acquired HIV prior to arriving in the United States. However, little is known with any certainty. PHSKC data indicate that between 2006 and 2010, 46 percent of all new HIV infections in Washington State were among this population (Washington State Department of Health, 2012a). Identifying acquisition of HIV is challenging for many reasons, including lack of documentation or knowledge of previous testing; stigma and subsequent nondisclosure of HIV serostatus; and misinformation (Wood & Eteni, 2003). Regardless of where infection occurred, the result is increased HIV prevalence and community viral load in the local African-born community, placing African immigrants at higher risk of infection in sexual encounters (CDC, 2012a). As with most racial groups, African-born individuals are more likely to have sexual relationships with individuals of the same racial group. High HIV prevalence in a sexual network might increase transmission rates, particularly when individuals in the network are engaging in concurrent sexual relationships.

The increasing number of HIV-positive African-born immigrants in Washington State has highlighted the need for improved HIV/AIDS prevention and care for immigrants through a better understanding of socioeconomic and cultural factors that influence HIV transmission. Furthermore, disproportionate HIV infection among African Americans and African-born women calls for broader and contextualized understanding and analysis of HIV risk factors to inform HIV prevention interventions.

**Generalization of HIV Experience Misinforms Interventions**

Little is known about how African-born immigrants perceive HIV and sexually transmitted infections (STI) risks, and even less is known about whether they talk about their sexual experiences and their knowledge of sexual practices in relation to HIV (Maposa, 2010). Because heterosexual sex is the primary risk factor for HIV infection for African-born women, it is imperative that we understand traditional norms and beliefs about HIV risks, concurrent
practices, and discussions of sexual practices within the African-born community. Concurrent sexual relationships are sexual relationships that overlap in time—both within and outside of marital relationships. Although sexual practices are not openly discussed in the African-born community, concurrent behaviors may be taken as a sign of manhood for men, and implications for HIV risk (for example, the connection between concurrency and HIV transmission) are largely unknown (Andrasik et al., 2012). Traditionally existing taboos hinder African-born immigrants from talking about their sexual experiences with their partners and families, let alone people from within and outside their ethnic group (Gupta, 2000; Weiss, Whelan, & Gupta, 2000). Exploring how African-born women discuss sexual relationships may thus promote better understanding of fundamental contributors to traditional practices and taboos and promote improved communication about sexual risk and HIV transmission. There is a need to explore safe spaces like those created in the focus groups within the concurrency project (Andrasik et al., 2012), whereby African-born and African American women discussed and shared their experiences. Such safe spaces become informative, educational, and a way of exploring prevention interventions based on shared experiences. Bringing their voices up front in prevention intervention development also empowers immigrant women to take leadership in their health issues.

Few studies exist that focus on African-born women and their sexual risk behaviors as they migrate to and eventually resettle in the United States, despite the fact that HIV prevalence among foreign-born Africans in the United States is high (Maposa, 2010). Such studies have the potential to inform HIV prevention intervention designs. As is the case with national HIV surveillance data, the majority of existing HIV/AIDS-related studies present African-born data as part of a larger black group regardless of cultural variations, values, beliefs, and identity differences (Gillespie-Johnson, 2008). Considering African-born women (and men) as homogeneous entities, despite inter- and intragroup differences, also creates barriers to understanding and responding to specific HIV risk factors in culturally appropriate ways (Bradby, 2003; Rosenthal, 2003). Acknowledging cultural diversities and health practices through African-born women’s sexual experiences therefore becomes imperative in understanding how and whether African-born women discuss their health conditions, ask for information and education, and reach out for HIV and other STI-related treatments.

**Sociocultural Norms Silence Women**

Less is known about how African-born women in the United States interpret their sexual experiences and sexual relationships in the context of existing disparities in HIV infection (Maposa, 2010). Understanding the ways in which black women from Africa living in the United States interpret their sexual practices and make decisions to protect themselves from HIV infection is imperative when HIV disease burden for domestic African-born communities is so disproportionally high (T. O. Pearce, 2000).

Several social and cultural norms may hinder women from knowing about and protecting themselves from sex-related diseases. Generally, African women are culturally silenced when it comes to sex-related issues and abuses (Gupta, 2000; Kesby, 2000; Mebrahtu, 2000). Several factors contribute to the silencing of African-born women, including poverty, gender roles, and women’s lower status in a patriarchal society despite their socially assigned and imposed roles in households and communities as mothers and caregivers (Krieger & Margo, 1991; D. Pearce, 1983; United Nations Development Programme, 1995). Patriarchy designates women’s role in society as subordinate to husbands; marriage is arranged by parents, and men have the right to dominate, oppress, and exploit women. In such a situation, women may often become men’s property, and violence against women may be considered legitimate. Research suggests that sexual abuse and violence are among the major indicators of HIV risk in black women, and displacement and forced migration render women victims of violence (Ciambrome, 2001; Watkins–Hayes & Pittman–Gay, 2012).

Moreover, African women are more often than not socially and culturally considered to exist to meet the needs of men (Krieger & Margo, 1991), which objectifies them and also limits their legal rights, including access to health care and information. Discussing sex, sexual relationships, and sexual practices is traditionally considered taboo in most African communities and often restricts women from voicing their experiences of sexual issues (Gupta, 2000; Weiss et al., 2000). For instance, concurrent sexual relationships are not openly discussed. This inability to discuss topics related to one’s health and HIV risk results in normatively “enforced silences,” many of which have gender-based concurrency norms.
(Andrasik et al., 2012). Indeed, among some African communities, married men’s concurrent sexual relationships are related to norms of masculinity, while it would be considered immoral for married and unmarried women to participate in concurrent relationships; if discovered, women would suffer public ridicule and isolation. The fear of isolation may further prevent women from communicating their concerns, thus leading to muteness or ambivalence about discussing these issues.

Unequal power relations due to patriarchal structures and patrilineal community facets, abusive relationships, and lack of information often inhibit women from making independent and informed decisions in their sexual relationships (Dickson, Paul, & Herbison, 1993; Wingood & DiClemente, 2000). Poverty contributes to power imbalances and may result in women’s inability to protect themselves from infectious diseases (Gorbach, Stoner, Aral, Stubblefield, & Holmes, 2002). In such culturally and economically unbalanced power relationships, poor women and those socially and culturally on the margin remain victims of gender and power dynamics in sexual relationships.

**Forced Migration and Resettlement Processes as Risks**

Most African-born women resettled in Washington State were forced to leave their homes in Africa as a result of global economic forces, climate change and drought, war, ethnic conflicts, and poverty that led to forced migration (Abdool Karim & Frohlich, 2000; Lohrentz, 2004; Matsuoka & Sorenson, 2000). For African women, displacement and forced migration are two of the major risk factors of HIV transmission (United Nations Population Fund, 2005; UN Women, 2013). Women who have had violent and abusive experiences, also known as “women at risk” cases in the international community, rarely receive necessary care and services. Experiences in refugee camps, trauma, and cultural shock further adversely affect individuals during and after their resettlement in the host society.

Once resettled as refugees, these women often live in low-income public housing, experience poor working conditions and low wages if employed, raise children as single mothers, and care for and support their families while relying on either minimum wages or public assistance (Tigerson, Spigner, Farwell, & Stubblefield, 2006). Such conditions call for an exploration of African-born women’s HIV infection and related risk factors that includes a contextualized understanding of their migration processes and broader socioeconomic contexts that shape their everyday lives. In other words, poverty, traditional practices, and power imbalances migrate with African-born women and should be central in exploring and addressing their sexual relationship concerns.

Focusing on African-born women in Seattle–King County of Washington State, this article draws secondary data from a study developed to design HIV prevention and concurrency messaging for the black community (Andrasik et al., 2012). Key informant interviews and focus groups with African-born women were conducted using CBPR to explore perceptions, beliefs, and knowledge of HIV and concurrent sexual relationships.

**METHOD**

The methods used for this study were part of a larger three-phase study (Andrasik et al., 2012). The goal of the study was to design a culturally appropriate concurrency messaging campaign using a CBPR approach for the African American and African-born communities in Seattle and King County, Washington. Human subjects approval was obtained from the University of Washington institutional review board. A Disparities Working Group, composed of community members from over 15 community-based organizations, academic partners, and HIV service providers, identified a sample of eight female leaders and stakeholders from the African-born community (four Kenyan, three Ethiopian, and one Tanzanian) to participate in key informant interviews that would inform a focus group guide. Four of the African-born leaders and stakeholders were HIV/AIDS service providers, and four were community members.

In phase 1 of the study, stakeholders were asked to participate in key informant interviews lasting 60 to 90 minutes. Key informants (N=8) were compensated with $20 for their time. Interviews were audio-recorded and transcribed, and all identifying information was removed from the final transcript. Interview topics included perceptions and beliefs about HIV/AIDS; HIV/AIDS prevention; sexual networks and concurrency; message framing and development; message dissemination; and community norms and beliefs. Key informant interviews focused on obtaining stakeholders’ perceptions of concurrency and HIV/AIDS knowledge and awareness in the local community.
In phase 2 of the study, stakeholder data were used to develop appropriate questions for the focus groups. Stakeholders perceived the most important factor underlying the spread of HIV in their community as the way in which Africans conceptualize their HIV risk or lack thereof. Key informants agreed that the connection between concurrent sexual behaviors and HIV transmission in the community was not understood. As a result, the focus group interview guide focused on exploring participants' understanding of the intersection between concurrency and HIV. Questions were also included to obtain data to inform the development of an HIV prevention campaign focusing on concurrency education (phase 3).

A total of 13 African-born women participated in three women's focus groups. The final number of focus groups was selected to ensure that participants mirrored the HIV/AIDS epidemiological data available for the local African-born community. As such, participant recruitment focused on Kenyans and Ethiopians. Although the focus groups also included African American women, we focused on the analysis of the African-born women's data for this article. All focus groups were held at community locations to ensure convenience for participants.

African-born community members were hired and trained to facilitate focus groups and conduct qualitative data analysis. Facilitators for each group were matched to focus group participants by age, race, and country of origin. Focus groups were 90 to 120 minutes long. Each focus group discussion was audio-recorded and transcribed, and all identifying information was removed from the final transcript. Each participant received $30 to compensate her for her time. Focus group discussion topics included perceptions of concurrency, beliefs about concurrency, perceptions of HIV/STI risks as they relate to concurrent behaviors, and concurrency messages.

After providing informed consent, each participant reviewed an educational sheet that provided local HIV incidence and prevalence data and described concurrency. The educational sheet also provided an example of Uganda’s 1986 successful concurrency campaign (Green, Halperin, Nantulya, & Hogle, 2006; Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006).

Focus groups were used because this method is well suited to facilitate open dialogue within and across groups around very sensitive issues. Focus groups also allow flexibility and openness in the dialogue, thus allowing participants to voice their main concerns.

An advantage of focus groups is the creation of a space that allows expression of varied ideas and ensures that participants’ viewpoints are given equal validity (Krueger & Casey, 2009). The composition of the focus groups allowed black women to discuss experiences, share similarities, and work through differences with other women in the group. This led to an open discussion of dating experiences, frustration with men, and perceptions of concurrency and concurrent behavior.

**Participants’ Characteristics**

A total of 13 African-born women participated in three women’s focus groups, and seven participated in key informant interviews (N=20). Participants’ ages ranged from 25 to 58 years. African-born women’s countries of origin were Eritrea (one), Ethiopia (six), Gambia (two), Kenya (nine), Senegal (one), and Tanzania (one). The three overarching themes that emerged from African-born women’s data—(1) lack of knowledge or awareness of HIV/AIDS and concurrent relationships; (2) ambivalent silence as a reaction to concurrency; and (3) gender differences in perceptions of concurrent relationships—are the focus of this article. These are part of the overall themes that were used to guide the development of concurrency messages for the African-born community living in Seattle–King County of Washington State (see Andrasik et al., 2012).

**Data Analysis**

Key informant and focus group data were analyzed using thematic data analysis (Moustakas, 1994; Polkinghorne, 1989). A group of five staff members, two of whom were community members, individually coded the first four key informant interviews and the focus group discussions. Team members then met to discuss the meaning of significant statements (for example, avoiding discussions, feeling quieted), identifying areas of agreement and discrepancy. Each discrepancy was discussed until a consensus from all team members was reached as to the meaning of the significant statement. Next, team members developed themes that were used to construct an initial codebook (for example, concurrency as normative, gender differences). The final step of data analysis consisted of reviewing all the codes and transcripts to identify umbrella themes (for example, enforced silences, lack of knowledge or awareness). The data analysis team met weekly and held in-depth discussions about each theme and how it arose across and within
groups. Any discrepancies were discussed until consensus was met.

RESULTS
Themes
Lack of Knowledge or Awareness of HIV. Key informant interviews revealed that stakeholders believed that the larger African-born community was unaware of HIV/AIDS prevalence in their community. This was supported by the data collected in the focus groups. Before each focus group, women were provided with an educational sheet detailing HIV/AIDS rates in the local African-born community. Most participants learned about the rates of HIV/AIDS in their local community for the first time in the focus group. As one woman stated, “HIV is the fastest growing epidemic in Ethiopian and African American communities, yet we don’t know it.” Many of the African-born women in the focus groups were unaware of the disproportionate impact of HIV/AIDS on the black community in Seattle–King County. Indeed, most of the women believed that HIV is not a big concern in their local areas. One participant noted, “HIV is not really a problem here.”

This perception was strengthened by the fact that many women had never seen or encountered any messaging about HIV/AIDS in their local areas in particular. One woman explained, “No one is talking about concurrency, or HIV”; another commented, “Nor is there any information about HIV/AIDS in the media.” The lack of public information also resulted in the women’s assumptions that HIV/AIDS is “not a real problem” for Africans living in the United States. Many of the women reported being exposed to intensive outreach and campaigns about HIV while in Africa. They were accustomed to encountering daily media coverage, pictures, and flyers about HIV. However, many had not seen or heard HIV messages since moving to the United States, which led them to assume that the prevalence of HIV is low to none in Seattle–King County and that HIV is not a serious health issue for Africans in America. Engaging in focus group discussions about HIV and concurrency helped the women to be aware and realize that HIV is invisible in their communities, that it is “a silent killer.” As one participant noted, “Ignorance about the epidemic is what’s killing people.”

However, provision of massive information is only one aspect of prevention intervention. Other contributors to HIV transmission within the African-born communities need to be explored and addressed appropriately. For instance, as Andrasik and colleagues (2012) found, concurrent practices are considered traditional for African-born men and may increase HIV risk in African communities, underscoring the need for culturally appropriate educational interventions.

Ambivalent Silence as a Reaction to Concurrency. In contrast to the lack of knowledge reported by African-born women about HIV incidence in the black community in Seattle–King County, their knowledge of concurrent sexual relationships in the community was apparent. However, many of the participants endorsed beliefs that women’s cultural and social expectations create the biggest barriers to discussing sex-related issues. Moreover, the women were unable to identify the association between concurrent sexual relationships and HIV transmission.

African-born women tend to, and are socially forced to, remain silent with regard to sex-related issues and their husbands’ concurrent partnerships. The silence was attributed to stigma and fear of how one might be perceived or talked about by others. “I’m from Ethiopia, so talking about sex, it’s like a phobia, you know? You don’t really talk about it. We’re not really open. We’re not raised to talk about it openly like this,” said one woman.

Women tend to ignore men’s concurrent sexual relationships. There are cultural and social expectations from women that remain difficult to transgress because of consequent socially isolation. Many participants felt that it is socially and culturally acceptable for men to have concurrent sexual relationships even if they are married, while women are expected to remain silent about their partner’s extramarital sexual relationships. One participant explained, “It’s like a man can do whatever. You turn a blind eye to what they’re doing. You stay there because you are married in that family, you’re supposed to stay there.”

Many of the women were keenly aware of men’s social status and power over women and often acknowledged women’s powerlessness to talk about their current sexual relationships and HIV transmission. Moreover, the women were unable to identify the association between concurrency and HIV transmission. This perception was strengthened by the fact that many women had never seen or encountered any messaging about HIV/AIDS in their local areas in particular. One woman explained, “No one is talking about concurrency, or HIV”; another commented, “Nor is there any information about HIV/AIDS in the media.” The lack of public information also resulted in the women’s assumptions that HIV/AIDS is “not a real problem” for Africans living in the United States. Many of the women reported being exposed to intensive outreach and campaigns about HIV while in Africa. They were accustomed to encountering daily media coverage, pictures, and flyers about HIV. However, many had not seen or heard HIV messages since moving to the United States, which led them to assume that the prevalence of HIV is low to none in Seattle–King County and that HIV is not a serious health issue for Africans in America. Engaging in focus group discussions about HIV and concurrency helped the women to be aware and realize that HIV is invisible in their communities, that it is “a silent killer.” As one participant noted, “Ignorance about the epidemic is what’s killing people.”

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regardless of their partner’s extramarital sexual relationships, adding additional challenges to addressing partner behavior. Many of the participants believed that the women’s cultural and social expectations create the biggest barriers to discussing sex-related issues. They felt that these barriers were more persistent than the conventionally assumed women’s economic dependency on men. The women gave examples of cultural and social traditions and expectations that fostered silence among African-born women.

**Gender Differences on Perceptions of Concurrent Behaviors.** Most of the African-born women identified gender differences about concurrent practices and behavior. According to one participant, “Men brag about [concurrency] and women remain kind of quiet.” Participants stated that although men may brag about concurrent sexual practices among themselves, public knowledge of these actions is unacceptable. Women prefer not to talk about men’s concurrent sexual relationships because they are expected not to. Although public knowledge would be shameful for both, the repercussions would be more difficult for the woman than for the man to bear because she is looked down on and shamed in the community, and her self-respect is endangered. Hence, women are forced to remain silent. One participant observed: “A man who cheats on his wife or a woman who does the same thing is looked down on in the community. It’s a really, really bad thing and that’s why people hide and go behind closed doors and they don’t talk about it is because of that I think.” Participants noted that any public gossiping about concurrency occurring in a woman’s household brings more shame to the woman than to the man and may be yet another factor preventing open discussion.

Concurrent behaviors among African-born men living in the United States are often linked to polygamous practices in some African countries (Andrasik et al., 2012). As one African-born woman stated in the focus group discussion,

> Culturally, my grandpa had five wives and it was not a secret because that’s a traditional thing. I think the new generation was taught to be monogamous Christian. Otherwise, they’re still trying to be like grandpa. They’re just hiding it.

Her statement complements Andrasik and colleagues’s (2012) findings from African-born men who believe in traditional practices and that Christianity has changed traditional polygamous practices in some African societies.

Hence, people do gossip about men’s and women’s outside marital relationships. However, people condemn women more than they do men for this behavior. This is a reflection of the ambivalent nature of social and cultural norms that seem to be enforced on a whole society while also upholding male supremacy. Thus, men care less than women do about people’s comments, regardless of whether their concurrent practices are obvious or hidden.

However, women question their silence about men’s concurrent relationships, too. As one participant stressed,

> I think we also have to be blamed because every time there is a man committing infidelity and he’s going to own it up, there’s a woman standing by that man. So it means the wife is supporting the husband for what they have done, so we . . . also contributed to the man feeling more macho because they know that we are there.

Many participants echoed this feeling that women indirectly support men practicing concurrent sexual relationships and, as such, indirectly encourage or help men maintain relationships outside of marriage. The majority of the participants stated that many African-born women are aware of their husband’s concurrent relationships, yet they remain silent because they do not want to lose their husband or because they care and feel more social responsibilities than the men do. One participant commented,

> Unlike men who think that it is cool to be that way [in concurrent relationships], I think they [women] need to explore. . . . I think women are very intuitive and I think they’re very intelligent and they’re more centered around their families.

Beyond societal expectations from women, the understanding that women focus on family values and social responsiveness more than men also contributes to African-born women’s silence and how they view men’s concurrent relationships, ultimately increasing HIV infection risks in their respective communities. The question is, how can these women break the silence without endangering their social status and family ties to stop this fast-spreading infectious disease in African-born communities?
DISCUSSION
This study sought to explore African-born women’s experience and understanding of HIV and the connection between HIV and concurrency. The themes that emerged from the study illustrate the dilemmas and complex experiences of African-born women as they face HIV, concurrent relationships, and sociocultural pressures in their everyday life. The lack of information described by the participants may have a negative impact on an individual’s perception of the epidemic and might also misinform African-born women about the prevalence of HIV in the United States. A break in the continuous flow of HIV/AIDS information and education could also halt sustainability of knowledge and awareness efforts in Africa, resulting in decreased efforts to protect oneself, one’s sexual partner, and the community as a whole. Participants’ lack of knowledge and awareness suggests a critical need for more information and education about the existing disproportionate impacts of HIV/AIDS and concurrent sexual relationships on African-born communities.

African-born women’s perceptions and attitudes toward concurrency varied greatly. Some participants believed there were no concurrent relationships in their households; others preferred to ignore and behave as if they were unaware of concurrent behaviors. Previous studies have found that for many people, ignoring the fact that concurrency was taking place in their relationship, and in the relationships of others, was the preferred way of addressing concurrency (United Nations Population Fund, 2005). Reasons for ignoring concurrent practices also varied. For some, cultural pressure forces them to remain silent (Dickson, et al., 1993; Wingood & DiClemente, 2000). For others, dependence on the husband to retain social status or for economic reasons (one of which is poverty) makes silence essential (Gorbach et al., 2002). Having children also forces women to stay in relationships because life is harder for single mothers (Women’s Funding Alliance, 2005). In addition to shame, what forces women to hide their family stories is fear of community gossip and gender differences in how concurrent relationships are perceived—central to African-born women’s fear of social and cultural pressures exerted on them as a consequence of family breakdowns. In a report of potential sustainable interventions in health services delivery and HIV/AIDS prevention in sub-Saharan Africa, McPherson (2008) described how restrictions on open discussions about sex may contribute to undermining the development of women’s sex-related agency and decision making.

Limitations
One key limitation of this study was having to extract data specific to African-born women from the focus groups conducted in the broader study (Andrasik et al., 2012). Another limitation in conducting focus groups is that individual women’s voices could be influenced by or dominated in group interactions (Duggleby, 2005). Intergroup interactions may also influence the focus and direction of topics discussed, and individual perceptions may not be captured from group discussions because all participants co-construct the data (Mishler, 1991).

Recommendations and Areas for Future Research
The data suggest a need for increased awareness about HIV prevalence in the African-born community. This information should emphasize the connection between concurrency and HIV transmission, which was not immediately obvious to African-born women in our focus groups. There is also a need to break African-born women’s silence on sex-related issues and move toward making HIV/AIDS and concurrent sexual relationships the focus of ordinary discussions in their daily lives. Empowering women plays a major role in women taking charge of their bodies and blocking risk factors from their partners.

Men should be included in this endeavor because reductions in concurrent relationships are dependent on male behavior change within the African-born community. The main risk factor among African-born individuals is heterosexual sex, and the HIV/AIDS epidemic among women has been exacerbated by their role in society and their biological vulnerability to HIV infection. Women are significantly more likely than their male partners to become infected with HIV through unprotected heterosexual intercourse (European Study Group on Heterosexual Transmission of HIV, 1992; Padian, Shiboski, & Jewell, 1991). Because of male dominant social status and power in African-born communities, women are often less likely to negotiate and are more likely to be subjected to nonconsensual sex. Effective HIV prevention programs for the community will require provision of information on the connection between HIV and concurrent relationships to all members of...
the African community. This will include a focus on factors that place one’s partner at risk. This information will have to include a focus on reducing the stigma associated with HIV/AIDS in African-born communities.

Because the women indicated their social responsibility in keeping family ties intact, there is a need of strengthening women’s roles within their household and respective communities as organizers and educators in promoting communities’ interests on HIV and STI-related infectious diseases in particular. Empowering women to take charge of educating their families and communities empowers households, communities, and nations. Addressing stigma and rejection, designing culturally specific care and prevention, and developing communication skills to address practices prohibiting African-born women from disclosing their health status could be strategies to initiate the process. Creating spaces where African-born women feel safe to share sex-related experiences could also have a broader impact on HIV and STI prevention in the larger African-born community.

In current HIV prevention efforts, little attention has been given to African-born communities. We present these data in an effort to increase attention to the disproportionate impact of HIV/AIDS on African-born individuals in the United States and to inform future intervention efforts.

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