

challenges of HIV Prevention Efforts IN THE AFRICAN COMMUNITIES

Ribka Berhanu, MAP women and families systems advocate recently had a chance to interview Elizabeth Namarra, a pre and post test counselor at Hennepin County Medical Center about working with Minnesota's African communities. Namarra is employed by the African American AIDS Task Force under a Minnesota Department of Health Eliminating Health Disparities grant.

Ms. Namarra was formerly a case manager of refugee resettlement and the HIV education coordinator at Lutheran Social Services. During that time she conducted a survey of HIV knowledge in African communities in order to develop linguistically and culturally appropriate HIV educational materials. She continues to work on this project to develop educational materials on HIV for Africans in Minnesota. She is Oromo and has lived in Minnesota for sixteen years. She can be reached at 612-347-5795.

Ribka Berhanu: When you do HIV prevention education in African communities, what types of responses do you get?

Elizabeth Namarra: I hear all sorts of things! I've heard some people say that white people invented HIV in a laboratory or that HIV originated on a different planet. It is hard to get people to focus on the prevention message. Often people focus on the origin of AIDS, finding it difficult to accept that HIV originated in Africa.

RB: How do you respond to that?

EN: I tell people that knowing where the virus came from won't make it go away. The fact of the matter is that it is in our communities now. What we need to focus on is how the virus is spread and how to protect yourself. That is the only way we are going to stop the disease.

RB: How have leaders in the African communities reacted when you've talked to them about the need for HIV education?

EN: Some do not want to own up to the disease because they feel it reflects badly on their community. Some claim that AIDS doesn't exist in their community. But many community leaders locally are starting to change. Gradually they are finding out that in fact there are people from their country who are living with HIV. I think the refugee resettlement program opened up people's eyes because people from all over Africa with HIV were resettled here in Minnesota. Since that time, a lot more people are open to hearing about HIV.

RB: What types of myths about HIV did you find in your survey?

EN: Some deny that HIV exists. I also heard that AIDS is the American way of discouraging Africans from having sex! Then other people believe that HIV is predestined, and you can't do

anything about it. Many tell me: "Why should I learn about preventing HIV transmission if it is Allah's/God's will that a person should have HIV? Good things and bad things all come from Allah/God." Christians tend to place a lot of blame on people with HIV. They say that if they were good Christians and had controlled their sexual desire they wouldn't have been infected. Many Christians also believe that if people prayed earnestly they would be healed, not just from HIV but other diseases. Some HIV-positive people interviewed in the survey believed that they could be healed through prayer as well.

RB: What would you say to an African who is interested in learning more about HIV or doing something to help their community?

EN: I always encourage people who are interested in learning more about HIV to take the Red Cross HIV course, or any HIV training course, and become educators themselves. The more educators we have in our communities the faster we can spread the word about prevention and the sooner people will stop becoming infected.

RB: What is your sense from the survey and from your experiences? Are Africans in Minnesota getting tested for HIV?

EN: Africans have very different attitudes about taking care of their health than westerners. If you don't feel sick, you don't look sick, why go to the hospital? It would be a waste of time and money! Checkups, regular physicals, these are foreign concepts to most Africans. The issue is not HIV specific, it is a much broader health issue. There is a need to encourage people to take care of their health, to get primary care, routine checkups, physicals, and if they are at risk for HIV get tested. HIV is particularly dangerous because it can take a long time for symptoms to appear. Many Africans already have AIDS by the time they get tested.

RB: Of those Africans who do know their status, what prompted most to get tested?

EN: The Immigration and Naturalization Service requires all refugees to be tested for HIV before they are resettled in the United States. However, HIV-positive Africans in the United States who are not refugees usually find out at a hospital. Many women find out they are positive when they are pregnant and take the routine HIV test that doctors recommend for every pregnant woman. Or else someone goes to the hospital with clear symptoms of HIV and a doctor recommends a test. It is very rare that Africans ask for an HIV test just to know their status. People do not get tested because of risky behavior. I believe that anybody who has ever had sex needs to get tested, even if they have only had sex with their spouse.

RB: When you do HIV education do you say to people that anyone who has had sex should get tested? Many people could be offended; implying that you can't trust your partner or spouse.

EN: If you reach people's hearts, if you let them know you are truly worried about their well-being, then people respond well. When I talk about intimate, private, things I always say beforehand: "I apologize if these words make you feel uncomfortable. It is hard for me too because it is my culture to be embarrassed about sexual matters but I don't have a choice but to talk about them." You see, I am from the same culture, same place, I understand the reasons people left Africa and came to the United States. I tell people, we left a home we loved to save ourselves from guns and wars. We didn't run away from our homes to come to the United States and die from AIDS. In Africa people don't have a chance. If they get HIV, they die. Here we can get treated, we can teach our children how to protect themselves and we can live. When you put prevention message in those terms people are willing to talk about difficult subjects.

RB: How do you feel that the stigma surrounding HIV affects men differently from women?

EN: When I was doing the survey, I found out that the men always blame the women for spreading HIV. One of the survey questions was: "how do people get HIV" and one respondent said: "from a woman". Women on the other hand are often not willing to believe that their husbands or boyfriends are not trustworthy. Even when they may suspect that he may be unfaithful to them they don't want to say anything. It is almost as if it reflects poorly on the woman, not the husband!

RB: What do you think is the best way of doing HIV prevention in African communities?

EN: In the survey most people ranked drama and television as their top choice for a method of education about HIV. It is connected with our cultures because oral and visual means of transmitting information are very important in African communities. I have been trying to raise funds to produce a drama about HIV for a long time. It makes me mad because nobody is willing to fund that type of project. It isn't going to do any good if we keep handing out brochure after brochure in English. Give a roomful of people a brochure and you will find half of them in the garbage can outside. Many do not know how to read and write in English. And most HIV prevention information is in English. I was disappointed to find out that there is so little HIV information available in other languages. I did some research and all I could find was a one-sheet brochure in Kiswahili at a non-profit in California. That just made me sad.

RB: What do you think the Department of Health and local non-profits should do to respond to the growing numbers of Africans with HIV?

EN: There are so many intelligent, well-educated people in African immigrant communities who cannot respond because of a lack of funding and resources. Just talk to a few cab drivers, you will find out that many of them have PhDs, they were doctors, engineers in their country but in the United States they drive a taxi cab. While doing the survey I talked to people from Somalia, Kenya, Oromo, Sudan, Ethiopia, Cameroon and Nigeria and in each of these communities there were physicians and health professionals who could not practice because they didn't have licenses in the United States. These are people who could be effective at providing health services, and especially HIV education. The American system has to figure out a way to put health professionals from immigrant communities to good use. I don't mean that American professionals are not capable of working with Africans. It is amazing how many health professionals pour their hearts into reaching out to Africans. But it is difficult for them to understand the hardship and trauma from loss of home, culture and language that Africans in America experience. It would be much easier and more effective to use African health professionals who can identify with their patients.

MAP Systems Advocates work to make health care and social service systems more responsive to the needs of people affected by HIV through research, policy recommendations, education and training. For more information on Women and Families Systems Advocacy, contact Ribka Berhanu at 612-373-9175.