

Risk perception and sexual relations among African migrants in Amsterdam

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Dit onderzoek probeert meer inzicht te geven in het socio-seksuele 'risico' gedrag van Afrikaanse migranten in Amsterdam Zuidoost. Risicoperceptie en preventiegedrag ten aanzien van HIV staan hierin centraal. Respondenten zijn geselecteerd uit een parallel lopend kwantitatief onderzoek naar HIV en seksueel gedrag onder migranten; als op basis van hun antwoorden bleek dat zij mogelijk risicogedrag vertoonden. De uitspraken in deze tekst komen uit de analyse van 24 diepte-interviews met Afrikaanse migranten uit Amsterdam Zuidoost. Wij concluderen dat HIV niet als een dreigend gevaar wordt beschouwd binnen de persoonlijke risicoperceptie van deze migranten. Van vele ziekten, waaronder HIV/AIDS, bestaan dusdanig andere percepties met betrekking tot hun oorzaak, voorkoming en/of behandeling dat aansluiting met een westerse wetenschappelijke opvatting hierover niet altijd voor de hand ligt. Daarbij bestaan er mythen en ideeën dat genezing mogelijk is hetgeen de angst voor HIV doet verminderen. Preventief gedrag komt vaker neer op partnerkeuze, intuïtie and een positieve instelling dan op het gebruik van condooms. Daarbij moet ook de noodzaak van consequent condoomgebruik nog eens benadrukt worden. Kennis van HIV is in het algemeen wel aanwezig maar wordt niet gemakkelijk toegepast in het dagelijks bestaan. Wil men een grotere bewustwording van het risico op HIV en een grotere persoonlijke verantwoordelijkheid voor ziektepreventie bewerkstelligen, dan zou een nieuwe aanpak van voorlichting aansluiting moeten bieden met traditionele standpunten en feitelijk gedrag in plaats van deze zonder meer te verwerpen.

[etniciteit, risico, HIV/AIDS, seksualiteit, migranten, Amsterdam, Afrika, Ghana, Nigeria]

The population of sub-Saharan Africa is the most heavily afflicted with HIV/AIDS. Of the estimated 36.1 million adults and children living with HIV/AIDS world-wide, sub-Saharan Africa is home to more than two thirds (25.3 million) of these people. It is the only region of the world where more women (55%) are found to be HIV-positive than men (WHO 2000). In seven countries in the southern cone of Africa, at least one in five adults is living with the virus. South Africa is the country with the largest number of people infected with HIV in the world, with an estimated total of 4.2 million (UNAIDS 2000). West Africa is relatively less troubled, yet the prevalence in some large countries is increasing. Migration is one of the factors responsible for spreading the infection to new areas.

The Netherlands is now recognised as a migration country. More than one-third of the population of its largest city, Amsterdam, is comprised of ethnic minorities (36%). The proportion of migrants in the population varies by age: 70% of new-born babies are of foreign background; 60% of the population up to 18 years of age are ethnic minorities; the share decreases in older age groups. The percentages of foreign adults and elderly are estimated to increase by about 10% by the year 2020 (O&S 2000: 48-49). Many migrants come from AIDS-endemic countries, e.g. Suriname, Antilles, Ghana, and Nigeria. In Nigeria, by far the most populous country of sub-Saharan Africa, more than 5% of adults are HIV-positive. Ghana reports an adult prevalence rate of 3.6%. In other West African countries figures remain below 3%. Comparatively, in the Netherlands, the prevalence in adults is 0.19% (UNAIDS/WHO 2000).

In the absence of a vaccine against HIV/AIDS, sexual behaviour becomes the starting point for all preventive action. Knowledge about people's sexual preferences and behaviours can help to predict and to meaningfully intervene in the course of HIV infection and prevention. HIV in Ghana and Nigeria is mainly transmitted by heterosexual intercourse. Figures for Nigeria are not available by mode of transmission, but we can assume Nigeria has a similar pattern to that of other countries of sub-Saharan Africa. Infected blood transfusions and perinatal acquisition of HIV account for a just a fraction of HIV transmissions. When considering infection by age and sex, it appears that Ghanaian women and men become infected at an earlier age than people do in the Netherlands. In Ghana, most infections reported among women are in the age group 25-34, and among men aged 30-39. A commonly reported preference for relationships between young girls and older men throughout sub-Saharan Africa is an important risk factor for HIV transmission (UNAIDS/WHO 2000).

Several mostly quantitative studies have been launched to gain a better understanding of the potential for the heterosexual spread of HIV and other STD's among sub-Saharan African migrants in Amsterdam (van den Hoek & Coutinho 1994, Gras et al. 1995, Gras et al. 1999, Wiggers 2000). They address (1) HIV prevalence, (2) determinants of sexual risk behaviour, (3) sexual mixing patterns, and (4) condom use. A survey conducted May 1997 to July 1998 among these African migrants in the Bijlmer identified various determinants of dis-assortative mixing and high-risk behaviour. It concludes that unprotected sex mostly occurs among migrants of the same ethnic group, while condom use increases in dis-assortative (inter-ethnic) relationships. HIV prevalence among black migrants in Amsterdam is measured at a conspicuous 1.1%.

This study intends to gain more insight in the socio-sexual behaviour of sub-Saharan African migrants, to better understand their risk perceptions as relating to HIV infection, and to further explore preventive measures taken. Qualitative methods, such as in-depth interviews, manage to come closer to the participant's reality and can offer better insight into how to reduce HIV risk in particular migrant groups. Specifically, the study investigates inter-related questions, such as: How do migrants perceive risk? What role do sex and sexual relations play? How do informants look upon illness and death? How do they experience the threat of HIV/ AIDS? How do these migrants protect themselves? What is at stake in their lives?

People and methods

The study objectives are operationalised as three broad research questions:

- 1 How do sub-Saharan African migrants perceive their and others' risk of HIV infection? (What does risk mean in the context of their lives? How does it matter, if at all?)
- 2 What do sub-Saharan African migrants do to prevent a possible infection? (Why do or don't they bother to take preventative measures, and in which situations?)
- 3 What socio-cultural factors affect the transmission of HIV among sub-Saharan African migrants? (Which norms, beliefs, practices, customs particular to their cultural identity are mentioned in relation to HIV risk?)

Qualitative methods have been chosen to approach these issues. In-depth interviews were held with a total of 24 African migrants living in the Bijlmer neighbourhood of south-eastern Amsterdam, eleven women and thirteen men. These 24 respondents had all participated in the concurrent survey of Gras et al. (1999, n=1660). As part of the survey questionnaire, the following eligibility criteria were considered: an age between 15-55, self-identification as a sub-Saharan African, a new sexual contact or more than one partner in the last 12 months or sleeping with the same partner who had more than one partner. If these criteria were fulfilled, the respondents were considered 'risky' and consequently asked to participate in an additional qualitative study, the results of which are reported in the present paper. If they agreed to participate, an appointment for an in-depth interview was made. Respondents each received 25 NLG for their participation. About 40% of eligible respondents chose not to participate in the qualitative part of the research, either by outright refusal or by missing the appointment. Interviews took place from May 1997 to December 1998. The majority of the recruitment and the interviews was done by two interviewers, a Dutch woman and a Ghanaian man. Conversations about intimate subjects seemed to reveal more when the interviewers and interviewees were matched for gender and ethnicity. Meetings were usually held in the Kraaiennest Municipal Health Centre's office (GGGD), in the Bijlmer. Interviews were based on a semi-structured topic list, and lasted for about 1-2 hours. Data collection and analysis followed the grounded theory approach (Glaser & Strauss 1987). Research questions were adapted throughout data collection until a point of saturation was reached. All conversations were recorded on tape and transcribed. The text was coded and categorised to form a modified topic list for analysis. Additionally, summary sheets were written, and information was organised in data matrices by various criteria. The majority of the women were Ghanaian nationals, while about half of the men were Ghanaians and the other half Nigerian. A few participants were from Togo (one male) and Liberia (two female). Throughout the paper, for literary purposes, the informants will be interchangeably referred to as respondents, migrants, men and women, Africans, without the intent to generalise the findings beyond this sample's limitation, or among African cultures.

African migrants in Amsterdam

"I want to establish something in my home country."

Ghanaians account for one of the largest migrant groups from AIDS-endemic countries in Amsterdam. Most informants, except for those escaping war situations, come to the Netherlands for economic reasons, "to find a job, make a fortune, live a good life." Eventually, they would like to return to their home country as a "successful person". Migrants have great expectations about their new homes, but upon arrival, they are generally disappointed. The people, the system, and the circumstances are not as they anticipated. Language is often a bigger problem than expected, and jobs are not that easy to find. Even so, migrant men and women prefer the Netherlands above other European countries because they perceive even more racial barriers outside the Netherlands.

The main reasons given for migration commonly are push and pull factors, that is, flight from economic hardship, political instability, unemployment, or attraction to the wealth and lifestyles in other countries. The home country's government policy regarding immigration and emigration also plays a role, as do the policies of neighbouring countries. Since Britain, a favourite place for sub-Saharan migrants coming to Europe, recently restricted immigration, the Netherlands has reported higher immigration figures.¹ Moreover, former colonial links also tend to pull migrants from the 'periphery' to the 'core' countries.

Africans as a group are seen as recent migrants to the Netherlands, when compared to other large migrant groups, such as people from Suriname or the Dutch Antilles. Within the group of informants, Ghanaians had resided in the Netherlands longer period than Liberians or Nigerians had. Women, on average, had resided two years longer in the Netherlands than men had (4 vs. 6 years), and came at a younger age (22) than men (28). Another difference between the sexes is that women all managed to have a legal permit of residence while eight out of 13 men were illegal. Though migrants often come from poor families with little education, all participants had completed at least primary school. Migrant men are generally more highly educated than women, some hold a secondary school degree or even lower vocational training. But Nigerian men are an anomaly for they are more highly educated, and often come to the Netherlands to pursue university studies.

Yet, higher education is not necessarily a prerequisite or marker for employment. In fact, most men and women with low to middle levels of education reported a trade of some sort, while most of the better educated ones were out of work. Because this study did not include any observation, it can draw no conclusions on actual time usage or activities of these migrants other than those reported. Based on their statements it seems that most illegal men and legal women did not work, while four of the five legal men had jobs. In fact, employed men are proud of their business, and like to distinguish themselves from other migrants in this regard: "Caribbean people are lazy. They come here to get money from the government. But we [Africans] don't get nothing for free, so we work." However, their plans of making enough money to send home were soon dissipated.

Money and social status influence the ways in which people deal with health issues. Social responsibility and time use are other important factors that influence risk taking. Legal African migrants shared in the public health insurance (fund), which generally encourages medical health seeking efforts. Another social aspect further dealt with in this paper is religious belief. All but one were affiliated with the Christian faith. In fact, the African communities participated in a revival of the Church in their local areas of residence, particularly in the Bijlmer. Religious affiliation becomes important when providing guidelines for (sexual) behaviour and interaction. A common affiliation is able to exert social pressure on the members to keep up the faith and the pertinent forms of behaviour. Most respondents reported of their faith in God, however, social responsibility stopped at the sexual border.

Women have different possibilities and responsibilities than men. Female respondents all obtained legality through marriage to a Dutch citizen or other legal residents, except for one unmarried Ghanaian woman who received the Dutch nationality from her father and Liberian women whom were asylum seekers and thus not dependent on their partner for residency. In spite of the fact that they were legally allowed to work, only two women chose to be employed. The others received unemployment money from the government; which gives them similar financial resources while leaving them with more time on their hands. Most women were married or had been but were now divorced, while most men reported themselves as never married. Neither men nor women considered working as a goal in itself, but more a means to make money. The brunt of responsibility to make money and support a family still weighs more heavily on men. In this regard, unmarried men enjoy more freedom, as they do not have to, or chose not to take care of a family. Most women had to take care of at least one child, in addition to the responsibility for the costs of running their households. Women often expect relationships to bring additional resources to their household, and often chose accordingly.

It is striking to note that the majority of male respondents were living in Amsterdam illegally (8/13). In order to make a living they needed to resort to whatever offers of work came their way, ranging from cleaning to drug dealing. Their illegal status makes them an easier target for criminal activities, as they already are outlaws. Their lifestyles were marked by irregularity and uncertainty about what the next day would bring. Such an existence further deprived men of their typical role of breadwinner and decision-maker, leaving them with further doubts about their identity. In relationships with women, illegal men tended to enforce traditional gender roles, with dominant patterns of male behaviour that was not backed up by the larger social picture.

Illegal immigrants suffer from the constant fear of being discovered and thus deported, in addition to the adjustment problems of loneliness and otherness that legal migrants report. As many migrants do not know about the free treatment options available many believe that their health seeking efforts must be paid out of their own (often empty) pockets, and were hence often neglected. As such, it is not surprising that once illegal immigrants decide to consult a medical doctor, they present rather grave health problems as compared to the general public.² More research must be done on the health and social situation of illegal residents and other persons falling outside the societal norm to better understand the risk perception and health seeking behaviour among this group.

Sex and culture

"In Ghana, people have sex all the time."

"Sex keeps you healthy."

The meaning of sex to these migrants must be seen through cultural glasses in order to understand the significance of the various issues at stake. Sex is an essential part of life among the respondents. It is a past time, a fulfilment of desires, and a pleasure for oneself. A comment of a male respondent: "In Ghana, people have sex all the time," denotes the importance of the activity, and a related social way of life. Men and women primarily see each other as potential sex partners, and seduction of one another is part of the good life.

Yet, having sex is not that perfunctory after all. It necessitates some preparation, some pre-emptive (not to be confused with preventive) efforts, as indicated by the unwritten law "If you want sex you have to do something for it." The event of actually having sex is therefore spoken of with a certain triumph; men in particular refer to sex with a self-assured smile. Women like to be chased and captured, that is, after they have thrown out the bait. Unlike men, they do not decorate themselves with the number of lovers they have. Sex becomes a game in which men and women assume different, yet well-defined roles.

African men like to boast of their libido: "African men have big balls" (too big for regular condoms), ... "they know how to satisfy women" (it is a man's duty to satisfy all women perceived to be in need), "they penetrate deeper than white men" (this also explains the sexual interest of "white women", and cross-cultural relationships). Overall, male respondents seem to be cocksure, and therefore, perhaps easily hurt in their manhood. To maintain this image, they must prove themselves again and again.

Women, on the other hand, have a relatively easier task to keep up appearances. They are expected to "control themselves better than men" (women have no sperm that needs to get out), ... "be satisfied with less" (you have a man, what more do you need?), ... and "not to go out looking for sex" (that domain belongs to men and prostitutes). Women's initiatives in sexual matters must be subtle, if at all, allowing the man to be in charge. Yet, there seems to be another category of women, namely those with a "big appetite". They are the sex workers, or sex workers to be. In fact, men argue that: "Women who have many men better make it a job", avowing to the differences in promiscuity between men and women. While men may have numerous partners with few social repercussions, women have to be more concerned about their reputation. The status of promiscuous women is ambiguous: some are labelled "desirable" and "sexy", others are called "prostitutes" regardless of whether they charge or not for sex. Professional sex workers who charge for sex are said to be smart as they take advantage of the fact that men are ready to pay for sex. Such discourse is male; the consequences are various. Sexual relations are not just a physical game, they mirror social relations affecting health and well-being, such as the case of HIV in Africa.

Migration and the exposure to different circumstances certainly affect gender relations. Women may earn their own money, they may have more power of decision, and

no longer take male transgressions as a matter of fact. Respondents tell of more egalitarian relationships, but their cultural background remains in the minds of people subtly affecting attitudes and behaviour.

“A woman can marry just one man, but a man is a man.”

Both men and women in general aspire to have a steady partner on whom they can rely, be with, and have children with. Children are an important aspect of a relationship: “You have to leave something behind when you go.” Men often prefer to leave behind a boy, “a picture of yourself.” No matter the age or marital status, also married men like to have casual sexual partners, “playmates”. In spite of their family aspirations, they cannot or do not want to limit themselves to a monogamous relationship. Men claim to leave women alone if they are already married or involved in a serious relationship. For women, this means that they can halt male attentions by explaining they are already involved, should these attentions be unwelcome. All married men like to believe that their wives would not commit adultery while married. Most male informants resist the idea that ‘promiscuous’ sexual desire could take hold of their women while they acknowledge that some of their girlfriends were married to other men. If a woman “shows interest” in spite of her private commitments, she becomes a “free woman”, free from moral obligation, free to do what she pleases, and free to be engaged with sexually. Responsibility is then readily placed on the adventurous women. There are many women who have multiple partners, carry condoms, satisfy their own needs, all on their terms. “Free women” can also be unmarried or divorced women, who are not by definition accountable to any man. Both men and women considered it improper for a woman to carry condoms in her bag: “Women that carry condoms are ready for sex.” This statement is meant to be derogatory rather than encouraging. The condom has become a symbol of sexual promiscuity, rather than prevention, as it transgresses existing codes of behaviour, especially when carried by women.

Relationships are not easy to fix into categories. Generally speaking, sexual relationships can be divided into two main categories, ‘steady’ and ‘casual’, though these are often blurred. Men may refer to several steady simultaneous relationships, and women may tell of their casual relationship with the father of their son. Details of the living situation, that is ‘living together’ or ‘living apart’ further complicate the categorisation. As a norm, informants’ voices can be ordered as follows: steady precedes casual relations, and living together precedes living apart. However, both in the Netherlands, among Dutch and migrants, and in Africa, a variety of relationship types is aspired and handled.³ The societal norm influences risk perception in the sense that official, serious, socially-sanctioned relationships (marriage, living together, being in love) are considered risk-free, while only naughty, secret, and excessive behaviour is avowed some sort of risk. Given the practice of relationship, and the mode of transmission of STD infections, concern should include any happening of sexual intercourse.

All respondents described the ideal partner as someone “reliable”, as a “life-time” pal, and as “someone to have children with”. Real life is much more pragmatic. As long

as the individual's basic needs are fulfilled, one can go beyond the moral boundaries. This is what men mostly do: stretching the boundaries. Polygamy used to be common in Ghana. The attitude survived while the method changed. Having more than one woman at the same time is no longer a public affair. It is done more or less secretly, or so men believe. One man argued not even to tell his male friends of his "success" as news could accidentally trickle down to the wives. Cheating is a favourite topic for gossip, therefore: "Nobody is to be trusted." If it comes out, it means trouble. Cheating, and therefore sex with anybody except your official partner becomes a private matter. In Nigeria, where the majority of people are Muslim, the definition of a legitimate partner is more lenient. Muslim law allows men to have up to four wives concurrently if certain conditions are given and maintained. However, this measure does not protect society from illegitimate relationships, neither by men nor women. Official partners claim exclusivity, public acknowledgement, and honesty. This counts both ways, although it is men who believe that their woman indeed is theirs only, while women know that men are "fooling around". When confronted with evidence of their husband cheating, African women will raise hell but eventually calm down and let him get away with it, both male and female informants acknowledged this sort of behaviour. STDs are considered strong evidence of cheating, but like most infections is a woman's anger treatable. Some women, not all, have secret boyfriends of their own. If her husband learns of this, she most certainly will be abandoned. "A woman having a friend? ... Of course that can happen. But only one time, I would end the relationship right away." Another man worded it more emotionally: "If my woman takes another man, I kill her." Again, both sexes agreed that there is a differential treatment of men and women's sexual unfaithfulness. Men do not overcome being cheated that easily, it seems to touch upon deeper, existential values than it does with women. Marriage then restricts the movements of a woman more than those of a man. In married relationships where both partners pretend monogamy (or specified polygamy for that matter), it is impossible to promote the use of condoms against STDs without introducing an element of doubt.

Relationships with "free women" and prostitutes are different. As trust is not at issue, condoms can be used more easily. In relationships with partners of another culture, trust and intimacy must grow rather than be taken for granted. The quantitative study among migrants in the Bijlmer shows that more condoms are used in dis-associative (cross-cultural) relationships (Gras et al. 1999). The evidence from the in-depth conversations also suggests that condom use is favoured by couples with cultural differences, or couples in which at least one partner knows how to combine sex and with the condom use for their both pleasure and satisfaction. This requires some experience with condoms, or at least the willingness to experiment, and a belief in their usefulness. As a group, only sex workers have such experience and willingness though some unattached, responsible men and women do, too. Informants used condoms with professional sex workers, or to prevent pregnancy. However, because there are alternative methods of contraception, condom use in non-professional sexual encounters remains minimal. The problem rests, according to the respondents, in associating responsibility with condom use, while still "keeping the fire burning". Moreover, responsibility is un-

dermined by prevailing cultural ideas that do not account for societal changes, such as migration and all that it involves, and 'new' risks, such as untreatable STDs.

In general, most migrants believed that there are enough men and women out there to have sex with "for free". Relationships, however, always require compensations of some sort. Basically all women in the study asserted that a man she is having a relationship with must contribute to the household expenditures, whether he lives with them or not. The man must compensate the woman in cash or in kind, e.g. by paying rent, groceries, or utilities, even if the couple is not living together. Men are also expected to give luxury presents, such as clothing, cosmetics and jewellery, "After all they want to go out with a beautiful woman, don't they!" Most women enjoyed being taken care of, and still expected the man to provide for them in one way or another. Such economic concerns are voiced more often than health issues are, by both men and women.

Language is an important tool for sexual and social mixing. Informants report that being able to communicate in another language influences one's mixing patterns. Migrants, especially men who are used to travelling, and who master the English language, are more at ease in cross-cultural relationships. They described condoms as just another thing to get used to when getting involved with different cultures. "You don't know the woman, you don't know her life. It's better to start with a condom. [...] it's not difficult to mention, no. She didn't mind." When sexually engaged with women they 'know', i.e. women of the same cultural background, it is different. A few respondents, whose English was difficult to understand, preferred to date "their own kind" or resort to prostitutes when they had the money. Since prostitutes usually direct the condom usage, the awkwardness with condoms remains in sexual encounters with non-professional, "familiar" women, with whom innovation is difficult despite the shared language.

"We don't discuss those things. We don't want to worry ourselves."

Since sex is so prevalent one would expect a lot of talk about it. And there is! Talk takes the form of gossip and 'dirty talking'. Gossiping about other people's sex lives, infidelities etc. is pleasurable, as long as the talk does not concern oneself. 'Sexy' conversation, pick-up lines, or non-verbal body talk when dancing or walking in the street is the other common talk. Ways of sexual communication are numerous, and they are all used, worldwide. Sex talk is mostly casual and serves as a sexual fore-play. Issues discussed or alluded to are purely for purposes of entertainment, and perhaps excitement. Such talk does not include discussion of illnesses or other sobering topics. Among the younger migrants, sex talk is held with peers, intra-generational family members, or at school. Older brothers or sisters may have offered useful advice, some recommended condoms. School curricula may include sex education and some specific AIDS awareness material, yet most respondents stated that they did not feel sufficiently informed at school. There is no intergenerational talk about sexual matters, except for the occasional prudent mother who reminds her son to use condoms to prevent impregnating the girl. Mothers of girls, on the other hand, seem to ignore the sexual needs of their

daughters until they become a fact. Doctors and researchers are exempted from the living silence around sex and illness. Yet in the private and public lives of the migrants AIDS is no conversation topic, let alone a motive to use condoms when having sex.

People prefer to talk about lighter issues. "It is a bad omen to discuss illness." As condoms are not liked by most Africans (also see upcoming prevention chapter for more details) they are not a subject of conversation unless there is an urgent reason for use, such as contraception. Sex history of partner is not talked about either. "What's the use? It's just stories, not to be trusted anyway." ... Women's sexual histories especially are not to be trusted since "they are excellent story tellers." So, men save themselves the embarrassment and shake off their curiosity by saying "Nobody knows a woman's mind." They feel they will not get to the truth anyway. So, they prefer to deal with the present, start off with a clean slate, in spite of all the hazards of ignorance. A last reason offered for the lack of conversation about sexual details is the politeness and discretion of a man. "Gentlemen do not discuss these kind of things." For the sake of decorum, much is left unsaid, much is taken for granted. Meanwhile, the risk surrounding sex remains, though it seems not big enough to trouble gentlemen, mothers, and school-children.

Risk perception

"I never think about AIDS, it's just a bad disease"
"Risk? Everybody is at risk."

What is risk? In a way, risk is part of life, it certainly is part of sex. Rationalising beforehand inhibits sexual pleasure, informants suggest. "Life is full of risks." If considering the AIDS risk meant reducing the pleasure of sex, most men and women opted for pleasure. They report 'good intentions': want to try condoms, stay with one partner, know of AIDS and its consequences, etc., but "in the heat of the moment" such rationalisation is forgotten. It is commonly held that having unprotected sex with healthy partners does not lead to infection. But how to know who is healthy?

Migrants do not lack basic information on the disease. Most people knew what AIDS is, however none of the respondents had any acquaintance with HIV-positive persons. When asked about people or activities associated with HIV risk, they refer to the standard risk groups: prostitutes and their customers, drug users, and homosexuals. Prostitution was the most realistic way for them to acquire a disease, they said, as intravenous drug use and homosexuality were not common among migrants, or Africans in general.

Yet, as a group, prostitutes are considered risky because "they do it with many people." They run the risk of attracting all kinds of sexual transmitted diseases, and then passing them on to their customers. However, this does not make the men 'want' to use condoms when visiting prostitutes. The preventive measure they take is either not visiting prostitutes at all, or surrender to the fact that most regular prostitutes do it with a condom. In the latter case prevention is regarded as part of the deal. Informal prosti-

tutes and drug addicts using prostitution for quick cash were considered more open to bargaining and thus more likely to cede to the wishes of their customers who unambiguously opted for “flesh-to-flesh”. At times, male customers’ willingness to pay more for “the real thing” places habit, pleasure, or economic benefit above safety.

Transmission from mother to child was not mentioned at all in this context, presumably because the child cannot help the risk of infection by its HIV-positive mother. The concept of risk seems to pertain only to voluntary action. Similarly, the faithful wife whose husband visits prostitutes or has many girlfriends does not consider herself to be at risk. Promiscuity appears to be a lifestyle more than a risk factor. Blood transfusions form an exception; they are considered to be particularly high risk. This is related to the unique place that blood is reported to have in African body and illness perceptions. Apart from being an essential body fluid, blood carries abilities significant to various rituals and ceremonies. Receiving blood from an unknown donor, and having it injected right into your ‘system’, is for that reason a terrifying deed. Blood in tin cans or plastic containers is perceived as a ‘matter out of place’, and therefore carries an inherent danger. Apparently, the medical ritual accompanying blood transfusions is not wholly satisfying.

Most male informants despised homosexual relationships, and seemed to consider only sexual encounters with women. Anal intercourse is commonly associated with impurity, it was described as “dirty”, “unnatural”, and “extreme”. Both male and female informants seemed to avoid that practice, as it is a breach of taboo. It was not even mentioned as a form of contraception. However, when the woman encourages anal sex (and this has reportedly happened in cross-cultural relationships) the man may succumb. In this case, overcoming taboo means a step towards another established risk behaviour rather than introducing an alternative, safe measure. It also means that taboos are not absolute but a matter of negotiation.

Oral sex is practised, but not with equal fervour by everyone. It does not enjoy the same status as “the actual sex act”, that is penetration, yet it may be used as foreplay. No risk is associated with it.

As for sexual preferences, heterosexual intercourse is the dominant type of sex among our informants. African men enjoy being in charge and this includes decisions about sex. Though women may state their preferences, yet a man’s makes the ultimate decision. Sex during menses is usually shunned. So is excessive lubrication. There exists a general preference for ‘dry sex’. Not all informants practised it, yet most knew of it when asked. Men like their women “hot, tight, and dry”. A dry vagina increases friction during sex, which men like. Women give men dry sex by putting herbal powders in the vagina, quite a dangerous practice, but it does make them hot, tight, and dry. The drying agents, combined with friction, cause tiny sores and ulcers on the vaginal walls, increasing women’s exposure to HIV infection. Advocates of dry sex are even further away from using condoms than those men who prefer just “flesh to flesh” intercourse. ‘Normal’ heterosexual intercourse, i.e. sex that does not involve deviant extreme techniques, or payment is not considered risky in the medical sense of the word, even though this is the most likely way of catching STD’s. The only ‘risk’ involved is being discovered by one’s wife or stable partner.

“To eat good food and take care of myself.”

In general, male respondents felt strong and healthy. According to them, they were hardly ever sick, if health could be measured by number of visits to the doctor. Treatment was sought when necessary but going to a doctor “before the illness” for check-ups, was not customary. The only preventive care mentioned involved “good food”, “rest”, and “stability”. Some complained about being unwell shortly after migration, e.g. suffering from headaches, and one respondent did consult a physician about this. Medical doctors were highly esteemed by the African respondents. Alternative healing methods exist and are used. Africans, alike Dutch people, tend to eclectically choose their healers and treatment options depending on the case. Self-help was the preferred choice among respondents. Many migrants were not aware that the Municipal Health Centre (GG&GD STD Clinic) provides free and anonymous HIV testing. Most respondents preferred “not to know” in order not to have to deal with a “terrible disease”.⁴ HIV is officially diagnosed by means of a scientific test, and respondents believe that also healing has to be placed into the hands of that very health system. The fact that doctors can detect but not completely heal HIV/AIDS adds to the general mystification of the illness.

*“There are different types of blood, some stronger, some weaker.
The weaker types have more chances to become sick.”*

Migrants were asked how they felt about their health, what they did about it, whether they felt in control of their own health, and what they did when they actually became ill. All respondents considered ‘health’ to be “very important” and worth doing something about. A variety of perceptions about contribution to and explanations of health co-existed and influenced one another. Most of them related to a body-machine model, in which the body, like a machine, needs certain inputs such as food, sex and care to function well.

Causes of health and illness are complex. Illness could be caused by one’s own doings, e.g. by not eating well or not resting enough. There was a general consent that some aspects of illness actually were in one’s hands, and that “you should not push your luck.” People were responsible for their health. “Taking a shower and going outside with your hair wet is asking for a cold,” warned a young Ghanaian mother. Blaming the bad or inconsiderate person inside oneself worked best as illness explanation. “Yeah, I smoke less since I am here, but sometimes I get some friends and we have drinks and talks. Then we smoke a lot. It’s not healthy, but what can you do?” Irresponsible behaviour was related to some sort of weakness in seeking immediate pleasure, including sex.

Yet, there is more to health and illness than personal (ir)responsibility. Illness can also be inflicted onto someone “from outside”, by other people, by evil wishes, or illness causing situations. Even without attributing illness to witches or superstition, injuries and accidents were considered events outside one’s direct control. Most Ghanaian

men and women were Christian and referred to God as the creator of all, including illnesses. They believed that taking good care of oneself reduced chances to get ill, “but in the end, it is not up to us.” They maintained, however, that God would not send an illness onto people if there was no reason, i.e. misbehaviour. Previously mentioned risk groups, homosexuals, intravenous drug users, and prostitutes become easy targets for blame. Such punishment from God seems to be social rather than personal making it even more difficult for the individual to prevent illness.

The respondents were divided on how to perceive illness, what causes illness and the appropriate response to it. All describe health as an all encompassing concept with overlapping elements and changing impetus. The event of illness, if sent by God, evil, others, or considered an injury, is to be accepted. There is not much to be done about it. But when it is situated within people’s capabilities, health change is considered a matter of willpower and responsibility. The divide is blurred. In any case, illness is a “punishment”: an impediment to the daily routine.

STDs retained a special place in illness perceptions and attributions of blame. If we imagine a scale of the ultimate source of illness, ranging from personal control to God, STDs are placed more on the personal control side. Guilt and shame are connected with contracting an STD, for not having taken the necessary precautions. STDs are also associated with extramarital or promiscuous sex, marking people’s sexual activity. An STD presents scientific evidence of cheating, it evokes anger at the victim more than concern. STD’s are believed treatable by modern medicine, and not considered a real health threat. However, since they technically can be prevented, catching an STD entails a blame. If informants were aware of having participated in risky sex and consequently were diagnosed with an STD, they thought of themselves as “stupid”, “inconsiderate”, “got carried away”, “lustful”. Informants diagnosed with an STD while ignorant of the means of transmission blamed the sex partner of being “selfish”, “cheating”, “disrespectful”, “stupid”. Once surfaced, STD’s are discussed in terms of faithfulness vs. cheating, trust vs. mistrust and their consequences for a relationship. In fact, ‘risk’ is seen more as a relational concept than a personal hazard. The infection itself does not matter so much as the way it got across and out. HIV stands out in this regard. Technically HIV is an STD, but it is perceived as being caused by a greater share of external, uncontrollable factors. It is not dealt with at the same level with other STD’s but is removed from people’s realities to embody a social phenomenon carrying several meanings and explanations. There is more to HIV than an STD. The moral element is not easily dissected from HIV transmission. Hardly anybody described this illness as transmitted by a purely biological action. There must have been a ‘second spear’, a second motive. Alongside the improper behaviour there ought to be a drive to perform that behaviour, whether this is found in a mean intention, a deviant passion, or excessive sexual activity.

“Is somewhat contagious, like TB.”

To make things even more complex, there exists a variety of AIDS myths. One common misunderstanding is the idea that physicians are omnipotent, and can immediately

tell if a patient has a disease. If blood was taken by a doctor most respondents assumed that the result would be indicative of their overall health status, including HIV. "If the doctor says, it's OK, then it's OK. If the blood test is good, you have no AIDS." Equally, many informants assumed that doctors are supposed to inform patients if "something is wrong". So, if after a doctor's visit one was not diagnosed with HIV, regardless of whether the topic was discussed at all, there was no need to worry about it. "It [HIV/AIDS] would show. The doctor would know." This strong belief in the capacity of allopathic physicians fits the amount of AIDS knowledge and treatment efforts in industrialised countries.

AIDS origin myths were not discussed by all respondents. While many Dutch believe that HIV is imported to the Netherlands by people coming from HIV-endemic countries, many migrants equally believed that HIV was introduced to their countries by other spiteful people or a vexed God. Some believed in a Western conspiracy to harm Africa. "Why otherwise would the disease kill so many more people in Africa?" Others believed that it was a collective punishment, with many people suffering for the wrong doings committed by some. Homosexuality was often cited as a transgression worthy of such a punishment, even if it is not practised in most of Africa, according to the respondents. The enormous epidemic was then explained by the fact that Africans are indeed of great number, and inclined to many a sexual activity. The explanation of the cause and the spread are not one and the same. While in the West, anal intercourse is regarded as a risk factor for HIV transmission, informants (8) rather consider it the cause. The anus makes it a disease, the very act of sodomy causes or once caused illness. The picture is vague, but the association with moral misbehaviour is firm. HIV and AIDS are related to an unlawful activity rather than certain bodily fluids. The individual bodies remain clean and healthy, it is certain interaction that is polluting. No one cared to expand on the details of transmission. This perception is important to keep in mind when talking prevention.

More rumours circulate to perpetuate the AIDS myth. "American Ideas Damaging Sex" supposes that AIDS is invented altogether, in order to spoil other people's enjoyment of sex. Other rumours claim that condoms themselves are infected with HIV. The fervent promotion of these condoms by Americans raised many doubts among the informants. Racist ideas about Americans trying to control the population at the expense of Africans are not uncommon. This theory at least explains why the AIDS epidemic is so rampant on the African continent. One single voice then saw no relationship whatsoever between sex and AIDS. He stated that others are jealous of the African libido and tried to make them feel guilty. "Who says it is AIDS? AIDS does not exist. It is an invention."

Other rumours referred to people intentionally spreading of the disease by cutting or damaging condoms. This action also was attributed to women who want to conceive while their partner does not. By secretly damaging the condom with their fingernails when putting it on, they literally take fate into their own hands. Rumours of the alleged inefficiency of condoms have been fed by these alleged deeds. Spitefully inflicting damage on someone in form of an unwanted pregnancy or an STD was considered a shameful activity, nothing more. STD's share a couple of characteristics with preg-

nancy: they are 'made' through sex, they are 'preventable' by a condom, they are 'curable', and, in the worst case, 'liveable'. The risk of death through an STD, or through childbirth, is not on the foreground.

Transmission was also believed to take place by "touch", "sharing a glass of water", or via "a plate of food". Some thought that the virus could be passed on through air; one could become HIV-positive just by being too long in the same room with an infected person. If a person was believed to have the virus, they were often shunned or dealt with at a distance because of the possibility of contagiousness.

Informants had labels for the stages of disease. Once infected, the person becomes a "carrier". At that stage, the disease is invisible, there is no evidence as to who carries the virus and who does not. Only when people start displaying symptoms that are commonly associated with AIDS, such as extreme loss of weight, long-lasting colds, skin rashes, they are suspected carriers diagnosed with AIDS. The lay definition resembles the medical one in this regard, for both acknowledge stages of disease and progression. The very details of progression differ. Even before getting infected, some people may be more likely to come across the virus in their lifetimes. These are the common risk groups or risk behaviours mentioned above, but are not perceived as applicable to the average migrant, and never the informant himself or herself. Sleeping around had a negative connotation among respondents, but not all of them, and many did not link this behaviour to the disease. AIDS was said to be "not discriminating", "unpredictable", so that "anybody can catch it, anywhere". It became a matter of "chance".

Stories of curing AIDS, such as Magic Johnson, whose viral load "disappeared" contribute to beliefs about curability. Healing was related to specific characteristics of Johnson himself, whom was believed to have "strong blood" that protected him from contracting diseases, or, in this case, helped him to overcome them. Also, healers in Africa claim to have found ways of healing AIDS. Perceived scarcity of AIDS among African migrants helps to explain the relatively little consideration that the disease is given in this community.

Prevention

"I was lucky."

Preventive care presupposes a clear vision of the outcome to be frustrated (HIV infection), and a rationale to do so (severity of illness, other disadvantages related to illness). Moreover, it presupposes that the responsibility of prevention lies in one's own hands. In the Western health system, prevention has become a personal responsibility for which individuals or groups are held accountable. In all cultures there exist norms for good and bad behaviour to which individuals should subscribe and for which they are judged. In the era of AIDS, promiscuous sexual behaviour is given a new meaning, namely that of contributing to the transmission of the disease. So far, the only prevention is changing one's sexual behaviour. Such a change assumes that promiscuity is generally understood to be a risky behaviour related to HIV. This is not the case among the respondents.

Migrants are generally perceived promiscuous by the general public as their sexual behaviour is considered more explicit and libidinous than the local social norm. Along with their common preference for flesh-to-flesh, sub-Saharan African migrants form a potential risk group of HIV infection. Obviously, not all respondents fit this image. Most informants acknowledged that many women “end up” as sex workers, or intentionally come to work in that business. Yet none of the female respondents happened to be a part of this. Most informants also acknowledged that having sex without condom was considered a risk, yet hardly anybody perceived themselves at risk although having mostly unprotected sex.

The most important means of prevention among the respondents was partner choice. This measure could indeed serve as a means of protection if the screening were reliable. Mostly everyone claimed to carefully choose their sex partners, including health aspects. Screening consists of “taking a good look” and inquiring of others about the person’s “reputation”. The weakness of partner screening is that evaluation has to happen rather quickly, and that reputation and appearance are unreliable criteria at a first glance. Reputation requires a good knowledge of each others’ social networks which often is not the case, especially for migrants. Appearance is just as tricky, as it is generally known that the pretty women and sly men are ‘risky’, yet at the same time they are the most appealing. Stimulation often interferes with a rational investigation. In fact, if it were not used for casual, immediate sex encounters partner choice could prove a fine means of protection when applied over a longer evaluation period. As it is, one cannot absolutely be sure of the other’s sexual health.

In addition to partner choice, most of the respondents believed that “God” and “positive thinking” were means of prevention. Here, the health care definition of prevention is stretched a little. God is considered not only to know events before they happen, he also caused them, and can therefore ‘prevent’ their onset, if so desired. Additionally, or alternatively, positive thinking is believed to be the right mindset. The belief in a good, caring God, like the common positive thinking attitude, reduces the risk of getting any disease or misfortune at all. Respondents also say that people worrying too much about their health, or other abstract risks, tend to get ill in the end. In fact, anticipating illness or accidents through preventive measures, or by constantly talking about them, is not recommendable as it anticipates the actual misfortune. A “good attitude” is prerequisite to a good health. This principle was held by non-religious informants alike, and is found in psychosomatic principles which state that the psychological state of mind can influence somatic conditions both positively and negatively.

Male circumcision is another socio-cultural measure found to reduce men’s risk of contracting HIV, once safely administered. It appeared that at the beginning of the HIV epidemic in Africa, countries with a general practice of circumcising their males did not develop into major HIV centres. However, when looking at contemporary Africa, circumcised communities no longer seem protected from the epidemic. Information on circumcision was not collected from the respondents, neither was it mentioned by any of them as a form of prevention.

Cultural perceptions of bodies, sex, and discharge have to be taken into account when promoting condoms. Using condoms as a preventive measure was not popular

among the respondents. Statements like “healthy, yes, but not pleasant ...”, “it does not feel natural ...” were often heard. Ideal sex ought to be “natural” and emotionally satisfying rather than responsible. Respondents also reported that the “condom comes off”, [... is] “too small for Africans”. All of these statements support the general notion that “Africans really favour flesh-to-flesh” and do not want to deal with any “interference” such as condoms. Another reported motivation for rejecting condoms was the inevitability of seeing and possibly touching sperm when removing the condom. Sperm is a bodily discharge that is not regarded as something desirable to touch or deal with otherwise. It has a clear function in procreation, and is typically ejaculated by man to find its way into a woman. Discharge that emanates from the lower parts of the body is known as impure excrement. As there exist rituals and rules surrounding female menstruation, there also exist agreements on how to socially deal with other bodily discharge. Thus, when using condoms, sperm has to be handled in a way that is culturally strange. Restrained in a condom, it also becomes a ‘matter out of place’.

Moreover, condom use needs mutual understanding, that is to say, both partners should agree to its usage to make sex a pleasurable experience. Women said, “men do not like it.” Men said, women do not like it: “I never met a woman who always wanted to use a condom,” (see following table for summary of arguments). The intention to use condoms seemed to vary by situation, and not by respondent. Therefore, it is difficult to speak of personality types. Risk awareness influenced migrants in so much as to wear condoms “at the beginning of a relationship” especially with “sexy women”, then gradually fading out its use. Doing so, they believed to fulfil some unwritten law on proper sexual behaviour. Both men and women felt strong and detached, the condom giving them a sense of distance, a sense of “not giving it all away” to the other. From the conversations it became clear that using a condom represented a restraint on oneself, and therefore on the relationship. The choice is made between being “in control”, or letting it be the “natural way”. Emotions associated with “good sex” interfere with controlling it, which lies at the very heart of illness prevention.

Rationale for condom use or non-use

| <i>condom use</i> | <i>no condom use</i> |
|--|--|
| 1 at beginning of relationship/ first time | a sex is unplanned/ heat of the moment |
| 2 with sex worker | b know him/her well/ trust/ no risk |
| 3 sexy woman | c HIV test negative |
| 4 woman wants it | d problematic to use/ brakes/ gets off/ gets stuck inside |
| 5 after [male] partner returns from abroad | e partner does not want/ does not like it |
| 6 don't want a(nother) baby | |

Often, condoms are not even addressed out of fear to spoil the situation. Forcing or convincing the other to use a condom is hardly ever done. Female respondents say that men are not that easily convinced. Contraception, however, appeared to be a good reason to engage in a conversation about condoms. Sometimes, a condom was used in

addition to contraceptive pills, as the latter is not fully trusted. Those who believed to be in a fertile monogamous relationship did not bother about condoms as they are associated with lack of trust. Others that had multiple partners did consider using condoms “every now and then”, yet never all the time. Only two out of 15 respondents, a man aged 34 and a woman aged 27, reported conscious use of condoms to protect themselves against STD’s in casual sexual encounters.

Mistrust also appeared to play a role when one partner, usually the man, returned from travelling abroad. Condoms were then used for a while on women’s initiative. They represented a means of conveying suspicion rather than prevention, as they were used too shortly to actually prevent any transmission of possibly acquired STD’s. To deliberately use a condom, one or the other had to have an immediate reason, i.e. anti-conception, disease, mistrust. HIV risk in particular is not considered an immediate reason, as the concept of risk is “too far away”. In fact, respondents simply argued that they would not have sex with infected people or people they believed to be infected. ‘Risk’ thus comes to mean: willingly engaging in unprotected sex with infected people. In this sense, respondents did not feel themselves at risk at all. Prostitutes and their clients formed an exception, as it is known that many prostitutes are infected, and accordingly it was said that condoms were used in such encounters. Having unprotected sex with common men and women was thus not considered especially risky. “It is a way of life.”

Some respondents, however, adhered to a narrower definition of risk, thus reducing the number of sex partners, or keeping to one steady partner, using condoms. They roughly categorise as long-term sexual partners, older men and women, and parents of young children. The responsibility for a child made people care more about their own health. Responsible health behaviour towards others starts with one’s own body; health care messages do well in stressing this aspect.

Conclusions and implications for health education

*“Positive thinking. Positive attitude.
You can come across it, but sometimes you just end up
with the right ones, the ones that are not infected.”*

The in-depth conversations revealed that despite extensive information available on the topic HIV and AIDS are still surrounded by vagueness and mysteries. Especially among recent black migrants, whom have not had the opportunity of getting exposed to consistent HIV information either ‘back home’ or during their short stay in the Netherlands, more eclectic risk perceptions are discernible. As it is, these migrants, more than indigenous Dutch people, adhered to a variety of evidence concerning HIV that in its controversy remained inferior to the more conventional, coherent forms of illness perception and behaviour. The doubt surrounding the disease mingles with the pleasure and other (economic) conveniences that sex brings along to form ‘risky’ behaviour. Even religious consolation does not seem to put people off sexual pursuit. Repeated

sexual interactions form a more rewarding diversion from existing social frustrations, such as illegality, low status, discrimination, low income, lack of social network.

Findings show that informants in general did not deal with the risk of HIV in their daily lives. Their attitudes and behaviour cannot adequately be captured with existing coping models as these presuppose the being of a 'threat' in the lives of people to which individuals are to react in various ways. Not dealing with the threat of HIV, for example, is easily placed in the category of 'denial', given the availability and accessibility of condoms, people's knowledge of using them, etc. In the case of most migrants the underlying illness perception may even discourage the individual from taking initiatives. In general, informants were aware of the existence of HIV, a dangerous disease that can be transmitted through unprotected sex, as well as acquired otherwise. However, HIV did not pose a particular threat to them for a) there are many, contradicting truths about the disease in circulation, and b) most migrants have other, more imminent worries on their minds, and c) sex and pleasure are not sufficiently linked to HIV.

The very concept of risk is tricky. All respondents agree that a person runs the risk of infection with HIV when having sex with a HIV-positive partner. For that reason they use condoms when visiting prostitutes and practice 'partner choice' as a working preventive method against STD's, and other discomforts. Any other definition of risk, such as multiple relationships, or unprotected sex, are not uniformly accepted and, consequently, no standard prevention takes place. One underlying explanation is that HIV infection, alike other illnesses, is believed visible on people's bodies or in their behaviours, so that ill people would 'naturally' get de-selected. Another reason for not consciously acting on HIV risk is that none of the respondents have had personal experiences with HIV in their social vicinity. Conversely, many described having had 'bad' experiences with condoms, and thereby weaken even more the possibility to promote (imperfect) condoms as a solution against (an indefinite) risk. Due to a change in social conditions and the advancement of science, formerly preventable and prevented conditions become treatable ailments. Myths of treatment lower the impact HIV could have turning it into a regular illness. However, condoms remain a prime (even if imperfect) method in preventing pregnancy, a common indisposition well-associated with the practice of sex. Other health complaints are commonly dealt with as they arise, not beforehand. Respondents finally admit to 'run risks' of invisible but treatable STD's, of pregnancy, and of getting caught at cheating. According to them, these are all minor risks able to be handled, and simply are "part of life". HIV and AIDS remain rather abstract phenomena.

Another important means of prevention is a positive outlook on life and good faith. They are both believed essential to help living a healthy life. Unnecessary trouble about (abstract) diseases only attracts bad luck and perhaps even the disease itself. A positive attitude towards life and all that it brings is a form of prevention and risk reduction. So far, the 'migrant way' has paid off, in the sense that no HIV infection was found among the group. This fact in turn seems to support the respondents' ideas and ways of life and, therefore, lessen the need for changes in behaviour. Prevention messages should try to convey more positive messages, giving the individual an even better outlook into the future and thus a good reason to take action.

Finally, future prevention efforts need to address more emotional aspects of sex than the technicalities of transmission. When researching sex as a means of illness transmission, the pleasure element is often forgotten. Emotions are not to be separated from rationality as they act as an essential element in decision-making. It is considered expedient to freely raise cultural and sexual issues and taboos, to address pleasure, traditions and 'risk' when talking prevention. So far, HIV prevention in the Netherlands mainly consists of two-dimensional information, like folders and lectures touching upon the biological realities of infection, even if in the native language of the migrants. More entertaining and/ or participatory approaches are needed to make sexually transmitted illnesses, and thus sex, relationships, etc. open for discussion. Once the silence is broken, information can be discussed and experiences compared. Several African and Caribbean efforts have successfully used theatre plays and songs to communicate educational messages. Using local humour and ways of interaction, health messages could be pronounced in a manner that touches the listener and makes him/her identify with the problem described. Additionally, people who actually got infected with HIV through sex could be valuable in spreading the prevention message. The ideas were gathered among prevention workers whom are eager to innovate the stagnating situation. Only when the association sex-illness is clearly made will health be consciously taken into the hands of people.

Notes

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- 1 Personal communication with immigration officer, IND, The Hague.
- 2 Personal communication with MD at Witte Jas, a free-of-charge health centre, one of the few possibilities for illegal migrants and homeless to receive free medical care in Amsterdam.
- 3 In Ghana, each ethnic group holds specific beliefs regarding health, sexual relationships and community. While the Akan, the predominant ethnic group, encourage exogamous marriage patterns (outside their ethnic group), the Ewe prefer endogamous unions (from within their

ethnic group). Rights of lineage and inheritance also vary among the different groups. The Akan are matrilineal with descent traced along the mother's lineage giving women a strong voice in the community. Among the Ga-Adangbe, men and women live in different households, while entertaining sexual and social relationships. In this group, households exist of unisexual kin (Kyei 1996: 12-14).

- 4 All 1660 participants from Sub-Saharan Africa, Surinam and the Dutch Antilles had been tested for HIV as part of the quantitative study, and only one respondent turned out HIV-positive. All African men and women were HIV-negative.

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