Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 83, No. 1
doi:10.1007/s11524-005-9006-5

HIV PERSPECTIVES AFTER 25 YEARS

Immigration and HIV/AIDS in the New York Metropolitan Area

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ABSTRACT *Because the HIV pandemic undergoes continual change in its locations and affected populations, it is crucial to study HIV risk behaviors among mobile and immigrant groups within and across borders. The impact of cross-cultural migrations and the importance of studying that impact in terms of demographic characteristics as well as cultural and environmental factors has not received adequate attention in public health research. This collaborative analysis utilizes data from three studies of immigrant groups in New York to describe and compare these factors that provide the context for risk and prevention of HIVAIDS and other health challenges. Data discussed were obtained utilizing multi-method approaches to identify and describe HIV risks among both new and more established immigrant populations within the urban settings of North America, with NYC as a central focus. Demographic and epidemiological data situate the analysis within the larger contexts of US migration and the HIV/AIDS epidemic in NYC. The authors identify risk and protective factors embedded to varying degrees in immigrants' multiple cultures and sub-cultures. The three populations studied include: 1) new Hispanic immigrants from the Dominican Republic, Mexico and Central America; 2) West Indian (Caribbean) immigrants from Jamaica, Trinidad/ Tobago and other anglophone Caribbean nations; and 3) South Asian immigrants from India (Indian Americans). The paper seeks differences and commonalities, focusing on the social, attitudinal and behavioral factors that contribute to increased HIV/AIDS vulnerability among these populations. The data presented also identify some of the attitudes and behaviors of individuals and groups, as well as other facilitators and obstacles to transmission for immigrants as they adapt to new environments. Topics addressed include factors affecting HIV/AIDS vulnerability of immigrant groups, goals and expectations, health and mental heath issues, gender role change, sexual risk, alcohol and other drug use, perception of HIV/AIDS risk and implications for prevention.*

KEYWORDS *Immigration, Immigrant health, HIV/AIDS risk, New York City*

INTRODUCTION

Because the HIV pandemic undergoes continual change in its locations and affected populations, it is crucial to study HIV risk behaviors among mobile and immigrant

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groups within and across borders. However, the impact of cross-cultural migrations on environmental and sociocultural factors influencing health risks and disparities has not received adequate attention in public health research. Given the recognized importance of prevention efforts, an understanding of immigrant communities and the sociocultural and migration-related factors affecting HIV risk and access to HIV-related health services become even more salient issues. Travel and migration patterns, particularly when they involve mobility to higher risk environments, have been related to increases in risky behaviors and HIV seroprevalence. Siegal et al.,[1] for example, found that an important predictor of seropositivity among IDUs in Ohio was having traveled to an AIDS epicenter (New York City). Deren and colleagues found that New York Puerto Rican injection drug users (IDUs) who had lived and injected in Puerto Rico before coming to New York evidenced riskier behaviors than New York Puerto Rican IDUs who had not injected in Puerto Rico[2,3] and that Dominican drug users who had traveled to New York City were more likely to be drug injectors.[4] Within this context, immigration continues to be a major factor in the health and social life of NYC with important implications for the HIV epidemic and for the city's AIDS policies and programs.

To explore these issues in more depth, this collaborative analysis uses data from three studies of immigrant groups to complement New York State (NYS) and New York City (NYC) Department of Health and Mental Hygiene (DOHMH) epidemiological surveillance data and US census data. The three populations include: 1) new Hispanic immigrants from the Dominican Republic, Mexico and Central America[5–7]; 2) West Indian (Caribbean) immigrants from Jamaica, Trinidad/Tobago and other anglophone Caribbean nations (data under analysis), and 3) South Asian immigrants from India (Indian Americans).[8]

These data sets are employed to describe and compare sociodemographic characteristics of the three immigrant groups as well as some of the cultural and environmental factors that provide the context for risk and prevention of HIV/AIDS and other health challenges. We identify a number of risk and protective factors embedded to varying degrees in immigrants' multiple cultures and sub-cultures. Inherent in this approach is the theoretical assumption that shared ethnic, experiential and historical elements influence and shape patterns of behavior and responses to new environmental options, alternatives, obstacles and risks.[9]

The authors have sought differences and commonalities, focusing on the social, attitudinal and behavioral factors that contribute to increased HIV/AIDS vulnerability among these populations as well as the specific risk and protective factors associated with different immigrant groups. Demographic and epidemiological data situate the analysis within the larger contexts of US migration and the HIV/AIDS epidemic in NYC. Some social ecological perspective is also provided through information on the micro-social structural and environmental factors that may affect risk and protection for these groups. The data presented also identify some of the attitudes and behaviors of individuals and groups, as well as other facilitators and obstacles to transmission for immigrants as they adapt to new environments. The authors illustrate that both quantitative and qualitative data are crucial to inform the development of sustainable HIV prevention interventions if they are to reinforce behavior change.[10]

The data presented were obtained utilizing multi-method approaches to identify and describe HIV risks among new and more established immigrant populations within the urban settings of North America, with NYC as a central focus. The communities studied represent important waves of migration to the Metropolitan

New York area, one of the most affected by HIV/AIDS in the nation. Over the last three decades, the growth and diversification of New York City's immigrant population has occurred concurrently with the growth of the HIV epidemic. However, accurate population estimates, reliable seroprevalence data, and risk behavior profiles do not exist for these populations. In part, this is because of the dynamic nature of immigration to NYC in this period (now at its highest level since 1900). Increasingly since September 11th, 2001, the dearth of data and research on immigrants is partially due to the fact that many of these groups are largely hidden and hiding - communities that fear deportation, stigma and a system with which they cannot communicate easily.

DEMOGRAPHIC, EPIDEMIOLOGICAL AND CENSUS BASED PROFILES

In the last three decades NYC has experienced two powerful trends converging in our population of 8 million: the highest levels of immigration since the great waves of the late 19th and early 20th century and a series of social and public health crises surpassing anything seen in the last 100 years—homelessness, crime, drugs, social marginalization, AIDS, TB, and the threats of terrorism. This conjunction is unprecedented in the modern era and calls for a new approach to research and action in public health. The high rates of immigration from over 50 countries has changed the demography of New York; in 2000 over 43% of the city's residents were born outside the US, over 50% in Brooklyn and Queens.[11] Echoing a trend seen nationally, Asian and Hispanic immigrants have become the dominant "minorities" (replacing African Americans) and alter the racial and ethnic landscape of the city in many important ways, such as in education, employment, housing—and of course, public health. Concurrent with these demographic changes has been New York's experience with one new epidemic, HIV/AIDS, and the resurgence of an old one, TB, closely related both to HIV and to immigration.

NYC currently has one of the highest HIV prevalence rates and more cases of AIDS than any city in the United States. As of March 31, 2004, 90,298 New Yorkers had been diagnosed and were known to be living with HIV/AIDS. The true number of persons living with AIDS (PLWAs) in New York is higher, however, since it is estimated that 25% of persons living with HIV have never been tested and thus do not know they are infected. By the year 2010, it is estimated that there will be 100,000–120,000 people living with HIV/AIDS.[12] This growth in the city's PLWHA population is associated with enhanced access to medical care, with the availability of antiretrovirals (extending life expectancy) and with access to a broad range of housing and supportive services throughout the city.[13] But the incidence of new HIV infections continues at 4,000–6,000 cases per year, most heavily concentrated among poor minorities and frequently among recent immigrant groups. In 2003, the most recent year for which data are complete, Blacks comprised 44.2% of PLWAs; Hispanics 31.9%; whites 21.5% and other races and ethnicities 2.4%.[12] Concurrently, there is a downward trend in available resources for all health and social services to indigent populations, even as their proportion of the city's AIDS cases increases, and new caps are in place or threatened for some key elements of service to these groups, such as ADAP support for medications.

In the last three decades, the growth and diversification of New York City's immigrant populations has led to the highest rate of foreign born NYC residents in over 100 years: >35% of NYC residents identified in the 2000 Census are foreign

born. Most AIDS surveillance data do not accurately obtain birthplace and do not collect information on time of residence in the US or travel and other linkages to the home country. Undocumented immigrants (estimated to be at least 300,000 in NYC) are the most economically marginalized and vulnerable to all social and public health risks, including HIV. Additionally, the pressures of Homeland Security have increased the risks of deportation, further driving these groups away from services out of fear of the potential exposure of their status.

NYC and its surrounding areas accounted for 91% of New York State's total increase in foreign-born populations from Central America between 1990 and March of 2000.[11] In 2000, approximately 136,000 Central Americans resided in NYC and the surrounding counties.[11,15] Of these, 98,000 (72%) were born in El Salvador, Guatemala or Honduras.[15] In addition, more than 600,000 individuals classified as Hispanic in the New York Metropolitan Area reported their native countries as Mexico or the Dominican Republic.[15] Demographers argue that US Census figures underestimate the size of these populations due to the undercount of undocumented residents.[14] Hispanics account for 25% of the New York City population but represent 31% of adults with AIDS (NYCDOH, 1999).[16] The incidence of AIDS among Hispanics in New York City has been increasing since 1996, when Hispanics and African Americans made up 70% of the cumulative AIDS cases, and increased to 76% in 1998. After Haiti, the countries with the largest number of people living with AIDS in New York City are from the Dominican Republic, Cuba and other Caribbean and Central/Latin American countries.

Black West Indian immigrants from the English-speaking Caribbean basin countries* are one of the largest foreign-born populations living in NYC, comprising almost one-third of the city's black population of 2.2 million.[17] The majority of West Indian immigrants live in NYC neighborhoods that are among the poorest and in which the prevalence of HIV and other sexually transmitted infections (STIs) is disproportionately high.[18] The Caribbean region has the highest HIV prevalence in the Americas—approximately 2% among adults[19]—and the latest available figures indicate that incidence in the English-speaking Caribbean is soaring, at 23 new cases per 100,000 per year.[19] Despite these figures, there is a paucity of research investigating the social and cultural contexts of HIV/STD risk behaviors among West Indian immigrants in the United States.

In the Caribbean region, 65% of the reported sexually transmitted HIV/AIDS cases have been attributed to heterosexual transmission,[20] making this infection route the most common for both men and women. However, there are almost no data on HIV rates or risk factors for infection among West Indian immigrants living in NYC. In most public health data, race is used as a proxy for ethnicity, making it difficult to estimate the prevalence of HIV infection among West Indian immigrants. Many immigrants are undocumented and fearful of being tested for HIV, rendering estimates even more challenging. Yet among known NYC immigrants living with HIV/AIDS, Jamaicans number the third largest group.[21] West Indian immigrants

*We use the Pan American Health Organization (PAHO) and WHO definition of the wider Caribbean, which includes the mainland nations Belize in Central America and Guyana in South America, as well as the Caribbean islands.[38] Although diversities exist within the anglophone Caribbean, as well as within the respective immigrant communities, over time a common West Indian culture has been forged, which distinguishes this group from Spanish- and French-speaking Caribbean immigrants.[39]

are most heavily concentrated in the neighborhoods of East Flatbush/Flatbush and Bedford Stuyvesant/Crown Heights, where the rate of new HIV diagnoses was 102 and 62 per 100,000 population, compared with 46/100,000 in Brooklyn overall.[18]

For West Indian and Dominican immigrants, bi-directional travel through the NYC–Caribbean corridor may increase opportunities for sexual mixing and disease transmission. Socio-economic and gender inequalities fuel the epidemic in the Caribbean, where masculinity is characterized by early sexual activity, multiple partnerships, and deep-seated homophobia.[22–24] Structural aspects of gender also shape the immigration process. While Central Americans tend to send young men first, for example, the predominant pattern among West Indian immigrants has been for women to emigrate first, as US employment opportunities favor them.[25,26] Although West Indian women have a high labor force participation in their home countries, they are even more likely to be employed when they move to the United States.[27] Jamaican, Trinidadian and Guyanese women were ranked 2nd, 3rd and 4th, respectively, in female work force participation amongst immigrant groups in NYC.[17] This often creates opportunities for shifts in gender power relations, especially in household roles and decision-making.[28]

Immigrants from India to the US present a different scenario. Migrant Indian men within and outside India (for example, in the Persian Gulf States) are known to be at high risk for HIV.[29] Between 1990 and 2000, the Indian American population in the US rose by 124%,[30] and it remains a population that travels back and forth between India and the US, socializing and having sexual contacts in both countries.[31] NYC has the nation's largest concentration and total number (206,228) of Indian Americans.[11,15] Indian Americans are a subgroup of Asian American and Pacific Islanders (AAPIs). AAPIs constitute 4% of Americans[30] and 1% of Americans with AIDS.[32] Between 1990 and 2000, this population grew 118%, while the city's overall Asian population grew 71%.[33] Seven of every ten Indian Americans are foreign-born. Over 70% of these foreign-born persons are between 18 and 64, the most at-risk age group for HIV.[34] AAPIs have been found to underreport HIV infection and underutilize HIV testing.[32,35]

APPROACH AND METHODS

New Hispanic Communities and HIV Risk utilized a qualitative approach to identify the range of experiences, attitudes and beliefs relating to HIV risk by men and women of the target groups. These methods were also used to develop rapport, to facilitate access to settings and hard-to-reach groups and to obtain information on the social context of behavior and its influence on HIV risk. Qualitative data collection involved: 1) semi-structured, in-depth individual interviews and 2) focus groups with the target groups; 3) key informant interviews; 4) focus groups with advocates and providers in health and social services; and 5) ethnographic observation in the different geographic locations of the study including specific national/ethnic communities and activities. Interview instruments were designed to explore migration-related experiences; individual and collective living conditions; continuities and changes in attitudes, behaviors, and interactions with existing social networks and environments; attitudes and behaviors related to HIV and other STIs; and access to/utilization of health and other social services. All immigrant interviews were carried out in Spanish by bilingual researchers and textual data were analyzed in Spanish.

Social Contexts of HIV Risk Behaviors Among West Indian Immigrants was conducted in the STD clinic of Kings County Hospital, a large public hospital located in the area of the West Indian immigrant community of Brooklyn. In-depth and quantitative assessments were conducted with a sample of West Indian immigrant men and women who had been diagnosed with one of several common STDs within the past year. Structured interviews elicited information on sexual risk behaviors, partner risks, relationship characteristics, travel patterns, drug and alcohol use, abuse, and acculturation level. Open-ended interviews explored migration experiences, differences and similarities in sexual and relationship behaviors by men and women in the US and country of origin, personal changes in these beliefs and behaviors experienced since immigration, and perceptions of risk for HIV/STDs at home and in the US.

Sociocultural Contexts of Immigration and HIV Risk was conducted in two phases. Phase I assessed HIV/AIDS issues in NYC's Indian American community. Using snowball sampling, key service and community informants were identified and interviewed, such as health officials, social workers, peer outreach workers, and community leaders. Phase I findings identified the most at-risk community subgroups, shaped the development of Phase II's eligibility criteria and sampling strategy, created community support for the study and established its feasibility. In Phase II, purposive sampling was used to select the participants for individual interviews using a semi-structured interview guide.

RESULTS: FACTORS AFFECTING HIV/AIDS VULNERABILITY OF IMMIGRANT GROUPS

Goals and Expectations

A number of interrelated aspects of immigration dynamics appeared to influence immigrants' psychological and behavioral experiences: the demographic characteristics of the migrants (especially sex, social class, relationship status and education); the purpose of immigration; the type and location of their receiving community and the existing supports; discrepancy between pre-immigration expectations and post-immigration experiences; and transnational movement between the U.S. and their home countries. However, daily survival efforts caused many men and women in all three immigrant populations reported here to question the feasibility of their aspirations, not only day laborers in the Hispanic and Caribbean samples, but also the students and blue-collar workers in the Indian sample.

Because migration dynamics and immigrant residential and employment patterns have always been strongly shaped by existing networks in the receiving country, people originating from particular towns and villages (e.g., the state of Puebla for Mexicans, Chiquimula for Guatemalans, and Tamboril for Dominicans and Metapán for Salvadorans) are common in receiving towns. These groups are sustained by the continuation of relationships and networks from sending localities, albeit in a more fragmented way in receiving environments. Additionally, immigrants must negotiate the transition from identification with an ethnic group (e.g., Garifuna, Mixteca) and national identity of origin (e.g., Honduran, Guatemalan, Jamaican, etc.) to identification with US citizenship and terms such as "Hispanic," "Latino," and "West Indian."

Thus, pre-migration hopes for achieving economic stability and acceptance frequently contrasted with post-migration experiences suggesting that they might not attain these goals, especially significant given the economic and psychological costs of migration and acculturation/adaptation. Many respondents discussed a loss of self-esteem, feelings of failure, and increased levels of frustration and disappointment. On the other hand, some immigrants' periodic travel between home countries and the US and regular family contacts by telephone reduced some acculturative stresses. These contacts, interestingly, and the tendency for individuals from the same villages and towns to live close together, continued the traditional information channels (gossip) serving as a form of social control for immigrants in their new environments.

The traditional goals of immigrants continue to influence migration in the Hispanic groups studied. Hispanic immigrants had come for a variety of reasons: to help the family, send money home, "to help myself," obtain better education for children, and to obtain better medical care. Women also explained that they migrated because men stayed "a long time" in the US and they feared that distance might threaten the stability of their relationships. Some women brought children because they had no one with whom they could leave them. Apart from fear of persecution by US immigration authorities, obstacles and limitations imposed by lack of legal status were a major focus of discussions. Obtaining a driver's license, jobs, car insurance, medical care, a telephone, opening a bank account, and conducting other daily necessities were said to be difficult or impossible. Men spoke of the high cost of obtaining false documents.

Similarly, West Indian respondents, both men and women, emphasized that they or their families had migrated with the goal of increasing their educational and employment opportunities. Many participants migrated as adolescents to rejoin one or both parents, who had previously come to the US to establish themselves. Whereas expectations were high, many experienced challenging post-migration experiences, including (for those who came as youth) difficulties adjusting to their peer group and to the new school system, being homeless, having difficulty with employment, and lacking interpersonal social support. In some cases, these circumstances also led to unstable sexual partnerships and the need to rely on partners for housing and support. For some of the men, in particular, their employment difficulties led to subsequent involvement in illegal activity.

Indian American participants (all male) shared a high level of education and stated that their primary motives for immigration were to earn money, to grow personally, and to raise their own and their families' social status. The participants' psychological and behavioral experiences were shaped by their motives for immigration, discrepancies between their pre-immigration expectations and post-immigration experiences, and their transnational movements between the US and India. However, daily experiences of hard, long work led the participants, especially the students and blue-collar workers, to question whether their hopes of socioeconomic improvement were actually achievable. Their pre-immigration hope of achieving the "American dream" contrasted with post-immigration experiences suggesting that they might not attain it. This contrast generated loss of self-esteem, feelings of failure, and increased levels of frustration and disappointment. On the other hand, their frequent travel between India and the US and regular family contacts reduced their acculturative stress by giving them a sense of belonging and bonding.

Health and Mental Heath Issues

Immigrants are more than twice as likely as citizens to have no health insurance—of the 33 million immigrants in the US, one third (11.2 million) have no health

insurance—yet this is the group most at risk for HIV and other health problems associated with social and economic marginality. For the most recent immigrants (less than 108 years in the US), the figure is 46% without insurance.[36]

For the Hispanic sample, few of whom had any type of insurance, health and social service providers noted serious pre-existing health conditions among these groups, including malnutrition, anemia, diabetes, asthma, toxoplasmosis, STIs (syphilis and gonorrhea), parasitic infections, hypertension, cardiovascular problems/high cholesterol (especially among Dominicans), malaria, tuberculosis, and dental decay.[37] Nevertheless, the lack of communication skills and the urgency of generating income resulted in a lack of attention to health unless the ability to work or care for families was threatened.

Hispanic men and women also reported lasting effects of the journey and the "suffering" they endured en route as well as from leaving homes and families, going into debt, and facing major disruption of their lives. Many men used the word "desperation" and expressed feelings of social isolation and frustration at not knowing the new laws or acceptable behaviors. The difficulty of finding work during the winter was particularly stressful for the Hispanic participants. Women, especially, discussed feelings of depression, some of which they related to the stresses of acculturation and separation from homes and family. Some of these feelings, however, were attributed to disillusionment with expectations for life in New York, as well as experiences of stigma and isolation.

West Indian participants also described feelings of loneliness and nostalgia for their home countries, which was reported to last for varying periods of time. Many of those migrating as youth after living without a parent at home experienced difficulty adjusting to living with that parent from whom they had been separated for a long period of time. Some described being teased by peers or experiencing difficulty adjusting academically. These pressures contributed to poor school attendance, dropout or affiliating with delinquent peers. A significant number (30% of women and 10% of men) reported childhood sexual abuse, neglect and physical abuse, details and sequelae emerging in qualitative interviews.

The Indian American participants saw their stress as linked to frustration, hopelessness, depression, and loneliness in their new environment, although these feelings varied somewhat according to occupational status. Blue-collar male workers feared losing jobs, and although all study participants spoke English, the blue-collar workers lacked job experience in American work settings. White-collar male workers expressed concerns about job stability as well because of the national economic downturn and rising anti-immigrant sentiment. Students reported feelings of uncertainty about obtaining jobs after graduation. In fact, expressions of failure were frequently emphasized in the interviews. Study findings have indicated a link between acculturative stressors and varieties of psychological distress that may influence Indian American immigrants to engage in HIV risk-related behaviors.

Gender Role Change

As is widely recognized at international and national levels, sex differences and gender inequalities impact on specific health problems, health services and behaviors. We have thus looked at our data to identify some of the ways these issues have manifested themselves among our study populations.

Hispanic men and women reported change in gender roles and expectations generally favorable to women. However, this "change" was not experienced uniformly. While Central American and Mexican men migrating alone generally

began to engage in domestic chores such as washing their own clothes, cooking, and so forth, men and women who were part of immigrant groups more strongly shaped by migration of couples (Dominicans) reported less change. Nevertheless, engaging in work seen as "women's work" was not a proxy for fundamental change in gender roles and expectations by men. Migration and settlement appeared to offer women new resources unavailable to them before and new frameworks to evaluate their experiences, but the data do not suggest that this transformed how women saw and evaluated themselves and others as women.

There were both similarities and differences identified in the descriptions of gender relations in West Indian countries and in NYC. In their countries of origin, even though women often work, they are expected to be homemakers and care for children. Women who migrated as adults frequently came to the U.S. to increase their educational and employment opportunities. These increased opportunities, coupled with the fact that West Indian women often migrate on their own, make it unlikely that women's roles will be confined to homemaking and raising children. Despite this, male dominant relationship dynamics were reported to be prevalent in both the US and West Indian countries of origin. With respect to gender norms for sexual behavior, both US-born and West Indian-born women living in the US were often described as being more open and direct concerning their sexual desires and, in relation to sexual activity, more able to 'do whatever they want and get away with it.' For example, although women obtain bad reputations for having multiple partners both in the Caribbean and in the US, the size and anonymity of the NYC environment was perceived to give women the freedom to have multiple partners without the knowledge of others. On the other hand, their immigration status may keep some women in positions of limited power in relation to men, especially where they rely on men for housing, economic support, or legal immigration status.

A salient difference between home countries and the US for both Hispanic and West Indian immigrants were reported norms and practices relating to domestic violence. Participants described frequent male perpetration of violence in relationships within their home countries, with many individuals in both studies reporting their own and family members' experiences of abuse. Abuse was viewed as reduced among Hispanic and West Indian couples within the US due to more effective police response and prosecution of offenders compared to their home countries. Awareness of the differences in laws and enforcement appeared to have an effect upon attitudes regarding the acceptability of violence toward women and children and women's perception of options for protection.

Because the Indian American sample was comprised of men only, data from this study illuminate *male* Indian American perspectives on gender roles, social norms, and behavioral expectations. While three groups of men—white collar, blue collar, and students—reported some similarities in their views, they also mentioned striking differences relating to prevalence of hierarchical social class attitude as in India and in developing intimate social relationship with women in NYC. All participants reported two major changes in their pre-immigration notions about gender roles: First, although they considered cooking, cleaning, and other household chores to be "women's duties," they did these tasks themselves in the US However, they refrained from "women's work" whenever they visited India. Second, participants believed that Indian women in the US, whether born in India or in the US, were independent and outspoken and sought to work outside the home. The men attributed these characteristics to "American culture," suggesting that women in India have different expectations. Indian American men further

rationalized these "American" characteristics as necessary adaptations to busy U.S. lifestyles. Moreover, while men considered these characteristics acceptable in women colleagues or female acquaintances, they clearly expressed their wish to not to marry women with these traits.

Sexual Risk

In addition to norms and behavior relating to gender role change in New York's new environments, data were examined regarding how traditional sexual norms and behaviors, especially those relating to HIV risk, were affected by new options and alternatives. In the Hispanic sample, for example, men reported unprotected sexual relations here and in their countries, noting that condoms were not associated with "pure love" and so were not used with wives or girlfriends. Condoms were also said not to be used where they did not perceive risk from girlfriends, with no acknowledgement that *they* could be infecting their female partners. Women's awareness of condoms varied. Some women said they had heard of condoms but were reluctant to discuss them. Others believed it was the role of doctors to tell men about condoms, but if men chose not to use them, there was nothing they could do. In fact, other than for family planning, there did not seem to be an expectation that male partners would use condoms. Women also explained that the men denied having other partners and thus saw no need for protection. Some whose husbands had been in the US without them, however, were told upon arrival that because there was a lot of disease in the US, they had used condoms with sexual partners, including sex workers.

Men and many women throughout the study locations reported the availability of sex workers targeting immigrant men. Central American and Mexican men living in suburban and semi-rural areas and working in farms reported that the *patron* (boss/owner) brought in sex workers from Manhattan and the Bronx to have sex with the men, sometimes only one woman for twenty men. Some of the men explained how sex workers would go to the farms on payday to have sex. In these encounters, the sex workers were expected to provide men with condoms, their supply seen as the responsibility of the sex worker. Most men agreed also that, if drinking, condoms were "the last thing" they would think about.

Not surprisingly, the West Indian immigrant participants, all of whom were STD clinic attendees, reported high levels of sexual risk. They reported multiple partners (a mean of 3.4 for men and 1.6 for women) in the past six months, with high numbers of unprotected sex events (men reporting a mean of 66 and women reporting a mean of 53 unprotected sex occasions). Participants noted especially the relative ease with which both men and women could engage in multiple partnerships in the US, relative to West Indian countries of origin where multiple partnerships are seen as the norm for men but not for women. Interviews explored whether travel to and from Caribbean countries was a context for sexual risk behavior, and although 13% said they had traveled home in the past year, only two individuals had sex with someone from that country during their stay, in both cases unprotected. This suggests that return travel may well contribute to additional sexual risk among this community.

The Indian American participants expressed beliefs about pre- and post-marital norms for sexual behavior that may contribute to HIV risk. Overall they saw casual sex as an appropriate release for unmarried men, with monogamous, emotionally invested sex being reserved for the special person one marries. Indian patriarchal society permits men to gain sexual experience through encounters with commercial sex workers. The participants generally perceived American culture as sexually

liberated, with more options for having multiple partners and/or not using condoms with casual partners.

Alcohol and Other Drug Use

While drugs were believed to be more accessible in New York than in home countries by all three groups, alcohol emerged as the primary drug of choice for these immigrant populations. Among the Hispanic sample, both alcohol and drugs were closely related to the venues and contexts of social interaction available to them. Apart from the workplace and from some bars, members of these groups socialized in their homes. Men and women reported that drinking took place in their own or friends' houses because there were few places to go and because men were afraid of the police. Women reported that men drank heavily and that they were frequently jailed locally for having fallen down drunk on the street or for drunk driving. The consumption of alcohol was seen as an outlet for men alone, depressed, and dealing with the stresses of a new environment without families and social support. Although occasional drinking among women in their home countries was noted—especially among women from the larger cities—it was suggested that alcohol use among women may tend to increase after migration. Social networks and spaces for socialization were also connected to the initiation of drug use. It appeared that both using and selling are being initiated in the areas of settlement. Some participants suggested generational differences in immigrants' attitudes towards drugs. Some respondents suggested that younger immigrant men were more likely to begin marijuana and cocaine use while older men continue traditional, though mitigated, beer binge drinking and some other alcohol use (e.g., rum).

Alcohol and marijuana use were common among the sample of West Indian immigrants. Among women, 75% reported current marijuana use, and 66% reported current alcohol use. Among men, 90% reported current alcohol use, and 50% reported current marijuana use. Participants viewed marijuana and alcohol as means of relaxation and generally did not consider their use to be problematic. Overall, 65% of men and 42% of women reported at least one sex occasion in the past six months in the context of their own alcohol or marijuana use. Drug use, other than marijuana and alcohol, was rare. One male participant had smoked marijuana mixed with crack-cocaine, and one female participant had used ecstasy.

The Indian American respondents used alcohol (chiefly beer and wine) to socialize, especially with peers. They saw the use of alcohol as necessary to alleviate job-related stress, hopelessness, and depression. In response to feelings of frustration and failure, some of the men described using alcohol in conjunction with visits to commercial sex workers, which they saw as means to relieve boredom and depression. Some blue-collar workers expressed a preference for hard liquor such as rum and vodka. Only the students reported illegal drug use (occasional marijuana, experimentation with ecstasy).

Perception of HIV/AIDS Risk

Knowledge of HIV/AIDS among new Hispanic immigrants varied. While most respondents knew little about HIV/AIDS beyond the fact that it is a life-threatening illness, most knowledge was related to modes of transmission. The majority of men associated risk of infection with whether or not they "knew" their sex partner. Some perceived less risk in their hometowns where they knew everyone; others saw

increasing risk in their countries with new freedoms and the increase of poverty causing many young women to accept sex work. The "Hispano," many agreed, was not aware of the risk of his behaviors or of the "magnitude" of AIDS, neither its symptoms nor its consequences. Most women, however, perceived risk from partners for diseases as well as pregnancy. They were generally aware that their partners had other sexual relationships, frequently citing behaviors common for men living alone. Some women even reported being with their male partners in crowded rooms when sex workers would come in to offer the men "fresh meat." While their response emphasized that *their* partners were not customers while they were present, some were concerned that partners would use sex workers in their absence.

West Indian participants were not uniformly aware of the severity of the HIV epidemic in their home countries, with many believing that the situation was much riskier in the US. They noted the greater visibility of HIV/STI prevention messages, more education on HIV/STDs, and greater acceptance of condom use within the US as compared to the West Indian countries of origin. Nevertheless, they believed that the "anonymity" of NYC compared to the close-knit nature of communities in their home countries fosters greater risk. When growing up in the West Indies, participants believed they had access to information about a potential partner's past and present sexual partners and STI history from members of a shared social network. The larger context of NYC, while increasing individuals' understanding of STI risk and the need for condom use with casual partners, also increased the likelihood that they could carry on multiple relationships undetected by others.

Most West Indian participants had not considered themselves to be at risk for an STI at the time they became infected and acknowledged that they had used condoms inconsistently, if at all. Women described surprise and shock on discovering their STI and viewed their risk as residing in their partner's infidelity. Men seemed less surprised when diagnosed with an STI. They viewed their risk pragmatically as due to an infected woman whom they were unlucky not to identify and avoid, not as resulting from unprotected sex with multiple partners.

Before immigration, the Indian American participants stated that they did not learn about HIV transmission routes and explained that infected men often did not disclose HIV risk behaviors to potential brides in India. Few said they personally knew people with HIV/AIDS. While all participants stated they now knew how HIV was transmitted, most denied any personal risk of infection. This perception may have been influenced by an overall lack of STI knowledge and a wish to differentiate themselves from truck drivers and commercial sex workers, the highest-risk behavior groups India.

Implications for Program Development and Future Research Directions

Historically, family and ethnically based community networks in receiving countries support immigrant populations by facilitating migration and assuring initial survival—including housing, jobs, and social integration. However, exploitation, overcrowded living conditions, and poor working conditions (frequently associated with high rates of undocumented status) may also pit immigrants against each other in the labor market and isolate them from mainstream supports (e.g. in public education and health services).

These old realities have taken on new significance in the exposure of immigrant populations to AIDS in NYC and their implications for prevention and treatment of

HIV infection in these groups. A sense of urgency has been added, since September 11, by the increasingly militant anti-immigrant policies and practices of government agencies concerned with terrorism and homeland security. These factors form the contemporary background for all recent immigrants in the US, and the specific cultural patterns that affect HIV risk, including sexual norms and behaviors, the role of women, patterns of alcohol and drug use, and specific culturally shaped responses to AIDS such as denial and stigma, are all affected by these social structural and environmental factors in ways that must be studied and understood quickly. Nevertheless, the dearth of conceptualization and rigorous documentation of even our limited experience in HIV relating to immigrant populations and their specific needs continues to impede progress.

The range of immigrant social networks and their place in diverse social settings, as well as the acquisition of new social identities and behavioral norms, present formidable challenges both for researchers and practitioners. This variety must be taken into account in any HIV-prevention intervention for immigrant communities. Intervention approaches must target very specific networks (especially those segmented by geography and social class as well as ethnicity) and provide immigrant individuals and communities with socially meaningful and rewarding behavioral options that are consistent with valued social identities and roles.[10] This diversity, in addition to complicating the allocation of resources (one size does *not* fit everyone), implies the critical role for collaborative approaches to prevention and the real involvement of immigrant communities in the formulation of policies and HIV prevention and treatment practices in NYC.

While different in their demographic characteristics, community infrastructures, resources, and risk behavior criteria, all three immigrant communities represented in this analysis, for example, revealed the importance of immigrant mental health issues and how acculturative and other types of stress may be influencing HIV risk for these communities. Even the more educated Indian American males illustrated the importance of social support from peers, generally Indians of similar age and occupation. These peers offered needed information and emotional resources, especially relating to health. Community-level supports were experienced in the form of community connectedness and pride with opportunities to participate in ethnic festivals, which alleviated loneliness and isolation and which were reinforcements of the community's growing size and image in NYC.

For the largely undocumented and new Hispanic immigrant communities, stressors included the sequelae of long, traumatic journeys, the obstacles to economic and social stability created by lack of documentation, and the influence and visibility of anti-immigrant forces and their manifestations in local discomfort over immigrant presence. The impact of these factors is illustrated by reported risk behaviors (e.g. binge drinking and unprotected sex) and the use of any services mainly on an emergency basis. In fact, interviews revealed that when Hispanic immigrant communities connect with local institutions at all, it is usually with the local churches. The reasons for this can partly be explained by the degree of religiosity of these community members, though the sense of "community," refuge and solace these institutions provide cannot be underestimated. In the case of immigrant populations in the more rural locations, religious institutions and leaders were often the only resource available. This finding has clear implications for both research and service agendas.

The West Indian participants, sampled from STI services, provide another perspective on immigrant risks, needs and resources. The roles and responsibilities of

women migrating alone, the norms supporting multiple sexual partners and marijuana and alcohol use, and the reports of domestic violence indicate both research and service priorities.

In fact, health and social services in the two studies that included women (Hispanic and West Indian) illustrated that services were more likely to be available and utilized by immigrant women than men. Women's service utilization generally was not for preventive or general health care but for reproductive health services and/or reporting instances of domestic abuse/violence. Clearly it is seen as more culturally appropriate for women and children to seek care by many ethnic and national groups, both in their home countries and as immigrants. Thus, not only do gender norms influence risk behavior, but also access to information and services, which could facilitate prevention and care for the whole family. The understanding of how traditional gender norms are enacted and undergo change in new environments, fostering preventive as well as risk behaviors, also provides an area of research with much potential to inform policy and programs.

Obviously, these and other issues raised in examining HIV risk factors for immigrant communities are almost universal issues for any prevention policy and program development. They become far more complex, however, in light of the civic and public responses that a city as large and diverse as New York must develop. The success or failure of this City's response to its HIV epidemic, now entering its fourth decade, will likely revolve around the adequacy of our responses to the challenges posed by our City's vital and growing immigrant communities. Thus it is increasingly more urgent not only to obtain and disseminate the demographics and epidemiological information on these diverse constituencies, but also to engage them in communication and partnerships that will foster cross-cultural/institutional understandings and thus more informed and appropriate HIV/AIDS prevention and care.

ACKNOWLEDGEMENT

The research by Drs. Shedlin and Decena at the National Development & Research Institutes (NDRI) was supported by National Institute of Child Health and Human Development (RO1HD42970: Michele Shedlin, PI), with major assistance from local community-based agencies, regional HIV/AIDS networks and committed individuals. Drs. Hoffman and Beckford acknowledge the assistance of Kimberly Bylander and Joanne Mantell in the collection and analysis of the data on West Indian immigrants and the directors and staff who assisted in recruiting at King's County Hospital Center. Their research was supported by a center grant from the National Institute of Allergy and Infectious Diseases to the Columbia-Rockefeller Center for AIDS Research (P30 AI42848: Scott Hammer, PI) and by a center grant from the National Institute of Mental Health to the HIV Center for Clinical and Behavioral Studies at NY State Psychiatric Institute and Columbia University (P30-MH43520: Anke Ehrhardt, PI). Dr. Beckford was supported by a training grant from the National Institute of Mental Health (T32 MH19139; Behavioral Sciences Research in HIV Infection; Anke.Ehrhardt, PI). Dr. Bhattacharya was supported by the Collaborative HIV Prevention Research in Minority Communities Program, Center for AIDS Prevention Studies, University of California, San Francisco (National Institutes of Mental Health Grant 5P50 MH42459). Dr. Bhattacharya thanks Drs. Barbara VanOss Marín and Héctor Carrillo for their comments on analysis of data on Indian immigrants.

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