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HIV sexual risk behaviors and intimate relationships among young sub-Saharan immigrants in Switzerland: A brief report

Objectives: This study explores the intimate relationship context in which sub-Saharan young immigrants (18-25) adopt HIV sexual risk behaviors.

Methods: Qualitative data from 37 in-depth semistructured interviews and 2 focus groups were analyzed through an inductive approach and constant comparative analyses.

Results: HIV sexual risk behaviors occurred in four types of intimate relationships. However, reasons for taking risks varied by relationship type and also depended on material resources, as well as interactional, cultural, and social dimensions related to sexual socialization and migration.

Conclusions: Findings support the importance of considering the intimate relationship context to understand how HIV sexual risk behaviors occur.

Keywords: intimate relationships; HIV sexual risk behaviors; young sub-Saharan immigrants

Introduction

In many European countries, immigrants from sub-Saharan Africa continue to bear a disproportionate burden of sexually transmitted HIV infection (Alvarez-del Arco et al., 2017). In 2015, 29 747 new HIV diagnoses were reported in Europe. Information on

country of origin is available for 25 785 cases. Of these, 9347 (37%) were immigrants, of which 3768 (15%) were immigrants from sub-Saharan Africa (European Centre for Disease Prevention and Control, 2016). In Switzerland, 27% of new HIV infections occurring through penile-vaginal sexual intercourse affect immigrants from this region, although they account for only 1% of the resident population (Ruggia, Bize, & Dubois-Arber, 2013). Most new infections in immigrants from sub-Saharan Africa are reported to have occurred before migration, in the high-endemic countries of origin. However, recent epidemiological analyses suggest that an increasing proportion of immigrants acquired HIV after arriving in Europe (Alvarez-del Arco et al., 2017).

Although this recent transformation of the epidemic raises concerns about the sexual and HIV preventive behaviors of young immigrants in their host countries, few studies have included young African immigrants in their samples (Maticka-Tyndale, Kerr, Mihan, Mungwete, & ACBY Team, 2016; Omorodion, Gbadebo, & Ishak, 2007). These quantitative studies, all conducted in Canada, showed that sexual behaviors among the young African immigrant population are embedded both in the traditional norms and values of their countries of origin and in those of their everyday life in Canada (Omorodion et al., 2007). Findings highlighted that "establishing residency in a modern developed society does not eliminate the influence of patriarchal and oppressive cultural values, norms and beliefs that subordinate women and make them powerless" (Omorodion et al., 2007, p. 435). Results also suggested that among young women, the ability to use condoms with male partners is influenced mainly by socialization, family relationships, and religious systems, whereas among young men condom use is influenced mainly by accumulated sexual experiences (Maticka-Tyndale et al., 2016).

Studies conducted in the United States among adolescents (aged 12-17) (Bauman and Berman, 2005; Feldstein and Bryan, 2015) and young adults (aged 18-25)

(Mullinax et al., 2017; Wildsmith, Manlove, & Steward-Streng, 2015) emphasized the importance of considering the intimate relationship context in order to understand both HIV risk and preventive behaviors. For instance, condom use among adolescents is linked less to length of relationship than to the presence of trust and monogamy, commitment, public awareness of the relationship, and emotional attachment between partners (Bauman and Berman, 2005).

Despite the importance of taking into account the intimate relationship context in which HIV risk behaviors occur, no empirical studies have focused on young sub-Saharan immigrants in Europe. Therefore, the present study addresses the notable lack of research in this population. Using data from multidisciplinary (sociology and sociolinguistics) and multimethod (individual interviews and focus groups) qualitative research, this article explores the intimate relationship context in which sub-Saharan young immigrants adopt behaviors that result in HIV risk. To achieve this, we first analyzed categories of relationships that emerged from individual interviews and discussed those with participants in the focus groups. Second, for each relationship type, we analyzed the reasons for engaging in condomless sexual intercourse.

There is evidence that HIV sexual risk depends on condom use (consistent use, inconsistent use, no condom use), on number and type of sexual partners (primary or occasional partners, same-sex or opposite-sex sexual partners), as well as on type of sex (oral sex, vaginal or anal sex) (Bolweg et al., 2015; Jolly et al., 2016; Koblin et al., 2006). HIV sexual risk might be low, moderate or high (Bolweg et al., 2015). The purpose of this article is to point specifically on inconsistent condom use in penetrative sexual intercourse, what we consider as HIV sexual risk behavior. We will refer to these sexual activities as condomless sexual intercourse.

Methods

Data were collected through 37 in-depth semistructured interviews and 2Focus Group Discussions (FGDs). Participants were between the ages of 18 and 25, first-generation immigrants (born in a sub-Saharan country and migrated to Switzerland after age 10) or second-generation immigrants (born in Switzerland to two parents native to sub-Saharan Africa or migrated after age 10), and reported ever having penetrative vaginal sex. One woman identified herself as bisexual and reported oral sex with women and penetrative vaginal sex with men. All other participants identified themselves as heterosexual and reported exclusively opposite-sex penile-vaginal sexual intercourse.

Participants were recruited through sexual health services, social and health care services for migrants, African associations, and through the snowball sampling.

All individual interviews and the FGDs were conducted in French. The 37 individual interviews lasted between 2 and 5 hours[1], and focus groups lasted 2.5 hours. The individual interviews (May 2016–July 2017) focused on sexual socialization, communication about sexuality, sexual practices, and migration. Discussions in focus groups (December 2017 and January 2018) focused on central topics that emerged from analyses of the interviews: gender and race stereotypes related to sexuality, HIV risk perceptions, and communication about sexuality. Each focus group had five participants: one comprised first-generation immigrants and the other, second-generation immigrants. All participants gave oral informed consent for study participation and received modest financial compensation. The president of the ethics committee at Lausanne University Hospital granted research approval.

[1] We conducted ten interviews in two phases. Since we could not cover all the topics of the interview guide in 2 and a half hours, we invited participants for a second interview. All accepted and the second interview lasted between 1 and a half hour and 2 and a half hours.

Both individual and FGDs were audio recorded, and the three researchers who conducted the interviews transcribed and coded all of them in NVivo 10 (QSR International 10). They independently read the transcripts and noted potential codes. Through collective discussions a preliminary list of codes was created and successively used by each researcher to code each transcript. Difficulties and disagreements were discussed until consensus was reached. Data were analyzed (also with NVivo software) according to grounded theory research (Glaser & Strauss, 1967), using an inductive approach and constant comparative method for coding. Once all transcripts were coded, researchers undertook a comparative analysis of the transcripts to describe commonalities and differences in responses. Data were systematically organized into categories through iterative rounds of data analysis, producing themes and subthemes. A fourth member of the research team, who did not conduct interviews, participated in the analysis, to provide an outside perspective.

Results

Participants in the 37 individual interviews were systematically asked whether they used condom or not during their penetrative vaginal sex. Twenty-nine of them reported inconsistent condom use categorized as occuring regularly, occasionally, or rarely, and was reported by first-generation as well as second-generation immigrants, both young women and young men (Poglia Mileti, Mellini, Sulstarova, Villani, & Singy, 2019).

We identified four categories of intimate relationships described here using the interviewees' own words that have been translated in English: "long-term relationships" (LTR), "friends-with-benefits relationships" (FWBR), "booty-call relationships" (BCR), and "one-night stands" (ONS). Our results showed that risky practices occurred in all four categories, but reasons for not using condom changed from one type of intimate relationship to another.

Love, commitment, and trust in long-term relationships

In the LTR category, respondents reported that relationship length was less important than emotional involvement: "It is when you are really together, for everything, not just for sex. There is also love, fidelity, respect, communication, trust, complicity, all that mixed" (YW2, FG2, age 19, born in Eritrea and migrated at age 10).[2] The assumption of monogamy was also at the heart of this type or relationship: "It has much more to do with exclusivity. When you are in a couple, you don't look elsewhere" (YM3, FG2, age 18, born in Guinea and migrated at age 17)[3].

For almost all respondents who experienced an LTR, they had protected sexual intercourse at the beginning of their relationship, but when the relationship became more established, condom use was discontinued. This happened when the partners felt a strong emotional attachment, which seemed to be independent of relationship length (in weeks or months).

Condom discontinuation was considered an expression of trust. Interviewees did not feel comfortable asking their partner to get tested for HIV. Trust also made them feel sure that their partner was monogamous: "It was serious, I didn't go to look elsewhere, he, he told me that he didn't go to see elsewhere, I trusted him. So, we said to each other that since we are only the two of us, there is no risk" (YW, age 23, born in Switzerland to parents native to Cape Verde). Even if a respondent knew that a partner had condomless sexual intercourse with previous partners, feelings of trust tended to minimize the perception of HIV risk and did not interfere with the decision to

[2] *YW* stands for "young women," and *FG* for "focus group."

[3] *YM* stands for "young man."

discontinue condom use. No differences were found between young women and men, first-generation or second-generation immigrants.

Desire, feelings, and fairness in friends-with-benefits relationships

Friends-with-benefits relationships were reported more from young people born in Switzerland or migrated at a young age (0–10 years) who described these as relationships in which two friends or "buddies" have sex. When they saw each other, friends with benefits engaged or not in sexual activity: "Sex friends, you are still friends. I mean, if one day you see that you don't have sex, you can still spend a day together" (YW2, FG1, age 22, born in Switzerland to parents native to Congo). Partners engaged in a FWBR were expected to be secretive and to avoid becoming emotionally involved, and monogamy was not expected: "When you are a sex friend, you must not count on being faithful. This means that you agree that it is like an open couple" (YW2, FG2, age 19, born in Eritrea and migrated at age 10).

Three reasons for condomless sexual intercourse in FWBR were identified. The first was the strong desire to have sex despite condom unavailability. The second was the presumption by some male interviewees that they could "feel" whether their partner was healthy or sick, after having investigated her sexual past.

The third reason for condomless sex in FWBR was "fairness." When interviewees felt that their partner was honest, as they believed a friend is supposed to be, they confided that they were not afraid to have condomless sex with him or her:

> At that moment, I don't think I took risk with him, because . . . actually, I thought he's someone honest about it. So, I didn't worry. . . . He told me [he got tested] . . . OK, he didn't show me the test, but he told me. (YW, age 22, born in Togo and migrated at age 11)

Condom unavailability and secrecy in "booty calls"

Like FWBR, booty-call relationships were also reported more by young people who were born in Switzerland or who migrated at a young age. Although BCR partners might share social activities (e.g., going out for a drink, going to the movies), sexual activity was central and happened repeatedly: "As I understand booty calls, you call each other, you do it two, three, or more times, but it is not someone who you just met, you did it and it's over" (YM1, FG2, age 24, born in Cameroon and migrated at age 5). BCR were not sexually exclusive.

Not having condoms available was the main reason for condomless sexual intercourse in the BCR category: interviewees had not bought condoms and/or did not have them on hand. Analyses showed that family expectations of virginity until marriage played a role, especially for young women, independent of whether they were born in Africa or in Switzerland. These expectations made female interviewees feel compelled to be involved in what they called "secret relationships" and made it more difficult for them to buy and have condoms on hand:

> No . . . even today, I never took the initiative to have condoms on hand, simply because I am so scared that my mother fell out of them, that she asks me questions. . . . [I]t is the confrontation with my mother. (YW, age 24, born in Switzerland to parents native to Congo)

Condom unavailability, no fear, and no request in one-night stands

Interviewees described one-night stands (ONS) as different from FWBR, because the focus was on the physical dimension of the interaction: "We just use the body and at the level of the relationship there is nothing, there is no friendship" (YW2, FG1, age 22, born in Switzerland to parents native to Congo). ONS also differed from BCR in that they occurred just once, between persons who did not know each other and so were not sexually exclusive.

There were three main reasons for condomless sex in ONS. The first was not having condoms available, which affected both young men and women, born in Africa or in Switzerland. The second reason pertained only to young men born in Africa who had migrated after age 15: "I don't think about, I don't fear it [AIDS]" (YM, age 20, born in Eritrea and migrated at age 16). These young first-generation immigrants had a biased perception of the Swiss HIV/AIDS epidemic. The invisibility of AIDS, thanks to available medical treatments, led them to feel that they were living in a safe environment with respect to HIV.

The third reason for engaging in condomless sex in an ONS was reported by some male respondents who said that their partner did not ask for condom:

> I would take protective measures, but if a girl says to me, "Let's do without," it would be difficult to convince her to do . . . me too, I don't like very much condom, because there are condoms that smell very strong, quite embarrassing. (YM, age 19, born in The Gambia and migrated at age 16)

Discussion

The objective of this study was to explore the intimate relationship context in which young sub-Saharan African immigrants take HIV sexual risks by engaging in condomless penetrative vaginal sex with a partner whose HIV status is unknown to them. Results show that these HIV sexual risk behaviors occur in different intimate relationship contexts and affect young women and men, first- and second-generation immigrants. Our analyses demonstrate that the intimate relationship context in which sexual intercourse takes place is much more complicated than the binary classification of long-term or romantic versus occasional or casual relationships. Results on FWBR, BCR, and ONS are in line with those of Wentland and Reissing's (2011, 2014) works on casual sexual relationships among youth. Both names and descriptions of these

relationships are close to those that we found, meaning that they apply also for young immigrants.

On HIV sexual risk behaviors, our results contribute some important findings to research outlining the importance of taking into account the relationship context in which condomless sexual intercourse occurs (Bauman & Berman, 2005). First, young immigrants of sub-Saharan origin do not have condomless sex only in LTR, when partners become more intimate, which is well documented in previous studies on youth (Wildsmith, Manlove, & Steward-Strang, 2015). Condomless sex also occurs in FWBR, BCR, and ONS.

Second, analyses highlight that reasons for HIV sexual risk behaviors change from one type of intimate relationship to another. However, two tendencies emerged. In the context of LTR and FWBR, reasons are more emotion oriented, whereas in the context of BCR and ONS, condomless sex is more related to structural, social, and material factors. These include sexual norms around virginity and not having condoms available (for many reasons, such as embarrassment in buying condoms, not thinking to have condoms on hand, the cost of condoms, and fears that parents could discover condoms), and more specifically for first-generation immigrants gender inequality and knowledge about the Swiss HIV epidemic.

Third, results indicate that feelings of trust, which may lead to condomless sexual intercourse, are independent of relationship length and concern both LTR and FWBR. Yet the assumption of monogamy is a characteristic only of LTR. Therefore, trust in FWBR refers to the fact the partner uses condoms when having sex with other partners. From this perspective, FWBR is an intimate relationship context with higher HIV risk than LTR, as are BCR and ONS.

Our results are not in line with those of Beltzer, Lagarde, Wu Zhou, Vongmany, and Gremy (2005), who found that fear of HIV among adult migrants (aged 18-69) from sub-Saharan Africa living in France is three times higher than in the general population. This is due to stigma associated with HIV that, from the perspective of these migrants, is strong in their communities of origin. A possible reason for this difference is that our study population was exclusively composed of young adults (aged 18-25). Indeed, our results are consistent with other studies on young adults (Mullinax et al., 2017), who fear pregnancy more than they do HIV. Our findings also differ from those of Marsicano, Lydié, and Bajos (2013), who demonstrated that less frequent condom use is associated with a longer relationship and cohabitation with the partner. Analyses presented here show that inconsistent condom use is largely associated with love, commitment, and trust rather than relationship duration. Once again, this difference is probably due to the age of our interviewees, who were younger than participants in the cited studies. Nevertheless, our findings also show that emotions and feelings are not enough to explain HIV sexual risk behaviors. Gender inequalities and socially transmitted sexual norms play a role as well.

This study has some limitations related to method, recruitment, and sample. The qualitative nature of this research does not allow for generalizing findings beyond the sample. Self-reported condom use in an interview setting can be subject to social desirability bias. Other bias related to the interviewers' sociodemographic characteristics (three white women, in their thirties and forties, with a migration background for two of them) and recruitment strategies (intermediate networks and snowball sampling) cannot be excluded. Finally, despite researchers' considerable efforts to recruit LGBT+ young immigrants, only one woman self-identified as bisexual. All other participants identified themselves as heterosexual.

HIV prevention programs with young immigrants from sub-Saharan Africa should address the various intimate relationship contexts in which condomless sexual intercourse occurs. Barriers to accessing and using condoms should be addressed. HIV prevention programs with these young immigrants should also consider gender differences, as well as differences between first-generation and second-generation immigrants. Further research is needed to better understand how gender inequalities and socially transmitted sexual norms play a role in HIV sexual risk behaviors among young sub-Saharan immigrants.

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