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'If you know the person, there are no risks': 'in-between' strategies for reducing HIV sexual risk among young sub-Saharan migrants living in Switzerland

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In the past decade, theoretical essays have criticised the dichotomy of rational and irrational strategies for managing risk as neglecting an entire range of strategies that individuals mobilise in everyday life. Neither completely rational nor irrational, 'in-between' strategies rely on the use of knowledge and previous experiences, as well as trust, intuition, and emotion. Drawing on data from a multidisciplinary (sociology and sociolinguistics) and multimethod (in-depth interviews and focus-group discussions) qualitative research conducted in 2016–2018 among young sub-Saharan migrants living in Switzerland, this article explores the potential of, and provides empirical relevance for, the concept of in-between strategies in HIV/AIDS research. We argue that strategies for managing HIV sexual risk may not be fully rational, because individuals mobilise them in their social interactions. Indeed, from a sociological perspective sexual activity is a social experience that involve attitudes, practices, intimate relationships, and emotions. Strategies for managing HIV sexual risk depend on power relations between partners, as well as on the social competences and resources of each partner. We found that young sub-Saharan migrants use in-between strategies, which involve rationalisation, knowledge, experience, feelings, and emotions. Our findings highlighted five types of HIV sexual risk-reduction strategies: consistent condom use, HIV testing before discontinuing condom use, selection of partners and investigation of their sexual history, the feeling of familiarity with a partner, and commitment and trust in intimate relationships. Our analysis showed that the in-between strategies concept is particularly useful for capturing the complexity of social processes involved in individuals' HIV sexual risk management.

Keywords: risk management; risk-reduction strategies; in-between strategies; HIV/AIDS; migration

Introduction

In 2017, 15% of new human immunodeficiency virus (HIV) diagnoses reported in Europe were among migrants (European Centre for Disease Prevention and Control, 2019). Some ethnic communities of migrants may be more vulnerable to HIV infection

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as a result of a higher prevalence in their countries of origin (Amo et al., 2009; Yin et al., 2021). This is the case, for example, of migrants from sub-Saharan Africa living in Europe. Compared to the resident population and migrants from other countries and regions, migrants from sub-Saharan Africa continue to bear a disproportionate burden of HIV (Gosselin et al., 2020; Koschollek et al., 2020; Loos et al., 2017). Regarding the context of the HIV infections, recent epidemiological data collected in many European countries, including Switzerland, indicate that an increasing proportion of sub-Saharan migrants acquired HIV after arriving in Europe (Alvarez-del Arco et al., 2017).

There are many reasons for post-migration HIV infections. For example, post-migration infection might be a result of 'African sexual networks,' defined by Marsicano, Lydié, and Bajos (2013) as racially bounded social networks that transcend national origin (p. 819). Consequently, migrants from countries with low HIV prevalence have sexual intercourse with migrants from countries with high HIV prevalence, thus contributing to the epidemic among migrant populations in Europe. Post-migration HIV infections might also be a result of hardships faced by migrants (Desgrees-du-Lou et al., 2016). Indeed, hardships increase HIV risks, especially for women without stable housing. Recent studies highlighted structural barriers to HIV prevention due to immigration policies that restrict access to the health care system (Fakoya et al., 2018; Poglia Mileti et al., 2022). These studies have emphasised the importance of considering living conditions in receiving countries, as well as migrant's legal and social context. This consideration allows for the creation of distance from the very stigmatising conception of 'risky' or 'threatening' migrants.

Post-migration HIV infections raise concerns about migrants' sexual and preventive behaviours in the receiving countries. Studies conducted in sub-Saharan Africa (Davidoff-Gore et al., 2011; Moyo et al., 2008; Negeri, 2014) as well as in Western countries to which sub-Saharan people migrate (Mitha et al., 2009; Omorodion et al., 2007; Poglia Mileti et al., 2019) showed many barriers to condom use among migrant populations. These barriers include male partners' reluctance to use condoms because of a perception of reduced pleasure, female partners' inability to negotiate condom use, commitment and trust in intimate relationships, lack of accurate knowledge about HIV transmission, and lack of awareness about an HIV epidemic in receiving countries. These barriers to consistent condom use put sub-Saharan migrants at risk of contracting HIV. However, as we show here, these barriers may also lead migrants to alternative constructions of safety that reduce this risk.

Strategies to reduce HIV risk may be related to a rational analysis of the situation, but using elements that could be considered irrational or non-rational. The purpose of this article is to show the potential of the concept of 'in-between strategies' (Zinn, 2008; 2016; 2019) in the HIV research – that is, strategies that are neither rational nor irrational, but rather are based on prior knowledge and experience as well as feelings and emotions. Using data from recent qualitative sociological research conducted among young sub-Saharan migrants living in French-speaking Switzerland, we provide empirical relevance to the concept of 'in-between strategies'.[1] We explore strategies that these young migrants mobilise in order to reduce HIV sexual risk. More specifically, as previous studies highlighted gender differences in risky sexual behaviours (Collado et al., 2015), our intention is to understand whether gender differences are also relevant in HIV risk-reduction strategies. In addition, as studies conducted with migrants have stressed the need to distinguish generation and age at migration in order to understand

migrants' health behaviours (Hussey et al., 2007; Kramer et al., 2013), we investigate differences between first- and second-generation migrants.

The social construction of HIV sexual risk and safety

While international HIV prevention programmes include condom use among highly effective methods for reducing HIV sexual risk (UNAIDS, n.d.), studies conducted in sub-Saharan Africa have revealed inconsistent condom use among young people (Moyo et al., 2008; Negeri, 2014). Reasons for this are complex and intersecting, involving cultural and socioeconomic dimensions (Moyo et al., 2008), as well as education level and peer pressure (Negeri, 2014). Moreover, these dimensions intersect with individuals' own perceptions: Kuumuori Ganle (2016) stated that, even though awareness of the HIV epidemic and the risk of HIV infection is very high among sub-Saharan youth, a combination of hegemonic masculinity and perceptions of personal invulnerability affect individuals' HIV risk construction and preventive behaviours.

Inconsistent condom use is also an issue that concerns young African migrants living in Western countries (Poglia-Mileti et al., 2019; Maticka-Tyndale et al., 2016; Mitha et al., 2009; Omorodion et al., 2007). Barriers to condom use in this youth population are multidimensional and embedded, and an understanding of inconsistent condom use among African migrants must take into account social, cultural and religious dimensions. For instance, gender inequalities increase the risk of HIV infection among young women. Because of socially constructed male dominance, women may find it difficult to negotiate condom use (Omorodion et al., 2007). Other reported barriers to condom use among young male and female migrants involve a lack of adequate knowledge about HIV transmission, lack of awareness about the HIV epidemic in the receiving country, family-transmitted sexual norms and parental control, perceptions of condoms causing reduced pleasure, and issues of relational commitment and trust (Poglia Mileti et al., 2019).

Along with sexuality, safety and HIV risk are also socially constructed. Despite vigorous scientific and medical debates about risk, the definition of risk is still contested (Aven & Renn, 2009). According to the constructivist approach to risk (Bajos & Marquet, 2000), risk (perception) is a social construction that depends on individual characteristics (such as age, gender, socioeconomic status) as well as socioeconomic, cultural and political context (Körner et al., 2005). Individuals construct their own definition of HIV sexual risk, 'drawing on the epidemiological and preventive discourse, but also, and more importantly, according to their social position, personal identity and type of sexual relationships in which they are engaged' (Bajos et al., 1997, p. 26).

This leads us to consider more generally the relationship between risk and risk perception. For some authors, risk and risk perception are different (Campbell, 2005; Rosa, 1998); for others, they coincide (Beck, 1986, p. 55): 'because risks are risks in knowledge, perceptions of risks and risk are not different things, but one and the same.' According to the constructivist approach, we assume that risk 'does not exist independent of the assessor, as the uncertainties need to be assessed by somebody" (Aven & Renn, 2009, p. 8). Thus, risk perception "is based on personal beliefs, affects and experiences irrespective of their validity' (Aven & Renn, 2009, p. 6).

Finally, from an individual's perspective, any risk is related more to the future than the present: 'Risk, because it involves an incipient rather than a realised threat or danger, is about projecting ideas into the future, about imagining the consequences of an action

or event' (Lupton, 2013, p. 638). Indeed, 'risk refers to uncertainty about and severity of the events and consequences (or outcomes) of an activity with respect to something that humans value' (Aven & Renn, 2009, p. 6).

Strategies for constructing sexual safety and managing HIV risk

Policies around HIV and acquired immune deficiency syndrome (AIDS) focus largely on rational strategies to construct ideas of safety and to reduce HIV sexual risk. Such rational strategies based on epidemiological and preventive discourse include condom use (UNAIDS, n.d.). Condoms are the cornerstone of HIV prevention and sexual health campaigns. However, studies conducted with a narrative approach (Körner et al., 2005, p. 358) have shown that 'discourses of risk should not be seen in dichotomous terms of "rationality" versus "irrationality", or "control" versus "lack of control", but rather hybrid discourses of control are enmeshed with other discourses.' Studies on HIV sexual risk also show that individuals adopt hybrid strategies to manage this risk that depend on their gender, socio-sexual biography, social networks and context of the intimate relationship (Bajos et al., 1997).

These previous studies suggest the importance of going beyond the rational strategies promoted in HIV prevention campaigns to understand how individuals deal with HIV sexual risk. For this purpose, the concept of in-between strategies as developed by the sociologist Jens Zinn (2008; 2016; 2019) is particularly relevant. When taking decisions to manage risk and uncertainty, besides 'rational' or 'irrational' decision making, individuals may use a third category of strategies: in between. According to Zinn (2008, p. 439), the dichotomy of rational and non-rational (or irrational) strategies neglects many 'everyday approaches to risk that are neither completely rational nor irrational as they may involve the use of prior knowledge and experience. These *in between strategies* include the use of emotion, trust and intuition to make decision.'

Whereas trust and intuition involve feelings and emotions, individuals' sociocultural environment mediates emotions (Giddens, 1991): 'Since emotions are linked to a variety of socio-cultural values, trust and intuition are not just influenced by the available knowledge but also by the ways in which they are embedded in the culture and social relations' (Zinn, 2008, p. 445). They consist in 'estimations based in feelings-take place not through the understanding, but through the imagination and more immediately through sensation' (Lash, 2000, p. 53). Emotions play a significant role in influencing how individuals tackle risk (Lupton, 2013; Slovic, 2010; Tulloch & Lupton, 2003).

Seen in this way, in-between strategies follow their own logic – not a cause-and-effect logic – that is adapted to circumstances and that works through analogy: 'a situation or event is like a previously-experienced situation and therefore the decisions, actions, and feelings from the previous situation are pertinent to the current situation' (Zinn, 2008, p. 446). In-between strategies are 'reasonable strategies': 'an important element in our understanding of how people in everyday life mobilise different resources to manage risk' (Zinn, 2016, p. 350).

In our study, we conceptualised in-between strategies for reducing HIV sexual risk as reasonable ways to manage HIV risk in the context of sexual relations. These in-between strategies are based on young migrants' knowledge of sexual transmission of HIV, as well as prevention methods such as condom use and HIV testing. They are also based on prior sexual experiences: risk-taking experiences related to unprotected sex might lead

young migrants towards one protective strategy over another. Finally, in-between strategies for reducing HIV sexual risk include feelings and emotions. These strategies, adopted in the context of an intimate relationship, also draw on emotion, trust, love and commitment. The aims that we seek to achieve through the use of this conceptualisation is to capture the complexity of protective strategies for HIV, which involve knowledge, experiences, and feelings.

Methods

A multimethod investigation

We collected data through 47 in-depth interviews (Kvale & Brinkmann, 2009) and two focus-group discussions (Hennink, 2007), each with five participants. All participants gave oral informed consent for study participation and received modest financial compensation at the end of the study. The president of the ethics committee at Lausanne University Hospital granted research approval after validating our ethics plan (including anonymity of interviewees, confidentiality of the data, informed consent).

Before preparing the individual interview guide and recruiting participants, we held an advisory group meeting to discuss issues related to recruiting strategies, the interview setup, and the interview guide. Five experts in sexual health and migration, three of whom were members of African local associations and communities, participated in the advisory group. They provided us with important suggestions on methods and locations for contacting sub-Saharan African migrants. With them, we discussed ethnic-sensitive approaches, as well as strategies for talking about intimate issues.

After this advisory group, the three researchers who conducted interviews participated in many events involving local African associations and communities for networking purposes. Thanks to those encounters in a vast variety of contexts, the researchers gained access to some key gatekeepers who facilitated contact with potential participants. These persons were either professionals working in the fields of migration and sexual health or influential members of African-immigrant communities. To complete the sample, we used snowball sampling (Browne, 2005) to draw on interpersonal relationships and connections between people. Because of the sensitivity of the topic, this technique was particularly efficient for accessing hard-to-reach populations (Atkinson & Flint, 2001).

The 47 individual interviews lasted between 2 and 5 hours, and the focus-group discussions were 2 hours and 2.5 hours, respectively. The individual interviews focused on three main themes: socialisation and communication about sexuality and sexual health, sexual practices, and migration. Indeed, the larger study from which the data presented here are drawn, had three main objectives. First, it aimed to describe the practices and representations of young sub-Saharan migrants regarding sexuality and HIV, and to explore the influence of representations on their preventive and risky behaviours. Second, the study aimed to understand the sexual socialisation of these young people and identify the role of various socialisation agents (such as family, peers, school). Third, the study aimed to describe communication with sexual partners and socialisation agents, as well as to identify the functions of choice of language (whether in French or African languages, for example).

Within each of the three themes discussed in the interviews, the interviewers allowed interviewees to organise their stories as they wished. If the three themes were not

revealed after 2 or 2.5 hours of interviewing, the interviewers asked participants if they were interested and available for a second interview. This was the case for 11 participants, who told interviewers how much they appreciated being able to talk about their intimate relationships in a relational context of trust and non-judgment.

The in-depth, semi-structured individual interviews occurred between May 2016 and July 2017, and the two focus-group discussions took place in December 2017 and January 2018. Eligible participants were between the ages of 18 and 25, were born in a sub-Saharan country or in Switzerland to two parents native to sub-Saharan Africa, and lived in French-speaking Switzerland. We considered as first-generation migrants (FGMs) young people born in a sub-Saharan country who migrated after age 10, and second-generation migrants (SGMs) young people born in Switzerland to two parents native to sub-Saharan Africa or born in a sub-Saharan country who migrated before age 10. Participants in the first focus-group discussion were SGMs, whereas participants in the second focus-group discussion were FGMs.

We are aware that the terms 'first- generation' and 'second- generation' raise scientific and social debates, especially 'second generation', which has been criticised for its stigmatising effect (Santelli, 2004). We have shown in previous research that individuals either accept or reject this term, depending on the interactions and the social context in which it is used (Poglia Mileti, 2018, 2019). It is nevertheless true that the term 'second generation' tends to imply that the migrants' country of birth does not recognise their children as citizens (Chimienti et al., 2021). While we understand these critiques, and follow them generally, here our use of the terms of 'first generation' and 'second generation' specifically refers to the Swiss context. In official statistics, these terms are used to distinguish people who migrated to Switzerland and people born in Switzerland to migrant parents. Most 'second generation' migrants are not Swiss, unless they have applied for and obtained Swiss nationality, or one of their parents is Swiss. For our purposes, whether or not one is born in Switzerland is relevant to understanding (early) socialisation with regards to sex and sexuality.

Because the larger study aimed to analyse socialisation and communication on sexuality, we chose participants whether or not they had initiated sexual activity before. However, because this article focuses on strategies to reduce HIV sexual risk, our analyses are drawn from the 37 individual interviews with participants who referred to having previously engaged in sexual intercourse. Half of the participants identified as women ($N = 19$), and the other half identified as men ($N = 18$). With the exception of one woman who self-identified as bisexual, all other respondents self-identified as heterosexual. Twenty-six young people were born in Africa and 11 in Switzerland. Twenty-four participants held Swiss nationality or a long-term residence permit, 12 participants had a temporary permit, and one participant was undocumented. The vast majority of participants were students or apprentices ($N = 28$), eight participants were employed and one respondent was in search of employment. Four participants had a primary education level only, 11 participants had a secondary education certificate, and 22 participants had completed high school education. Table 1 provides more detailed information on the sociodemographic characteristics and sexual experiences of these participants.

In order to consider the understandings of intimate relationships and HIV/AIDS, as held by young people with a migration background from sub-Saharan Africa, we also use data from individual interviews with participants who were not sexually initiated as well

Table 1. Sociodemographic characteristics of sexually active interviewees (n = 37).

Variable		n	%
Gender	Female	19	
	Male	18	
Age in years	18–21	16	
	22–25	21	
Place of birth	Africa	26	
	Switzerland	11	
Age of immigration	0–5	5	
	6–10	5	
	11–15	5	
	16–20	8	
	21–25	3	
Immigration status	Nationality	17	
	B permit	7	
	C permit	7	
	F permit	3	
	N permit	2	
	Undocumented	1	
Relationship status	In a relationship	14	
	Single	23	
Age at sexual debut	12–15	7	
	16–21	30	
Number of sexual partners	1–5	29	
	6–15	5	

(*continued*)

Table 1. (*Continued*).

Variable		n	%
	25–50	3	
Sexual orientation	Heterosexual	36	
	Bisexual	1	
Condom use	Consistent	6	
	Inconsistent	29	
Employment status	Employed	8	
	Unemployed/searching for apprenticeship	1	
	Apprentice	5	
	Student	19	
	Traineeship/upgrade courses	4	
Degree of education	Primary	4	
	Secondary	11	
	High school	22	
Religion	Catholic	16	
	Muslim	7	
	Protestant	5	
	Orthodox	5	
	Evangelical	1	
	Agnostic	2	

Notes. Participants came from 17 countries: Angola, Burundi, Cameroun, Cape Verde, Congo, Eritrea, The Gambia, Ghana, Guinea, Ivory Coast, Nigeria, Rwanda, Somalia, Senegal, Sudan, Togo, and Zimbabwe. Permit B is a residence permit, permit C is a settlement permit, permit F is a permit for provisionally admitted foreigners, and permit N is a permit for asylum seekers. For more information, see the website 'Entry and Stay in Switzerland,' at https://www.ch.ch/en/entry-stay-switzerland.

as from focus-group discussions. These collective interviews focused on gender and race stereotypes as related to sexuality, HIV risk perceptions, and communication and language about sexuality.

Both individual interviews and focus-group discussions were audio recorded, and the three researchers who conducted the interviews transcribed and coded all of them in NVivo 10 (QSR International 10). We independently read the transcripts and noted potential codes. Through face-to-face team discussions, we created a preliminary list of codes and successively used it to code each transcript. In case of difficulties or disagreements, we discussed until a consensus was reached.

To analyse our data, we used an inductive approach and constant comparative method, following grounded theory research (Glaser & Strauss, 1967). We constantly compared each transcript to find commonalities and differences in responses. More specifically, we systematically organised data into categories through iterative rounds of data analysis, in order to produce themes and subthemes. Afterwards, with further data collection, we refined emerging categories and added new ones (Corbin & Strauss, 2008). Our analysis continued until we reached thematic saturation, that is, the point at which further interviews produced little or no significant information relative to the study objectives.

Reflexivity and validity

Given the intimacy of the topic and the ethical dilemmas of investigating HIV-related topics among people of sub-Saharan origins (e.g., the risk of stigmatising participants), throughout the research process we aimed to adopt a sensitive and reflexive approach. This was reflected, for example, in the several exchanges (such as via WhatsApp messages, mails, and calls) that we had before the interviews with potential participants, to ensure their understanding of the study's aims and their voluntary participation. We then asked participants to decide where they wanted to be interviewed. During the interview, we put a lot of care into building a relationship of trust so that the participants felt comfortable expressing what they wanted to share with us and interrupting the interview at any time.

More generally, we implemented some methodological strategies and resources developed in a previous study that we conducted on HIV-positive sub-Saharan migrant women (Villani et al., 2014; 2015). The advisory group had been part of these strategies and resources, as were methodological notes that each of the three researchers who conducted interviews wrote regarding each participant and interview context. In the notes, we systematically analysed age, gender, race and class differences between the participant and interviewer, as well as their impact on the interview's exchange and content. Then we read these notes and discussed them in our face-to-face collective meetings.

In order to improve the validity of our findings, instead of using triangulation methods, we used multiple analytical perspectives, taking advantage of the presence of three researchers who were in the field while two others in the team were not; while three researchers were sociologists and two sociolinguists. The three researchers who conducted the individual interviews read each transcription and identified relevant themes in interviews. Then, they compared each theme with themes identified by the other

researchers. Finally, from selected themes, these researchers produced intermediate analyses and discussed them within the wider research team.

Findings

The young migrants in our research described adopting five different strategies to manage HIV risk: consistent condom use, HIV testing before discontinuing condom use, careful selection of partners and investigation of their sexual history, feeling of familiarity with a partner, and commitment and trust in intimate relationships. Young migrants often referred to mobilising more than one strategy over time or combining different strategies at the same time. The strategies varied across the sample, also according to participants´ age and sexual experiences, as well as the type of intimate relationship in which they engage.

Consistent condom use

Young participants who reported consistent condom use (8 out of 37) presented this preventive practice as 'logical,' 'normal,' 'self-evident' and 'loud and clear.' Some young people considered condom use a 'habit.' This was the case of Keyran[2] (23 years old, born in Switzerland to two parents native to Somalia), as indicated when talking about sexual intercourse that occurred during his 3-year-long intimate relationship:

> It [condom use] was really integrated in the habits—yes, we did not really ask ourselves the question. Actually, we both had our habit [of using condoms]. We had our habit and everything was going fine … We even did not have to discuss [it]. We just talked before the act … 'OK, let's [use] the condom, which one?'

Second-generation migrants reported more consistent condom use than did FGMs. Among SGMs, condom use was a topic brought up primarily by women, with the exception of some male interviewees who described their couplehood as based on egalitarianism. They said that they felt comfortable talking about condoms and negotiating their use with partners, which was not the case for FGM women. Indeed, many FGM female and male interviewees reported that their socialisation occurred in cultural contexts where only men made decisions about sexual issues. This male predominance it was commonly referred to as making it difficult for young women to negotiate condom use during sexual intercourse. FGM women and men agreed that condom use was a matter specific to men, as mentioned by Sam (24 years old, migrated at age 25 from Eritrea): 'With us, it's not women who bring condoms. It is always the man.'

HIV testing before discontinuing condom use

Some SGMs with a higher education degree and experience being in a couple that they perceived as more communicative (four participants) reported talking about HIV testing before discontinuing condom use in the context of what they considered 'long-term' or 'serious' relationships. Among the four participants, no one reported getting tested together with her or his partner: each partner got tested individually. With respect to asking for results, only one participant, Megan (19 years old, migrated at age 9 from

Cameroon), reported that she asked her partner to see his HIV test result. When her partner, with whom she had been in a couple relationship for one year, asked her to abandon condom use, she told him:

> I don't sleep without [a] condom! That's excluded, as long as I don't have the test sheet [the test results] under my eyes!" . . . We do the test, both. It's imperative! I do the test, he does the test, and we show each other the results.

The other three participants said they did not share results with their partner and their partner did not share results with them. This was a matter of trust, as Emma (24 years old, born in Switzerland to two parents native to Cape Verde) explained:

> Actually, I told . . . myself that . . . I think that it is also for this reason that I didn't want to ask him [for] a sheet that states that [the results] . . . because . . . I think that I felt as I was asking him to prove something, [which] he did not ask me for . . . I didn't want to give him the impression that I didn't trust him.

If participants considered 'feeling trust' as 'normal' in a serious or long-term relationship, then this appears to be a logic that precluded them from asking to see the HIV test results. It appears, then, that trust was an important nonrational dimension that played a role in strategies for managing HIV risk.

Selecting partners and investigating their sexual history

In order to reduce HIV risk, some male SGMs reported being careful and precise in 'selecting' their partners. Selection proceeded through two operations. First, they were looking for what they called a 'serious' person in their social networks, at school, among friends or in their neighbourhood. This was the case of Abel (20 years old, born in Eritrea and migrated at age 1). During the interview, he stated: 'I'm sure about me'. When asked how he could be sure about his partner, he answered: 'You have to know the person . . . if the person is serious, you know her a little bit, you know her frequentations, you can evaluate her.'

Second, partners' selection consisted in investigating the potential partner's reputation in such networks, avoiding 'easy girls.' An SGM man (21 years old, born in Switzerland to two parents native to Eritrea) who participated in the first focus-group discussion described this process:

> Often our friends know the person and they can say "she's in my class, she has this kind of frequentations, she's famous for being an easy girl . . . " And then, you have to judge . . . you have to handle . . . this information [and decide what to do] . . .

Selecting a 'serious person' might be a strategy used on its own or in combination with another strategy that interviewees adopted later, when the potential partner became real: talking with the partner about his or her sexual past. The same young man explained:

> But then we ask each other questions. It is not just through friends and rumours that we judge the person. We ask each other how many partners we had . . . who were our partners . . . if we knew them, things like that.

Clara (23 years old, born in Switzerland to two parents native to Cape Verde), the only female participant in this category, also reported adopting this strategy, which involved talking with the partner about his partner's sexual past:

> He said to me that he was not protecting himself all the time. He had many, let's say, conquests, and he said to me that he did not always use [a] condom. If the girl obligated him [to], he used it. If not, well, he did not protect himself. If the girl did not ask for [it], he, here, he did without.

Even if Clara knew that her partner had unprotected sexual intercourses in the past, she reported not asking him to undergo HIV testing before stopping condom use. After assessing her partner's risk of contracting HIV, she decided that he could be an 'acceptable' partner compared to others, because he had 'just some' unprotected sexual intercourse.

Feeling of familiarity with a partner

Some participants said they felt that they knew their partner well, because they attended the same class, lived in the same neighbourhood, or met during events organised by their own community, or because the partner was a friend of a friend: 'the buddy of my buddy,' to use one interviewee's expression (Souma, 20 years old, migrated from Sudan at age 16). Since then, independently of the relationship's type and duration, they felt that they were not at risk of contracting HIV when having unprotected sexual intercourse with the partner. Among FGMs and SGMs, both young women and young men reported feeling of familiarity as affecting their risk assessment.

However, feeling of familiarity associated with unprotected sex could expose participants to different degrees of risk depending on partner profile (including, age, number of past sexual partners, concurrency in partnerships or not), as well as the type of the intimate relationship in which unprotected sexual intercourse occurred. Indeed, HIV risks were described as being greater in relationships that participants considered 'friends with benefits,' 'booty calls' and 'one-night stands' than in 'long-term' or 'serious' relationships, because in these relationships sexual exclusivity was not expected (Mellini et al., 2020). So, as Keyran (previously presented) explained, he felt safe with his partner and trusted her, because he knew her since school. On the contrary, he would not feel safe with a person he did not know:

> K: I asked her if she was OK, if her body was healthy, if everything was OK, and she reassured me [it was]. I was reassured in the moment, when she said she had nothing.
>
> Interviewer: So, did you rely on what she said?

K: Yes.

> Interviewer: And that's enough, do you think?
>
> K: Actually, it depends on the situation. Let's say that if you are in a nightclub and you don't know the girl, [then] actually not. There I think that speech doesn't count, you don't know the person.

Commitment and trust in intimate relationships

While logics of familiarity and knowledge of others were common across the participants, deeper feelings of commitment and trust were discussed more by young women than by young men, regardless of their first or second generational status. As one young woman explained in the first focus-group discussion, trust appeared to be an essential condition for having sex: 'I think that a relationship is two persons and then, actually, I find that to have sex with someone, you have to totally trust him. That's why for me, one-night stands are inconceivable.'

Participants who engaged in long-term relationships mostly reported commitment, whereas participants involved in relationships they considered 'friends with benefits' or 'booty calls' reported trust (Mellini et al., 2020). Specifically, participants who were engaged in long-term relationships considered commitment a distinctive feature of their intimate relationship, which they also referred to in terms of being 'serious'. From their point of view, commitment consisted in taking responsibility for making the couple relationship work and in taking care of the partner, including aspects of love and sex. According to the experiences reported by the participants, though, trust was not related to the duration of an intimate relationship. It had much more to do with feelings and emotions. One partner could feel trust in the other partner even if the two had known each other for a short time. For example, Syra (22 years old, born in Switzerland to two parents native to Congo) told us:

> When I had this [incident of] unprotected sex, it was with a person that I didn't know for a long time, but he clearly . . . I don't know, he told me that he got tested and that he had just one girlfriend before me. But then actually, I started to freak out, and he [did] too, he freaked much more than I did. He told me that he really, really feared [the consequences]. He called me every day to ask me if I got tested or not, and actually that's exactly what comforted me, because I trusted him, he trusted me, and that was important.

Participants who experienced long-lasting relationships said they commonly stopped using condoms after some months into the intimate relationship. This occurred when participants felt they 'knew' their partner and trusted them, as Kelya (24 years old, born in Switzerland to two parents native to Congo) explained:

> K: It is clear that at the beginning of a relationship, I like using [a] condom. Later I say to myself that when I know the person, and . . . I know that he hasn't disease, that he is clean, finally, I think this way . . . then, I don't see any problem, since I see that the person doesn't have problems, that he doesn't go looking elsewhere.
>
> Interviewer: How do you know that the person is 'clean', as you said?
>
> K: Actually, I have the idea that at first, it is necessary to protect herself [*sic*], because it is necessary to know the person. I have the idea that if I trust the person and if the person trusts me, I don't see why he's going to lie to me in the end, because we start from a principle, from a mutual trust.

Besides the duration of the relationship, participants explained that the feeling that the partner was on good terms with their parents could also reinforce commitment and trust. This was the case of Emma (previously presented): 'Knowing that he had a very good relationship with my parents, I said to myself, he's not going to disappointing us . . . he will maybe be the person with whom I will get married.'

Discussion

This study has some limitations related to type of data. More specifically, limitations are due to method, participants' recruitment and the sample. First, although we used a multidisciplinary and multimethod approach, the qualitative nature of this research does not allow for findings to be generalised beyond this sample. Moreover, both in individual interviews and in focus-group discussions, social desirability bias could lead participants to answer in a manner that they perceive the researcher as favouring and as conforming to social expectations. This bias is particularly strong in studies on risk behaviours (Rao et al., 2017).

Second, there are some other biases related to recruitment strategies. Key resource persons who helped us recruit study participants might have had their own criteria for selecting young migrants to whom they talked about our research. Snowball sampling depends on the subjective choices of the respondents we first spoke with, who may reach out to individuals in their network with similar characteristics (e.g., ethnic origin, education, socioeconomic status) and the inclusion of such individuals may lead to a more homogeneous sample and overemphasise cohesiveness in social networks. Finally, despite researchers' considerable efforts to recruit LGBTQI+ young migrants, only one woman self-identified as bisexual. Therefore, HIV risk-reduction strategies found in this research are limited to those that self-identified heterosexual young migrants reported using.

Despite these limitations, our findings point to the potential of the concept of in-between strategies (Zinn, 2008; 2016) in HIV/AIDS research to generate insights into how young FGMs and SGMs manage HIV sexual risk. An understanding of these multiple strategies can contribute to the development of an empirical understanding of how people mobilise and combine strategies in specific contexts of socialisation and in specific social conditions (Zinn, 2016). In this study, the specific context consisted in the migration experience and the specific social conditions included unequal power relations, as young sub-Saharan migrants belong to a minority population and deal with gender inequalities, gendered sexual norms and unequal resources between first- and second-generation migrants.

Our findings showed that the young participants with a sub-Saharan African migrant background referred to five HIV sexual risk-reduction strategies: consistent condom use, HIV testing before discontinuing condom use, selection of partners and investigation of their sexual history, feeling of familiarity with a partner, and commitment and trust in the intimate relationship. These strategies are neither completely rational nor irrational. They are in-between strategies (Zinn, 2008; 2016); that is, they are reasonable ways to manage HIV risk. They involve use of prior knowledge and experience and also include drawing on emotion, trust and intuition to take a decision.

The rational actor theory, at the centre of HIV/AIDS campaigns, would predict that consistent condom use prevents HIV and other sexually transmitted infections. However, our findings showed that consistent condom use – which we would consider as a rational strategy – also encompasses nonrational dimensions. Indeed, from a sociological perspective, it is important to place condom use in the context of the interaction in which sexual intercourse occur. Condom use is the result of social processes that involve relations, resources and emotions. Relations between partners may or may not be egalitarian. Unequal power relations that emphasise men's and women's roles and assert gender inequalities make negotiating condom use more difficult for women. Our findings

showed that this is the case, for example, for FGM women, who had fewer resources (linguistic, material and symbolic) than men and than SGM women. Their sexual socialisation, intended as the adoption of attitudes, norms, beliefs and behaviours regarding sexuality (Tolman & McClelland, 2011) occurred in a context in which female sexuality was not discussed, as young women were expected to adhere to the norm of virginity until marriage. Gender inequalities, lack of resources and lack of discussions about female sexuality often made FGM women uncomfortable talking about sex and negotiating condom use. This was also the case for asking for HIV testing before discontinuing condom use, the second HIV risk-reduction strategy highlighted in this study. These findings are in line with those of Omorodion and colleagues (2007), whose work was based on the experiences of African youth in Canada. Both studies highlighted the influence of gender power in risky sexual behaviours. Indeed, these risk behaviours often reflected power asymmetries between women and men in couples.

The three other strategies (selecting partners and investigating their sexual history, feeling of familiarity with a partner, and commitment and trust in the intimate relationships) involved feelings, intuition and emotion. Therefore, these are clear empirical examples of in-between strategies (Zinn, 2008; 2016). Selecting partners and investigating their sexual history, a strategy mostly invoked by SGM men, shows that these young migrants tended to trust young women who had a 'good reputation' in their friendship groups. This meant that trust played a double role in this strategy: first, the young men trusted their friends, who informed them about the reputation of their potential partner, and second, when the potential partner would become a 'real' partner, they trusted her.

Our findings regarding feeling of familiarity with a partner are in line with those of Bourne and Robson (2009), who pointed out that familiarity instils a sense of safety. They revealed that people often make the assumption that those in their friendship groups or those with similar social conditions tend to adopt the same behaviours as themselves. This was also the case for the young migrants in our study. They reported feeling safe when they had sexual intercourse with partners whom they presumed to know because they lived in the same neighbourhood, attended the same school or were part of the same peer group.

Our findings regarding the last strategy related to commitment and trust in intimate relationship are in line with Emmers-Sommer and Allen (2005). They indicated that ending condom use became a marker that signified for both partners the existence of a committed and exclusive relationship. Indeed, as emotional intimacy grew over time in the relationship, the perception of risk decreased (Remien et al., 2005). In this relational context, partners suggested that they perceived asking for condom use or HIV testing as marking mistrust. Our findings confirm that risk and trust are interconnected concepts (Dibben & Lean, 2003), but also that trust is embedded in personal relations and communications (Alaszewski & Coxon, 2009).

Our findings also showed a nuanced vision of trust and commitment in intimate relationships, which has important implications for HIV prevention. Indeed, they suggested that while feelings of commitment depended on the duration of an intimate relationship, this was not the case for feelings of trust. Commitment was an intimate construction over time and through shared experiences, including sexual relations. It was associated with long-term or 'serious' intimate relationships. Trust was a feeling that was considered more instinctive; it did not require as much time or shared experience to develop, as the concept of 'swift trust' (Dibben & Lean, 2003) suggests. As a result, trust

could put young migrants at greater risk of HIV than commitment, because it might be involved in intimate relationships that young migrants identified as 'friends with benefits' or 'booty calls' (Mellini et al., 2020) in which sexual exclusivity was not expected.

In relation to the wider literature on health risks, our findings lead to some important considerations on safety. Although practitioners and sexual health policies present safety as a rational construction, the young migrants in our study engaged more in what we call 'emotional safety,' following Bourne and Robson (2009). Based on commitment and trust, emotional safety showed that young migrants did not question their own individual safety. In their life histories, they used feelings to construct safety: they felt 'safe' with a given person, in a given intimate relationship's context and time. They felt 'comfortable,' 'confident' and in control of the sexual situation. In such a relational context, participants told that becoming HIV infected was an unthinkable issue to them. In line with Bourne and Robson (2009), the risk of contracting a sexually transmitted infection is not always the primary concern. For many young adults, feeling safe with their partner was of far greater importance.

Concerning individuals' gender and migration background, our findings indicated that SGMs, regardless of gender, used more rational strategies such as consistent condom use and asking for HIV testing before condom discontinuation than did FGMs. However, there were gendered differences in using emotional strategies such as feeling of familiarity with a partner or commitment and trust in the intimate relationship. Young women reported these last strategies more often than the young men in our study, regardless of their first or second generational status. Finally, with the exception of one young woman, only young SGM men used the strategy of investigating a partner's sexual history.

Conclusions

In this article, we have argued that the dichotomy between rational and irrational strategies is not useful for understanding preventive strategies in HIV/AIDS research. Rather, we have found in-between strategies (Zinn, 2008; 2016) to be much more adapted to discerning the complexity of strategies that individuals mobilise for managing HIV risk. The five types of strategies we identified show that developing and using in-between strategies is a socialised and social process. Indeed, it occurs in interactions between partners and involves attitudes, practices, emotions, competences and resources. As a social process, the development and use of strategies for managing HIV risk depends on power relations between partners.

Negotiating condom use and HIV testing implies knowledge about sexually transmitted infections, prevention and health systems in the country of residence, financial resources to buy condoms and medical costs for the HIV testing, as well as the capability to ask a partner to use condoms or get HIV testing. All these conditions make using these strategies more complicated for FGMs, especially for young women who often faced unequal power intimate relationships, because of gender inequalities and gendered sexual norms.

Strategies of carefully selecting partners and investigating their sexual history, feeling of familiarity with a partner, and commitment in intimate relationships each involve trust, intuition and emotion. However, carefully selecting partners and investigating their sexual history also implies social and material resources, as well as social and linguistic skills, which many FGMs in our study seemed to lack. Indeed, these approaches implied

having a strong network at school and outside school, economic resources to participate in leisure activities and the social competence and linguistic skill to communicate with particular (trusted) peers.

Studying strategies for managing HIV sexual risk among young people born in sub-Saharan Africa or in Switzerland to parents native to sub-Saharan Africa highlights some specificities of populations with a migrant background, though these characteristics may also be relevant to other marginalised or vulnerable groups. Their competences for developing and using strategies depend on their knowledge about the HIV epidemic in the country they live in, sexually transmitted infections, preventive behaviours and the local health system. The mobilisation of strategies for HIV sexual risk management also depends on the social networks that young migrants develop in the receiving country, their capabilities to face gender inequalities and family-transmitted sexual norms and their economic resources and linguistic skills.

Further research is needed to continue this operationalisation of the in-between concept in contexts of HIV/AIDS and migration. For instance, research based on more heterogeneous samples could allow for exploration of whether strategies for HIV sexual risk management change according to migrant country of origin and/or sexual orientation. Such knowledge regarding processes that lead people with a migrant background to develop and use in-between strategies for managing HIV sexual risk are crucial for improving the effectiveness of HIV prevention, as well as prevention of other sexually transmitted infections.

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Notes

1. 'Young migrants from sub-Saharan Africa and HIV/AIDS: Sexual health representations and practices', Francesca Poglia Mileti, Pascal Singy, Laura Mellini, Michela Villani & Brikela Sulstarova.
2. All participants' names are pseudonyms.

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