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When social, relational and sexual vulnerabilities increase vulnerability to HIV/AIDS: the case of migrants living in Switzerland

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ABSTRACT

There is emerging evidence that a significant proportion of migrants acquire HIV after arrival in Europe. Thus, to strengthen prevention efforts, it is crucial to understand migrants' vulnerability to HIV/AIDS. This article contributes to this understanding by analysing the perspectives of prevention actors and migrants. Data were collected through a qualitative and participative research study conducted in Switzerland. Twenty prevention actors and 28 migrants participated in in-depth interviews. Results show that migrants' difficulties in accessing and adopting measures to prevent HIV are related to three types of situational vulnerability that increase their vulnerability to HIV/AIDS: social vulnerability, which refers to social inequalities in access to care; relational vulnerability, which refers to unequal distribution of power within intimate relationships; and sexual vulnerability, which refers to stigmatization of sexualities that some people may consider as socially nonconforming. For HIV/AIDS prevention to be successful among migrants, power structures such as sexism, heterosexism, cisgenderism, ethnocentrism, and racism need to be addressed. Reducing stigma related to HIV among migrants requires a struggle against these power structures as well as health inequities.

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HIV/AIDS vulnerability; migration; social; relational and sexual vulnerabilities; social inequalities; power structures

Introduction

In Europe the HIV epidemic is characterized by a disproportionate number of infections among migrants. Despite that people born outside the European Union (EU) account for only 8.4% of the EU's population (Eurostat, 2021), in 2020 an estimated 44% of new diagnoses in the EU/European Economic Area (EEA) were among migrants (European Centre for Disease Prevention and Control/WHO Regional Office for Europe, 2021).

Migrants from countries with a generalized HIV epidemic do not necessarily contract HIV in their country of origin. On the contrary, there is an emerging body of evidence suggesting that a significant proportion of migrants acquire HIV after arrival in the EU/EEA (Alvarez del Arco et al., 2017; Fakoya et al., 2015; Pantazis et al., 2021). These data suggest the need for specific HIV prevention for migrants. For this purpose, in 2016 the Swiss Federal Office of Public Health (FOPH) set up a framework for the prevention of HIV and other sexually transmitted infections (HIV/STIs) specifically for the field of migration (FOPH, 2016).

To strengthen the evidence base for prevention in the area of HIV/STIs and migration, the FOPH mandated the qualitative and participatory research Mi.STI (Migration and Vulnerabilities to HIV and other STIs in Switzerland) the results of which are presented in this article. This research explored the vulnerability to HIV/STIs of migrants living in Switzerland from the perspective of both prevention actors and migrants. In this article, we focus on vulnerability to HIV/AIDS. Vulnerability to HIV pertains to people without HIV and to contracting HIV. Vulnerability to AIDS pertains to people living with HIV and to contracting AIDS. Preventive behaviors for HIV include consistent condom use, HIV testing, post-exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP) to reduce vulnerability to HIV, whereas antiretroviral therapy (ART) reduces vulnerability to AIDS.

Migrants often find themselves separated from their social network in their new country. They may experience language barriers, precarious living conditions, exploitative labor conditions and a lack of social protection, such as health insurance and other social security (Poglia Mileti, Mellini, & Tadorian, 2022). Previous studies showed that these conditions may lead migrants

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to engage in risky behaviors, such as sex without condoms (Dias et al., 2020; Kramer et al., 2014) or drug use (Deren et al., 2010). In addition, migrants may face sexual violence and other human rights abuses (Maher & Segrave, 2018).

Studies conducted in different European countries have already shed light on some dimensions of vulnerability to HIV. For instance, inadequate access to HIV prevention, treatment and care services increases migrants' vulnerability to HIV/AIDS (Thomas et al., 2010). Difficulties in accessing testing and treatment lead migrants to late HIV diagnosis and also increased risk of an AIDS diagnosis (Alvarez-del Arco et al., 2013; Fakoya et al., 2018). This is because migrants, particularly undocumented migrants, rarely have the same entitlements as citizens to insurance schemes that make health care affordable (Deblonde et al., 2015). Institutional barriers including lack of community clinics, lack of cultural understanding, and failure to integrate care with support organizations are well documented (Burns et al., 2007). Finally, the fear of being stigmatized for seeking HIV-related information or support also increases exposure to HIV/AIDS risk (Manirankunda et al., 2021; Stutterheim et al., 2012).

Materials and methods

Study design and sampling

Mi.STI is participatory research. A group of migrants and people who worked in the field of sexual health and migration (referred to as "partners' group") collaborated across the entire research process. They participated in many activities, including assisting with research questions and methods, recruiting respondents and discussing results.

Both prevention actors' and migrants' samples were purposive. The research team selected the categories of prevention actors eligible for interviews from an inventory of institutions working on HIV issues with migrants. Migrants were eligible if they were 18 years or older and belonged to the categories identified as vulnerable in the FOPH's, 2016 framework: men who have sex with men, sex workers, transgender persons, and undocumented migrants. The research team discussed the profile of both categories of interviewees with the partners' group.

The partners' group and nongovernmental organizations working in the areas of HIV/AIDS, sexual health and migration helped with recruiting participants. As some categories of migrants belonged to marginalized groups, we also used the snowball technique (Naderifar et al., 2017) for recruiting participants while also ensuring that their profiles fit the FOPH's vulnerability categories.

All participants provided verbal informed consent prior to interview. The research received ethical approval from the ethics commission for research on human beings, Canton VD (N° 2019-02265).

Data collection

Researchers collected data through in-depth interviews with actors working in the areas of HIV/aids, sexual health and migration ($N = 20$), and in-depth interviews with migrants ($N = 28$). The in-depth interviews were conducted between January and November 2020. These were semi-structured interviews based on a thematic guide. The interviews with prevention actors were designed to collect their experience with migrants, their intervention practices and the difficulties they encountered in these. The purpose of the interviews with the migrants was to collect their stories, experiences and representations of HIV/AIDS prevention. We stopped at 20 and 28 interviews because we reached saturation. Tables 1 and 2 provide sociodemographic characteristics of each group of participants.

The in-depth interviews with both prevention actors and migrants lasted an average of 2 h. All participants consented to have their interviews audio-recorded and transcribed.

Data analysis

To analyse data, we used an inductive approach and constant comparative method, following grounded theory research (Glaser & Strauss, 1967). Through iterative rounds of data analysis, we let themes, categories and properties emerge. Afterward, with further data collection, we refined emerging categories and added new ones (Corbin & Strauss, 2015). Thematic analysis (Braun & Clarke, 2019; Braun et al., 2019) continued until we reached thematic saturation.

Researchers coded data using NVivo 10. They resolved contradictions within and between themes and subthemes through an iterative process (Strauss & Corbin, 1996). They compared the categories and kept those for which there was consensus.

Results

Three situational vulnerabilities that exacerbate vulnerability to HIV/AIDS emerged from the thematic analysis: social, relational and sexual vulnerabilities.

Social vulnerability

The socioeconomic and legal status of migrants emerged as central dimensions of their social vulnerability. The

Table 1. Sociodemographic characteristics of the prevention actors interviewed.

Prevention actors ($N = 20$)		
Sex assigned at birth	Female	15
	Male	5
Gender identity	Cisgender	19
	Queer	1
Sexual orientation	Heterosexual	19
	Pansexual	1
Age	21–30	3
	31–40	3
	41–50	7
	51–60	5
	61+	2
Origin	Switzerland	7
	Other European country	5
	African country	6
	Middle Eastern country	1
	Asian country	1
Permit/Nationality	Swiss nationality	15
	Permit C	3
	Permit B	1
	Missing information[3]	1
Religion	Catholic	6
	Protestant	6
	Atheist	8
Education	Graduate studies (BA/MA) in the medical field	10
	Graduate studies (BA/MA) in the social field	5
	Graduate studies (BA/MA) in other field	3
	Apprenticeship	2
Professional status	Physician	4
	Nurse	3
	Sexual Health Counsellor	3
	Project Manager	3
	Coordinator	3
	Mediator	2
	Interpreter	1
	Pastor	1
Duration of employment in the institution	0–5 years	7
	6–10 years	8
	11–15 years	3
	16–20 years	2
Institutions ($N = 18$)[4]		
Type	AIDS service of the Swiss AIDS Federation	4
	Sexual Health Centre	1
	Health and social care service for people in precarious situations, undocumented migrants, sex workers	3
	Service in a hospital setting	3
	Health center for men who have sex with men, trans people and other queer people	2
	NGO in the area of sex work	1
	NGO in the area of LGBTQI + asylum	1
	NGO in the area of migration	1
	Centre for asylum seekers and refugees	1
	Religious institution	1
Legal status	Public service	4
	NGO	14
Financing	Public sources	4
	Mixed sources	13
	Private sources	1

prevention actors interviewed reported that most migrants they encountered in their services lived in a situation of economic insecurity. Both the sociodemographic data we collected from the migrants interviewed and the descriptions of their living conditions that they shared with us during interviews reflected this economic insecurity. No interviewee had a permanent job, and one-quarter of participants worked illegally. More than half of the interviewees depended on social welfare, emergency aid or disability insurance.

As to legal status, one-third of interviewees had a refugee permit (valid for 5 years and renewed every year), one-third had temporary permits and one-third were undocumented.[1] These very precarious legal statuses limited migrants' access to work, housing and health care. Undocumented migrants lived in even more precarious conditions. Interviewees reported that they made a living from odd jobs, which put them at risk of exploitation, as this migrant expressed:

> Here, especially when they see that you don't have papers, everyone takes advantage of you. They offer you work, but they'll pay you … half of what you're getting. (Cisgender heterosexual man, aged 39, from Sub-Saharan Africa, undocumented)

This precarious socioeconomic and legal status reduced migrants' access to HIV testing, PrEP and ART.[2] Although health insurance is compulsory for all people residing in Switzerland, it is difficult to access and often very difficult to afford for migrants in precarious economic situations. Moreover, health insurance does not in all cases guarantee coverage of preventive interventions. Prevention actors reported that HIV tests are too expensive for migrants who live in insecure conditions. So these migrants present only when they have symptoms, which leads to a "late diagnosis." PrEP is not affordable for migrants in precarious economic situations. For this reason, a prevention actor working in a sexual health center for men having sex with men and for queer and transgender people confided to us that he did not promote PrEP with migrants:

> I think it's tricky to promote something when you can't even offer it to them. You can't tell them, "Hey, there's this, but it costs, you can't even afford it." I find that a frustrating story. (Man, aged 35, nurse, center for HIV/STIs for queer people)

Concerning the legal dimension, prevention actors reported that undocumented migrants do not access HIV prevention and treatment because they fear that the police will report them and that the immigration authorities will expel them from Switzerland. Even though strict data protection rules exist between the health care sector and immigration authorities, migrants are often not aware of those.

Many prevention actors undertake efforts to address the difficulties that migrants face. They have built expertize in granting undocumented migrants access to health insurance and helping people in

Table 2. Sociodemographic characteristics of the migrants interviewed.

	Migrants ($N = 28$)	
Sex assigned at birth	Female	13
	Male	15
Gender identity	Cisgender	24
	Transgender	3
	Queer	1
Sexual orientation	Heterosexual	24
	Homosexual	2
	Bisexual	1
	Queer	1
Age	18–30	8
	31–40	11
	41–50	8
	51–60	1
Country of origin	Afghanistan, Argentina, Brazil (2), Burkina Faso (2), Colombia, Democratic Republic of the Congo, Dominican Republic, Eritrea, Ethiopia (3), Gambia, Georgia, Ghana, Guinea-Conakry (2), Iran, Ivory Coast, Jamaica, Kenya, Nigeria (2), Philippines, Romania, Syria, Turkey	22 countries
Time in Switzerland	1–5 years	13
	6–10 years	11
	11–15 years	4
Permits[5]	B	12
	F	4
	N	1
	Visa work for 90 days	3
	Undocumented	8
Marital status	Single	12
	Married	6
	Separated	3
	Divorced	6
	Widow(er)	1
Relationship status	Single	21
	In a relationship	7
Children	Without children	15
	With children (1-3)	13
Housing form	In an apartment alone	9
	In an apartment as a couple/family	7
	In a shared apartment	6
	In a collective accommodation (for asylum seekers, refugees, homeless)	5
	Room in an erotic massage salon	1
Training	Primary	6
	Secondary I	8
	Secondary II (apprenticeship/BAC)	9
	Superior	5
Sources of income	Declared sex work	4
	Illegal work, odd jobs	6
	Apprenticeship	3
	Social welfare/Emergency aid/Disability insurance	12/2/2
	Scholarship	1
	Internship	4
	Spouse/partner salary	2
Income[6]	<1000 CHF	6
	1001–2000 CHF	15
	2001–3000 CHF	2
	highly variable	5
Health insurance	Yes	21
	No	7
Religion	Christian	15
	Muslim	9
	Other	1
	Atheist	3
HIV	No HIV diagnosis	23
	HIV diagnosis	5

precarious economic conditions obtain premium reductions for health insurance. The Swiss AIDS Federation organizes free testing campaigns. However, social vulnerability continues to exacerbate vulnerability to HIV/AIDS.

Relational vulnerability

Relational vulnerability emerged with respect to social vulnerability and, in some cases, to gender inequalities as well. Socioeconomic and legal insecurity may lead

migrants to get involved in intimate relationships of subordination, in which they are economically dependent on their partner. These situations affect women more than men, because they tend to be less educated and do not work or work in low-paid jobs. This was also the case when migrants were legally dependent on their spouse because they acquired a residence permit through marriage to someone with Swiss nationality or a permanent permit, as this interviewee working in a hospital explained:

> I even saw situations of Cameroonian women who had joined their Cameroonian husband in Switzerland. Even if the husband cheated on them, was mean, beat them … if they asked for a divorce or separated, they lost their permit. They were in a power relationship: dependence for the permit, financial dependence. (Woman, aged 45, nurse, hospital)

Subordination also occurred in transactional sex, or sex associated with financial, material, and/or symbolic exchange (Broqua & Deschamps, 2014). From the prevention actors' perspective, transactional sex involves male and female, heterosexual and nonheterosexual, cisgender and transgender migrants. Moreover, the socioeconomic insecurity created by the COVID-19 pandemic seemed to result in an increase in this type of sexual relationship. Some migrants confided that they were in transactional sex relationships, as this self-identified undocumented transgender woman who offered sex in exchange for housing:

> This man, he's married. I met him in and discuss with him my situation […] So I pay … I have no choice, I have no place to stay, I pay with my body. […] Even if I don't want [it] anymore, because I don't love him, I don't have the choice. […]. I have nothing, so I need this place, I need to live. (Transgender heterosexual woman, aged 50, from Asia, undocumented)

Migrants who legally and/or economically depended on another person and experienced subordination in a couple relationship or in transactional sex expressed less autonomy over the exercise of their sexual self-determination. They reported feeling that their dependent relationship could not end and discussed the difficulty they had in negotiating condom use and/or asking the partner to undergo HIV testing. This was especially reported by female participants, demonstrating gender inequalities.

Sexual vulnerability

Sexual vulnerability emerged as a vulnerability related to sexualities perceived as non-conforming and therefore stigmatized, especially in migrants' own ethnic communities. This includes anal sex, paid sex, and premarital sex. Each of these forms of stigmatized sexuality enhanced vulnerability to HIV in a specific way.

Prevention actors reported that many migrants they met in their services adhered to a heteronormative view of sexuality. Many interviewed migrants also expressed this view. They presented heterosexuality as "natural" and "normal" because it can lead to procreation. Migrants who identify as sexual minority (i.e., self-identifying as LGBTQI + or non-heterosexual) reported on the discrimination and persecution they faced in their country of origin, in the countries they crossed during migration, and in Switzerland. This discrimination occurred from members of their ethnic community but also from other migrants and Swiss citizens. They reported verbal, physical and sexual abuse, which took the form of unwanted advances based on stereotypes, as a migrant who self-identified as queer told us:

> When you wear a dress and you live in a home [for refugees], people look at you. They don't understand, they don't know about gender identity … And they think that you can sleep with everybody … (Queer, aged 31, from Middle East, refugee)

Stigmatization and marginalization may lead migrants who identify as gender and sexual minority to more hidden sexual practices in which it could be more difficult for them to negotiate condom use. These migrants also reported finding it difficult to use health services for LGBTQI + people because they did not identify as part of the LGBTQI + community. From an intersectional perspective, this shows how ethnic and sexual minorities can be limited in the construction of social network. The experiences they recounted were in line with the findings of prevention actors who reported difficulties in reaching sexual minority migrants.

Migrants who practiced sex work described being assaulted and insulted (on the street, in bars and in other public spaces). The fear of stigmatization also pertained to the health care setting, a fear that further increased vulnerability to HIV. Actors involved in prevention among sex workers said that these persons rarely asked for PEP out of fear of being stigmatized. Among the five sex workers interviewed, no one informed caregivers of their work unless they were cared for in a specialized setting for sex workers.

Many migrants, especially women, talked about the sexual norm of virginity until marriage. They related it to their religion and education, as this female migrant explained:

> In our upbringing, it is strictly forbidden by the law of our religion, by the Islamic law, and by the upbringing of the parents, in fact, to have sex before marriage.

(Cisgender heterosexual woman, aged 37, Sub-Saharan Africa, refugee)

Conforming with this norm may lead sexual partners to engage in anal sex to preserve the female's virginity, which can greatly increase vulnerability to contracting HIV. Prevention actors reported that young heterosexual migrants who engaged in anal sex were not always aware of increased HIV risk and did not use condoms.

Finally, stigmatization of these sexualities contributed to HIV stigmatization: HIV was perceived as a consequence of "bad" behavior. Migrants explained that in their own ethnic communities, those who identified themselves as religious – regardless of the religion they practiced – considered HIV "divine punishment" for having engaged in "deviant" sex, for example anal sex, paid sex, and premarital sex.

Discussion and conclusion

This study has some limitations due to method, participants' recruitment and sample. The qualitative nature of this research does not allow for findings to be generalized beyond this sample. Indirect recruitment through stakeholders and snowballing techniques may introduce some bias, because it impacts the sample characteristics. The purposive sampling impacts findings because these are limited to the selected participants' profile.

Our results reveal how migrants face social, relational and sexual vulnerabilities that exacerbate their vulnerability to HIV/AIDS. Our results also point to the importance of considering migrants' legal status, their living conditions in the receiving country and the relational context in which they engage in sex. Results also suggest the importance of situating migrants' characteristics in the social context in which representations and stereotypes about gender, sexual orientation and gender identities are produced. Indeed, vulnerability to HIV/AIDS is more structural than individual. It arises less from a lack of information and risk perception than from social inequalities in accessing care, unequal distribution of power in intimate relationships and stigmatized forms of sexuality.

Our results are partially in line with previous studies on barriers to condom use conducted among migrants living in Switzerland. Indeed some studies highlight migrants' lack of knowledge about HIV prevention (Simonson et al., 2015) over their legal and socioeconomic precarity. However, in a previous study that we conducted among young sub-Saharan migrants *[author 2]*, we found that barriers to condom use included power inequalities in couples' relationships that made young women unable to negotiate condom use. Our results are consistent with the literature that shows how hardships faced by migrants after arriving in Europe shape their sexual behaviors and partnerships, increasing their vulnerability to contracting HIV. The lack of a residence permit correlates to an increase in casual and transactional partnerships, especially among women (Desgrees-du-Lou et al., 2016).

For HIV testing, our results are consistent with a study conducted among migrants living in nine European countries, including Switzerland (Fakoya et al., 2018). This study showed that for heterosexual women and men, stabilizing their legal status has a great positive impact on access to HIV testing. For heterosexual men, testing frequency was positively associated with permanent residence.

Our results on stigmatization expand the findings of a study conducted on descendants of sub-Saharan migrants in Belgium (Manirankunda et al., 2021) that documented strong HIV-related stigma and discrimination. Indeed, the belief that HIV is punishment for not conforming to sexual norms also concerns migrants from other regions of the globe, including Asia and Eastern Europe. As a result, migrants anticipate rejection, especially among their ethnic communities, and avoid HIV testing.

As for access to ART, our results are in line with a previous study that we conducted on vulnerabilities faced by HIV-positive female migrants *[authors 3]*. This research revealed how insecurity in socioeconomic and legal status, as well as HIV-related stigmatization, affect an individual's use of HIV care and social services. Our results are also consistent with another Swiss study conducted among HIV-positive sub-Saharan migrants who presented with symptoms for late diagnosis. This study revealed that drivers for late presentation include difficulties in accessing testing facilities and fear of deportation (Hachfeld et al., 2019).

Finally, our results on the difficulties in accessing health care faced by migrants in precarious socioeconomic and legal situations, due to the cost of health insurance, confirmed the need to offer free HIV testing, PrEP and ART to reduce social inequalities in health and to slow the spread of HIV (Deblonde et al., 2015). However, our results suggested that effective HIV/AIDS prevention among migrants must also include a struggle against various power structures, such as sexism, heterosexism, cisgenderism, ethnocentrism and racism. This means helping to stabilize migrants' legal status and guaranteeing free prevention and care for people in precarious socioeconomic situations. It also means enacting more inclusive laws to promote diversity of gender, sexual orientation and ethnicity.

Notes

1. Those with refugee permit and temporary permit have the right to live, work, travel within Switzerland and abroad, as well as the benefit of social welfare and health care. However, they face some restrictions. For instance, to change the canton to which they have been assigned, they must submit an application to the immigration authority of the canton to which they wish to move. If they are permanently dependent on social welfare benefits, their application is often refused. There is no work restriction with these permits, but in practice finding a job with a B or F permit is very difficult.

   Undocumented migrants do not have the right to live or work in Switzerland, or the right to social welfare. If they have no health insurance, they are entitled to receive basic medical assistance when in need (for more information, see the State Secretariat for Migration, https://www.sem.admin.ch/sem/en/home.html).
2. Switzerland offers neither free HIV testing nor PrEP. The average cost for an HIV testing is 50 CHF. For PrEP, the cost of provider-initiated testing is covered by health insurance. For those participating into the national program SwissPrEPared, the cost of PrEP is 40–60 CHF a month. The first PrEP consultation costs approximately 400 CHF. Control consultations, around 300 CHF each, take place three times a year. The most commonly prescribed medication (Biktarvy) is 1166 CHF per month. Generic drugs are hardly ever used in Switzerland. HIV treatment costs, about 21,000 CHF per year, are covered by health insurance.
3. A field worker did not want to give us this information.
4. Two interviews were conducted with two field workers.
5. Permit B is a temporary residence permit (valid one year for one year but can be extended annually), 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.
6. There is no national minimum wage in Switzerland. However, some cantons do have a minimum wage that applies in that canton. It is around 4000 CHF. In 2020 the average monthly salary in Switzerland was CHF 6538. https://www.ch.ch/en/work/minimum-wage-and-average-salary/

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