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Contexts of risk and networks of protection: NYC West Indian immigrants' perceptions of migration and vulnerability to sexually transmitted diseases

Susie Hoffman[a,b,*], **Jenny A. Higgins**[c], **Sharlene T. Beckford-Jarrett**[d], **Michael Augenbraun**[e,f], **Kimberly E. Bylander**[g], **Joanne E. Mantell**[a], and **Tracey E. Wilson**[f]

[a]HIV Center for Clinical and Behavioral Studies, New York State Psychiatric Institute and Columbia University, New York, USA

[b]Department of Epidemiology, Joseph L. Mailman School of Public Health, Columbia University, New York, USA

[c]Heilbrunn Department of Population and Family Health, Joseph L. Mailman School of Public Health, Columbia University, New York, USA

[d]National HIV/STI Prevention and Control Programme, Ministry of Health, Kingston, Jamaica

[e]Department of Medicine, Infectious Diseases Division, State University of New York Downstate Medical Center, Brooklyn, USA

[f]Department of Community Health Sciences, Graduate Program in Public Health, State University of New York Downstate Medical Center, Brooklyn, USA

[g]New York City Department of Health and Mental Hygiene, New York, USA

Abstract

To generate insights into how migration shapes sexual risk and protection, we interviewed 36 female and 20 male West Indian (WI) immigrants attending a public sexually transmitted disease (STD) clinic in Brooklyn, NY between 2004 and 2005. Migration theory suggests that shifts in sexual partnership patterns, bi-directional travel, and changes in sexual norms may alter risk. We found evidence of sexual mixing across ethnic groups: a large proportion of participants' partners were not born in the WIs, despite what is expected among first generation immigrants. Recent travel "home," another potential source of risk, was uncommon. In open-ended interviews, two themes around sexual and social networks emerged. First, immigrants believed that access to wider, more anonymous sexual networks in NYC and the weakening of social controls that limit multiple partnerships (especially for women) promoted greater risk. Second, immigrants experienced greater opportunities for protection in NYC, both through exposure to safer sex messages and availability of condoms. Reported changes in their own condom use, however, were not attributed to migration. WI immigrants' risk in NYC may be driven by access to wider sexual networks but failure to alter reliance on "networks of knowledge" for protection.

Keywords

Caribbean; West Indian; migration; sexual health; sexual networks; HIV/STD

*sh51@columbia.edu.

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Introduction

Immigrants constitute a larger proportion of the total US populace than they have in eight decades, comprising over 12% of the population and up to one-third in several cities and states (US Census Bureau 2000). Although a substantial body of research has focused on the effects of migration, settlement, and acculturation on diverse health behaviours and health outcomes, how these social forces influence *sexual health*—and HIV/AIDS in particular—remains understudied. Migration, and population mobility more generally, have long been linked to increased transmission of HIV (Quinn 1994; UNAIDS and IOM 1998; Lurie 2000), yet there has been limited exploration of the diverse mechanisms through which this increased risk might occur (Li et al. 2007; Brockerhoff and Biddlecom 1999), or even—as has been demonstrated for a range of health conditions—whether migrants in some settings might experience lower risk for HIV than native-born residents. Nor have many studies sought to explore migrants' own understandings of the ways in which sexual behaviours and HIV risk shift as they move from their home countries to new environments in a foreign land.

One neglected group in the study of migration and sexual risk and protection is English-speaking black West Indian (hereafter, WI)[1] immigrants from the Caribbean basin countries, who constitute a large immigrant population in Eastern seaboard cities such as Miami and New York City (NYC). Newly-reported HIV cases among immigrants from some WI countries are high,[2] making their experiences germane to a study of sexual health. NYC WI immigrants represent over 20% of the foreign-born population and more than one-quarter of the city's black population (US Census Bureau 2000).

To contribute to understanding how migration and acculturation may shape sexual risk and protection among WI immigrants, in this paper we present descriptive data from structured and open-ended interviews with 56 WI immigrants attending a public sexually transmitted disease (STD) clinic in Brooklyn, NY. Given the diversity of migration flows to the USA over time, place, social, cultural, and economic circumstances in countries of origin and receiving communities, theory development needs to build on findings across these diverse migration contexts. To frame the context for this study, we draw briefly from migration theory and salient features of the migration experience of one immigrant group in one US city to suggest some possible pathways to sexual health or risk.

Migration and sexual health in relation to West Indian migration characteristics

Migrants who move from a lower to higher HIV/STD prevalence region may increase their risk of infection merely as a consequence of greater risk of exposure to infected partners in the new setting (Doherty et al. 2005). This risk increase can occur even without substantial changes in behavioural norms or sexual behaviours. Prevalence of HIV is high in both the WIs and NYC; in Trinidad/Tobago, it is estimated to be 1.5%, in Jamaica, 1.6% (UNAIDS 2008), and in NYC, 1.3% (NYC Department of Health and Mental Hygiene 2008). Because these overall statistics mask myriad variations, however, it is difficult to say whether WI immigrants face an increased, decreased, or the same risk of exposure to HIV. In this paper we focus on the sexual experiences of immigrants, which might give insight regarding exposure to high vs. low-risk sexual networks.

[1]West Indian describes the people from the former British West Indies, a Caribbean region colonized in the 17th century mainly by the British and populated by imported African slaves that currently comprises 19 nations (Inciardi, Syvertsen, and Surratt 2005). WI societies are multi-ethnic, but the majority of inhabitants are Black.

[2]Among all foreign-born New Yorkers, the rate of new HIV diagnoses is lower than among US-born New Yorkers (19 vs. 49 per 100,000), but among immigrants from Trinidad and Tobago, this rate is 48/100,000 (NYC Department of Health and Mental Hygiene 2006). Surveillance statistics are not available for immigrants from the WI countries only, as distinct from the entire Caribbean.

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An imbalance in the age and gender structure of the immigrant population—a consequence of gendered migration opportunities (Pessar 1999; Hondagneu-Sotelo 2003)—may lead to alterations in patterns of sexual mixing, as, for example, when Mexican men migrate to the US for agricultural work, but leave their female partners at home (Hirsch et al. 2002). Since the 1960s, the predominant pattern among WI immigrants has been for women to immigrate first, as US employment opportunities in household services favour them (Foner 1987; Pessar 1999; Scott 2003). Little is known about the partnership patterns of WI immigrants, e.g., to what extent they partner with compatriots, including those known prior to and those met since migrating, and to what extent they partner with the local non-immigrant population. However, the gender imbalance in this population, with about 70 WI immigrant men to every 100 women (NYC Department of City Planning 2004), suggests that there may be sexual mixing across nationality groups. Moreover, WI women's high level of workforce participation (NYC Department of City Planning 2004) may give them greater access to a range of partners than they would have had at home.

Circular migration and bi-directional travel are other forms of population movement that can increase risk of STDs through the linking of sexual networks (Lurie et al. 1997) with higher vs. lower degrees of risk. Although WI immigrants in the USA do not typically engage in employment-related circular migration, their migration experience is characterized by the maintenance of strong social ties within networks that span national boundaries (Basch 2001; Olwig 2001). Bi-directional travel is one feature of this transnationalism, but little is known about how this form of travel shapes patterns of sexual behaviour and HIV risk. Some studies show that travel (especially for tourism) is a context of drastically reduced social controls on sexuality (Hawkes and Hart 1993). Among Haitian immigrants in Montreal, those who had recently travelled to Haiti had a higher HIV prevalence than those who had not (Adrien et al. 1999).

Longer-term behavioural changes constitute another pathway from migration to sexual health or risk. Across a broad range of health outcomes, research shows that first-generation immigrants to the USA tend to be healthier than their US-born counterparts. With greater time in the USA, this health advantage tends to diminish and the prevalence of many adverse health behaviours increases (Abraido-Lanza et al. 2006). Shifts in beliefs around appropriate and acceptable sexual behaviours are one way that settlement and acculturation may lead to changes in sexual health. If migrants move from a more traditional to a more modern society, women may find that pre-marital sex or multiple partnerships are more acceptable (Pessar 1999). Alternately, immigrants may choose to adhere to traditional norms, rejecting what they may view as the lax sexual norms of modernity. Another shift may relate to open private and public discussion of sex and sexuality. In the West indies, discussion of sexuality between parents and children, or between women and men, is considered culturally unacceptable (Harris-Hastick and Modeste-Curwen 2001), and school-based sex education is limited (Vince Whitman 2004). This lack of sexual discussions/ sexual information sharing may mean that WI adolescents and young adults lack knowledge about their options for disease and pregnancy protection.

In the present study, we used quantitative data to describe rates of travel to countries of origin and patterns of partner mixing with respect to ethnicity and qualitative data to explore participants' perspectives concerning contexts and sources of risk and protection. We chose to conduct the study in a clinic population to enable a focus on the social and behavioural pathways to sexual risk among those at clear elevated risk. Through this "high risk" lens, however, we aim to contribute to building a testable theory of sexual risk among WI immigrants and, more generally, to development of theory around migration and sexual health. No less important, insights from such a study are critical to designing interventions targeted to WI immigrants.

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Methods

Participants, setting, and recruitment

Twenty men and 36 women participants were recruited from an STD clinic of a public hospital between May, 2004 and February, 2005. The hospital where the study was conducted is situated in the heart of the WI immigrant community; the neighbourhoods surrounding this clinic have high reported HIV incidence (57.1 HIV diagnoses/100,000 population compared with 47.3 for NYC overall) (NYC Department of Health and Mental Hygiene 2008).

Eligible participants had to be between the ages of 18-40 years, report a birthplace in the English-speaking Caribbean, self-identify as black or African-American, and have been diagnosed with one of several common STDs (including gonorrhoea, chlamydia, and trichomoniasis) within the past year. Clinic patients were referred sequentially to study interviewers by the physician or nurse practitioner who examined them if they had an STD currently or within the past year (documented in the medical record). We screened 134 individuals to obtain interviews with 56 clinic patients. The protocol was approved by the IRBs of the NYS Psychiatric Institute, SUNY Downstate Medical Center, and Kings County Hospital of the Health and Hospitals Corporation of NYC.

Procedures

Quantitative and in-depth qualitative assessments were conducted at the clinic by trained female interviewers on the day of the participant's clinic visit or, if that was not possible, at another scheduled time. Both portions of the interview were audio tape-recorded—the quantitative portion for quality assurance and the qualitative portion for subsequent transcription. Participants were reimbursed US$40 for their participation.

Quantitative data and analysis

In structured interviews we asked participants about migration characteristics, travel to countries of origin and sexual behaviour during these visits and overall. Sexual mixing was examined by eliciting the racial/ethnic and risk characteristics of all recent partners. Descriptive statistics were generated for women and men separately.

Qualitative data and analysis

Open-ended interviews lasting approximately one hour explored how WI immigrants experienced divergent sexual norms and contexts, and how they perceived these normative shifts to influence their own and other WI migrants' sexual behaviour and risk for HIV.

Audio-tapes of 55 in-depth interviews were transcribed and cleaned to remove specific place names and other potential identifiers (1 audio-tape was unintelligible). Based on the topics in the open-ended assessment guide, we developed an initial set of major codes and sub-codes. Eight interviews were coded by two of four rotating pairs of coders, after which the team jointly refined the codes and developed coding rules. We continued to code interviews in pairs until coding consistency for major codes was 75% or greater across pairs. The code book was finalized at this stage and the remaining interviews (N=30) were coded independently. To maintain high reliability, we continued to have regular coding meetings, during which any difficult coding decisions were jointly discussed and decisions documented. Final coded text was entered into a qualitative coding program.

The current analysis focuses on migrants' perceptions of the circumstances that promote HIV/STD risk and protection in NYC and their countries of origin. Text for these codes was read by two investigators, who developed sub-codes and created a summary matrix to

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explore the relationship among themes and between themes and participant migration characteristics. Because the themes explored in this analysis were most appropriately analysed among those participants who had lived for long enough in their WI home country to make meaningful comparisons between the two locales, we focused subsequent analysis on a subset of 27 participants (16 women and 11 men) who had migrated at age 13 or older *and* who had been in the US for 10 years or fewer. Among this subset were 17 who had migrated in the past 5 years.

Results

Quantitative data

Demographic and risk data for the entire sample are shown in Table 1.

Travel—Seven participants (12.5%) said they had travelled in the past year, in all cases to a Caribbean country. Of these seven travellers, one man and one woman had vaginal intercourse with someone from that country during their stay, and in both cases, sex was unprotected.

Ethnicity of partners—As shown in Table 2, summing partners from the past six months across participants, the 20 men in the sample reported 19 main partners and 37 other partners. The 36 women reported 35 main partners and 22 other partners. Main partners of both men and women were predominantly of WI origin— 84% (16/19) of men's and 83% (29/35) of women's partners. By contrast, non-main partners were less likely to be WI: only 38% (14/37) of men's and 55% (12/22) of women's partners were born in the WIs. When they did not partner with other WI immigrants, men and women were most likely to partner with African Americans, who accounted for 28.6% (16/56) of all partners of men and 17.5% (10/57) of all partners of women.

Qualitative data

Two important themes emerged in relation to contexts and networks of risk and protection. First, participants described how the size and anonymity of NYC promoted greater risk compared to the close-knit communities in their countries of origin. Second, participants highlighted how greater exposure to STD information and treatment and widespread safer sex messaging in NYC increased opportunities for protection. However, despite experiencing these differences, no participant highlighted increasing his or her own condom *use* after migration. By contextualizing participants' sexual behaviours within a larger fabric of sexual perceptions and norms related to the migration experience, these themes highlight areas for further exploration in understanding how migration influences sexual health in this immigrant population.

Expanding sexual networks, diminishing informational networks in the US—A frequently reported difference between the WIs and NYC, and one strongly related to perceived sexual risk, pertained to the size, scope, and character of sexual networks. The hidden nature of sexual behaviour in NYC was a central theme. Participants overwhelmingly believed that anonymity enabled people to hide their sexual pasts as well as current sexual behaviours. From one perspective, this afforded greater freedom; from another, anonymity prevented people from knowing about their partners' behaviours.

Participants often noted that in NYC there were more sexual opportunities and a large pool of potential partners.

> There's a lot of opportunity here and stuff and people, you know -- they just go. They try new things with people.

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> ~Shanique, 21 year old Jamaican woman who migrated at age 18
>
> Sex here, in this country, is a lot. Lots of sex happenin', lots of people to have sex with…
>
> ~Wendy, 34 year old Trinidadian woman who migrated at age 28

Many participants highlighted not only a greater number of potential partners and increased sexual availability in NYC, but even more important to their perception of risk was their belief that the "anonymity" of NYC fostered greater risk compared to the close-knit communities in their home countries.

> Guyana's still…a largely underdeveloped country. Everyone pretty much lives on the coast. So you can say, pretty much, that if a pin drop it will be heard in the next village…who have AIDS and this person suspect if they have it, that's the type of thing that circulates. So you can't help but…to try to protect yourself. […] So I say the risk is probably more here [NYC], because it's a wider, larger place. You come from a small speck in the Caribbean to this large, vast, country. Everyone is busy runnin' up and down, all about, you know? And you don't know who…is who.
>
> ~Christopher, 28 year old Guyanese man who migrated at age 23

Notably, this idea was expressed by women as well as men.

> Here [in NYC], I would say my risk is very high because you don't know who is who. You don't know who these people are. Because…I could see somebody and whatever, he's nice—and he could be carryin' the most STDs out of everybody else.
>
> ~Marsha, 21 year old St. Lucian woman who migrated at age 15

In the small, close-knit communities in their home countries, participants believed they had access to "word on the street" information about a potential partner's past sexual partners and STD history from members of a shared social network.

> So, like, that person might tell that person, "Oh be careful…she had sex wit' that guy," you know what I'm saying? …
>
> ~David, 23 year old Grenadian man who migrated at age 19

David continued to describe how social networks enabled him to learn about a potential partner's risk in Grenada.

> Even though you don't know that person, you could always get somebody who know that person, you know? Even though you aren't the person's friend, you could go to them and be like, "Yo, that girl…who she used to go with?" You know, you could ask a question.

In contrast, David explained, more anonymous networks in NYC make it less likely that information on partners' risk status would be available:

> But up here now, I can't just see you and ask who you used to go with….'Cause…nobody know you,

Thus, sexual safety, in the view of these respondents, was ensured (and denoted) by access to informational networks that they perceived as facilitating intimate knowledge of others' past and current partners. Such information was understood as a protective factor, as it would allegedly reveal who had had an STD, multiple partners, or other undesirable risk profiles, and allow people to screen out such partners.

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Besides ensuring the availability of vital information about a potential partner's risk status, the close-knit social networks of communities back home in the WIs were believed to foster sexual safety in another way -- by limiting concurrent partnerships. As one woman reported, referring to her ability to know if her partner was unfaithful,

> Here [in the US], it's a more open place and, as I say, the population is greater by the hundreds, by the thousands, so you have to check…. Sometimes men here feel they can always cheat and a woman don't know.
>
> ~Keisha, 30 year old Jamaican woman who migrated at age 25

She continued by explaining the difference in her ability to monitor a partner's whereabouts in Jamaica.

> Because Jamaica is so small … You want to go out and do something? You going to get caught….Unless it's going to be not in your area – where you live, but once you go out of the area and come -- you [meanings "one's partner"] going to find out….

In Keisha's experience, the small communities of Jamaica enabled her to more easily learn if her partner was cheating. But, in the USA, she noted,

> I'm never going to know unless I see a sign or I happen to just meet you on the road.

Notably, she did not say that men cheat less in Jamaica; rather, her distress was related to learning about the cheating through contracting an STD (which had just occurred).

Thus, from participants' perspectives, larger communities in the US and wider and more anonymous sexual networks fostered greater sexual risk because men's multiple partnerships or infidelity were not as visible, monitored, or socially stigmatized.

Changing sexual mores and norms, especially for women—Differences in women's sexual behaviour between the two locales were perceived to be even greater than those described above for men. Speaking about the consequences for women of having multiple partners, this woman noted,

> And it's easier to…get away with it [in NYC]. But down there, you can't escape it [the gossip], 'cause… they're gonna talk.
>
> ~Jodi, 22 year old Trinidadian woman who migrated at age 14

Not only could women hide multiple partnerships more easily in the US, but in some cases, they could reinvent themselves sexually.

> If a woman has more than one partner… it's easier to hide how many people you've been with sexually here. Because you could have somebody…out-of-state come back here, act like, 'I'm still a virgin' because when I came here a lotta people thought I was a virgin. I lived on it for awhile.
>
> ~Marsha, 21 year old St. Lucian woman who migrated at age 15

Another interviewee spoke of the control of young women's sexual behaviour in the WI by close family networks, which lessened considerably in the USA.

> If I was back home, to be honest with you …I would've been in church. I would've been good, you know? Because…I have people there who would direct me…takin' care of me, makin' sure I go to the right places…up here, I don't have that, okay?
>
> ~Terri-Ann, 19 year old St. Lucian women who migrated at age 16

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As this quote suggests, besides affording access to information about the risks of potential partners, close-knit networks in the WIs were perceived to facilitate moral guidance (at least for women) by supporting and reinforcing traditional values of sexual restraint. By contrast, in NYC women were viewed as being much less restricted sexually and, therefore, less virtuous.

Men were especially likely to criticise women's increased sexual liberties in NYC -- their ability to have more partners and more sex with fewer reputational consequences. In speaking about women who "move around with more than one partner," Owen noted,

> Up here one doesn't care. They just do it and everyone…doesn't know your business.
>
> ~Owen, 40 year old Jamaican man who migrated at age 36

However, as Terri-Ann's comment (above) suggests, a number of women expressed ambivalence about more permissive sexual values and moralised their own behaviour, which they indicated was less respectable than had they stayed in the WIs.

> I have a greater risk here than I do in Jamaica. When I had come here…I always thought that…you only sleep with someone that you're with. Your boyfriend or your girlfriend. Because that's just how I was raised…Here, it's so different… It's like you just used to sleep wit' anybody because you wanna bust a nut. There, actually, because of how you were raised, in like this Christian…environment… you just know that…sex is something sacred. It really has meaning.
>
> ~Nadine, 22 year old Jamaican woman who migrated at age 14

Thus, participants highlighted a kind of double-edged nature to what they perceived as the more liberal sexual mores of US culture. In some ways, NYC fostered greater sexual liberties and more sexual outlets—especially for women, whose sexual behaviour may have been more tightly controlled in the Caribbean. Whereas greater freedom increased sexual possibilities and provided cover for sexually active women, more sexual openness elicited moral disdain for some and a sense that the relative sexual conservatism and more overt gender-differentiated norms of the WIs were preferable.

Access and exposure to information and prevention messages—Perhaps paradoxically, given that interviewees highlighted their increased risk for STDs in NYC from more anonymous sexual networks and more liberal sexual practices, they also noted that being in the US offered them the tools to avoid or cope with these risks. These included general awareness of STDs, more widespread condom promotion, and greater access to STD services.

More openness about sex in the US leads to more disease awareness and openness about safer sex—Participants repeatedly indicated that in NYC it was much easier to encounter information about sex, sexually transmitted diseases, and prevention practices. In fact, it was difficult to avoid this kind of information.

> Here, there's always a poster, there's always an advertisement. Everywhere you turn, there's a flyer showing you that…you need to be protected—you need this, you need that, you need to prevent an STD.
>
> ~Carla, 22 year old Trinidadian woman who migrated at the age of 20

As a recent immigrant, Carla contrasted the saturation of sexual information in NYC with its relative dearth in Trinidad.

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> Whereas in Trinidad, it's not as in-your-face as it is here. […] The awareness is lacking in Trinidad.

Similarly, many participants reported that they lacked awareness of STDs before they came to the USA.

> Like, you would never even think about a STD. You would not even think about it. We knew nothing about chlamydia till we came here [..] The only time you would think about protecting yourself in Trinidad was around Carnival time.
>
> ~ Sonya, 28 year old Trinidadian woman who migrated at the age of 25

In keeping with the theme of more disease awareness in the US, respondents overwhelmingly reported that in the US condom promotion was greater and condoms were more available than in the WIs.

> Like, here, you watchin' TV and every other commercial is about "wrappin' it up" and "AIDS and this and…all that."
>
> ~Nadine, 22 year old Jamaican woman who migrated at age 14
>
> In Trinidad, you don't see the ads, they don't give you condoms. Everything, you have to buy it. And if people don't have the money, they're not gonna buy it. […]
>
> ~ Sonya, 28 year old Trinidadian woman who migrated at the age of 25

The above quotations indicate that the perceived ubiquity of condoms in both advertisements and clinical settings engendered a sense that a culture of safer sex was far more prevalent in NYC than in the WIs.

Some participants also spoke of the lower cost and greater access to STD testing and treatment services in NYC as compared with WI countries of origin.

> Even the family plannin' is not a big thing in Trinidad you don't know where it is. […] There's not like an STD clinic, there's nothing like that.
>
> ~ Sonya, 28 year old Trinidadian woman who migrated at the age of 25

Another woman described how, upon arrival, she immediately took advantage of the free STD clinic in NYC.

> …when I just came here, [I wanted to] be checked out early 'cause […] you have a clinic that you can go to and it's…free at the time.
>
> ~ Keisha, 30 year old Jamaican woman who migrated at the age of 25

In summary, participants perceived a stark difference in overall STD awareness, in promotion and availability of condoms, and in access to STD services between their WI countries of origin and the US. However, even as they noted the differences between the two locales, some participants referred to growing awareness of HIV and other STDs in their home countries, which they suggested was due both to the rapid increase in prevalence of HIV as well as to increasing public health responses to the situation. As Sonya, a recent Trinidadian immigrant (who earlier had emphatically articulated the absence of STD awareness in her country) noted,

> It's just recently. And they still don't do much about it. But they just recently makin' it like a topic now.
>
> ~ Sonya, 28 year old Trinidadian woman who migrated at the age of 25

Therefore, in thinking about alterations in risk due to migration, both place and time need to be considered. We also suggest that regardless of whether place, time, or place and time are

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the *reason* for the differences, the comparisons participants made between their countries of origin and NYC help illustrate how migration can influence people's perceptions and norms relating to sexual health and risk.

Condom use contrasts—Besides noting the greater availability of condoms in NYC, some participants also commented explicitly on US cultural expectations around safer sex.

> When I was in high school [in NYC], when I took my health classes… they tell you…there's no such thing as having unprotected sex. You always have to wear a condom.
>
> ~ Nadine, 22 year old Jamaican woman who migrated at age 14

Expectations for condom use in the US were matched, according to some participants, with a greater frequency of actual use.

> Here, I think people take it [STD risk] more serious. They take it more serious here, because they know it's out there. [..] Back in Jamaica, a man will take more of a chance [i.e., not use a condom].
>
> ~Owen, 40 year old Jamaican man who migrated at the age of 36

Along these lines, another man suggested that people back home may be less motivated to protect themselves due to fewer opportunities for upward mobility in the West Indies.

> Because people down there [Jamaica], they normally don't use condoms. They live for the day. Live for today, but not for tomorrow. Over here, you have a lot of opportunities.
>
> ~Kevaugn, 21 year old Jamaican man who migrated at age 18

Other participants believed that failure to use condoms was common in both settings.

> And even if there is a lot of…sex technology in the U.S. than it is in Grenada, I think it's the same, because some people really don't care…If they wanna have sex with somebody, they'll..just go ahead and act.
>
> ~Nardia 22 year old Grenadian woman who migrated at age 15

Moreover, it was notable that even though participants commented on US cultural norms of expected condom use, none indicated that his or her *own* condom use behaviour had changed as a consequence of migrating to NYC. Rather, changes in condom use (both increases and decreases) were attributed to individual circumstances such getting older and settling down with one partner or becoming infected with an STD. As Brian stated in speaking about his own increase in condom use,

> There have been a change, yeah…I don't even think about it. I just use it [a condom].

Then, responding to a query from the interviewer, Brian added

> Nah, coming here don't have nothing to do with me wearing condoms… It happened to me here, when I get …this STD… After that…very rarely I ain't trying to take no risk.
>
> ~Brian, 21 year old Trinidadian man who migrated at age 16

This last remark illustrates a powerful paradox: whereas many participants experienced a greater perception of risk in NYC from more hidden multiple partnering and lack of information about a potential partner's risk status, they did not alter condom use behaviours in response, despite their perception of wider promotion of and access to condoms.

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Discussion

This study of WI immigrants is one of the few to focus on the HIV/STD risk of this "hidden" (Kasinitz 2001) immigrant population. Despite the large number of WI immigrants living in NYC and other Eastern seaboard cities, and evidence that HIV prevalence is higher in WI than in other US immigrants, strikingly little is known about their sexual health. In this paper, we have begun to fill this gap. We postulated how WI migration characteristics might influence their risk for HIV/STDs and then drew on participants' reflections on sexual risk in their countries of origin and NYC to explore possible pathways to migration-related changes in risk of HIV/STDs.

Contrary to what might be expected among first generation immigrants, we found that a large proportion of participants' sexual partners, especially casual partners, were not born in the WIs. US-born African-Americans constituted the largest ethnic group of sexual partners after WI immigrants. Given that rates of HIV/STDs are higher in NYC blacks than whites (NYC Department of Health and Mental Hygiene 2008), future research might fruitfully investigate how West Indian sexual mixing patterns across racial/ethnic groups might influence STI risk.

Also contrary to our expectations, recent travel to home countries was not common in this group: only seven (12.5%) individuals had done so in the past year. Over a longer period of time this percentage might be larger. However, in this relatively impoverished population, frequent travel seems to be uncommon and, therefore, is probably a less significant risk context than anticipated.

In the qualitative analysis of more recent adolescent and adult migrants, one of the most prominent contrasts pertained to the perceived size and quality of their social and sexual networks. Small close-knit WI communities, in which more was allegedly known about others' behaviours, were perceived as protective against STDs compared to the large and anonymous communities of NYC, where women (as well as men) could—and did—engage in multiple partnerships without fear of detection.

Participants were overwhelmingly aware of, and often favourable toward, greater public discussion of sexual protection in NYC than in their home countries. Some also indicated that they experienced greater social expectations for condom use. Despite being cognizant of these structural facilitators to adoption of safer sex, participants' stories did not indicate a positive effect of these messages on their own condom use.

Our data suggest, therefore, that indirect "partner assessment" was the main safer sex strategy used by these WI immigrants in their countries of origin. Although "knowing' one's partner" (versus condom use) has been described as a common approach to protection among populations in the US (Hoffman et al. 2000), many immigrants' first experience of the fallibility of this approach may have occurred after coming to the USA.

Why these immigrants fail to access prevention tools and services the availability of which they are strikingly aware remains a question for future investigation. But regardless of the links (or lack thereof) between attitudes and behaviour, the present study, through both its synthesis of literature and its empirical findings, has helped to identify elements of a theory of how migration shapes wider sexual contexts, perceptions, and realities.

Although shifts in gender relations were not the main focus of the present analysis, we highlight one important gendered aspect of our findings. Whereas gender inequality in WI societies has frequently been described as promoting the spread of HIV and other STDs (Beckford, O'Sullivan, and Hoffman 2008), restricting women's sexual behaviour is also a

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way of limiting the size of interconnected sexual networks, which may play a role in the rapid transmission of HIV (Shelton 2007). Therefore, in some respects, gender inequality may serve to reduce, rather than exacerbate, risk. We do not wish to suggest by this that women's empowerment is detrimental to their sexual health; rather, we want to resist the longstanding assumption that with greater sexual, social, and/or relationship power, women will always be more protected. Our data suggest in part that shifting gender dynamics can also contribute to situations of increased sexual opportunity, less sexual surveillance, and therefore potentially increased risk.

Limitations

One limitation of this study is that we cannot distinguish developmental changes in individuals or societies from changes due to migration. Our findings also are limited to a particular time and place: rapid change has occurred in WI societies around public discussion of sex; in US cities and neighbourhoods other than the study site access to information and clinics may be more limited. We also are aware that because the sample included people who had migrated as adolescents and adults, their migration contexts varied in ways that we could not fully account for in our analyses. As well, in drawing from life stories, our data are subject to myriad motivations that can diminish their veracity, including participants' remembrances of a rosier past or desire to show success or generate sympathy about their lives in the USA. Of course, perceptions of factors creating risk or safety may not accord with the actual behaviours of participants or other immigrants, and they may not reflect a valid assessment of social environments, either in immigrants' countries of origin or NYC.

Nevertheless, immigrants' views of factors creating greater sexual risk or safety are important because such perceptions may, of themselves, guide behaviour. Viewed in these ways, our data provide insights into immigrants' own understandings of how migration shifts discourses and experiences around sexuality and health, and, in turn, can generate testable hypotheses for future studies aimed at demonstrating links between migration, settlement, acculturation and sexual health.

Future directions for intervention and research on migration and sexual health

The findings of this study can help inform preventive interventions for this high-risk population of WI immigrant men and women. Such interventions need to be grounded in the knowledge of how the social contexts of migration influence sexual health. Sexual health education has a key task: to help immigrants develop the understanding and skills to transition from a more traditional society in which men tend to rely on the social control of women, and both women and men rely on local informational networks concerning "safe" and "risk" partners to a society in which women have greater freedom and access to partners, and local "knowledge" about partner risk is unavailable.

Several issues emerging from this study call for further investigation: How do WI immigrants' perceptions of the appealing (greater sexual freedom), disdainful (loss of virtue), and worrisome (limited knowledge of partners' risks) aspects of anonymity play out over time, and differently for women and men? Do perceptions by some migrants of increased multiple partnering in NYC accord with reality? What accounts for the apparent discordance between greater exposure to safer sex promotion but lack of increased condom use? To what extent does sexual mixing with higher risk US residents or sex during travel to home countries generates risk for WI immigrants?

More broadly, to build theory around migration and sexual health, comparative studies will be critical. Although we have (elsewhere) compared WI immigrants with US-born blacks

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recruited from the same STD clinic as the present study (Hoffman et al. 2008), studies of non-clinic samples – those comparing WI immigrants to global immigrants from other regions, second generation WI immigrants, or WIs residing in their countries of origin will deepen understanding of migration and sexual health.

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Table 1

Demographic characteristics and sexual risk of West Indian immigrant women and men recruited from a sexually transmitted diseases clinic, Brooklyn, N.Y.

	Women		Men	
	Full Sample N = 36	Qualitative Sample N = 16	Full Sample N = 20	Qualitative Sample N = 11
Age – median years	22.5	22	22.5	25
Median age at migration	15.0	19.5	17.5	19.0
Median years in US	8.5	4.0	7.5	5.0
Countries of origin (N)				
- Jamaica	19	6	14	6
- Trinidad	9	6	2	1
- Other WI	9	4	4	5
Education (N)				
- Less than high school	15	8	11	6
- High school	10	2	3	1
- More than high school	11	6	6	4
Employed (N)	24	11	17	9
Gets financial assistance from partner (N)	25	12	7	3
Currently in school (N)	11	6	7	3
Has health insurance (N)	7	2	4	3
Has children (N)	20	7	9	3
Ever incarcerated (N)	1	1	6	3
Ever homeless (N)	5	0	3	3
Known HIV+ (N)	2/31	2/14	1/14	0/7
Number of partners past 6 months				
0	1	1	0	0
1	22	9	4	3
>1	13	6	16	8
Partner risk factors, known or suspected	N = 35*	N = 15*	N = 20	N = 11
- HIV+	0	0	0	0
- Recent STD	15	5	14	8
- Has other partner	31	12	17	9
- Ever IDU	1	0	3	0
- Ever crack	2	0	0	0
- Ever sex with men	1	0		
- Ever incarcerated	16	7		
- Paid partner	10	3		
- Any partner risk factor	32	12	20	11
Traveled to WI, last year	4	3	4	1

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	Women		Men	
	Full Sample N = 36	**Qualitative Sample N = 16**	**Full Sample N = 20**	**Qualitative Sample N = 11**
Had sex with someone from WI during travel	1	1	1	1

*One woman had no partner.

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Table 2

Country of origin and ethnicity of main and other partners of West Indian immigrant women and men recruited from a sexually transmitted diseases clinic, Brooklyn, N.Y.

	Men N = 20			**Women N = 36**		
	Main partners N = 19	**Other partners N = 37**	**All partners N = 56**	**Main partners N = 35**	**Other partners N = 22**	**All partners N = 57**
West Indian-born	16	14	30	29	12	41
Other Caribbean-born	0	2	2	0	0	0
US-born West Indian	0	1	1	0	1	1
US-born African American	2	14	16	4	6	10
US-born white & other	0	3	3	0	1	1
Other	1	1	2	2	2	4
Unknown	0	2	2	0	0	0