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Young women's views on testing for sexually transmitted infections and HIV as a risk reduction strategy in mutual and choice-restricted relationships

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ABSTRACT

Aim: The aim of this study was to identify relationship dynamics that influences the use of STI/HIV testing among young, urban African American women.
Background: Increasing STI/HIV testing is a key prevention strategy, but more research is needed to identify barriers to testing for young women such as intimate partner violence (IPV).
Methods: Thirty semi-structured interviews were conducted with African American women ages 18–24. Content analysis was used.
Results: Women in choice-restricted relationships were unable to negotiate safer sex practices and testing was viewed as the best option. Women in relationships where the desire to use condoms was mutual used STI and HIV testing as a sign of trust building that preceded unprotected sex.
Conclusions: STI/HIV testing must be viewed as one strategy within a package of possible risk reduction. For those in choice-restricted relationships, clinicians should screen patients for partner abuse and provide additional support and referrals as clinically appropriate.

1. Introduction

Despite efforts of the Patient Protection and Affordable Care Act (ACA) that include expanded access to sexual and reproductive health services among vulnerable populations with a history of limited access—young adults, racial and ethnic minorities, and women continue to be disproportionately affected by the disease burden of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) [Centers for Disease Control and Prevention (CDC), 2014]. For example, rates of chlamydia in the year 2013 were twice as high among women compared to men, and young women ages 15–24 had the highest overall prevalence (CDC, 2014). Women are not only faced with disparate rates of infection, but they are also faced with more severe health consequences associated with undetected, untreated infections including pelvic inflammatory disease (PID), chronic pain, infertility, ectopic pregnancy, and an increased likelihood of acquiring HIV (CDC, 2014; Galvin & Cohen, 2004). Rates of chlamydia infection are five times higher among black women than white women aged 15–24 (CDC, 2014) and young minority women also comprise a growing portion of new HIV infections (CDC, 2013). Additionally, women comprise about 25% of all those living with HIV/AIDS in the U.S. (WHO, 2013) and 84% of all new HIV infections in women that occurred in 2010 were attributable to heterosexual contact (CDC, 2013).

Many cases of HIV infection in women are diagnosed very late in the course of their illness (unless they are pregnant and receiving prenatal care) potentially as a combined result of lack of knowledge about HIV/AIDS transmission prevention and treatment, socio-cultural beliefs and barriers regarding HIV/AIDS testing, and barriers to HIV/AIDS counseling and testing (Hernandez, Zule, Karg, Browne, & Wechsberg, 2012; Paxton, Williams, Bolden, Guzman, & Harawa, 2013; Yee & Simon, 2014). It is for this reason that targeted, national public health initiatives have been designed to specifically address disparities in access to screening and promote routine STI/HIV screening for all sexually active people (CDC, 2013; Cohen, Chen, McCauley, et al., 2011). Additionally, initiatives have been designed to promote preventive measures including but not limited to abstinence, limiting number of partners, consistent condom use, expedited partner therapy for STIs, HIV pre-exposure prophylaxis (PrEP), HIV post exposure prophylaxis (PEP), and HIV treatment as prevention for uninfected partners (TasP) (Chin et al., 2012). Evidence-based interventions have been designed to

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specifically address disparities to promote uptake of STI/HIV prevention practices among women, minorities and those who are socioeconomically disadvantaged (El-Bassel et al., 2011; Jemmott & Jemmott, 2000; Strathdee, Mausbach, Lozada, et al., 2009; Villarruel, Jemmott, & Jemmott, 2006; Wingood, Robinson, Braxton, et al., 2013). While significant gains have been made in STI/HIV prevention for women, barriers persist including intimate partner violence.

Intimate partner violence (IPV), or partner abuse, is an attempt to dominate or control a partner and includes acts of physical, psychological, emotional, or sexual violence as well as threats of violence (Wekerle & Wolfe, 1999). Often occurring as a result of gender power imbalances between men and women, such circumstances often leave women in choice-restricted relationships with limited sexual relationship power, or control over one's sexual decision-making (Teitelman, Tennille, Bohinski, Jemmott, & Jemmott, 2011). This type of partner abuse is a form of sexual coercion that can manifest as unwanted unprotected sex with a partner who has other partners or other forms of active interference by a partner with safer sex practices (American College of Obstetricians and Gynecologists, 2014; Teitelman, Tennille, Bohinski, Jemmott, & Jemmott, 2013). Approximately 40–50% of women living in predominantly racial/ethnic minority low-income neighborhoods have experienced some form of IPV (Benson & Fox, 2004; Phillips et al., 2014). Women with a history of IPV indicate that their partner had more power than they did over determining the use of safer sex practices (Beadnell, Baker, Morrison, & Knox, 2000; Pulerwitz, Gortmaker, & Jong, 2000). More specifically, studies have found that young women who are victims of IPV are more likely to fear their partner's response to condom negotiation (Raj, Silverman, & Amaro, 2004), less likely to use condoms (Teitelman, Ratcliffe, & Cederbaum, 2008; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003), more likely to have multiple partners (Wu et al., 2003) and more likely to report having non-monogamous male partners (Bauer et al., 2002; Raj et al., 2004). Women with a history of IPV have a 2.5 times greater risk of ever having had an STI compared to non-abused women (Wu et al., 2003). Similarly, a national study in the U.S. found that 12% of all HIV infections among women were a result of IPV (Sareen, Pagura, & Grant, 2009). Among women living in predominantly racial/ethnic minority low-income neighborhoods with high HIV/AIDS prevalence, 37% reported some type of IPV in the past 6 months (Hodder et al., 2013). Males who perpetrate IPV have higher rates of STI/HIV than those who do not perpetrate (Decker et al., 2009). IPV could interfere with HIV/AIDS counseling and testing as well as violent retribution toward a partner who discloses HIV-positive status (Adams et al., 2011; World Health Organization [WHO], 2004). Recent systematic reviews showed that more research is needed to examine causal relationships between IPV and HIV infection, between IPV and HIV risk behaviors, as well as between IPV and barriers to HIV/AIDS counseling and testing (Gielen et al., 2007a; Luseno & Wechsberg, 2009; Phillips et al., 2014).

Increasing STI/HIV testing, particularly among young adults and women, is a key prevention strategy outlined in the Healthy People 2020 goals (United States Department of Health and Human Services, 2011). As described by a report on preventive services for women released by the Institute of Medicine, "to 'prevent' is to forestall the onset of a condition; detect a condition at an early stage, when it is more treatable; or slow the progress of a condition that may worsen or result in additional harm" (Institute of Medicine (IOM), 2011). On the spectrum of preventative health measures, STI/HIV testing falls into both primary and secondary prevention categories. Among those with STIs or HIV who are screened and treated, testing can be identified as a primary prevention measure that avoids transmission to future uninfected partners. Among those who are screened and treated, it can be identified as a secondary prevention measure that lessens the risk of negative sequelae. Primary prevention strategies, which avoid disease in the first place, are optimal but not always possible. STI/HIV testing is not a primary prevention strategy for those who are found to be infected and are in need of treatment, yet is an important approach for reducing further harms and empowers individuals with retrospective knowledge about their sexual health status.

In 2006, the CDC released new guidelines for HIV testing (Branson, Handsfield, Lampe, et al., 2006), recommending the integration of routine HIV testing into all health care settings and modifying the framework of screening so that individuals would have to opt-out of services if they did not wish to be tested (Branson et al., 2006). This replaced an approach of opting-in for HIV testing after an extensive counseling and consent process. Additionally, the guidelines encouraged health care practitioners to incorporate HIV screening into regular care for all sexually active individuals including adults, adolescents, and pregnant women (Branson et al., 2006). In effect, this shift in framework was a public health prevention measure intended to increase awareness about HIV status, promote access to treatment, and reduce occurrence of disease transmission (Cohen et al., 2011). As a result of integrating screening into regular care and decreasing barriers to HIV testing, recent findings suggest that more individuals are being tested and are aware of their HIV status (Mullins, Kollar, Lehmann, & Kahn, 2010). In order to continue to advance the positive impact of STI and HIV testing and reduce disparities, particularly for vulnerable groups, an understanding of current practices and existing barriers to access is needed.

The following study seeks to understand how relationship dynamics influence young women's use of STI/HIV testing, and explores the ways in which young women are using testing to reduce their risk of infection. The findings presented will contribute to the literature by providing insight into the context in which STI/HIV testing is being used by young women who are at high risk for acquiring infections. This study has implications for clinicians who provide reproductive health services to young women and men, and can also be used to inform future STI and HIV testing campaigns. These findings are part of a larger study examining partner-related factors that influence young women's safer sex practices in healthy and unhealthy relationships to inform the development of future interventions.

2. Methods

Individual interviews were conducted to identify strategies used by young African American women to reduce unsafe sex in their current and prior relationships. Using a semi-structured interview guide, participants were first asked to describe observations of their relationships in order to understand the interpersonal context of sexual decision-making, including their views about desirable and undesirable relationship qualities, what made them want to stay in or get out of a relationship, and the strategies they used to maintain a relationship. The women were also asked to share their experiences related to sex, STI/HIV prevention, sexual decision-making, and relationship conflicts especially pertaining to these topics.

2.1. Sample and recruitment

Young women were recruited from an urban family planning clinic where study flyers were placed in the waiting room and exam rooms. Most participants were recruited from the clinic waiting room by trained members of the research team, and a few called the study telephone number after seeing a flyer or hearing about the study from a friend. Young women who expressed interest in the study were screened for eligibility. To be eligible for the study, women needed to self-identify as African American and be between the ages of 18 and 25. It was also necessary for the participants to speak and understand English well enough to complete the requirements of the study. Once deemed eligible, an appointment was made to conduct the interview at a later date. The study focused on how healthy and unhealthy relationship dynamics influenced STI/HIV risk; therefore, purposeful sampling was used to ensure that at least half of the study participants had experienced some form of partner abuse.