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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—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.

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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.

Keywords

women; STDs; HIV; partner abuse; sexual behavior; prevention

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) ¹. 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 ¹. 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 ^{1,2}. Rates of Chlamydia infection are five times higher among black women than white women ages 15-24 ¹ and young minority women also comprise a growing portion of new HIV infections ³. Additionally, women comprise about 25% of all those living with HIV/AIDS in the U.S ⁴ and 84% of all new HIV infections in women that occurred in 2010 were attributable to heterosexual contact ³.

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 testing⁵⁻⁷. 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 ^{3,8}. 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 ⁹(TasP). Evidence-based interventions have been designed to specifically address disparities to promote uptake of STI/HIV prevention practices among women, minorities and those who are socioeconomically disadvantaged ¹⁰⁻¹⁴. 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 ¹⁵. 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-making¹⁶. 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^{17,18}. Approximately 40-50% of women living in predominantly racial/ethnic minority low-income neighborhoods have experienced some form of IPV^{19,20}. Women with a history of IPV indicate that their partner had more power than they did over determining the use of safer sex practices^{21,22}. More specifically, studies have found that young women who are victims of IPV are more likely to fear their partner's response to condom negotiation²³, less likely to use condoms^{24,25}, more likely to have multiple partners²⁴ and more likely to report having non-monogamous male partners^{23,26}. Women with a history of IPV have a 2.5 times greater risk of ever having had an STI compared to non-abused women²⁴. Similarly, a national study in the U.S. found that 12% of all HIV infections among women were a result of IPV²⁷. 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 six months²⁸. Males who perpetrate IPV have higher rates of STI/HIV than those who do not perpetrate²⁹. IPV could interfere with HIV/AIDS counseling and testing as well as violent retribution toward a partner who discloses HIV-positive status^{30,31}. 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^{19,32,33}.

Increasing STI/HIV testing, particularly among young adults and women, is a key prevention strategy outlined in the Healthy People 2020 goals³⁴. 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"³⁵. 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 testing³⁶, 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 tested³⁶. 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 women³⁶. 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 transmission⁸. 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 status³⁷. 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 way 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.

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.

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 18-25. 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.

Data Collection

The appropriate Institutional Review Board approved this study. Informed consent was obtained prior to each interview. All interviews took place in a nearby university building and were conducted by a research team member. All interviewers were trained by the

Principal Investigator (PI) in conducting qualitative in-depth individual interviews and debriefed with the PI after each interview was completed. On average, the interviews lasted 60 to 90 minutes. After the interview was complete, the participant was asked to fill out a brief health and demographic questionnaire. Participants received \$25 as compensation for their time.

The young women were asked to talk about the strategies they used to protect themselves from STIs and HIV in their current and former heterosexual relationships. Questions included: Who was responsible for preventing STIs and HIV in your relationship? How did you protect yourself from STIs and HIV in your relationship(s)? Did you and your partner ever talk about STIs and HIV? Did you ever have a disagreement about whether to use condoms or not to use condoms? How did you resolve sex-related disagreements?

Data Analysis

All interviews were audiotaped, transcribed verbatim, and checked for accuracy by members of the research team. Each participant was given a pseudonym and the interviews were coded and analyzed by two team members, one primary and one secondary, using Atlas.ti 5.0 software³⁸. Using content analysis, a team member and the principal investigator developed an initial code list, including the definitions of approximately 50 codes based on the topics covered in the interview guide³⁹. The team member doing the primary coding and data analysis met weekly with the principal investigator to discuss any issues with coding and data analysis. In these meetings, emerging themes in the data were discussed and explored. In addition, cross-case analysis was used to compare similar themes and patterns across interviews. Narrative summaries were used to understand the overall story of the participant and connect different pieces of the interview together⁴⁰. Data analysis and data collection were conducted concurrently, allowing for data saturation in relation to the primary aims of the study to be achieved. SPSS software was used to analyze the health and demographic survey⁴¹. The current analyses focused on codes, patterns and themes related to condom use, sexual decision making, relationship conflicts and STI/HIV prevention practices.

Results

Sample Characteristics

The final sample consisted of 30 participants. All participants self-identified as African-American and were between the ages of 18-25. All participants had at least 1 child. Eighty-three percent were single and had never been married. Twenty percent had some high school education, 60% graduated from high school or received their GED, and 20% had at least some college education. Purposive sampling for women who experienced abuse within a relationship resulted in 56.7% who reported experiencing verbal abuse, 50% who reported being threatened, and 43.3% who reported experiencing physical abuse. Nearly half (47%) of the participants reported being treated for an STI and more than two-thirds (67%) had been tested for HIV. None of the participants were HIV-positive.

Safer Sex Choices in Relationships

In the interview, we asked the women to describe what they did to reduce their risk for STI and HIV infection. Most of the young women described using one or more of the following strategies: condom use, practicing monogamy, and STI/HIV testing.

Condom use—Many of the young women in the study held favorable attitudes toward condom use, citing that condoms were an important part of pregnancy prevention and STI/HIV protection. This was especially true in purely sexual or emerging sexual relationships. As one participant, Katrina, explained, “You know, he have his friends and I have my friends so we'll both, like . . . it's an important decision to use condoms to me.” Thus Katrina, like many young women in similar situations, acknowledged she was at risk for STIs/HIV and viewed condoms as a necessity.

Despite this view, condom use did not always persist over time, especially within committed relationships. One participant, Lelani, provided a clear description of this phenomenon: “Actually like, in the beginning . . . we were using condoms but then like . . . I guess deep in the relationship or whatever you wanna call it . . . we weren't using condoms.” Thus, in more committed sexual relationships condoms were often abandoned.

In some instances both the young woman and her partner expressed an equal desire to not use condoms, however, this was not always the case. In relationships where the decision was not mutual, the young women often experienced various forms of sexual coercion by male partners. Sexual coercion described strategies used to persuade a partner to forgo condom use against their will, including emotional manipulation, condom sabotage, and various forms of physical/sexual abuse and threats. For example, Erica described her experience:

I always tried to use condoms...But every time that I tried to make him use a condom, he would put it on and then end up takin' it off or somethin' like that, in the middle of us havin' sex...And one day I had went to the doctors and I had found out that he had gave me a STD so at that point, I don't wanna talk to him or anything like that. I didn't want him to touch me and he got mad about that and forced me to have sex anyway.”

As a result of sexual coercion, many of the young women were unable to use condoms and instead used other strategies, such as monogamy and STI/HIV testing, to reduce their STI/HIV risk.

Monogamy—Participants discussed practicing monogamy, or having one sexual partner at a time as a risk reduction method. In addition to being monogamous themselves, many of the young women sought out partners who they thought were practicing monogamy as well. Nevertheless when reflecting on past relationships, a majority of participants (N=18/30) admitted to being involved with a past or current partner who was not consistently monogamous, placing them at increased risk for HIV and other STIs. One participant, Gena, described the outcome of using monogamy as a primary risk reduction method after having been in a relationship with a man she suspected was not consistently monogamous.

I was just dumb and young like, you know still wanting to be with him and stuff like that and . . . still having sex for him until I realized that one day I had sex with him and I had um, find out I had gonorrhea . . . felt stupid like, “Why should I be staying here?” You know, accepting this (him having sex with other women) and now I got this disease...”(Gena)

While some young women chose to end non-monogamous relationships, many did not or could not leave their partner and instead relied on other strategies to reduce their STI/HIV risk. One young woman who remained in a non-monogamous relationship attempted condom negotiation. She tried to compel her partner to use condoms with her and his other partners in order to reduce her risk of infection:

I asked him, I said, “So do you still . . . Do you still have other partners and stuff? Cause I heard about you with some girl.” And he said “yeah.” I said, “Do you use condoms when you with them?” He said “no.” I said, “But you won't use condoms with me . . .” And he said, “I know” [and she replied] . . . “Like I'm not gonna have sex with you unless you stop havin' sex with the other girls.” (Wanda)

Despite Wanda's attempts to negotiate condom use, her partner continued to refuse to use condoms. As a result, she eventually ended this relationship. While both Gena and Wanda ended relationships in which partner non-monogamy and partner resistance to condom use placed them at high risk for STIs/HIV, other young women described using STI /HIV testing as a risk reduction strategy.

STI and HIV Testing—Almost one-third (N= 9/30) of the sample used STI/HIV testing as a risk reduction strategy. We identified two distinct pathways leading to this decision: *Next-best choice* and *Increasing commitment*. The *Next-best choice* pathway was typically a response to a woman's limited control over her ability to negotiate for safer sex measures, like condom use or mutual monogamy, and was often associated with abusive and controlling behaviors that restricted a young woman's safer sex choices. Those women who chose or felt compelled to stay in a relationship in which there was acknowledged risk (via non-monogamy and condom non-use) mitigated that risk by suggesting STI/HIV testing as a last, but often successful, resort. In the second pathway, *Increasing commitment*, the decision to get mutually tested was the result of a shared desire to start having unprotected sex, a decision commonly made by young women who believed that they were in committed and monogamous relationships. In these situations, mutual testing was seen as a normal step in a relationship's progression to signify trust and commitment. Below are a few exemplar cases to illustrate the two different pathways to STI/HIV testing.

The Next-best choice—Angela's story exemplifies how a partner's refusal to use safer sex measures, despite engaging in high-risk behaviors, can result in the use of testing as a risk reduction method. She described a recent relationship of short duration in which she and her partner were having unprotected sex, when she discovered that her sexual partner was having unprotected sex with a male partner in addition to her. Recognizing her heightened STI/HIV risk, she asked him if they could use condoms to ensure her safety:

Like, right after I found out, I wanted to start usin' condoms and he said, "Why start somethin' new?" There was conflict with that. [He said to her] "It's the same guy [that he was having sex with all along]. Like why start somethin' new?" (Angela)

Despite her desire to use condoms and his engagement in a known high-risk behavior, her partner refused to use condoms. Instead, he told her that because he had been with the same male partner while having unprotected sex with her, there was no new risk. As a result, she then suggested that they get tested together:

That's when I thought about bein' tested because I'd rather be safe than sorry . . . So we sat down. We had an agreement we both went . . . 'Cause I wanted him to get tested. I knew I had nothin' but to make him feel safer I said, "Why don't we both go here [to the clinic]. We'll get all these tests ran 'cause I don't trust that you not gonna bring me somethin'." (Angela)

Thus, although Angela's partner would not agree to using condoms or ending his other sexual relationship, she *was* able to employ an alternative risk reduction strategy: STI/HIV testing. Erica, also described following the *Next-best choice* pathway as a result of a partner's refusal to end his own high-risk behaviors or use safer sex measures. Erica's story, though different from Angela's, also illustrates how her male partner was more agreeable to getting testing for STIs/HIV than he was to practicing monogamy and using condoms (described above). Later, her partner suggested alternative solutions to Erica's desire to remain safe: "We talked, sat down and talked about it and he was tellin' me that he was gonna go to the doctors and he went to the doctors and brung his test results back and stuff like that." Subsequently, he used his negative test results to negotiate for unprotected sex while continuing to have unprotected sex with other women. Erica's story highlights how negative STI/HIV testing results may provide short-term reassurance but might also be used to further pressure a partner into having unprotected sex. Fortunately, both of the young women were eventually able to end their unhealthy relationships as they continued to feel at risk for STIs/HIV and recognized that it did not provide on-going protection.

Increasing commitment—Several participants got tested as a result of following the *Increasing commitment* pathway. One participant, Denise discussed two meaningful past relationships in which she followed the increasing commitment pathway. In both of these relationships, she and her partner started off using condoms and then got tested together before having unprotected sex:

Um, in both my, my son's dad and her [her daughter's] dad, in the beginnin', we did start out usin' condoms, but we only stopped usin' them when we both went to the clinic and got checked out for everything . . . Like if I don't, like if I'm not a hundred percent sure with you, then I know you can't be a hundred percent sure with me. Like you can tell me anything, but I would rather read it for myself and know, and I would rather you have the same results. Read mine, and I could read yours and then we'll both know instead of it bein' secrets. (Denise)

Denise made the mutual decision with both partners to get STI/HIV testing as both a risk reduction strategy and as a method of establishing trust in a committed relationship. She

described both partners as being supportive of this, and the decision to subsequently stop using condoms was mutual.

Cynthia also recalled a moment in a past relationship where she and her partner agreed to get tested prior to having unprotected sex.

It was a . . . it was both of our decisions Not to use them and like, we was together for like, three months or whatever. And he had got tested and I got tested . . . [tested for] gonorrhea, chlamydia, HIV. Those are the only, even though there's way more out there, we got tested for that and we both came back negative so, I just was like, "What's up?" So he's like "What's up?" . . . and then we just started havin' [unprotected] sex. (Cynthia)

Cynthia's story is particularly illustrative of the typical progression of a relationship in which *Increasing commitment* is used. In this relationship the decision to use condoms was mutual, as was the decision to stop using condoms once mutual testing had occurred.

Another participant that described following the *Increasing commitment* pathway was Beverly. Beverly and her partner had a long history together, during which they both agreed to take some time off due to her partner's non-monogamous behavior. During this time, she and her partner both had sex with other people. When they got back together, they agreed that they should use condoms.

"When we broke up for that like six months or a year, it was, like when we got back together like startin' to have sex, 'Yeah, we gotta use a condom, I don't know who you was dealin' wit'." (Beverly)

Both Beverly and her partner understood that their interim partners placed them at risk of infection and subsequently agreed use condoms as their primary safer sex method. Similarly they both viewed mutual STI/HIV testing as a necessary precaution they needed to take before engaging in unprotected sex.

He told me how many, how many people he slept with when we was broke up. I told him how many people I slept with, you know, I was like I just got my AIDS test done. You know, you could see my results. I get a print out, whatever you need to, you know, let's do this. Go to the doctor's, you know, I, I'm open with mine, ain't nothin' to hide, so . . . (Beverly)

After getting tested together, they eventually stopped using condoms, "Um, I mean, I guess after we got comfortable with really, you know, knowin' that we were just exclusively with each other." Beverly's situation provides another example of how the decision to get STI/HIV testing can be a mutual one.

For Cynthia, Denise, and Beverly, STI/HIV testing was considered both an act of trust building and a necessary risk reduction step before having unprotected sex. Initially, their partners were agreeable to using condoms. The women described their journey to unprotected sex upon making the decision to get tested with their partner. Thus, all three of these women had relative control over their safer sex choices and sexual decision making. The experiences of these women differ greatly from the experiences of the women whose

narratives followed the *Next-best choice* pathway, one that resulted from a lack of control over their sexual decision making and lack of options to protect oneself from HIV and STIs.

Discussion

The findings from this study indicate that young women are actively using STI/HIV testing as a risk reduction tool in their relationships. We identified two distinct pathways used by participants that resulted in the use of STI/HIV testing as a safer sex strategy. Women whose narratives followed the *Next-Best Choice* pathway had limited control over their sexual decision-making due to their partner's abuse, participation in high-risk behaviors, and/or refusal to wear condoms. Furthermore, our findings indicated that for young women who had little control over their safe sex decisions, negative test results made it more difficult to negotiate condom use, further undermining one of the most effective risk reduction strategies. These findings are consistent with those of other studies that have shown that abusive and controlling relationship dynamics tend to restrict young women's ability to negotiate for condom use or mutual monogamy, thereby increasing HIV risk^{16,18,23,24,26}. Recognizing this increased STI/HIV risk, these young women chose to negotiate for HIV/STI testing because it was the only risk reduction tool their partners would agree to.

Comparatively, women whose narratives followed the *Increasing commitment* pathway had more control over their sexual decision-making. These women described themselves as being in committed monogamous relationships in which both partners expressed a desire to stop using condoms. Within these relationships, mutual testing was viewed both as a necessary precaution to be taken prior to engaging in unprotected sex, and a trust building tool.

One misconception about mutual testing was that negative results were interpreted as a “go ahead” to have unprotected sex. Although mutual testing *is* a safer sex strategy it only measures risk retrospectively. Thus, for continued effective risk reduction, mutual monogamy, condoms or PrEP are still needed. Another commonly held misconception was, as one young woman described, at routine clinic visits they got “tested for everything.” At a routine STI screening, however, a patient is not usually tested for all STIs. Instead, the tests performed at a routine screening may not include screenings for trichomoniasis and herpes unless the patient reports having visible symptoms that would warrant further testing⁴². In addition, while Human papilloma Virus (HPV) is a very common STI, men are usually not tested for this virus and women under 21 no longer receive routine screening according to current guidelines⁴³. Another common belief was that negative test results are one hundred percent accurate. For HIV, there is an incubation period during which antibodies may not be detected and a negative test result does not always mean that a person is infection free. This window time can last up to 3 months for HIV, and varies depending on the STI⁴³. Therefore, it is important for individuals to consider other primary prevention measures, even if they have received a negative test result. These topics are often covered in STI/HIV counseling but misconceptions persist.

Implications for Policy, Practice and Future Research

One positive aspect of our findings is that there was no apparent stigma associated with STI/HIV testing among this particular population of young women. Secondly, STI/HIV testing was a commonly used safer sex strategy that both partners were generally agreeable to, even in cases where they opposed other prevention methods. This is important because STI/HIV testing raises the chance that individuals who have acquired infections will be identified and can decrease transmission in several ways. First, individuals who test positive for HIV can be started on treatment regimens that may reduce viral load; thereby, reducing potential HIV transmission and the risk of HIV related complications³⁶. In addition, research shows that individuals who are aware of their diagnosis are more likely to employ safer sex strategies, reducing the transmission of HIV and other STIs⁴⁴.

On the other hand, misconceptions about STI/HIV testing can, in some situations, lead to reduced condom use and can ultimately put young women at an increased risk for STIs/HIV. Thus, it is critical that providers and public health educators examine and clarify the messages about the appropriate use of STI/HIV testing. In order to change these misconceptions, providers and public health educators must advocate for STI/HIV testing as a prevention strategy in addition to, but not in place of, other safer sex strategies.

Our findings also indicate that the motivations for seeking STI/HIV testing can be influenced by relationship dynamics. Women in choice-restricted relationships have very limited options for preventing exposure to infections. As a result, the women in our study discussed making the decision to get screened for STIs/HIV as a last resort in an attempt to determine if they already had an infection. Women in relationships where the desire to use condoms was mutual used STI/HIV testing as a risk reduction method and as an important trust building exercise before having unprotected sex. However, women may be largely unaware of the limitations of testing and need to be counseled about the proper use of STI/HIV testing according to their individual situations.

To identify women in choice-restricted relationships, clinicians can make it a priority to routinely screen patients for IPV including sexual and reproductive coercion. Examples of screening questions that clinicians could use to screen for limited sexual control are provided in Figure 1. In the event that screening identifies a young adult in an abusive relationship, clinicians can offer support and refer them to further counseling and/or agencies that can provide additional IPV-specific services. Furthermore, clinicians can offer other harm reduction measures in addition to STI/HIV testing including female condoms, offering PrEP and assessing the need for contraceptives that can be used covertly if needed.

In addition to screening and appropriately referring young women who may be in abusive relationships, it is also important for clinicians to be prepared to screen for and counsel coercive partners, as they are similarly indicated. This is important because the findings presented in the *Next-best Choice Pathway* demonstrate that coercive partners can interpret negative results as a justification to continue to abandon primary prevention methods (to not use condoms and/or have multiple concurrent partners), indicating some individuals may harbor potentially harmful misconceptions. Clinicians can counsel these clients about the pitfalls of their misconceptions, as well as screen them for potential coercive practices.

Furthermore, it is also important to keep in mind that safer sex options may be limited for young men just as it is for young women, as coercive behaviors may present regardless of gender and occur in same sex and opposite sex relationships.

In cases where young women have control over their sexual decision making and mutual testing is seen as a step before safely engaging in unprotected sex, clinicians can counsel clients on the limitations of testing and the importance of continuing condoms use despite receiving a negative test result. To do this, clinicians can clearly explain to their clients which STIs they are and are not being tested for during their visit. In addition, clinicians can stress the importance getting to know a partner and negotiating for mutual monogamy before engaging in an unprotected sexual relationship. Furthermore, as our study indicated that testing was used as a trust-building tool, clients should be reminded that it is important for both members of the relationship to trust and respect each other and that testing should not be a replacement for this. Commonly held misconceptions about STI/HIV testing and important counseling points are provided in Table 1.

Limitations

The findings presented in this paper were volunteered by participants in qualitative interviews when they were asked about strategies they used to reduce their STI/HIV risk in their relationships but they were not specifically asked about STI/HIV testing unless it was brought up by the participant. Additionally, this sample was homogenous in that it was comprised of only heterosexual young women of one race. Therefore, further research is needed to establish how both young women and men in different types of relationships use STI/HIV testing as a safer sex strategy. The findings represent the views of African-American women attending an urban federally funded clinic and may not generalize to all women. Therefore, research is needed with diverse samples to more fully understand how young women view and use STI/HIV testing and how relationship dynamics influences testing behaviors. In addition, recent research shows that substance use is a strong predictor of HIV risk behaviors that often co-occur with IPV, and the confluence of these factors, substance abuse, violence, and HIV/AIDS has been labeled the SAVA syndemic^{45,46}. Future studies should also consider substance abuse as a factor that might potentially interfere with STI/HIV testing and how the factors of SAVA syndemic interact with each other to interfere with STI/HIV testing behavior. Finally, it is important that programs be created to teach young women and men about healthy relationships, the appropriate and effective use of safer sex techniques, and of the warning signs of an abusive or coercive relationship including sexual and reproductive coercion.

Conclusion

Young African American women are actively using STI/HIV testing as a risk reduction tool in their relationships. STI/HIV testing is an important safer sex strategy; however, some may not be fully aware of the limitations of STI/HIV testing. Thus, more research and education is needed to identify and effectively address these issues. Furthermore, among women who have limited control over their sexual decision-making, negative STI/HIV results may be used to limit condom negotiations. Thus, health care providers need to counsel clients about

the use of STI/HIV testing, offer other safer sex strategies and screen for partner abuse including more subtle types that limit control over sexual decision making.

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- I know that not everyone feels comfortable or safe asking their partner(s) to use protection. Would you feel comfortable asking your partner(s) to use a condom or dam?
- How do you think your partner(s) would respond to you asking them to use protection?
- A lot of young people we see want to use condoms but they worry about their partners not wanting to use them. How often does this happen to you?"
- How often have you felt afraid feel afraid to ask your partner(s) if he or she is having sex with other people?
- Have you ever told your partner you wanted to use protection, but they either refused to use a condom or got angry at you or accused you of cheating on them?
- Has your partner ever used their negative test results to try to get you to have unprotected sex?

Figure 1.

Example Screening Questions for Sexual Coercion to identify women in Choice-Restricted Relationships

Table 1**HIV/STI Testing Myths, Facts, and Counseling Points**

Common Myth	Fact	Counseling Point
If my partner and I receive negative test results that means we are no longer at risk and we can stop using condoms.	HIV/STI tests only measures risk retrospectively. Consistent condom use or PrEP is necessary to continue to decrease HIV/STI risk.	Mutual testing is a good safer sex strategy; however, it only measures risk retrospectively. Counsel patients that in order to remain protected, a condom should be used each and every time they have sex. If that is not possible then PrEP may be a good alternative
I got a negative test result – that means I am “all clean.”	Patients are only screened for certain STIs at routine clinic visits. Often patients are not screened for trichomoniasis and herpes unless the patient reports having visible symptoms.	Explain to the client which STIs they are and are not being screened for at their clinic visit.
I received negative test results. This means I am one hundred percent sure I don't have an STI.	A negative HIV test result does not mean that a person is not infected with HIV because there is an incubation period during which antibodies may not be detected.	Counsel clients to continue to use male or female condoms even when they screen negative for HIV because there can be a lag time between being infected and having detectable antibodies.