Sexual health prevention for incarcerated women: Eroticizing safe sex during re-entry to the community

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Abstract

Introduction—In the United States, incarcerated women are disproportionately affected by sexually transmitted infections (STIs) including HIV. Transitioning from incarceration into the community is accompanied by elevated risk behaviours related to acquisition of STIs, yet few efficacious interventions address sexual health prevention among incarcerated women.

Methods—We conducted an exploratory qualitative study with 21 incarcerated women at four women's state prison facilities in two Northeastern states in the U.S.A. Qualitative data were

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Contributorship

All authors contributed significantly to the manuscript. JJ and CZ were responsible for the design and execution of the study. JJ, RR, CZ, and WW contributed to study design, data collection, analysis, and writing. CK and MM contributed to data collection, analysis, and writing with CK taking the lead on this manuscript's analysis and writing.

Competing Interests

There are no conflicts of interest to report.

gathered from 4 focus groups to guide future intervention development. Focus group discussions were guided by a semi-structured protocol exploring perceptions of sexual health prevention methods, experience with implementing prevention technologies and protective behaviours, and strategies to overcome challenges in implementing sexual health prevention behaviours. Focus groups were audio recorded and transcribed verbatim. Data were analysed using thematic analysis.

Results—Women described challenges in uptake of existing low-cost sexual health prevention strategies such as condoms. They identified strategies to facilitate use of prevention tools, and to increase protective behaviours relating to sexual health during the transition from incarceration to the community. For example, women described methods for eroticizing male and female condoms, including selecting condoms with novel features, explaining to partners that condoms could increase sexual pleasure, and incorporating condom application into foreplay and/or oral sex.

Conclusions—Incorporating these insights, including how to eroticize safe sex, can inform the design of future preventive interventions tailored to meet the urgent sexual health needs of incarcerated women preparing for reintegration into the community.

Keywords

incarcerated women; HIV risk; STI; sexual experience; qualitative research

Introduction

Reducing risk for sexually transmitted infections (STIs) is an urgent priority for incarcerated or criminal justice-involved populations in the U.S.A., especially women. Incarcerated women have higher HIV prevalence than men (1.9% vs. 1.5% in 2010).¹ Similarly, the prevalence of syphilis, chlamydia, gonorrhoea, and HIV are significantly higher among incarcerated women compared to the general population.² Disparities in STI prevalence are driven by elevated risks, including unprotected sex, substance use, and mental health vulnerabilities.^{3–8} The period of transition from incarceration to the community is accompanied by increased risk for poor sexual and reproductive health outcomes.⁹ In a study among recently released prisoners, women were significantly more likely than men to report unprotected sex (44% women vs. 21% men, $p < 0.005$).¹⁰ The period prior to release and the reintegration period offer an ideal opportunity for intervention.

However, we have limited evidence to guide effective intervention approaches to promote sexual and reproductive health among women with criminal justice involvement. In a systematic review of 37 HIV and STI interventions for incarcerated and criminal justice-involved populations across the globe, only 12 interventions focused on women.¹¹ We urgently need to develop interventions during the critical period prior to release and during re-integration. Interventions with this population should maximize the use of condoms as efficacious, widely available, and low-cost technologies for prevention of STIs. Even though a strong body of evidence supports the efficacy of male and female condoms to prevent STIs, two recent meta-analyses highlighted a concerning gap between efficacy and effectiveness.^{12,13} This paper examines narratives of sexual pleasure to better understand how to increase uptake of condom use among incarcerated women in future interventions. A

better understanding of how this population incorporates condoms into safe sex negotiation and implementation could significantly advance prevention.

Methods

Patient and Public Involvement and Procedures

The study took place at four women's prison facilities in the United States. All study procedures received ethical approval by Brown University Institutional Review Board (Protocol #1012000314) and by the Departments of Corrections managing the facilities. This study did not involve any patients.

For recruitment, announcements were made in common areas and paper slips were provided for women to indicate interest in hearing more about the study. Trained research staff met privately with potential participants who indicated interest ($n = 47$) to tell them more about the study and to screen for eligibility. To be eligible, participants had to: a) be aged 18 years or older; b) report experiencing at least one lifetime episode of physical or sexual violence or victimization based on the Trauma History Questionnaire¹⁴ and c) report at least one episode of unprotected sex with a male in the thirty days prior to incarceration. We focussed upon incarcerated women with a history of sexual and physical abuse since the literature suggests that this may increase risk for STIs through poor self-efficacy for protective behaviours,^{15–18} impaired ability to assess risk,^{19,20} and emotional dysregulation that can result in responses that elevate HIV risk.²¹

Of the 47 women screened for eligibility, $n=25$ were eligible. All eligible women provided written, signed informed consent, and were told of mandated reporting issues regulated by the state Department of Corrections, and procedures for study confidentiality. Twenty-one of the 25 eligible and consenting women attended the focus groups. Four of the 25 women did not participate because they changed their minds or had scheduling conflicts. Four focus groups were conducted with 3–8 women each. Focus group discussions took place in a private room in each facility and lasted approximately 1.5 hours. Study investigators facilitated the focus groups. Focus group discussions were guided by a semi-structured discussion guide (Table 1).

Discussions focused on experiences before and after prison among justice-involved women in general. Focus groups were audio recorded and accompanied by notes capturing visual affirmations and physical cues important for interpretation of data. To evaluate saturation, we audio-recorded a debrief after each focus group. In each debrief, we evaluated whether or not we were hearing new data. We stopped the data collection process for the specific questions in the interview guide that were not yielding new data.

Data Analysis

Audio recordings were transcribed verbatim. Transcripts were analysed using NVivo qualitative data analysis software (QSR International Pty Ltd), using applied thematic analysis. In this process, three coders (JJ, CK, RR) individually coded the first transcript, creating a personalized list of codes. Coding was initially conducted on the specific concept level (e.g., perceptions of condoms, condom negotiation, etc.). Coders then compared each

of the three lists, compiling and ordering them into a codebook of key topic areas with sub-nodes. That codebook was then used by the trio to individually code the second transcript. After coding the second transcript individually, the group met to compare and verify codes, and reconcile coding disagreements. Disagreements in coding were discussed and consensus reached via a discussion process. At these meetings, the three coders refined their shared understanding of the meaning and use of each code and clarified the definitions in the codebook which was revised as needed. Changes were applied to the first transcript. Remaining transcripts were handled in the same manner. Final codes were subsequently clustered into broader unified themes and constructs including the themes presented here.

Results

Participants were an average age of 35.1 years, primarily identified as White (90.5%), and approximately half had never been married (52.4%). The majority of the sample had been incarcerated for less than a year (71.4%). The demographic details of participants are shown in Table 2.

Perceptions of condoms as not “sexy”

Participants diverged in their opinions of whether condoms were sexy.

Condoms are a “buzz-kill”—One group of participants did not like male and female condoms. This group of participants expressed their dislike for condoms with comments such as, “I don’t like those little buggers.” Three primary reasons emerged among participants who perceived that condoms were not sexy. First, using condoms decreased the feeling of intimacy with partners: “I just want a physical relationship with somebody because I like how it feels to be intimate. I like to feel that closeness. I would prefer to go back to someone I’ve already been with, so I’ll probably use condoms for the first week or two, but then to feel more intimate, I’m not gonna use condoms with somebody that I know.” A second, related reason for disliking condoms was due to the perception that male condoms decreased sexual sensation for partners: “Most men at a certain age, like their 20s, or like 18, 20 years old, they don’t want to strap up because it doesn’t feel the same as having it raw.” Third, participants disliked both condoms because they interrupted sexual foreplay: “It ain’t right when, you’re all tingly, your clothes are half off, and, ‘Oh, we got to use a condom.’ I learned that because it was a buzz killer.” This group of participants seemed to view using male and female condoms as an unpleasant necessity of protecting oneself from disease, summed up in the statement, “I’ll carry ‘em if I have to.”

Negotiating safe sexual pleasure can be challenging—Among participants who felt that condoms were not sexy, negotiating condom use – especially male condoms – emerged as a challenge. Participants preferred the female condom because it was female-controlled, offering women the possibility of preparing for potentially risky encounters: “So, like you put [the female condom] in before you go to the bar or what you gotta do. Yeah, you can keep it in for like 48 hours.” Thus we focus primarily on presenting results related around the challenge of negotiating safe sexual pleasure with male condoms.

Requests for male condom use were often interpreted as distrust in partners, resulting in confrontation. One participant described her partner's likely reaction, saying he would ask, "“Why do you want me to use a condom? Are you dirty? Whore. Where have you been?” ... I feel like I would alter that relationship for the worse. I'll just let him do what he has to do.” For this population, the threat of, or actual, physical and sexual violence was a considerable factor that made negotiation difficult. One woman described condom use during incidents of rape: “I have been attacked, and you know, hit ... I literally lied and said, ‘Use a condom because I have that [HIV]’ Another one, I said I had AIDS. [Then] they're ... gonna use a condom. There's a couple incidents where I ended up blacked out, got knocked out, and I'm not sure if the condom was used or not.” Finally, participants described feeling fearful of losing partners as a consequence of negotiating male condom use: “If a woman says she wants to talk to the man about that, and he's says, ‘Oh, you don't trust me, you don't trust me.’ She's afraid she'll lose him.” This issue of partner loss was particularly salient among women who had few options for housing, social, and economic support upon exit from incarceration. One participant described balancing this vulnerability with the decision to ask a partner to use a male condom: “To me, getting a disease or not getting a disease that can or can't be curable is not worth me losing my house and my money. It's like I weigh it out and I figure, well, you know what, I really don't want to sleep on the street tonight. I really would like to not be dope sick. I'd like to have money in my pocket, so don't use a condom. Do whatever you want. Then, if I get a disease, I have damage control backup [i.e., I can get medications] for that.” Overall, participants who perceived condoms as not sexy described challenges with condom negotiation.

Perceptions of condoms as “sexy”

In contrast, other participants asserted that male and female condoms were sexy due to condom characteristics and how condoms were utilized during the sexual encounter.

Condoms can be erotic—Among these participants, condoms with special features were particularly sexy, features more prevalent for male rather than female condoms. For example, when the facilitator asked the question, “Are condoms sexy?” women responded with affirmative responses for male condoms including: “They can be. Yeah, you can get different colored ones, everything, yeah, glow in the dark.” Another participant elaborated, saying, “I like the ones that they have a flavor because they smell good. I don't like the regular ones that are all rubbery.” The perceptions of condoms as being sexy largely had to do with how condoms were incorporated into sexual negotiation, sexual intercourse, and sexual foreplay.

Strategies for eroticizing condom use for safe sexual pleasure

Some participants were adept at implementing strategies that eroticized condoms. The first strategy focused on negotiating condom use with partners as an opportunity to increase their own sexual pleasure: “I know your erection lasts longer if you wear a condom and I want to be with you for as long as I can.” Similarly, participants described incorporating condoms into sexual role play, thereby contributing to the sexual experience. One participant described how she incorporated female condoms into role play as the “dominant”: “Well, I

like it when a guy doesn't know what they [female condoms] are, and then I can tell him. They think they know everything, but like I said, they really want to be told what to do."

Participants also eroticized condom use by enhancing their partner's sexual experience and/or minimizing partner awareness of, or distraction by, the condom. Participants described covert integration of male condoms into sexual foreplay: "I try to put it on with—like within the excitement, or if I'm giving somebody oral sex, like I'll put it on while I'm doing it, like I try to put it in with what we're doing, so it doesn't turn into a kill, especially if you're with a person for the first time, it's like I want to enjoy it. It's somebody you really enjoy; you want to try to mix it in." Other participants described more overt methods including selling condoms as an opportunity to "sexually experiment": "I think that men actually like using a female condom because not so many females use it, so it's a new experience for them, so they like it. They want to try it, be something new for sex."

Finally, participants were adept at negotiating condom use, particularly male condoms, even with partners who were resistant. Strategies focused on flattering partners in regard to their sexuality: "I always make that guy feel good. I said, 'Uh-oh, for you it's the extra-extra-L [condom].' I make him feel good about [wearing a condom], so he always wear." The woman was aware that male condoms must fit properly to be effective, and would make this statement regardless of the actual size of the condom being used. In summary, participants who perceived condoms as sexy viewed condoms as sources of both pleasure and protection. This was articulated well by one participant: "I think that it's good to know how to please your man. It's a big turn-on, so in order to be safe and please at the same time."

Discussion

This study explored narratives of sexual negotiation among incarcerated women at high risk for STIs, especially focusing upon condoms as an accessible but underused prevention technology. One group of participants felt that condoms were not sexy, largely to do with the perception that condoms decreased sexual pleasure for themselves or partners or interrupted the spontaneity of sex. These participants viewed condoms as a necessary but unpleasant tool for protecting themselves from STIs or pregnancy. For the most part, these women described poor self-efficacy for male condom negotiation but not when using female condoms. Participants described fear of physical or sexual violence reprisal upon requests for male condom use, and fear of partner loss particularly when faced with uncertainty in regard to housing, social, or economic support. Studies with at risk populations of women show similar results, suggesting that negative condom attitudes are associated with poor self-efficacy, risk for partner violence,²² and increased socioeconomic vulnerability.^{23,24} Negative attributions may be related to gender inequality and circumstances that make it difficult to refuse sex.^{25,26}

In contrast, a second group of participants perceived male and female condoms as sexy because of their potential to be utilized as tools for simultaneous protection and pleasure. The physical characteristics of condoms – colour, texture, taste – contributed to perceptions of condoms as sexy. Strategies for eroticizing condoms during sex included incorporating condoms into role play, foreplay, sexual experimentation and by using flattery. Eroticizing

condom use emerged as a strategy to increase sexual pleasure while negotiating condom use with resistant partners. These narratives are consistent with the more recent shift in the sexual and reproductive health literature on the importance of positive motivations for safe sex in public health messaging.²⁷

Our findings suggest a need for interventions that emphasize erotic, yet safe and consistent condom use. One limitation of this study is the focus upon women's perspectives; more research needs to be done to elicit male partners' perspectives. Yet our findings indicate that tailoring for this population may boost women's safety, both in terms of STIs and their ability to implement erotic yet safe sexual behaviours during negotiation with potentially violent partners.

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Key Messages

- Incarcerated women are disproportionately at risk for acquisition of sexually transmitted infections in the transition from incarceration into the community due to social and economic vulnerability linked to their recent incarceration.
- Incarcerated women described motivation to engage in preventive behaviours – including condom use – when these behaviours supported sexual pleasure.
- Future interventions that incorporate preventive behavioral training emphasizing sexual pleasure may be effective in reducing risk in this population.
- Exploring challenges experienced by this population during the period of transition from incarceration back to the community can guide the development of tailored sexual and reproductive health intervention to better meet this population's needs.

Table 1.

Interview Guide

Perceptions of male and female condoms	
1. What do you think about condoms?	i) Male condoms ii) Female condoms
2. Where can you get male and female condoms in the weeks after you leave prison?	i) How hard/easy is it to get them soon after prison release?
3. What do male partners think about condoms?	
4. When do women talk with partners about using condoms?	i) How does that conversation go? ii) What can be difficult about that conversation?
5. Are condoms sexy?	i) Can you make them sexy?
6. Do you think women should be ready to put a condom on a man or to use one themselves?	
7. How does any of this change when a woman thinks her partner might be violent?	
8. Do you think that women can talk about condoms with their partners without getting hurt?	

Table 2.

Demographic Characteristics of Participants

Demographic Details	Sample of N=21 Participants
Age	Mean age 35.1 years (Range 19–60 years)
Race/Ethnicity	
White	90.5%
Other (mixed race)	9.5%
Marital Status	
Never married	52.4%
Married or living with someone as if married	28.6%
Separated	19.0%
Incarceration Length	
Less than a year	71.4%
1–3 years	28.6%